COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY OF SERVICES TO MEET THE DEVELOPMENTAL NEEDS OF WESTERN AUSTRALIA'S CHILDREN

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in the 38th Parliament

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Community Development and Justice Standing Committee

Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children

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INQUIRY INTO THE ADEQUACY OF SERVICES TO MEET THE DEVELOPMENTAL NEEDS OF WESTERN AUSTRALIA'S CHILDREN

Report No. 1

Presented by:
Hon A.J.G. MacTiernan, MLA
Laid on the Table of the Legislative Assembly
on 13 August 2009

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COMMITTEE'S FUNCTIONS AND POWERS

The functions of the Committee are to review and report to the Assembly on: -

(a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

(b) annual reports of government departments laid on the Table of the House;

(c) the adequacy of legislation and regulations within its jurisdiction; and

(d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual reports of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

INQUIRY TERMS OF REFERENCE

That the Committee will examine and report by 31 July 2009 on:

(a) whether existing government programs are adequately addressing the social and cognitive developmental needs of children, with particular reference to prenatal to 3 years;

(b) how to appropriately identify developmentally vulnerable children;

(c) which government agency or agencies should have coordinating and resourcing responsibility for the identification and delivery of assistance to 0-3 year old children;

(d) what is the best model to ensure interagency and intergovernmental integration of developmental programs delivered to 0-3 year old children;

(e) how to best prioritise the resources available for meeting the needs identified;

(f) what is the most appropriate measure of program outcomes; and

(g) any other related matter deemed relevant by the Committee.

CHAIR'S FOREWORD

This is the first report of the Community Development and Justice Standing Committee of the thirty eighth Parliament. This Report finalises the Committee's Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children.

As a community we are investing heavily into researching and understanding the extraordinary reality of a child's development in utero and during its first few years of life. At the same time there is strong evidence that the complexities of modern living and family structures are resulting in many children achieving fewer developmental milestones in those early years. This entrenches a disadvantage that undermines the child's capacity to enjoy a secure and fulfilling life. Disadvantage and vulnerability impact our community, reducing our productive capacity, increasing crime and affecting the community's sense of well being.

There are a range of causes suggested for the growing number of children with developmental vulnerability, including the role of television suppressing conversation in the home, pressures on working parents and the impact of family breakdown.

This Report makes it clear that whatever the cause of these problems we need to make more effort to share the growing knowledge of child development with parents and other child carers and to support parents in strengthening their skills.

Universal support programs delivered by child health nurses need to be restored to the levels enjoyed twenty years ago. The medium used in providing information to parents also should be updated.

At the same time vulnerable populations will need more targeted and resource intensive help, both in parenting skills and in preparation for school.

Childcare must be more highly valued and childcare workers properly trained and remunerated. Coordination of the government delivery of early years services needs much greater attention.

And, finally, real attention must be given to mandating phonics as the bedrock of our teaching of reading and writing.

I thank my fellow Committee members for their insightful and often passionate contribution. We were all profoundly affected by the evidence and developed a strong united view on what needs to be done to enhance the opportunities for vulnerable children.

I would also like to thank very much Dr Brian Gordon our Principal Research Officer and Jovita Hogan who worked hard in the compiling of this Report, in organising our visits to communities, and the public forum on literacy. Your enthusiasm for this subject is much appreciated.

HON A.J.G. MACTIERNAN, MLA
CHAIR

ABBREVIATIONS AND ACRONYMS

- ACT Australian Capital Territory
- AEDI Australian Early Development Index
- AGACCS Australian Government Approved Child Care Services
- CaLD Culturally and Linguistically Diverse
- CCRCC Child Care Regulations Consultative Committee
- COAG Council of Australian Governments
- DECS Department of Education & Children's Services (South Australia)
- DET Department of Education and Training
- DCP Department of Child Protection
- DfC Department for Communities
- DoH Department of Health
- DSC Disabilities Service Commission
- ECEC Early Childhood Education and Care
- EIP Early intervention program
- ESP Extended Scope Practitioner
- FaHCSIA Commonwealth Department for Families and Housing Community Services and Indigenous Affairs
- FAS Foetal Alcohol Syndrome
- FASD Foetal Alcohol Spectrum Disorder
- FDC Family Day Care
- FTE Full Time Equivalent
- KEMH King Edward Memorial Hospital for Women
- IPSP Inclusion and Professional Support Program
- ISP Inclusion Support Program
- LDC Long Day Care
- LSAC *Growing Up in Australia* a Longitudinal Study of Australian Children
- MCEETYA Ministerial Council on Education, Employment, Training and Youth Affairs
- MEYP Municipal Early Years Plan
- NGO Non-government Organisation
- NIFTeY National Investment for the Early Years
- OCECD Office for Children and Early Childhood Development (Victoria)
- OECD Organisation for Economic Cooperation and Development
- PAWG Productivity Agenda Working Group
- PDC Pilbara Development Commission
- PIs Performance Indicators
- PMH Princess Margaret Hospital for Children
- SES Socio-economic Status
- TCCP The Centre for Cerebral Palsy
- WA Western Australia

GLOSSARY

Cohort: a well-defined group of subjects who have something in common - in this Report it may refer to an age or socio economic grouping.

Early childhood: for the purposes of this Report, while early childhood is defined as 0-8 years of age; it should be noted it does not exclude children before they are born.

Early childhood intervention: early childhood interventions are formal attempts by agents outside the family to maintain or improve the quality of life of young children, starting with the prenatal period and continuing through entry into school.[1]

Early remediation: identifying and addressing problems before they become entrenched or lead to other problems.

Evidence-based policy: policy based on reviews and meta-analysis of robust research studies.[2]

Extended scope practice: defined as professional practice that, while recognised and validated, exists at the very periphery of professional boundaries, often unconventional and challenging.[3]

Foetal Alcohol Spectrum Disorder: a range of disabilities caused by exposure to alcohol in the womb

Intervening at critical transition points: intervening along a causal pathway of a child's development.

Pari passu: of equal standing, equably.

Pedagogy: the art of teaching.

Prevention: intervening before problems develop.

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1 Professor Collette Tayler, 'The policy challenges in early childhood and early intervention', 2006. Available at: www.premiers.qld.gov.au/library/scripts/objectifyMedia.asp. Accessed on 26 March 2009.

2 Argyrous, G, *A practical guide for evidence for policy and decision making*, UNSW Press, Australia, 2009, p5.

3 Carr, P., 'Review of extended scope roles in professions allied to medicine', Available at: http://www.chl.wales.nhs.uk/resource/electives/report-peter.pdf. Accessed on 16 April 2009.

Synthetic phonics: refers to an approach to the teaching of reading in which phonemes [sounds] associated with particular graphemes [letters] are pronounced in isolation and blended together (synthesised). For example, children are taught to take a single-syllable word such as *cat* apart into its three letters, pronounce a phoneme for each letter in turn /k, æ, t/, and blend the phonemes together to form a word. Synthetic phonics for writing reverses the sequence: children are taught to say the word they wish to write, segment it into its phonemes and say them in turn, for example /d, ›, g/, and write a grapheme for each phoneme in turn to produce the written word, *dog*.[4]

[4] National Literacy Trust, 'Definition of synthetic phonics',. Available at: http://www.literacytrust.org.uk/Database/primary/phonicsdef.html. Accessed on 7 August 2009.

EXECUTIVE SUMMARY

The wealth of scientific research around childhood development is truly staggering. Importantly that research tells us that a child's intellectual, emotional and social development are deeply interconnected and that experiences in the first three years of life are critical for optimum development in all these areas.

At the same time detailed data particularly from Australian Early Development Index (AEDI), and anecdotally from teachers, show that many children are presenting at school at four or five years old with one or more developmental vulnerabilities. This severely compromises their capacity to learn and to be successfully integrated into the school community.

The Committee took evidence on the causes of developmental delay and what strategies could be used to improve the learning opportunities for a child prior to arriving at school. The Committee also looked at the basic teaching framework for early school years and the implications various frameworks had for delivering successful outcomes for children with developmental vulnerabilities.

It is the Committee's view that the failure to provide so many children with a better developmental platform is depriving them of an opportunity to live a fulfilling life and has grave social and economic consequences as a whole.

It is the Committee's view that the Governments, state and federal, need to engage far more extensively in the development of young children 0-4.

The Committee takes the view that enhancing the understanding and skills of parents in child development, both ante natal and post natal, is critical to this task. The Committee recognises that there is a wide range of health care and support programs, but that in most instances these are of inadequate reach and insufficiently coordinated.

In particular:

- There must be a more concerted effort to ensure all parents have the opportunity to understand their child's developmental needs and how they can best meet their child's needs.

- In the view of participants to the Inquiry, Western Australia lacks an integrated guiding framework for early childhood at the state policy level. As a consequence the capacity of both government and non-governmental providers has been less than optimal. It has also impeded opportunities to successfully tackle the volume and complexity of early childhood needs in an integrated fashion and resulted in duplication and inefficiencies.

- Services are often fragmented and lack coordination. The lack of coordination and collaboration in early childhood services in Western Australia exists across various levels of Government, between different Government agencies as well as with the non-

government sector. There is evidence of consequential frustration for families and their children as well as for front line early childhood service providers.

- There are significant issues of access and resourcing. Despite the increasing population and the changing complexity of families needs, there has been a per capita reduction in the resourcing of allied health services. This has led to a narrowing of eligibility criteria.

The Committee has made a number of consequential recommendations. The Committee is also of the view that a clear best practice evidence based early years education and reading syllabus needs to be developed and entrenched into our schools.

Chapter One outlines the background to the establishment of the Inquiry, together with the parameters and conduct of the Inquiry.

Chapter Two contextualises the Inquiry. It considers the various stages of physical, social, and psychological growth that occur even before birth and the factors that affect development in the early years.

Chapter Three frames the prevailing economic argument for government intervention in early child development. This increased scrutiny on the economic benefits of investing in early childhood represents an evolutionary shift in the focus of our policy settings. It has arisen in the light of a the growing recognition that early identification of behavioural and developmental problems and the subsequent treatment and management of these issues promotes positive long term social, emotional, health, education and employment outcomes. Failure to implement effective intervention strategies in the early years necessitates a range of intervention strategies in adult life in the health, justice and welfare environments. These are often more expensive and less effective.

Chapter Four The Federal Government has launched two interrelated initiatives collecting relevant, coherent and systematic data to support evidence based policy to guide Early Childhood Education and Care (ECEC) practice. These are:

- The Australian Early Development Index (AEDI)
- *Growing Up in Australia* a Longitudinal Study of Australian Children (LSAC)

This chapter reviews these two initiatives in particular as they relate to Western Australia.

Chapter Five provides a demographic backdrop to Western Australian services; together with an overview of those services as detailed by state government agencies.

Chapter Six In December 2007, the Council of Australian Governments agreed that the Commonwealth Government and state and territory governments would work in partnership to develop a National Quality Standards Framework for early childhood education and care and an Early Years Learning Framework. This chapter looks at the lack of a complementary Western Australian 'early years' framework and the consequences of that deficiency together with the fractured nature of service delivery and the need for collaboration, if services are to be improved.

Chapter Seven details concerns raised by government and non-government agencies, and professionals, in relation to services in the early childhood sector. It also canvasses some possible ways forward.

Chapter Eight In recent years there has been a significant move to what is known as 'evidence based policy'; in other words, policy that is informed by evidence. This forms the premise of most Western Australian government funded initiatives in early childhood. This chapter briefly reviews the extent and adequacy of the data collection and the evidence underpinning those initiatives.

Chapter Nine This chapter considers some of the factors contributing to school 'unreadiness' along the continuum of family, community and school. In doing so, it looks at the related process of the successful transitioning of children in early childhood care and education settings. In particular it considers the value of an integrated model of service delivery that may be delivered through these early childhood settings, linking parent support, education, health and child care programs as a possible response to this 'unreadiness'.

FINDINGS

Page 21

Finding 1

The learning that occurs during the first three or four years after birth, affects the very architecture of the brain. This places children on developmental pathways that become increasingly difficult to alter as time passes. In recent years changed social circumstances have made parenting of young children a more challenging and stressful business than in the past. With this change in the social environment there is a role for governments to provide more support to parents to enhance their effectiveness as parents.

Page 30

Finding 2

There are significant economic benefits to be gained by investing in early childhood with reported returns on investment of up to $17 for every dollar spent. In particular, significant savings are achieved by investing in disadvantaged, or 'at risk' infants. Savings made include the number of specialist therapists required, the lack of need for remedial education and intervention for behaviour management. In addition there is a reduction in long-term human and social costs (including mental disability, increased medical service usage, chronic health problems, lost productivity, juvenile delinquency, adult criminality, homelessness, substance abuse and intergenerational transmission of abuse). Instead the next generation will pay back the initial investment through a lifetime of productivity and responsible citizenship.

Therefore, government decisions regarding investments in early childhood development would benefit through greater attention to the long-term societal benefits relative to the program costs incurred.

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Finding 3

There is no well developed Western Australian overarching framework for the early years nor an 'early years whole of government strategy'. This inhibits Western Australia's capacity to do what the evidence shows is best for children. This also is a major contributor to the lack of collaboration and coordination between service providers.

Page 79

Finding 4

In the absence of a collaborative or integrated approach to service delivery, there is a fragmentation of services. This fragmentation of services leaves many families without a clear pathway for support.

The Committee believes that the absence of an Early Years Framework impedes successful collaboration. The lack of collaboration, in turn, is currently preventing substantive progress in the effective improvement of early childhood education and care services. If this situation is not addressed and accompanied by a parallel commitment to long-term action, there are negative implications for both Western Australia's economy, and its social fabric.

Page 86

Finding 5

The role of the recently created Office of Early Childhood Development and Learning has yet to be finalised. There is however a broad based sector wide agreement on the need for such a coordinating office.

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Finding 6

The child health nurses' visitation program is, in practice, no longer universal as the number of child health nurses has declined, on a per capita basis, across the State of Western Australia. The reduction in available support restricts access to this key link in early childhood health services. Given the child health nurse's role in our community, as 'an early warning and intervention system in identifying a wide range of early childhood disorders', this is a major shortcoming and indeed a regression in the provision of services to young children.

Page 95

Finding 7

The rapidly increasing Western Australian population together with the changing complexity of developmental concerns has outstripped the resources of allied health services. This has led to a reduction in accessibility to a number of support services. The position is compounded by the limited number of WA graduates in some disciplines, such as speech pathology.

Page 97

Finding 8

At a critical time of a child's development there are significant waiting lists for therapy or related intervention. In a significant number of cases, this compounds existing behavioural problems and may have life-long consequences for some Western Australian children.

Page 99

Finding 9

Internationally and nationally there are a number of alternative approaches which seek to address the deficits of service delivery, involving a range of allied medical professionals. Such initiatives attempt to improve the character and nature of the processes involved. The most far reaching of these is the creation of the role of the 'extended scope practitioner'. Other strategies with proven value include interdisciplinary and trans-disciplinary approaches.

Page 100

Finding 10

No data is currently maintained across services that would reflect the present adequacy of service provision or the referral system for families and children. Such anecdotal evidence as exists suggests that there are significant delays in seeing a specialist at a critical time of a child's development.

Page 103

Finding 11

There is a need for improved referral pathways for the developmentally vulnerable in the early childhood sector. Anecdotally, many families in need of support services 'get lost' due to confusion in negotiating the multi-layered early childhood maze of programs and related services.

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Finding 12

The current system is particularly failing families of children with special needs, including children with a disability or a developmental delay. These families have to navigate not only universal services, but also specialist and allied health care. They often experience long waiting times for specialist and allied health services, especially in rural areas, and poor continuity of care.

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Finding 13

While recognising the recent Federal mandating of hearing screening of newborn children to take effect in 2010/11, in the interim there remains a problem for children not yet screened. Limited resources restrict the capacity of school nurses to provide adequate hearing screening and ongoing support. The result is reduced language and literacy skills in the first year(s) of schooling.

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Finding 14

There are major systemic issues in Indigenous communities in the North-West of Western Australia leading to a high proportion of children being developmentally vulnerable and unready for schooling.

Page 123

Finding 15

There is inadequate access to services offered by allied health professionals in the North-West. This is attributed to a lack of resources, both human and financial.

Page 123

Finding 16

There is a shortfall in the provision of accessible child care places in the Pilbara and anecdotally in some other regional areas. This is despite the involvement of the State and Federal governments and major mining interests in some regions. This problem is exacerbated by the transient nature of the population and the consequent absence of family support. This leads to the use of unlicensed child care with uncertain developmental outcomes.

Page 127

Finding 17

There is a perceived lack of resourcing for early child development in regional communities, when measured against the needs. Limited resources are exacerbated by the geographical distances involved and low population density, as well structural and process issues. In addition some services are considered to have been initiated in an ad hoc manner and are not sustainable.

Page 127

Finding 18

The difficulty experienced by disadvantaged groups in accessing services in regional areas is compounded by difficulties in securing transport to available services.

Page 129

Finding 19

Even where positions have been allocated there is a high level of turnover amongst health professionals in some regional and remote areas. In part this is because of the cost of living and more particularly the absence of adequate housing and in some cases of any housing in these areas. There are also lifestyle issues and staff burn out which contribute to high turnover. High turnover not only leads to positions been vacant for extended periods but loss of experience and institutional memory.

Page 133

Finding 20

At-risk Aboriginal families often will not engage in general support programs for a range of reasons. There is also evidence that programs specifically and sensitively targeted for Aboriginal communities can overcome this barrier,

Where at risk families do not respond to normal overtures robust interventions are needed if we are to break the cycle of poverty and despair.

Page 138

Finding 21

Foetal Alcohol Spectrum Disorder (FASD) affects the development of a significant number of children born in some regions of the state. FASD is an intergenerational and escalating issue which impacts whole-of-life outcomes and requires intensive and ongoing support to enable any level of remediation. The long-term development of children born with FASD is therefore severely compromised. The problem is exacerbated by the lack of existing appropriate services and support programs.

Page 144

Finding 22

There is a lack of Western Australian data around the level of need of client groups and on outcomes. There is currently no systemic way of determining whether the financial investments are having the desired impact of improving specific outcomes for children and young people. This impedes the determination of program design, relevant policy development and optimal resource allocation.

Page 145

Finding 23

Western Australia currently lacks the capacity to monitor specific outcomes for children as they grow into their early teens and as young people and does not have any detailed information as to how Western Australian children are faring on key health, education and social inclusion indicators.

Page 163

Finding 24

Playgroups perform a critical role in providing opportunities for children's social, emotional, physical and intellectual development, while also providing opportunities for parents and caregivers to establish social and support networks to encourage and assist them in their parenting role.

Supported playgroups can perform an important additional role of modelling for parents methods of engaging with their children and so enhance their development. There are sound developmental and practical reasons for these playgroups to be collocated with primary schools.

Page 167

Finding 25

While the standards set by the National Child Care Accreditation Council require child care service providers to maintain a record of each child's progress, there is no consistent system to ensure that where developmental problems are identified that the child is referred for a formal assessment e.g. within the child health system.

Page 173

Finding 26

Increasing numbers of West Australian children are spending time in child care. The care and qualifications of child carers influences the child development outcomes and therefore school readiness. In relation to quality, there is a widespread concern by those connected with the child care sector that over the past two decades the focus has been on parents as consumers, and children as a corporate commodity. This has resulted in a weak child development agenda. This has been reflected in the minimal requirement for qualifications and generally poor remuneration in the industry.

Page 175

Finding 27

A contributing factor in the lack of school readiness of some children is the need for families to create a patchwork of unrelated child care arrangements for individual children, with up to eight different arrangements in a week. This acts as barrier to access and disadvantages some of those children affected by the need for such arrangements.

Page 178

Finding 28

Developmentally vulnerable children benefit from a quality three year old kindergarten program and/or pre-primary school.

Page 183

Finding 29

While there is recognition of the needs of children from culturally and linguistically diverse families, services supporting the development of these children are limited. The lack of appropriate services is exacerbated by difficulties that may arise due to language difficulties and incongruence in values and practices between home and care environments.

Page 187

Finding 30

There is widespread support in the government and non-government sectors for the development of an integrated range of services in the health, care, and education arena, usually co-located, working in a multi-agency way for the development of young children aged 0-8.

Page 188

Finding 31

Schools provide a low threat environment for families requiring support in meeting the developmental needs their children

Further, actively integrating pre-school (0-3 years) learning into the school experience is enhanced by the successful transition of children from their first learning experience to their next. Therefore schools are an ideal environment for the delivery of parent support for the 0-3 year old cohort.

Page 189

Finding 32

There is a general consensus around the need to interlink early education, child care, health, and parenting support programs and services. The benefits of linking early child development services include improved access for parents and care givers to a range of support services, a more efficient use of resources, and, through information and skill sharing, more knowledge amongst the staff of providers of those services.

Page 193

Finding 33

Optimally, integrated services are seen to be more than the co-location of services. Child development centres are understood to provide a suite of programs across the care, education, social services and health sectors, in a seamlessly linked and a mutually supportive environment.

Page 205

Finding 34

Around Australia there is an increasing recognition of the value of bringing health, care, and education into one co-located integrated service centre. Each such centre offers different services; depending upon contextual community needs, government priorities and funding. Most of these centres have been located in disadvantaged communities and link into related existing services to supplement their own suite of services. This approach is seen to provide an effective approach to existing child development issues relating to health screening, the fragmentation of services, and the patchwork of child care services. It is also seen to improve access to support for parents and children and to improve school readiness, enhancing a child's opportunities in school life.

Page 218

Finding 35

Current AEDI and NAPLAN results highlight deficiencies in the existing approach taken to teaching literacy and numeracy. In response to these results and to recent research there has been a growing awareness in the Department of Education and Training of the need to place a stronger emphasis on the teaching of literacy using phonics. This increasing emphasis is in line with the findings of Australian and international inquiries into the pedagogy of literacy in the early years. However there appears to be no strong curriculum development supporting these recent moves on the teaching of phonics.

RECOMMENDATIONS

Page 22

Recommendation 1

Recognising the scientific evidence of the critical development pathways that occur in utero and in the first four years of life, together with the evidence that many children are commencing school with significant developmental vulnerability, the Committee strongly recommends a major investment to share with parents the growing understanding of child development and to enhance support in developing good parenting skills.

Page 22

Recommendation 2

The Committee recommends that the Department of Health provides new parents, on a universal basis, with a quality, engaging DVD detailing a child's developmental stages and clear information as to how they can best assist in their child's development; and that maternity hospital staff be requested to promote the viewing of it.

Page 22

Recommendation 3

The Committee recommends that the Minister for Health proposes to the Commonwealth Minister for Families, Housing, Community Services and Indigenous Affairs that the receipt of the baby bonus be linked to attendance at post natal parenting classes.

Page 80

Recommendation 4

The Committee strongly recommends that the Government develops a whole-of-government perspective with respect to early childhood and places all the relevant health, care, education, and parent support programs under the banner of Early Development within one Ministerial portfolio; with the exception of the statutory intervention services of Department of Child Protection.

This will address the lack of coordination and collaboration in early childhood services in Western Australia. This lack currently exists across various levels of government, between different government agencies as well as the non-government sector.

The Committee recognises the positive step forward taken in the creation of an Office of Early Childhood Development and Learning, but believes that a single responsible Ministry is the most effective way of breaking down the barriers impeding the delivery of cost effective, meaningful, programs and services.

Page 92

Recommendation 5

That the Auditor General reviews the accuracy of the reported performance of the face to face contact program (in home of other place) as reported by the Department of Health - via the Child and Adolescent Health in the metropolitan area and the Area Health Services in regional areas.

Page 92

Recommendation 6

The Committee strongly recommends that the Government, as a matter of urgency, restores the number of full time equivalent child health nurses delivering the home visitation program and operating child health centres, on a per capita basis to levels prevailing in Western Australia in the 1980s, since which time the number of child health nurses has significantly declined on a per capita basis.

This improvement is critically needed to restore the efficacy of a fundamental universal community health service, thereby ensuring that all families and children receive appropriate, timely, accessible guidance and support. All evidence is that the need for such a service is increasing and not decreasing.

Additional resources should be provided to allow the child health nurses to actively promote and encourage regular developmental checks on children from nine months to pre-school.

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Recommendation 7

There is clear requirement for cohesive, consistent and seamless clinical services designed around the needs of all children and their families and communities, to be developed to improve service delivery in line with such concepts as the '*one stop shop*' or the '*no wrong door'* approach. This approach would resolve the need for those needing to access a service having to go from agency to agency or office to office, to string together a response to their need.

The Committee recognises that pending the drawing together of early childhood services under one Ministry this strategy will need to be taken forward within the existing departmental structures. Accordingly, the Committee recommends that the Department of Health, within twelve months, consultatively improves referral pathways for the developmentally vulnerable, creating effective linkages between key services to ensure a continuum of care for families.

Page 104

Recommendation 8

While in the long term the aim must be to reduce the need for intervention by therapists, there is nevertheless an immediate demand to dramatically improve the availability of remedial therapists.
The Committee strongly recommends that to address the undersupply of therapists for children, the Department of Health, within twelve months:

• Undertakes a comprehensive 'needs analysis' of the levels of speech pathology and occupational therapy positions required to provide both clinical therapy services, and systemic delivery of therapy services, in schools and early childhood settings;

• Develops targets for numbers of therapists per head of population for each Area Health Service, with equity weightings; and

• Allocate sufficient funding to ensure these positions are filled.

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Recommendation 9

The Committee recommends that the Department of Health consults with relevant professional bodies and affected agencies to look at ways service provision could be improved in the allied health sector through the creation of:

- 'extended scope practitioners';
- interdisciplinary or trans-disciplinary model of service delivery; and
- key therapy service providers.

Page 108

Recommendation 10

The Committee strongly recommends that every child is screened for hearing capacity within the first six months of commencing school, be that pre-compulsory or compulsory years. Adequate resourcing for school health nurses will need to be made available.

Page 121

Recommendation 11

The Committee recommends the significant expansion of the three year old indigenous kindergarten program in areas of need as established by AEDI and/or NAPLAN or where children do not have English as their first language.

Page 122

Recommendation 12

The Committee recommends that special consideration be given to parental support programs in Pilbara mining towns where there are an unusually high percentage of young families who have no family networks and limited social networks.

Page 127

Recommendation 13

The Committee recommends that the Minister for Education prioritise a review of existing early childhood and parent support services in the regional and remote areas of Western Australia and that the Minister takes the lead, at Cabinet level, on improving collaboration, coordination, funding and structures for those services.

Page 128

Recommendation 14

The Committee recommends that Minister for Education extends the remit of the Department of Education and Training so that its role can include the learning development of 0-3 year olds, ensuring they are ready for school. This capacity should be exercised particularly in schools identified by the AEDI as having a high level of developmentally vulnerable students in their district or below average NAPLAN results.

Page 134

Recommendation 15

The Committee recommends that, as the interests of the child are paramount, agencies running early childhood support services for 'at risk' families develop an approach of robust intervention where all overtures for voluntary engagement fail.

Such an approach would seek to ensure that support services were accessed by those who need them most. It would ensure the ongoing engagement of the target population in services supporting families of young children. An example of a 'robust' intervention approach would be the management of a clients' Centrelink income.

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Recommendation 16

Recognising that Foetal Alcohol Spectrum Disorder (FASD) affects a significant number of children born in some regions of the state, the Committee recommends:

1. That children affected at the severe and moderate end of the spectrum of FASD are made eligible for the Disability Services Commission's Individual and Family Support program or for a specially developed program for FASD.

2. That the Department of Health jointly with the Office of Early Childhood Development and Learning urgently develop an interagency strategic approach to the delivery of services in Foetal Alcohol Spectrum Disorder affected regions advising Parliament of progress within twelve months. This strategy should have an emphasis on the needs of Indigenous children and include the mapping of aligned services and agencies to ensure efficient use of resources. It would also identify opportunities for collaboration and service alignment.

Page 139

Recommendation 17

The Committee recommends an urgent and significant targeted increase in housing for indigenous families in the Kimberley and Pilbara. Without this issue being addressed, families in overcrowded housing will remain unstable and chaotic.

Page 139

Recommendation 18

The Committee recommends that the critical shortage of housing and accommodation for government staff and support workers in the Kimberley and Pilbara is urgently addressed. Failure to do so will result in the essential support programs remaining undeliverable.

Page 148

Recommendation 19

The Committee recommends that the Auditor General undertakes a review of selected early childhood parental support programs to examine the adequacy of the existing short and long term performance indicators and the adequacy of the measurement of outcomes against these performance indicators.

Page 160

Recommendation 20

The Committee strongly recommends the development of a more systematic researched and stable approach to the provision of parenting programs. Best practice models for particular communities should be developed and funded for periods of at least five years.

Page 164

Recommendation 21

The Committee recommends that in high need areas, as identified by AEDI or NAPLAN, the development of properly funded structured playgroups for 0-3 become a standard facility in primary schools.

Page 167

Recommendation 22

The Committee recommends that a system is established that ensures that child care service providers refer identified developmentally vulnerable children for a formal assessment within the child health system.

Page 174

Recommendation 23

The Committee recommends that a minimum qualification should be required for child contact staff in Long Day Care, with this qualification being set at Certificate III in Children's Services or equivalent. The requirement for this qualification should be phased in over a period of five years, with an exemption for current workers aged 40 and over at the time of introduction of the requirement.

Consideration should also be given to establishing appropriate qualifications in early childhood development for principals of child care centres.

This recommendation supports, in principle, Recommendation 3 of the Western Australian Report on the Children's Services Regulations Review, 2008.

Page 178

Recommendation 24

The Committee recommends that, in vulnerable target populations, as identified through AEDI results, kindergarten eligibility be extended to three year olds.

Page 178

Recommendation 25

The Committee recommends that serious consideration be given to making the pre-primary school year compulsory.

Page 200

Recommendation 26

The Committee strongly recommends that, in line with Recommendation four, the health, care, and education components of the four Federally funded early learning centres and the five Indigenous Children and Family Centres all report to the Minister for Education.

Page 205

Recommendation 27

The Committee recommends that:

1. the Minister for Education extend the co-located integrated early child development service hub model throughout the State with prioritisation of locations based on the level of developmental challenges faced in a given community, as recorded in the AEDI process.

Additionally:

- that a formal evaluation methodology is established from the outset in each case;
- that health is incorporated into the suite of services provided at each location; and
- that integrated early childhood development and parenting programs should be linked to appropriate primary schools.

2. a system of clustering schools to take advantage of service hubs be developed.

Page 219

Recommendation 28

In line with the *National Inquiry into the Teaching of Literacy* (2005), the *Independent Review of the Teaching of Early Reading* (Rose, 2006) and the *WA Literacy and Numeracy Review* (Louden 2006) the Committee recommends that students be provided with systematic direct instruction in synthetic phonics so that they can master the essential alphabetic code-breaking skills required for foundational reading proficiency. Equally, they must be provided with an integrated approach to reading that supports the development of oral language, vocabulary, grammar, reading fluency, and comprehension.

Page 219

Recommendation 29

The Committee recommends that a clear, best practice, evidence based, approach be adopted to teaching literacy. Priority should be given to developing a comprehensive syllabus to ensure a consistent standard in the delivery of early years literacy. This syllabus should commence at kindergarten and be part of an integrated and coordinated program for primary school literacy.

Page 219

Recommendation 30

DETWA consider imposing requirements for kindergarten and primary teachers entering the profession to have completed a mandated literacy teaching program. Ideally such a program would be developed in conjunction with tertiary institutions offering teacher training but would give DETWA a direct role in guiding course content in this important area.

MINISTERIAL RESPONSE

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Community Development and Justice Standing Committee directs that the Premier, the Minister for Community Services, the Minister for Education, the Minister for Health, and the Minister for Housing and Works, report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

CHAPTER 1 INTRODUCTION

1.1 Background

> *I think that even if you don't care much about children, at the end of the day you can't ignore the life course perspective. The life course perspective is that things that happen to young children have an impact not just in childhood but over the long-term. There is evidence now, for example, that many of the conditions in adult life that challenge us as a community, like mental health problems, obesity and its consequences, family violence, crime participation, poor literacy, welfare dependency and a whole raft of other problems, have their roots in pathways that begin much earlier in life.*[5]

It is internationally recognised that experiences in early childhood have lifelong implications for health, development and well-being, and that our ability to become productive, well socialised contributors to society is largely dependent upon a positive learning environment in the early years.

In particular, the importance of the quality of a child's experiences in the first three years of life is crucial. Neurological studies show that brain development in this period is far greater than at any other like period. Gaps in children's functioning and achievement consequently develop early and can be significant by the time they reach school.

In Western Australia, the Hon Alannah MacTiernan expressed her concern in Parliament in November 2008 about the long term consequences of failing to respond to the needs of parents and their children in the early years, stating that:

> *[The]Australian Early Development Index*[6]*… found that 40 per cent of the students in the Armadale area are developmentally vulnerable in one or more of the key areas: physical, health and well-being, social competence, emotional maturity, and language and cognitive development. The results indicated that 20 per cent of students were vulnerable in the language and cognitive domain area, with a number of suburbs in Armadale having absolutely no children assessed as performing well. This is a major social problem. We are allowing an intergenerational disadvantage to emerge. Whichever party is in government will have to try to deal with children who will be angry and underachieving. These children will grow up to become those who create vexation on our trains; they will be more likely to be involved in antisocial behaviour across the community. They will be far more likely to become welfare dependent, and then lack the skills to ensure that their own children have a chance to at least get to the first rung on the ladder of opportunity.*[7]

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5 Professor Frank Oberklaid, 'Early childhood, pathways, interventions and the life course', 2006. Available at: www.premiers.qld.gov.au/library/scripts. Accessed on 21 April 2009.

6 The Australian Early Development Index (AEDI) will be further discussed in Chapter 4.

7 Hon Alannah MacTiernan, Member for Armadale, Legislative Assembly, *Parliamentary Debates* (Hansard), 27 November 2008, p638.

The Community Development and Justice Standing Committee of the 38th Parliament subsequently initiated this Inquiry to determine the adequacy of existing services in Western Australia in meeting the developmental needs of children.

1.2 Inquiry Parameters

Both nationally and internationally early childhood years are seen to cover the ages from birth to 8 years. Children in this age range are characteristically different from children at older ages. This definition of the early years forms the context of the Committee's report with particular reference to 0-3 year old children.

As defined by the Terms of Reference, the Inquiry focuses on the adequacy of the Western Australia State Government services in providing support to their families and carers and meeting the social and cognitive needs of children in Western Australia. The assessment of 'adequacy' has been made in relation to:

- accessibility of services;
- quality of services;
- effectiveness of services; and
- the application of constrained resources.

In so doing the Inquiry considered aspects of health, care and early development as well as the needs of supporting families and carers.

The Committee makes Findings and Recommendations in relation to the above based upon the research, briefings and evidence received by way of submissions and hearings.

1.3 Conduct of the Inquiry

The Inquiry's Terms of Reference were announced to the Legislative Assembly on 11 December 2008 and were placed on the Parliament's web site following the Speaker's Statement. Advertisements inviting submissions to the Inquiry appeared in *The West Australian* newspaper on 20 December 20 2008 and in *The Weekend Australian* on 27-28 December 2008. Submissions were also sought from a number of State Government agencies, as well as other relevant stakeholders. In response, the Committee received 37 submissions. These are listed in Appendix Three.

A total of 9 public hearings were conducted during which the Committee heard evidence from 26 witnesses. Witnesses who gave evidence to the Committee are detailed in Appendix Four.

In addition to public hearings, the Committee held briefings in Perth, Canberra, Melbourne and Adelaide in relation to the Inquiry. Those people who provided information to the Committee are listed in Appendix Five.

CHAPTER 2 CHILDREN'S HEALTH AND DEVELOPMENT

2.1 The importance of the early years of children

> *The single most important determinant of positive outcomes in a young child's environment is the quality of the child's relationships with his/her parents and caregivers.*[8]

There is a significant volume of research on early childhood development and it has been estimated that 'reading solidly for 40 hours a week, 52 weeks a year, it would take a policymaker 18 months to get through the 6,000 articles on "early childhood intervention" alone.'[9] Having regard to this, it is not the intent of this Report to provide more than a small insight, in this chapter, into the context of some of the key issues which form the backdrop against which the adequacy of Western Australia's services can be assessed.

There are however several major themes that consistently emerge from any review of the research literature on childhood. These were summarised in the Government of South Australia's report 'The Virtual Village'[10] as:

> *1/ the learning that occurs in early childhood is particularly crucial during the first three or four years after birth, affecting the very architecture of the brain and our dispositions to think and act, so building life-long habits of mind;*
>
> *2/.attachment and consistent warm, loving behaviour provide the best prevention of dysfunctionality in adulthood; and*
>
> *3/.the effects of poverty on early childhood development are universally noted as long lasting and may be cripplingly debilitating, often eroding relationships, responsibility, creativity and any chance of future economic well-being.*

These factors have a formative impact on how a child's physical social and emotional needs are met and their future life pathways.

(a) The developmental characteristics of early childhood

> *It is too late by the time kids get to school; they are already on a trajectory.*[11]

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8 Submission No. 8 from Department of Health, p10.

9 Leigh, A., 'What evidence should social policymakers use? Available at: http://www.apo.org.au/linkboard/results.chtml?filename_num=267580. Accessed on 13 March 2009.

10 The Virtual Village, report prepared by The State of South Australia, Department of Education and Children's Services, DECS Publishing, Hindmarsh, 2007, p28.

11 Professor Frank Oberklaid, Briefing 25 February 2009.

Child development encompasses the various stages of physical, social, and psychological growth that occur even before birth. While individuals change throughout their lives, it is universally recognised that developmental changes are especially dramatic in the early years.

Many of these changes are underpinned by social determinants in the early phases of conception, pregnancy, and post-natal periods of children's development. The saying 'it takes a village to raise a child' is relevant because 'the extent to which these processes lead to healthy development depends upon the qualities of stimulation, support, and nurturance in the social environments in which children live, learn and grow.'[12]

It is now understood that the brain's foundations are laid even before birth. The architecture of the brain subsequently develops over the ensuing years, but most especially in early childhood. This is because during early childhood the brain is particularly sensitive and its development involves the formation of circuits which link to a person's abilities.

> *Vivid MRI images [reveal] how early experience builds the scaffolding for everything that follows, as the brain incorporates early experience into its biological structure….. A new generation of studies shows that genes and the environment don't occupy separate spheres, that much of what is labelled 'hereditary' becomes meaningful only in the context of experience. When it comes to explaining life outcomes, it's not nature versus nurture, but nature through nurture.*[13]

This is well demonstrated, for instance, in the literature linking risk factors associated with parental alcoholism with the development of children's behaviour problems. It is also evidenced in studies of fathers which note the importance of fathers' antisocial behaviour in predicting children's conduct problems, especially if these antisocial fathers reside in the home.[14]

The link between nature and nurture in early childhood development is also highlighted by the NSW Department of Community Services, who state, amongst other things, that:

> *Several large longitudinal studies from the US (Campbell, Shaw & Gilliom, 2000), England (Deater-Deckard & Dunn, 1999) and Australia (Prior, Sanson, Smart & Oberklaid, 2001) have found consistent correlations between infant temperament, parenting styles and later behaviour problems. Infants with difficult temperaments, that is, infants who are irritable, have strong negative emotional reactions, lack persistence, are overactive and difficult to soothe, may be at greater risk for conduct disorder and anti-social behaviour in early and middle childhood. Whether these difficult infants do, in fact, become distressed is assumed to relate to the quality of parenting. Insecure parent-child relationships and/or parenting styles that are harsh, inconsistent and coercive are related*

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12 World Health Organisation, 'The Social Determinants of Early Child Development', 2005. Available at: http://www.who.int/social_determinants/resources/ecd.pdf. Accessed on 1 April 2009.

13 Kirp, D.P., 'Nature, Nurture and Destiny', *The American Prospect*, 19 November 2007.

14 Edwards et al, 'The development of aggression in 18 to 48 month old children of alcoholic parents', 1 June 2006. Available at: http://www.accessmylibrary.com/coms2/summary_0286-30912012_ITM. Accessed on 3 February 2009.

to poor outcomes in children. A 'vicious cycle' begins as difficult infant temperament attracts harsher parenting, with mothers becoming more coercive than other mothers by the time their children are two years.[15]

The developmental characteristics that contribute to positive outcomes for children in later life are generally recognised as falling into five main areas:

- ***Cognitive Development:*** *This is the child's ability to learn and solve problems. For example, this includes a two-month-old baby learning to explore the environment with hands or eyes or a five-year-old learning how to do simple math problems.*

- ***Social and Emotional Development:*** *This is the child's ability to interact with others, including helping themselves and self-control. Examples of this type of development would include: a six-week-old baby smiling, a ten-month-old baby waving bye-bye, or a five-year-old boy knowing how to take turns in games at school.*

- ***Speech and Language Development:*** *This is the child's ability to both understand and use language. For example, this includes a 12-month-old baby saying his first words, a two-year-old naming parts of her body, or a five-year-old learning to say "feet" instead of "foots".*

- ***Fine Motor Skill Development:*** *This is the child's ability to use small muscles, specifically their hands and fingers, to pick up small objects, hold a spoon, turn pages in a book, or use a crayon to draw.*

- ***Gross Motor Skill Development:*** *This is the child's ability to use large muscles. For example, a six-month-old baby learns how to sit up with some support, a 12-month-old baby learns to pull up to a stand holding onto furniture, and a five-year-old learns to skip.*[16]

(b) The long-term importance of the early years

The successful development of these developmental characteristics in the early years is reflected in the emotional, social and intellectual ability of an individual in later life. Research shows that skills and competencies acquired in the first years of a child's life have outcomes in adult life. For example, 'The ability to interact successfully and cooperatively with others is a central life skill

15 Department of Community Services NSW, 'The development of aggressive behaviour in children and young people', Available at: http://www.community.nsw.gov.au/docswr/_assets/main/documents/aggression_discussionpaper.pdf. Accessed on 3 February 2009.

16 The Child and Adolescent Services Research Center, 'How Kids Develop', 2008. Available at: http://www.howkidsdevelop.com/developSkills.html. Accessed on 2 February 2009.

…. adult success is dependent on communication skills." Similarly, "Cognitive competencies are also linked to better social and behavioural outcomes.'[17]

Unsurprisingly then,

> *What happens to children in the early years has consequences right through the course of their lives. While there are many opportunities to intervene and make a difference to the lives of children and young people, research suggests that intervening in early childhood, including the antenatal period, is the most effective phase to impact on the future development of the child.*[18]

And again,

> *Early mastery of a range of cognitive and social competencies improves the ability of children to learn at later ages. Early interventions have the potential to improve life chances.*[19]

Children are born interested in the world around them. It is natural for them to use all their abilities to learn. From birth, children are learning about themselves, other people and the world around them, and playing an active role in their own learning and development. It is acknowledged that the construction of the brain is a protracted process that begins just a few weeks after conception and is not complete until the late teens or early 20s; however in their early years children's brains rapidly 'wire up'. During this time their experiences, both good and bad have an enduring affect.[20]

A strong scientific base supports a whole of government emphasis on protecting and promoting early childhood health, learning and development. It shows that:

- Safety, development and stability in the early years of a child's life are the foundation for learning, behaviour and health through both the school years as well as adult life.
- Negative experiences in the first three years of a child's life can have long lasting effects on brain development.
- Those children who experience significant stress and trauma in their early years are at risk of subsequent behavioural, social and learning problems.

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17 Rintoul, B. et al., 'Factors in Child Development', Available at: http://www.rti.org/pubs/child-development.pdf. Accessed on 2 February 2009.

18 The Australian Research Alliance for Children and Youth, 'Early Childhood and Long Term Development', 2006. Available at: http://www.aracy.org.au/AM/Common/pdf/Topical%20Papers/Importance.pdf. Accessed on 2 February 2009.

19 Duncan, G.J., 'High quality preschool as antipoverty', *The American Prospect*, 22 April 2007.

20 Victoria Human Services, 'Making the most of childhood', Available at: http://www.education.vic.gov.au/ocecd/docs/making_most_of_childhoodv2.pdf. Accessed on 13 February 2009.

- Good nutrition and parenting enhances the physical, emotional, intellectual and social well-being of a child.[21] [22]

(c) Brain development in early childhood

There is increasing evidence world wide, as exampled below, which suggests that intervening in both the prenatal and the early years of a child's life will have the most significant and lasting impact on the future of a child because of the plasticity of the infant brain.[23]

> *We now know about how experience in the early years affects brain development and how the development of the brain and biological pathways in this period influences health, learning and behaviour throughout the life cycle.*[24]

> *There is now overwhelming evidence regarding the significant influence of early childhood experiences on brain development and on a range of long term social, emotional, health, 'education and employment outcomes (Heckman, J. J. 2006; Elliot, A. 2006; Lynch, R. 2004; Thomas, K. 2006). When health and developmental concerns are detected, treated and managed early, significant individual and societal burdens of lifelong impairment can be alleviated.*[25]

The reason for the key role these factors play lies in the infant's early brain and sensory pathway development.

> *A child's brain is not mature at birth. Different areas of the brain develop, organise and become fully functional at different stages during childhood, with the first three years of life being the most critical phase. During this time, a young child will develop crucial intellectual, emotional and social abilities. Nurturing and responsive primary relationships build healthy brain architecture and establish a strong foundation for positive lifelong learning, behaviour and health outcomes. When such relationships are not provided, levels of stress hormones increase which, in turn, disrupts the brain's development (Centre for Community Child Health, 2009).*[26]

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21 Department for Human Services, 'Early years science – brain development', Available at: http://www.dhs.vic.gov.au/office-for-children/cpmanual/Output%20files/Practice%20research/Output%20files/Execute/early_%20years_%20science_brain_development.pdf. Accessed on 4 February 2009.

22 The Australian Research Alliance for Children and Youth, 'Early Childhood and long term development', 2006. Available at: http://www.aracy.org.au/AM/Common/pdf/Topical%20Papers/Importance.pdf. Accessed on 4 February 2009.

23 The Australian Research Alliance for Children and Youth, 'Early Childhood and long term development', 2006. Available at: http://www.aracy.org.au/AM/Common/pdf/Topical%20Papers/Importance.pdf. Accessed on 4 February 2009.

24 Mustard, F.J., 'Early Childhood Development', 2008. Available at: http://www.thinkers.sa.gov.au/images/Mustard_Companion_Document.pdf. Accessed on 13 February 2009.

25 Submission No. 8 from Department of Health, p8.

26 Submission No. 8 from Department of Health, p10.

While brain development is protected during pregnancy by the general health and well-being of the mother, the first two years of life heralds the period of the most rapid brain organisation.

> *A baby's brain is dynamically developing from birth with most of the essential neuronal connections established by the age of three enabling the child to regulate emotions, communicate, solve problems, and form relationships.*[27]

For example, 'we know from brain neurological connection time, the key time for the neuronal connection for readiness for literacy is about the six-month mark.[28]

A child's early years therefore provide a great window of opportunity or vulnerability. For example, during this period, brain growth and long-term outcomes are enhanced by secure and stimulating relationships and damaged by poor nutrition, stress, and trauma. Plasticity remains after this period, but the pace of change/organisation is slower. 'Brain development in the early years creates a base that influences the development of language and literacy….. Children with poor verbal skills at age 3 performed poorly in language and literacy competence at age 9 in the school system,'[29] with long term consequences. For instance, the links between the economy and literacy are several and direct. High literacy skills are determinant of individual economic potential: higher employment participation, lower unemployment probabilities and higher skilled employment.

Literacy proficiency is affected by language development, and language development is enhanced by certain types of stimulation. In particular language development is affected by what occurs in the child's home. Children who are spoken to regularly by their parents learn to speak more words by the age of two, compared with children who lack such conversational interaction. However, while verbal stimulation increases brain circuitry, 'not all stimulation is equal. Children who are exposed to language through television or overhearing other people speak to one another receive little benefit to language development.'[30] On the contrary, 'children from birth to three exposed to more than two hours a day of television have a much greater likelihood of having attention deficit disorder.'[31]

In the early years the brain is genetically designed to overproduce neural connections or synapses, most notably between the ages of the seventh month in the womb and two years of age.[32] These synapses support a whole range of human functioning, not least emotional and cognitive development. However if these are not used they wither away or are 'pruned' over ensuing years. In other words, 'If you don't use it, you lose it.' Pruning is significantly regulated by early interactions with caregivers. The brain's development is therefore both experience and use

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27 Submission No. 13 from National Investment for The Early Years, p1.

28 Dr Trevor Parry, National Investment for the Early Years (WA), *Transcript of Evidence*, 25 March 2009, p4.

29 Mustard, F.J. 'Early Childhood Development', 2008. Available at: http://www.thinkers.sa.gov.au/images/Mustard_Companion_Document.pdf. Accessed on 13 February 2009.

30 Davies, D, *Child Development a practitioners guide*, Guildford Press, New York, 2004, p45.

31 Dr Martha Burns, *Transcript of Evidence*, 6 April 2009, p7.

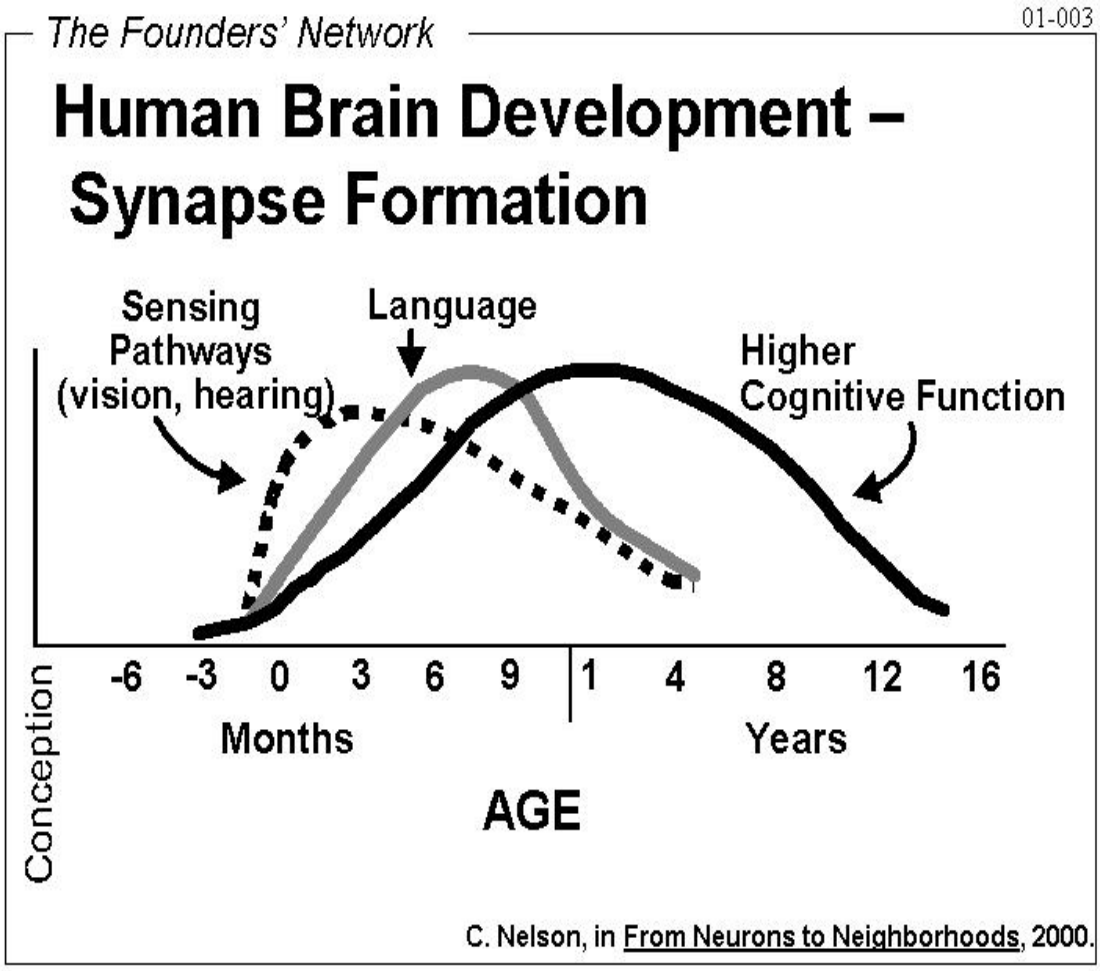
32 Davies, D, *Child Development a practitioners guide*, Guildford Press, New York, 2004, p42.

dependant. In particular, experiences establish the neurological and biological pathways that will affect health, learning and behaviour. The more a system, or set, of brain cells is activated, the more that system changes in response. The stronger the repetitions, the stronger the memory.

The following figure reflects the ages and stages of synapse development from conception to sixteen years. 'It is of interest that the basic capability for language is largely set by four years of age. Higher cognitive functions, which is [sic] where education programs have their major affect, are built upon the neural pathways that are started earlier.'[33]

[33] C. Nelson, in From Neurons to Neighborhoods, 2000 Available at: http://www.oacrs.com/News/Conference2008/OACRS2008_OpeningKeynote.ppt#575,21,01-003. Accessed on 19 February 2009.

Figure 1.1 Human Brain Development - Synapse formation



In 2002 Martin Teicher published the results of his research into the effects of physical and sexual abuse in the early years on behaviour and development in the *Scientific American*. He found, 'the aftermath … can appear as depression, anxiety, suicidal thoughts, or post-traumatic stress – or as aggression, impulsiveness, delinquency, hyperactivity.'[34]

His work has shown how traumatic events can change the brain structure as a result of these traumatic stimuli. Thus, adverse circumstances in early life can produce what appear to be permanent alterations in brain structure.

[34] Council for Early Child Development, 'Working together to put science into action', Available at: http://www.successby6ottawa.ca/docs/CECD_Success_by_6_Ottawa_2.ppt#527,6,`Sensitive periods' in early brain development. Accessed on 20 February 2009.

One witness to the Inquiry put it this way:

> *When parents neglect children or are abusive to children, the children actually have genetic changes. Their genes that regulate certain neurotransmitters in the brain are altered, so the children have a difficulty responding to stress in a positive way. The children are very reactive in stressful situations.*
>
> *You actually have DNA changes that result. Some of it is RNA, some of it is how the genes are expressed, but what they are also finding is genetic mutations, actual changes in a very specific gene that affects the neurotransmitter associated with stress, which is called cortisal, and that gene becomes altered when children are neglected and abused during the first four years of life, so they are more prone to suicide—that was the most dramatic effect of the research that came out—and severe depression, chronic depression that is not amenable to medication.*[35]

What happens in early childhood does not predetermine a person's life's outcomes, but it does place children on developmental pathways that become increasingly difficult to alter as time passes. As Professor Frank Oberklaid puts it, 'It is too late by the time kids get to school; they are already on a trajectory.'[36]

Therefore, in a very real sense the brain's development in early childhood holds to ransom that child's future.

> *A fundamental paradox exists and is unavoidable: development in the early years is both highly robust and highly vulnerable. Although there have been long-standing debates about how much the early years really matter in the larger scheme of lifelong development, our conclusion is unequivocal: what happens during the first months and years of life matter a lot, not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or a fragile stage for what follows.*[37]

(d) Factors affecting development: family, environment, and life events;

Given the criticality of the early years on a child's long-term future, there has been an increased focus on the factors that affect development. Much of the debate centres on the varying contribution of nature (genes) and nurture (the environment in which the child finds itself). It is generally agreed however that it is a combination of the interaction of the two.[38] Genes interact with experiences creating a dynamic that affects lifelong health, learning and behaviour.

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35 Dr Martha Burns, Professor, Northwestern University, Chicago, *Transcript of Evidence*, 6 April 2009, p3.

36 Professor Frank Oberklaid, Briefing 25 February 2009.

37 Shonkoff, J., & Phillips (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

38 Associated Content, 'The Childhood development debate, nature versus nurture, continues', 2005. Available at: http://www.associatedcontent.com/article/16572/the_childhood_development_nature_vs.html?cat=25. Accessed on 19 February 2009.

Therefore the quality of the child's early experiences is formative. For instance, to what degree are a child's relationships nurturing? How stimulating is his/her environment and what is the nature and quality of that stimulation? Such issues sit along-side the more readily identified issues of nutrition and adequate sleep in the optimisation of brain development from conception on.

A child's life experience in the early years is shaped to a considerable degree by the quality of parenting and familial relationships that he/she enjoys. However, since the 1970s there have been significant changes in family demographics and related circumstances which provide the context for those relationships and the way in which children are brought up. This was highlighted by a number of witnesses to the Committee who spoke of the increasing complexity of family life and the impact this has on children. For example:

- *We know that, in reality, families have many more complex needs these days*[39]
- *The issues are increasing and becoming more complex*[40]
- *We are seeing families with increasingly complex needs present to government services.*[41]

Many reasons have been advanced for the increasing complexity of family life and the context of childhood; notably:

- *Families have become smaller.*
- *Childlessness is increasing.*
- *Mother's age at first birth is increasing. This has risen from 22 years or so to around 29 years. In 2001, 48% of babies were born to women over the age of 30, compared with 30% in 1961.*
- *There are more single parents. This is not due to marriage break-ups and divorce, but to an increase in the number of mothers without partners who are having children. Only 3 per cent of children born between 1963 and 1975 were born to a single mother, and by 2001 this had grown to 11.4 per cent.*
- *There are more blended families. Nearly 9% of families are blended or step families. Remarriages between parents with children from previous marriages can create difficulties in terms of new attachments and shared responsibilities.*
- *There are more shared custody arrangements.*[42]

In addition, the wider social conditions in which families are raising children have changed in other ways as well:

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39 Margaret Abernethy, Senior Policy Officer, CACH Policy Unit, *Transcript of Evidence*, 25 March 2009, p8.

40 Dr Trevor Parry, National Investment for the Early Years (WA), *Transcript of Evidence*, 25 March 2009, p2.

41 Erin Gauntlett, Senior Portfolio and Policy Officer Child Development Services; DoH, *Transcript of Evidence*, 25 March 2009, p17.

42 Centre for Community Child Health, Royal Children's Hospital, Melbourne, 'The underlying factors affecting child health and development and family functioning', 2004. Available at: http://www.rch.org.au/emplibrary/ccch/EY_UF_Summary.pdf. Accessed on 12 March 2009.

- *There has been a partial erosion of traditional family and neighbourhood support networks, due to factors such as increased family mobility and the search for affordable housing. This does not apply to all families with young children – many are well supported and are doing well. However.... a greater proportion of parents of young children have relatively poor social support networks and are therefore more vulnerable.*

- *There has been an increase in the number of parents whose own experiences of being parented were compromised, and who therefore have difficulty parenting their own children. Our ability to parent well is at least partly based on our experiences of having been parented well ourselves. An increasing percentage of parents have not had good parenting for a whole range of reasons – family break-ups, parental mental health problems, parental drug or alcohol abuse, child abuse and neglect, foster placements etc.*

- *The most dramatic example in Australia of disrupted early parenting is the Stolen Generation of Aboriginal children (Burns, Burns and Menzies, 1999), whose capacity to act as effective parents for their own children was compromised from early removal from their own parents and communities. However, there are many others within the community whose early lives were disrupted by other factors.*

- *All these factors have contributed to an increase in the number of families with complex needs. Many services report that they are dealing with a higher percentage of families with multiple needs – e.g. problems with finances and employment, housing, mental health, drug abuse, parenting skills, health, social support, and any combination of the above.*

- *These social changes have also contributed to an undermining of confidence among parents in their ability to raise their children well. Again, there are many families that are perfectly confident in their child rearing, but there is an increasing percentage who are unsure and anxious. Child rearing has become more problematic for such parents and they are subjected to a variety of professional opinions and research evidence that often only compounds rather than allays their anxieties.*

- *There is no longer a social consensus about the right way to bring up children, or even that there is a single right way. As our society has become more diverse and multicultural, child rearing beliefs and practices have also diversified.*[43]

The result of this is that parenting young children is seen to have become a more complex and a more stressful business for many families, a fact that is well recognised by educators and governments alike around the world.

Additionally, every parent will approach parenting differently.

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43 Centre for Community Child Health, Royal Children's Hospital, Melbourne, 'The underlying factors affecting child health and development and family functioning', 2004. Available at: http://www.rch.org.au/emplibrary/ccch/EY_UF_Summary.pdf. Accessed on 12 March 2009.

> *How we raise young children is one of today's most highly personalized and sharply politicized issues, in part because each of us can claim some level of "expertise." The debate has intensified as discoveries about our development-in the womb and in the first months and years-have reached the popular media.*[44]

While the approach to parenting is individualised, those parenting styles, that is to say the behavioural choices that parents make, have a great impact on their children.

> *Parenting is more likely to be effective when parents adapt their practices to meet their children's changing needs – when they are perceptive of these needs, responsive to them, and flexible in this responsiveness. Many factors can affect a parent's capacity to do this, creating vulnerability for the child.*[45]

As the Centre for Community Child Health, at the University of Melbourne, is at pains to point out in their training modules, 'There is no one right way to bring up children – children grow up successfully in a range of different cultures with diverse values and child-rearing practices.'[46] What we do know however is that there is a qualitative difference on a child's development attributable to the parenting style adopted. This is well illustrated in the figure below, which reflects the vulnerability of children according to the parenting style adopted.

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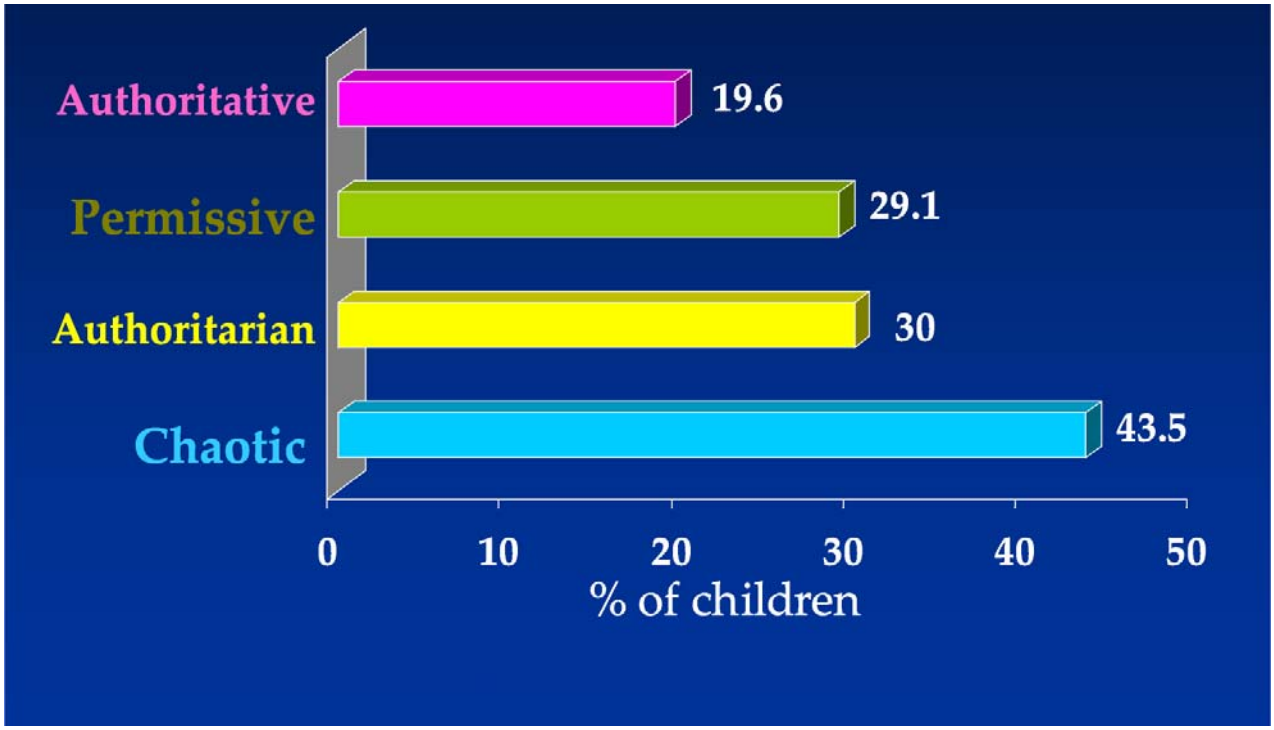
44 C. Nelson, in From Neurons to Neighborhoods, 2000 Available at: http://www.oacrs.com/News/Conference2008/OACRS2008_OpeningKeynote.ppt#575,21,01-003. Accessed on 19 February 2009.

45 Submission No. 14b from Ngala, p7.

46 Centre for Community Child Health, Royal Children's Hospital, Melbourne, 'The underlying factors affecting child health and development and family functioning', 2004. Available at: http://www.rch.org.au/emplibrary/ccch/EY_UF_Summary.pdf. Accessed on 12 March 2009.

Figure 2.2 Percentage of vulnerable children by parenting style.[47]



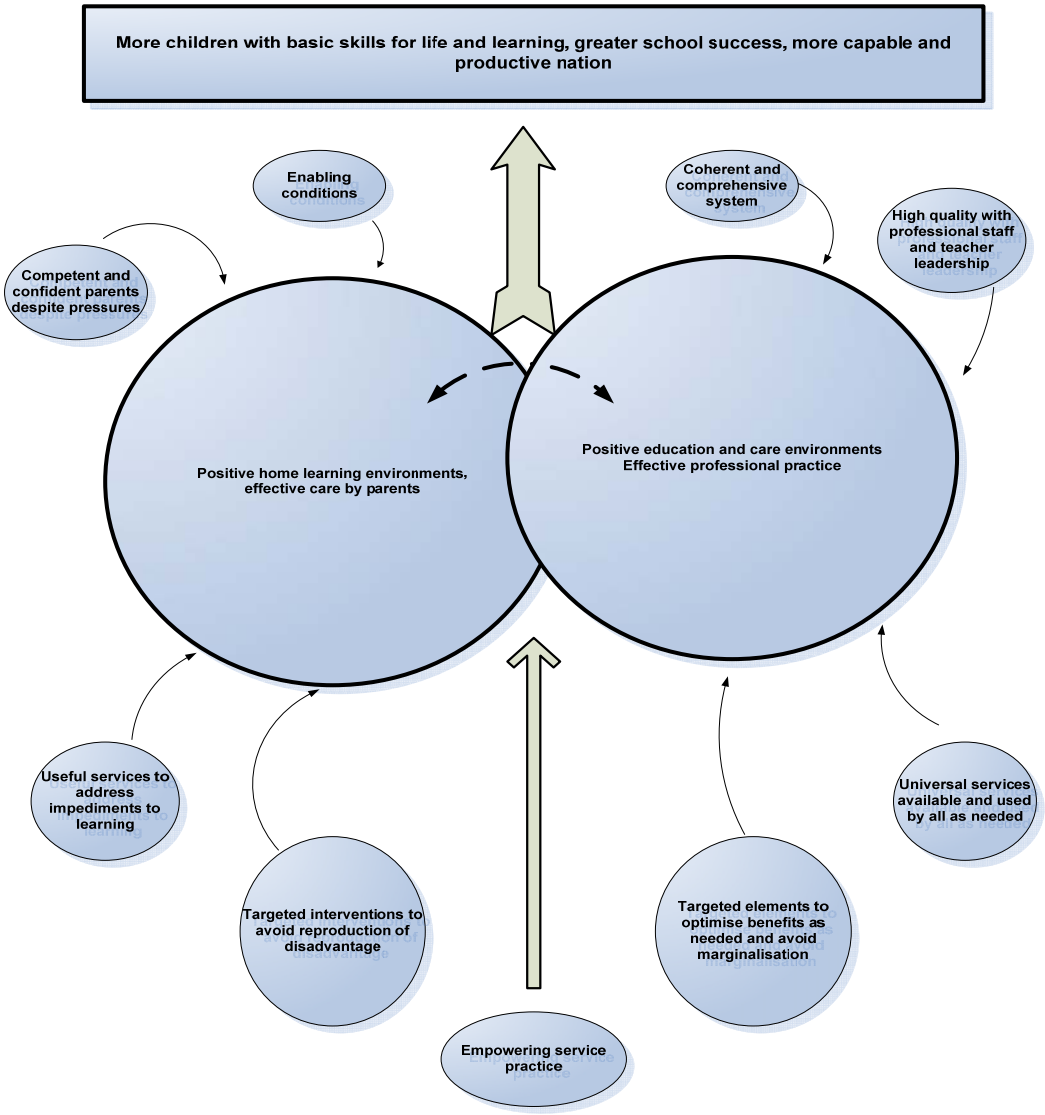
The impact of the quality and style of parenting on a child's development is both significant and lasting. But it is no longer seen to be 'up to the parents' alone. In the twenty first century with the increasing complexity of the family environment, the task of improving health and developmental outcomes for children is seen, increasingly, to be a joint responsibility of parents, carers and the government.

Governments of all complexions now provide universal services that support the role of parents, as well as targeted services where there are challenging circumstances or disadvantage. These contribute to future workforce productivity by improving the developmental outcomes of children.

This is illustrated below:

47 Council for Early Child Development, 'Working together to put science into action', 2006. Available at: http://www.successby6ottawa.ca/docs/CECD_Success_by_6_Ottawa_2.ppt. Accessed on 7 April 2009.

Figure 2.3 It takes a village



2.2 Intervention/support strategies for early childhood

> *Early childhood interventions are formal attempts by agents outside the family to maintain or improve the quality of life of young children, starting with the prenatal period and continuing through entry into school.*[48]

Recognising the importance of the early years and the increasing complexity of the family environment, governments around the world have funded a diverse range of early years intervention strategies to improve child development outcomes. Many of these target the provision of support for parents, because of the fundamental role they play.

The most effective way to deliver improved early years experience is to strengthen the skills of parents. That must be the primary focus. However, it will not always be possible or sufficient where there is a high level of challenges in the family. Therefore there must be a suite of initiatives that go beyond strengthening parenting to enhance the learning opportunities for pre-schoolers.

The aim of early intervention in parenting and early childhood is that of prevention and/or the resolution of problems before they escalate. The intervention strategies adopted will either seek to reduce risk factors or to increase protective factors or a combination of both. Such strategies may be 'universal', that is to say they are accessible by parents and children generally; for example the immunisation program. Alternatively, they may be targeted towards a single section of the population considered to be at risk.

Whatever approach is adopted there is agreement on three important principles to improve early child development:

1) intervene early;

2) intervene often; and

3) intervene effectively.[49]

(a) The evidence of the effectiveness of early intervention

Decades of research in Australia and internationally have demonstrated the benefits of early intervention strategies supporting parents, children and their communities. Such early intervention has been shown to achieve, at relatively modest cost, changes to prevent damage that is very

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48 Professor Collette Tayler, 'The policy challenges in early childhood and early intervention', 2006. Available at: www.premiers.qld.gov.au/library/scripts/objectifyMedia.asp. Accessed on 26 March 2009.

49 Hamilton Project, *Success by Ten*, report prepared by Ludwig, J and Sawhill, I., The Brookings Institution, USA, 2006 , p8.

expensive to remediate.[50] Such intervention strategies, when well resourced and implemented, can demonstrate specific benefits, including:

- *improvements in parent child relationships;*
- *fewer behaviour problems;*
- *higher levels of cognitive functioning;*
- *improved 'school readiness' and school attainment; and*
- *lower levels of domestic violence.*[51]

As outlined in a later chapter, there are a many parenting intervention and support programs funded in Western Australia delivered by a range of government and non-government agencies. Each of these programs is different in context, content and target, making a universal assessment difficult. International research studies of many such programs show that they are generally successful in reducing antisocial and hyperactive behaviour, and in increasing self-control in the target population compared to the control children in the study.

The evaluation of one program, the South East Sydney Positive Parenting Program, was for instance shown to have:

> *Demonstrated a reduction in disruptive child behaviour, lower levels of dysfunctional parenting, reduction in conflict between parents over child-rearing, and gains in parental mental health. Gains in all of these domains were maintained at 6 and 12 month follow-up.*[52]

Parenting support strategies work in the environmental context faced by both parent/carer and the child. For this reason, a program run in one country, or even community, may not prove as efficacious in another. In Australia, parent support strategies generally will include the development of the family's personal support networks, the creation of social capital in their local communities, and connecting the parent/carer to the available social infrastructure.

Such networking strategies embedded in early childhood programs assist in the creation of a good quality early intervention program which will make a lasting difference in the lives of children, families and society.

> *Studies of good quality early intervention programs have shown that:*
> - *they lead to improved psychosocial and health outcomes in the long-term;*
> - *they are particularly effective with children from disadvantaged backgrounds;*
> - *the earlier the intervention begins (and the longer it lasts), the more effective it is likely to be;*
> - *interventions need to address multiple environmental risk factors simultaneously rather than focusing on single issues - intervention programs that address a*

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50 QCOSS, *Cost effectiveness of Early Intervention Programs for Queensland*, QCOSS, Brisbane, 7 April 2009, p1.

51 QCOSS, *Cost effectiveness of Early Intervention Programs for Queensland*, QCOSS, Brisbane, 7 April 2009, p1.

52 Dean, C. et al, 'Community-wide implementation of a parenting program: the South East Sydney Positive Parenting Project', 2003. Available at: http://www.auseinet.com/journal/vol2iss3/dean.pdf. Accessed on 226 March 2009.

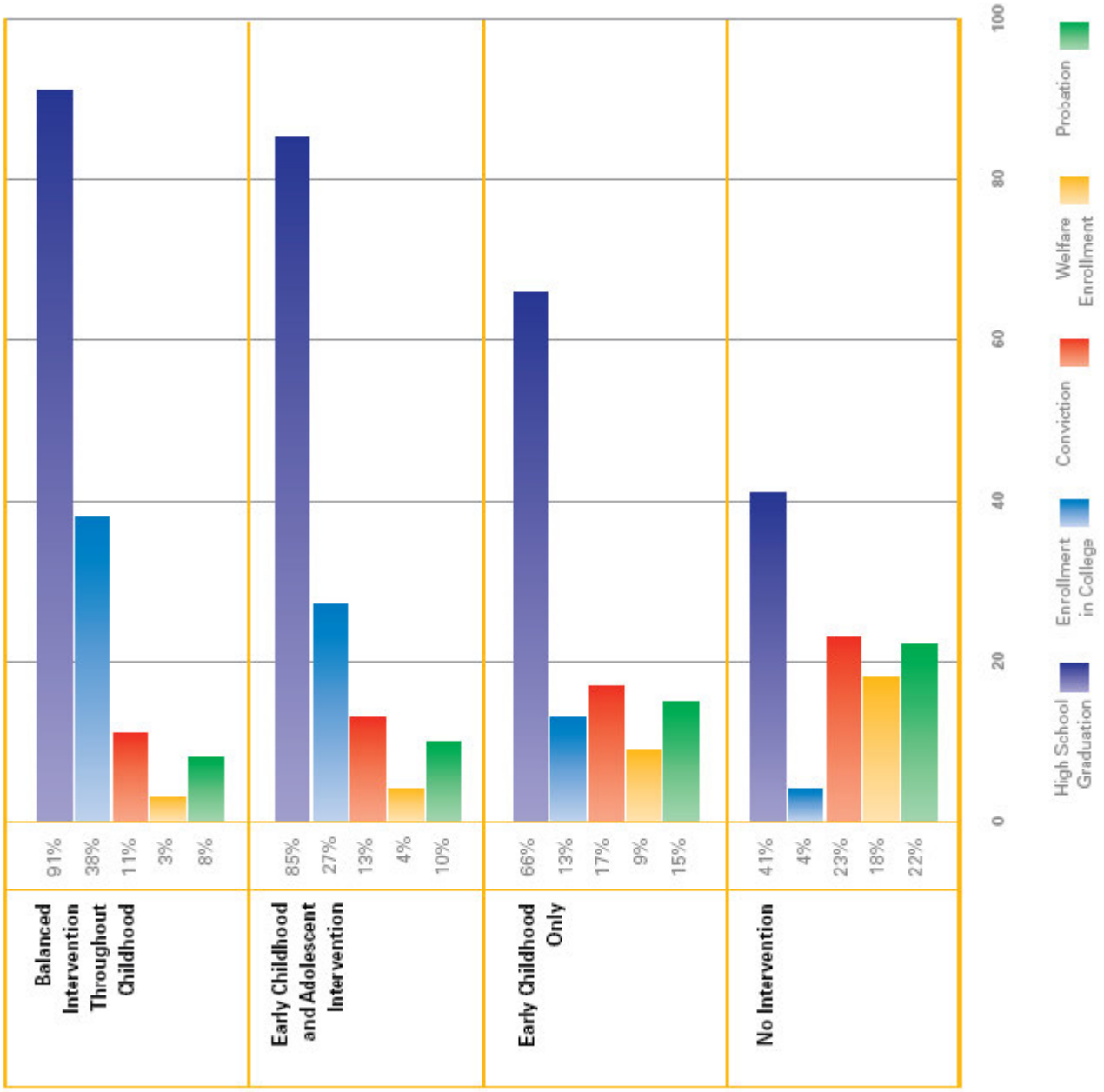
single aspect of child and family functioning are likely to fail by ignoring other factors that can undermine family functioning and child development;

- *sustained intervention over time (rather than intervention at a single time point) is most likely to be effective; and*
- *the nature and intensity of the intervention may vary over time because of changing circumstances and developmental needs and needs to be flexible.*[53]

Intervention is most effective when sustained across the span of childhood. The effectiveness of such intervention is illustrated below:

53 The Australian Research Alliance for Children and Youth, 'Early Childhood and Long Term Development', 2006. Available at: http://www.aracy.org.au/AM/Common/pdf/Topical%20Papers/Importance.pdf. Accessed on 2 February 2009.

Figure 2.4 Importance of intervention when *sustained* across a child's life course[54]



The evidence for the effectiveness of such early intervention strategies is often framed in the twenty-first century in economic terms. It is discussed in the context of that framework in the next chapter.

[54] Elaine Henry, CEO Smith Family, .presentation at CEDA Forum 'Why Investment in Early Childhood makes Economic Sense' 9 March 2009.

(i) Resourcing new parents

Acknowledging that no-one has a greater role to play in child development than a child's parents, the Committee considered that it is essential that every parent is equipped with the knowledge to fully realise their new role. With shorter stays in hospital and less access to infant health services, there is decreasing access to the increasing wealth of information now available in respect to a child's development.

The Committee noted that upon discharge of the mother and baby from hospital the parent(s) are given relevant forms for Centrelink and the Births, Deaths & Marriages Registry Services together with a booklet titled: 'Its all about me'. This is designed as a personal health record for all babies born in Western Australia. In addition to a child's personal health record, this booklet contains:

> • *topics for parents to consider, including baby talk, baby cues, side lying play, tummy time and sensory stimulation.*
>
> • *questions for parents, developed with input from allied health professionals including physiotherapists, occupational therapists, speech therapists and audiologists.*[55]

While this is positive, it is the Committee's view that more must be done to provide quality information on a child's development and to communicate that information in a contemporary fashion. In short there needs to be more emphasis on sharing with parents what we know about critical development pathways and it needs to be delivered in a way that captivates. As a first step, a quality engaging DVD should be produced and distributed to all new parents and that maternity hospital staff be requested to promote its viewing.

Funding should also, in the Committee's view, be allocated for universal post natal parenting classes. Parents should be encouraged to attend at least one or two of these classes. Additionally, the Committee believes that it would not be unreasonable to consider tying the receipt of the baby bonus into the attendance of these post natal classes. This would be recognition of the responsibility that comes with the rights of parenthood.

Finding 1

The learning that occurs during the first three or four years after birth, affects the very architecture of the brain. This places children on developmental pathways that become increasingly difficult to alter as time passes. In recent years changed social circumstances have made parenting of young children a more challenging and stressful business than in the past. With this change in the social environment there is a role for governments to provide more support to parents to enhance their effectiveness as parents.

[55] GP Down South, 'New look 'baby book' renamed "All About Me", 2005. Available at: http://www.gpdownsouth.com.au/images/Winter.pdf. Accessed on 27 July 2009.

Recommendation 1

Recognising the scientific evidence of the critical development pathways that occur in utero and in the first four years of life, together with the evidence that many children are commencing school with significant developmental vulnerability, the Committee strongly recommends a major investment to share with parents the growing understanding of child development and to enhance support in developing good parenting skills.

Recommendation 2

The Committee recommends that the Department of Health provides new parents, on a universal basis, with a quality, engaging DVD detailing a child's developmental stages and clear information as to how they can best assist in their child's development; and that maternity hospital staff be requested to promote the viewing of it.

Recommendation 3

The Committee recommends that the Minister for Health proposes to the Commonwealth Minister for Families, Housing, Community Services and Indigenous Affairs that the receipt of the baby bonus be linked to attendance at post natal parenting classes.

CHAPTER 3 THE ECONOMIC ARGUMENT - PAY NOW OR PAY LATER

3.1 The changing focus of ECEC from survival to economics

> *Biological, social, family, community, and economic influences during childhood impact on children's physical and brain development and therefore have a profound impact on children's capacity to become healthy and productive contributors to society. Much is already known about the factors that facilitate optimum child development; however there is a wide gap between what is known, and what is done. The reality is that most resources are focused at the crisis end, with less concern for preventative or early intervention strategies.*[56]

In recent years there has been increased scrutiny on the economic benefits of investing in early childhood. This represents an evolutionary shift in the focus of our policy settings. The paradigms that have framed our policy settings over the last two hundred years are illustrated the figure below:

Figure 3.1 Early Western childhood paradigms [57]

Period	Paradigm	Focus
18th Century	Survival	Interest in the physical well-being of children
Late 19th Century	Moral	Interest in the appropriate socialisation of children
Early 20th Century	Physical	Interest is in protection of children within the home
1940s – 50s	Psychological	Development problems
1960s - 1980s	Equity	Interest in equitable access to early childhood, education and care
1990s on	Economic	Early childhood, education and care is seen as providing foundations for a productive workforce

> *Applying economic criteria to programs that benefit a child's health, nutrition, and development may appear unnecessary but can be illuminating and serve to document potential returns on investment, thereby encouraging public and private action.*[58]

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56 Australian Research Alliance for Children and Youth, 'Submission to the Review of the National innovation System', 2008. Available at: http://www.innovation.gov.au/innovationreview/Documents/473-%20ARACY.pdf. Accessed on 19 February 2009.

57 Professor Helen May (2006) 'Pedagogy, Politics and the Profession'. NIFTeY Conference February 2006.

58 World Bank, 'Early Child Development: An Economic Perspective'. Available at: http://siteresources.worldbank.org/INTECD/Resources/investing.pdf. Accessed on 13 March 2009.

This increasing focus on the economic outcomes of investing in early childhood has resulted in a parallel growth in the research on this subject world-wide.

The underlying reason for the shift in attitudes to the economic argument is the growing recognition that early identification of behavioural and developmental problems, and the subsequent treatment and management of these issues, promotes positive long term social, emotional, health, education and employment outcomes. Failure to implement effective intervention strategies in the early years necessitates a range of intervention strategies in adult life in the health, justice and welfare environments. These are often more expensive and less effective.

3.2 The economic argument for supporting early childhood development and parenting strategies

> *When we invest wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship. When we do not make wise investments in the earliest years, we will all pay the considerable costs of greater numbers of school-aged children who need special education and more adults who are under-employable, unemployable, or incarcerated.*[59]

There is a strong consensus among the experts who have studied high-quality early childhood education and care (ECEC) programs that these programs reap substantial long-term benefits. In particular, assessments of 'quality' ECEC programs have established that 'participating children are more successful in school and in life after school than children who are not enrolled in high quality programs.'[60]

In the United States, research suggests that many major economic and social problems can be traced to low levels of skill and ability in the population. Of these, most notably:

- 20% of the US workforce is functionally illiterate;
- violent crime and property crime remains high with research documenting the importance of deficits in cognitive and non-cognitive skills in explaining these pathologies;
- the US will add many fewer college graduates to its workforce in the next twenty years than it did in the past twenty years; and
- the high school drop out rate is increasing.[61]

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59 *The Science of Early Childhood Development.* (2007) National Scientific Council on the Developing Child. http://www.developingchild.net accessed on 19 March 2009.

60 Heckman, J.J., 'Skill Formation and the Economics of Investing in Disadvantaged Children', *Science*, No.312, 30 June 2006, p1900.

61 Heckman, J.J., 'Skill Formation and the Economics of Investing in Disadvantaged Children', *Science*, No.312, 30 June 2006, p1900.

In the United Kingdom the *Family and Parenting Support in Sure Start Local Programmes* were developed in direct response to research showing links between parenting and educational achievement/school drop-out, behaviour problems, delinquency, criminality and violence, teenage pregnancy, drug and alcohol misuse and mental and physical health.[62]

Professor Frank Oberklaid summarised the current Australian position in respect to our children and young adults as follows:

- *One in six Australian children [aged between] 4-12 years old have identifiable mental health problems (National Survey of Mental Health and Well-being 2000); [as do] one in four of 12-17 year olds (WA Child Health Survey 2002);*
- *Australia has one of the highest youth suicide rates in world -this rate has quadrupled for young men in past 30 years, doubled for young women (Australian Bureau of Statistics);*
- *Crime is estimated to cost 4% of GDP and rising and assault rates and violent crime rising in Australia;*
- *Juvenile violence and crime [are] rising dramatically compared to adults (Homel R, 2001);*
- *Nearly half (6.2 million) Australians aged 15-74 have literacy skills described as 'poor' or 'very poor' (Aust Bureau Statistics); and*
- *There is an epidemic of obesity - nearly doubled in children over past decade. This is linked in adult life with diabetes, heart disease, stroke with huge implications for health expenditure in future.* [63]

On the basis of similar research, the Federal Reserve Bank of Minneapolis[64] and others have argued the case for early childhood development to be portrayed as an economic development initiative since, without supporting the child's formative years (under five), 'a child is more likely to drop out of school, receive welfare benefits and commit crime.'

In plotting optimal intervention points, there is strong evidence now to suggest that investments made in the early years of a child's life result in better returns than interventions made later on.

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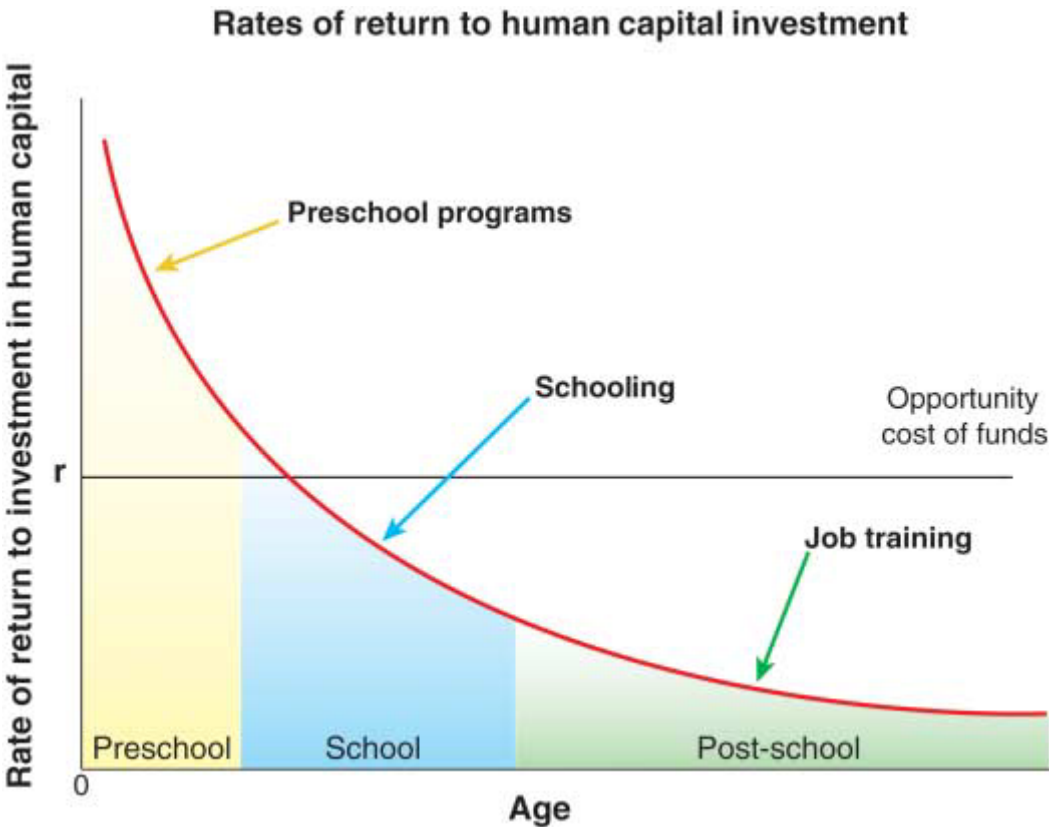
62 Sure Start, '*Family and Parenting Support in Sure Start Local Programmes*', 2007. the Department for Children, Schools and Families.. Her Majesty's Printer and Controller of HMSO United Kingdom.

63 Centre for Community Child Health, 'Development trajectory and the life course', Available at: http://www.vscn.org.au/pages/documents/oberklaid.pdf. Accessed on 13 March 2009.

64 Federal Reserve Bank of Minneapolis, 'Early Childhood Development: Economic Development with a High Public Return', 2003. Available at: http://www.minneapolisfed.org/publications_papers/pub_display.cfm?id=3832. Accessed on 13 March 2009.

Economic analyses such as those conducted by Heckman and others show that a dollar invested in early childhood (0-6 years) yields three times as much as for school-aged children (6-18 years) and eight times as much as adult education (over 18 years).

Figure 3.2 Rates of return to human capital investment.[65]



There are two economic costs that flow from a lack of support for developmental outcomes. The first of these is the direct costs incurred through the need for consequential support or intervention services in later life:

> *All the poor developmental outcomes identified have associated social and financial costs that cumulatively represent a considerable drain on societal resources.*
>
> *To give a single example, a report by the Kids First Foundation (2003) estimated the costs of child abuse in Australia during the 2000 / 2001 financial year as **$4,929m.** This is made up of:*

- *direct human costs of those abused (including fatal child abuse, suicide related to child abuse, medical costs, injury requiring treatment, additional medical service usage arising from abuse and neglect, psychological trauma, educational support and pain and suffering);*

65 Heckman, J.J., 'Skill Formation and the Economics of Investing in Disadvantaged Children', *Science*, vol. 312, 30 June 2006, p1901.

- *long-term human and social costs (including mental disability, increased medical service usage, chronic health problems, lost productivity, juvenile delinquency, adult criminality, homelessness, substance abuse and intergenerational transmission of abuse);*

- *public sector interventions (such as child protection services, out-of-home care, child abuse prevention programs, assessment and treatment of abused children, law enforcement, judicial system, incarceration of abuse offenders, treatment of perpetrators and victim support), and*

- *community sector services (such as services provided by charities, services provided by volunteers and community contributions to out-of-home care).*[66]

The second cost is that of opportunity cost:

> *Investment in disadvantaged young children has high economic returns with reported returns on investment of up to $17 for every dollar spent. Australia's investment in young children is reportedly amongst the lowest of all Organisation for Economic Cooperation and Development (OECD) countries with expenditure (2005) of 0.1% of GDP on pre primary educational services, which equates to 1.7% of the education budget.*[67]

When the benefits are combined and outcomes measured, long-term studies show identifiable benefits from investing in early childhood development. Such studies include:

- The Perry Preschool Program (Ypsilanti, Michigan)
- The Abecedarian Childhood Intervention Project (North Carolina)
- The Chicago Parent Centre Program (Chicago, Illinois)
- The Elmira Prenatal Early Infancy Project (Elmira, New York)

> *Several longitudinal evaluations all reach essentially the same conclusion: The return on early childhood development programs that focus on at-risk families far exceeds the return on other projects that are funded as economic development. Cost-benefit analyses of the Perry Preschool Program, the Abecedarian Project, the Chicago Child-Parent Centers, and the Elmira Prenatal/Early Infancy Project showed annual rates of return, adjusted for inflation, ranging between 7 percent and 18 percent.*[68]

The cost/benefit analysis of these programs is illustrated in the following figure, where the dollar benefit for each dollar invested is charted according to the program evaluated.

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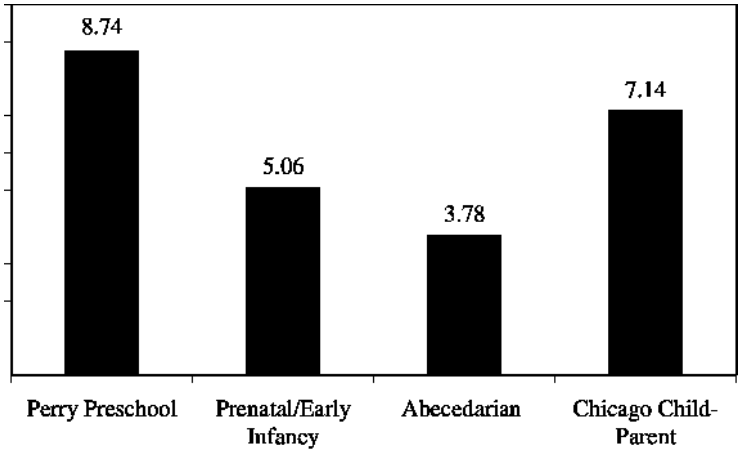
66 Centre for Community Child Health, Royal Children's Hospital, Melbourne, 'The underlying factors affecting child health and development and family functioning', 2004. Available at: http://www.rch.org.au/emplibrary/ccch/EY_UF_Summary.pdf. Accessed on 12 March 2009.

67 Submission No. 8 from Department of Health, p5.

68 Rolnick. A.J. and Grunewald, R., 'The Economics of Early Childhood Development as Seen by Two Fed Economists1', 2007. Available at: http://www.frbsf.org/publications/community/investments/0709/economics_early_childhood.pdf. Accessed on 12 March 2009.

Figure 3.3 Benefit: cost ratio of early child development.[69]



The evaluations of these programs compared children participating in the program with a control group of comparable children not participating in the program, controlling for socioeconomic status.

The implication of studies such as those listed above is that investing in disadvantaged, or 'at risk' infants, produces much higher returns than later interventions. This is particularly the case where those interventions are sustained by quality learning experiences.

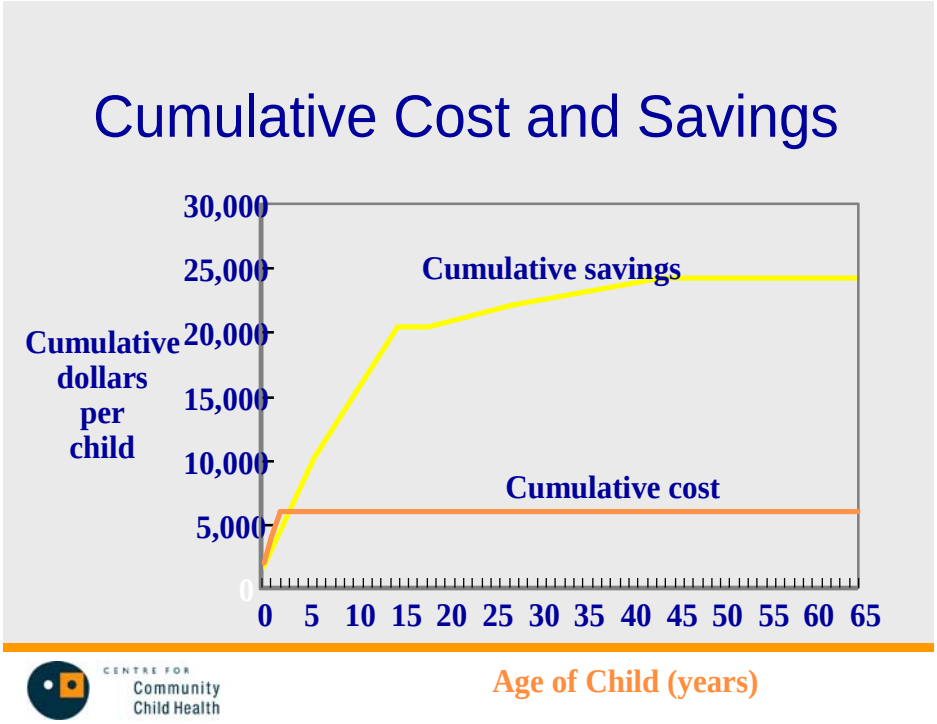
However it is argued by many[70] that since the incentive to invest is one of transferred benefit (as the parents do not receive any direct or immediate benefit themselves) there is a need for the governments to invest in the area. A government/parent partnership is therefore seen as necessary to reduce the incidence of poor developmental outcomes. It will subsequently produce financial benefits for the whole society.

It is readily acknowledged that benefits accrued by such long term strategies take a while to outstrip the costs, but the gap becomes substantially favorable over time. This is true whether calculated per child or as a measure of GDP:

69 Barnett (1993), Karoly et al. (1998), Masse and Barnett (2002), Reynolds et al. (2002,. Available at: http://www.montanakidscount.org/Portals/6/reports/exceptional%20returns.pdf. Accessed on 1 May 2009.

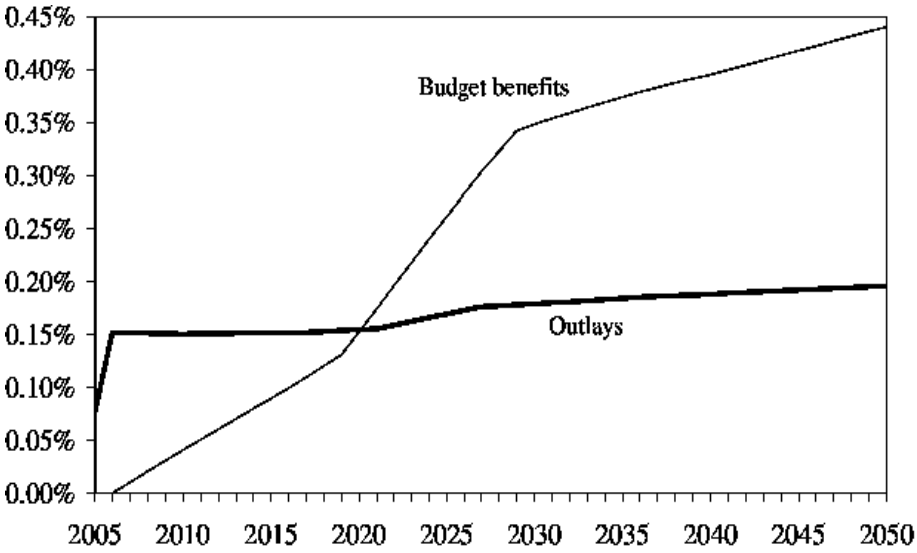
70 Professor Collette Tayler, Briefing 25 February 2009.

Figure 3.4 Cumulative cost: Savings per child



Or:

Figure 3.5 Outlays: benefits as a proportion of GDP[71]



[71] Lynch, R.G. 2004, *Exceptional returns* Economic Policy Institute, Washington D.C.

Finding 2

There are significant economic benefits to be gained by investing in early childhood with reported returns on investment of up to $17 for every dollar spent. In particular, significant savings are achieved by investing in disadvantaged, or 'at risk' infants. Savings made include the number of specialist therapists required, the lack of need for remedial education and intervention for behaviour management. In addition there is a reduction in long-term human and social costs (including mental disability, increased medical service usage, chronic health problems, lost productivity, juvenile delinquency, adult criminality, homelessness, substance abuse and intergenerational transmission of abuse). Instead the next generation will pay back the initial investment through a lifetime of productivity and responsible citizenship.

Therefore, government decisions regarding investments in early childhood development would benefit through greater attention to the long-term societal benefits relative to the program costs incurred.

CHAPTER 4 MEASURING CHILDREN'S DEVELOPMENT

For governments to achieve evidence-based policy to guide Early Childhood Education and Care (ECEC) practice there is need for the collection of relevant, coherent and systematic data. While the data collected by the Australian Bureau of Statistics contains large scale information data sets on population, it does not deliver the kind of data needed to advance ECEC nationally. In recent years the Federal Government has launched two interrelated initiatives that seek to remedy the shortfall. These are:

- The Australian Early Development Index (AEDI); and
- *Growing Up in Australia* a Longitudinal Study of Australian Children (LSAC).

The information gained over time from these studies will help to both target intervention strategies and to provide answers to policymaker's questions about the level and nature of the impact of ECEC programmes on children and their families.

4.1 Measuring child development

(a) Australian Early Development Index (AEDI)

The AEDI is based on the Canadian Early Development Instrument (EDI) and has been adapted for use in Australia. The EDI was developed in response to a need to develop a uniform methodology that would assess children's level of development in the first year of schooling.

In 2003, Australia adopted the EDI for use in Australia where it became the Australian Early Development Index (AEDI). The AEDI is a community measure of young children's development, based on the scores from a teacher-completed checklist. In Western Australia the surveys have been conducted in 23 communities across the state.

Funded by the Federal Department of Education, Employment and Workplace Relations, AEDI is coordinated through the AEDI National Support Centre. This is based at the Centre for Community Child Health in the Royal Children's Hospital in Melbourne, which coordinates AEDI activity across Australia. The AEDI National Support Centre:

- *Supports State and Territory AEDI Coordinators, national advisory groups and local communities;*
- *Supports schools and teachers completing the AEDI;*
- *Processes, analyses and maps the AEDI data; and*

- *Develops and disseminates a wide range of community tools and resources to support the dissemination and use of the AEDI results.*[72]

Through the AEDI National Support Centre, the AEDI gives a picture of what skills children arrive at school with. It provides a base line for intervention strategies.

- *The AEDI helps communities understand how their local children are doing developmentally and compared to children nationally and in other communities.*
- *AEDI results are mapped to provide communities with a picture of the early childhood development strengths and vulnerabilities in each community and on each of the developmental areas.*
- *The AEDI provides evidence that can be used to support policy, planning and action for health, education and community support, to ensure all children get the best start in life.*[73]

The project began in 2004 encompassing 32,500 children from 648 suburbs or local areas. Communities voluntarily applied to opt in. WA has received the most coverage compared to other states. Subsequent to its initial 'pilot' phase, the Australian Government Department of Education, Employment and Workplace Relations has committed a further $15.9 million for the national roll-out of the AEDI, commencing in May 2009.[74]

Pre-primary teachers complete the AEDI checklist for each five year old child in their class based on their knowledge of the children. AEDI results are mapped to provide communities with a picture of the early childhood development strengths and vulnerabilities in their community and on each of the developmental areas. AEDI can then be used by policy makers to plan and evaluate place-based initiatives for children.

The AEDI checklist consists of 104 questions in the 5 developmental areas of:

- physical health and well-being;
- social competence;
- emotional maturity;
- language and cognitive skills; and
- communication skills and general knowledge.

(b) Longitudinal Study of Australian Children (LSAC)

AEDI is embedded into the National Longitudinal Study of Australian Children (LSAC) "Growing Up in Australia." The LSAC study is being conducted by a consortium of nine research

[72] The Royal Children's Hospital Melbourne, 'AEDI', Available at: http://www.rch.org.au/australianedi/index.cfm?doc_id=6210. Accessed on 17 March 2009.

[73] The Royal Children's Hospital Melbourne, 'AEDI', Available at: http://www.rch.org.au/australianedi/index.cfm?doc_id=6210. Accessed on 17 March 2009.

[74] Dr Sharon Goldfeld, Briefing 25 February 2009.

organisations, with the Australian Institute of Family Studies acting as the lead organisation. This study was initiated and funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs as part of its Stronger Families and Communities Strategy. The study aims to examine the impact of Australia's unique social and cultural environment on the next generation and will increase understanding of early childhood development, inform the social policy debate, and be used to identify opportunities for early intervention and prevention strategies in policy areas concerning children.

> *Data are being collected over seven years from two cohorts every two years using a large, and nationally representative, sample of Australian children in two age groups. The first cohort of 5000 children aged less than 12 months in 2003-04 will be followed until they reach 6 to 7 years of age, and the second cohort comprising 5000 children aged 4 years in 2003/04 will be followed until they reach 10 or 11 years of age. Study informants include the child (when of an appropriate age) and their parents, carers and teachers.*[75]

To date the findings indicate that most children are doing well. 'However, a considerable number of children do show poorer developmental outcomes, and the distribution of these children is not evenly spread across the Australian population.'[76]

4.2 What does AEDI tell us about Western Australia?

In Western Australia AEDI data is used by:

- Department for Communities;
- Department of Education and Training;
- Department of Health; and
- Community Health Services (to some degree).

What the AEDI data has shown is that the distribution of developmental vulnerability is very broad. The data for Western Australia has acted as a catalyst for community and government to work together to address local areas of vulnerability. There is then an opportunity to put programs in place and see if change data shows improvement, as was demonstrated in Armadale when the 2004 data acted as a catalyst for intervention strategies whose effects were positively reflected in the 2008 data.

The AEDI maps use five shades of green from dark green through to light green, representing the national quintiles. The darkest shade represents most vulnerable communities and the lightest shade represents least vulnerable communities.[77]

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75 Uniting Care Queensland, 'Moving forward – research and applications'. Available at: www.ucareqld.com.au/index.php?option=com_docman&task=doc_download&gid=41. Accessed on 17 March 2009.

76 Department of Families, Housing, Community Services and Indigenous Affairs , 'Longitudinal Study of Australian Children', 2008. Available at: http://www.facsia.gov.au/research/prp36/exec.htm. Accessed on 23 March 2009.

77 The Royal Children's Hospital Melbourne, 'AEDI', Available at: http://www.rch.org.au/australianedi/index.cfm?doc_id=6210. Accessed on 17 March 2009.

Most Vulnerable ... Least Vulnerable

		Proportion of children developmentally vulnerable (%)							Average Scores (0-10)				
	#	Phys	Soc	Emo	Lang	Com	Vul 1	Vul 2	Phys	Soc	Emo	Lang	Com
ARMADALE	330	6.7	14.6	13.4	29.4	11.4	39.0	19.7	8.64	8.13	7.69	7.31	7.50
BEDFORDALE	23	0.0	4.8	9.5	4.8	0.0	19.0	0.0	9.55	8.96	8.46	9.23	9.38
BROOKDALE	54	7.7	15.4	23.1	37.3	15.4	51.9	30.8	9.09	7.29	7.40	6.54	7.99
FORRESTDALE	24	21.7	26.1	22.7	26.1	21.7	56.5	26.1	7.73	8.75	9.04	6.92	6.88
KELMSCOTT	112	3.6	12.6	10.8	18.0	10.8	32.4	13.5	9.55	8.96	8.46	7.50	8.75
MT NASURA	33	0.0	3.1	0.0	6.3	0.0	6.3	3.1	10.00	9.38	8.27	8.27	9.38
ROLEYSTONE	66	7.6	4.5	6.1	7.6	6.1	21.2	7.6	9.09	9.27	8.85	8.08	8.75
WESTFIELD	94	23.6	27.0	28.1	46.1	29.2	53.9	40.4	7.73	7.29	7.50	5.77	6.25

The following table provides an explanation of the AEDI domains and a profile of children who would be considered to be developmentally performing well or vulnerable.

Vul 1 and Vul 2 - the proportion of vulnerable children.		
Vul 1	The proportion of children vulnerable (i.e. falling below the 10th percentile) on one or more of the 5 AEDI developmental domains. In general about 24-26% of the population of children in Australia covered by the AEDI thus far fall within this Vul 1 category.	
Vul 2	The proportion of children vulnerable on two or more of the 5 AEDI domains. In general about 13-16% of children fall in this category - these are children we would call high risk for not coming to school with the developmental capacity required for school.	
	Children "performing well"	**Children "developmentally vulnerable"**
Physical health and wellbeing		
Physical readiness for school day	Never or almost never experience being dressed inappropriately for school activities, and do not come to school tired, late or hungry.	Have at least sometimes experienced coming unprepared for school by being dressed inappropriately, coming to school late, hungry, or tired.
Physical independence	Are independent regarding their own needs, have an established hand preference, are well co-ordinated, and do not suck a thumb/finger.	Range from those who have not developed one of the three skills (independence, handedness, coordination) and/or suck a thumb to those who have not developed any of the skills and suck a thumb.
Gross and fine motor skills	Have an excellent ability to physically tackle the school day and have excellent or good gross and fine motor skills.	Range from those who have an average ability to perform skills requiring gross and fine motor competence and good or average overall energy levels, to those who have poor fine and gross motor skills, poor overall energy levels and physical skills.
Social knowledge and competence		
Overall social competence	Excellent or good overall social development, very good ability to get along with other children and play with various children, usually cooperative and self-confident.	Have average to poor overall social skills, low self-confidence and are rarely able to play with various children and interact cooperatively.
Responsibility and respect	Always or most of the time show respect for others, and for property, follow rules and take care of materials, accept responsibility for actions, and show self-control.	Only sometimes or never accept responsibility for actions, show respect for others and for property, demonstrate self-control, and are rarely able to follow rules and take care of materials.

	Children "performing well"	Children "developmentally vulnerable
Approaches to learning	Always or most of the time work neatly, independently, and solve problems, follow instructions and class routines, easily adjust to changes	Only sometimes or never work neatly, independently, are rarely able to solve problems, follow class routines and do not easily adjust to changes in routines.
Readiness to explore new things	Are curious about the surrounding world, and are eager to explore new books, toys and games.	Only sometimes or never show curiosity about the world, and are rarely eager to explore new books, toys and games.
Emotional Maturity		
Prosocial and helping behaviour	Often show helping behaviours including helping someone hurt, sick or upset, offering to help spontaneously, and invite bystanders to join in.	Never or almost never show most of the helping behaviours including helping someone hurt, sick or upset, offering to help spontaneously, and inviting bystanders to join in.
Anxious and fearful behaviour	Rarely or never show anxious behaviours, who are happy and able to enjoy school, and are comfortable being left at school by their caregivers.	Often show most of the anxious behaviours; they could be worried, unhappy, nervous, sad or excessively shy, indecisive; and they can be upset when left at school.
Aggressive behaviour	Rarely or never show aggressive behaviours and who do not use aggression as a means of solving a conflict, do not have temper tantrums, and are not mean to others.	Often show most of the aggressive behaviours; they get into physical fights, kick or bite others, take other people's things, are disobedient or have temper tantrums.
Hyperactivity and inattention	Never show hyperactive behaviours and who are able to concentrate, settle to chosen activities, wait their turn, and most of the time think before doing something.	Often show most of the hyperactive behaviours; they could be restless, distractible, impulsive; they fidget and have difficulty settling to activities.
Language and cognitive development		
Basic literacy	Have all the basic literacy skills including how to handle a book, are able to identify some letters and attach sounds to some letters, show awareness of rhyming words, know the writing directions, and are able to write their own name.	Do not have most of the basic literacy skills; they have problems with identifying letters or attaching sounds to them, rhyming, may not know the writing directions and even how to write own name.
Interest in literacy/numeracy and memory	Show interest in books and reading, maths and numbers, and have no difficulty with remembering things.	May not show interest in books and reading, or maths and number games, or both, and may have difficulty remembering things.
Advanced literacy	Have at least half of the advanced literacy skills such as reading simple words or sentences, and writing simple words or sentences.	Have only up to one of the advanced literacy skills; who cannot read or write simple words or sentences, and rarely write voluntarily.

Basic numeracy	Have all the basic numeracy skills and can count to 20, recognise shapes and numbers, compare numbers, sort and classify, use one-to-one correspondence, and understand simple time concepts.	Have marked difficulty with numbers, cannot count, compare or recognise numbers, may not be able to name all the shapes and may have difficulty with time concepts.
Communication skills and general knowledge		
Communication skills and general knowledge	Have excellent or very good communication skills and can communicate easily and effectively, can participate in story-telling or imaginative play, articulate clearly, show adequate general knowledge, and are proficient in their first language.	Can range from being average to very poor in effective communication, may have difficulty in participating in games involving the use of language, may be difficult to understand and/or have difficulty in understanding others; may show little general knowledge and may have difficulty with their first language.

The previous AEDI chart highlighting the results for the Armadale, Brookdale, Forrestdale and Westfield districts reflects a high percentage of children vulnerable in two or more of the five AEDI domains. (Vul. 2) The consequence of such high percentages of vulnerable students in the classroom is reflected in significant behavioural issues, which also impacts other students, learning difficulties and pressures on the teaching staff.

The new AEDI census data will provide change data for 60% of WA which can be used. Both DfC and DET use the data extensively when proposing a full services school. DET currently has no policy that enables them to look at children prior to entry.

CHAPTER 5 SERVICES IN WESTERN AUSTRALIA

5.1 The demographics behind service delivery

Western Australia is the largest state in the Commonwealth of Australia covering an area of 2.5 million square kilometres with a population of c. 2,188,500;[78] less than one person per square kilometre. Additionally, the population is distributed very unevenly across the state.

Figure 5.1 Population distribution in Western Australia

As at 30/6/2006[79]	Major Cities incl. Perth	Inner Regional	Outer Regional	Remote	Very Remote
	71.5%	12.5%	9.3%	4.5%	2.3%

In Western Australia as at the 2006 census there were 230,078 children 0-8. These numbers are broken down as follows[80]:

Figure 5.2 Distribution of children in Western Australia

Country and Metro	0-4 years	% Distribution	0-8 years	% Distribution
Country*	35,122	28.13%	66,169	28.72%
Metropolitan*	89,506	71.69%	163,551	71.08%
No Usual Address	210		358	
Total	124,838		230,078	

(a) Population growth and birth rates in Western Australia

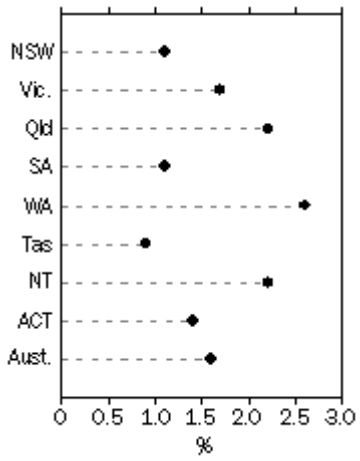
As at June 2008, Western Australia recorded the strongest rate of population growth of all the States and Territories in Australia.

78 Australian Bureau of Statistics, 'Australian Demographic Statistics, Sep 2008', Available at: http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0/. Accessed on 15 April 2009.

79 Australian Bureau of Statistics, 'Population Distribution', 23 July 2008. Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008. Accessed on 16 March 2009.

80 Yayoi Ikeda, Department for Communities, email, 8 April 2009, p1.

Figure 5.3



This growth is attributable both to immigration from the other states and overseas and a recent sharp increase in the birth rate.

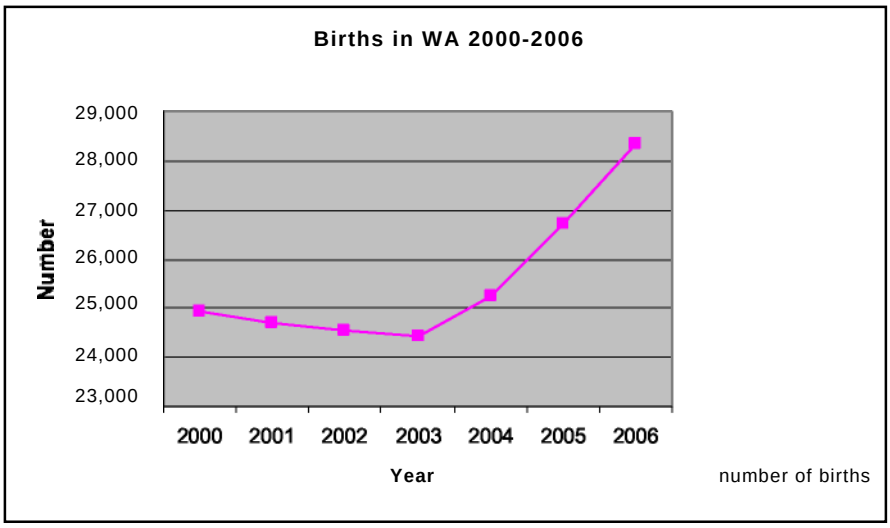
> *The population of Western Australia continues to increase faster than that of any other Australian state and territory, growing by 2.3% (46,700 people) in 2006-07.[5] In the year ended 30 June 2008, Western Australia recorded the largest percentage increase in Australia in the number of children aged 0-14 years (2.4%).[6] Western Australia has experienced a sharp and significant increase in the birth rate, up by 15.6% since 2002.* [81]

This recent change to Western Australia's birth rate poses significant policy challenges to service delivery. This is the more so when combined with a changing international economic landscape and the consequent constraints placed on all governments budgets.

The increased birth rate is powerfully illustrated in the figure below:

81 Submission No. 15 from Commissioner for Children and Young People WA, p4.

Figure 5.4



The impact of the increasing birth rate is evidenced in the number of children in each succeeding cohort, as follows:

> *Estimated number of children 0-4 in Western Australia as at 30/6/2008 was 143,035.*
>
> *Estimated number of children 5-9 in Western Australia as at 30/6/2008 was 138,804.*[82]
>
> *Since 2002 .there has been a 24% increase in live births in the Perth metropolitan area, (22405 infants)*Midwifes Notification System DOH August 2008. 6% of these infant were Low birth weight infants. 7.5% of these children have medically diagnosed movement disorders and 4.3% have been diagnosed medically with developmental delay* WA DOH Child Health Survey 2007. Despite the population growth and increased survival rate of Very Low Birth weight infants the Allied Health clinical staff levels has been static for 15 years in Child Development Services, KEMH, TCCP and DSC.* [83]

The significance of this increase will be felt in the coming years and influence the shape of future policy direction.

> *The increased birth rate in the present will obviously lead to an increase in the number of young children in the future; in the metropolitan area alone, the 0-4 year old population is expected to reach more than 105,000 by 2016 (a 13.8% rise in the ten years since 2006).*[84]

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82 Australian Bureau of Statistics, 'Estimated Resident Population ', Available at: http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/7912EA974955B9A1CA25757C00137DD1/$File/31010_sep%202008.pdf. Accessed on 2 April 2009.

83 Submission No. 22 from Touch Move & Play Physiotherapy Services, p2.

84 Submission No. 15 from Commissioner for Children and Young People WA, p4.

Outside of the Perth metropolitan area Western Australia is relatively sparsely populated. This provides particular challenges to service provision and equity of access across the state. In fact, "service provision, particularly in remote communities, is often compromised by accessibility and workforce availability."[85] Yet it is in the regions, especially the Pilbara and the Kimberley where the highest per capita birth rate occurs and has the highest percentage of children (aged 0-14 years) as a proportion of the population.[86] One of the reasons for that is the higher birth rate amongst Aboriginal women.

> *In 2006 Aboriginal mothers represented 6.3% of women who gave birth and Aboriginal women had birth rates on average almost twice as high as non-Aboriginal women. Of births to teenage mothers, the proportion to Aboriginal mothers was six times greater than for non-Aboriginal mothers. Children born to adolescent mothers are at increased risk of being premature and of low birth weight.*[87]

However, there is a correspondingly greater level of 'low birth weight' mothers with the collateral developmental issues low birth weight carries.

> *In 2006-07, 8.5% of the total births were premature (less than 37 weeks gestation) and 6.8% of births were of low birthweight (weighing less than 2500 grams). Low birthweight infants face a higher risk of death within the first year of life and have higher rates of disability, developmental delay and disease than other infants. Trends indicate that the proportion of low birthweight babies from Aboriginal mothers ranged between 13.1% in 1993 to a high of 16.5% in 2005. In contrast, the proportion of low birthweight babies from non-Aboriginal women ranged between 6.0% in 1994 and 6.6% in 2004 (Department of Health, 2007).*[88]

When the geographical size of the state is combined with the disproportionate rate of child bearing of the Aboriginal population compared to the non-Aboriginal population, the issue of accessible and resourced services for non-metropolitan areas is significant.

> *Particular issues also arise in some regional areas. The Midwest/Murchison and Pilbara regions have reported increasing numbers of young families with many isolated from their extended families. In the Kimberley, Pilbara and Goldfields, there are many Indigenous families with complex problems including drug, alcohol and gambling addictions, child sexual abuse, single parents and mental health problems.*[89]
>
> *Teenage Mothers: Across 2002 to 2007, approximately 11% of Aboriginal mothers in metropolitan area gave birth aged 17 years or less, compared with approximately 1.5% of non- Aboriginal mothers. Children born to teenage mothers are at increased risk of poorer health outcomes. This includes higher rates of infant mortality, low birth weight, childhood*

85 Submission No. 8 from Department of Health, p4.

86 Australian Bureau of Statistics, 'Population Distribution', 23 July 2008. Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3002008. Accessed on 16 March 2009.

87 Submission No. 8 from Department of Health, p10.

88 Submission No. 8 from Department of Health, p10.

89 Submission No. 8 from Department of Health, p18.

accidents and hospital admissions. Teenage mothers themselves are at increased risk of experiencing poverty, unemployment and not completing education or training.[90]

Such factors have a bearing on subsequent Aboriginal disadvantage.

(b) The Indigenous population in Western Australia

Many Indigenous people, especially those living in remote communities, do not have adequate quality housing, reliable supplies of water and electricity or adequate sewerage and drainage systems, all of which have an impact on health. The Indigenous population of Australia generally has poorer health than the non-Indigenous population and compares unfavorably on most other socioeconomic indicators.

Indigenous children were over-represented in child protection systems across most of Australia in 2001-02. The incidence of Indigenous children being placed under care and protection orders and in out-of-home care was around six times that for non-Indigenous Australian children. Almost two-thirds of children in out-of-home care were placed with Indigenous relatives/kin or with other Indigenous care givers. These are the preferred placements under the Aboriginal Child Placement Principle that all jurisdictions have adopted.

The age structure of the Indigenous population, their level of health and their socioeconomic status has a great impact on the types of services Indigenous people need.[91]

Figure 5.5 Estimated resident population: Indigenous status: 2001 and preliminary 2006

	2001	2006			2006 Indigenous		
	Indigenous	Indigenous	Non-Indigenous	Total	Proportion of total Indigenous population	Proportion of state/territory population	Intercensal change 2001-2006
	'000	'000	'000	'000	%	%	%
Western Australia	**65.9**	**77.9**	**1 981.1**	**2 059.0**	**15.1**	**3.8**	**18.2**
Australia(b)	458.5	517.2	20 184.3	20 701.5	100.0	2.5	12.8

There is a sharp contrast in the age distribution of the Aboriginal population when compared to the non-Aboriginal population for two reasons:

i) the total fertility rate for Indigenous women (2.4 babies per woman) is considerably higher than the fertility rate for all women (1.9 babies per woman) and

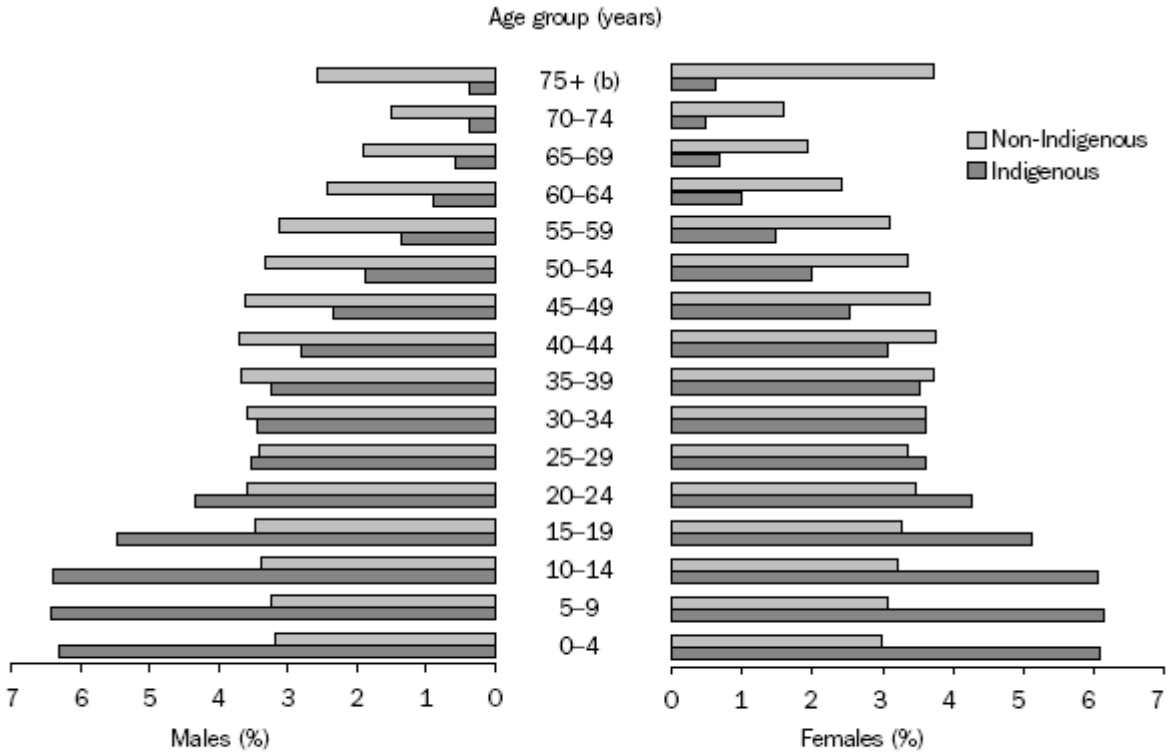
90 Health WA, Population profile of 0-19 year olds residing in Perth, WA, report prepared by Research & Planning team Strategic Support Unit Child and Adolescent Community Health , October 2009, p18.

91 Department of Infrastructure Transport Regional Development, and Local Government 'Services to Indigenous communities', Available at: http://www.infrastructure.gov.au/local/publications/reports/2002_2003/C5.aspx. Accessed on 7 April 2009.

ii) the median age of the Indigenous population is 21 years (37 years for non-Indigenous).[92]

The demographic consequence nationally is illustrated in figure 5.6 below which highlights the differences in the age profile between the two population groups.

Figure 5.6



(a) Preliminary estimate based on the 2006 Census of Population and Housing.
(b) Includes all ages 75 years and over and is not directly comparable to other age groups.
Source: Australian Demographic Statistics (3101.0).

Much of the Aboriginal population face significant health, care and education issues. This is in some part due to geographical factors contributing to inadequate service provision, combined with poverty and unemployment:

- *Aboriginal Australian babies have the lowest birth weight in the OECD.*
- *42% of children in out of home care are Aboriginal.*
- *Aboriginal infants die at around three times the rate of non-Aboriginal infants. Australia.*

92 http://www.fahcsia.gov.au/Indigenous/closing_the_gap/p2.htm - ft6#ft6.

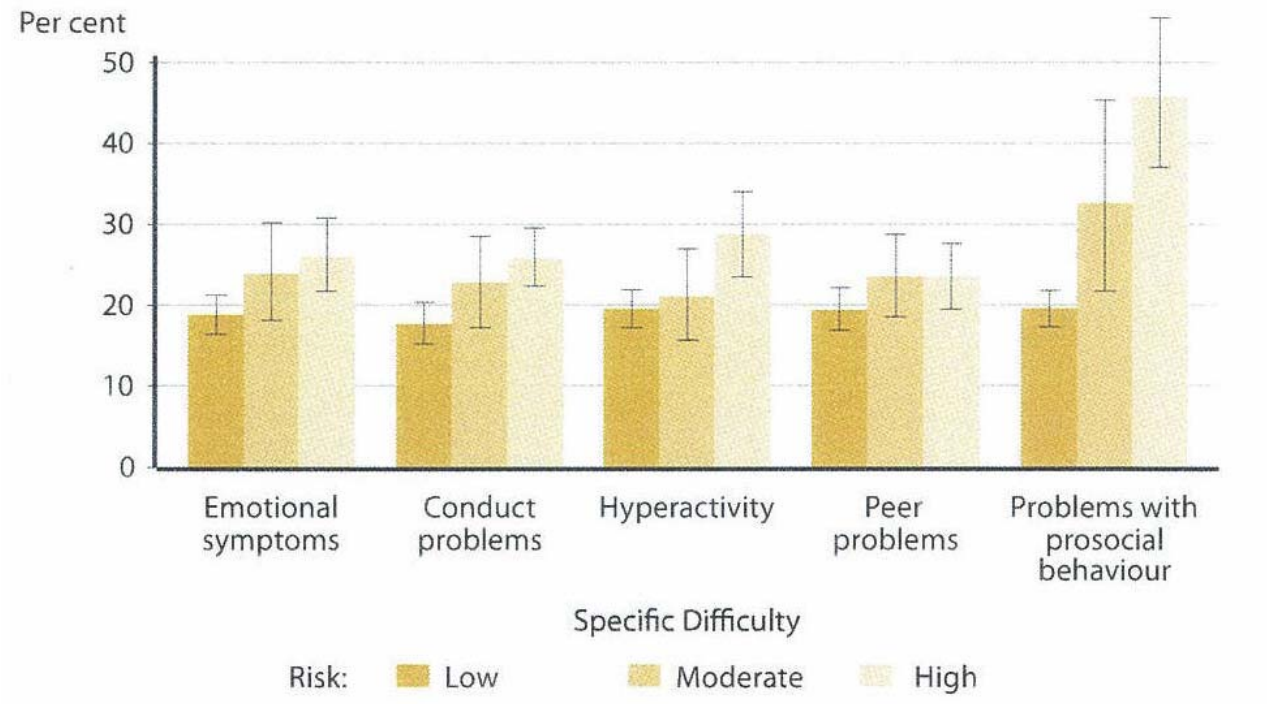
- *Aboriginal Australian children rank 23rd out of 24 OECD countries in the area of mental health.*
- *In WA schools, in every year and every area tested, Aboriginal student achievement is significantly lower than non-Aboriginal student achievement.*
- *75% of young people in juvenile detention are Aboriginal.*[93]

Additionally:

> *Indigenous children currently experience much poorer outcomes than non-Indigenous children, with high levels of disadvantage in early childhood associated with poorer outcomes in health and education.*[94]

A strong association exists between family functioning and children's behaviour. The Institute of Child Health Research published their findings in relation to poor family functioning diagrammatically with respect to Aboriginal children 4-17 as illustrated below:

Figure 5.7



93 Submission No. 15 from The Commissioner for Children and Young People WA, p20.

94 Department of Family Housing Community Services and Indigenous Affairs, 'The challenge facing Australia', 2008. Available at: http://www.fahcsia.gov.au/Indigenous/closing_the_gap/p2.htm. Accessed on 7 April 2009.

(c) Prevalence of developmental disorders in the general population

NIFTeY estimate the prevalence of developmental problems indicates that 1 in 7 will have significant learning problems, 1 in 3 serious behaviour disorder, 1 in 20 one of the forms of ADHD, 1 in 10 language disorders, 1 in 160 ASD, and 1 in 1000 a disorder of vision or hearing. It is also known that Australia has only 17% of its population functioning at levels 4 and 5 of Literacy competency, skills neurologically connected in the early preschool years of life.

Furthermore, we note the increase in parental mental health disorders, alcohol and drug addiction, Foetal alcohol syndrome, child physical and sexual abuse and neglect. Concern is being expressed about the tendency to added risks to children in out of home care.[95]

(d) Rates of severe and profound disability in early childhood

The Australian Bureau of Statistics (ABS) estimates that the prevalence of severe and profound core activity limitation is 4.1% of children 0 to 4 years, i.e. approximately 5000 children in Western Australia.

Disability projections for the period 2008 to 2013 indicate a 3.9% growth in the preschool age group, less than 1% a year. This number is derived from the population projection and the prevalence of disability in this age group.[96]

Of these 5,000 children only 1,000 children 0 to 4 years are in receipt of funded early childhood intervention.

It is not known how many of the 4000 children estimated by ABS as at risk but who are not known to the [Disability Services]Commission in their preschool years:

- *have been in receipt of appropriate services from other government or non-government agencies;*
- *are on the pathway of referral and assessment;*
- *have families who have been advised to `wait and see'; and*
- *have families and carers unaware that a child's experiences in the early years have a major impact on their future development; or have not been involved with any universal program and their developmental needs remain unrecognized.*[97]

95 Submission No 13 from NIFTeY (WA), p2

96 Submission No. 37 from Disability Services Commission, p4.

97 Submission No. 37 from Disability Services Commission, p4.

5.2 An overview of existing programs and services in Western Australia

In Australia the overall health and development of children rates highly on many indicators. However,

> *There are increasing proportions of children and young people with complex diseases such as asthma, diabetes, over-weight and obesity, increasing levels of behavioural, developmental, mental health and social problems, along with the significant disparities between Indigenous and non-Indigenous children.*[98]

It is in this context and that outlined in the previous chapters that the Western Australian Government delivers services and programs to support families with young children. These programs include maternal and child health support, early childhood education and care, parenting information and family support. Most of these services have evolved quite separately over time and continue to evolve in response to diverse and changing child and family needs.

These services/programs are delivered primarily under the auspices of five departments.

- The Department of Education and Training (DET)
- The Department of Child Protection (DCP)
- Department for Communities (DfC)
- Department of Health (DoH)
- Disabilities Service Commission (DSC)

These programs and services for children and their families have as their foci any or all of five key areas. These are:

- promoting healthy pregnancy, birth and infancy;
- improving parenting and family supports;
- early intervention;
- strengthening early childhood development, learning and care; and
- strengthening community supports.

The Committee notes that the Western Australian Government provides significant support to not-for-profit organizations that work to advance children's health and well-being through the funding of initiatives by the listed departments.

The resultant programs, which are outlined below, are a mix of universal and targeted strategies with some overlap, notably those run by DCP and DfC. The reason for the overlap is partly explained by the recent creation of these two departments from the former Department for Community Development, in 2007.

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98 Submission No. 8 from Department of Health, p13.

> *The theory of the break-up—the underlying principle—was that the Department for Child Protection is responsible for what are called tertiary and secondary services, and the Department for Communities is responsible for primary services. So tertiary in our department is children who have been taken into the care of the state—child protection, intervention. So when there are accusations of abuse, we intervene on that basis. They are tertiary; so really when things have gone totally awry and there is a need for strong state intervention. Secondary services are captured in our program, which we call family and individual support. This is where people are really struggling and are at significant risk, and takes in significant issues such as homelessness throughout the whole population; or families that, if some sort of support and intervention does not occur, are at risk of requiring a tertiary child protection service. So they are quite wide ranging. The other way of looking at those secondary services is that they are the more traditional welfare services that the state of Western Australia has been providing since 1882 through the poor relief department. So that is the theory of the break-up, and as near as possible the programs are provided in that way.*[99]

Three significant parenting programs that were run by the former Department for Community Development went to the Department for Communities. They were the parenting program, which was previously the parent help centre in Mt Lawley, the parent coordinators and the parent link programs.

In Western Australia the programs and services delivered by the five departments were advised as follows:

(a) Services delivered through the Department for Communities[100]

Parenting WA Centre:

This centre, based in Mt Lawley, is a 'one stop shop' for families or agencies seeking information or support with parenting, child care and 'early years' activities in WA. Core functions include:

- The Parenting Line (free call), which answers parenting queries regarding children 0-18 years re child development, behaviour management, school matters, health issues and family relationships. Local program options and referrals are provided.

- The Community Services database, which is a comprehensive list of services for families, parenting and child development throughout Western Australia. The database is housed on the Departmental intranet and assists staff with referral processes. It is updated regularly.

- The Courses Guide, which is available to the general public via the DfC website. It has information on courses in the greater Perth region about parenting and child development.

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99 Mr Terry Murphy, Director General, Department of Child Protection, *Transcript of Evidence*, 11 March 2009, p3.

100 Submission No. 3 from Department for Communities, p1-5.

- Publications and brochures are sourced by Parenting WA to distribute to callers, other agencies and professionals.

- The state-wide Parenting Library which provides a free lending service of resources to parents, families and others seeking parenting information, including people living in rural and remote areas.

Two other initiatives being developed are:

- establishing a parenting forum with guest speakers and other activities focused on 'parenting'.

- developing a clearing house to disseminate useful research and information to practitioners and organisations.

Parent Link:

Parent Link provides a home visiting service for families with young children 0-5 years. Coordinators and trained volunteer visitors provide practical parenting strategies to families. The volunteers work with families to strengthen the parent/child relationship and increase their confidence in raising their children. Families are linked into their local community agencies and supported to access these resources. Parenting workshops and programs are provided.

Thirteen Parent Link services operate in WA. These include:

- Eight DfC programs located at Scarborough, Armadale, Joondalup, Mandurah, Albany, Geraldton, Port Hedland and Northam.

- Five non-government programs funded by DfC:

    - CLAN WA: two services at Cannington and Rockingham

    - Centrecare: one service at Mirrabooka

    - Meerilinga: two services at Fremantle and Midland/Forrestfield.

Community Parenting Services:

The focus of this program is families with children from babies to teenagers. Coordinators work with parents to develop their skills, knowledge and confidence in roles as parents. Strategies used include workshops and parent training programs, one to one support and referrals. Many clients come from vulnerable populations such as teen parents, newly arrived migrants, refugees, Indigenous families and prisoners.

Fourteen DfC staffed services currently operate in WA in the following locations:

- Metropolitan: Cannington, Joondalup, Mandurah, Midland, Mirrabooka, Rockingham

- Country: Kalgoorlie, Paraburdoo, Albany, Broome, Bunbury, Carnarvon, Geraldton and Northam

Family and Community Support

Fifty-four non-government services in locations across the State are funded (for a total of approx $3.9 million) to strengthen families through engaging with and working in partnership with families and community groups. A strengths based approach is used to develop skills and knowledge and build self esteem. Families are linked to social support networks and other community resources. The focus is on families with dependent children, especially low income families.

Home visiting services

Five non-government organisations are funded (for a total of approx $300,000) to support the development of strong families. The family support home visiting services recruit, train, supervise and support volunteers to go into family homes to provide assistance including emotional support, building self esteem, linking with social support networks, information and practical assistance.

A key target group for this service is low income families with dependent children up to the age of 12 years.

Parenting preventive services

Five non-government organisations are funded (for a total of approx $2.1 million) to support parents who require individual support to develop or increase their parenting skills. The services use a positive approach to strengthen the parent/child relationship and reduce difficulties experienced by families. Ngala's Family and Early Parenting services and Early Education and Mobile programs for carers and parents with children aged between 0-5 years are included.

Early Years Grants and Activities

DfC early years programs (for children in the 0-8 year range) are based on the evidence demonstrating the critical role that positive early experiences can have in predicting later health and well-being outcomes in adolescence and adulthood.

The Early Years Activities fund of $200,000 supports local grass-roots early years activities including activities and events for children and their families, guest speakers or small, one-off projects. Examples include: setting up a dads' playgroup, developing early literacy resources for Aboriginal children, and an early brain development workshop for parents-to-be. This program provides a timely, responsive and accessible source of small amounts of funding and contributes to successful partnerships between DfC and local organisations to promote community building.

Children's Services

DfC Children's services programs include both licensed and non licensed services for children from 0-13 years. Child care services that require a licence include family day care, out of school care and long day care centres. The licensing process is a way to safeguard and monitor the protection of young children in any environment where someone other than a family member is responsible for the child's care and well-being.

Services that do not require a licence typically include playgroups, crèches, in home care, and holiday activity based services. Families are responsible for their child's care in these circumstances, and parents often participate in associated community activities.

Licensing and monitoring of licensed children's services

In Western Australia, as at the 2006 census, there were 230,078 children 0-8. These numbers are broken down as follows[101]:

Figure 5.8

Country and Metro	0-4 years	0-8 years
Country*	35,122	66,169
Metropolitan*	89,506	163,551
No Usual Address	210	358
Total	124,838	230,078

For many working parents the need for child care is an imperative and the Child Care Licensing and Standards Unit (CCLSU) provides services to the child care industry. This includes assessment and processing of licence applications for all service types and providing information to potential and existing child care licensees so that they understand and comply with the regulations prescribed under the *Child Care Services Act 2007*.

As at February 2009 there were 42,248 licensed child care places available across the State including out-of-school-care.[102]

101 Yayoi Ikeda, Department for Communities, email, 8 April 2009, p1.

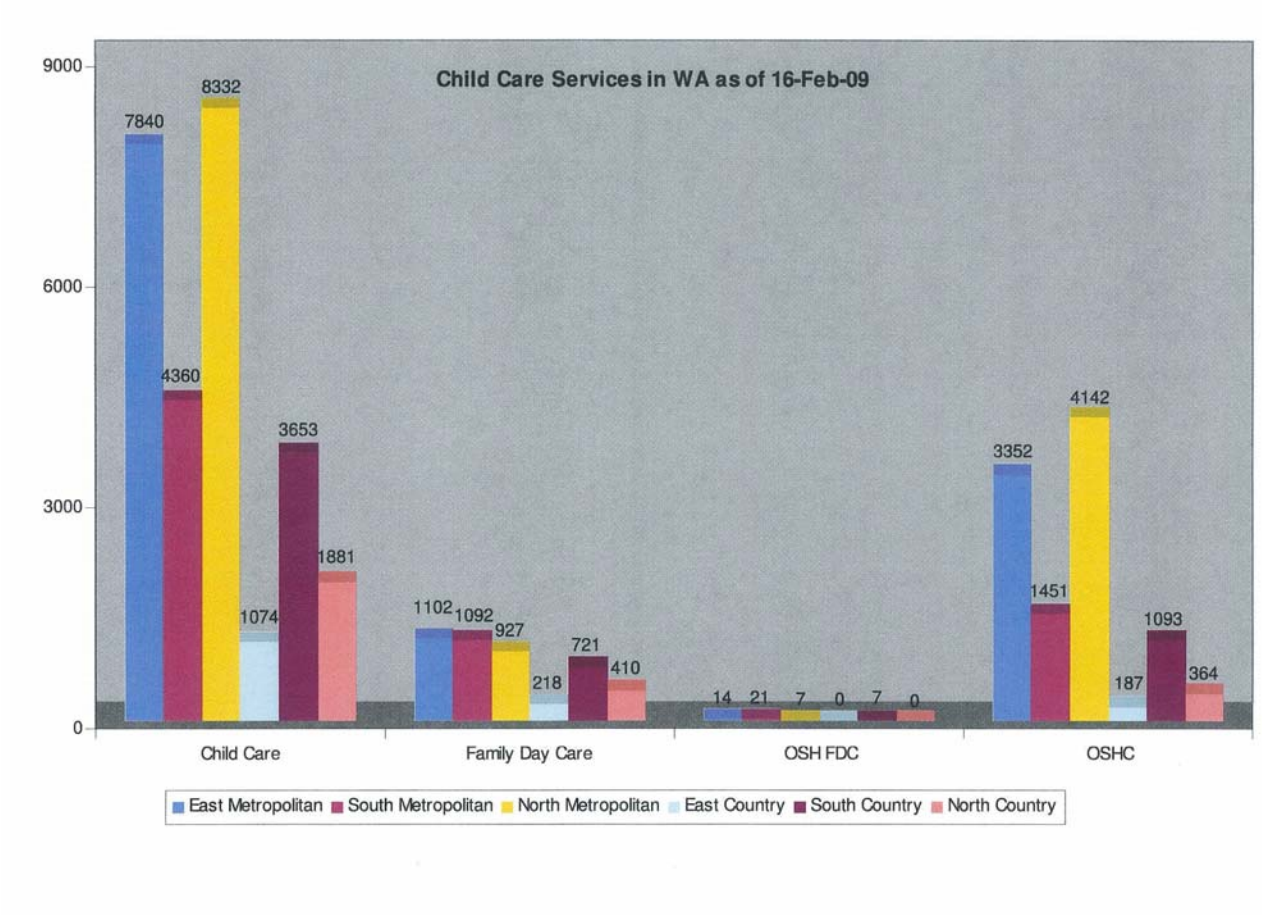
102 Yayoi Ikeda, Department for Communities, email, 6 April 2009, p1.

Figure 5.9

Sum of Total Places	Type				
Region	Child Care	Family Day Care	OSH FDC	OSHC	Grand Total
East Metropolitan	7840	1102	14	3352	12308
South Metropolitan	4360	1092	21	1451	6924
North Metropolitan	8332	927	7	4142	13408
East Country	1074	218		187	1479
South Country	3653	721	7	1093	5474
North Country	1881	410		364	2655
Grand Total	27140	4470	49	10589	42248

This is represented graphically as follows[103]:

Figure 5.10



Child care services are monitored across the State to ensure compliance with the regulations, and to respond to concerns and complaints from parents and families of non-compliance.

103 Yayoi Ikeda, Department for Communities, email, 6 April 2009, p1.

The recent review of the child care regulations took into account new knowledge about child development and care environments, changes in the expectations of the broader community and the diverse range of service providers and service types. Recommendations from the review included increasing minimum staff qualifications, increased qualification requirements for service leaders and ongoing staff professional development to ensure that the knowledge of staff remains current.

Support and advice to children's services

Children's Services Officers (CSOs) based in metropolitan and regional locations throughout WA provide child care industry support and information services. This includes advice to prospective licensees about setting up child care service types and licensing processes and ongoing support to ensure that services maintain the standards in the child care regulations.

CSOs provide information to parents about local child care options and issues to consider re placement. Families are encouraged to develop positive partnerships with their child's carers to enhance well-being and optimal development. Referrals and resources are provided to parents seeking general information about activity and support services for their children, including those with additional needs.

Occasional Child Care (OCC) program

The Commonwealth/State Occasional Child Care Program subsidises the operation of 39 services (for a total of approx $640,000) with a focus on children 0-6 and their families.

This strategy helps establish child care and child focussed activities in rural and remote locations. Requirements, families and providers differ greatly from region to region, from town to town and season to season. CSOs provide extensive support to the development of these services. A key outcomes is that seven Indigenous communities in the Kimberley have been supported over several years to develop confidence by running play activities initially, progressing to playgroups and eventually to a child care service.

Aboriginal Early Years Service

Best Start

This voluntary program aims to improve life opportunities for Aboriginal children aged between 0-5 years, with co-operation from local health, welfare and Indigenous agencies. Coordinators and activity leaders are employed to create a family friendly, Aboriginal specific service in a suitable venue. Improving school readiness through play based activities is a key objective, but this starts from birth and transitions through to school enrolment. Several factors differentiate this program from other ‘supported playgroup’ models. Parents and carers must attend with their child, and are an integral part of all activities. Mothers and fathers are made welcome even before their first baby is born, and many families continue to attend with each subsequent sibling. Coordinators refer and support 'at risk' and/or socially isolated families to local agencies and resources to deal with family violence, accommodation, addiction and legal and other issues.

There are three metropolitan and ten regional/remote services operating across WA. Each service has been designed and developed with local Indigenous input and the co-ordination role ensures support from local agencies. Indigenous families recognise the benefits of Best Start and promote this service model to their extended families and friends.

Foetal Alcohol Spectrum Disorder (FASD)

The higher prevalence of FASD in Indigenous children is as a key area of concern. DfC's initial focus is to identify existing prevention and intervention resources and programs, so that these can be used or adapted to better support children and families living with FASD.

DfC is developing training packages for professionals, parents, carers and parenting practitioners dealing with FASD.

Aboriginal Early Years

Six non-government agencies are funded (for a total of approx $590,000) to focus on Aboriginal families with children 0-3 years old. This voluntary service promotes parenting knowledge, skills and positive behaviour during a child's first three years of life. Families either self refer or may be referred by health, welfare and Indigenous agencies. The program builds on the cultural strengths within families providing short to medium term support and linking families to social support networks and community resources.

Family Centres

There are 33 Family Centres in WA, along with 8 other community buildings.

The Community Facilities Support program provides approx $1.1 million or an average of $36,000 per Family Centre to coordinate services and activities with the local community.

Family Centres provide a venue for many activities for very young children and their families, including playgroups, parenting workshops and information, young mums groups and child care services. The key goal is to enhance the well-being of individuals and families in the local region.

(b) Services delivered through the Department for Child Protection[104]

(i) Responsible parenting services

Best Beginnings

The *Best Beginnings* Program is an evidence-based, early-intervention home-visiting service provided to families and their new-born children. The service aims to improve outcomes for families and children for whom there is a risk of poor life outcomes. The service is holistic, building on strengths within individuals and families to enhance infant health and well-being and

104 Submission No. 36 from Department for Child Protection, p3-9.

parenting skills, and facilitate linkages with community support systems. The service promotes parental competence, knowledge, skills and positive behaviour.

The service employs an evidence-based clinical framework which is outlined in the Best Beginnings Manual. The program is modeled on Queensland's Department of Health's Family CARE program, incorporating the Olds model of home visiting. The Best Beginnings Program has adapted the model to suit the local service context and clients' needs. Clinical practice occurs under the supervision of Child Protection District Office Team Leaders and WA Health Clinical Nurse or Community Health Managers, and is supported by a Child Protection Senior Practice Development Officer, ongoing training, regular team case conferencing and clinical supervision.

Best Beginnings is provided collaboratively with the Department of Health.

ParentSupport

ParentSupport is an evidence-based, multi-intervention through casework, specialist service. The program contains relational, educational, therapeutic and tailored components including home visiting for up to six months. The service aims to enhance parenting capacity and confidence. *ParentSupport* teams are typically situated within each Department of Child Protection district office in the metropolitan area and across the Kimberley.

ParentSupport has developed its own clinical framework which is targeted and tailored to context, operationalised using the "Family Functioning Profile", flexible and responsive to local needs and conditions. Operational principles are in keeping with the latest formal and practice evidence, and are in keeping with other principal articulations such as the 'C' Frame. It is supported by background papers, training, accreditation, supervision and a database. Continued pursuit of best practice is achieved through a Clinical Governance System with on-going research and review of current literature, and application of key learning from the program into improved structures, systems and processes.

The Signs of Safety child protection practice framework

The Department is adopting and implementing Signs of Safety as its child protection practice framework. It is anticipated that over time, *Signs of Safety* will form the basis of a consistent, evidence-based approach to child protection practice across the Department and partner agencies.

Constructive working relationships between professionals and family members, and between the professionals themselves, are a critical factor in practice in situations where children suffer abuse. A significant body of thinking and research suggests that best outcomes for vulnerable children arise when constructive relationships exist *in* both *these arenas.* Research *with* parents *and* children who *have* been through the child protection system assert the same finding.

The Signs of Safety framework supports an approach to practice that is inclusive of all people significant to the safety and well-being of the child/young person. Signs of Safety is designed to create a shared focus among all stakeholders in child protection cases, both professional and family. It is designed to help everyone 'think their way into and through' the case, and is simply a

process of creating a map of the circumstances surrounding a vulnerable child. Central to this approach is the use of specific practice tools and processes where professionals and family members are encouraged to engage with each other in partnership to address situations of child abuse and neglect. As such, the framework helps create a shared focus among all stakeholders in child protection cases.

(ii) Services provided to children in care and those at risk of coming into care

The following information relates to services provided to children in the care of the CEO [of the Department of Child Protection] and those at risk of coming into care. Services are provided directly by the Department and also by the community services sector.

Family Enhancement Services

The Department works to support families and avoid children coming into care wherever possible - underpinned by the principle that a child's best interests are most likely to be met within the family.

The funded Family Enhancement Service is a preventive service which supports families where parenting issues have been identified as affecting the well-being of the children but prior to the point where children are at risk of immediate harm, or being placed in care. The service supports parents and families with children aged 0-12 years.

Support is provided where there are identified parenting issues having a serious effect on the well-being of the children. The services use a range of strategies and activities to strengthen the skills of parents to provide safe care for children within the family. The intended outcomes are as follows:

- Parents or families develop knowledge and skills to provide safe care for their children.
- Parents or families develop their knowledge, skills and abilities to provide a nurturing environment.
- Parents or families develop the knowledge, skills and confidence to access community resources and networks to enhance family functioning.

Tertiary Family Preservation Services

The Department for Child Protection funds three services, including one specifically for Aboriginal families, to help keep families together and avoid children coming into care.

Tertiary Family Preservation Services are specialised services that work with families whose children are at immediate risk of being taken into provisional protection and care as a result of child protection concerns. The service has the primary aim of preventing children coming into care by providing intensive services to reduce the risk to the children and enhance safety in the family.

The families provided with the service often have complex and inter-related issues. These issues may include substance abuse, disability, mental health and family and domestic violence, as well as family dysfunction and poor parenting skills. Priority of access is for families with children under five years of age.

Reunification Services

Child reunification is the planned process of reconnecting children and young people in placement with their families through providing a variety of services and supports to the children and young people, their families, significant others and their carers.

The Department has a key role in actively supporting and facilitating reunification, provided the safety of the child or young person is not compromised. Reunification services are underpinned by the principle that a child or young person's best interests are most likely to be met within the family.

Five agencies which provide placement services for children also receive funding to undertake reunification work with their families, where they have been placed in care for protection reasons. There is also one funded service which works directly with families in the metro area and provides advice and consultation on a statewide basis on reunification issues where the Department is working with the family.

Reunification services provide intensive, specialist intervention to address safety issues, strengthen family functioning and create possibilities for significant change within high risk families for the purpose of reunification.

Contact for children in care

Contact with family members for children and young people who are in the CEO's care is a critical part of promoting a child's development. Contact is a key element in maintaining, supporting or developing attachment to significant people in a child's life which is required for normal emotional, social and cognitive development. It can include face to face visits as well as phone and mail communication.

The Department facilitates contact for children to promote their emotional well-being and the development of a sense of identity. Contact also assists children to make sense of feelings of loss or blame associated with separation. Often contact needs to be supervised to protect the child, or to monitor the parent's parenting skills.

Research suggests that the younger the child, the more frequent contact needs to be in order to preserve attachment and consequently minimise the subsequent development of disturbed attachment behaviors. In infants, the development of attachment is an important consideration to be addressed when they enter care. Adequate resourcing of contact services is an issue for DCP, especially for younger children who usually require more frequent contact with parents.

(iii) Services provided to at risk families through the community services sector

The Department for Child Protection provides funding to a range of agencies who deliver support and assistance to enable at risk parents to safely care for their children and meet their developmental needs.

Children's Support and Counselling in Homeless Adult Services

Two metropolitan support and counselling services for children in family supported accommodation services assist children in addressing issues associated with homelessness. It is expected that children receiving these services will be supported and assisted to work through issues associated with homelessness. Children receive services to overcome the trauma and disruption resulting from their homeless experience.

Young Parents in Homeless Youth Accommodation Services

Five metropolitan homeless youth accommodation services receive additional funding to provide parenting support to young parents, to assist them in meeting the needs of their children. Parents receiving these services develop an increased confidence in their ability to provide a supportive and developmentally appropriate environment for their children. Children receive the services they need for optimal development at age appropriate levels.

Support for Children in Country Women's Domestic Violence Refuges

Eighteen country women's domestic violence refuges receive additional funding to provide support for children accompanying women during their stay. Information and linkages to ongoing support and counselling services for the children are also provided.

Domestic Violence Children's Counselling and Support Services

Two metropolitan and two country counselling and support services provide counselling, advocacy and support for children and their caregivers, in circumstances where violence has occurred or has been threatened in an intimate or family relationship.

Accompanying Children Projects

One metropolitan and three country pilot projects to work with mothers and children in refuges, building linkages between other community services including schools, child health, recreation and providing counselling with a view to reducing the impact of homelessness and domestic violence on children. The model has focussed on providing supports to women and children to enable them to link with and remain safely in the community once they have left the refuge.

Home Visiting Service for Children at Risk

One country service provides home visiting support and in home emergency care for young children when the parent/carer is in crisis and unable to care for the children. This model provides

for families in crisis in the form of in home child care and practical assistance, family support, transport and linking to other available community resources and support networks.

Indigenous Family Program

One metropolitan service, the Indigenous Family Program, works with families who have been identified as being at risk. The model is based on community development and empowerment principles. This involves utilising holistic and realistic approaches to enable clients to find their own solutions to the problems they face on a daily basis.

Parenting at Risk Children

One metropolitan based service focuses primarily on parents with at least one child aged between 0-8 years of age who require individual support - to develop or increase their parenting skills. Strategies are in place to strengthen the parent/ child and family relationship through focussing on the strengths and needs of the parents. Parents are responsible for identifying their own goals and develop their own strategies to achieve their goals while being supported by the service.

(c) Services delivered through the Department of Health[105]

The Department of Health recognises the importance of identifying child health conditions and developmental problems early, before they become entrenched. By intervening early in the course of a health issue, there is an increased chance of a positive outcome.

The Department's services for the antenatal to three year period include:

- Women's and Newborn's Services, including specialist services at King Edward
- Memorial Hospital for Women and specialist perinatal mental health services
- Child and Adolescent Health Service, including the newborn hearing screening program and Child and Adolescent Community Health which has responsibility for the provision of metropolitan community-based child health, child development, school health and at-risk services
- WA Country Health Service, which has responsibility for the provision of maternity services, community-based child health, child development, school health, at-risk services, and mental health services in regional, rural and remote areas
- Metropolitan Infant, Child, Adolescent and Youth Mental Health Service
- Drug and Alcohol Office
- Office of Aboriginal Health

105 Submission No. 8 from Department of Health, p20-27.

The statewide community child health service, provided by Community Child Health Nurses at a local level, is a key platform for the health and development surveillance of children from 0-3 years. This service aims to provide six contacts for families with young children at key developmental ages in the first three years of life. Community Child Health Nurses evaluate the health and development of children and provide a clinical pathway to more intensive and specialist treatment services.

The DOH Child Development Services are the main statewide providers of specialist treatment services in WA. Services located in 20 metropolitan sites and within WA Country Health Services comprise of multidisciplinary health teams, including paediatricians and medical officers and a range of allied health professionals.

(i) Maternal and newborn services

In Western Australia (WA), DOH Area Health Services have a central role in the provision of maternal and newborn services. Other providers including General Practitioners, obstetricians, Aboriginal Medical Services, Aboriginal Community Controlled Health Organisations, the Community Midwifery Program and private hospitals have a key role in the provision of antenatal, postnatal and newborn care.

King Edward Memorial Hospital (KEMH) forms part of the Women and Newborn Health Service (WNHS). KEMH is a metropolitan based service with a number of Statewide functions. Services focus on the special needs of women and promote a physically and emotionally safe pregnancy and birth experience.

Pregnancy provides an opportunity to address substance misuse and support the positive development of the child. The Women and Newborn Drug and Alcohol Service offers specialist multidisciplinary care for substance misusing women who are attending KEMH, and supports a harm reduction model as the most appropriate way to manage the care of pregnant women who are misusing alcohol.

While most maternity hospitals in WA provide primary neonatal care, the Neonatal Intensive Care Unit at KEMH is one of the largest in Australia and is considered to be world class in its research and high quality outcomes.

Pre-term infants are a particularly vulnerable group and at significant risk of developmental delay; these infants start their lives in critical conditions and require highly specialised care to ensure the best possible outcome. The Neonatal follow up program: In WA all babies less than 33 weeks are followed until 12 months of age. This includes monitoring the babies' growth, neuro-development and behaviour. Babies less than 29 weeks gestation are followed up until school age. Incidence of intellectual impairment, cerebral palsy, hyperactivity, blindness and deafness are monitored during follow up.

(ii) Mother and child intervention and mental health support services

The Psychological Medicine Clinical Care Unit delivers eight specialist programs addressing the needs of women, children and adolescents presenting with mental health problems and trauma from sexual assault, including a range of inpatient and outpatient services at both KEMH and Princess Margaret Hospital, and in-home therapy services.

The Western Australian Perinatal Mental Health Unit (WAPMHU) is a collaborative, interagency initiative from the *Western Australian Mental Health Strategy*. WAPMHU *is* a statewide service that aims to improve coordination and access to perinatal mental health services for women and their families. Priority groups include CALD, Aboriginal, and rural and remote communities.

The KEMH Mother and Baby Unit is a statewide inpatient treatment centre for acute perinatal mental health conditions. Women with significant mental health problems following birth, such as severe depression, anxiety or psychotic illness, may be admitted to this eight-bed inpatient program with their babies (0-12 months).

Family Pathways, a statewide child and family mental health service provides assessment and intensive intervention for children (4-12 years) and their families experiencing protracted, co-morbid and complex mental health problems. The service has recently recruited staff with expertise in infant mental health to provide a limited service to children aged 0-3 years.

A recent audit conducted by the Telethon Institute of Child Health Research found that Aboriginal women are more likely to visit, and frequent more regularly, a service that is primarily used by Aboriginal women and provided in a community setting. The Boodjarri Yorjas Business is one example of an antenatal outreach service including home-visiting, delivered by a midwife and an Aboriginal Health Worker in the Armadale and Maddington areas of Perth. The service aims to increase antenatal visits, improve maternal health and well-being including mental health and improve child health outcomes. The Aboriginal women are linked into the local maternity hospital rather than having to travel to a major tertiary centre. Similar approaches in New South Wales have demonstrated significant improvements in attendance at antenatal care, breastfeeding and higher birth weights. Similarly in the Kimberley region, community midwifes are based in local community centres and offer accessible antenatal and postnatal services to families in remote communities.

(iii) Newborn Hearing Screening Program

Universal newborn hearing screening is a strategy to improve the learning and life outcomes, and reduce the cost to society, for hearing-impaired and deaf children through very early intervention. As a result of advances in hearing screening technology mean that babies with congenital hearing loss can now be detected within a few days of life. This allows for critical intervention during the first six months of life that help develop speech and language skills. Without newborn hearing screening, three quarters of children with congenital hearing loss remain undiagnosed by 12 months, and the chance of normal language and cognitive development is greatly diminished.

Western Australia (WA) has a limited newborn hearing screening program. The current program covers 50% of births and is confined to certain hospitals (public and private) in the metropolitan area. There are currently equity issues in the program, with accessibility to the service dependent on place of birth and/or ability to pay. The advancements in technology and training programs for non-professional personnel have made universal screening a feasible service. The DOH is currently exploring options for expanding this program statewide.

The Telethon Speech and Hearing Centre has established a private Newborn Hearing Screening Service offered at six private hospitals, and a fee is charged for this service. Parental uptake is limited and therefore screening coverage is lower than required for an effective screening program. WA is the only State without a universally available screening program.

(iv) Community Health Services Statewide

Child and Adolescent Community Health (metropolitan) and Western Australia Country Health Services provide a comprehensive range of health promotion, early identification and community-based intervention services to children and families. Services focus on growth and development in the early years and promoting well-being during childhood and adolescence. Services include child health, child development, school health, young people, and at-risk services. All have a focus on groups at risk of poorer health outcomes, such as Aboriginal and Torres Strait Islander peoples and newly arrived refugees.

These services fulfill a central role in the early detection and prevention of child health and developmental problems across the State. A three tiered approach is used:

- Screening for defined conditions
- Child health surveillance
- Promotion of health

Child Health Services

Child health nurses play a key role in supporting all parents to care for their young children (0-4 years), providing important prevention, early detection and early intervention services. A universal service is offered, beginning with contact with all mothers with new babies. It is a vital entry point for families with young children into health and social services and a unique opportunity to improve outcomes for families experiencing difficulties in caring for their children.

Programs and Services

In WA, child health services offer a universal schedule of child health and developmental assessments at the key developmental ages of 0-10 days, 6-8 weeks, 3-4 months, 8 months, 18 months and three years, as well, a range of targeted and specialist services are offered as required. Included in the universal assessments are: developmental assessment, screening and surveillance, psychosocial assessment, information regarding parenting, child health and development, child

behaviour, maternal health and well-being, child safety, immunisation, breastfeeding, nutrition and family planning and referral to other specialist services.

The child development assessment includes observations of gross and fine motor development, vision and hearing ability, speech and language development, personal and social behaviour as well as eliciting parental concerns. Assessments are observational and were strengthened in 2009 by the introduction of parent completed child development screening tools, namely the Parent's Evaluation of Developmental Status (PEDS), Ages and Stages Questionnaires (ASQ) and Ages and Stages Questionnaires: Social Emotional (ASQ:SE). These tools recognise parents as an important source of information and have critical knowledge and experience of their child's history.

Evidence supports that the quality of information provided by parents regarding perceived developmental deficits is of high integrity, especially with the more subtle conditions like delayed language development, behaviour and attention problems. Western Australia is the second State after New South Wales to introduce these tools into the universal system.

Parents can also seek additional support from the child health nurse if they have concerns about the health, development or well-being of their child, or are experiencing problems with their own health, or have family troubles that are affecting the well-being of their children. When health or developmental problems are identified, the child health nurse establishes a plan of care or clinical pathway for the child, in collaboration with the parents. This may involve offering secondary screening tools, further counselling and guidance, or a referral to the child development service or general practice.

Child health service delivery is more flexible and responsive to the way contemporary families live and work, taking into account Western Australia's diverse population. In addition to face to face meetings in child health centres, contact with families may involve alternatives such as phone calls, email, groups and meeting parents outside the home in community venues, and delivery of service in other settings such as childcare, Aboriginal Community Controlled Health Organisations or other service locations such as shopping centres and schools.

The provision of screening services has been an important part of the work of child health nurses for many years. However in recent years there has been a shift in emphasis from screening to providing a more holistic, respectful and responsive approach to working with families, offering targeted and specialist services through intensive home visiting, multifaceted case management, or enhanced services for families with complex needs. Examples include the Best Beginnings Program which is offered in partnership with the Department for Child Protection.

(d) Services delivered through the Department of Education and Training[106]

Within the *School Education Act 1999*, the first year of pre-compulsory education is called kindergarten. Children are eligible to enrol in kindergarten from the start of the year in which they reach the age of four years and six months. Enrolment figures show that over 90% of all age-eligible Western Australian children enrol in a kindergarten program; approximately 70% at a public school which children may attend free of compulsory charges (though parents are asked to contribute up to $60 per year in voluntary charges).

Kindergarten teachers in Western Australian public schools hold a four year university qualification, work alongside trained teacher assistants and enjoy parity of pay and conditions with other primary and secondary teachers. The maximum child to staff ratio of kindergartens at a public school is 1:10 which sets the benchmark for early childhood education across Australia.

Western Australia currently leads Australia by guaranteeing universal access to 11 hours of kindergarten for a full year prior to children commencing full-time schooling in their pre-primary year. Through the Universal Access element of the COAG Early Childhood Education National Partnership, this will increase to 15 hours per week of kindergarten, 40 weeks per year by 2013. An important extension to kindergarten provision made possible through funds provided under the Universal Access initiative is that the current guarantee of a kindergarten and pre-primary place at a public school will be extended to guarantee a kindergarten and pre-primary place at the child's *local* public school. At present, the guarantee of local access applies only to the compulsory years of schooling which start at Year 1. This change will significantly enhance the continuity of provision that the Department of Education and Training is able to offer because some children currently have to attend a different (non-local) school for kindergarten and/or pre-primary when places at their local school are not available.

The Department is also exploring opportunities to offer more integrated education and care on school sites. This may be through expanded provision of Outside School Hours Care (OSHC) services in a larger number of communities with identified needs and unmet demand. While children attending OSHC must necessarily be enrolled in a school, this service would apply to children enrolled in kindergarten and pre-primary and would assist many working families by offering quality assured child-care for their children either side of the school day. Another form of more integrated education and care services may take the form of Early Learning and Care Centres (ELCC) which will be located on school sites. These Centres will offer Long Day Care for children from birth to the age of five, and will be jointly funded by the Australian government and industry partners. Negotiations have commenced in relation to the establishment of an ELCC in Karratha, Port Hedland, Mirrabooka and Darch.

The fact that kindergarten in Western Australia is integral to a cohesive K-7 primary school program means that transitions (of place, relationships, routines and learning programs) for children are minimised as they proceed from kindergarten to Year 7. The location of kindergarten

106 Submission No. 5 from Department of Education and Training, p1-3.

within the schooling sector also means that kindergarten programs are included within the same regulatory mechanisms that apply to all schools. This includes implementation of the *Curriculum Framework*, Western Australian College of Teachers (WACOT) membership for all kindergarten teachers and a well established quality assurance framework which enables the Department of Education and Training to plan for improvements in areas of identified need.

While the provision of services and/or programs for children prior to kindergarten is outside the School *Education Act 1999*, the Department of Education and Training recognises the value of building strong relationships with young children and their families long before children are eligible to enrol in kindergarten. Accordingly, many public schools offer programs for younger children accompanied by their parents. Such programs are focussed on (in collaboration with health professionals) the early identification of language delay and/or growth and developmental difficulties, parent education sessions, playgroups, and sessions for parents to support transitions and readiness for school.

In addition, culturally inclusive and age-appropriate kindergarten programs are provided for Aboriginal children from the age of three at 28 metropolitan and regional Aboriginal Kindergartens and at all Remote Community Schools in the Kimberley, Pilbara, Midwest and Goldfields. A key element of Aboriginal Kindergartens is the pivotal role of Aboriginal and Islander Education Officers (AIEOs) who work in partnership with early childhood teachers to ensure that cultural perspectives are incorporated into the kindergarten program.

National Partnership bilateral agreements currently being negotiated with the Australian Government present a significant opportunity to consolidate, expand and improve the provision of early childhood education and care already provided to children, families and communities by the Department of Education and Training.

Key initiatives being progressed through the Early Childhood Education National Partnership include:

- development of an Early Years Learning Framework which seeks to articulate, lead and support the nature and importance of learning through early childhood regardless of setting (school, childcare or home);
- a National Quality Framework for early education and care which will articulate the key elements of quality standards and a quality rating system;
- national roll out of the Australian Early Development Index, a population-based measure of child development which enables communities to assess how whole communities of children are developing by the time they reach school age; and
- Universal access for all kindergarten aged children to a 15 hour a week program.

As well as the above, the integrated nature of service provision in early childhood education also provides the following:

- High quality early intervention for Deaf and Hard of Hearing students is imperative to their development and long term educational, social and emotional outcomes. The Western Australian Institute for Deaf Education (WAIDE) currently provides early intervention for 43 children (aged 0-6 years). WAIDE anticipates children requiring early intervention will increase to 60 within five years, due to the improvement of newborn screening and audiological diagnostic technology.

- The Vision Education Service (VES) provides early intervention (aged 0-6 years) to 26 children across the State. This includes access to resources, equipment and Braille services immediately after diagnosis.

- The Department and Education and Training *Enrolment* policy enables students to enrol in one of 28 statewide Aboriginal kindergartens or remote community schools if they turn four years of age by the 31 December of the same year.

(e) Services delivered through the Disability Services Commission[107]

The Commission provides a range of direct services and supports and also funds non-government agencies to provide services to people with disabilities, their families and carers.

In accordance with the Disability Services Act, `disability' means:

- attributable to an intellectual, psychiatric, cognitive, neurological, sensory, or physical impairment or a combination of those impairments;

- permanent or likely to be permanent;

- may or may not be of a chronic or episodic nature; and results in a substantially reduced capacity of the person for communication, social interaction, learning or mobility; and

- a need for continuing support services.

Not all services for people with disability are within the jurisdiction of the Disability Services Commission. People with disabilities access government and community services along with other Western Australians.

[107] Submission No. 37 from Disability Services Commission, p2.

CHAPTER 6 OVERARCHING STRATEGIC AND STRUCTURAL ISSUES AND THEIR CONSEQUENCES

> *Nationally, health agencies have identified the need to build on whole of government approaches, through collaboration between portfolios and interagency activity.*[108]

A number of agencies considered that Western Australia lacked an integrated guiding framework at the state policy level. As a consequence, they believed, the capacity of both government and non-governmental providers has been less than optimal. It has also impeded opportunities to successfully tackle the volume and complexity of early childhood needs in an integrated fashion and resulted in duplication and inefficiencies.

6.1 The need for an Early Years Framework

In February 2006, at a Federal level, the Council of Australian Governments (COAG) agreed to support and invest in a National Reform Agenda. In December 2007, COAG then agreed that the Commonwealth Government and State and Territory Governments would work in partnership to develop a National Quality Standards Framework[109] for early childhood education and care and an Early Years Learning Framework. The Early Years Learning Framework covers birth to 5 years. Subsequently this was supported by initiatives in the 2008 budget of approx. $2.4 billion over a five year period to support a more integrated and comprehensive high quality ECEC.

This includes:

a. the provision, by 2013, of universal access to early childhood education for all four year-olds (including Indigenous children in remote areas), with the programmes (delivered by both private and public providers) being funded for 15 hours per week, a minimum of 40 weeks a year;

b. the development of an Early Years Learning Framework, aiming to provide for continuity of learning and transition across early childhood settings and the first years of school, and new quality national standards for child care and pre-schools;

c. more university places to train early childhood educators, along with the provision of financial incentives for graduates to work in areas of specific needs (such as rural areas and Indigenous communities) and abolition of study fees for child-care trainees; and

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108 *The Virtual Village*, 2005, p91. Available at: http://www.ecsinquiry.sa.gov.au/files/links/Virtual_Village_report.pdf. Accessed on 19 March 2009.

109 Refer also Appendix. Two

d. *measures to improve access to child-care facilities by helping parents meet the cost of formal care and an increase in the number of child-care places.* [110]

e. *To reduce the "tail" of underperformance among disadvantaged students, and achieve the COAG agreed target of halving the gap for Indigenous children in literacy and numeracy performance within a decade, additional resources will be available to schools most in need of help...*[111]

In support of the COAG National Reform Agenda the individual States developed complimentary action plans. However there is a widespread view that Western Australia's plan which was, anecdotally, done with little consultation, is far from adequate and that there is in fact no overarching strategic agenda.

> *There is an urgent need to have an Early Years Strategy and Plan for Western Australia. In Victoria the Blueprint for Education and Early Childhood Development forms the basis for strategic planning. This provides a framework for macro public policy development in relation to Commonwealth State negotiations; local government authorities; government and non-government agencies; universities and training bodies; parents and communities. All the other jurisdictions have similar plans in place but in WA there is a policy vacuum.*[112]

And:

> *The development of an early childhood agenda is critical to ensure that services are guided by an overarching strategic agenda, informed by the best available evidence and delivered in a coordinated and consistent manner by relevant government and non-government agencies as well as private practitioners including general practitioners.*[113]

Or again:

> *Research conducted by National Disability Services WA revealed that both families and service providers have expressed concern regarding the absence of any framework for the coordination of services to children and their families.*[114]

And:

> *As a fundamental and urgent part of the process to improve the adequacy of services for Western Australia's children, it is necessary to develop a comprehensive plan for early*

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110 OECD, *Enhancing Educational Performance in Australia*, report prepared by Vassiliki Koutsogeorgopoulou, Economics Department , March 2009, p19.

111 OECD, *Enhancing Educational Performance in Australia*, report prepared by Vassiliki Koutsogeorgopoulou, Economics Department , March 2009, p85.

112 Submission No. 4b Ngala p12.

113 Submission No. 8 from the Department of Health, p6.

114 Submission No. 24 from Therapy Focus p3.

> *childhood. Such a plan is required to provide the framework for the provision of early childhood services throughout the State and address the fragmentation and ad hoc service delivery that currently exists.*[115]

And:

> *My view is that we have not been well-positioned in WA to take full advantage and put to the commonwealth what we require for children aged zero to eight years. That is my concern; that we need to really get our act together so that we can position ourselves to access these resources that are available federally.*[116]

This has significant consequences for the State.

> *A strong argument is put for developing a systematic approach to policy development within a common policy framework, setting consistent goals across the system and with clearly defined responsibilities at all levels of government. Sadly, no such direction is evident in Western Australia and no leadership is being shown at any level of the State Government. Opportunities to optimise outcomes for young children will be missed at a time when there is considerable national and international activity aimed at recognising the increasing evidence about how young children learn and develop and the importance of delivering services for them and their families in an integrated way – a way that makes sense to families. There is still no well developed Early Years Strategy or any sort of a coherent Plan for Children that cuts across Ministerial portfolios and is supported by appropriate levels of shared funding. Western Australia has no complementary structures at a Government level to enable a strategic bilateral position to be made in the COAG context. This inhibits Western Australia's capacity to do what the evidence shows is best for children. The evidence demands structures and resource allocation that support collaborative working between government departments. The current arrangements appear to make such collaboration difficult. ….other Australian jurisdictions have developed comprehensive Early Years Plans and restructured Government agencies to facilitate implementation through an integrated and collaborative approach. These jurisdictions are better placed to respond to COAG initiatives than Western Australia.*[117]

And again:

> *I believe there is a need for an overarching framework, and I think it has been identified in conversations between the various departments. I understand the last endeavour was the Premier's Statement in 2003, the Early Years framework, which may need to be revisited.*

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115 Submission No. 15 from The Commissioner for Children and Young People WA, p14.

116 Ms Michelle Scott, Commissioner for Children and Young People WA, Briefing 9 December 2009, by permission.

117 Submission No. 1 from Early Childhood Australia, (WA Branch), p3-4.

> *That is a personal view. I think we would all benefit from a more robust approach to that.*[118]

There are many benefits to a comprehensive early years policy framework, including the effective design of services in a way that avoids duplication and supports cooperation, collaboration and integration.

> *The advantages of delivering early childhood services under a comprehensive framework are wide ranging, but, overall, it will be a way of ensuring that services can be mapped, there is a clear understanding of where and what services are needed, evidence-based programs are delivered in coordinated ways and the entire State—including regional and remote communities—are incorporated in future planning.*[119]

Given the spectrum of government and non-government agencies voicing their concerns to the Committee on this issue, as exampled above, it is clear to the Committee that the existing State plans to improve ECEC in conjunction with COAG are perceived as being inadequate.

Finding 3

There is no well developed Western Australian overarching framework for the early years nor an 'early years whole of government strategy'. This inhibits Western Australia's capacity to do what the evidence shows is best for children. This also is a major contributor to the lack of collaboration and coordination between service providers.

6.2 The need for collaboration

There are a broad spectrum of stakeholders in meeting the needs in the early years of Western Australia's children.

> *Early childhood intervention includes information, assessment, therapy, counselling, health services, education, respite care, equipment and inclusion support to participate in mainstream programs. Services are delivered by a wide range of professionals such as occupational therapists, physiotherapists, paediatricians, psychologists, social workers, speech pathologists, child health nurses, teachers, inclusion workers, educational assistants and behavioural therapists in a variety of settings such as homes, clinics, family and community centres, child care centres and preschools.*[120]

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118 Mr Mark Morrissey, Executive Director, Child and Adolescent Community Health, DoH, *Transcript of Evidence*, 25 March 2009, p20.

119 Submission No. 15 from Commissioner for Children and Young People WA, p14.

120 Submission No. 23 from Early Childhood Australia (WA), p1.

(a) The acknowledged need to collaborate in early childhood education and care (ECEC)

Consultations held by the Commonwealth during 2003 identified coordination and collaboration as major issues for an early childhood agenda.[121]

The multiplicity of stakeholders and pathways in supporting early childhood development means that effective service delivery in such a complex environment necessitates collaboration. The first step towards effective collaboration is seen to be the development of an overarching framework for ECEC. This would foster better planning and collaboration through a more effective delineation of roles and responsibilities, and deliver better value for current and future investments in early childhood services.

Figure 6.1 Model of the overarching strategic framework leading to collaboration and service integration for stronger outcomes in early childhood development.[122]

INPUT	• Overarching early years framework • State policies and infrastructure • Community resources, services and supports • Service coordinator
↓	
OUTPUT	• Service coordination • Local collaborative practices • Services coordinator activities
↓	
IMMEDIATE OUTCOMES	• Family obtains support information, and education to address individual needs • Family communicates the needs of the child • Family makes informed decisions about services, resources, and opportunities for their child • Child and family receive quality service • Agencies and professional are coordinated
↓	
LONG-TERM OUTCOMES	• Child and family get supports and services that are coordinated, effective, and individualized to their needs

121 Premiers Policy Alert, *The policy challenges in early childhood and early intervention*, report prepared by Queensland Government, Edition 18, February 2006, p9.

122 Modified model of that prepared by the Centre for Community Child Health for the Office for Children and Early Childhood Development, Department of Education and Early Childhood Development, Victoria April 2008.

IMPACT	• Parent/caregiver acquires and/or maintains a quality of life to enhance their well-being • Parent/caregiver meets the special needs of their child • Child's health and development is enhanced

Internationally and across Australia, including Western Australia, joined-up or collaborative strategies are seen as the most effective response to complex issues that have many stakeholders amongst whom power is dispersed. Collaboration is particularly relevant where part of the solution to the problem involves sustained behavioural change by many stakeholders and/or citizens.

However, collaboration requires a change of perspective. It is a relational strategy. At the core of collaboration is a 'win-win' view of problem solving. Collaboration is a means to an end, not an end to itself. Ultimately, the benefit of collaboration is to improve outcomes for citizens.

There is a generally and often strongly held view amongst those testifying or making submissions to the Committee that a 'whole-of-government' approach is essential in achieving strong outcomes in early childhood care and education. Such an approach would facilitate cooperation, collaboration and integration as appropriate.

> *The need for an integrated cross government approach to child development is overwhelming. Current policy, service provision and resource allocation is made by individual Departments within the context of Departmental pressures. It has lead to WA being significantly behind other jurisdictions both in terms of investment and coordination.*[123]

And:

> *High quality and integrated early childhood education and care services, encompassing the period from prenatal up to and including the transition to the first years of school, are critical to increasing the proportion of children entering school with basic skills for life and learning. Similarly, the OECD also highlighted the importance of coordinated policy frameworks at the centralised level due to the complexity and breadth of early childhood policy issues. Early childhood policy is not only concerned with child development and child poverty but also with workforce participation, social well-being, early education and child care.*[124]

And:

123 Submission No. 28 from Playgroup WA (Inc.), p8.

124 Submission No. 1 from Early Childhood Australia, (WA Branch), p3-4.

> *We strongly urge an integrated approach to service delivery for children 0-8 years in this state. The fragmented governance in Western Australia exacerbates the dichotomy between education and care.*[125]

And again:

> *No single government department can build strong communities by itself or meet all the needs of young children. There will always be a need for collaboration and coordination.*[126]

At a policy level, there are strong arguments for ensuring that 'whole-of-government' aspirations should not be at the expense of the inherent strengths of departments. Nonetheless, it is widely acknowledged that issues such as ECEC cut across individual departmental remits. As such, collaboration provides far greater flexibility to meet personal and community needs than silo'd departments, while connecting resources and activities across entire systems of governance.

In parallel to the policy drivers for collaboration, citizens now expect governments to provide a coordinated, accessible and integrated experience, and to provide services that meet the needs of citizens, rather than reflecting departmental structures and boundaries.

Transforming and integrating government processes around the needs of the citizens to improve service delivery has led to such concepts as the '*one stop shop*' or the '*no wrong door*'[127] approach. This approach aims to resolve the need for eligible citizens wanting to access a service having to go from agency to agency or office to office, to string together a response to their need.

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125 Submission No. 35 from the staff of the Early Childhood Studies Program, School of Education, Edith Cowan University, p3.

126 Ms Susan Barrera, Director General Department for Communities, *Transcript of Evidence*, 11 March 2009, p2.

127 Professor Frank Oberklaid, Briefing 25 February 2009.

Figure 6.2 Current 'knock on many doors' policy[128]

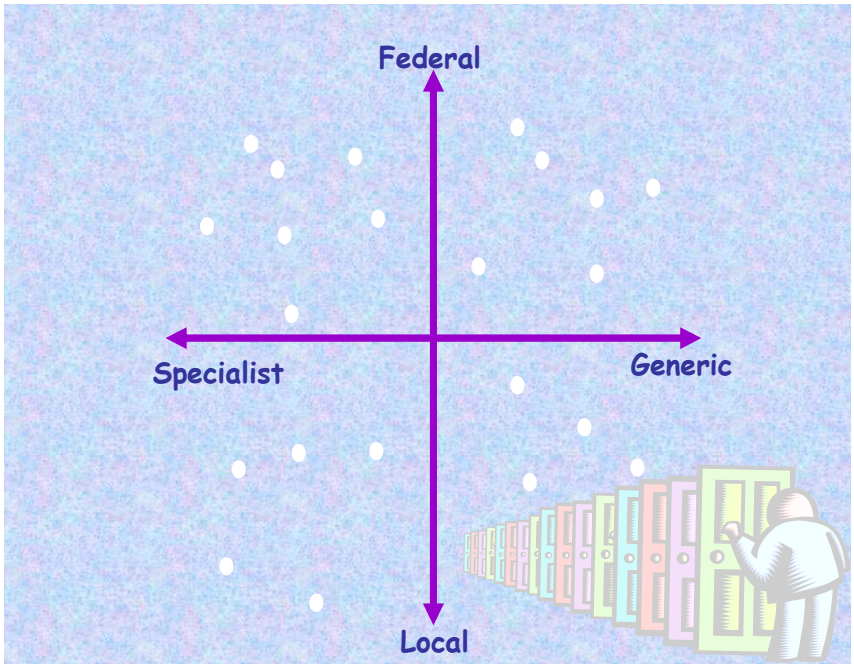
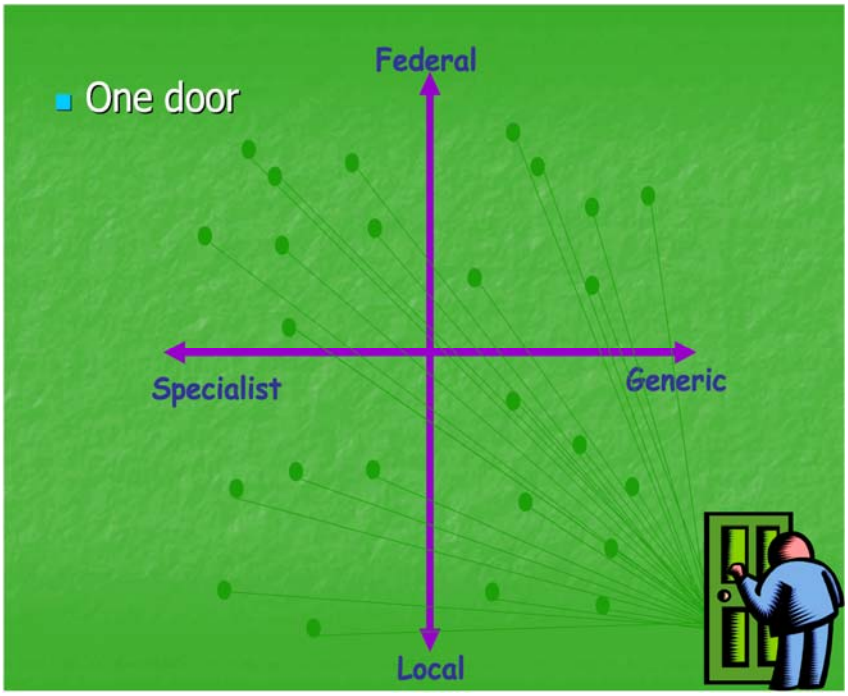


Figure 6.3 Suggested 'No wrong door' policy[129]



128 Mr Tim Farland 2007.

129 Mr Tim Farland 2007.

(i) Barriers to collaboration

Many submissions made it clear to the Committee that there is a broad inter-sectoral agreement on the need to develop a collaborative strategy within an early childhood framework. However it is also clear that collaboration poses some significant challenges for would-be collaborators if they are to be successful.

The Committee was concerned that, at an operational level, a significant lack of initiative was demonstrated by some Departments and their officers in proactively seeking engagement and collaboration. While in some communities the Committee visited, people work across agencies to great effect, the Committee was alarmed at the lack of awareness of the imperative to work collaboratively in other communities or agencies.

In the developing push to provide some level of coordination and collaboration between government agencies to address complex problems, the strength of the various departmental boundaries with their individual performance targets have worked against greater joining up of policy and resources.

> *Problems regarding interagency collaboration have beset child protection systems since the 1960s. The problems are well documented They include issues regarding lack of ownership amongst senior managers; inflexible organizational structures; conflicting professional ideologies; lack of budget control; communication problems; poor understanding of roles and responsibilities and mistrust amongst professionals.*[130]

The dilemma facing government is that government, by nature, is constructed around departmental boundaries. Boundaries between administrative agencies shape clarity of purpose; but with boundaries come barriers to collaborative working. These might include the protection of territories, ring-fencing of budgets, issues of departmental culture and models of service, and the placing the concerns of individual departments above those of effective collaborative programs.

> *The organisational structures of traditional service providers have also meant that many agencies who have sought to operate in a more collaborative and holistic manner have found their efforts frustrated by, among other things,*

- *Differing models of service (e.g. traditional medical vs. family-centred early intervention approach)*
- *Linguistic barriers (professional and cultural)*
- *Lack of leadership and involvement of high-level decision-makers*
- *Agency inflexibility*
- *Competition for financial resources / profile*
- *Bureaucratic rules and hierarchical regulations hindering collaboration*
- *Fear of hegemony by one sector*
- *Feelings of jealousy, resentment and lack of trust and respect between agencies.*

130 Collaboration, integration and change in children's services: Critical issues and key ingredients, 2007. Available at: http://intranet/parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/793DC953C236902FC82574510021D52D/$file/Sub+42+South+Metro+Area+Health+Internet+Ver.pdf. Accessed on 27 March 2009.

- *A lack of documented / comprehensive evidence with which to support the increased efficiency of collaborative initiatives in terms of child outcomes*
- *Lack of incentives / rewards for people who work outside traditional department boundaries.*[131]

And:

> *Achieving collaboration is an enormous task …when viewed from the consumers perspective agencies currently function as quite separate entities.*[132]

Collaboration is also made harder by the disbursement of funds by Government agencies to small community-based entities to run insular compartmentalised programs.

> *It is fair comment that over the years we have established too many non-government programs that are too small. A lot of programs have almost one staff person funding, whether they are in a larger agency or that, in fact, defines the total agency. That is partly due to the challenge of covering the geographical territory in this state, and beyond that is a range of historical decisions. Certainly there is room for consolidation among non-government services and some stronger differentiation between that programs that they provide.* [133]

Additionally, studies show that in organisations where coordinated activity is successful, the senior leaders have invested significant time and energy modelling and supporting this way of working. This applies equally to the success of joint agency initiatives.[134] However in the absence of Ministerial support even those Departments that are charged with facilitating a collaborative response will fail. This was highlighted to the Western Australian public in 2008:

> *Fred Chaney, a former Federal Aboriginal affairs minister, told the inquest Aboriginal affairs departments needed absolute commitment from heads of government to be effective. The Department of Indigenous Affairs, like other government departments, struggles to live up to its coordinating role when it doesn't have authority," said Mr Chaney, who fought back tears at one stage of the hearing. "It's very difficult because DIA doesn't command anybody."*[135]

(ii) Consequence of failure to collaborate

Collaboration is not simply about the choice between 'joined-up working' and retaining a silo-based approach. It is about what the issue/situation in question demands in terms of

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131 Submission No. 10 from The Smith Family, p12-13.

132 Submission No. 22 from Touch Move & Play Physiotherapy Services, p6.

133 Mr Terry Murphy, Director General, Department for Child Protection, *Transcript of Evidence*, 11 March 2009, p4.

134 Lynda Gratton and Tamara J., 'Eight ways to Build Collaborative Teams', Harvard Business Review, November 2007, pp.100-109, http://harvardbusinessonline.hbsp.harvard.edu/hbsp/hbr/index.jsp?ml_issueid=BR0711.

135 The West Australian, 'Government shelved Aboriginal suicide report', 13 June 2008. Available at: http://www.thewest.com.au/default.aspx?MenuID=77&ContentID=78746. Accessed on 16 June 2008.

integration and differentiation at different levels and for different goals. In ECEC the issue demands a holistic approach across the sectors of education, care, health and disabilities.

Those engaged in the early childhood care and education sector argue that separating health, care, and education in the early years fails to acknowledge the interwoven nature of early learning and development. However, for philosophical, historical, structural, and cultural reasons that separation is a reality to varying degrees across Australia. As a consequence,

> *Children's services remain inconsistent, un-coordinated and fragmented, involving different systems in each of the states and territories with significant variations in government responsibility.*[136]

In many of the submissions there is a general sense of frustration evident at the failure of the key state government agencies to collaborate:

> *There is poor coordination of resources…. Service coordination is defined as an active ongoing process that assists families to access services.*[137]

And:

> *All Government departments have an awareness of the importance of the early years, with early identification and early intervention for identified concerns. Ngala has concern re the silos that exist particularly with Health, Education and Child Protection continuums. Ngala are developing quite strong links with the Health Department in some areas. The Education Department is mainly focussed on 4 years above and there is frequently a lack of cooperation and even a tendency to rivalry between departments and agencies without a shared vision, cooperative partnership and shared resources. This issue is also magnified with the different layers of Commonwealth funded Local Government and regional services…. This situation points to the need for adequate planning and services funding.*[138]

There is, in ECEC, often a strong argument for collaboration with some agencies currently providing overlapping services or services that form a pathway of service delivery. In the absence of such collaboration fragmentation occurs and this is reflected in many instances in Western Australia.

> *There is service fragmentation in the community. Families do not know where to go for parenting support, play groups or speech therapy. From a very personal experience, the services for children and young people are highly fragmented. The institute has talked about chaos in communities relating to service provision.*[139]

The silo'd approach is also seen to lead to communication breakdown between service providers:

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136 Professor Frank Oberklaid, Briefing 25 February 2009.

137 Submission No. 26 from Australian Physiotherapy Association, p3.

138 Submission No. 14b from Ngala, p6.

139 Ms Michelle Scott, Commissioner for Children and Young People WA, Briefing 9 December 2009.

> *There are lots of services in Armadale, all operating in isolation from one another. There is no communication between any departments. Many families are falling through the net.*[140]

The difficulties families face in accessing suitable services for families was highlighted in another submission:

> *The lack of a clear and cohesive framework makes it difficult for service providers and, importantly, families to identify and locate the services / programs needed.*[141]

A lack of collaboration the silos position is seen to be aggravated by scarce resources leading to cost shifting between departments:

> *The public sector spends an extraordinary amount of time, human resources and money developing recommendations, programs, MOU for coordinating and defining the resource responsibility, cost shifting, for service delivery for children and families. With the end result of less services are provided to the consumer but it will always be another agencies' responsibility. When transference of services occurs, the original agency responsible saves money while the new agency has to pick up the tab with in its own resources. This occurs when PMH transfers clients to the community and DSC ceases to provide services to its clients.*[142]

However some departments will attempt to fill the policy void and endeavour to establish some level of collaboration themselves:

> *In the absence of such an integrated system, the Department of Health has developed or is in the process of developing a number of formal and informal collaborative arrangements both within Health and with other agencies. Examples include the Memorandum of Understanding between the Department of Health and the Department of Education and Training, the Memorandum of Understanding between the Child Development Service and the Disability Services Commission, the Service Level Agreement between the Child Development Service and the Child and Adolescent Mental Health Service, the Memorandum of Understanding between the Department of Health and the Department for Child Protection.*[143]

But from the perspective of the Health Reform Implementation Taskforce, this is not always a positive outcome:

> *Notwithstanding that none of the child development services have the mandated role to coordinate care between agencies or for complex cases that require multiple services across the health sector, they all do this to differing degrees. This compounds the*

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140 Mrs Lee Musumeci, Principal Challis Early Childhood Education Centre, Briefing, 9 December 2009. By permission.

141 Submission No. 28 from Playgroup WA (Inc.), p8.

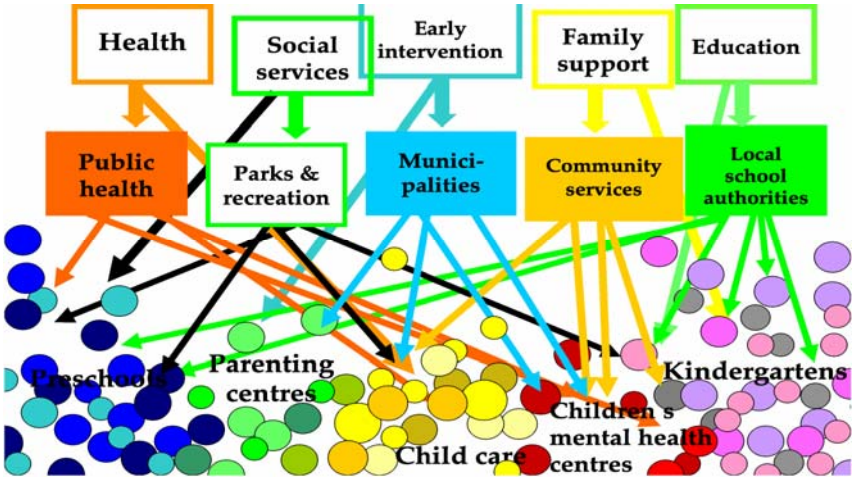
142 Submission No. 22 from Touch Move & Play Physiotherapy Services, p6.

143 Submission No. 8 from the Department of Health, p6.

fragmented and inconsistent nature of the services and highlights the potential for service improvement if this situation was addressed appropriately.[144]

The fragmented nature of ECEC services (which is not unique to Western Australia) has been described as Chaos, and is illustrated below:

Figure 6.4



The many submissions, from Government and non-government agencies, whether regional or metropolitan based, demonstrate the lack of coordination and collaboration in early childhood services in Western Australia. This lack exists across various levels of government, between different government agencies as well as the non-government sector.

There is evidence of significant consequential frustration for families and their children as well as for front line early childhood service providers.

Finding 4

In the absence of a collaborative or integrated approach to service delivery, there is a fragmentation of services. This fragmentation of services leaves many families without a clear pathway for support.

The Committee believes that the absence of an Early Years Framework impedes successful collaboration. The lack of collaboration, in turn, is currently preventing substantive progress in the effective improvement of early childhood education and care services. If this situation is not addressed and accompanied by a parallel commitment to long-term action, there are negative implications for both Western Australia's economy, and its social fabric.

144 Health Reform Implementation Taskforce, *Future Directions for Western Australian Child Development Services*, Western Australia, 2006, p3.

Recommendation 4

The Committee strongly recommends that the Government develops a whole-of-government perspective with respect to early childhood and places all the relevant health, care, education, and parent support programs under the banner of Early Development within one Ministerial portfolio; with the exception of the statutory intervention services of Department of Child Protection.

This will address the lack of coordination and collaboration in early childhood services in Western Australia. This lack currently exists across various levels of government, between different government agencies as well as the non-government sector.

The Committee recognises the positive step forward taken in the creation of an Office of Early Childhood Development and Learning, but believes that a single responsible Ministry is the most effective way of breaking down the barriers impeding the delivery of cost effective, meaningful, programs and services.

(b) Collaboration going forward

There is a general agreement amongst agencies and services, with some reservations, as to the value of some form of whole of government approach to ECEC.

> *No single individual, discipline or government department can meet the diverse and complex needs of children and families. A comprehensive, integrated service system response involving all relevant government and non-government agencies is essential to meet the needs of all families effectively.*[145]

There are a variety of views as to what the mechanisms for such an approach might entail, for instance:

1. A Memorandum of Understanding (MOU) between agencies:

> *A Memorandum of Understanding between agencies such as the Department of Health, Department of Education and Training, Disability Services Commission, and Department for Child Protection should be sought as a matter of urgency. The memorandum should include agreement of their roles and service delivery in supporting families with young children, and incorporate common principles and processes within the agencies in their*

145 Submission No. 8 from Department of Health, p6.

provision of services to families. A similar process for Information sharing and service provision, could facilitate streamlining of services, and reduce duplication.[146]

2. The establishment of a one stop shop (collaboration at a program level):

There is a need for a better platform for service delivery - a one stop shop model - services to work differently with each other - not necessarily more workers. "I call it 'the no wrong door policy'. Ministers and advisors get it but senior policy people don't.[147]

3. Strategic and operational collaboration:

When people discuss integrated services they are generally referring to horizontal or service integration. Service integration means a combination of strategies to simplify and facilitate client access to benefits or services. There can be a distinctive mix of strategies, processes, partner agencies, governance and accountability.

Service integration can be characterised by features such as common intake processes and seamless service delivery: the client may receive a range of services from different programs without repeated registration procedures, waiting periods or other administrative barriers. This seamlessness is enabled by a multi-disciplinary service focus where the client's needs are assessed in totality and holistically.

Accessing services, especially early intervention services, is made a part of the service contract with clients, without the discontinuities arising from referral.[148]

4. Mandated or legislated collaboration:

The APA believes that early intervention service coordination should be mandated and appropriately resourced by state government to achieve this.[149]

5. The establishment of an overarching Office of Early Childhood:

There seems to be a need to have an overarching body to overcome the fragmentation of service delivery, funding and policy in early education and care sector. We support the WA Commissioner for Children and Young People's proposal to establish an Office of Early Childhood. However, in order to adequately meet the needs of young children, especially those between 0~3 years, and their families, this office would have to include a diverse

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146 Submission No. 18 from Bachelor of Social Science (Children and Family Studies) team, Edith Cowan University, p10.

147 Professor Frank Oberklaid, Briefing 25 February 2009.

148 The Virtual Village, *Report of the Inquiry into early Childhood Services*, 2005, p88. Available at: http://www.ecsinquiry.sa.gov.au/files/links/link_80523.pdf. Accessed on 31 March 2009.

149 Submission No.26 from Australian Physiotherapy Association, p3.

> *range of professionals from an array of disciplines such as education, child care, family support and health.*[150]

This range of thinking evident in submissions to the Committee on how best to achieve a more seamless level of service delivery results from a recognition that the choice is not between joined-up working or retaining a silo-based approach. In fact the complexity of issues demands appropriate forms of integration and differentiation at different levels and for different goals.

(i) Office of Early Childhood Development and Learning

> *We need an office for early childhood like they have in Victoria and South Australia. That is a one-stop shop for the provision of government services, but it also becomes a one-stop shop for parents and families in the community.*[151]

Recognising some of the barriers to collaboration that exist in the public sector, both South Australia and Victoria have taken steps starting at Cabinet level to facilitate integration.

In a move to address these issues South Australia has created the new role of Minister for Early Childhood Development. While early childhood spans 0-8, the Minister has carriage of the under 5 year olds, with responsibility for all early childhood services in education - hence the recent development of a children's centres policy; but he does not have carriage of resource allocation. Child visitation sits within the health portfolio. To assist in achieving a greater level of collaboration, the Minister chairs an inter-ministerial group comprising Early Childhood, Health, Indigenous Affairs and Child Protection.

Similarly, in Victoria, the Office for Children and Early Childhood Development (OCECD) has been established, reporting to the Minister for Children and Early Childhood Development. OCECD was established subsequent to a decision by Premier Brumby to have health components (in relation to children) moved from Health to OCECD. All the universal programs were transferred into OCECD as well, with the exception of those relating to statutory intervention. Part of the role of the Office is to licence child care centres. Program funding also shifted with the programs.

OCECD coordinates the government's policy and programs in relation to early childhood, school/community and parent/school partnerships. This involves developing close relationships with central agencies.

While the original focus of the Victorian education department was the learning environment there is now a whole of government perspective for the alignment of services. This includes, for example, the mental health of children. The focus is now on the whole child.

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150 Submission No. 18 from Bachelor of Social Science (Children and Family Studies) team, Edith Cowan University, p10.

151 Ms Michelle Scott, Commissioner for Children and Young People WA, Briefing 9 December 2009.

In Western Australia, the Premier has recently announced a change of portfolio responsibility with the Minister for Education taking over responsibility for Early Childhood Development. This has led to the creation of the Office of Early Childhood Development and Learning within the Department of Education and Training.

Unfortunately, the Committee was unable to determine what the intended scope and operation of the Office will be:

> *There have been some high-level statements of role from government—when I say "government", from ministers—and there is still some clarification of what I would call the scope and structure of the office.*[152]

In general terms the role of the new Office is advised as:

> *Broadly, the office has been established to better coordinate development and learning programs, policies and services for children between zero and eight years old. In direct answer to your question, the education department would take some role in learning development in the zero to three, or three and a half years old age group at school entry. As yet, we are unsure as to the specifics of that, but my sense would be there would be coordination and working with and through other service providers or program providers.*[153]

(ii) The sector's view of a role for the new Office of Early Childhood Development and Learning

From an agency perspective there were a number of views as to what the Office's role might look like. Prominent amongst them were the views of National Investment for the Early Years (NIFTeY). NIFTeY is a community of individuals from diverse areas including child development practitioners, advocacy and welfare groups, mental health practitioners, community health workers, academics, paediatricians and the juvenile justice system.[154] NIFTeY (WA) stated that:

> *We are recommending that there be established a unifying body for Early Childhood - such as an Office for the Child – that is independent of the present Government Departments but a partnership from the relevant departments and agencies reporting directly to the Minister responsible for Early Child Development and Learning with close links to the Commissioner for Children.*[155]

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152 Mr David Ansell, A/Exec Director, Office of Early Childhood Development and Learning, *Transcript of Evidence*, 25 March 2009, p3.

153 Mr David Ansell, A/Exec Director, Office of Early Childhood Development and Learning *Transcript of Evidence*, 25 March 2009, p3.

154 National Investment For The Early Years, Available at: http://niftey.cyh.com/Content.aspx?p=47. Accessed on 27 March 2009.

155 Submission No. 13 from NIFTeY (WA), p4.

Endorsing NIFTeY (WA)'s comments, Ngala recommended that 'a Western Australian Office of Early Childhood Development [be created] which will set up cross-Agency coordination of effort for children in the early years.'[156] NIFTeY (WA)'s comments were also supported by Early Childhood Australia (WA) which is the Western Australian chapter of the peak national body. In fact there is strong evidence that NIFTeY (WA)'s recommendations enjoy sector wide support.

The Commissioner for Children and Young People argued strongly for both the existence and the potential role of an Office of Early Childhood:

> *It is my view that Western Australia needs an Office of Early Childhood that would become a central office for early years matters.*
>
> *A Western Australian Office of Early Childhood would achieve the following:*
>
> 1. *Become a central office, bringing together the key elements of:*
>   - *i. Early childhood health services;*
>   - *ii. Childcare; and*
>   - *iii. Early childhood education.*
> 2. *Liaise with other government agencies that have a role in the social inclusion and healthy development of young children (for example the Disability Services Commission).*
> 3. *Become a central location for the coordination of parenting support programs, playgroups, other programs for the support of families and young children.*
> 4. *Be responsible for liaison with the Commonwealth, NGOs and the private sector on early childhood matters.*
> 5. *Function as a 'one stop shop' for industry, providing the much needed advice and support for companies wanting to invest in early years projects/programs.*
> 6. *Identify the best research and evidence for 'what works' for young children and families, evaluating programs, and translating research into practice for parents and workers.*
> 7. *Develop a set of agreed outcomes for children across government agencies and monitor and report on these outcomes every two or three years to monitor progress and inform policy and program development.*[157]

Playgroup WA (Inc.), claiming to speak for 16,000 families across the State, recommended that such an Office should also enjoy statutory powers to back up collaborative intent:

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156 Submission No. 14b from Ngala, p11.

157 Submission No. 15 from The Commissioner for Children and Young People WA, p13.

> *The State Government demonstrate a real commitment to the 0–3 years through concrete policy and action [by] establishing an Office of Early Childhood with statutory powers to oversee and monitor early childhood service provision and resources.*

Supporting legislation is seen as giving the Office a strong mandate to secure collaboration from other agencies. In the case of the Disability Services Commission this has indeed proven to be the case, with the *Disability Services Act 1993 (WA)* proving to be a highly successful medium in securing the support and engagement of other agencies, across the State, in the provision of 'Disability Access and Inclusion Plans.'

The role of the Office of Early Childhood Development and Learning, as envisaged by sector agencies, would see it:

- *Develop policies and strategic objectives specific to 0~3 years within a framework that takes a broad view of developmental needs (such as those proposed by the World Health Organisation, Solid Facts; and the Ecological model.*
- *Develop a more coherent and integrated framework around government and government funded programs to reduce fragmentation and the resultant duplications and gaps due to ad hoc governmental programs.*
- *Adopt preventative approaches to emotional and cognitive development for 0 ~3 year olds through improved access to antenatal and postnatal services, parenting services, family support and community and supported playgroups.*[158]

One submission suggested that an improved budgetary process might be an outcome of the creation of a new Office:

> *So we are constantly having to come up with creative ways of getting money to sustain a project that is having great outcomes because there is no strategic plan. There is no overarching body. Even in our own department it is very difficult to try to get the funding.*[159]

In line with the Victorian model the Bachelor of Social Science (Children and Family Studies) team at Edith Cowan University recommended that the Office be multidisciplinary:

> *There seems to be a need to have an overarching body to overcome the fragmentation of service delivery, funding and policy in early education and care sector. We support the WA Commissioner for Children and Young People's proposal to establish an Office of Early Childhood. However, in order to adequately meet the needs of young children, especially those between 0~3 years, and their families, this office would have to include*

158 Submission No. 28 from Playgroup WA (Inc.), p4.

159 Mrs Lee Musumeci, Principal, Challis Early Childhood Education Centre, Briefing 9 December 2009.

> *a diverse range of professionals from an array of disciplines such as education, child care, family support and health.*[160]

However, there were some reservations expressed by members of the Health fraternity as to what might be the impact of such close interaction with other Departments given competing priorities, cultures, demographic and structural differences between Western Australia and Victoria and South Australia.[161] Others were particularly doubtful about the Department of Education and Training in particular and its culture in WA, and therefore its ability to oversee developmental services through the envisaged Office.

> *It is another bureaucracy that has many layers before services are actually given to the consumer and many individuals in the top and middle layer of the service do not know what their consumer's needs are, or what the skills, abilities of their employees [are] that connect with the consumer.*[162]

Finding 5

The role of the recently created Office of Early Childhood Development and Learning has yet to be finalised. There is however a broad based sector wide agreement on the need for such a coordinating office.

160 Submission No. 18 from Bachelor of Social Science (Children and Family Studies) team, Edith Cowan University, Children and Family Studies, p10.

161 Mr Mark Crake, Director, Child and Adolescent Community Health, DoH, Mrs Kate Gatti, Director, WA Country Health Service, DoH, and Mr Mark Morrissey, Executive Director, Child and Adolescent Community Health, Department of Health *DoH, Transcript of Evidence*, 25 March 2009, p17-18.

162 Ms Helen Beaton, Physiotherapist, Touch Move Play, email, 27 March 2009.

CHAPTER 7 SERVICE ISSUES IDENTIFIED BY THE EARLY CHILDHOOD SECTOR AND RELEVANT AGENCIES

In all governments there is a gap between policy and practice, between what governments know and plan to achieve as against what they do. In part this is a consequence of resource constraints, whether financial or human, and in part it may be attributable to poor communication, a lack of leadership or a lack of clearly articulated and agreed objectives. Western Australia similarly experiences a gap between policy and practice in service delivery in supporting the development of children. The lack of an overarching strategic framework and an inability to collaborate in the early childhood sector, outlined previously, has further exacerbated the service and program deficiencies; some of which are outlined below.

A number of the concerns raised by agencies and NGOs focussed on health, which is unsurprising as, operationally, health has a large role to play in addressing the needs of both parent and infant in the first three years of the child's life.

Those participating in the Inquiry made it clear to the Committee that there are many barriers to accessing health-related services. Such barriers included:

- limited resourcing resulting in limitations to the capacity or accessibility of a service; and
- individual family circumstances including the distance to services, or systemic problems.

The outcome is that for many families requiring primary or secondary levels of intervention, existing service provision has significant shortcomings. This is especially so for the more vulnerable families in the community whose need is arguably the greatest. 'Yet these families are often the ones who, because of the poor outcomes they and their children eventually present, will need intensive support and intervention later.'[163]

The following sections of this chapter explore specific agency and professional concerns in greater detail.

7.1 Child Health Nurses and the home visitation program

A 'community health nurse' is a broad term that includes the following group of nurses who have a specialised focus [stream]

- Child Health
- School Health
- Migrant/Refugee Health
- Immunisation Nurses

163 Moore, T.G. (2008), 'Rethinking universal and targeted services' *CCCH Working Paper 2* (*August 2008*). Parkville, Victoria: Centre for Community Child Health.

- Child Development Nurse (work in child development centres)

As a result the term 'community health nurse' and 'child health nurse' has been used interchangeably in some submissions and testimony to the Committee.

Child health nurses are an integral part of the Western Australian health services, working across the State. They are registered nurses with specialist qualifications who work with their local communities primarily from a preventive and health promotion perspective.

> *For many families they are the only link into health services, and they provide ongoing assessments of child health and development, early identification of any health and development issues, and where possible, early intervention prior to referral to other agencies. Community health nurses also provide information on becoming a parent, breastfeeding, child behaviour, diet/nutrition, family health matters, growth and development, immunisation, infant/child feeding, injury prevention and child safety, playgroups and other community resources, play, postnatal stress and depression, sleeping/settling and toileting. Child health nurses act as a link between hospitals and the community, work closely with General Practitioners' and are part of a larger interdisciplinary team.*[164]

There are currently 129 Full Time Equivalent (FTE) child health nurses in the metropolitan area, and 67 FTE child health nurses in the country health services. They operate out of 300 child health centres. Some of these are only open part-time, depending on need and depending on the population.[165]

Child health nurses 'provide an early warning and intervention system in identifying a wide range of early childhood disorders.'[166] In recent years the number of child health nurses has declined, on a per capita basis, across the State. In other words, the numbers of nurses has remained static while the population has increased.

> *The reality is that over the past five years there has been an increase in the number of births of between 20 per cent and 21 per cent. There has also been a high level of migration, and therefore a higher number of children than before. There are also many families with additional complex needs. There has not been a commensurate increase in child health nurses.*[167]

Their case load was highlighted to the Committee by one submission in particular, as follows:

> *Anecdotal evidence from some of our professional members note that in many communities within the Metropolitan area, child health nurses are currently working on an acuity ratio*

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164 Submission No. 19 from Community Health Nurses Western Australia, p3.

165 Mr Mark Crake, Director, Child and Adolescent Community Health, *Transcript of Evidence*, 25 March 2009, p13.

166 Submission No. 15 from Commissioner for Children and Young People WA, p8.

167 Mrs Margaret Abernethy, Senior Policy officer, DoH, *Transcript of Evidence*, 25 March 2009, p13.

> *of 1:420 new birth notifications per year. This is increasingly untenable, resulting in limited services and availability to families at a critical time in their child's life.*[168]

In Western Australia, the policy is to offer a universal schedule of child health and developmental assessments at the key developmental ages of 0-10 days, 6-8 weeks, 3-4 months, 8 months, 18 months and three years. The Department of Health claims that some 94 % of newborns and their mothers are visited within 21 days of birth, as the following tables demonstrate.

Table 1: Face to face contact (in the home or other place) within 10 days and 21 days after birth.in 2007 by CACH Metropolitan Area.

Zones	**Universal 0-10 days** (%)	**Universal 11-21 days** (%)	**Total within 21 days**
North Coastal	35%	62%	97%
North Inland	47%	48%	95%
South Inland	60%	36%	96%
South Coastal	42%	47%	89%
Total average			94.25%

Source: Child and Adolescent Community Health

and

Table 2: Face to face contact (in the home or other place) within 10 days after birth in 2008 by Area Health Service

Area Health Service	**Universal 0-10 days** (%)
Wheatbelt	97%
Goldfields	95%
Great Southern	95%
South West	90%
Pilbara	97%
Midwest	86%
Kimberley	99%
Total (e.g. average)	94%

Source: WACHS — Area Health Services

However these figures have been questioned by some informants and the Committee believes that they should be subject of verification by the Auditor General.

Further, in practice, after the first visit, what was a universal schedule has effectively become more targeted with the impact of the growing population combined with a lack of resources and a limited take up of services after the initial assessment. In fact, by 12 months of age, only about 10-

168 Submission No. 19 from Community Health Nurses Western Australia, p3.

20% of WA's children are still attending the Child Health Clinics or receiving visits from a child health nurse.[169]

> *In WA a child will have seen their Child Health Nurse only if the parent is proactive enough to make the appointment and follow through after the first couple of appointments during the first few weeks of after birth. Unless they are in the 'at risk category.'*[170]

The issue is acknowledged by the Department of Health in correspondence with the Committee stating that, 'It has been recognised that the current universal child health contact schedule needs to be expanded upon to address the specific needs of vulnerable and at risk children.'[171]

An example of how the resource pressure can impact the service take-up is reflected in that 'families with older children (1-3 years) have longer waiting periods to access the child health nurse as families with newborn babies are a priority.'[172] Because of this priority given to new born infants, families with older children may not be able to be seen for some weeks. The result is that a number of them do not then show up for their appointment further reducing the utility of the service to the community.

The outcome of the resourcing shortfall is the de facto curtailment of what is supposed to be a universal program.

> *The existing foundation of publicly funded universal child health services and specialist treatment services is well-balanced but need to be strengthened to meet increasing demands. The current staff shortfall in community child health and specialist treatment services is impacting on the effective and timely management of developmental concerns. Additional resources are needed across all existing services to ensure all families have equitable access to community child health nurses in their local area, reduce waiting lists for specialist maternal and child health services, and extend effective early childhood programs such as Best Beginnings to all families in WA.*[173]

To restore this service to the level required to provide a universal program in line with population trends, would mean an additional '100 child health nurses and around 135 school health nurses.'[174]

In another pointer to an outcome of under-resourcing of this lynch pin of community health services, the Disabilities Services Commission advises that 'The Australian Bureau of Statistics (ABS) estimates that the prevalence of severe and profound core activity limitation is 4.1% of

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169 Submission No. 30 from Dr John Wray, p2.

170 Cathy Hewick, CHILD Australia, email, 15 April 2009.

171 Dr Peter Flett, Department of Health, written correspondence, 9 June 2009.

172 Submission No. 8 from Department of Health, p20.

173 Submission No. 8 from Department of Health, p8.

174 Mr Mark Crake, Director, Child and Adolescent Community Health, *Transcript of Evidence*, 25 March 2009, p13.

children 0 to 4 years, i.e. approximately 5000 children in Western Australia.'[175] What is surprising is that of these 5,000 children only 1,000 children 0 to 4 years are in receipt of funded early childhood intervention and 4,000 are not known to the Department in their pre-school years. Nor is it known whether the 4,000:

- *have been in receipt of appropriate services from other government or non-government agencies;*
- *are on the pathway of referral and assessment;*
- *have families who have been advised to `wait and see';*
- *have families and carers unaware that a child's experiences in the early years have a major impact on their future development; or have not been involved with any universal program and their developmental needs remain unrecognised.*[176]

Given that these statistics only cover '*severe and profound core activity limitation'* who should be readily identifiable, this lack of knowledge by the key government agency supporting families of the disabled suggests some real gaps in family support, community nursing screening and the referral process.

This view is supported by the Commissioner for Children and Young People who noted that compared to our Eastern States counterparts, WA is lacking in the provision of this service.

> *In South Australia and Victoria they have much better provision of maternal health nurses; in South Australia every child, I think, sees a maternal health nurse within 10 days—or a very high proportion; 80 per cent, 90 per cent. Every Aboriginal child is entitled to an additional 34 visits in the first two years of their life. If you look at the Western Australian figures, a significant proportion do not see them—I think it is 40-odd per cent within the first 10 days—and with Aboriginal children it just goes down and down.*[177]

The problem was also drawn to the Committee's attention by the Department of Health:[178]

> *The current staff shortfall in community child health and specialist treatment services is impacting on the effective and timely management of developmental concerns. Additional resources are needed across all existing services to ensure all families have equitable access to community child health nurses in their local area, reduce waiting lists for specialist maternal and child health services, and extend effective early childhood programs such as Best Beginnings to all families in WA.*

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175 Submission No. 37 from Disability Services Commission, p4.

176 Submission No. 37 from Disability Services Commission, p4.

177 Ms Michelle Scott, Commissioner for Children and Young People WA, Briefing 9 December 2008.

178 Submission No. 8 from Department of Health, p49.

Finding 6

The child health nurses' visitation program is, in practice, no longer universal as the number of child health nurses has declined, on a per capita basis, across the State of Western Australia. The reduction in available support restricts access to this key link in early childhood health services. Given the child health nurse's role in our community, as 'an early warning and intervention system in identifying a wide range of early childhood disorders', this is a major shortcoming and indeed a regression in the provision of services to young children.

Recommendation 5

That the Auditor General reviews the accuracy of the reported performance of the face to face contact program (in home of other place) as reported by the Department of Health - via the Child and Adolescent Health in the metropolitan area and the Area Health Services in regional areas.

Recommendation 6

The Committee strongly recommends that the Government, as a matter of urgency, restores the number of full time equivalent child health nurses delivering the home visitation program and operating child health centres, on a per capita basis to levels prevailing in Western Australia in the 1980s, since which time the number of child health nurses has significantly declined on a per capita basis.

This improvement is critically needed to restore the efficacy of a fundamental universal community health service, thereby ensuring that all families and children receive appropriate, timely, accessible guidance and support. All evidence is that the need for such a service is increasing and not decreasing.

Additional resources should be provided to allow the child health nurses to actively promote and encourage regular developmental checks on children from nine months to pre-school.

7.2 Issues around early childhood intervention services

While early detection is an essential part of ensuring healthy outcomes for children, the value of early detection lies in the effectiveness and availability of subsequent interventions. Once an issue is detected, one of the best ways to support the families of children with developmental difficulties is to ensure their children receive appropriate intervention to address their difficulties. Parents also feel supported if their child receives timely access to therapy, or gains a place in an early intervention service. Such intervention services, at a secondary level, fall within the ambit of allied health professionals such as those working in the fields of physiotherapy, occupational therapy, speech pathology, psychology, social work and in some instances podiatry, audiology, and dietetics services.

(a) Access to allied health professionals[179]

Many concerns about access to allied health services, in particular, therapy and support services for children with developmental difficulties, were raised by participants in the inquiry. This was an area that witnesses clearly identified as one where services could do better.

The problem arises through a combination of factors, notably:

- budgetary pressures;
- shortages of specialists in the Allied Health sector, particularly in the regions; and
- a rising infant population,
- the increasing percentage of children displaying developmental difficulties

The shortage of available specialists, in some fields, is demonstrated by the fact that even where funding exists, agencies such as the Disabilities Services Commission have difficulties filling positions.[180] For instance, one explanation for the shortage of available speech pathologists lies in the limited number of Western Australian graduates.

> *There has been a shortage of Speech Pathologists across the disability sector for many years. This is mainly due to the limited numbers of graduates from the only WA School of Speech Pathology at Curtin University. It is encouraging Edith Cowan University has commenced an undergraduate bachelor degree course in Speech Pathology this year.*[181]

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179 Allied Health is an umbrella term which covers such professions as Physiotherapy, Occupational Therapy, Speech Pathology, Psychology, Social Work and in some instances Podiatry, Audiology, and Dietetics services.

180 Marion Hailes-MacDonald Manager - Strategic Policy and Programs, Disability Services Commission, email, 3 April 2009.

181 Vicki Larkins, Therapy Focus, email, 15 April 2009.

However funding and salary levels remain intrinsic to the problem in relation to most other disciplines.

> *In the metro area, it is definitely a case of not enough funding as paediatrics is a popular choice of employment for physiotherapists. Many physios work for long lengths of time in the area gaining skills once they have secured a position in the paediatric sector.*[182]

And:

> *Many paediatric disability service providers face significant challenges providing services to a large number of families and children when resources are inadequate to meet the identified needs. Each year, client numbers continue to grow but available funding does not always match this growing need. Where demand exceeds supply, efforts are made to set priorities and manage caseloads.*[183]

Dr Trevor Parry traces the evolution of this problem in Western Australia as follows:

> *For many years Western Australia has had a comprehensive early health and developmental surveillance and screening program offered through Community Child Health and School Health Nurses of the Department of Health.*
>
> *Surveillance: was the availability for monitoring the health and developmental status of children and offering advice and support to parents at Child Health Centres.*
>
> *Screening: was the routine use of tests to check specific aspects of health development at specified times. When concerns arose, referral was encouraged to General Practitioners, and for developmental concern; referral could also be made for team assessment to the Child Development Centres in various districts, or to the State Child Development Centre for more complex problems, latterly in particular for suspected autistic spectrum disorders (ASD).*
>
> *These centres staffed with specialised allied health and paediatric professionals could provide initial and ongoing assessment as initial and sometimes ongoing management – or arrange referral to other intervention and management agencies.*
>
> *However over time the population increase and the changing complexity of developmental concerns outstripped the resources of these services leading to a reduction in availability of access to Community Child Health Nurses, a pruning of the Screening schedule, a closure of the central Health Department Preparation for Parenting program, a restriction of Allied Health services to those up to age six only in most Child Development Centres, as a way of managing the increasing waiting list time. Even so it can for example be a six to nine month wait for Speech Pathology, up to 12 months for clinical psychology, and a 12-month wait for a primary school age assessment for ASD.*[184]

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182 Kim Laird, Department of Health, email, 15 April 2009.

183 Vicki Larkins, Therapy Focus, email, 15 April 2009.

184 Submission No. 13 from NIFTeY (WA), p2.

Finding 7

The rapidly increasing Western Australian population together with the changing complexity of developmental concerns has outstripped the resources of allied health services. This has led to a reduction in accessibility to a number of support services. The position is compounded by the limited number of WA graduates in some disciplines, such as speech pathology.

(b) Waiting lists

Those participating in the Inquiry all agreed that the support services, particularly those in the allied health field, are having difficulty coping with the overall demand resulting in inordinately long waiting lists.

> *There is inadequate funding and significant gaps in services. Particular diagnoses and clinical presentations are more affected by service gaps than others. Waiting times from identification to Early Intervention are too long and the standards suggested by Wang et al (2006) are not being met. In the community infants are waiting for as long as 12 months for therapy services following a diagnosis of being at risk of developmental delay. Infants also have to travel long distance to tertiary centres for therapy as therapy closer to home is unavailable due to either strict intake policies at the local centre or the wait list at the centre places the infant further at risk as they wait for up to 12 months for therapy.*[185]

These significant waiting lists exist at primary, secondary and, to a lesser extent, tertiary levels of intervention and in turn create referral bottlenecks. The outcome, reflected in many submissions, suggest that children and their parents are not getting the help that they need.

> *The pathway, from first concern to developmental screening, referral for diagnostic assessment and further referral for determination of eligibility for a disability specialist service, involves a number of agencies and professionals and can be quite complex for families and professional alike. At each stage there can be bottlenecks with the risk that the process can take so long some children miss out altogether on intervention in the important early years.*[186]

And:

> *For marginalised families and families who have been through trauma it can take time to build the trust needed for parents to accept referrals to new service. If intervention is dependent on enrolment in a separate specialist service children may wait too long.*[187]

The problem is evident in the metropolitan area as well as in the regions:

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185 Submission No. 26 from Australian Physiotherapy Association, p2.

186 Submission No. 37 from Disability Services Commission, p4.

187 Submission No. 23 from Early Childhood Intervention Australia (WA), p5.

> *Unfortunately, in the current environment, even when children are identified as having health or developmental issues, most forms of support or treatment services have long waiting lists. I have been advised that, even in the metropolitan area, therapeutic services such as speech pathology can have a waiting list of six to twelve months for an initial assessment, and even then, services are prioritised to younger children who are more likely to benefit from intervention. Mental health services for children through Child and Adolescent Mental Health Service (CAMHS) are also stretched, with long waiting lists. Where this occurs behavioural problems can compound.*[188]

In the regional/rural areas it is however exacerbated:

> *Currently in most rural settings with state government models it takes up to two years for assessment of a child suspected of having autism, up to six months to receive early intervention services for developmental disability and, in public hospitals, several years to have a regular general paediatric outpatient appointment. There is a demonstrable failure to maintain services for children in the Australian rural community.*[189]

The problem is also compounded by the lack of uniformity and eligibility for service in the tertiary hospital system:

> *It is common that infants under 12 months of age who have been diagnosed with cerebral palsy or developmental delay are waiting an average of 8 – 12 months before they receive therapy intervention. These families are required to access private services unless the child has coexisting medical concerns and they can access PMH services. However if they are admitted as a private patient for medical issues they can not always access Allied health services as some departments will not treat private patients. The lack of uniformity and eligibility for service in the tertiary hospital system is frustrating. The same can be said for metropolitan child development services. However there is optimism that since the CDS review there will be equity of access for families in the metro area*[190]

For children with significant but less obvious developmental problems the outcome may be lifelong:

> *Too few children receive services in their first three years. Service access to specialist disability early childhood intervention requires evidence that a child meets eligibility criteria. Children with profound disability are more likely be referred early frequently from Princess Margaret Hospital. Other children with significant but less obvious developmental problems may be overlooked until they fail in early education. The opportunity of support for positive development in the early years has been lost.*[191]

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188 Submission No. 15 from Commissioner for Children and Young People WA, p8.

189 Australian Paediatric Society (2008), Submission 479 to the National Health and Hospitals Reform Commission. Available at: http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/CHAPTER%203.pdf. Accessed on 31 March 2009.

190 Submission No. 22 from Touch Move & Play Physiotherapy Services, p2.

191 Submission No. 23 from Early Childhood Intervention Australia (WA), p3.

Finding 8

At a critical time of a child's development there are significant waiting lists for therapy or related intervention. In a significant number of cases, this compounds existing behavioural problems and may have life-long consequences for some Western Australian children.

(i) Alternative models of service delivery

As outlined earlier, many witnesses pointed to a lack of resources as the problem. This was exampled by Princess Margaret Hospital.

> *There is always a greater than 6/12 wait list and often greater than 12/12 wait list given for any service; medical or Allied health. For a child with developmental concerns this is an unacceptable delay.*[192]

Some of the delays are a result of cost shifting by other departments:

> *The cutting of medical services by Disability Services Commission has lead to increased transfer of medical care of these children through tertiary referral centres such as PMH and other regional CDC's and this has been with no transfer of medical funding. This compounds wait lists for medical review.*[193]

While the application of additional resources is one solution to the issue, there is also a realisation that it is not always possible to simply apply significant amounts of extra money to a myriad of specialist services such as those in health, mental health, disability, special education, family support, parenting, and child protection for example.

The alternative put to the Committee is that specialist services review their processes, consider integration and trans-skilling, so as to best to utilise their expertise and so meet the needs of the greatest number of people.[194] In some cases this might mean an experienced clinician working as an extended scope practitioner[195] (ESP), or key therapy provider, rather than as a generic specialist. They might, in this role, make also assessments and referrals avoiding the need for families to join waiting lists for assessments.

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192 Submission No. 20 from Princess Margaret Hospital, p3.

193 Submission No. 20 from Princess Margaret Hospital, p3.

194 Professor Frank Oberklaid, Briefing 25 February 2009.

195 Extended scope practice: is defined as professional practice that, while recognised and validated, exists at the very periphery of professional boundaries, often unconventional and challenging.

A review conducted in the United Kingdom for the National Health Service has suggested that 'there are huge opportunities and benefits to be gained by all professions and by the NHS in extending this approach to all professions allied to medicine.[196]

This approach would reduce the need for the most intensive forms of specialist help while additional funds would still be required, the overall total increase would be reduced.[197]

In a similar approach, the Disability Services Commission has adopted the use of an interdisciplinary or trans-disciplinary model of service delivery. This approach is not as far reaching as that of an ESP but is a significant move to blur silo'd professional boundaries.

> *With an interdisciplinary approach, team members (occupational therapist, physiotherapist and speech pathologist) collaborate with the family to set goals, make intervention plans and share information on progress. However each team member only provides intervention within the scope of his/her discipline, essentially retaining professional boundaries.*
>
> *With a trans-disciplinary approach, team member roles overlap and the professional boundaries are blurred compared to an interdisciplinary approach. There is constant, close communication between all team members so all will be conversant with the goals and intervention plans for the other disciplines. As the team members spend so much time working together, they often become skilled at incorporating goals and intervention strategies from other disciplines into each therapy session, rather than just concentrating on the goals of their own discipline (e.g. a physiotherapist running a hydrotherapy session may incorporate communication goals into the session format). This approach generally requires team members to have reasonably high levels of skill and experience to have successful outcomes.*
>
> *Of course there are limits to how far roles can overlap due to legal concerns and professional regulation issues in certain areas. Examples include the treatment of swallowing disorders by speech pathologists and treatment of respiratory problems by physiotherapists. In these instances the relevant team member is wholly responsible for managing treatment in these areas.*
>
> *With a transdisciplinary approach often one member of the team is selected to be the primary contact person for the family. Feedback indicates that many families find this less confusing than keeping in contact with three different team members.*
>
> *Internationally there is not a great deal of solid research to suggest that there is an optimal approach - either multi-, inter- or trans-disciplinary (in a multidisciplinary approach the team members only interact in a formal manner such as through meetings or forwarding through reports etc). However anecdotal evidence and data collected by Commission funded service providers indicates that an interdisciplinary or trans-disciplinary approach works well with our preferred model of family centred practice. This*

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196 Carr, P., 'Review of extended scope roles in professions allied to medicine', Available at: http://www.chl.wales.nhs.uk/resource/electives/report-peter.pdf. Accessed on 16 April 2009.

197 While few studies have been undertaken into the cost benefit of ESP those that have indicate lower costs as an outcome.

> *is likely due to the fact that family centred practice involves a partnership between the team members and family (instead of the 'expert model' more commonly experienced in medical settings), goals are functional and strategies for achieving them are integrated into everyday activities in natural settings.*[198]

The Committee was advised that South Australia has a home visiting program which is 85% universal, with 15% of the client group being targeted of which 5% is too chaotic to for nurses to deal with as they do not see themselves as doubling for social workers. Therefore multi-disciplinary teams are being considered to deal with those 5%.[199]

Finding 9

Internationally and nationally there are a number of alternative approaches which seek to address the deficits of service delivery, involving a range of allied medical professionals. Such initiatives attempt to improve the character and nature of the processes involved. The most far reaching of these is the creation of the role of the 'extended scope practitioner'. Other strategies with proven value include interdisciplinary and trans-disciplinary approaches.

(ii) How long are the waiting lists?

Anecdotally submissions suggest 12-18 month delays in seeing a specialist at a critical time of a child's development.

> *It is difficult to ascertain the degree to which children in WA, aged 0-3, is affected by the current level of early intervention services in the State because of the lack of information provided to the public on waiting times for children to access Early Intervention Services. The Health Department is not willing to provide this information, so one is dependent on anecdotal reporting of waiting times. One such report suggests a 12-18 month wait for Speech Therapy Service and another tells of a wait of 12 months to see a Paediatrician in the Health Department. With much evidence to support the belief that if children are to achieve to their full potential they must be supported in acquiring the necessary skills at the appropriate 'windows of opportunity', then timely early intervention is essential. A waiting period of 6 months or more to access an assessment and therapy is not in a child's best interests.*[200]

198 Marion Hales, Disability Services Commission, email, 17 April 2009.

199 Hon Jay Weatherill, Minister for Early Childhood Development, Briefing 23 February 2009.

200 Submission No. 33 from CHILD Australia, p6.

Finding 10

No data is currently maintained across services that would reflect the present adequacy of service provision or the referral system for families and children. Such anecdotal evidence as exists suggests that there are significant delays in seeing a specialist at a critical time of a child's development.

(iii) The need to improve pathways of intervention and the waiting list:

Resource constraints are compounded by the increasing costs of providing secondary and tertiary level interventions, and the increasing complexity of the type and quality of response required. The result is the need to prioritise children and their families. An example by the Child Development Service of how this is done is outlined in Appendix one. However the Committee is advised that even so, 'there are still not enough resources to meet the needs of the most highly-prioritised children.'[201]

Prioritisation and other forms of gate-keeping are the direct result of limited finance available for interventions by allied health professionals and the size of the need for pre-specified interventions.

One suggested approach to better managing demand is to improve pathways of intervention to overcome the existent problems with the referral process. These problems 'can result in a disparity of access to services.'[202]

The Australian Physiotherapy Association recommends centralising intake processes to simplify the creation of good pathways of intervention.

> *Centralised intake processes aim to eliminate disparities across regions, and when functioning efficiently, can be beneficial in identifying and facilitating uptake of early childhood intervention services. However complicated referral procedures and intake staff who lack appropriate training in interpretation of eligibility criteria can delay families' access to suitable services.*[203]

Good pathways outline the services required and the timeframe of those services. Such services are not infrequently multidisciplinary. Currently many pathways of intervention face significant problems. These may be a result of compartmentalisation of service provision, or complexity or demand as exampled here:

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201 Submission No. 30 from Dr John Wray MB BS FRACP, p4.

202 Submission No. 26 from Australian Physiotherapy Association, p5.

203 Submission No. 26 from Australian Physiotherapy Association, p5.

> *The pathway from when parent first raise their concerns, or are informed* [of] *possible developmental problems, to developmental assessment, tests, diagnosis and determination of eligibility for a services is complex, takes time, may involve multiple agencies and professions. There may be bottlenecks and waiting lists and frequently there is no intervention while the child is on this path. Some children may not complete this pathway until too late for effective early intervention.*[204]
>
> *There are adequate referral pathways within PMH for PMH* [Early Childhood Intervention] *EIC program and it is fully booked and has a wait list. There are specific at risk children e.g. cardiac patients, and other specific diagnostic groups who are not seen by EIC to due extensive wait list and limited resources.*[205]

Uncoordinated pathways of intervention become readily fragmented as the following example outlines:

> *[If] They [the client] are referred to an agency, they will receive some continuation of therapy from the referee agency for a time … then they are discharged and wait on the other agencies wait list. If they are referred by a private Medical practitioner they may not even be referred to other Allied health services as the Med-Practitioner could be expecting the Public funded agency to pick up the child/family for all services.*
>
> *The dilemma for clients once they are identified, either at a Child Development Service (CDS), KEMH, or PMH with a diagnostic label that entitles them to receive services from another publicly funded agency, is that these disability services have a defined capacity of clients that they can manage in their Early intervention program (EIP). (remember they are all metropolitan based services too and don't provide direct intervention services to country rural clients, In rural areas they utilise available AH health dept staff to provide the intervention services and they give "Consultancy support").*
>
> *So if a child is identified as needing ongoing services and meets the criteria for a particular agency they are referred onto that agency. If that agency is at capacitance the child and family will wait for ongoing intervention services until there is a vacancy in their EIP. Both DSC & TCCP [The Centre for Cerebral Palsy] run their service upon a twice yearly intake January and July.*[206]

The cause of the problem is outlined in a submission by a physiotherapist with both government and private practice experience, who writes:

> *The first wave of waiting is engaged in accessing a service provider. The criteria for client eligibility to access to services from the various government funded service providers consistently undergoes change, becoming more and more restrictive. This has been occurring over the past 2 decades. Families and referees experience enormous challenges and bureaucratic barriers when trying to gain access to the appropriate, or any,* [Early Intervention] *EI service provider for their child, clients. The diagnostic acceptance criteria*

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204 Submission No. 23 from Early Childhood Intervention Australia (WA), p4.

205 Submission No. 20 from PMH, p4.

206 Helen Beaton, Touch Move Play, email, 17 April 2009.

> *change, the demographic acceptance criteria change, the perceived therapeutic need for the client/ family from the service provider change. Families and referees have no control over this process. Many clients, families that are or have become ineligible for publicly funded services are required to access private services. On a positive note are the recent commonwealth initiatives, Medicare enhanced primary care program for children with chronic disabilities- they can access a maximum of 5 Private Allied Health treatments per calendar year and the Helping Children with Autism package access to assessment and therapy intervention for children with autism. However if a child is not eligible for any government support and do not have financial, social, resources their infants, children will receive no service.*
>
> *When eligibility criteria for service is met, for the majority of publicly funded services there becomes the second wave of long wait times for assessment and in some agencies the third wave of waiting for actual intervention therapy services. Some agencies will only take in new clients at set calendar dates. Young chronically disabled and developmentally delayed infants, children, and their families can wait 8-9 months to receive therapy services from public funded agencies. Many families will often access private EI services. This incurs considerable cost to the family but also involves the infant young child and family having to develop and redevelop new relationships with a variety of adult clinicians as well as the difficulty of having fragmented services and less efficient cohesive coordinated therapeutic management.*[207]

There is a significant impact on families when faced with imperfect pathways to early intervention:

> *Families may 'get lost' due to confusion in negotiating the multi-layered early childhood maze of childcare, parent education programs (mainstream and specialist), kindergarten, early intervention programs, playgroups, family drop-in clinics, community health appointments, specialist appointments etc. In these instances parents may have received a referral for a service but may not have followed it through due to confusion over what the service offers or how to access it.*[208]

And:

> *Families experience significant wait times, phases of waiting, to access community based early intervention services in WA and often encounter more than one wait in their journey between time of identification of disorder, potential for disorder, referral, initial assessment and commencement of intervention. These families experience enormous stress and frustration which sometimes can have devastating effects on the child, the parents or other members of the family*[209]

The effectiveness and efficiency of such pathways is improved when services become joined-up and focus on the family or child rather than their own requirements. This is contingent on:

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207 Submission No. 22 from Touch Move & Play Physiotherapy Services, p1.

208 Marion Hailes-MacDonald Manager - Strategic Policy and Programs, Disability Services Commission, email, 3 April 2009.

209 Submission No. 22 from Touch Move & Play Physiotherapy Services, p2.

- broad alignment of programmatic frameworks;
- general agreement on outcomes sought; and
- appropriate information sharing.

While not resolving waiting lists, integrated pathways mitigate bottlenecks and take account of individual needs, and the resources required. Such pathways can reduce costs and. are evidence of the level of quality of the response.

There have been a number of clinical initiatives in this direction in recent times:

> *A positive development in the public sector has occurred in health where child development services have integrated in the metropolitan area, developed clinical pathways for its, clients 0-17years, client prioritisation and key performance indicators for the service and Memorandums of Understanding between DSC and Mental Health Service to permit collaborative client care. However the funding required to implement these new integrated clinical services to clients and families has yet to be delivered*[210]

> *The Metropolitan Child Development Service Review has recently developed good clinical pathways and interagency policies, Memorandum of Understanding between DSC and Mental Health services.*[211]

Finding 11

There is a need for improved referral pathways for the developmentally vulnerable in the early childhood sector. Anecdotally, many families in need of support services 'get lost' due to confusion in negotiating the multi-layered early childhood maze of programs and related services.

210 Submission No. 22 from Touch Move & Play Physiotherapy Services, p2.

211 Submission No. 27 from Paediatric Physiotherapy Services Network, p7.

Recommendation 7

There is clear requirement for cohesive, consistent and seamless clinical services designed around the needs of all children and their families and communities, to be developed to improve service delivery in line with such concepts as the '*one stop shop*' or the '*no wrong door'* approach. This approach would resolve the need for those needing to access a service having to go from agency to agency or office to office, to string together a response to their need.

The Committee recognises that pending the drawing together of early childhood services under one Ministry this strategy will need to be taken forward within the existing departmental structures. Accordingly, the Committee recommends that the Department of Health, within twelve months, consultatively improves referral pathways for the developmentally vulnerable, creating effective linkages between key services to ensure a continuum of care for families.

Finding 12

The current system is particularly failing families of children with special needs, including children with a disability or a developmental delay. These families have to navigate not only universal services, but also specialist and allied health care. They often experience long waiting times for specialist and allied health services, especially in rural areas, and poor continuity of care.

Recommendation 8

While in the long term the aim must be to reduce the need for intervention by therapists, there is nevertheless an immediate demand to dramatically improve the availability of remedial therapists.
The Committee strongly recommends that to address the undersupply of therapists for children, the Department of Health, within twelve months:

• Undertakes a comprehensive 'needs analysis' of the levels of speech pathology and occupational therapy positions required to provide both clinical therapy services, and systemic delivery of therapy services, in schools and early childhood settings;

• Develops targets for numbers of therapists per head of population for each Area Health Service, with equity weightings; and

• Allocate sufficient funding to ensure these positions are filled.

Recommendation 9

The Committee recommends that the Department of Health consults with relevant professional bodies and affected agencies to look at ways service provision could be improved in the allied health sector through the creation of:

- 'extended scope practitioners';
- interdisciplinary or trans-disciplinary model of service delivery; and
- key therapy service providers.

7.3 Screening

(a) Hearing screening

Research, both nationally and internationally, evidences the value of early intervention programs for children and their families. Such strategies have long term benefits for physical and mental health, educational achievement and emotional functioning of the child.

Early detection of developmental impediments in public health includes:

- Screening;
- Developmental assessment;
- Monitoring of risk factors;
- Protective factors and
- Child health surveillance.[212]

Significantly, given its impact on future literacy, there is in Western Australia, no universal newborn hearing screening program which would form a part of the general health screening program.

> *Western Australia (WA) has a limited newborn hearing screening program. The current program covers 50% of births and is confined to certain hospitals (public and private) in the metropolitan area. There are currently equity issues in the program, with accessibility to the service dependent on place of birth and/or ability to pay. The advancements in technology and training programs for non-professional personnel have made universal screening a feasible service. The DOH is currently exploring options for expanding this program statewide.*
>
> *The Telethon Speech and Hearing Centre has established a private Newborn Hearing Screening Service offered at six private hospitals, and a fee is charged for this service.*

[212] Child and Youth Health Intergovernmental Partnership, '*Child Health Screening and Surveillance: A Critical Review of the Evidence*', 2002. Available at: http://www.nphp.gov.au/publications/chip/screening.pdf. Accessed on 30 March 2009.

> *Parental uptake is limited and therefore screening coverage is lower than required for an effective screening program. WA is the only State without a universally available screening program.*[213]

The consequence is that there is often a failure to both identify developmental delays and to make appropriate referrals.

> *Children aged 0-3 years are infrequently exposed to professionals in the community including child health nurses, general practitioners and child care workers. Currently there are there are no formal screening processes of children aged 0-3 years, therefore key people often fail to identify delays in development and early referral to services does not occur.*[214]

This failure occurs despite the evidence that early detection of hearing impairment and subsequent quality early intervention can result in vastly improved outcomes for these children and their families.[215] This failure is significant given that statistics indicate 'that 1 in 7 will have significant learning problems, 1 in 3 serious behaviour disorder, 1 in 20 one of the forms of ADHD, 1 in 10 language disorders.[216]

Failure in early detection means that for many children, speech and language difficulties are not identified until the child enters pre-primary or primary school[217]. This represents a lost opportunity and impacts on the future acquisition of literacy.

There is universal hearing screening once a child reaches pre-primary level, however a Department of Education and Training forum in 2008 identified a number of surrounding issues which impact on the recognition and treatment of a child's difficulties, including:

- *Screening may not occur until the end of Year 1 resulting in a significant amount of time being lost before appropriate interventions and educational management can be put in place. Given the impact on educational outcomes for students, screening should occur earlier, perhaps at K level. This may be difficult, given it is dependent upon gaining informed parental consent and Year One is the first compulsory education period.*

- *Regional and remote service delivery is difficult due to limited staffing availability. Many support services are provided on a fly in / fly out basis, which potentially reduces the impact of the intervention and follow-up.*

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213 Submission No. 8 from Department of Health, p17.

214 Submission No. 24 from Therapy Focus, p3.

215 Submission No. 15 from Commissioner for Children and Young People WA, p5.

216 Submission No. 13 from NIFTeY (WA), p2.

217 Speech Pathology Australia, 'Submission 2008', Available at: http://intranet/parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/8E72A329283E6FB1C825749F000BC667/$file/Sub+7+RUCSN.pdf. Accessed on 30 March 2009.

- *There is a lack of follow-up to ensure parents / carers have the capacity and commitment to access treatment. This is sometimes due to economic factors and distances required to travel, but can also be due to lack of parent / carer understanding of the impact of the disability and the need for timely and appropriate interventions. There can be a lack of understanding by teachers and other school staff of the impact of hearing loss.* [218]

The impact is severe since:

> *When children are exposed to a degraded speech it not only affects their development of language, it also has a permanent effect on their ability to read, because they cannot learn how to attach sound to a letter, because they have trouble perceiving the internal detail of words. They hear words as a whole; they do not hear all the component parts of words that, of course, we call phonics. So they have trouble learning phonics; they have trouble learning to decode in addition to the differences in their language.* [219]

The problem is exacerbated by a report that when the child does enter the formal school system the screening may not be effective for a variety of reasons:

> *Screening conducted by school/child health nurses and teachers is inconsistent in terms of*
>
> *a. the tools used*
> *b. the criteria used to assist in decision making, and*
> *c. the schools currently using screening tools across the state.* [220]

Finding 13

While recognising the recent Federal mandating of hearing screening of newborn children to take effect in 2010/11, in the interim there remains a problem for children not yet screened. Limited resources restrict the capacity of school nurses to provide adequate hearing screening and ongoing support. The result is reduced language and literacy skills in the first year(s) of schooling.

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218 Department of Education and Training, 'Submission 2008', Available at: http://intranet/parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/54E0AEB03C42A1CBC825749F00157828/$file/Sub+29+DET.pdf, Accessed on 30 March 2009.

219 Dr Martha Burns, *Transcript of Evidence*, 6 April 2009, p2.

220 Speech Pathology Australia, 'Submission 2008', Available at: http://intranet/parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/8E72A329283E6FB1C825749F000BC667/$file/Sub+7+RUCSN.pdf. Accessed on 30 March 2009.

Recommendation 10

The Committee strongly recommends that every child is screened for hearing capacity within the first six months of commencing school, be that pre-compulsory or compulsory years. Adequate resourcing for school health nurses will need to be made available.

(b) General screening

The Committee notes that the *Education and Health Standing Committee* has recently tabled a report on the inadequacies of screening in Western Australia. Therefore this report will not dwell on them other than to note some of the comments made in submissions to this Inquiry and to express their support for the thrust of the recommendations made by the *Education and Health Standing Committee.*

In addition to points canvassed previously in this report in relation to screening agencies noted amongst other things that:

> *Children aged 0-3 years are infrequently exposed to professionals in the community including child health nurses, general practitioners and child care workers. Currently there are there are no formal screening processes of children aged 0-3 years, therefore key people often fail to identify delays in development and early referral to services does not occur.*
>
> *It is recommended that a systematic, standardised screening of children is conducted in the early years of their life. Research indicates that without the use of standardised tools <30% of children with developmental disabilities or mental health problems are identified. This percentage increases to 70-90% when standardised tools are used.*[221]

And:

> *While child health nurses generally do an extraordinary job, funding for basic health screening is simply inadequate. The lack of funding impacts on the number of home visits, limits community involvement and reduces the capacity to introduce programs and services. All of those have reduced early identification opportunities over many years. The involvement of child health nurses and child development staff in playgroups has proved very successful in increasing early intervention though is unfortunately limited by staff restrictions.*[222].

And:

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221 Submission No. 24 from Therapy Focus, p3.

222 Submission No. 28 from Playgroup WA Inc, p5.

> *Between the ages of 9 months and Pre School, developmental checks by a CHN are not actively promoted or encouraged. Requests by parents for a health check are accepted only.*[223]

And again:

> *Many deficits in the current system of health screening and surveillance have been brought to my attention—many as a direct consequence of inadequate resources and the shortfall in child and school health staff. The existing limited take up of the two year old check, for example, means there is quite a long gap between milestone screening, so that some conditions are not identified and the opportunity to intervene and provide services is lost.*[224]

There are also issues of accessibility during non-standard working hours:

> *At present, identification of a developmental delay or any specific concern e.g. language difficulty, by a caregiver in childcare, cannot be promptly confirmed through observation or assessment by a Child Health Nurse visiting the child care service. Parents are instead advised by the child care coordinator to take the child to their local Community health Nurse. This can be a problem for working parents or for parents who are finding the concerns difficult to cope with.*

7.4 Regional issues with service provision

> *Rural communities have poorer health outcomes, poorer access to services and higher health risks.*[225]

The regions of Western Australia cover an area of some 2.55 million square kilometres with a combined regional population of 454,000 people (a little over a fifth of the State's population), including 44,900 Aboriginal people.[226]

Health-based early childhood intervention services in the metropolitan area are provided by health and disability specialist government and non-government services. In regional areas many of the health related services provided by disparate organisations in the metropolitan area are provided through the WA Country Health Service. This makes the WA Country Health Service (WACHS) the single biggest Area Health Service in Western Australia, and, geographically, the largest country health system in Australia. Their service provision includes the provision of allied health services which would be provided by the Disability Services Commission in the metropolitan area.

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223 Resource unit for Children with Special Needs, 'Submission 2008', Available at: http://intranet/parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/8E72A329283E6FB1C825749F000BC667/$file/Sub+7+RUCSN.pdf. Accessed on 30 March 2009.

224 Submission No. 15 from Commissioner for Children and Young People WA, p8.

225 WA Country Health Services, 'Developing a new partnership for Aboriginal health in WA', 25 March 2009. Available at: http://www.ahcwa.org.au/index.php?option=com_content&view=article&id=80&Itemid=76. Accessed on 14 April 2009.

226 WA Country Health Service, 2009. Available at: http://www.wacountry.health.wa.gov.au/. Accessed on 3 April 2009.

This is done with consultative support from the Disability Services Commission and in cooperation with other non-government organisations with a statewide focus.

The outcome in terms of allied health service provision is patchy at best:

> *There are a limited number of allied health services available in the two largest towns in the [Pilbara] region such as podiatry, chiropractic, naturopaths, however services vary between towns. Some services are available through a private provider with most services being provided through the health department. These services are generally not available in smaller towns and Indigenous communities. People are either required to travel vast distances, often in extreme conditions such as high temperatures or on unmade roads, to access these services or to wait long periods for visits. Given these circumstances, many people do not gain the benefit of the services, particularly where recurring or frequent visits are required.*
>
> *In addition, if a specialist service is provided by the health department, regardless of the time delay, people are generally unable to claim PATS if they choose to travel to Perth to seek attention earlier and the health matter is not regarded as being life threatening.*[227]

Many support programs are successfully implemented in regional areas despite the significant geographical challenges and the thinness of the population. One of those programs is 'Better Beginnings'. This Family Literacy Program is coordinated by the State Library of WA and is supported by Rio Tinto in a funding partnership with the State Government.

> *Better Beginnings has successfully overcome the geographical constraints to reach the remote, regional and metropolitan areas of Western Australian through its links with health professionals and the State's public libraries. Delivery of resources through the State Library of WA network and subsequent delivery of packs through community child health nurses and the local libraries ensures the program has a wide reach and, as every newborn child receives a pack, the delivery of the program is not impacted by socio economics.*[228]

Another successful initiative is the similarly named 'Best Beginnings' home visiting service. This service is designed for families whose children are at high risk of poor life. The program begins in the antenatal period and extends up until the child is 2 years old.

> *Best Beginnings is an evidence-based early intervention home visiting service provided to vulnerable families commencing in the antenatal period until 2 years of age. The program aims to enhance child development; build maternal health and life course competence; enhance parent and family skills; optimise parent child interaction; prevent child neglect and abuse; provide primary health services; and provide social support. Best Beginnings is available in 10 locations - Perth, Joondalup, Midland, Mirrabooka, Cannington,*

227 Trish Barron, Pilbara Development Commission, email, 14 April 2009.

228 Submission No. 25 from department of Culture and the Arts, p4.

> *Armadale, Fremantle, Kwinana, Kalgoorlie and Albany, with a further site planned for the Kimberley region in 2009.*[229]

This program has been evaluated with the evaluation findings indicating that:

> *Best Beginnings has been developed, implemented, resourced and supported in a manner that reflects well on both the Department for Community Development and the Department of Health.*
>
> *Key stakeholders at all levels perceive that Best Beginnings is running well across all sites. In some sites performance is exceptional. Overall the program has been implemented with integrity and coherence, which is reflected in the homogeneity of the program across sites, and in the degree of commitment and enthusiasm evident from those involved in the program, at all levels. Initial indications are that the program is appropriately targeting clients, retaining them in the program, and having a positive effect on the lives of client parents and children.*[230]

In regional areas, linkages with Aboriginal Health agencies are seen as an important strategy for supporting Indigenous children with disabilities and their families and carers.[231]

> *Regional and remote areas face a particular set of challenges, and are a priority for government. Many remote areas lack the services available in bigger centres, requiring considerable travel to see clients. Difficulties recruiting and retaining staff bring this into even sharper focus for regional and remote areas where program gaps may result in existing staff trying meet demands that are outside of their roles or training. Service planning in rural and remote areas needs to take into account the expectations and needs of the community in which the service will be based. Agencies need to engage with local communities when deciding what services are required and how they will be delivered.*[232]

The issues in the regions cannot be generalised because of the size of the state and the disparity of geography, demographics, and varying infrastructure support. However they all suffer from some service deficiencies in government programs in common with each other.

(i) Regional Challenges

Submissions were made that regional perspectives were not adequately dealt with in the development of policy.

> *Unfortunately, attempts from this region to input into the national agenda have been largely unsuccessful and there is no mechanism to provide ongoing feedback or input. The previous Ministerial Advisory Committees have utilised only 'peak bodies' and the discrete*

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229 Submission No. 8 from department of Health, p30.

230 Telethon Institute for Child Health Research, *Best Beginnings Evaluation Report*, report prepared by Robson, A. and Clark K., Perth, 2004, p2.

231 Submission No. 37 from Disability Services Commission, p2.

232 Department for Child Protection, *Secondary Services Consultation Paper*, 2009, p17.

> *issues that impact remote regions such as the Pilbara are overshadowed by the weight of metro-centricity.*[233]

There are felt consequences for ECEC that are seen to flow out of this lack of community consultation.

> *The issues for early childhood care and learning in rural, regional and remote Australia will not abate unless and until legislation, policy, funding and resources take into account and reflect the needs and do 'what it takes' to provide and enable substantive equality.*[234]

To overcome government policy and service delivery gaps and provide more 'substantive equity', a number of different approaches have been adopted by local stakeholders and other NGOs. These include:

- The involvement of corporations such as BHP and Rio Tinto in the provision of services in the Pilbara.

- Schools in the Wheatbelt are funding and running school based programs out of existing budgets. (It should be noted this is also occurring in metropolitan schools so it is not exclusively a regional issue.)

  > *Increasing number of schools developing school based programs for 0 – 4 years age group. These programs do not receive funding from the Department, and are not formally recognised.*[235]

- The establishment of regional groups to promote early years and general regional initiatives. Such groups include Eastern Wheatbelt Early Years Network, the Pilbara Development Commission, and the Bunbury Early Years Network.

- St John of God Health Care funds what is known as *The Strong Family, Strong Culture Program* in its initial phase until communities can self sustain the program. Once established 'Government funding and business corporation support is sought for the program's sustainability.'[236]

  > *The Strong Family, Strong Culture program promotes improvement in the health of Aboriginal women and their babies. It follows a successful initiative in the Northern Territory where an evaluation showed the program improved birth weights by up to 42%. Low birth weights influence the risk of chronic disease such as diabetes, stroke and heart disease in adult life.*

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233 Submission No. 29 from Pilbara Development Commission, covering letter.

234 Submission No. 29 from Pilbara Development Commission, covering letter.

235 Submission No. 34 from Eastern Wheatbelt Early Years Network, p2.

236 St John of God Health Care, 'Strong Family, Strong Culture program', 2009. Available at: http://www.sjog.org.au/portal/page?_pageid=415,408267&_dad=portal&_schema=PORTAL. Accessed on 2 April 2009.

> *The program recognises the traditional cultural approaches to parenting and lifestyle, supporting pregnant Aboriginal women and their babies through better diet, education and ante natal care, with the aim of increasing the birth weight of babies and improving early childhood development.*
>
> *The program is currently established in a number of communities in the Kimberley, Pilbara and Midwest region of WA.*
>
> *The program works with other established health service and/or community service providers as well as having operational links with community health clinics, health staff and health programs. With a substantial number of communities involved, collaboration with organisations such as the Derby Aboriginal Health Service (Derby), Marninwarntikura (Fitzroy Crossing Womens Resource and Legal Service, Fitzroy Crossing), Pilbara Indigenous Women Aboriginal Corporation (Pilbara) and Geraldton Regional Aboriginal Medical Service (Mid West) is paramount to the program's success.*[237]

(ii) Childcare

A number of childcare facilities and playgroups in the regions are underwritten by State and Federal government funding. For instance, the Department for Communities and the Commonwealth Department for Families and Housing Community Services and Indigenous Affairs (FaHCSIA) support a range of playgroups for children and families in the Midwest Gascoyne and Murchison and the Pilbara. Two new centres are planned, one in Port Hedland and one in Karratha, funded through the Australian Government's Early Learning and Care Centres program[238] and will be built on school sites. Others may be underwritten by corporate sponsors as outlined elsewhere.

In addition the Department of Education and Training provide culturally inclusive and age-appropriate kindergarten programs for Aboriginal children from the age of three at a number of regional Aboriginal Kindergartens and at all Remote Community Schools in the Kimberley, Pilbara, Midwest and Goldfields.[239]

Despite these initiatives, when the availability of child care is measured against the number of children in the metropolitan versus the regional areas there is a greater provision of licensed places per capita in the metropolitan area.

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237 St John of God Health Care, 'Strong Family, Strong Culture program', 2009. Available at: http://www.sjog.org.au/portal/page?_pageid=415,408267&_dad=portal&_schema=PORTAL. Accessed on 2 April 2009.

238 Submission No. 29 from Pilbara Development Commission, p1.

239 Submission No. 5 from Department of Education and Training, p2.

Figure 7.1

Country and Metro	0-4 years	0-8 years	Sum total of child care places	No. of children per available place
Country*	35,122	66,169	9,608	6.88
Metropolitan*	89,506	163,551	32,640	5.01
No Usual Address	210	358		
Total	124,838	230,078	42,248	5.44

There is reportedly significant shortfall between demand and supply in childcare places in the Pilbara in particular:

> *The Commission has identified child care and early childhood development as a priority area for the Pilbara and has been working with key stakeholders to identify and initiate a range of strategies to address the issues and needs in the region.*[240]

And:

> *In regions such as the Pilbara there are significant issues with children accessing quality early learning and development programs. There are substantial gaps in access to child care and early learning opportunities in all major towns which increase in smaller towns to being almost nonexistent in Indigenous communities and on isolated pastoral stations.*[241]

And:

> *The major resource companies in the Pilbara are working toward providing employment for local Indigenous people. However, child care places have been in shortfall in the region for a long period of time and formalised care for children in Indigenous communities is generally not available.*
>
> *Multifunctional Aboriginal Children's Services (MACS) operate in two of the towns that have high populations of Indigenous people i.e., South Hedland and Roebourne, however they offer limited if any early years programs, very limited parent support programs, places are limited and attracting and retaining child care workers is problematic. There are two mobile services that provide services to some isolated communities, however, given the size and remoteness of the region this is inadequate and difficult to deliver.*

In the case of Indigenous children, it was argued by the Productivity Commission, in their *Report on Government Services 2006*, that the extensive kinship networks within Aboriginal families may mean that aunts and grandparents play more significant roles in child rearing than in the case of

240 Submission No. 29 from Pilbara Development Commission, p1.

241 Submission No. 29 from Pilbara Development Commission, p1.

non Aboriginal families. Their conclusion was that Aboriginal children do not participate in child care to the same extent as non-Indigenous children. However the Pilbara Development Commission strongly states that there remains a significant problem:

> *The most lacking in formalised child care and early years programs are remote Indigenous communities, almost to the point of negligence. There is an immediate and urgent need for Indigenous communities to be better resourced to enable the delivery of more formalised, flexible early years programs specifically developed for Indigenous children.*[242]

Playgroup WA (Inc) similarly believes that there is a shortfall in places and access:

> *Equity of access is an important issue as while some families may have personal resources to purchase private assistance; this option is not available to disadvantaged communities. For those living in rural and remote areas there are often no private or public services available. This clearly impacts most severely on our Indigenous children.*[243]

The Pilbara Development Commission has endeavoured to quantify the shortfall in child care places in the Pilbara and advises that:

> *In each local government area's main towns where there is the ability to track waiting lists for existing services, the demand is always greater than the number of places actually supplied. It is also known that people relocating into the region, once aware of the lack of child care, generally do not bother to put their children on a waiting list and will use unlicensed care if necessary. In many instances, people do not move to the region because of the lack of child care.*
>
> *In smaller towns where there are no existing services, it is difficult to track the numbers of people seeking a service. The last figures on demand are from May 2007 and will be reviewed in the near future. An excerpt from the document is below.*[244]

Figure 7.2

LGA region	Ashburton	East Pilbara	Roebourne	Port Hedland
waiting list	40	58	365	241
LDC places	101	84	185	194

242 Submission No. 29 from Pilbara Development Commission, p1.

243 Submission No. 28 from Playgroup WA Inc, p3.

244 Trish Barron, Pilbara Development Commission, email, 14 April 2009.

Figure 7.3

Region	0 to 4 years		5 to 14	
Pilbara	3,717	9.1%	6,793	16.6%
Australia	1,260,405	6.3%	2,676,807	13.5%

NOTE: The Pilbara has markedly lower numbers of people in the 55+ age groups (9.1% in the Pilbara, 23.3% nationally) who traditionally provide support to adult children with care of the grandchildren.

Statistic from ABS 2006 snapshot data

As outlined in the section canvassing the demographic background to service provision, there is also a significant level of family dysfunction in the Aboriginal community. This also calls into question the quality of care that some extended families can provide within their kinship networks.

Such is the perceived level of the problem that the Pilbara Development Commission has responded to the gaps in child care and early childhood service provision by establishing a working group of key stakeholders. This group has been formed:

> *To develop strategic level responses to issues relating to early years development, care and learning. The Pilbara Early Learning Alliance[4] which is in the process of being incorporated comprises senior representatives from industry (BHP Billiton, Rio Tinto, Woodside etc), Australian government (ICC, DEEWR), WA state government (PDC, Department for Communities) and non-government / private organisations. Since its establishment the Alliance has provided input to state based reviews of legislation and practice relevant to this inquiry and has been a permanent agenda item on the State Government's Ministerial Council on Childcare.*[245]

(iii) Issues in health provision for young mothers and their children in the Kimberley

Background

There is a Community Health Nurse (CHN) in each district and a midwife in each town. They have different roles - antenatal and post natal. In particular, the Kimberley population health unit employs a total of 5 midwives across the Kimberley who are based at each of the 5 main towns. Their roles differ across the region – in Derby, Broome and Kununurra ante- natal clinics are held in the hospitals by hospital employed midwives. The community midwives in these 3 towns therefore concentrate on ante- natal education, women's health and immediate post natal home visiting up to day 10. The only cross over of roles is that the Child Health Nurse is involved in Ante natal education also. In Fitzroy Crossing and Halls Creek there are no midwives employed at the hospital to do ante natal clinics - so the community Midwife sees all women, both ante -natal

245 Trish Barron, Pilbara Development Commission, email, 14 April 2009.

and post-natal, prior to handing over their care to the Child Health Nurse 10 days following birth. The midwife also undertakes women's health checks (pap smears etc).[246]

Issues:

1. Distance:

For the Department of Health (DoH) staff, travelling to surrounding communities for both the Child Health Nurses and Midwives add to their workload and in Fitzroy Crossing this is especially an issue as communities are spread across the Fitzroy valley and some are 170kms from town.

Transport is a problem for many in the indigenous community as sometimes there is no one to bring them into town for appointments from outlying communities– so DoH time can be spent finding and organising transport etc. Lack of transport can be a major issue in accessing health care for people living in remote areas across the Kimberley.

2. Transient indigenous population

Additional to DoH staff workloads is time spent locating women and ensuring they have follow up appointments/scans etc (scans have to be done in Derby). Women in Fitzroy crossing and Halls Creek have to leave their communities to deliver in Kununurra or Derby or Broome and possibly Perth - if there are complications or high risks (i.e. prematurity/twins etc). In view of the mobility of Indigenous families this often causes extra work in locating women who move around and also finding women who are pregnant and about to deliver in a community - who are originally from another town or community in another region (i.e. Pilbara) and having to locate her history and medical records etc.

3. Databases

The provision of nursing care to these populations is further complicated by different databases between the WA Country Health Service and the Aboriginal Medical Service. Consequently information on a woman's ante- natal care and treatment cannot be shared. [247]

4. Accommodation for staff

In Halls Creek the Committee was advised that the turnover of doctors in the hospital exceeded twenty over a 12 month period. This turnover is exacerbated by a high turnover of nurses due to a very poor standard of available accommodation.[248] In Fitzroy Crossing there is no guarantee that private single accommodation, or accommodation for staff with a family will be available at the time staff are recruited.

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246 Melissa Williams, Kimberley Population Unit Briefing 5 June 2009 at the Nindilingarri Cultural Health Centre.

247 Melissa Williams, Kimberley Population Unit Briefing 5 June 2009 at the Nindilingarri Cultural Health Centre.

248 Dr David Shepherd, Senior Medical Officer, Halls Creek Hospital, Briefing 5 June 2009.

(iv) Parenting in Indigenous Communities

> *Parental capacity is an important predictor of children's academic success at school – as Zubrick et al have shown, one of the three key factors associated with poor school performance is the lower level of academic achievement of the carers of Indigenous students. The evidence strongly suggests that poor school performance is occurring trans-generationally highlighting the need for all health and children's services with a stake in early child development to develop strategies and programs to engage with Indigenous parents at all stages of development.*[249]

In the Pilbara 13.7% of the population identified themselves as indigenous compared with 3% across the state of Western Australia.[250] Chapter five of this report outlines the demographic challenges faced by many in this section of the Western Australian community. In addition, Australian Bureau of Statistics data outlined in Figure 7.3 reflects the Pilbara as a region of higher than average numbers of families with dependant children, where the average age of the population is pre-pubescent.

There is strong evidence showing high levels of vulnerability in the Indigenous population across a range of areas of development impacting on indigenous children's school readiness. This vulnerability is reflected in the Australian Early Development Index (AEDI) findings for the Pilbara as follows:

[249] Shepherd, C. and Walker, R., 'Engaging Indigenous Families in Preparing Children for School', 2008. Available at: http://www.aracy.org.au/publicationDocuments/TOP_Engaging_Indigenous_Families_in_Preparing_Children_for_School_2008.pdf. Accessed on 24 June 2009.

[250] Australian Bureau of Statistics update 2007as provided by the Pilbara Development Corporation.

Figure 7.4 Proportion of children developmentally vulnerable in the Pilbara[251]

(The AEDI maps use five shades of green from dark green through to light green, representing the national quintiles. The darkest shade represents most vulnerable communities and the lightest shade represents least vulnerable communities.) For a full explanation of the terms used refer Chapter 4.2 of this report.[252]

Most Vulnerable ... Least Vulnerable

		Proportion of children developmentally vulnerable (%)						
	#	Phys	Soc	Emo	Lang	Com	Vul 1	Vul 2
DAMPIER	24	0.0	0.0	4.2	0.0	0.0	4.2	0.0
JIGALONG	26	50.0	27.8	13.3	68.8	44.4	72.2	50.0
KARRATHA	225	3.9	2.0	4.0	11.8	3.9	17.1	5.9
MARBLE BAR AND SURROUNDS	26	12.5	34.8	33.3	52.2	39.1	62.5	45.8
NEWMAN	261	18.5	12.4	19.4	29.9	16.7	39.6	24.7
ONSLOW	18	27.8	27.8	11.1	38.9	22.2	44.4	38.9
PANNAWONICA	20	0.0	5.0	0.0	5.0	5.0	15.0	0.0
PARABURDOO	85	1.3	2.5	5.1	17.5	3.8	20.0	7.5
PARNNGURR	23	5.0	35.0	40.0	70.0	40.0	80.0	60.0
PORT HEDLAND	49	8.7	13.0	8.7	21.7	15.2	26.1	17.4
PUNMU	18	68.8	43.8	75.0	75.0	81.3	100.0	87.5

251 Royal Children's Hospital Melbourne, 'AEDI Pilbara Communities WA',. Available at: http://www.rch.org.au/australianedi/results.cfm?doc_id=11396. Accessed on 25 June 2009.

252 **Vul 1** = the proportion of children vulnerable (i.e. falling below the 10th percentile) on one or more of the 5 AEDI developmental domains. In general about 24-26% of the population of children in Australia covered by the AEDI thus far fall within this Vul 1 category.
Vul 2 = the proportion of children vulnerable on two or more of the 5 AEDI domains. In general about 13-16% of children fall in this category - these are children we would call high risk for not coming to school with the developmental capacity required for school.

ROEBOURNE	90	**11.3**	**16.9**	**16.9**	**31.4**	**21.1**	**47.9**	**23.9**
SOUTH HEDLAND	151	**17.4**	**13.0**	**11.7**	**24.2**	**6.8**	**34.8**	**18.2**
TOM PRICE	162	**6.8**	**10.8**	**9.5**	**14.9**	**10.1**	**25.0**	**13.5**
WICKHAM	107	**9.2**	**11.2**	**7.4**	**27.6**	**16.3**	**35.7**	**18.4**

As in all families, Indigenous families play a pivotal role in shaping their children's sense of identity and culture. Yet, as reflected in the AEDI data, many Indigenous children are not ready to make the transition to school across the range of indicators, whether the physical, social and cognitive areas of development. The transition to school can be especially difficult for those Indigenous children when English is not their first language.

Problems faced by aboriginal families include the young age of the family with 46.2% of those aged 15 or over being married, and the average age that girls get pregnant being 13-15[253]. Other factors include Foetal Alcohol Syndrome, otitis media or glue ear which in some communities affects the majority of children. For instance in Roebourne Primary school, 95% of the students suffer from conductive hearing loss This is more significant because it is reported that most teachers do not have an understanding of the impact of hearing loss on learning.[254]

Additionally there are issues around:

- A lack of knowledge about nutrition;
- Discipline , which proves to be very difficult as the parents did not have modelling;
- There are too many children for the grandmothers to look after;
- There is lack of readiness and willingness to engage in programs;
- Overpriced food affects budget affects the standard of food available and family budgets;
- Overcrowded housing. This also impacts on cooking space when there are 24 to a house; and
- High levels of domestic violence and alcohol abuse.[255] [256] [257]

Despite this complex and challenging backdrop there are programs that are working such as Best Start and Responsible Parenting, families that are healing, children that are doing well and communities, such as Fitzroy Crossing, that are determined to provide a future for their children.

253 Department of Child Protection Fitzroy Crossing Briefing 5 June 2009.

254 Ms Vicki Jack District Education Office Director, Briefing 4 June 2009.

255 Department of Child Protection Fitzroy Crossing Briefing 5 June 2009

256 Nindilingarri Cultural Health Centre Briefing .5 June 2009.

257 Roebourne Strong Womens Group, Briefing 4 June 2009.

However the programs available have limited capacity and in some instances are said to be inadequately staffed.

Finding 14

There are major systemic issues in Indigenous communities in the North-West of Western Australia leading to a high proportion of children being developmentally vulnerable and unready for schooling.

Recommendation 11

The Committee recommends the significant expansion of the three year old indigenous kindergarten program in areas of need as established by AEDI and/or NAPLAN or where children do not have English as their first language.

(v) Parenting in mining communities

The Pilbara has low levels of unemployment[1] however, due to its remote location, it is a high cost area in which to live. Most families have both partners engaged in the workforce which is largely based around mining[258]. While not sharing the range of issues faced by Indigenous families, parents in mining communities of the North West of the state face a number of difficulties related to the remote location of the industry they work in. In particular the juvenile population in mining towns tends to fall between the ages of 0-8 as most families start to move on as the children get older.[259] While in the region these families have few support networks with no extended families and limited social networks.

With both parents working the position is exacerbated by a shortage of early learning and development programs in the region.

> *In regions such as the Pilbara there are significant issues with children accessing quality early learning and development programs. There are substantial gaps in access to child care and early learning opportunities in all major towns which increase in smaller towns to being almost nonexistent in Indigenous communities and on isolated pastoral stations.*[260]

258 Submission No. 29 from Pilbara Development Commission, covering letter.

259 Ms Vicki Jack District Education Office Director, Briefing 4 June 2009.

260 Submission No. 29 from Pilbara Development Commission, p1.

Recommendation 12

The Committee recommends that special consideration be given to parental support programs in Pilbara mining towns where there are an unusually high percentage of young families who have no family networks and limited social networks.

(a) Resources and the regions

As is the case in the Metropolitan area, there is a widespread plea for increased resourcing in the regions:

> *Even though they are required to deal with complex and disparate systems across DHS regions, central intake services are under resourced, resulting in difficulty in meeting the increased needs of families. Staff require adequate resources and training to provide for face to face client visits, clarify the needs of the child, and link families into appropriate and available services in a timely manner.*[261]

And:

> *There is a lack of accessible funding to support motivated communities, and a lack of resources, research and directive from higher levels of government*[262]

In respect to the difficulties experienced in regard to accessing allied health professionals, the Pilbara Development Commission (PDC) advises that:

> *The West Pilbara covers the Shires of Roebourne and Ashburton and includes the smaller inland towns of Pannawonica, Tom Price and Paraburdoo and the remote coastal town of Onslow. Most allied health staff servicing the West Pilbara are based in Karratha.*
>
> *There are three speech therapy positions to cover the West Pilbara of which only one is currently filled. Two further positions will be filled by mid year which is the first time in more than six months that all positions will be staffed. However, in many instances the staff remain for one or two years and provide no long term sustainability of the service to the region.*
>
> *Rural Health Services funding enables the West Pilbara Allied Health team to travel inland once every three weeks by charter flight at a cost of $9,000 for plane only. Staff stay inland for three days traveling by car between the inland towns.*

261 Submission No. 26 from Australian Physiotherapy Association, p5.

262 Submission No. 34 from Eastern Wheatbelt Early Years Network, p1.

> *With the significant population increases across the region there is sufficient to warrant a dedicated team to be located in central Pilbara (Tom Price, Paraburdoo and Newman and surrounding communities) however, there is no funding, qualified people and staff support to enable that to occur.*[263]

While the issue is partly attributable to financial resources, it is a broader issue as the PDC explains:

> *The region has, as highlighted in our submission, extreme difficulty in attracting and retaining professionals and personnel to the region. This is due to a wide range of issues but certainly inclusive of salaries not adequately compensating people for living in particularly remote and regional areas. This is particularly true when living conditions (standard of housing, services, health and safety) are not at a standard that most people consider adequate in the 21st century.*[264]

Finding 15

There is inadequate access to services offered by allied health professionals in the North-West. This is attributed to a lack of resources, both human and financial.

Finding 16

There is a shortfall in the provision of accessible child care places in the Pilbara and anecdotally in some other regional areas. This is despite the involvement of the State and Federal governments and major mining interests in some regions. This problem is exacerbated by the transient nature of the population and the consequent absence of family support. This leads to the use of unlicensed child care with uncertain developmental outcomes.

It has also been suggested to the Committee that there is duplication in the funding of services by different tiers of Government. The funding may be for related programs with differing guidelines and funding provisions leading to confusion both amongst service providers and the consumers of the services.

263 Trish Barron, Pilbara Development Commission, email, 14 April 2009.

264 Trish Barron, Pilbara Development Commission, email, 14 April 2009.

> *Currently, there are many players involved in the delivery of children's services, including the 3 levels of government and a diversity of government departments. Funding arrangements for service delivery can be across Federal, State and Local levels of government and result in a duplication of services in some regions and no services in another. For example, some WA regions have received both Commonwealth 'Communities for Children' funding and State 'Early Years Funding' ,creating confusion at times amongst stakeholders when reporting on programs, extent of services and lines of responsibility. This also results in confusion amongst possible consumers of these services as to "who is eligible for what". An example that CHILD Australia is familiar with is the eligibility for inclusion support for children with disabilities in children's services. Schools, kindergartens, child care and other children's programs all have different guidelines on inclusion, funding, equipment provision and support, leading to confusion and sometimes disappointment for those trying to access support.*[265]

This lack of an integrated approach is seen in the Central Wheatbelt where:

> *Primary Health is attempting to address these needs, [of 0-3 yo] but they have no directive nor is it part of government policy. Have prioritised this area, and therefore allocate staffing this area, but there is not enough financial and physical resources to address this on the ground. Early intervention needs can be identified by Allied Health / Child Health Nurses as they are most likely to have contact with families and children prenatal to 3 years.*
>
> *They offer no prenatal care, and have no allocation of resources for prenatal care.*[266]

The lack of coordination at a government level will involve NGOs in spending significant amount of time in pursuing scarce dollars across a fragmented system.

> *Successful programs utilise a significant amount of their project time sourcing ongoing funding to ensure continuation. A streamlined funding process needs to be developed to ensure that programs of high benefit can focus on project delivery rather than financial survival. Many resources and knowledge bases are lost due to ceased funding, which reflects poorly on the service provider and government. Significantly, rapport developed with high risk / disadvantaged families are broken.*[267]

This can result in some local agencies working outside their formal frameworks:

> *An increasing number of schools developing school based programs for 0 – 4 years age group. These programs do not receive funding from the Department, and are not formally recognised. Require funding into schools for these programs as they have great social and*

265 Submission No. 33 from Child Australia, p6.

266 Submission No. 34 from Eastern Wheatbelt Early Years Network, p1.

267 Submission No. 34 from Eastern Wheatbelt Early Years Network, p3.

> *cognitive benefits for all, particularly regarding familiarisation with the school environment.*[268]

The Pilbara Development Commission summarised the ad hoc, duplicated and slightly chaotic nature of existing programs in their region as follows:

> *It would be fair to say that there are services and programs being delivered across the region to support the developmental needs of children. However, it would also be fair to say that many of these services have been initiated in an ad hoc manner, are not consistent or sustainable, lack sufficient funding, are culturally inappropriate, only operate where there is staff available, there is little planning or collaboration between agencies and NGO's around the delivery of these services and there is likely to be considerable duplication of service delivery. It would be fair to say, that on more than one occasion a service has been initiated as a knee jerk response to a critical problem that may have been better managed through early planning and some preventative measures to lessen the impact and that there is little done to support and build on the strengths of existing NGO service providers in the region to support their sustainability.*[269]

(i) Integration/collaboration - a response to scarce resources in regional areas

The integration of services has been suggested earlier as a way of responding to scarce resources, waiting list issues, and more ready access to support services. The need for a better integration of service delivery is supported across Western Australia for the same reasons succinctly summarised by the Principal of Ocean View College Children's Centre, Taperoo (Adelaide), itself an integrated site, as follows:

> *There is a far better knowledge of family histories and individual family's needs through the integrated approach that allows for earlier intervention strategies to be developed to greater effect.*[270]

Collaboration at an operational level is seen to be symbiotic for all stakeholders:

> *In a regional centre in WA's mid-west the playgroup was co-located in the same building as the Child Health Nurse. This presented an opportunity to improve immunisation rates by allowing the nurse to access the group while they were attending the centre.*[271]

Significantly, submissions to the Committee from regional Western Australia emphasised the need for the engagement of the local community in program design and delivery, ensuring that the initiative is contextually relevant to the needs of the local community.

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268 Submission No. 34 from Eastern Wheatbelt Early Years Network, p2.

269 Ms Trish Barron, Pilbara Development Commission, email, 14 April 2009.

270 Ms Kerry Dolmain, Briefing 25 February 2009.

271 Submission No. 28 from Playgroup WA, p6.

Once the money is available at a local level, a working party of agencies involved with young children that includes Aboriginal people from this community. Not just agencies working together, which is good, but not enough. They need to be listening to the community.[272]

Communities must be given the flexibility to respond to their individual Early Years needs. Important that government does not dictate to communities, but rather allows them to respond uniquely to their community's needs.[273]

The most successful programs are generally driven from the bottom up. Need to give key drivers the capacity to address their own community's needs – local ownership builds community capacity and sustainability.[274]

(ii) Integration/collaboration/co-location - a response to isolation in regional areas

One of the realities of living in thinly populated communities is that the difficulties of such things as transport are not always fully understood.

Western Australia ….. is a dispersed community. Travel to a central clinic for assessment or intervention can be difficult and expensive for families without transport, again the most disadvantaged families. [275]

And:

Transport is a BIG issue. The Shire runs a bus service to Karratha 2 times a week; this is good but you have to be ready and be at the bus stop at each end, at the time the bus runs. If you want to go at other times or on others days, then there is nothing. When there is a meeting or training or a group is run, lots of people from Roebourne and Wickham have to be picked up. Or sometimes they are not picked up because there is no transport. Agencies have to think about vehicles and driving /collecting time.[276]

And again:

Access is also impacted by the availability of transport and, in relation to playgroups the availability of venues, again highlighting the need for broad cross government involvement. In our experience the provision of transport has been a critical factor in the establishment of many playgroups and is often neglected in funding models.[277]

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272 Submission No. 21 from Strong Women's Group Roebourne, p9.

273 Submission No. 34 from Eastern Wheatbelt Early Years Network, p2.

274 Submission No. 34 from Eastern Wheatbelt Early Years Network, p3.

275 Submission No. 23 from Early Childhood Intervention Australia (WA), p5.

276 Submission No. 21 from Roebourne Strong Women's Group, p9.

277 Submission No. 28 from Playgroup WA Inc, p3.

The Australian Physiotherapy Association argues for co-location of services to overcome the difficulties presented by a lack of available transport:

> *Families living in rural areas are often further disadvantaged as there are fewer services in these areas and some people living in these areas often do not have access to transport to travel the distance to health clinics. Health clinics need to be collocated to other community resources and be responsive to community needs.*[278]

Finding 17

There is a perceived lack of resourcing for early child development in regional communities, when measured against the needs. Limited resources are exacerbated by the geographical distances involved and low population density, as well structural and process issues. In addition some services are considered to have been initiated in an ad hoc manner and are not sustainable.

Finding 18

The difficulty experienced by disadvantaged groups in accessing services in regional areas is compounded by difficulties in securing transport to available services.

Recommendation 13

The Committee recommends that the Minister for Education prioritise a review of existing early childhood and parent support services in the regional and remote areas of Western Australia and that the Minister takes the lead, at Cabinet level, on improving collaboration, coordination, funding and structures for those services.

278 Submission No. 26 from Australian Physiotherapy Association, p2.

Recommendation 14

The Committee recommends that Minister for Education extends the remit of the Department of Education and Training so that its role can include the learning development of 0-3 year olds, ensuring they are ready for school. This capacity should be exercised particularly in schools identified by the AEDI as having a high level of developmentally vulnerable students in their district or below average NAPLAN results.

(b) Workforce issues in the North West

The need for a holistic approach to regional service provision is acutely seen in the Pilbara where such issues as housing availability and affordability impact on staff recruitment and retention leading to a reduction in the adequacy of services.

> *The limited access to quality, affordable accommodation in the region is creating difficulties in attracting high quality professionals in the health and early years development sectors into the Pilbara. Low salaries and the high cost of living is also impacting the attraction of people into the child care, education and allied professions and most non-government agencies that are funded by government to deliver a range of critical early years programs and services struggle to retain employees as they are not allocated sufficient funds to cover the additional costs.*[279]

The position was exemplified to the Committee in Fitzroy Crossing where the last person recruited only stayed 3 weeks as the only accommodation available was shared and this was not acceptable to her. It was stated that it is difficult to attract staff to work in Fitzroy crossing, possibly due to the remoteness of the location and a lack of any guarantee that private single accommodation, or accommodation for staff with a family will be available at the time they are recruited.

Government agencies, such as the Disabilities Service Commission advise that there are similar difficulties in attracting and retaining staff elsewhere:

> *Services in rural and remote areas are variable and dependent on the individual attitude, knowledge and skills of the current allied health workforce. In country areas there can be a high staff turnover with gaps in service availability.*[280]

This is the case in the Wheatbelt:

> *Difficulties generally in recruiting [allied health professionals] in country areas are also linked to housing availability and the cost of living, when government salaries do not compensate at a level to support the higher cost of living.*[281]

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279 Submission No. 29 from Pilbara Development Commission, p1.

280 Submission No. 37 from Disability Services Commission, p4.

As much as it is the case in the Pilbara:

> *The [Pilbara] region has the ongoing issues of attracting and retaining professionals to the region that have specialised training.*[282]

One outcome is that there is a lack of knowledge by medical professionals of prevailing local health issues.

> *There is a high turnover of doctors and nursing staff across the region which results in loss of valuable knowledge and experience. The lack of longevity of tenure means that many Pilbara doctors who are registrars or are from overseas may have no prior knowledge or experience in working with communities that are impacted by endemic and emerging issues such as Foetal Alcohol Syndrome.*[283]

Another outcome is that even diagnosed early childhood developmental disorders cannot be properly treated:

> *Children who are most likely to miss out on early childhood intervention are children from families with multiple and complex needs, who are marginalised, living in outer metropolitan and regional areas and children whose development is delayed or disordered without a specific diagnosis. Families may be known to many agencies without any having the capacity to respond to their needs comprehensively.*[284]

Finding 19

Even where positions have been allocated there is a high level of turnover amongst health professionals in some regional and remote areas. In part this is because of the cost of living and more particularly the absence of adequate housing and in some cases of any housing in these areas. There are also lifestyle issues and staff burn out which contribute to high turnover. High turnover not only leads to positions been vacant for extended periods but loss of experience and institutional memory.

(c) Indigenous service issues in the regions

Every Western Australian government department has strong Aboriginal policy directions supported by the Department of Indigenous Affairs. However there are well publicised shortcomings in the translation of policy into practice due to a number of factors including the lack of coordination and collaboration between departments, the size of the state, scarce resources

281 Marion Hailes-MacDonald Manager - Strategic Policy and Programs, Disability Services Commission, email, 3 April 2009.

282 Ms Trish Barron, Pilbara Development Commission, email, 14 April 2009.

283 Ms Trish Barron, Pilbara Development Commission, email, 14 April 2009.

284 Submission No. 37 from Disability Services Commission, February 2009, p4.

and cultural barriers. Such issues affect early childhood care and education as much as they impact on other ages and stages of Aboriginal life and well-being.

In 2007, when considering what made initiatives successful in overcoming Aboriginal disadvantage, the Steering Committee for the Review of Government Service Provision stated:

> *Analysis of the 'things that work', together with wide consultation with governments and*
>
> *Indigenous people identified the following 'success factors':*
>
> - *cooperative approaches between Indigenous people and government (and the private sector);*
> - *community involvement in program design and decision-making — a 'bottom up' rather than 'top-down' approach;*
> - *good governance; and*
> - *on-going government support (including human, financial and physical resources).*
>
> *Many of those consulted felt that the lack of these factors often contributed to program failures. Where possible, broader programs demonstrating sustained success have been reported. However, programs that are successful in individual communities or for short periods are frequently only funded as pilot projects. Even when evaluated as successful, such programs are not always continued or expanded. The need for greater sustainability of successful programs was a common theme in consultations.*[285]

Since 2007 there is no reason to believe that these factors for success do not remain applicable.

The problems on the ground are not only complex but are interwoven with a fractured heritage, poverty, inadequate housing and a lack of services. One group of Aboriginal women outlined the resultant parenting and child rearing issues that their communities in the Pilbara and Kimberley need to overcome in very explicit terms as follows:

- *Adults who don't know how to parent because they were taken away or their parents or grandparents were taken away. You don't learn to parent in institutions.*
- *Adults who don't know how to parent even though their parents knew. Those parents drank too much to use their good parenting skills with their own children so that generation did not have good role models.*
- *Mums drinking while they are pregnant.*
- *Families drinking after the children are born not looking after the kids enough.*

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285 Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage - Key Indicators 2007*, Overview.

- *Not looking after children properly because of drink, gunja or playing cards late into the night or all night.*
- *Adults shouting, harsh, angry at their kids instead of talking to them and helping them.*
- *Family violence.*
- *Kids are traumatised when there is shouting and violence around them all the time. It's even worse if they can't get away because there are too many people around.*
- *Overcrowding: Housing where there are others who move in to share. Too many people.*
- *Kids are more at risk, especially when there is drinking going on.*
- *Or housing with insufficient space for the allocated family. Some people don't put their names down for housing, but move in with others when they get houses so there is overcrowding again.*[286]

The Midwest/Murchison and Pilbara regions have reported increasing numbers of young families with many isolated from their extended families. In the Kimberley, Pilbara and Goldfields, there are many Indigenous families with complex problems including drug, alcohol and gambling addictions, child sexual abuse, single parents and mental health problem.[287]

Aboriginal families who spend large amounts of time living both in the city and in regional or remote areas will also receive a disrupted service due to the different programs operating in the country and the city. So even these children who do make it into the system can often receive a disrupted service that does not reach the required intensity to achieve outcomes.[288]

(i) Need for aggressive intervention

It is generally acknowledged both from within and outside the Indigenous community that Aboriginal people suffer from significant levels of disadvantage. The problem is one that is both entrenched and intergenerational. The reason for its generational iteration lies partly in the early childhood truth that once a child falls behind, he or she is likely to remain behind. In Aboriginal communities, as elsewhere, the child's generally impoverished early environment is a powerful predictor of future adult failure. In this context impoverishment is not so much about the lack of money as it is about the lack of early skill and motivation as a precursor to a lack of future skill and motivation. There is therefore a need to adopt early intervention strategies that enrich early

286 Submission No. 21 from Strong Women's Group Roebourne, p2.

287 Submission No. 8 from Department of health, p18.

288 Marion Hailes-MacDonald Manager - Strategic Policy and Programs, Disability Services Commission, email, 3 April 2009.

childhood environments to produce more successful adults. However many Aboriginal families do not access universal services:

> *Indigenous people are generally less likely to access pre or post natal health services and this can make it difficult to keep track of an infant's condition and progress. Indigenous mothers, whose children have been diagnosed with specific issues such as Foetal Alcohol Syndrome, are often difficult to monitor or follow up on due to their culture, transient lifestyle, remote locations, language barrier, a lack of understanding, suspicion of "government" services, family pressure etc.*[289]

And:

> *Children from Indigenous families may not be involved with local universal services unless families have gained confidence that the program is culturally welcoming. They are even less likely to participate in separate specialist programs where they may be the only family from their community.* [290]

The problem of gaining the attendance of Aboriginal women even at prenatal clinics is very real in some communities:

> *Many local Aboriginal women do not access prenatal services because they are worried about having their babies in Hedland or other places, and not in their local community. They also fear being in trouble for their alcohol and drug use.*[291]

Often the ways in which services operate are perceived to be inimical to the needs of the Aboriginal culture and way of doing things:

> *Programs like Triple P might be good for white middle class parents. But they don't quite fit for us, so it's good that we are developing our own program through Yaandina. There should be more programs designed for Aboriginal people, not just using white programs.*[292]

> *Writing letters: Sometimes people are told they have to put complaints in writing, they don't feel comfortable doing this, so the complaint doesn't get made…. Agencies need to record verbal complaints... SOCIAL JUSTICE. (like when you tell police evidence, they don't send you away to write it yourself.)…….If people don't feel heard, they might want to send something in writing. Needs someone in town who could help with this.*[293]

> *Work out a better way to communicate with the community. We need to know more about how kids are going. Just because were Aboriginal doesn't mean we don't care.*

289 Ms Trish Barron, Pilbara Development Commission, email, 14 April 2009.

290 Submission No. 23 from Early Childhood Intervention Australia (WA), p5.

291 Submission No. 2 from Yaandina Family Clinic, p2.

292 Submission No. 21 from Strong Women's Group Roebourne, p7.

293 Submission No. 21 from Strong Women's Group Roebourne, p7.

> *Parents need to take responsibility. But sometimes schools need to think "what could we do differently?*[294]

Other issues are a common complaint regardless of ethnicity:

> *There should be a better link between services. The people not the rules matter!*[295]

The Institute of Family Studies confirms that research demonstrates that families most in need of services do not access them.[296]

To overcome the perceived or real barriers between the service and the target population, agencies need to adopt an approach of aggressive intervention, of actively seeking out and engaging with families at risk or risk waiting too long to be effective.

> *Follow up, follow up, follow up!!! When people have bad problems, don't wait for them to fall in a hole again. Check up on them every now and then. Have support groups for them. Make sure someone is watching out for them.*[297]

Finding 20

At-risk Aboriginal families often will not engage in general support programs for a range of reasons. There is also evidence that programs specifically and sensitively targeted for Aboriginal communities can overcome this barrier,

Where at risk families do not respond to normal overtures robust interventions are needed if we are to break the cycle of poverty and despair.

294 Submission No. 21 from Strong Women's Group Roebourne, p6.

295 Submission No. 21 from Strong Women's Group Roebourne, p5.

296 Professor Alan Hayes, Briefing 25 February 2009.

297 Submission No. 21 from Strong Women's Group Roebourne, p3.

Recommendation 15

The Committee recommends that, as the interests of the child are paramount, agencies running early childhood support services for 'at risk' families develop an approach of robust intervention where all overtures for voluntary engagement fail.

Such an approach would seek to ensure that support services were accessed by those who need them most. It would ensure the ongoing engagement of the target population in services supporting families of young children. An example of a 'robust' intervention approach would be the management of a clients' Centrelink income.

(d) Foetal Alcohol Spectrum Disorder

One of the major issues affecting the Indigenous community in the north west of Western Australia is Foetal Alcohol Spectrum Disorder (FASD). Described by one agency as a 'scourge,'[298] FASD is a range of disabilities caused by exposure to alcohol in the womb. The brain of the foetus grows for the full nine months of pregnancy so this is the first organ affected by alcohol consumption.

Of these Foetal Alcohol Syndrome is the extreme end of the disorder.

> *FASD is a lifetime disability with lifelong implications. It is not curable, though it is one hundred percent preventable. Prevention strategies must focus around education and early intervention, and not only involve health professionals but link clearly with education, housing, justice and other community services.*[299]

The spectrum of FASD includes:

- FAS - foetal alcohol syndrome
- pFAS - partial foetal alcohol syndrome
- ARND - alcohol related neuro-developmental disorder
- ARBD - alcohol related birth defects

Foetal Alcohol Syndrome (FAS). A child with FAS will have confirmed prenatal alcohol exposure, a set of characteristic facial features, central nervous system dysfunction and growth restriction.

Alberta Education provides the following explanation for educators of other FASD terms:

- *Partial Foetal Alcohol Syndrome (pFAS)* indicates confirmed maternal alcohol exposure. A child with pFAS exhibits some, but not all of the physical signs of FAS,

298 Submission No. 2 from Yaandina Family Centre Inc, p 2.

299 Rural Health Education Foundation, 'Foetal Alcohol Spectrum Disorder', 2006. Available at: http://www.rhef.com.au/programs/program-1/?program_id=66. Accessed on 14 April 2009.

and has learning and behavioural difficulties which imply central nervous system damage.

- *Alcohol related birth defects (ARBD).* A child with ARBD displays specific physical anomalies resulting from confirmed prenatal alcohol exposure. They may include heart, skeletal, vision, hearing and fine/gross motor problems.

- *Alcohol Related Neuro-developmental Disorder (ARND).* A child with ARND exhibits central nervous system damage resulting from confirmed prenatal alcohol exposure. This may be demonstrated as learning difficulties, poor impulse control, poor social skills, and problems with memory, attention and judgement.

In Australia research "It is likely that many affected children with FAS, ARBD and ARND will never receive a diagnosis."[300]

FASD - children suffering from pre-natal exposure to alcohol can't self-regulate their behaviour. Kim has noticed a decline in behaviour of children since the year 2000. Only a fraction of affected children are identifiable facial features.

The behavioural and learning characteristics of FAS are:

- *Primary* - slower processing pace, impulsive, distractibility, memory problems, inconsistent performance.

- *Secondary* - frustration, anxious, fearful, overwhelmed, shut down, poor self concept, isolated, school problems, acting out, aggression, sexual problems, truancy.

- *Neurological impairment*: The IQ may vary from well below average to above average

- *Information processing deficit*: This results in gaps and inconsistencies in understanding, sequencing, and auditory processing of information.

- *Memory and attention deficit*: this results in spotty or faulty memory and limited attention span.[301]

It is estimated that 80 per cent of children with FASD demonstrate hyperactivity

The size of the FAS affected population is unknown as it is not readily diagnosed at birth and is stated as being easily misdiagnosed. The rate will vary between communities and is estimated to range between 5% and 20%.[302]

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300 Ms K. Crawford, Principal Karatha Educational Support Unit and Churchhill Fellowship recipient, Briefing 4 June 2009.

301 Ibid.

302 Ms Emma White District Director Department for Child Protection East Kimberley Briefing 5 June 2009.

In Halls Creek the proportion of children affected by this irreversible condition is reportedly high;[303] and it is reported that girls as young as 13 are giving birth to babies with Foetal Alcohol Syndrome. These teen mothers were themselves born with Foetal Alcohol Syndrome.[304] The intergenerational situation in Halls Creek is far from unique. Yaandina Family Centre (Inc.) reported to the Committee that 'some women have FASD themselves and low capacity in caring for themselves and their unborn baby.' When this problem is intergenerational, one of the consequences is that mother and child are unable to relate naturally to each other or anyone else.[305] For the vast majority, the experience of the mother's care is the first experience of reality. Given the importance of early infant attachment this last point in itself is destructive of healthy child development and has profound consequences for the child subsequently relating intimately with others, including spouses and children. 'The effects of infant attachment are long-term, influencing generations of families.'[306]

One of a number of affected communities in the north-west is Roebourne. It encapsulates many of the problems faced by similar communities in the region:

> *Roebourne is a remote and predominately Indigenous community located in the Pilbara region of WA. It is made up of a number of related language groups and has a high proportion of children, youth and young people between the ages of 0 to 18 years. The community is impacted by a range of socio-economic factors including limited employment, low school retention rates and academic achievement, substance and alcohol abuse, family violence and poor health.*
>
> *In addition, Roebourne lacks access to a number of modern facilities that are common to other Pilbara communities with most of the existing community infrastructure being of poor design and costly to manage and maintain.*
>
> *These are just some of the issues impacting Roebourne, a community in relatively easy proximity (30 kms) to the services and facilities available in Karratha, one of the two main regional centres in the Pilbara. However many of community members do not have access to a vehicle and there is limited public transport available.*[307]

The Strong Women's Group in Roebourne, acutely aware of the growing problem of FASD, emphasised the need to develop multi tiered communication and support strategies to address this most easily preventable form of birth defect or brain damage in unborn children. They make the following points:

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303 Dr David Shepherd, Senior Medical Officer, Halls Creek Hospital, Briefing 5 June 2009.

304 'Halls Creek must show why alcohol ban shouldn't be imposed'. *WA Today*.24 March 2009.wwwwatoday.com.au

305 Paige Taylor, 'Teen mothers giving birth to babies with Foetal alcohol syndrome', *The Australian*, 24 March 2009.

306 US Department of Health and Human Services, 'Infant attachment: what we know now', 1991. Available at: http://aspe.hhs.gov/daltcp/reports/inatrpt.htm. Accessed on 14 April 2009.

307 Ms Trish Barron, Pilbara Development Commission, email, 14 April 2009.

- *Education needs to start at High School on the effects of alcohol on the unborn baby and then on that baby as it grows up.*

- *Support for mothers with Foetal Alcohol Effects or difficult children. Support for Foetal Alcohol effects mothers and mothers who don't have good parenting skills because their parents didn't have good parenting skills (they might have been taken away).*

- *Planning for children living with Foetal Alcohol effects, especially when they get to school and even more as they enter High School. Teachers learn about Foetal Alcohol effects.*[308]

- *Everyone, community and agencies learn more about the effects of alcohol on people, from before they are born to old age. Support and plan for children with Foetal Alcohol Effects in the community and in school. Support mothers and fathers who are Foetal Alcohol Effects because they will find it hard to be good parents. Provide ongoing help for parents who are themselves Foetal Alcohol Effects. They need ongoing support, meeting in support groups (e.g. around parenting) As these children can be very difficult to parent and likely to be more often in trouble with the law, prevention and intervention would save a lot of money and heartache further down the track.*[309]

- *Before girls have babies: Information about Foetal Alcohol effects.*

- *During pregnancy Information on Foetal Alcohol effects and support to stay off alcohol. Individual support and support groups. Mentoring from other Mums When the baby is born.*

- *Young children: Support parents of Foetal Alcohol effects children with parenting programs and support groups (others mums can come too. Don't discriminate).*

- *If mothers are Foetal Alcohol effects themselves, they need even more support.*

- *School age: Support children with Foetal Alcohol effects. Teach them a bit differently. They don't have good concentration. They forget.*[310]

Unfortunately what support there was has been further reduced with the departure of the last drug and alcohol counsellor from the Roebourne community:

> *<u>Drug and Alcohol Counsellor</u>: Make sure there is one. The last one left and there has not been a replacement: Get out of the office, meet people. Tell them you're there. Run*

308 Submission No. 21 from Strong Women's Group Roebourne, p6.

309 Submission No. 21 from Strong Women's Group Roebourne, p6.

310 Submission No. 21 from Strong Women's Group Roebourne, p9.

> *groups for people who want to change. Have support groups for follow up. When some people stop drinking have them be mentors for other people who want to stop.*[311]

The problem is exacerbated by the turnover of professional staff, noted previously, with incoming staff being unfamiliar with FASD and the prevalence of the condition:

> *FASD is not widely diagnosed in Australia and little training in identification is available. Although, we would say every family in Roebourne is affected by its reach.*[312]

The need for education of young Aboriginal children, as outlined by the Strong Women's Group, was also emphasised by the Yaandina Family Centre saying that, 'A culture of blame exists that will need persistence to overcome with messages that hit the mark. All young women need to hear the messages about drinking during pregnancy from a young age.'[313]

Finding 21

Foetal Alcohol Spectrum Disorder (FASD) affects the development of a significant number of children born in some regions of the state. FASD is an intergenerational and escalating issue which impacts whole-of-life outcomes and requires intensive and ongoing support to enable any level of remediation. The long-term development of children born with FASD is therefore severely compromised. The problem is exacerbated by the lack of existing appropriate services and support programs.

Recommendation 16

Recognising that Foetal Alcohol Spectrum Disorder (FASD) affects a significant number of children born in some regions of the state, the Committee recommends:

1. That children affected at the severe and moderate end of the spectrum of FASD are made eligible for the Disability Services Commission's Individual and Family Support program or for a specially developed program for FASD.

2. That the Department of Health jointly with the Office of Early Childhood Development and Learning urgently develop an interagency strategic approach to the delivery of services in Foetal Alcohol Spectrum Disorder affected regions advising Parliament of progress within twelve months. This strategy should have an emphasis on the needs of Indigenous children and include the mapping of aligned services and agencies to ensure efficient use of resources. It would also identify opportunities for collaboration and service alignment.

311 Submission No. 21 from Strong Women's Group Roebourne, p5.

312 Submission No. 2 from Yaandina Family Centre Inc, p2.

313 Submission No. 2 from Yaandina Family Centre Inc, p2.

(e) Accommodation in communities

The Committee noted the consistent problem that inadequate housing presented communities in the North West of the State, with up to 24 people being accommodated in one house. The indigenous population in the Kimberly is a fast growing demographic and there is a generally acute lack of housing with a priority waiting list in excess of two years. In addition the existing stock is in need of maintenance.[314] Dr David Shepherd told the Committee that in his view, the absolute priority is housing.[315]

The underlying issue to this longstanding problem, is that the native title claimants or holders are not necessarily the same people who are seeking housing in a given locality – so in places like Fitzroy Crossing and Halls Creek which are (arguably) right on the boundaries of various language groups or clan groups, there are a number of competing pressures and interests. For instance, Fitzroy Crossing is a complex collection of language groups – principally Bunupa from the north and Walmajarri from the south but with other language groups east and west and elsewhere. Some of these groups occupy land for various "historical" reasons and have leases or occupancy arrangements that have no relationship to any rights as native title claimants or holders In addition, native title groups seeking a resolution of their native title claim might choose not to relinquish approval for the release of any land for housing development.[316]

Recommendation 17

The Committee recommends an urgent and significant targeted increase in housing for indigenous families in the Kimberley and Pilbara. Without this issue being addressed, families in overcrowded housing will remain unstable and chaotic.

Recommendation 18

The Committee recommends that the critical shortage of housing and accommodation for government staff and support workers in the Kimberley and Pilbara is urgently addressed. Failure to do so will result in the essential support programs remaining undeliverable.

314 Ms Emma White District Director Department for Child Protection East Kimberley Briefing 5 June 2009.

315 Dr David Shepherd, Senior Medical Officer, Halls Creek Hospital, Briefing 5 June 2009.

316 Nindilingarri Cultural Health Centre Briefing 5 June 2009.

CHAPTER 8 EVIDENCE, EVALUATION AND DATA COLLECTION IN WESTERN AUSTRALIA:

8.1 Evidence

> *Evidence for the effectiveness of interventions that focus on a single issue or single risk factor is poor or non-existent. Given the above, why are we still funding, and even expanding, individual services and programs which work in isolation and have a narrow focus?*[317]

This section briefly considers the collection and use of data by Western Australian agencies in a Western Australian context.

In recent years there has been a significant move to what is known as 'evidence-based policy,' in other words, policy that is informed by evidence. A definition of evidence based policy is policy based on reviews and the meta-analysis of robust research studies.[318]

The term has broad currency and is referred to in many of the submissions received by the Committee. For instance:

> *While Department of Health continues to provide a range of evidence based models of service delivery, service capacity has not kept pace with an increased demand for services.*[319]

> *The first evidence based clinical pathways for child development services in Australia including an overarching pathway for the Service and eight specific pathways for core presenting conditions/disorders.*[320]

> *The Department for Communities uses an evidence based approach to inform the service and program design for young children and their families.*[321]

> *We currently have, what works well, and be fair about resource allocation in relation to evidence based cost benefits of health prevention, early detection and early intervention.*[322]

While recognising that evidence is only one of a number of factors that drives policy, the Committee was interested to learn of the adequacy or otherwise of data collection and analysis in

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317 Professor Frank Oberklaid, 'Early Childhood Services: An Australian context', 2001. Available at: http://nrha.ruralhealth.org.au/conferences/docs/papers/6_KN_27.pdf. Accessed on 20 April 2009.

318 Argyrous, G, *A practical guide for evidence for policy and decision making*, UNSW Press, Australia, 2009, p5.

319 Submission No. 8 from Department of Health, p3.

320 Submission No. 8 from Department of Health, p31.

321 Submission No. 3 from Department for Communities, p1.

322 Submission No. 19 from Community Health Nurses Western Australia, p4.

Western Australia. In particular this is because of the stated premise that services delivered to meet the developmental needs of children are to be grounded in evidence. While the Committee was provided with evidence of evaluation in a few instances, such as the Best Beginnings program, it is apparent from the testimony of the participants to the Inquiry, that in Western Australia there are significant problems in the collection of data on Western Australian programs and services.

For instance, in relation to the Department of Health it was said:

The health data in Western Australia is crap; we do not know whether it is the same person coming in repeatedly, or different people. You don't know whether they are Indigenous, and so on.[323]

There is also, for example, a lack of hard data available on waiting lists, and while it has been suggested that the Department of Health is unwilling to provide the information, the Department itself advises that it simply does not currently keep such data although with the development of a database this position should be remedied in the future.[324]

One submission expressed their concern as to whether policy development is in fact based on the use of evidence:

> *It is clear that WA child development policy and resource allocation has not been based on evidence.*[325]

The Department for Communities advised similarly that there is a dearth of data around their programs:

> *Our team is not aware of a WA evaluation, as the programs and training that we use to underpin our response to families have an evidence base from elsewhere, whether that be Australia or international research.*[326]

And in relation to their performance indicators they stated that:

> *I think this is an area for which I can admit that probably further work is required.*[327]

The attention of the Committee was drawn to the gaps in data gathering by the Disability Services Commission who advised that children from a range of circumstances might miss out on early childhood intervention. Such circumstances include children from families with multiple and complex needs, who are marginalised, living in outer metropolitan and regional areas and children

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323 Ms Sally Brinkman, Epidemiologist Briefing 25 February 2009. With permission.

324 Ms Erin Gauntlett, Senior Portfolio and Policy Officer Child Development Services; DoH, *Transcript of Evidence*, 25 March 2009, p16.

325 Submission 28 from Playgroup WA (Inc.), p13.

326 Ginny Dadd, Department for Communities, email, 3 April 2009.

327 Ms Susan Barrera, Director General, Department for Communities, *Transcript of Evidence*, 11 March 2009, p7.

whose development is delayed or disordered without a specific diagnosis. However the number of these children is not known.[328] As highlighted elsewhere in this report, ABS statistics suggest that the number missing out may be as high as 80% of the total.

The Western Australian situation was summarised by the Commissioner for Children and Young People who stated that:

> *In Western Australia, despite the myriad services and programs available, there is currently no systemic way of determining whether the financial investments are having the desired impact of improving specific outcomes for children and young people.*[329]

The Department of Health has acknowledged the existing inadequacy of its data gathering and analysis and advises that it has taken steps to begin to address the issue:

> *A customised information management system is due to be rolled out to all Child Development Service sites in March 2009. The Child Development Information System (CDIS) will enable ongoing data collection and reporting on client characteristics and services delivered across the CDS, for the first time providing reliable, service-wide data to facilitate service planning and to enable evaluation, benchmarking and research. CDIS will be critical in terms of monitoring and measuring clinical outcomes for children and the effectiveness of the Service.*
>
> *Work is also underway to develop an integrated data system for other areas of community child health. This system will enable comprehensive monitoring, evaluation and reporting for all service areas.*[330]

As has been stated data highlighting developmental vulnerability in some Western Australian communities has been provided through:

- The Australian Early Development Index (AEDI); and
- *Growing Up in Australia* a Longitudinal Study of Australian Children (LSAC).

This data is drawn on by key Western Australian state government agencies, including

- Department for Communities;
- Department of Education and Training;
- Department of Health; and
- Community Health Service (to some degree).

The data is used to better target their policies. In part this is because the AEDI is seen to be a more robust measurement tool than typical WA statistical data collection.[331]

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328 Marion Hailes-MacDonald Manager - Strategic Policy and Programs, Disability Services Commission, email, 3 April 2009.

329 Submission No. 15 from Commissioner for Children and Young People WA, p21.

330 Submission No. 8 from Department of Health, p35.

Finding 22

There is a lack of Western Australian data around the level of need of client groups and on outcomes. There is currently no systemic way of determining whether the financial investments are having the desired impact of improving specific outcomes for children and young people. This impedes the determination of program design, relevant policy development and optimal resource allocation.

8.2 Evaluation

> *Services will not be supported on the basis of rhetoric and warm feelings - Need to be able to justify what we do, and show that we are doing it effectively.*[332]

This section responds to the sixth Term of Reference for this Inquiry which is: 'How to appropriately measure program outcomes.'

(a) At a strategic level: a statewide evaluation framework

At a macro level, a number of states in the United States as well as the State of Victoria in Australia issue a high-level and comprehensive overview of the well-being of children in the state in question at a given point in time. These overviews focuses variously on key public policy developments in the period under consideration that impact children's well-being; policy objectives for improving the well-being of children; recent data representing the current status of the particular states children. In Victoria the report considers the broad domains of health, economic well-being, learning, safety and community engagement.

The Victorian focus is on:

> *Outcomes for all young Victorians and for young people from four priority populations: Indigenous young people, young people with a disability, young people from culturally and linguistically diverse backgrounds (CALD) and young people affected by chronic disadvantage.*[333]

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331 Dr Sharon Goldfeld, Prof Steve Zubrick, Briefing 25 February 2009.

332 Department of Health, 'Future Directions for Child Health', Available at: http://www.chnwa.org.au/docs/conf06/stratton.pdf. Accessed on 16 April 2009.

333 Department of Education and Early Childhood Development, 'The State of Victoria's Young People' Available at: http://www.eduweb.vic.gov.au/edulibrary/public/govrel/Policy/children/sovcreport07.pdf. Accessed on 16 April 2009.

Such a strategic evaluation framework would have an intrinsic value in Western Australia as the State moves to a 'whole of Government' approach to early childhood development, with the creation of the Office of Early Childhood Development and Learning.

The Commissioner for Children and Young People has proposed such an overarching Statewide evaluation framework of services delivered in Western Australia, drawing on the Victorian experience.

> *Victoria currently reports on the outcomes for children and young people every two years. The Victorian experience shows that this system will enable Government to plan and monitor the impact of investments and to target these investments to the outcomes that are most important and to those people who need them most.*

It is proposed by the Commissioner that Western Australia build on the comprehensive approach undertaken in Victoria and on other developments nationally. This would provide for the first time data on specific outcomes for children and young people and enable Government to determine where it should direct its limited resources to obtain the most effect.[334]

Finding 23

Western Australia currently lacks the capacity to monitor specific outcomes for children as they grow into their early teens and as young people and does not have any detailed information as to how Western Australian children are faring on key health, education and social inclusion indicators.

(b) At an operational level: program evaluation

The adequate measurement of program outcomes supports accountability and is evidence of the effectiveness of these programs. That is, being accountable for both the quantity and quality of outcomes without regard to procedures followed.

It has been suggested that 'outcomes accountability' 'links baseline data to strategies and therefore ensures that the success, or otherwise, of individual strategies can be clearly identified by linkage to reliable evaluation data.'[335] It is also recognised that in early childhood development there is often a lag time between effort and effect, making outcome accountability more problematical.

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334 Commissioner for Children and Young People, *2009/10 Budget Submission*, prepared by The Commissioner for Children and Young People, p4.

335 Anglicare, 31 March 2008. Available at: http://intranet/intranet/piframesi.nsf/iframewebpages/Committees+Past. Accessed on 15 April 2009.

This lag, when combined with the possibility that families and service providers will at times become caught up in service provision, can lead to the service provider losing sight of the over-riding purpose of their activities.[336] In other words, the processes of service delivery become more important than the outcomes. One solution is the development of both clear measurable outcome statements with relevant long and short term performance indicators.

The Productivity Commission suggest the use of well designed performance indicators because:

> *Performance measurement provides one means of shifting the focus from the level of resources to the use of those resources. Performance measurement can:*
>
> - *help clarify government objectives and responsibilities*
> - *promote analysis of the relationships between agencies and between programs,*
> - *allowing governments to coordinate policy within and across agencies*
> - *make performance more transparent, allowing assessment of whether program objectives are being met*
> - *provide governments with indicators of their performance over time*
> - *inform the wider community about government service performance*
> - *encourage ongoing performance improvement.*[337]

Performance indicators (PIs) and targets have played an ever increasing role in the accountability framework, in maintaining control, and in incentivising performance. However, when poorly designed, performance indicators do not necessarily provide a basis for the satisfactory assessment of an individual agency's performance, for example:

> *At one level the increasingly large, disparate and complex performance indicators and league tables have not provided the public with clear information on which to base their performance judgements. On the other hand crude league tables of waiting times for instance have hidden more than they reveal, both distorting the public's perceptions and creating unfortunate incentives amongst practitioners and managers to focus on the wrong things, neglecting real priorities.*[338]

In terms of PIs for the early childhood sector this issue was well illustrated in one submission which stated that:

> *Measuring program outcome is a challenge. To adequately capture the richness of impact requires a comprehensive approach to evaluation –this is particularly so when a program is intended to be preventative or early intervention and when working with sub clinical populations. In these instances it is often difficult to see or measure change, particularly in the short term ~what occurs is indeed preventative, that is, there is no 'clinical'*

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336 Early Childhood Intervention Australia, 'Outcome Statements for Early Childhood Intervention services', 2005. Available at: http://www.eciavic.org.au/publications/ECIOutcomesPaper_Aug05.pdf. Accessed on 16 April 2009.

337 Productivity Commission, 'Report on Government Services 2009', 2009. Available at: http://www.pc.gov.au/gsp/reports/rogs/2009. Accessed on 7 April 2009.

338 Powell, A. M. 2002, *Evaluating new Labour's welfare reforms,* The Policy Press, London, p52.

behaviour to observe in the first instance. In these instances, what must be captured are changes in understanding and attitude rather than necessarily in behavior.[339]

As one submission put it: 'Given the diverse life impacts associated with child development, population level outcomes need to be longitudinal.'[340]

While this is demonstrably correct there remains a need for both long term and short term evaluation in parallel.

(i) Short term performance indicators

When considering suitable short term performance indicators, the Committee recognises that simply measuring the occasions of service is not enough. It is also important that an identification of 'who is being seen and who is not being seen' is made, together with a longer term assessment of how effective the service is.

To overcome the difficulty of measuring long term child development outcomes in the short term, a number of strategies were proposed by participants to the Inquiry. These are summarised as follows:

- *The establishment of benchmarks in relation to minimum service levels be developed to ensure service delivery grows with population levels and emerging needs. These could then be measured.*[341]

- *Base line data on prevalence rates in a range of areas be established in the context of a cross government early years framework outcome targets.*[342]

- *Evidence of such things as attendance, client satisfaction ratings and snowballing referrals.*[343]

- *In terms of client satisfaction rating, there should be independent, not a service based, client/family evaluations of a service that can keep the anonymity of families and permit true expression of opinions. There are lots of anecdotal stories some families have good service access some have dreadful service access and most have in between. We do not have good objective data.*[344]

- *Measure early referral and priority for assessment and treatment, through waiting lists and intervention times at child development services.*[345]

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339 Submission No. 17 from Dr C. Reid and Dr L Lee, p3.

340 Submission 28 from Playgroup WA (Inc.), p14.

341 Submission 28 from Playgroup WA (Inc.), p12.

342 Submission 28 from Playgroup WA (Inc.), p14.

343 Submission No. 17 from Dr C. Reid and Dr L Lee, p3.

344 Helen Beaton, Touch Move Play, email, 16 April 2009.

345 Submission No. 19 from Community Health Nurses Western Australia, p4.

- *Greater awareness and demand for delivery of government funded programs and services available for 0 – 3 in regional WA.*[346]
- *Significant increase in the number of communities, and particularly Indigenous communities, accessing government funded programs in regional WA.*[347]
- *Other health measures could include age at diagnosis, tracking and wait lists analysis of referral and treatment services.*[348]

(ii) Long term performance indicators

The long term performance indicators will measure the effectiveness of individual service and program strategies. The evaluation will also reflect whether the service strategy started with the end in mind and was clear about what the desired outcomes were to be.

- *Before outcomes can be measured there needs to be agreement as to what should be the desired outcomes for children, families and communities.*[349]
- *School readiness to include social development, skill development, emotional maturity as well as literacy and numeracy.*[350]
- *Health measures, particularly around speech and hearing; sight; dental health; language; immunisation; cognitive development and physical skills set development.*[351]

Recommendation 19

The Committee recommends that the Auditor General undertakes a review of selected early childhood parental support programs to examine the adequacy of the existing short and long term performance indicators and the adequacy of the measurement of outcomes against these performance indicators.

346 Submission No. 29 from Pilbara Development Commission, p5.

347 Submission No. 29 from Pilbara Development Commission, p5.

348 Submission No. 32 from Wanslea Family Services, p5.

349 Submission No. 23 from Early Childhood Australia, p11.

350 Submission No. 32 from Wanslea Family Services, p5.

351 Submission No. 32 from Wanslea Family Services, p5.

8.3 Service mapping - the evaluation of need

Currently, AEDI is an initiative that has enabled some Western Australian communities to obtain a map of the needs of young children and families in order to determine the programs and services to best meet those needs:

> *AEDI results are mapped to provide communities with a picture of the early childhood development strengths and vulnerabilities in each community and on each of the developmental areas. AEDI can be used by policy makers to plan and evaluate place-based initiatives for children.*[352]

As such AEDI demonstrates the value of a community map of young children's development. The Department of Health is unequivocal in the need for better mapping if it is to effectively manage resources.

> *To effectively plan, delivery and evaluate services provided to meet identified developmental needs, an integrated information system is also needed to identify priority regions and sub-populations in WA, respond with an appropriate mix of service providers, and monitor outcomes.*[353]

This is a view supported by Early Childhood Intervention Australia:

> *Service development needs to involve early consultation and mapping of aligned services and agencies to ensure efficient use of resources and identify opportunities for collaboration and service complementarity.*[354]

Service mapping is a process that maps existing service networks and referral processes in a given community. For example what happens to a family, carer or child when they come for support, where they wait, who they see first, and so on is mapped. After the mapping of services, there is an exact picture of the way services are delivered in the community. This makes it easier to see what works well and what doesn't. It forms an essential component of service design.

> *"Mapping" of services and areas of need should be in place to prevent overlaps and gaps.*[355]

The map provides a starting point (a baseline), against which the effects of the changes made can be measured. Service mapping:

- provides a picture of what is available now;
- highlights where things aren't working well;

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352 Dr Sharon Goldfeld, Briefing 25 February 2009.

353 Submission No. 8 from Department of Health, p49.

354 Submission No. 23 from Early Childhood Intervention Australia, p9.

355 Submission No. 33 from CHILD Australia, p13.

- reflects how things currently happen and how they could be improved;
- help to assess the flow of activity;
- identifies how resources are being applied; and
- provides the baseline data for the future.

For example:

> *In Enfield a co-ordinator mapped area and looked at families with non attendance issues, asking what would make a difference to the attendance.*[356]

The engagement of communities in service mapping is seen as advantageous because of their local knowledge:

> *We have to get the local communities involved in mapping services. Communities are different in terms of their demographic, their geography and available services and the accessibility of those services. So communities need to collect data on their demography, need to map existing services, establish local leadership, consult widely and develop an evidence based plan.*[357]

In Victoria and South Australia there is a funded position which supports early childhood hubs that has a focus on service mapping and community development. In Victoria every local government area (LGA) has a 'Municipal Early Years Plan (MEYP)'. This is a strategy to reach families. The plan may envisage the use of data collection, mapping of services, the undertaking of a needs analysis, the establishment of a steering committee, and the development of an action plan. But "while every LGA has a MEYP, there is, as you would expect, considerable diversity with respect to how far they have gone in their thinking and implementation."[358]

In South Australia new positions of Community Development and Family Services Coordinators have been established, similar to those in Victoria undertaking service mapping and creating linkages.[359]

These officers are located in the children's centres to facilitate a 'no wrong doors' strategy.

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356 C.a.F.E Enfield, Briefing 26 February 2009.

357 Professor Frank Oberklaid, Briefing 25 February 2009, by permission.

358 Professor Frank Oberklaid, Briefing 25 February 2009.

359 Meeting of Heads of Agencies, Adelaide, Briefing 26 February 2009.

> *The Centre, in common with its counterparts, has a community development officer who works with other agencies. This officer maps the services and needs of the local community and then creates the networks of support that are available. The Centre seeks to be a 'one stop shop' for parents utilising this network for referrals where their own service is unable to meet the presenting need.*[360]

As in South Australia, the Australian Capital Territory employs family services co-ordinators to map and make connections across the community.[361] Their purpose is to identify children and families who may be vulnerable and/or 'at risk' and then engage and connect them in a range of early childhood services and programs.

360 Ocean View College Children's Centre, Taperoo (Adelaide) Briefing 23 February 2009.

361 Narrabundah Early Childhood School in the ACT., Briefing 24 February 2009.

CHAPTER 9 TOWARDS AN INTEGRATED SERVICE MODEL - LINKING THE EARLY YEARS TO THE SCHOOL YEARS

Readiness for school is a seemingly simple concept. It should indicate a likelihood of school success, a synchronising of physical and cognitive development, maturity, and skill, allowing a child to fit into the expectations of schooling. It is the culmination of the child's experiences with its parents, carers, and community to that point in time.

However, in Western Australia, a significant number of children arrive at school with a range of developmental disorders, leading to poor future prognosis for their lives whether in their school years or adult life.

This is clearly demonstrated by the AEDI data as highlighted in chapters four and seven and in the information provided by the Challis Early Childhood Education Centre as outlined later in this chapter.

The transition from home to school is one of the major social adjustments that children have to make. It represents a major change in a child's life and is generally their first encounter with a large social institution where many new rules, both written and unwritten, are to be followed. The successfulness, or otherwise, of this transition can have long-lasting effects on a child's ability to adapt to the new learning environment. There is clear evidence that readiness for this transition is predictive of later developmental outcomes:

> *Children who are less 'ready' are less likely to excel academically, more likely to have behavioural and emotional problems and more likely to be retained in a grade and drop out of school. Such children are also more likely to become teenage parents, engage in criminal activities and have poorer employment records.*[362]

This chapter considers some of the factors contributing to school 'unreadiness' along the continuum of family, community and school. In doing so, it looks at the related process of the successful transitioning of children in various early childhood care and education settings. In particular it considers the value of an integrated model of service delivery that may be delivered through early childhood settings, linking parent support, education, health and child care programs as a possible response to this 'unreadiness'.

9.1 School readiness

Early definitions of school readiness saw the focus on the child in isolation from its external environment. The concept of "readiness" has now broadened and is no longer seen to be applying to the child alone; but as a shared responsibility:

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362 Home-to-school transitions for financially disadvantaged children, Final Report: The Smith Family, Australian Institute of Family Studies, November 2008, p2.

> *Children will not enter school ready to learn unless families, schools and communities provide environments and experiences that support the physical social, emotional, language, literacy and cognitive development of infants, toddlers and preschool children.*[363]

The concept of shared responsibility for school readiness recognises that early childhood development is influenced by characteristics of, and the relationship between, the child, the family, and the broader social environment. The US National School Readiness Indicators Initiative developed the 'Ready Child Equation' to express this broader concept:[364]

Ready Families + Ready Communities +
Ready Services + Ready Schools = Children Ready for School.

In the above equation, 'ready families' refers to children's family context and home environment. 'Ready communities' refer to the resources and supports available to those families. 'Ready services' refers to availability, quality and affordability of proven programs that influence child development and school readiness. 'Ready schools' describes critical elements of schools that influence child development and school success.[365]

In detail:

> *'Ready families' refers to children's family context and home environment. There are large differences in family resources, including parenting skills and attitudes. Support is needed to help families provide responsive care and appropriate learning experiences for their children and to develop family well-being during the early years' period.*
>
> *'Ready services' refers to the availability, quality and affordability of programs and services that positively support child development and contribute directly and indirectly to school readiness. These include the care and education environments provided in preschools, kindergartens and childcare settings. Linking services and establishing integrated service networks provides additional gains, including continuity and consistency.*
>
> *'Ready communities' refers to both informal and formal resources and supports available to families with young children. Examples of informal resources include social networking opportunities for families to meet in family friendly environments, and for their children to socialise – in parks, for example. Formal resources include health services and libraries. Children whose families have easy access to such resources have better developmental outcomes than children whose families lack such access.*
>
> *Ready schools' describes critical elements of schools that influence child development and school success. These include links established with early years services, transition*

363 School Readiness, Australian Research Alliance for Children and Youth, Farrer, et al, p4.

364 School Readiness, Australian Research Alliance for Children and Youth, Farrer, et al, p7.

365 School Readiness, Australian Research Alliance for Children and Youth, Farrer, et al, p7.

support programs for children commencing schools, a range of programs and supports available to cater for children with diverse needs during the early years of schooling, and teachers with an understanding of early childhood development.[366]

(a) Parenting - part of the jigsaw of school readiness

As noted previously in this report, research demonstrates the critical role of parenting in a child's development in the early years. This is demonstrably true in both a positive and negative sense. Children learn from interacting with those central to their lives in the family and community, and the family environment plays a fundamental role in young children's socialisation and learning.

The risks and protective factors in the family environment in the early years have a cumulative effect on behaviour and therefore on school readiness and the transition to school. These factors may be summarised as follows:[367]

Risk factors have been found to be:

- family violence and disharmony;
- marital discord;
- disorganised; [sic]
- negative interaction/social isolation;
- large family size;
- father absence; and
- long term parental unemployment.

Similarly, negative parenting styles include:

- poor supervision and monitoring of child;
- discipline style (harsh or inconsistent);
- rejection of child;
- abuse;
- lack of warmth and affection;

366 Rethinking School Readiness, Policy Brief, No. 10, 2008, p3.

367 Pathways to Prevention: developmental and early intervention approaches to crime in Australia, Summary Volume, Table 1, p.13.

- low involvement in child's activities; and
- neglect.

Protective factors include:

- supportive caring parents;
- family harmony;
- more than two years between siblings;
- responsibility for chores or required helpfulness;
- secure and stable family;
- supportive relationship with other adult;
- small family size; and
- strong family norms and morality.

Parenting and learning outcomes

The UK "Effective Provision of Pre-School Education" project (EPPE), a longitudinal study following 3000 children, their parents, home environments and pre-school settings found that parental involvement increases the 'preschool advantage.'[368] Parental involvement might mean parent-child interaction through activities such as reading, teaching nursery rhymes and songs, painting and drawing, playing with numbers and letters. Such activities were more strongly associated with children's intellectual and social development than a parent's occupation or education.

Similarly, findings from the *Longitudinal Study of Australian Children Wave 1* highlight the significance of a home environment on developmental trajectories with the following statement:

> *Family learning environments are strongly associated with children's learning outcomes.*[369]

This study, similarly to the EPPE study, found that 'children's overall and learning outcomes were associated with family factors such as being read to by a family member, the number of children's books in the home, and the child's access to a computer at home.'[370]

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368 School Readiness, Australian Research Alliance for Children and Youth, Farrer, et al, p11.

369 How well are Australian infants and children aged 4 to 5 years doing? Social Policy Research Paper No. 36, FaHCSIA, p.viii.

370 How well are Australian infants and children aged 4 to 5 years doing? Social Policy Research Paper No. 36, FaHCSIA, p viii.

Positive influences were found to include:

- a family member read to the child on three or more days per week;
- there were 10 or more children's books in the family home;
- the child enjoyed being read to by a family member for more that 10 minutes at a time;
- the child had access to a computer at home; and
- the child had medium or high engagement in out-of-home activities with family members.

The out of home activities referred to above are those that can provide cognitive and language stimulation. Research demonstrates that enrichment activities in the community, taken with family members, contribute to children's emergent literacy skills and social development, and that parental time spent with a child in such activities is also a significant predictor of later educational achievement.[371]

Linking the aforementioned care and education factors, there is a body of evidence linking a child's speech, language and communication ability with the social determinants of health including:

- early attachment, social and emotional development; and[372]
- language skills as the building blocks for development of literacy, numeracy and learning and as a protective factor in ensuring academic success, positive self esteem and improved life chances.[373]

The overall developmental outcomes when these are in deficit include:

- significant co-occurrence with behavioural problems and juvenile offending; and
- the costs to individuals, families and at a national level of children's poor communication.[374]

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371 How well are Australian infants and children aged 4 to 5 years doing? Social Policy Research Paper No. 36, FaHCSIA, p80.

372 R Holms et al, Pathways to Prevention project, Mission Australia and Griffith University http://www.griffith.edu.au/_data/assets/pdf_file/0017/1332/pathways-final.pdf.

373 Snow, P C and Powell MB (2004) Developmental Language Disorders and Adolescent Risk: A Public Health Advocacy Role for Speech Language Pathologists? Advances in Speech Language Pathology 6 (4) 221 – 229.

Language skills are the foundation for all other learning areas and are strongly linked to successful transition to school. A large body of research exists that evidences a significant number of children have some level of language or communication difficulty. For instance, UK data[375], finds that up to 10% of all children have a long-term *persistent* communication disability[i], and upwards of 50% of children on school entry have more *transient* difficulties and, with the right support, are likely to catch up. However there may well be interim learning difficulties.

The role of parent support programs

The importance of effective parenting means that strengthening the local capacity of parents, and families to better provide for the needs of all young children is seen as paramount in the provision of support services.

As noted in Chapter 5, there are a number of agencies providing both information and support to parents in the raising their children:[376]

- The Department of Education and Training (DET)
- The Department of Child Protection (DCP)
- Department for Communities (DfC)
- Department of Health (DoH)
- Disabilities Service Commission (DSC)

The remit of the above agencies is to both provide information and assistance to parents requesting or in need of support in raising their children. Such services offered by individual agencies can be either targeted or universal, depending upon the nature of the service or the referral pathway.

The issue of access: the advantages of integration

There are clear advantages of identifying children with developmental delays as early as possible, before the condition becomes entrenched. Early intervention increases the chances of a positive outcome.

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374 I Can Talk Series - Issue 2: The Cost to the Nation of Children's Poor Communication I CAN Talk Series - Issue 2: The Cost to the Nation of Children's Poor Communication http://www.ican.org.uk/upload2/chatter%20matter%20update/mcm%20report%20final.pdf.

375 Lindsay G. et al. (2002) Educational Provision for Children with Specific Speech and Language Difficulties in England and Wales Cedar and Institute of Education, University of London Law J. (1992) The Early Identification of Language Impairment in Children London, Chapman and Hall.

376 A list of individual programs run by the respective agencies can be found in Chapter 5.

It has been suggested to the Committee that one way to ameliorate the risk of poor developmental outcomes is to apply a policy of 'aggressive intervention.' That is to identify families in need of support and to actively apply planned interventions.

One of the more obvious ways to target those parents in need of support is to integrate all early childhood services to ensure a continuum of support and service delivery. Café Enfield Children's Centre, for example, in South Australia, is able to apply this strategy due to the co-location of health, education and childcare, family and community support services. Children at risk - and any siblings - are then identified and given appropriate support services. Likewise Narrabundah Early Childhood Education Centre in the ACT is being established with the integration of early childhood services as its' driving force.

What is common within the realm of an integrated early childhood and care system is the role is service mapping and community development. The Committee was advised that in both Victoria and South Australia the role of a community services development co-ordinator, or family services co-ordinator, has evolved to work with and support vulnerable families. The Officers work along with a range of stakeholders to connect families with the support needed.

Aside from the more overt benefits of assessment, intervention and therapy services that may be embedded within an integrated setting, there are a range of other benefits to families. The Committee heard, from those centres visited,[377] that these benefits included:

- families find it easier to use health, child care, education and family support services;
- families have more child care and early learning options;
- families link up with other families with young children;
- families get information about parenting and young children's learning and healthy development;
- families get help from staff if concerned about their child's health or learning needs; and
- families have options to consider a return to school, further study or employment.

The Commissioner for Children and Young People (WA) advocates for integrated settings here in Western Australia:

> *Another element for the best outcomes for Western Australia's children is the use of integrated childcare centres….The centres are friendly places for families to meet, learn more about parenting, gain advice and information on health, personal and family support, therapy services, vocational education and employment.*[378]

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377 Ocean View College Children's Centre, SA; Narrabundah Early Childhood Education Centre ACT; Café Enfield Children's Centre, S.A.

378 Submission No. 15 from Commissioner for Children and Young People WA, p 16.

Therapy Focus likewise supports the 'hub' concept:

> *Children's Centres are designed to be a "one stop shop" where a variety of services are available to families in their local communities. These centres offer early childhood education together with childcare, support for parents and families, on-site access to health services and links to other services such as children's information, libraries and employment. Another important focus of these centres is to ensure that ALL families are able to access services equally.*[379]

Recommendation 20

The Committee strongly recommends the development of a more systematic researched and stable approach to the provision of parenting programs. Best practice models for particular communities should be developed and funded for periods of at least five years.

(b) The role of playgroups

The first Western Australian playgroup was established in Subiaco in 1970, and since then numbers have grown so that today the peak body, Playgroup WA, has more than 500 member playgroups comprised of approximately 16,000 family memberships across WA.[380]

It is widely acknowledged across Australia that playgroups provide opportunities for children's social, emotional, physical and intellectual development while also providing opportunities for parents and caregivers to establish social and support networks to encourage and assist them in their parenting role. Research demonstrates that they make a valuable contribution to a child's school readiness.[381] In particular:

> *Playgroups have a number of important functions for families and children in the early years, they:*
>
> *• Provide a fun and learning environment for babies and young children.*
> *• Promote emotional, physical, social and cognitive development through play.*
> *• Foster attachment between parents / caregivers and children.*
> *• Reduce social isolation through the formation of locally based social networks.*
> *• Peer support for parents and caregivers.*

379 Submission No. 24 from Therapy Focus, p4.

380 Submission No. 28 from Playgroup WA (Inc.), February 2009, p1.

381 Dadich, A., 'Evaluating playgroups: An examination of issues and options', 2006. Available at: http://www.playgroup.org.au/LinkClick.aspx?fileticket=eJ02eBIT6R0%3d&tabid=127. Accessed on 30 June 2009.

> • *Are a point of contact for parents / caregivers to access advice and information on a range of things including support services, parenting information, managing challenging behaviours, play and early child development.*[382]

Playgroups are generally seen as community-based, localised groups that bring together preschool-age children, their parents and or carers for the purpose of play and social activities.

> *The value and contribution of Playgroups is acknowledged and supported as they too emphasise the importance of play based learning and parent-child engagement. There are various models that can be considered. Whatever model is preferred there must at least be recognition of the core importance of secure attachment, play based learning, self-regulation, literacy and emotional literacy. Also we note the importance of parental involvement in early childhood development.*[383]

In fact there are two main types of playgroups in Western Australia. These are:

- *Community playgroups* operated by parents; and
- *Supported playgroups* which are initiated and facilitated by a third party. These aim to engage families who would not normally access self-managed playgroups.

Families that might not readily access playgroups include, for differing reasons, Indigenous families, families suffering from disadvantage and Culturally and Linguistically Diverse (CALD) Families. Anecdotally there is a lack of understanding in these groups of their relative importance in terms of child development and parental support.[384]

Playgroup WA Inc argues strongly for an integrated approach to playgroups with other early childhood services to help overcome the disconnect between health, education, early childhood workers and parents/caregivers.[385]

(i) Supported Playgroup

There is a range of government funded or partially funded supported playgroups in Western Australia providing differing degrees of support.

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and/or the Department for Communities are the primary funding bodies in Western Australia for supported playgroups. Currently there is funding provided for three main playgroup strategies:

1. Funding to Playgroup WA Inc provides start up funds to develop low level supported playgroups for CALD and disadvantaged groups. These supported playgroups usually meet once a week for two hours, and are facilitated by a Coordinator. The Supported Playgroup Coordinator

382 Submission No. 28 from Playgroup WA Inc, February 2009, p2.

383 Submission No. 13 from NIFTeY (WA), p3.

384 Submission No. 16 from Ethnic Communities Council of Western Australia, February 2009, p2.

385 Submission No. 28 from Playgroup WA Inc, February 2009.

works with families attending the playgroup for between three and twelve months, to help them develop the skills to participate in and run their playgroup independently.

> *The program has been operating for 4 years and is currently under negotiation. The target group is reasonably broad and is essentially groups that would not otherwise attend the traditional parent led playgroups, including: indigenous, CALD, young parents and other socially isolated parents. We provide for venue hire, toys and consumables and a 4 hour per week playgroup facilitator plus supervision. Given there are only 7 per year we don't widely advertise. Community people and agencies contact us throughout the year to propose sites. Factors we consider in nominating a new group include: evidence of interested parents; venue and worker availability, transition possibilities and interagency involvement. It is important to note that these groups are only funded for a maximum of one year with the expectation that they transition into parent led groups. This is clearly not enough for people with high needs or where high level engagement is required such as indigenous groups.*[386]

2. In one submission a not for profit agency outlined through their work, an example of a supported playgroup which enjoys a greater continuity of funding than that exampled above.

> *CHILD Australia is funded by the state Department for Communities and the Commonwealth Department for Families and Housing Community Services and Indigenous Affairs (FaHCSIA) to support a range of playgroups for children and families in the Midwest Gascoyne and Murchison and the Pilbara. The focus of the CHILD Australia support is for families who are socially isolated, or in some way challenged by their circumstances. These playgroups provide culturally and developmentally appropriate activities for the children and social and community networking opportunities for their families. The CHILD Australia playgroup leaders have early childhood qualifications and are thus aware of, and responsive to, children's development. The playgroups provide an opportunity for observations of each child's development, and play leaders talk with parents and support referral for developmental assessment where appropriate.*[387]

3. The third initiative is that of Best Start. The Best Start initiative endeavours to foster attachment and bonding between mothers and infants. As a part of that strategy a qualitatively different model of a supported playgroup is run under the auspices of the Department for Communities.

> *This voluntary program aims to improve life opportunities for Aboriginal children aged between 0-5 years, with co-operation from local health, welfare and Indigenous agencies. Co-ordinators and activity leaders are employed to create a family friendly, Aboriginal specific service in a suitable venue. Improving school readiness through play based activities is a key objective, but this starts from birth and transitions through to school enrolment. Several factors differentiate this program from other "supported playgroup" models. Parents and carers must attend with their child, and are an integral part of all activities. Mothers and fathers are made welcome even before their first baby is born, and many families continue to attend with each subsequent sibling. Co ordinators refer and*

386 Mr David Zarb, Playgroup WA Inc, email, 2 July 2009.

387 Submission No. 33 from CHILD Australia, February 2009, p3.

support 'at risk' and/or socially isolated families to local agencies and resources to deal with family violence, accommodation, addiction and legal and other issues.

There are three metropolitan and ten regional/remote services operating across WA. Each service has been designed and developed with local Indigenous input and the co-ordination role ensures support from local agencies. Indigenous families recognise the benefits of Best Start and promote this service model to their extended families and friends.[388]

(ii) School based Playgroups

There is strong community support for playgroups, whether supported or parent led to be co-located with schools. Many schools have taken the initiative to re-direct school funds for this purpose, in order to improve a child's school readiness.

We are very keen for schools to provide venues for both parent led and supported playgroups. The availability of venues is a significant issue for playgroups, particularly in the developing areas of Perth and regional WA. The amount of community centres and local government facilities has not kept pace with population and schools offer infrastructure that is in place and appropriate for children. There are added benefits in terms of promoting positive school family relationships and smoothing the transition to school. Many schools do have playgroups but it is entirely dependent on the attitude of the Principal ….. DETWA have said they would like to encourage schools to host playgroups.[389]

The Committee has been impressed by the effectiveness of this approach in preparing young children and integrating families into school life.

Finding 24

Playgroups perform a critical role in providing opportunities for children's social, emotional, physical and intellectual development, while also providing opportunities for parents and caregivers to establish social and support networks to encourage and assist them in their parenting role.

Supported playgroups can perform an important additional role of modelling for parents methods of engaging with their children and so enhance their development. There are sound developmental and practical reasons for these playgroups to be collocated with primary schools.

388 Submission No. 3 from Department for Communities, February 2009, p4,5.

389 Mr David Zarb, Playgroup WA Inc, email, 2 July 2009.

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Recommendation 21

The Committee recommends that in high need areas, as identified by AEDI or NAPLAN, the development of properly funded structured playgroups for 0-3 become a standard facility in primary schools.

(c) Child care - part of the jigsaw of school readiness.

Children are born ready to learn and families are children's first educators. As discussed earlier in this Report, 'Because of the critical nature of children's brain development in the first three or four years, the learning that takes place within families, communities and the formal arrangements of child care is of the utmost importance.'[390] The quality of 'care' provided to the child in its early years will impact on the child's emotional behaviour, their cognitive development and their use of language.

> *The benefits of high quality care is hugely beneficial to all children but even more so for children from disadvantaged backgrounds. The high proportion of very young children in child care should focus the attention of policy makers and others on the need to ensure these environments are of the highest quality given what is now known about the possible detrimental impact of poor quality care during the early years of a child's life.*[391]

Poor quality care may arise because of prevailing paradigms as to why child care is being provided, for instance:

- If, as the OECD suggests, from a government perspective care services for children under three are provided simply as an adjunct to labour market policies, then infants and toddlers may find themselves in services with weak developmental agendas.[392]

- If child care is simply seen as a money making opportunity then, as was argued by the peak body Early Childhood Australia following the recent collapse of ABC Learning:

> *Australian taxpayers are funding shareholders at the expense of adequate investment in early learning and care and parental leave. Children become commodities in this equation. The focus should be on the children and not on the money. The provision of high quality early learning and care is an essential service for children and families and to the*

390 The ACT Department of Education and Training, 'Early Childhood Schools', 2008. Available at: http://www.det.act.gov.au/__data/assets/pdf_file/0005/23855/Early_childhood_schools_final_web.pdf. Accessed on 24 April 2009.

391 Submission No. 1b from Early Childhood Australia, p4.

392 Starting Strong II: Early Childhood Education and Care, Organisation for Economic Cooperation and Development, 2006, p16.

> *economic future of the State and country. It is far too important to be left to the whim of market forces.*[393]

The Committee was concerned to hear accounts suggesting that there is, in some quarters, an attitude that undertaking a career as a childcare worker was an option of last resort, rather than recognition of it being an important and valued occupation in its own right. Such attitudes support a lack of interest in the quality of care provided in respect to a child's development.

Professor Fraser Mustard suggests that such paradigms are seen to be reinforced as, given the cost of day-care services, families come to accept that child care is essentially a fee-for-service commodity.

> *Parents have become consumers of day-care services that appear to meet their immediate needs of care for children while they work, but not necessarily their needs in terms of development for their children.*[394]

Nationally, it is Professor Mustard's view that Australia is at a cross roads because of the conflict between the concepts of many child care programs, where child development is compromised in this way, as against similar centres with early child development programs. He contends that there is a subsequent polarisation of concepts which are underwritten by the relative affluence or, alternatively, the disadvantage of parents. This exacerbates existing inequities in early child development.[395]

Many submissions to this Inquiry support the case that child care and related services, including playgroups, could play a pivotal role 'in identifying children's developmental vulnerability and actively assist families in developing their social capital'.[396] They argue the case for child care centres being of paramount importance in child development and as such there is a significant reason to consider them in the context of child development, rather than in the context of simply child minding.[397] In that context, issues around quality and integration become paramount considerations.

(i) Child care in Western Australia

> *The majority of Western Australia (73%) children attending long day care centres are 3 years of age or younger:*
>
> - *4% are under one year of age;*
> - *17% are one year olds;*

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393 Submission No. 1b from Early Childhood Australia, p4.

394 Early Childhood Development: the best start for all South Australians, J. Fraser Mustard, Govt of South Australia, p39.

395 Department of Education and Children's Services, *Early Childhood Development*, report prepared by Mustard, J.F., Government of South Australia, 2008, p39.

396 Submission No. 14b from Ngala, p9.

397 Pam Cahir CEO, Early Childhood Australia, Briefing 24 February.

- *25% are 2 year olds; and*
- *27% are 3 year olds.*[398]

As at the 16 February 2009, the number of licensed places in child-care were as follows:

- Child Care Centres 27,140
- Family Day Care 4,470
- Outside School Hours Care 10,589[399]

Services that do not require a licence typically include playgroups, crèches, in home care and holiday activity based services.[400]

The nature of the main types of day care are summarised as follows:

> *Long Day Care (LDC) provides group care for children, usually in 3 age groups (0-2yrs, 2-3yrs, and 3-5yrs), in purpose built facilities. Daily average attendance ranges from 40 – 120 children, depending on the size of the service. There is a least one qualified caregiver in each age group and the remainder of the staff have a Certificate III in Child Care or are untrained. Children in LDC attend on a regular basis, between one to five days per week and between the hours of 7am – 6pm. Children can attend child care 55 hours / week up to 52 weeks of the year.*
>
> *All 'Australian Government Approved Child Care Services' (AGACCS) must meet standards set by the State Licensing Division of the Department for Communities and also adhere to the 7 Principles of Quality Assurance established and monitored by the National Child Care Accreditation Council (NCAC). Under the Principle 3 of NCAC, caregivers are obliged to undertake regular written observations of each child and maintain a record of each child's progress/milestones/activities.*
>
> *Thus, there is within child care a system of "surveillance" of each child. However, there is no consistent system to ensure that information pertaining to a child's development leads to a referral, when necessary, to a more formal level of assessment i.e. within the child health system.*

This present day lack of a formal health assessment stands in contrast to the period leading up to the late 1990's when child health nurses were able to undertake developmental assessments of children in child care centres. Some did this on a regular basis, screening all children in the centre, while others assessed certain children (with parental permission) 'when the Early Childhood Educator had concerns about a child's development. If the child was considered to be delayed in any area the child health nurse would then refer that child to a Child Development Centre'.[401]

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398 Submission No. 1b from Early Childhood Australia, p4.

399 Department for Communities, *Data of child care licensed places by Metro/Country as of 16 Feb 2009.*

400 Submission No. 3 from Department for Communities, p3.

401 Submission No. 33 from CHILD Australia, p4-5.

Finding 25

While the standards set by the National Child Care Accreditation Council require child care service providers to maintain a record of each child's progress, there is no consistent system to ensure that where developmental problems are identified that the child is referred for a formal assessment e.g. within the child health system.

Recommendation 22

The Committee recommends that a system is established that ensures that child care service providers refer identified developmentally vulnerable children for a formal assessment within the child health system.

Other forms of child care include:

> *Family Day Care (FDC) is a system of child care where a small group (usually of 4-5) children are cared for in mixed age group in a private home. Standards of care in each home are monitored by a Family Day Care Scheme Field Officer who visits the carers' homes to ensure standards of care are met and that the program provided is developmentally and culturally appropriate. FDC carers often have a qualification in early childhood development (Cert III or higher) and Field Officers also have appropriate qualifications. FDC is subject to state Regulations and NCAC standards, which require that children's developmental progress and needs regularly are observed and recorded by caregivers.*
>
> *Multicultural Aboriginal Child Care Services provide a range of child and community services, primarily for Indigenous families. MACS operate in a similar way to LDC, and where possible employ both qualified early childhood staff and untrained caregivers.*
>
> *Occasional Care Services are similar to LDC, providing care in purpose built facilities, for children 0-5 yrs, but offering the option of irregular or short term attendance for children. Many children in Occasional Care only attend for one half day per week, making it more difficult for caregivers to maintain regular or complete records of children's "progress.*[402]

(ii) The importance of quality in child care

There are a number of drivers of quality, amongst them:

- *Government regulation and legislation*: In Western Australia, child care centres are licensed by the State government and their use is supported by Federal measures that

402 Submission No. 33 from CHILD Australia, p4-5.

ensure 'parents can benefit from tax relief or vouchers only when they use day care services – public or private – registered and supervised by public authorities'.[403]

- *The size of the individual group*: Group care that is not high quality can be detrimental to children. This is true where individual groups are too large.[404]

- *Qualifications of the carers*: A number of participants to this Inquiry highlighted the need for improving the standards of qualifications and therefore the remuneration in the child care sector. This was seen as critical:

    - to improve the quality of care and child development;

    - to reduce the churn rate of staff, currently 40%) in the industry and thereby increase experience; and to make the profession more attractive

In their 2009 Report to the Commonwealth government, the Expert Advisory Panel on Quality Early Childhood Education and Care noted that:

> *Raising the effectiveness of early childhood education and care will most likely require a broad range of initiatives including increasing the supply of qualified early childhood educators, and providing targeted professional development activities that support, amongst other things, teachers' pedagogies including interactions with children. In the Australian context quality standards should include specifications about entry-level qualification requirements for early childhood staff coupled with a requirement for continuing professional development.*[405]

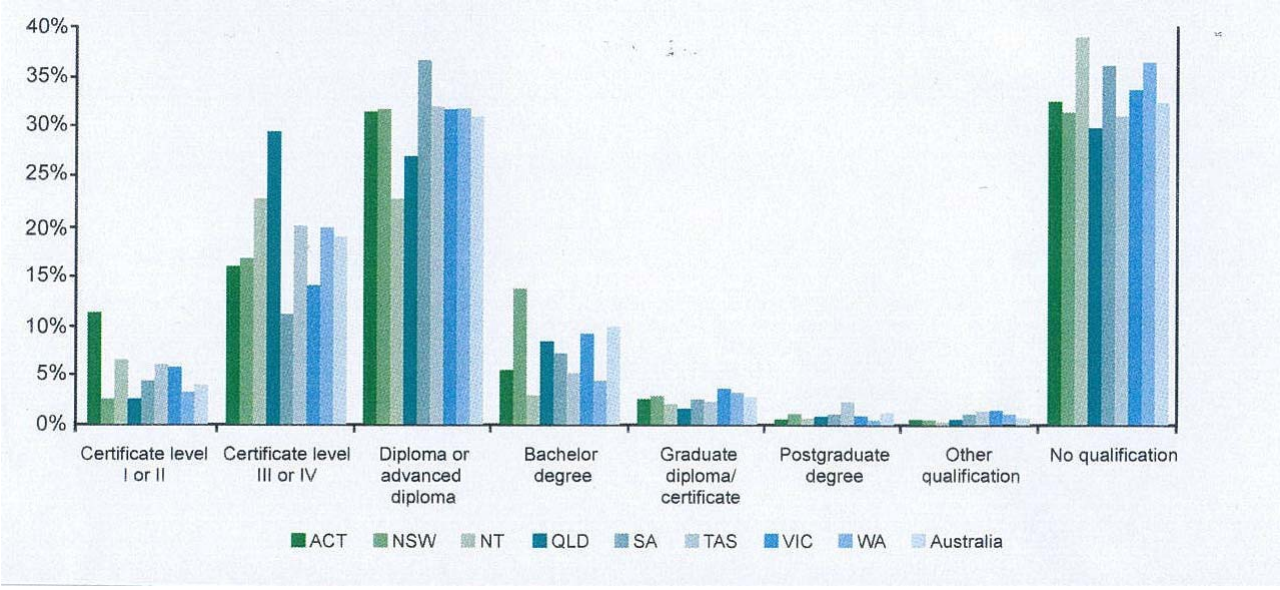
In Western Australia, as the figure below demonstrates, approximately 35% of childcare staff working in licensed service providers currently have no qualifications.

403 Starting Strong II: Early Childhood Education and Care, Organisation for Economic Cooperation and Development, 2006, p134.

404 Pam Cahir CEO, Early Childhood Australia, Briefing 24 February.

405 Report of the Expert Advisory Panel on Quality Early Childhood Education and Care, 'Towards a national quality framework for early childhood education and care', 2009. Available at: http://www.deewr.gov.au/EarlyChildhood/Policy_Agenda/Quality/Documents/Expert%20Advisory%20Panel%20Report.pdf. Accessed on 9 July 2009.

Figure 9.1 Qualifications of childcare staff by jurisdiction [406]



Research shows that;

- high quality care enhances achievement;
- the effects are strongest for children from lower socio economic backgrounds, and for children whose parents have had little education; and
- positive benefits continue into late primary and high school.[407]

A child's learning is a continuum from birth. Many in the field of early childhood development emphasise the need to design services accordingly:

> *There exists therefore a substantial gap between what is clear from the research about early childhood and current education policy, the way services are organised, and practice. In particular experts highlight as especially problematic the totally artificial and illogical distinction that continues to be made between child care and education. There needs to be a clear recognition that learning begins at birth, and a concerted effort made to ensure that early learning environments, wherever they happen to be...are as good as we can make them.*[408]

If children are not simply a commodity in the nations productivity or corporate agenda the issue of quality in care supporting a child's development is paramount.

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406 Report of the Expert Advisory Panel on Quality Early Childhood Education and Care, 'Towards a national quality framework for early childhood education and care', 2009. Available at: http://www.deewr.gov.au/EarlyChildhood/Policy_Agenda/Quality/Documents/Expert%20Advisory%20Panel%20Report.pdf. Accessed on 9 July 2009.

407 OECD, 'Starting Strong II', 2006. Available at: http://www.oecd.org/dataoecd/16/48/37423214.pdf. Accessed on 17 March 2009.

408 Reinventing Education, Professor Frank Oberklaid, p2.

The issue of quality is therefore seen central to the successful development of a child in care.

> *A recent media release by the Minister for Education referred to early intervention to improve literacy and numeracy levels and focused on the assessment of Year One students and related resources. The intent of this project is to identify students requiring remedial intervention. If quality early childhood programs were in place for 0 – 3 year old children and their families this remediation would not be necessary.*[409]

A lack of quality in child care is generally seen as particularly damaging to those children at risk or from disadvantaged backgrounds where there may be few compensatory features.

> *Poor quality child care affects all children, but it has an especially negative effect on children from vulnerable families and areas. This includes families from low economic backgrounds or remote communities, Indigenous families or families from culturally and linguistically diverse backgrounds.*[410]

In his paper, *Reinventing Education*, Prof Frank Oberklaid calls for a paradigm shift in our thinking about education. He states that our new understanding of brain development demands a new template about what is needed. One component of that new template is:

> *High quality early learning and care experiences for children - a focus on quality means 'best practice' child/carer ratios and appropriate group sizes; a well trained and highly skilled and appropriately remunerated workforce; an abolition of the false distinction between childcare and preschool.*[411]

The goal of a well trained and highly skilled and appropriately remunerated workforce is well supported throughout the early childhood sector.

> *The quality and qualifications of child carers influences the quality of care. ECA [Early Childhood Australia] is working to develop advanced teaching standards in early childhood, but is looking for resources to assist them do that. There is strong research that the best quality services are those services led by individuals with solid qualifications. In France this requires a Masters in Education. As a community we need to move from the idea that child care is merely child minding. There needs to be a clear career structure in the industry with a qualified person to provide pedagogical support. Currently the sector sees a staff churn rate of 40% p.a. attributable to very low wage rates (c$17/$18 p.h.) and a lack of a career path.*[412]

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409 Submission No. 1b from Early Childhood Australia, p3.

410 Submission No. 1b from Early Childhood Australia, p5.

411 Reinventing Education, Professor Frank Oberklaid, p3.

412 Pam Cahir CEO, Early Childhood Australia, Briefing 24 February.

The CEO of Early Childhood Australia went on to question the parity between what TAFE certificates mean 'when in dollar terms, a certificate III in a trade equates to $27 per hour however certificate III in child care equates to $17.95 per hour.'[413]

> *Quality carers should be paid according to the standard of their qualifications. This would provide better continuity of care. We need to change the language of "child care" to that of "child education".* [414]

This was supported by Professor Margaret Simms.

> *ALL services working with young children and their families should be appropriately resourced so they can deliver the best possible services to prevent accumulation of long term risk. That means examining pay and conditions in those support services currently existing. For example child care workers are currently paid less than those who collect our garbage.* [415]

To achieve this improvement in qualifications it was argued that the standards of those providing the training also needed to be looked at again.

> *We currently do not have QA processes for training agencies so it is not unusual to find a Cert.3 person teaching a Cert.3. Additionally the competencies are totally inadequate.* [416]

The issue of quality was also raised by Professor Mustard in his report for the South Australian Government where he said 'some of the for-profit day-care programs are not quality early child development programs. Some may be damaging early child development and should be closed.'[417] A submission by staff of the Early Childhood Studies Program at Edith Cowan University points to differences in quality here in Western Australia when they say:

> *It is widely recognise that quality care and delivery of services for children in 0-3 in child care centres varies significantly from centre to centre and this places additional stress on families and children.* [418]

Being in group child care can contribute to considerable amount of stress experienced by children. However, research by Gunnar and colleagues (2001) demonstrates that high quality centres for infants and toddlers contribute to the reduction of stress levels. Therefore, there is a need to identify centres of low quality, where children are emotionally distressed due to the lack of

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413 Pam Cahir CEO, Early Childhood Australia, Briefing 24 February.

414 Pam Cahir CEO, Early Childhood Australia, Briefing 24 February.

415 Submission No. 7 from Professor Margaret Simms, p2.

416 Pam Cahir CEO, Early Childhood Australia, Briefing 24 February.

417 Early Childhood Development: the best start for all South Australians, J. Fraser Mustard, Govt of South Australia, p.39.

418 Submission No. 35 from Staff of Early Childhood Studies Program, School of Education, Edith Cowan University, Mount Lawley Campus p1.

positive interactions and programs which are not stimulating and play-based. It is of prime importance to put in place strategies to prevent such centres from operating to reduce the risk of children's negative developmental outcomes.[419]

In 2008 the Western Australian State Government released a Report on children's services and regulations. This report was the product of the Child Care Regulations Consultative Committee (CCRCC) which was established in late 2006 to review the regulations for child care under the *Children and Community Services Act 2004* and to recommend improvements[420].

The report found that, with some expressed reservations, there is widespread support both within government and externally in the community sector. This support was predicated on the belief that "minimum qualifications in child care, will lead to the improvement of the status of the industry and the development of higher standards of care for children."[421]

The CCRCC considered the

- most practical ways regulations affecting minimum qualifications could be introduced;
- the range of prescribed qualifications outlined in the current child care regulations; and
- took into account submissions proposing the current child care regulations be broadened to include qualifications.

The CCRCC recommended that

> *a minimum qualification should be required for child contact staff in all service types (except for OSHC), with this being set at Certificate III in Children's Services or equivalent and that this is phased in over a period of five years, and with an exemption for current workers aged 45 and over at the time of introduction of the requirement.*[422]

The issue of quality in child care has been on the COAG agenda since 2007 when .COAG agreed to a partnership between the Commonwealth and State and Territory governments to pursue substantial reform in the areas of education, skills and early childhood development These reforms envisage a new national quality agenda for early childhood education and child care, comprising:

- strong national quality standards for early childhood education and care;
- a quality rating system to drive continuous improvement and provide parents with robust and relevant information about the quality of learning and care;

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419 Submission No. 14b from Ngala, p9.

420 Department for Communities, 'Report on the Children's Services Regulations Review', 2008. Available at: http://www.community.wa.gov.au/NR/rdonlyres/321499C4-B80D-4A84-840C-FBF0C061D474/0/CCRCCreport.pdf. Accessed on 26 may 2009.

421 ibid

422 ibid

- streamlining or integrating licensing and accreditation arrangements; and
- a national Early Years Learning Framework.

The process has been fairly drawn out - is still ongoing and is as follows:

- A discussion paper was released on 2 August 2008
- The first wave of public consultations took place during August and September 2008
- A public invitation was also issued to provide written submissions on the issues raised in the discussion paper. Around 400 submissions were received.
- At its meeting on the 2 July 2009 COAG agreed to seek further public comment.[423]

While acknowledging the COAG initiative, the Committee believes that Western Australia should take action in the interim, by making an early commitment to these initiatives nationally and implementing standards locally.

Finding 26

Increasing numbers of West Australian children are spending time in child care. The care and qualifications of child carers influences the child development outcomes and therefore school readiness. In relation to quality, there is a widespread concern by those connected with the child care sector that over the past two decades the focus has been on parents as consumers, and children as a corporate commodity. This has resulted in a weak child development agenda. This has been reflected in the minimal requirement for qualifications and generally poor remuneration in the industry.

[423] Department of Education, Employment and Workplace Relations, 'National Quality Agenda for Early Childhood Education & Care', 2009. Available at: http://www.deewr.gov.au/EarlyChildhood/Policy_Agenda/Quality/Pages/home.aspx. Accessed on 10 July 2009.

Recommendation 23

The Committee recommends that a minimum qualification should be required for child contact staff in Long Day Care, with this qualification being set at Certificate III in Children's Services or equivalent. The requirement for this qualification should be phased in over a period of five years, with an exemption for current workers aged 40 and over at the time of introduction of the requirement.

Consideration should also be given to establishing appropriate qualifications in early childhood development for principals of child care centres.

This recommendation supports, in principle, Recommendation 3 of the Western Australian Report on the Children's Services Regulations Review, 2008.

(iii) Patchwork Child Care

The level of children entering the school system with behaviour or learning problems, as outlined previously, is a strong indicator of past failure and a predictor of continued school difficulty. Another of the contributing factors, it has been suggested, is that:

> *Children, who are as young as 3 years 7 months, are subjected to a myriad of arrangements including:*
>
> - *some attend child care and kindergarten and are transported to and from kindergarten on school sites either by the child care service, parents, grandparents, neighbours or other arrangements; and*
> - *some attend only child care and do not attend a school based kindergarten. As there are no common standards across child care and kindergarten, and in some low quality child care services there is lack of appropriately trained staff to provide developmentally appropriate play based curriculum and ensure positive interactions, children who attend such services could potentially be disadvantaged on commencement of pre-primary.*[424]

This statement is supported by NSW research which identified the range of multiple arrangements was from one to eight different forms of care in a week including a finding that 75% of two year olds and 64% of one year olds used more than two types of care in a week.

> *For many families in NSW the relationship of work and family life and child care arrangements has become increasingly complex and many families are being forced to*

424 Submission No. 1 from by Early Childhood Australia (Western Australian Branch) Inc, February 2009, p5.

> *create a patchwork of child care arrangements to accommodate the demands of their work and family responsibilities.* [425]

The South Australian report, The Virtual Village: Raising a Child in a New Millennium concluded that:

> *The delivery of services to young children in many different locations prohibits access to the full range of services that a family may wish to use, with some resorting to extraordinary measures such as transporting children during their lunch break to access services. This is particularly the case for families needing to access preschool and childcare services.*[426]

Finding 27

A contributing factor in the lack of school readiness of some children is the need for families to create a patchwork of unrelated child care arrangements for individual children, with up to eight different arrangements in a week. This acts as barrier to access and disadvantages some of those children affected by the need for such arrangements.

(d) Kindergarten/Pre-school - part of the jigsaw of school readiness

Preschool is a planned education and developmental program for children in the year before they begin school where children are taught by a degree qualified early childhood teacher. Preschool aligns early childhood education with the aims, requirements and practices of primary school.[427]

Research supports the idea that one of the most effective ways in assisting the transition to school is prior participation in a quality preschool program. That is, access to good early childhood programs with appropriate curricula and pedagogy can provide children with social and cognitive experiences that promote independence and positive attitudes to learning. Such quality programs facilitate the transition to school and underpin later academic success.[428]

Most children in Australia have access to early education prior to the year of compulsory schooling. As the tables below indicate, the names of the programs vary from state to state as do the entry ages:

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425 Office of Childcare, 'Accommodating child care and work', 2004. Available at: http://www.workandfamily.nsw.gov.au/strategy/expsem/jw.html. Accessed on 24 April 2009.

426 Department of Education and Children's Services, The Virtual Village: Raising a Child in a New Millenium, report, DECS Publishing, South Australia, 2005, p161.

427 www.deewr.gov.au/EarlyChildhood/OfficeOfEarlyChildhood/Documents/UniversalAccesstoEarlyChildhoodEducation_RFT.rtf, accessed 22 April 2009.

428 School Readiness, Australian Research Alliance for Children and Youth, Farrer, et al, p11.

Figure 9.2 Hours of attendance prior to compulsory schooling

State/Territory	Name of program	Hours attended	Provider
Western Australia	Kindergarten	11 hrs a week	Department of Education and Training
New South Wales	Pre-school	12 hrs 30 mins a week	Dept of Education and Training; Dept. of Community Services
Victoria	Pre-school	10 hrs a week	Dept of Education, Employment and Training
Queensland	Kindergarten	Up to 12 hrs 30 mins a week	Education Queensland; Community Kindergarten sector
South Australia	Kindergarten	11 hrs a week	Dept of Education, Training and Employment
Tasmania	Kindergarten	10 hrs a week	Dept of Education
ACT	Pre-school	10 hrs 30 mins a week	Dept of Education and Training, Children's Services Branch
Northern Territory	Pre-school	12 hrs a week	Department of Employment, Education and Training

Figure 9.2 Programs one year prior to entry into Year 1 in Australian States and Territories[429]

State/Territory	Name of program	Days attended	Provider
Western Australia	Pre-primary	5	Department of Education and Training
New South Wales	Kindergarten	5	Department of Education and Training
Victoria	Preparatory	5	Dept of Education, Employment and Training
Queensland	Preschool	5 half days	Education Queensland
South Australia	Reception	5	Dept of Education, Training and Employment
Tasmania	Preparatory (compulsory)	5	Dept of Education
ACT	Kindergarten	5	Dept of Education and Training
Northern Territory	Transition	5	Department of Employment, Education and Training

The effect of quality and specific 'practices' in pre-school, in the opinion of the Director of the Australian Institute of Family Studies is:

- High quality pre-schooling is related to better intellectual and social/behavioural development for children.
- Settings that have staff with higher qualifications have higher quality scores and their children make more progress.

[429] http://www.det.wa.edu.au/education/ece/enrolments.html. Accessed 26 March 2009.

- Quality indicators include warm interactive relationships with children, having a trained teacher as manager and a good proportion of trained teachers on the staff.

- Where settings view educational and social development as complementary and equal in importance, children make better all round progress.

- Effective pedagogy includes interaction traditionally associated with the term 'teaching', the provision of instructive learning environments and 'sustained shared thinking' to extend children's learning.[430]

As highlighted in the Figure above, Western Australia schools have one year of (non-compulsory) kindergarten, followed by a (non compulsory) pre-primary year. Although attendance at kindergarten and pre-primary is not compulsory, more that 90% of children in Western Australia attend kindergarten and 95% of children attend a pre-primary program. This reflects the strong support for guaranteed universal access for such preparatory schooling.

> *Western Australia currently leads Australia by guaranteeing universal access to 11 hours of kindergarten for a full year prior to children commencing full-time schooling in their pre-primary year. Through the Universal Access element of the COAG Early Childhood Education National Partnership, this will increase to 15 hours per week of kindergarten, 40 weeks per year by 2013. An important extension to kindergarten provision made possible through funds provided under the Universal Access initiative is that the current guarantee of a kindergarten and pre-primary place at a public school will be extended to guarantee a kindergarten and pre-primary place at the child's local public school. At present, the guarantee of local access applies only to the compulsory years of schooling which start at Year 1. This change will significantly enhance the continuity of provision that the Department of Education and Training is able to offer because some children currently have to attend a different (non-local) school for kindergarten and/or pre-primary when places at their local school are not available.*[431]
>
> *The Department is also exploring opportunities to offer more integrated education and care on school sites. This may be through expanded provision of Outside School Hours Care (OSHC) services in a larger number of communities with identified needs and unmet demand. While children attending OSHC must necessarily be enrolled in a school, this service would apply to children enrolled in kindergarten and pre-primary and would assist many working families by offering quality assured child-care for their children either side of the school day. Another form of more integrated education and care services may take the form of Early Learning and Care Centres (ELCC) which will be located on school sites. These Centres will offer Long Day Care for children from birth to the age of five, and will be jointly funded by the Australian government and industry partners. Negotiations have commenced in relation to the establishment of an ELCC in Karratha, Port Hedland, Mirrabooka and Darch.*[432]

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430 Professor Alan Hayes, Briefing 25 February 2009.

431 Submission No. 5 from Department of Education and Training, p1.

432 Submission No. 5 from Department of Education and Training, p1.

Evidence suggests strongly that children who have not had the opportunity to attend a preschool program may be disadvantaged when they begin school. Children without a preschool experience have greater levels of difficulty in making the transition to the first year of school, take longer to settle into the routines of a classroom and find it harder to respond appropriately to tasks and expectations.[433]

The difference in children who attend school without having prior experience in other early learning centres shows itself in a number of ways. Kindergarten teachers in NSW (equivalent to the pre-primary level here in WA), when interviewed, commented that kindergarten children start school with 'the language of school' distinguishing them from their non-attending peers. This manifested itself in numerous ways, including social and emotional competence and fostering independent life skills.[434]

Finding 28

Developmentally vulnerable children benefit from a quality three year old kindergarten program and/or pre-primary school.

Recommendation 24

The Committee recommends that, in vulnerable target populations, as identified through AEDI results, kindergarten eligibility be extended to three year olds.

Recommendation 25

The Committee recommends that serious consideration be given to making the pre-primary school year compulsory.

433 National Preschool Education Inquiry Report, Kathy Walker, http://www.aeufederal.org.au/Ec/ecfullreport.pdf, accessed 3 April 2008, p18.

434 Partnerships in learning: linking early childhood services, families and schools for optimal development, Australian Journal of Early Childhood, 33.2 (June 2008), p4.

(e) Indigenous and CaLD children in transition

Family characteristics such as ethnicity and language spoken at home have been found to be related negatively to children's school readiness. The Australian Institute of Family Studies publication *Home-to-school transitions for financially disadvantaged children* reports that, 'numerous North American Studies have found that ethnicity is related to school readiness, with African-American and Hispanic-American children having poorer cognitive, behavioural and socio-emotional development compared to children of other backgrounds'.[435] Some studies have shown, however, that the impact of ethnicity was substantially reduced after accounting for socio-economic status (SES). This suggests that income maybe responsible for a large part of the developmental differences between children from different ethnic backgrounds.[436] However, this finding is contrary to the Australian research data collected from the first wave of the Longitudinal Study of Australian Children. This indicated that Aboriginal and Torres Strait Islander children had poorer overall development at 4-5 years of age compared to children of other backgrounds even after controlling for a range of family characteristics including SES indicators.[437]

The Commonwealth Government itself has found that the absence of equitable access means that Indigenous children are less school ready and start formal education at a disadvantage. Indeed one of the recommendations of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) is to:

> *Provide Indigenous children aged 0-5 with universal access to high quality early childhood education services to improve 'school readiness' and successful participation in primary school education.*[438]

MCEETYA has found that while there has been a significant rise in the Indigenous proportion of preschool enrolments in recent years, it is estimated that approximately half of those eligible to not enrol.[439]

Data from the 2006 Census of Population and Housing[440] shows that of the 22,388 Indigenous children aged three and four identified in the Census, only 11,365 (or 49.2%) were enrolled in preschool education.

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435 Home-to-school transitions for financially disadvantaged children, Final Report: The Smith Family, Australian Institute of Family Studies, November 2008, p6.

436 SES - a composite measure that usually combines parental education, occupational status and/or income.

437 Home-to-school transitions for financially disadvantaged children, Final Report: The Smith Family, Australian Institute of Family Studies, November 2008, p6.

438 Australian Directions in Indigenous Education 2005–2008, MCEETYA p 5.

439 Australian Directions in Indigenous Education 2005–2008 MCEETYA p 18.

440 2006 Census of Population and Housing ABS.

Table 9.1

Preschool enrolments and estimated participated rate, 2006[441]

	3 year olds	4 year olds	Total 3 & 4 year old Indigenous population	Preschool enrolments	Estimated participation rate %
NSW	3323	3425	6748	3994	59.2
VIC	705	741	1446	761	52.6
QLD	3260	3291	6551	330	50.4
WA	1389	1441	2830	1387	49.0
SA	631	615	1246	638	51.2
TAS	350	375	725	236	32.6
ACT	95	84	179	108	60.3
NT	1313	1338	2651	946	35.6
AUST	11073	11315	22388	11365	50.8

The reasons for low participation rates by Indigenous children are multi-faceted. The Australian Education Union state two barriers to access as being:

- Indigenous children in Australia do not have equity of access to quality preschool education; and

- problems in a lack of inclusiveness, structures, staffing, appropriate resources and information.[442]

An additional factor is that children from Indigenous families may not be involved with locally available universal services because they were not perceived to be culturally welcoming, they are even less likely to participate in separate specialist programs where they may be the only family from their community.[443] The need for culturally specific programs was made in a submission from the Roebourne Strong Women's Group where they say:

> *Programs like Triple P might be good for white middle class parents. But they don't quite fit for us….There should be more programs designed for Aboriginal people, not just using white programs.*[444]

Recognising such issues, there are a number of culturally specific programs operating to assist Indigenous families in preparing their children for school. 'Best Start' and 'Aboriginal Early Years' for example. The Department of Communities has provided a description of their activities:

- 'Best Start' a program that a program designed to assist Aboriginal children aged between 0 - 5 years. Co-ordinators and activity leaders are employed to create a family friendly,

441 AEU Briefing Paper: Universal Preschool Education for Aboriginal and Torres Strait Islander Children, October 2007, p7.

442 AEU Briefing Paper: Universal Preschool Education for Aboriginal and Torres Strait Islander Children, October 2007, p1.

443 Submission No. 23 from Early Childhood Australia (WA Chapter), p5.

444 Submission No. 21 from Roebourne Strong Women's Group, p7.

Aboriginal specific service in a suitable venue. Improving school readiness through play based activities is a key objective, but this starts from birth and transitions through to school enrolment. Several factors differentiate this program from other "supported playgroup" models. Parents and carers must attend with their child, and are an integral part of all activities.

- Six non-government agencies are funded (for a total of approx $590,000) to focus on Aboriginal families with children 0-3 years old. This voluntary service promotes parenting knowledge, skills and positive behaviour during a child's first three years of life…The program builds on the cultural strengths within families providing short to medium term support and linking families to social support networks and community resources.[445]

The Department of Education and Training also provides culturally inclusive kindergarten programs for Aboriginal children from the age of three "at 28 metropolitan and regional Aboriginal Kindergartens and at all Remote Community Schools in the Kimberley, Pilbara, Midwest and Goldfields."[446]

In our multi-cultured Western Australian society, with its high levels of immigration, there are significant numbers of families from culturally and linguistically diverse (CaLD) backgrounds, whose children are also seen as developmentally vulnerable.

Their progression into a formal learning environment is challenging for educators, families and the children themselves. There are limited services available for older children of that background and there are no ethno-specific services available for the pre-natal to 3 years age group.[447]

In their submission, the Ethnic Communities Council of Western Australia raised a range of issues impacting upon children within diverse ethnic communities:

- children with emerging developmental delay or disability miss out on services due to delays in entering the formal childcare system. This is further exacerbated by the delay in CaLD children attending formal schooling;

- lack of follow-up tied to a 'wait and see' approach if the delay or dysfunction is due to unfamiliarity with the childcare system. This is further complicated by long waiting lists once a problem has been determined;

- lack of knowledge by CaLD families about playgroups and their relative importance in child development and parental support;

Their submission goes on to say that:

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445 Submission No. 3 from Department for Communities, p4-5.

446 Submission No. 5 from Department of Education and Training, p2.

447 Submission No. 16 from Ethnic Communities Council of Western Australia, p1.

> *It is clear that children from CaLD are more likely to have their developmental needs addressed if they are linked into formal child care, and if their parents gain access to enriching ideas and activities for their children…*
>
> *It follows that families without any links to this sector may find very little explicit support with regard to the needs or development of their very young children. This is especially the case with families who rarely access services, are linguistically, socially or geographically isolated and come from societies where such services do no exist.*

The Bachelor of Social Science (Children and Family Studies) team at Edith Cowan University argue that, to ensure the best developmental opportunities for children from CaLD backgrounds, high quality childcare inclusion support is necessary to develop strong links between home and childcare and to support CaLD children's language needs.[448] Inclusion support works at ameliorating those difficulties that may arise when children come into care from different cultural backgrounds than those of the caregiver. Difficulties may arise due to possible language difficulties and incongruence in values and practices between home and care environments.[449]

In terms of providing access to appropriate childcare programs, the federally funded 'Inclusion and Professional Support Program (IPSP) has identified children from CaLD backgrounds as one of the target groups for inclusion support. Under the Inclusion Support Program (ISP), a number of Inclusion Support Agencies operate on a regional basis to coordinate assistance provided by networks of Inclusion Support Facilitators (ISFs) to work at a local level with childcare services. The role of the ISFs is to assist childcare services to build their skill base and capacity to include children with additional needs.[450]

The abovementioned submission from Edith Cowan University agues that, while the funding of the IPSP indicates a level of governmental support for inclusion support, there is a vast degree of anecdotal evidence indicating concerns in the WA field that such support may not be meeting the needs of CALD families.[451] One submission supporting the University's view states:

> *The concept in developmental services is to provide both universal and targeted programs. There is room for improvement in both areas, but at the moment, there is a severe deficit in resources for targeted programs. The most significantly underserved 0~3 year olds are:*
>
> - *Indigenous children*
> - *CALD (Culturally and Linguistically diverse) children.*[452]

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448 Submission No. 18 from Bachelor of Social Science (Children and Family Studies) team, Edith Cowan University p3.

449 Submission No. 18 from Bachelor of Social Science (Children and Family Studies) team, Edith Cowan University p3.

450 Submission No. 18 Bachelor of Social Science (Children and Family Studies) team, Edith Cowan University p3-4.

451 Submission No. 18 from Bachelor of Social Science (Children and Family Studies) team, Edith Cowan University p4.

452 Submission No. 30 from Dr John Wray, p3.

Finding 29

While there is recognition of the needs of children from culturally and linguistically diverse families, services supporting the development of these children are limited. The lack of appropriate services is exacerbated by difficulties that may arise due to language difficulties and incongruence in values and practices between home and care environments.

9.2 The 'why' of integration of health, care and education

At an international as well as a national level there is a broad based agreement on the benefits of an integrated approach to early childhood development. In February 2006 the Council of Australian Governments (COAG) stated:

> *High quality and integrated early childhood education and care services, encompassing the period from prenatal up to and including the transition to the first years of school, are critical to increasing the proportion of children entering school with basic skills for life and learning.*[453]

Even before the issue of integration became one that received endorsement at a national level, South Australia had published a report which called for the better integration of early childhood services.

> *There was an inquiry into early childhood services in South Australia undertaken in 2004. This resulted in report "The Virtual Village: Raising a Child in the New Millennium" One of its recommendations in the report called for the development of integrated child and family centres as a priority.*[454]

The reasons for this growing recognition have been highlighted earlier in this report in looking at the need for collaborative approaches to child development, but also include:

(a) The problem of fragmentation

The current reality is that children's services remain inconsistent, un-coordinated and fragmented, involving different systems in each of the states and territories with significant variations in government responsibility. This inconsistency is demonstrated in the approach to child care and preschool/kindergarten services and conveys to both staff and parents that service provision differs depending on the sign on the door.

> *Separating care and education in the early years fails to acknowledge the interwoven nature of early learning and development. We must recognise that it is a false paradigm to*

453 Submission No. 1 from Early Childhood Australia (Western Australian Branch), p3.

454 Hon Jay Weatherill, Briefing 23 February 2009.

> *separate child care from kindergarten. The child's brain is a learning machine. Child care should not be separate from kindergarten and pre-school.*[455]

The Australian Institute of Family Studies held a similar view stating that:

> *There are significant differences between individual pre-school settings and their impact on children; some settings are more effective than others in promoting positive child outcomes. Good quality can be found across all types of early years settings; however quality was higher overall in settings integrating care and education and in nursery schools.*[456]

Such fragmentation is exacerbated by the lack of a common framework for early childhood development and poor communication between stakeholders, reducing the effectiveness of services.

> *Communication between agencies and professionals in relation to early childhood is severely hampered by the lack of a common framework and a language that can be understood by professionals, parents and caregivers. Initiatives driven through individual Departments are inevitably based on the language and professional background of those Departments and are all but incomprehensible to outsiders let alone parents. The absence of a common language complicates referral and reduces the effectiveness of early identification and assessment of issues. At present there is significant disconnect between health, education, early childhood workers and parents/caregivers as agencies and individuals pursue goals in isolation. For example schools and child care centres have no agreed communication despite child care settings often having intimate knowledge of children and families. There are of course individual exceptions but there is no systemic requirement or encouragement of this type of information sharing.*[457]

In Western Australia, as in a number of other jurisdictions, there is still perceived to be a lack of practical action that will support integration, even though the existing fragmentation of service delivery is acknowledged and there is an acknowledged need for better integration.[458] Individual agencies respond to the recognised need with individualised approaches:

> *While the provision of services and/or programs for children prior to kindergarten is outside the School Education Act 1999, the Department of Education and Training recognises the value of building strong relationships with young children and their families long before children are eligible to enrol in kindergarten. Accordingly, many public schools offer programs for younger children accompanied by their parents. Such programs are focussed on (in collaboration with health professionals) the early identification of language delay and/or growth and developmental difficulties, parent education sessions, playgroups, and sessions for parents to support transitions and readiness for school.*[459]

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455 Professor Frank Oberklaid, Briefing 25 February 2009.

456 Professor Alan Hayes Director, Australian Institute of Family Studies (AIFS), Briefing 25 February.

457 Submission No. 28 from Playgroup WA Inc, p10.

458 Submission No. 1 from Early Childhood Australia (WA Branch), p3.

459 Submission No. 5 from Department of Education and Training, p1.

Integration is seen as way of overcoming the barriers to access that result from fragmentation:

> *Integrated service delivery centres be they called Children's Centres, one stop shops or Child and Family Centres bring the opportunity to break down such barriers and allow parents and children to more easily access a range of services.*[460]

Integration is also seen as a more effective deployment of scarce resources:

> *An integrated approach with a single governance model will streamline resources and processes for identification of needs and provision of services.*[461]

(b) The problem with silos

The existence of departmental silos is believed to create a segmented view of children and their families which not only leads to less efficient service delivery but also poorer resource allocation.

> *Families and services providers alike are well aware of and regret the silo nature of service provision and there have been frequent calls for better integration of services. There are examples of good government developments which have brought together the relevant services such as maternal and child health, education, care, community services and specialist early intervention.*[462]

And:

> *Centralising services for children and families into Hubs is possibly the most effective way of assisting families to access the support they need in every area – care, education, health, early intervention, welfare and counselling – with minimal barriers. Of greatest importance is the need to avoid 'silos', whereby a child's life is viewed in parts rather than as a whole.*[463]

And again:

> *Current policy, service provision and resource allocation is made by individual Departments within the context of Departmental pressures. It has lead to WA being significantly behind other jurisdictions both in terms of investment and coordination.*[464]

(c) Sector support for integration

The recognised benefits of an integrated service acting as a service hub for the community by bringing together a range of services in the health, care and education arena, usually under one

460 Submission No. 28 from Playgroup WA Inc, p10.

461 Submission No. 35 from Early Childhood Studies Program, School of Education, Edith Cowan University, Mount Lawley Campus, p4.

462 Submission No. 23 from Early Childhood Intervention Australia, p8.

463 Submission No. 33 from CHILD Australia, p14.

464 Submission No. 28 from Playgroup WA Inc, p8.

roof, working in a multi-agency way to deliver integrated support to children and families has widespread support in Western Australia.

Such support is exampled by the Commissioner for Children and Young People (WA)'s comments:

> *Another element for the best outcomes for Western Australia's children is the use of integrated childcare centres; centres that provide a 'one-stop shop' by bringing together a mix of services for children and their families. Qualified early childhood staff and health professionals work together with families to provide quality learning and care to support children's development, health and well-being…… The integrated childcare model exists in a number of places in Western Australia but is not supported by an overarching government policy or plan. As such, the integrated centres that do exist tend to only because of the dedication and commitment of particular individuals. For example, Challis Parenting and Early Learning Centre has, against the odds and with considerable cost, managed to bring together various departments on one site to form an integrated centre where parents and children receive a range of advice and supports. It is accomplishing marked results, thanks to the Principal who is firmly committed to the Centre's success. Unfortunately, as I have learnt in my regional and remote travels, programs such as this are the exception rather than the rule, despite being widely recognised as a most effective way of providing childcare.* [465]

Many other submissions spoke strongly to the need for an integration of service delivery, for example Wanslea Family Services[466] and Playgroup WA Inc[467] to name but two. Some submissions expanded on the concept as follows:

> *CHILD Australia advocates for an integrated delivery of services through a coordinated and centralised program. Such "hubs" or children's centres would provide a suite of family and children's services at a local community level. Ideally, the centres would operate in a venue that is welcoming, non-threatening and convenient to access, such as primary school or community centre. Co-location with a library, cafe, recreation facilities or shops is likely to make it a place where anyone can "drop in" without being labelled as "someone in need of help."* [468]

And again:

> *We strongly urge an integrated approach to service delivery for children 0-8 years in this state. The fragmented governance in Western Australia exacerbates the dichotomy between education and care. With the Minister for Education acquiring the Office of Early Childhood Development it seems an opportune time to amalgamate the various services and provisions of early childhood from the Departments for Communities, Health, and*

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465 Submission No. 15 from Commissioner for Children and Young People WA, p17.

466 Submission No. 32 from Wanslea Family Services, p5.

467 Submission No. 28 from Playgroup WA Inc, p2.

468 Submission No. 33 from CHILD Australia, p14.

> *Education into this portfolio. Changes to governance and services in this area should be done with the BEST interests of children in mind.*[469]

And:

> *No single individual, discipline or government department can meet the diverse and complex needs of children and families. A comprehensive, integrated service system response involving all relevant government and non-government agencies is essential to meet the needs of all families effectively.*[470]

Finding 30

There is widespread support in the government and non-government sectors for the development of an integrated range of services in the health, care, and education arena, usually co-located, working in a multi-agency way for the development of young children aged 0-8.

(d) Transition and integration

As outlined previously, patchwork child makes it difficult for the child to make relationships with staff and the other children.[471] This can lead to subsequent difficulties with transition between the phases of care/kindergarten/pre-primary and school.

Starting Strong II: Early Childhood Education and Care highlights the importance of transitions between child care and school based early childhood education programs. The smooth transition is enhanced by implementing strategies to ensure children moving from child care or informal kindergarten programs to school based early childhood education programs are not disadvantaged. The most effective way of doing this is to have a common set of outcomes to be achieved in all early childhood and care environments. In this context, the concept of a 'curriculum' framework for early childhood would be cognizant of the long hours some children spend in child care environments and the related nurturing and care elements of the program.[472]

The transition between child care and school based early childhood education programs is often problematic for working parents. The Department of Health Child Care Program makes mention of the "dreaded double drop-off" which involves parents having to transport children between child care and schools. The situation becomes even more problematic when children are involved in kindergarten activities as well as long day care, as the kindergarten program is only part time.

469 Submission No. 35 from Early Childhood Studies Program, School of Education, Edith Cowan University, Mount Lawley Campus, p3.

470 Submission No. 8 from Department of Health, p6.

471 Starting Strong II: Early Childhood Education and Care, Organisation for Economic Cooperation and Development, 2006, p64.

472 Submission No. 1 from Early Childhood Australia (Western Australian Branch), p6.

Children are then juggled back and forth between day care and kindergarten or outside school hours care.[473] [474]

Schools and early years service systems are not well integrated, contributing to the difficulty in providing cohesive support during the transition to school phase: This puts all children at risk and is particularly problematic for children from disadvantaged backgrounds.[475]

Research conducted at the Mungullah Aboriginal community in Carnarvon in Western Australia found that:

> *Actively integrating pre-school (0-3 years) learning into the school experience is essential to the successful transition of children from their first learning experience to their next. Particularly in high risk families, parents often have their own histories of difficult engagement with school and so a process of re-engagement is essential from the earliest opportunities so that their fears for their own children's experience at school do not present an unsurmountable obstacle at the age when schooling becomes compulsory.* [476]

Finding 31

Schools provide a low threat environment for families requiring support in meeting the developmental needs their children

Further, actively integrating pre-school (0-3 years) learning into the school experience is enhanced by the successful transition of children from their first learning experience to their next. Therefore schools are an ideal environment for the delivery of parent support for the 0-3 year old cohort.

(e) Additional reasons for integration

An additional reason for the development of more integrated approach to health, care and education in early childhood included issues with transport. This issue was highlighted to the Committee in several submissions and confirmed by South Australian research:

> *Transport services for families with young children were identified as a major barrier across the State. Few services provide transport for their client group and if families do not have access to their own vehicle, they must rely on public transport. This is a particular issue for Aboriginal families. Catching two buses to reach an appointment with two or more children under eight years of age is a difficult task, especially in the rain or*

473 Child Care Program: work, life, balance, Department of Health Child Care Program, November 2005, p12.

474 Submission No. 1 from Early Childhood Australia (Western Australian Branch), p4.

475 Rethinking the transition to school: Linking schools and early years services', Policy Brief, vol. 11, 2008, p1.

476 Submission No. 17 from Drs. Corinne Reid & Libby Lee, p3.

> *heat. Transferring children between different childcare, preschool, school and after school care services is also problematic for many families.*[477]

The benefits of integration were seen to be manifold for both staff and parents:

> *Other advantages of integrated services include improved access for consumers; more efficient use of resources; more knowledge amongst providers of services available to families; streamlining of service delivery through information and skill sharing; less time and effort for families in moving between programs and less chance of them dropping out of the system. Also of importance and value to staff, is the sharing of skills, knowledge and philosophy which develop from integrated service delivery. There is an adoption of common models and language as underlying principles are translated into policy and services. This contributes to seamless approach which benefits both staff and stakeholders.*[478]

Additionally, early child development and parenting centres linked to primary schools are seen by governments and evidenced by research to provide settings that:

- best respond to the developmental needs of young children and their families;
- encourage community involvement in early childhood development;
- reduce isolation of young children and their parents
- facilitate access to early childhood specialists in health, care and education; and
- provide parents with opportunities to participate in programs with other parents in the community.[479]

Finding 32

There is a general consensus around the need to interlink early education, child care, health, and parenting support programs and services. The benefits of linking early child development services include improved access for parents and care givers to a range of support services, a more efficient use of resources, and, through information and skill sharing, more knowledge amongst the staff of providers of those services.

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477 Department of Education and Children's Services, The Virtual Village: Raising a Child in a New Millenium, report, DECS Publishing, South Australia, 2005, p162.

478 Evaluation of DEECD Children's Centres Literature Review, Centre for Community Health, Royal Children's Hospital, April 2008, p14.

479 Mustard, J. F., *Investing in the early years: Closing the gap between what we know and what we do*, Department of Premier and Cabinet, South Australia, 2008, p17.

9.3 What does an integrated service model for Early Childhood Development look like?

While there is a general consensus around the need for interlinked programs and services that include early education, child care, health, and parenting support, in practice integrated delivery of services can take a variety of forms and be delivered through a variety of locations. Similarly, what is sometimes referred to as service integration is the co-location of independent services sharing a site for delivery of those services.

Across Australia and internationally, schools are recognised as effective centres for the co-location of integrated services for children and families. Public schools in the Australian Capital Territory are already recognised for providing a universal service, for providing venues for community services, and for facilitating community connectedness. An integrated system built around a school helps meet the needs of all children and all families in a supportive, non-judgemental and community-driven way. Where schools are selected as sites for integrated services in early learning and development, the focus is on preparing children for effective participation in school life. Research indicates that the most effective way to improve educational outcomes for all children is to ensure that they experience the rich environments and nurturing relationships they need before they come to school and in their early school years.[480]

However, as one submission pointed out:

> *Such centres require more than a simple collocation of agencies but require a genuine collaborative approach to service delivery that includes new governance structures and the involvement of local communities to ensure optimal outcomes in widely differing communities. Such centres also need to encourage the involvement of parents and wider community activities. Locating a child care centre on school grounds does not produce an integrated service centre for children and families. In our view such centres would have facilities for playgroups, parent education, early child care and education and child and parent health and development services with the particular combination determined by consultation with the local community and under a common centre governance model that includes centre service providers and service users.*[481]

And:

> *Current discussion of integrated service delivery models such as Children's Centres needs to be viewed more broadly than physical collocation of services.*[482]

Internationally the trend is towards service integration in early childhood learning. For instance nine members of the Organization for Economic Co-operation and Development (OECD)

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480 The ACT Department of Education and Training, 'Early Childhood Schools', 2008. Available at: http://www.det.act.gov.au/__data/assets/pdf_file/0005/23855/Early_childhood_schools_final_web.pdf. Accessed on 23 April 2009.

481 Submission No. 28 from Playgroup WA Inc, p10

482 Submission No. 28 from Playgroup WA Inc, p10.

countries and three Canadian jurisdictions have now combined their early education and child care systems for children under one government department.[483]

In their purest form, integrated services are characterised by

> *a unified management system, pooled funds, common governance, whole systems approach to training, information and finance, single assessment and shared targets….Partners have a shared responsibility for achieving the service goals through joint commissioning, shared prioritization, service planning and auditing.*

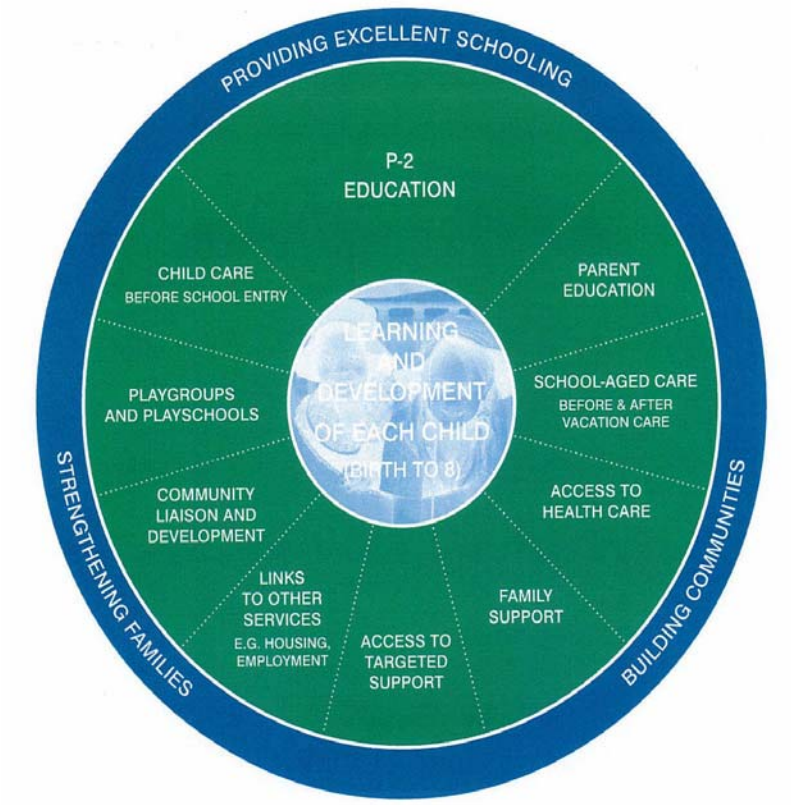
In practice there are many levels of relationship along the spectrum of services ranging from cooperation and co-location to collaboration and integration.

As this Report has outlined in its earlier chapters, parents and their children's' experiences and lives are inextricably intertwined. They are reflected in the child's subsequent learning, health and general well-being. Recognising this, the aim of a collaborative or integrated approach to early learning and development is to provide a 'one stop shop' for parents and their children by giving them access to a comprehensive suite of programs across the care, education, social services and health sectors. These are resourced by the various levels of government and respective agencies.

Figure 9.3 below illustrates the components that may go into making up an integrated model of service delivery. In practice a number of these components may not exist as the model is community specific and will vary in according to locally determined needs of families and their children.

483 Toronto First Duty: Lessons from the TFD Project, December 2008, http://www.toronto.ca/firstduty/tfd_research_summary.pdf, p5.

Figure 9.3



In one overseas example, the UK Sure Start Children's Centres provide families with seamless, holistic integrated services and access to multi disciplinary teams of professionals. It includes three broad levels of service provision, based on the levels of need amongst families and young children in a locality.

> *Level 1 is "universal", available to all families and includes free early years education and care parenting advice, and prenatal and child health services.*
>
> *Level 2 is aimed at families experiencing challenging circumstances with greater access to care and parenting support.*
>
> *Level 3 provides specialist support for families where children are at significant risk of poor outcomes and includes home visits; support in the home (delivered in collaboration with other agencies); and speech therapy, family therapy and safeguards for children at risk of harm and neglect.*[484]

484 Submission No. 33 from CHILD Australia, p14.

In an integrated system, a common vision of education and care can be forged with agreed social and pedagogical objectives.[485]

Finding 33

Optimally, integrated services are seen to be more than the co-location of services. Child development centres are understood to provide a suite of programs across the care, education, social services and health sectors, in a seamlessly linked and a mutually supportive environment.

The Committee considered several models of integration in the ACT and South Australia in the course of its Inquiry. These models are summarised as follows:

(a) South Australia

In South Australia, seven integrated child and family centres are operating with a further 13 to be completed. These centres provide education, care and family support in the one area. Accordingly, the Department of Health, the Department of Education & Children's Services (DECS) and the Department of Communities jointly decide upon the site and facilities in consultation with the local community. Each centre is therefore different; depending upon contextual community needs, government priorities and funding.

The service mix may include

- family support for parents and children
- parenting programs
- playgroups
- immunisation
- child health services
- allied health services
- community development programs.

485 Starting Strong II: Early Childhood Education and Care, Organisation for Economic Cooperation and Development, 2006, p45.

(i) Ocean View College Children's Centre, Taperoo (Adelaide)

This centre is one of seven Early Childhood Development Centres currently operating in Adelaide. Each centre is designed individually (service-wise) in order to meet the needs of the local community. Ocean View has long day care in an integrated early childhood education and care program. The site also contains a high school. The catchment area includes comprises Indigenous families, families unemployed to the third generation as well as those employed making up 60% of the families in the district.

The Ocean View College Children's Centre (the Centre) is open 7am to 6pm 5 days per week for Child Care. The pre-school is sessional however the centre opened all but two weeks of the year. It has the following features:

- The ratio of carers to children
  - At 6 weeks to 2 years - 1 carer to 3 babies This compares to the normal 1:5.
  - At 2 - 3 years - there is 1 carer to 7 children
  - At 3+yrs - there is 1 carer to 6 children
- The Centre provided priority access for high risk children, e.g. foster kids. The Centre then works with other agencies in providing a suite of responses.
- The Centre provides transport if needed in response to issues raised above.
- In common with its counterparts, the Centre has a community development officer who works with other agencies. This officer maps the services and needs of the local community and then creates the networks of support that are available. It seeks to be a 'one stop shop' for parents utilising this network for referrals where their own service is unable to meet the presenting need.
- A support group for young mothers is drawn from the children's centre, while a parent group is drawn from whole school.
- The Centre has a full catering capacity and breakfast and lunch is provided for with an eye on nutritional benefits.
- It is estimated pre-school and children's centre caters for 150 families, while the total school campus caters for 950 students (100 in yr 12).
- There are 30 rostered staff in the Centre.
- Outcomes are still being framed for evaluation purposes but fine motor skills, oral, literacy and cognitive skills are seen to have improved significantly through the program. Tracking is qualitative and not based on population cohorts.

- There are significant waiting lists to access the program but no sibling is ever turned away.

- Approx 50% of the school enrolment is external from the children's centre with different strategies used to integrate those from other areas to alleviate any 'us and them'.

There is now a clear focus by the South Australian government on childhood development recognising the first 3 years of life sets learning (along with heath and well-being) trajectories for the future experiences. It is considered that a heavy allocation of resources is better applied in the early years for the long term benefit of the community.

(ii) C.a.F.E. Enfield Children's Centre.

Located in the suburb of Enfield, in Adelaide, this centre is co-located with a primary school. The building was originally an old child care centre built in the 1980s. When the operating subsidy was withdrawn the centre closed for 8 years and has been since renovated. Planning for the site commenced with 'Stronger Families' funds.

In Enfield a co-ordinator mapped the area and looked at families with non attendance issues, asking them what would make a difference to the attendance. The outcome was the creation of a hub.

C.a.F.E. Enfield is led by a community advisory group who also support young parents. 'People come in with a crisis, are topped up by way of our suite of services, and sent out.'[486] The programs are very much about linking with other services (the 'no wrong door' model) and with the broader community. It is a collaborative model that sets out to create a virtual village. It seeks to engage with and support young parents as major focus of its work. It also has a strong focus on health related services, with 15 nurses working from the site.

The management structure at Enfield is one that sees the Director education and care reporting to the school principal. This contrasts with the ACT model where the two roles were *pari passu* and great care was taken to maintain that equal status.

Unlike Ocean View, only 25% of children at C.a.F.E. Enfield go to the co-located primary school and there is significantly less cross over between the two, although some facilities are shared. In particular the children access the school library and hall.

No evaluation has taken place as to the effectiveness of the service to date, but Department of Education & Children's Services is currently looking at what indicators might be appropriate, such as levels of community engagement or levels of attachment.

The reception centre (see below) at Enfield is also an activity room which contrasts with the approach taken in Canberra where the reception is distinct from the operational part of the centre.

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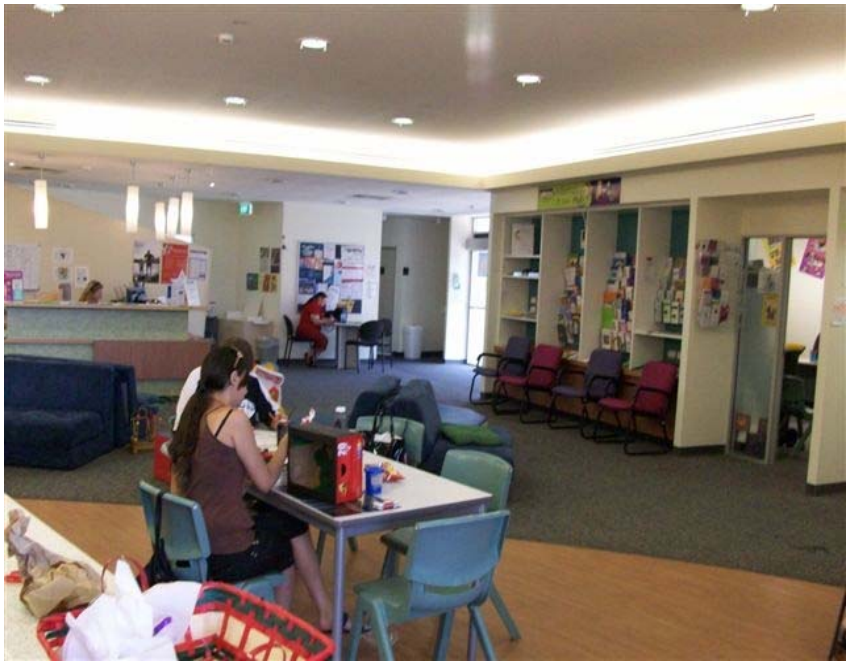
[486] Joan Gilbert, Director Education and Care, Briefing 26 February 2009.



Café Enfield operates within a low socio-economic area and has a culturally diverse community with Indigenous, Iraqi, Afghani and Sudanese families living within the surrounding suburbs. A high percentage of families using the centre are comprised of single mothers. Many of the children come in with delayed speech that is with only ‘demand type’ speech e.g. give’… or ‘want water’ etc as opposed to more conversational speech

Features of C.a.F.E. Enfield include:

- a birth to school age facility. The childcare and pre-primary commenced 3 years ago and is running at 100% capacity which means 84 children;
- health facilities for women and children, community centre, pre-school, childcare, and also a crèche that can be accessed by parents doing on-site courses. The Centre runs an immunisation program which tends to engage families;
- the Children Youth and Women's Health Service component opened 4 years ago. The Child and Family Health services based at C.a.F.E Enfield are free and are provided by qualified nurses, medical staff, social workers, other allied health staff;
- 15 maternal and child health nurses on site. They provide home visits and can link people with other programs when the need arises;
- a two year supported program is available for mothers under 16 or Aboriginal or refugee or in need;

- a number of community programs are offered for both children and parents;
- playgroups: 'Learning Together' are funded by the state and co-ordinated and run by paid professionals. Ratio is usually 2 families to 1 leader. Because these programs are well supported by professionals they provide effective parent education. It is NOT a traditional playgroup;
- play-based learning forms the forms the platform. The aim is to try and get parents of eight week old children in. the program promotes the principle of attachment and cycles of security;
- the DECS funded pre-school is integrated into the childcare centre;
- Families SA has approached Café Enfield to oversee supervised access visits but there is no agreement as yet on this issue; and
- there is joint funding for operating the pre-school, childcare and kindergarten.

The Committee was advised that about 25% of the children from the Children's Centre go on to the Enfield Primary School.

Support for families at risk is a major reason for the Centre's existence. At risk newborns are introduced by the hospital and the Centre has strong links with women's refuge centres as they do not provide child care. Women will often complete their schooling while using this combination of services.

The Family Services co-ordinator has a background in social work (can be health or education). That person is employed by DECS but managed by the Department of Communities

The 'Teach to Talk' (a Canadian program) is used to teach parents of at risk children how to speak and interact with their children.

(b) Australian Capital Territory

The establishment of these centres follows the ACT Government's "Toward 2020: Renewing Our Schools" proposal. The proposal was released in June 2006 and a consultation period of 6 months followed. The original proposal was based around the closure of some 30 schools. However, following community consultation, only 22 were closed. The ACT still maintains its original school models but has expanded it to include the new P-2 schools. The ACT formula for early childhood learning is pre-school, kindergarten, year 1.

(i) Narrabundah Early Childhood Education Centre

The Narrabundah Early Childhood Education Centre is an ACT Government funded preschool and is one of four new early learning and development centres operating in the ACT.

Narrabundah is located in a mixed socio economic demographic, with the highest Indigenous population in the ACT in its catchment. It was originally a K-6 school with declining numbers. Now Narrabundah Early Childhood School forms a part of a new Early Childhood entity incorporating a P-2 School, child-care and health services. The early childhood schools focus on early childhood education and early intervention. Support is given to Indigenous students and students with special needs. It is however a very recently commenced initiative, opening its doors in 2009 and is still evolving.

In the case of Narrabundah, it made sense insofar as the ACT was concerned to develop the school as a hub for early childhood services for at risk children. This is because there is no perceived stigma in attending school. It then becomes a logical place to locate other services.

The programs offered are universal and, along with a P-2 school, the complete range of services, when fully operational, will include:

- child care - a 70 place facility for which it offers some subsidised places. Between the ages of 0-2 the staff: child ratio will be 1:3 as was the case in Ocean View College Children's Centre. The idea behind the provision of child care is that it allows access to parents with a view to linking them into health services. In addition to 70 children in childcare there will be a cohort of 230 in the P-2. A pre-school teacher will work in the 4yo childcare assisting childcare staff outside of sessional work. Teachers will move to where the children are located rather than moving children into teacher's rooms;
- before and after school care for pre-school to year 2 students will be available;
- parenting programs and support groups;
- targeted playgroups;
- health programs such as maternal and child health clinics;
- immunisation;
- physiotherapy and speech therapy services; and
- there are also two consulting/counselling rooms.

Other features include:

- an education program for 4 year old children. There is also a 3 year old program and a playgroup;
- children not attending child care can attend for the pre-school only; and
- a pedagogical approach is used in teaching years 1 & 2 but it is still governed by the same curriculum as rest of the State. Each child's learning will be tracked through to

eight years of age. This is in contrast to South Australia where there is no intent to track the child's development past the pre-school.

There are shared staff facilities and both the Child Care Manager and the school Principal have offices in the same location. To ensure that any sense of discrimination between 'school staff' and 'care staff' is minimised the offices and relevant facilities are co-equal in what they offer and their relative size. Professional development will shared by both disciplines alike.

The premise behind the P-2 schools is based on research which shows that children are better equipped for transition at age 8 as against 4 or 5, and that Birth-8 are the most important years in which to form relationships and build platforms that better equip children to make changes.

Parenting classes will be provided. It is recognised that it is important that parents understand their role in raising children alongside the roles of child care providers and educators.

As in South Australia there is a community development co-ordinator employed to map and make connections across the community.

The ACT government will go to tender for short and long term evaluation of outcomes.

In the ACT a Director of a Child Care facility must have a B.Ed.

(c) Victoria

Victoria's Office for Children and Early Childhood Development has recently produced an evaluation of Victorian children's centres (an integrated model). It has produced a set of best practice principles, among which are the following:

Centres seek to integrate traditional forms of child care and kindergarten practices into a seamless early care and learning approach.

- *Programs and services are based upon the needs and priorities of families and communities.*
- *Families have available to them a range of support and intervention programs and services, including parental programs.*
- *Centres provide a range of opportunities for families to meet other families, and promote the development of social networks.*[487]

(d) Western Australia

In Western Australia the Minister for Education and the Office of Early Childhood Development and Learning has announced that nine parenting centres are to be opened funded by the Federal Government. The Department of Education and Training (DET) advises that they will be managing these Early Childhood centres, which comprise four Early Learning and Care Centres

487 Submission No. 15 from Commissioner for Children and Young People WA, p17.

and five Indigenous Children and Family Centres. The Department for Communities will undertake the community consultations for the Indigenous Children and Family Centres.[488]

The Early Learning and Care Centres will be co-located with schools to enable a single drop off point for parents, however at this stage there is no suggestion that health support for parents will be incorporated in the suite of services. The sites proposed are Mirrabooka, Darch, Port Hedland and Karratha.

The Indigenous Children and Family Centres will be full service hubs and include the provision of child and maternal health support. One will be located in the metropolitan area and four in regions. The precise locations for these Centres are yet to be announced as is the timetable for opening. It is currently envisaged that DET will oversight the care facilities and the Department of Health will oversight the health related programs.

Recommendation 26

The Committee strongly recommends that, in line with Recommendation four, the health, care, and education components of the four Federally funded early learning centres and the five Indigenous Children and Family Centres all report to the Minister for Education.

(i) Challis Early Childhood Education Centre

One example of an existing centre that is moving towards becoming a fully integrated hub in Western Australia, is that of Challis Early Childhood Education Centre (Challis ECEC), located in Armadale. Currently:

> *Challis ECEC focuses on Early Childhood strategies and innovations that produce a unique environment, staffed by experienced and motivated early childhood educators who are specialists in their area. Challis ECEC has 18 teaching staff who have a wide range of teaching experience.*[489]

The Principal of Challis advised the Committee that while the ECEC is a kindergarten and pre-primary school, they have recently been focusing on the development of children between the ages of zero to three years. This is largely in response to the poor language development and social skills evident when the children present for kindergarten at the school. The poor level of language skills and school readiness is a consequence of their level of disadvantage and chaotic lifestyles:

> *There are two schools on the one premises in Armadale, Challis Primary School, which caters for children from year 3 to year 7, and Challis Early Childhood Centre, of which I am the principal. I have 300 kids between kindergarten and year 2, so we are looking from*

488 Susan Barrera, Director General, Department for Communities, email, 9 April 2009, p1.

489 Challis Early Childhood Education Centre, Available at: http://www.thisreview.com.au/Reviews/Education/Specialists/Western-Australia/Challis-Early-CHood-Ed-Centre-Armadale-Western-Australia. Accessed on 29 April 2009.

four years of age through to eight years of age. A number of factors impact on our parents' ability to parent their children. We have a very high incarceration rate and a very high rate of alcohol and drug addiction and dependency. A wide range of factors result in dysfunctional and chaotic parenting and lifestyles that impact on the children's attendance at school and their literacy, numeracy and social skill levels of development. There are factors such as very low literacy rates, very large families, very young mums, single families and a lot of domestic violence.

Unfortunately, the latest demographic that is on the increase is homelessness. Families travel in cars and move from one driveway to the next driveway until the homeowner kicks them out of that driveway and they move on to the next driveway. Little kids of four years of age are coming to school still in the clothes they were in the night before. We have started a number of programs to try to address what is happening to support the families. Our department resources us quite well, with the aim of trying to improve the children's literacy levels. Unfortunately, by the time the children come to me at four years of age, because of what is happening to them from birth to, say, three or four years of age—they are not getting rich stimulation; they are not being parented and parents do not know how to spend time with their kids talking to them and developing their resilience and language skills—they are significantly behind where they should be at their stage of development.[490]

The profile of Challis ECEC children is advised as;

- Total number of children in K-Y2 = 300
- 18% of the children are from an indigenous background;
- 20 children are identified with an intellectual disability;
- 86 children are identified as being at educational risk in terms of literacy development in pre-primary and Year 1;
- 55 children in foster care; and
- 52% of pre-primary children are assessed as being developmentally vulnerable.

In addition between 33.3% and 50% require speech therapy but only those diagnosed as moderate to severe will get on the waiting list. The position is exacerbated by the perception that some parents have of the parent workshop preparatory to children being put on the assessment waiting list. This is because it is state to be structured for a middle socio economic background, resulting in many parents not attending them in this school district.[491]

As referred to above, the children attending the ECEC are detrimentally affected by a range of social and physiological problems. Specifically these include:

- mental health illness;
- either of both parents in gaol;
- spending excessive time in child care (6.00 a.m. to 7.00 p.m). The child care centres in the Armadale area are stated to be lacking in qualified staff, with some staff still

[490] Ms Lee Musumeci, Principal, Challis Early Childhood Education Centre, T*ranscript of Evidence*, 9 December 2008, p2-3.

[491] Ms Lee Musumeci, Principal, Challis Early Childhood Education Centre, Briefing 4 June 2009.

children in high school and yet these staff are the most significant people in the child care children's' lives.
- parent(s) with drug and/or alcohol addiction;
- adolescent mothers;
- domestic violence;
- children may be in foster care;
- parents are homeless;
- ill health; and
- trauma.

In the school district, poor health is another one of the factors that contribute to ongoing developmental delay:

> *…mums have the babies at the local hospital, discharge from hospital [and] then do not go back for any child health check-ups. This means that for any children who developmentally are not reaching their milestones, there is no safety net for them. They just slip through all the services until they enter school at four years of age. That means we have missed those crucial years….*[492]

Professor Mustard, in his companion document to the Adelaide Thinker in Residence Report, noted, in some communities, such as Aboriginal communities, very young children frequently suffer from middle ear infection with negative affects on experience based development of the brain for hearing and language capability. This is the experience at Challis ECEC:

> *Today the speech therapist, her assistant and an audiology team are there, because 13 of the 17 kids had undiagnosed glue ear. They are already three years of age, so all this time they had not been able to hear their sounds. Most of those kids will be in kindergarten next year, and that gap is just enormous.*[493]

In response to such identified needs, the Principal of Challis ECEC is moving to create a more fully integrated service hub, with the support of the Department of Education and Training.

> *We have developed a proposal that has been accepted by our department. It will involve a full range of service providers being on school premises to address any gaps or any needs that the children may have. Typically, at the moment with any one kindergarten cohort - let us say there are 20 children in the class - every year 12 out of 20 are referred for a speech assessment because their language and speech is so delayed.*
>
> *The Challis centre will be on the school site and will be staffed by a speech and occupational therapy teacher, an education assistant and Aboriginal health workers. These staff will be work only with those children from zero to three years of age… As soon*

[492] Ms Lee Musumeci, Principal, Challis Early Childhood Education Centre, T*ranscript of Evidence*, 9 December 2008, p2-3.

[493] Ms Lee Musumeci, Principal, Challis Early Childhood Education Centre, T*ranscript of Evidence*, 9 December 2008, p5.

as a child has not met a developmental milestone, the child will receive the service he or she actually requires.[494]

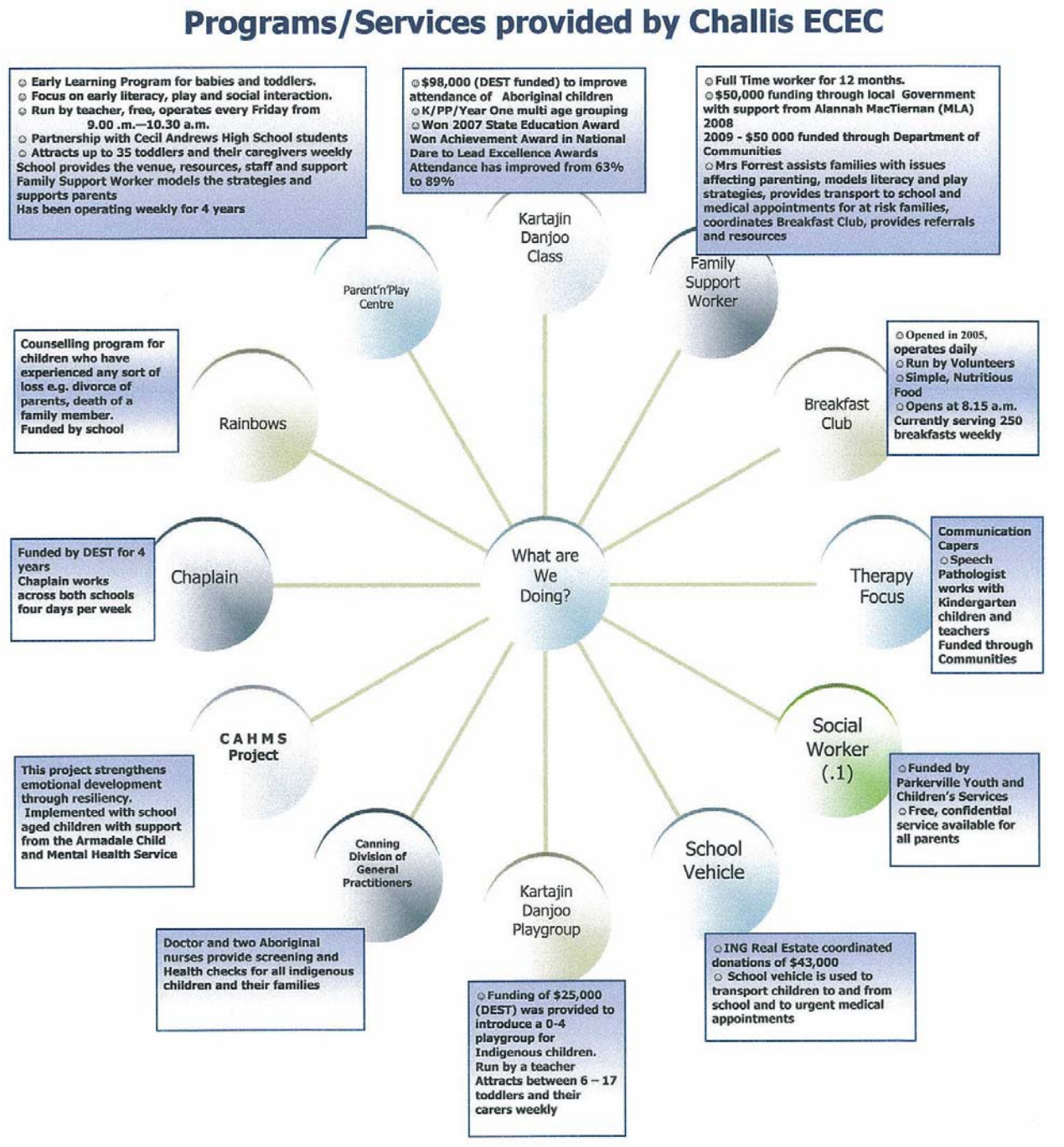
As part of the existing services Challis ECEC supports the health and well being of its children through the provision of:

- a breakfast club;
- a bus to collect children where parents have no available transport;
- a speech therapist provided through Therapy Focus;
- a part time social worker;
- a n culturally appropriate playgroup;
- grief counselling; and a
- family support officer who also does home visiting.

Diagrammatically the full suite of ancillary services provided through Challis ECE is represented in the Figure below.

[494] Ms Lee Musumeci, Principal, Challis Early Childhood Education Centre, T*ranscript of Evidence*, 9 December 2008, p2.

Figure 9.3



Challis ECEC has recently secured the services of a doctor on site for one day a week who will undertake health screening on all the children. His/her services will be bulk billed to Medicare.

The early year's assessment program, Performance Indicators in Primary School, shows that for Challis, only 29% of the children were at or above the national starting point when assessed in the

first week of pre-primary with 71% being up to 18 months behind the national starting point in reading phonics and numeracy. However, after Challis ECEC implemented a systematic instruction in phonics through a rich 'play based' literacy environment, 39% of the children reached the national starting point.

Challis ECEC works in strong partnership with the Department of Education and Training and a number of non government organisations such as Therapy Focus, Parkerville Children's Home Inc, and Foodbank. These strategies have seen an improvement in attendance from 63% to 89%.

Finding 34

Around Australia there is an increasing recognition of the value of bringing health, care, and education into one co-located integrated service centre. Each such centre offers different services; depending upon contextual community needs, government priorities and funding. Most of these centres have been located in disadvantaged communities and link into related existing services to supplement their own suite of services. This approach is seen to provide an effective approach to existing child development issues relating to health screening, the fragmentation of services, and the patchwork of child care services. It is also seen to improve access to support for parents and children and to improve school readiness, enhancing a child's opportunities in school life.

Recommendation 27

The Committee recommends that:

1. the Minister for Education extend the co-located integrated early child development service hub model throughout the State with prioritisation of locations based on the level of developmental challenges faced in a given community, as recorded in the AEDI process.

Additionally:

- that a formal evaluation methodology is established from the outset in each case;
- that health is incorporated into the suite of services provided at each location; and
- that integrated early childhood development and parenting programs should be linked to appropriate primary schools.

2. a system of clustering schools to take advantage of service hubs be developed.

CHAPTER 10 LEARNING TO READ

10.1 Background

There is evidence to suggest that a substantial number of school age children are presenting with a developmental delay of quite a serious nature—a delay that impedes their capacity to learn. This evidence includes the data coming out of the AEDI surveys which shows, as it does with National Assessment Program - Literacy and Numeracy (NAPLAN), areas of grave disadvantage and that the approach in the early education system is not working as effectively as it should.

NAPLAN tests have been developed collaboratively by the states and territories, the Australian Government and non-government schools sectors. NAPLAN operates under the auspices of education ministers. Students in the same year level across Australia are tested on the same items in Reading, Writing, Language Conventions (Spelling, Grammar and Punctuation) and Numeracy. In 2008 all students in Years 3, 5, 7 and 9 sat common national literacy and numeracy tests, which provided information about how Australian children are performing on a national basis.

A major purpose of the NAPLAN is to provide schools, parents and caregivers with information about student performance in relation to nationally-agreed achievement.

In 2008 the results show that students in Victoria, New South Wales and the ACT performed above the national average - with Western Australia and Queensland performing below expectations.[495] However in areas of disadvantage, schools with a significant proportion of developmentally vulnerable children significantly underachieved against expectations for the State as a whole.

Figure 10.1 NAPLAN Year 3 2008 State results[496]

	Percentage (%) WA at/or above national minimum standard.	Percentage (%) Aust at/or above national minimum standard	Ranking against other States and Territories
Reading	89.4	92.1	3rd lowest
Writing	95.0	95.4	= 3rd lowest
Spelling	89.4	92.5	3rd lowest
Grammar and punctuation	87.7	91.7	3rd lowest
Numeracy	94.5	95.0	3rd lowest

These averages show cause for concern, but they also mask the severity of problems in some schools. For example, one school in the south east corridor of the metropolitan area had only 44% of year threes achieve the national bench mark on reading and numeracy.

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495 The Journal, 2008. Available at: http://journal.techgeek.com.au/2008/09/12/naplan-results-show-one-in-ten-students-failed-to-meet-minimum-literacy-standards/. Accessed on 30 July 2009.

496 National Assessment Program, 2008. Available at: http://www.naplan.edu.au/verve/_resources/2ndStageNationalReport_18Dec_v2.pdf. Accessed on 30 July 2009.

While initially focusing the Inquiry on what was happening to children before they came to school, one issue that caught the Committees attention in particular, was whether the pedagogical style that is currently in vogue is in fact part of the problem related to a child's capacity to learn. Is a particular style of instruction in basic literacy and numeracy—that is the whole language immersion style of education—setting up some of these children to fail and particularly, but not exclusively, disadvantaging children from lower socioeconomic backgrounds?

10.2 Phonics 'v' whole language

There is a high level of debate amongst educators, professionals and parents over which is the best approach to take in teaching children how to read. Should it be:

- whole language?
- or phonics?
- or a combination of the two?

The definition of phonics and whole language is as follows:

Phonics:

Phonics is a method of teaching beginners to read and pronounce words by learning to associate letters or letter groups with the sounds they represent.

The essence of the rationale for phonics was given expression by one witness as follows:

> *I think we need to think about the logic of teaching literacy. English is an alphabetic language. Even though most of us find this very puzzling at times, four-fifths of the words in English are highly predictable and the prediction patterns can be learnt, and we used to learn them.*[497]

Whole language:

Whole language is a method of teaching children to read by emphasising the use and recognition of words in an everyday context. It involves not looking within the word and not looking at the phonemic features—that is, the sound to letter relationships and patterns.

The argument for phonics

The debate over the best way to teach reading isn't new. In fact, the question has been argued through much of the 20th century….. different approaches to teaching reading have dominated

497 Dr Steve Heath, Research and Clinical Psychologist, Child Study Centre, The University of Western Australia, *Transcript of Evidence*, 20 May 2009, p13,4.

during that time span.[498] In recent decades a 'whole language' approach has gained favour in many parts of the English speaking world.

The debate over the merits of the two approaches has resurfaced in the light of AEDI and NAPLAN results highlighting the number of developmentally vulnerable children and Western Australian children's performance in the language conventions. The debate may be summarised as follows:

> *Simply stated, supporters of the whole language approach think children's literature, writing activities, and communication activities can be used across the curriculum to teach reading; backers of phonics instruction insist that a direct, sequential mode of teaching enables students to master reading in an organized way.*[499]

The problem with the whole language approach is seen to lie in the needs of the developmentally vulnerable whose language skills are to some degree lacking.

> *It seems to me that this [is a] philosophy where we expect this sort of enriched environment to be available to a child and they will somehow by osmosis benefit from it. [This] is extremely prejudicial towards the higher end of the socioeconomic scale. If we have the prevailing philosophy … those [developmentally vulnerable] children, may have a high proportion of parents with low education or difficulty. …..… [Consequently] The children are not picking up the patterns automatically because they do not have the wiring to do it, and we are saying to them, "Look at the picture. What do you think? Look at the rest of the sentence. Work it out." These children are going to have low language experience—11 million words instead of 50 million words. So it is perpetuating the difficulty in that lower end. I guess I feel very strongly that the current practice of emphasising top-down processes in the way that we are teaching is extremely disadvantageous to the very people that we want to help.*[500]

and

> *The problem is that although some kids make the connections and some work it out, a lot do not. And those kids just get left further and further behind.*[501]

and

> *Unfortunately, English cannot be learnt unless you actually pay attention to those patterns. Eventually when you develop fully competent literacy, you no longer need to, but the middle strategies are to do that and to learn the relationships between what you hear and*

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498 Education world, 'Whole Language and Phonics: Can They Work Together' 1997 Available at http://www.education-world.com/a_curr/curr029.shtml Accessed 2 July 2009.

499 Education world, 'Whole Language and Phonics: Can They Work Together' 1997 Available at http://www.education-world.com/a_curr/curr029.shtml Accessed 2 July 2009.

500 Dr Steve Heath, Research and Clinical Psychologist, Child Study Centre, The University of Western Australia, *Transcript of Evidence*, 20 May 2009, p20.

501 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence*, 20 May 2009, p4.

> *what you see on the page, and then you can fluently decode that, if you like, so that it will become words again when you read.* [502]

Significant research, both overseas and in Australia has highlighted the need for a focus on strong phonemic awareness in teaching literacy even while it recognises that reading involves far more than decoding words on the page. The Australian Government's National Inquiry into the Teaching of Literacy included the suggestion that:

> *Initial and subsequent literacy instruction (in the case of children experiencing reading difficulties) be grounded in the basic building blocks of reading, namely, the set of integrated sub-skills that include:*
>
> - *letter-symbol recognition;*
> - *letter-sound rules (phonemic awareness and phonological knowledge);*
> - *whole-word recognition; and*
> - *the ability to derive meaning from written text.*[503]

That Inquiry found that phonics instruction helped a wide spectrum of children. These included those from low and middle socio-economic backgrounds; children for whom English is a second language; younger children at risk of experiencing reading difficulties; and older children experiencing reading difficulties.[504]

In similar vein, in 2006 the *Independent Review of Teaching and Early Reading* was published. This United Kingdom Inquiry had as its remit what best practice should be expected in the teaching of early reading and synthetic phonics and how this relates to the development of the birth to five framework and the development and renewal of the National Literacy Strategy.[505] Its key finding is encapsulated as follows:

> *The findings of this review argue strongly for the inclusion of a vigorous, programme of phonic work to be securely embedded within a broad and language-rich curriculum: that is to say, a curriculum that generates purposeful discussion, interest, application, enjoyment and high achievement across all the areas of learning and experience in the early years and progressively throughout the key stages which follow.…… Phonic work should be set within a broad and rich language curriculum that takes full account of developing the four interdependent strands of language: speaking, listening, reading and writing and enlarging children's stock of words.*[506]

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502 Dr Steve Heath, Research and Clinical Psychologist, Child Study Centre, The University of Western Australia, *Transcript of Evidence*, 20 May 2009, p4.

503 Australian Government: The Department of Education Science and Training, 'Teaching reading', 2005. Available at: http://www.dest.gov.au/nitl/documents/report_recommendations.pdf. Accessed on 6 July 2009.

504 Australian Government: The Department of Education Science and Training, 'Teaching reading', 2005. Available at: http://www.dest.gov.au/nitl/documents/report_recommendations.pdf. Accessed on 6 July 2009

505 Sir Jim Rose, *Independent Review of Teaching and Early Reading*, Department for Education and Skills, United Kingdom, 2006, p7.

506 Sir Jim Rose, *Independent Review of Teaching and Early Reading*, Department for Education and Skills, United Kingdom, 2006, p16 & 70.

10.3 Teaching methodology and literacy problems

The Committee was struck by suggestions that a failure to learn through a 'whole language' methodology may result in children being lumped together as possibly having a learning disability or being in need of speech therapy

> *The major issue as seen by the proponents of phonics is that "most of the children who are failing in literacy are not children who have a learning disability; they are children who have never really been exposed to how the English language works—the written code.*[507]

> *What I hear a lot of teachers saying is that children present in kindergarten with very limited oral language and the teacher refers them to speech therapy*[508]

The Committee recognised that the problem is inherent in those pre-cursors of schooling which support the development of language. For many children who may come from a family with a large number of books in the house, parents may both read to them and model reading. While this supports the development of a child, there was a general consensus amongst witnesses that this was less of a predictor for literacy development than the amount of language used in the household. This is also supported by research.

> *What they actually found when they disaggregated those figures further was that it was not actually about the books; it was about the amount of language that was used. …. I think that again is a heartening thing. …. I will say to them[less literate parents] that what is much more powerful that reading books is telling their children stories, singing with them, and walking through the park and talking about the birds and the trees. It is the language exposure, and I think that is a huge thing.*[509]

And

> *the more you talk to your children, the more you read to your children, tell stories, sing songs and do the oral language ground work, the more those foundation blocks are put in place so that the children grow up understanding and hearing their language and are comfortable with their language and then are also comfortable with the notion of books and the notion that when we say something and write it down somebody else can read it. That is the code. The verbal code is put into a written code. It is that life experience that they need to then bring to the three-year-olds when they start to get interested in letters and sounds. ….For zero to three, it is very much immersing them in as much language and literacy experience as we can.*[510]

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507 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence*, 20 May 2009, p3.

508 Dr Libby Lee-Hammond, Senior Lecturer, Murdoch University, *Transcript of Evidence*, 10 June 2009, p8.

509 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence*, 20 May 2009, p8.

510 Dr Jenny Jay, University Lecturer, Edith Cowan University, *Transcript of Evidence*, 10 June 2009, p12.

In 1995 longitudinal research was undertaken into the language exposure of children classified by parental income strata over a three year period. What the research found was that in those families participating in the study:

- in welfare funded families, children heard 620 words an hour;
- in blue collar families, children heard 1250 words an hour; and
- in professional families, children heard 2150 words per hour.[511]

The Committee was told that

> *[Language] is also highly correlated with Socio Economic Status (SES). We know that in a high SES household, particularly a professional family, the children could be by the age of four exposed to around about 50 million words, in comparison to the child in the lower SES, with about 10 million or 11 million. There is a big difference in that language exposure, and what we are trying to get parents to do is talk more to their children, sing more to them, and just chat. All of those things are important.*[512]

Poor literacy outcomes

With respect to spoken language development, the preschool years represent the key period of learning language. As children enter school, they are expected to use these newly developed language skills as tools for learning to read as well as for social negotiation. If these language skills are not developed then the approach taken to teaching literacy becomes paramount, if children are to learn.

Evidence was given to the Committee, by many witnesses, testifying to the partial failure of the present education system, including the following:

> ***Dr Heath**: We are talking about the other 17 or 18 per cent of kids. If you look at the Western Australian National Assessment Program Literacy and Numeracy data from last year, just on reading, for example, it is around 23 to 25 per cent of children in year 3, 5, 7 and 9, who are at benchmark or below it.*[513]*(*

and

> ***Ms Mears**: At Notre Dame we are very aware of poor literacy standards at all levels of education. We see this, from what you are saying, with our tertiary students. We question: how have these students gained entry to a tertiary institution when their literacy skills are poor? We congratulate this committee on actually raising the issue and looking for ways of improving literacy across the board. On entry, every single student who comes into Notre Dame, into education, must sit a literacy test. They have to get a 70 per cent pass,*

511 Novak, G. & Pelaex, M., *Child and adolescent development,* Sage Publications, California, 2003, p276.

512 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence,* 20 May 2009, p8.

513 Dr Steve Heath, Research and Clinical Psychologist, Child Study Centre, The University of Western Australia, *Transcript of Evidence*, 20 May 2009, p13.

> *whether or not they have done TEE. The TEE may be a very good course but it does not address functional literacy, from what we are seeing coming into tertiary institutions. If these students do not get 70 per cent on this entry literacy test, they are immediately enrolled in a literacy competency unit. They must pass that. They can have a second go; if they do not, their course is terminated. We are really working at improving our students' literacy; so much so that we have introduced a policy that, on any assignment, students cannot gain a grade higher than the literacy component. If they have got a distinction, high distinction, for, say, content, presentation et cetera, and if their literacy is a pass or a C—a credit—that is the only grade that they can get [in education]. It might sound a bit draconian, but it is so important. We want to get this through to the students.*[514]

and again

> *On the NAPLAN testing that you are talking about which takes place in years 3, 5, 7 and 9, we did not do as well; we were below the Australian average. We performed better than Queensland and better than the Northern Territory consistently across all the various things, but below the Australian average because of being below New South Wales and Victoria.*[515]

Preparation of Teachers

Many teachers feel under prepared for the task of teaching literacy. This was bought to the Committee's attention on more than one occasion both in briefings and in hearings. For instance, the Committee was advised that, during the recent English Teachers Association (ETA WA) 2009 State Conference, the session entitled "Secondary Students Struggling With Syntax, Spelling and Vocab was oversubscribed:

> *There was no room left and nobody went to the other sessions because, as they were all saying: first, they do not know anything about those and are really struggling to know how to teach those sort of things…….. A lot of English teachers in secondary schools are tearing their hair out wanting to teach a fantastically creative English syllabus, but they are working with kids who can, really, barely read and write.*[516]

The presenter, Mandy Nayton from D-SPELD Foundation has since been invited to present on this topic directly to English departments in a number of schools in relation to the topic.[517]

However, the responsibility for the preparation of teachers does not go undisputed. In response to concerns from the Committee regarding the lack of a detailed teaching program, and the fact that the Committee is aware that some schools have resorted to developing their own program in support of their teachers, Dr Lee-Hammond made the following comments:

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514 Ms Maureen Mears, Associate Dean, College of Education, University of Notre Dame, *Transcript of Evidence,* 10 June 2009, p11.

515 Mr David Axworthy, Executive Director School Support Program, Department of Education and Training, *Transcript of Evidence,* 10 June 2009, p15.

516 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence,* 20 May 2009, p2.

517 Information by telephone conversation 23 July 2009.

> *I think that what schools are doing in terms of developing a program for their school in that context is entirely appropriate. I do not believe it is the role of universities to prepare students for every possible context…It is not an achievable task, in a four-year university degree to prepare students for every possible scenario…*[518]

10.4 Social consequences of poor literacy

Poor literacy has significant consequences both for the child in terms of opportunity cost, but also for schools and society at large.

> *Literacy under-achievement has high social and economic costs in terms of both health and crime. The Committee received evidence indicating that the overlap between under-achievement in literacy (especially in reading) and poor behaviour, health and wellbeing, is a major issue to the extent that what should be an 'education issue' has become a major health issue (e.g., DeWatt et al., 2004). According to the Royal Australasian College of Physicians, an increasing number of parents are seeking help from health professionals throughout Australia for their children whose self esteem and behaviour problems have arisen as a consequence of (or are exacerbated by) learning difficulties and failure to acquire adequate literacy skills. Paediatric physicians refer to this phenomenon as the new morbidity in education and child/adolescent health (Oberklaid, 1988, 2004).*[519]

Two consequences in particular were brought to the Committees notice.

(a) Behaviour problems

There is significant evidence based research supporting the linkages between spoken language skills and both subsequent reading and behaviour development. It has been suggested by such research that "the behaviour problems may arise from the spoken and written communication demands of the classroom. Thus, communication failure serves as a stressor and behaviour problems are maladaptive responses to this stressor."[520] As one witness put it:

> *By year 3 the single most significant factor by a mile is reading ability. If you asked any year 9 teacher in a school in Rockingham, or somewhere—anywhere—which class is going to contain high readers or the competent readers and which is not, their response would be that the class in which most of the kids can barely read and write is where all the behaviour problems are. If we work with kids on improving their literacy, we are going to improve their behaviour and motivation to be at school. I think we have got the circle around the wrong way.*[521]

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518 Dr Libby Lee-Hammond, Senior Lecturer, Murdoch University, *Transcript of Evidence*, 10 June 2009, p19.

519 Australian Government: The Department of Education Science and Training, 'Teaching reading', 2005. Available at: http://www.dest.gov.au/nitl/documents/report_recommendations.pdf. Accessed on 6 July 2009.

520 Dr Bruce Tomblin, 'Literacy as an Outcome of Language Development and its Impact on Children's Psychosocial and Emotional Development', 2005. Available at: http://www.enfant-encyclopedie.com/Pages/PDF/TomblinANGxp.pdf. Accessed on 3 July 2009.

521 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence*, 20 May 2009, p13.

(b) Illiteracy and crime

Secondly, while the inability to read and write well is rarely the direct cause of criminal behaviour, there is evidence to suggest that low literacy and crime are related[522]

> *Prison systems that put in place literacy programs—with no other thing being introduced—immediately have a decrease in aggressive behaviour*.[523]

Canadian studies suggest the correlation occurs by virtue of the fact that low literacy can lead to low self esteem, poverty, poor health, lack of access to services and these factors may lead to criminal behaviour.[524]

10.5 Literacy education in Western Australia

(a) The reading syllabus and the curriculum

As advised by the department of Education and Training, there is in Western Australia no mandated syllabus for teaching literacy.

> *Let me be very clear so there is no misunderstanding. We have not got a mandated syllabus.*[525]

However there is:

> *a mandated curriculum framework that goes across government, non-government and Catholic schools. For department schools only, we have created a syllabus that says that in order to meet the mandated requirements of the curriculum framework, 'these are the things that we expect you to be doing'*[526]

However evidence from schools is that this syllabus is an optional syllabus and this optional syllabus is too broad to provide sufficient guidance for young teachers, particularly those dealing with developmentally vulnerable children. The optional syllabus does not include guidance on how to teach as opposed to what to teach. For example it does not advise on optimal letter/sound order.

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522 National Adult Literacy Database, 'Connection between literacy and crime prevention', 2008. Available at: http://www.nald.ca/info/whatnew/headline/2008/police.htm. Accessed on 3 July 2009.

523 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence*, 20 May 2009, p13.

524 Literacy Nova Scotia, 'Literacy and Justice', Available at: http://www.ns.literacy.ca/factsheets/fact5.pdf. Accessed on 3 July 2009.

525 Mr David Axworthy, Executive Director School Support Program, Department of Education and Training, *Transcript of Evidence*, 3 July 2009, p4.

526 Mr David Axworthy, Executive Director School Support Program, Department of Education and Training, *Transcript of Evidence*, 3 July 2009, p4.

New teachers are not provided with a developed programme for the teaching literacy. Unless the individual school has developed their own, new teachers are expected to construct their own. This approach condemns many children to a 'hit and miss' experience. It seems extraordinary not to provide new teachers with a detailed best practice model which they can adapt as they acquire experience.

One witness to the Committee considered this to be serious shortfall in the current system.

> *This [a mandated evidence-based approach to language or literacy education] is what teachers have been asking for, for about the past probably 20 years. ….. One of the things that teachers have been asking for the past 20 years is for somebody to say "This is what needs to be taught in year 1, year 3, year 5" and so on. That has been a perpetual cry for a long time.*
>
> *The difficulty then is if we are going to come up with something, and last year the department did come up with some scope and sequence documents that are on the internet and that I think have some real merit . They are very good and are quite structured. There are some very positive things about them, but they are not compulsory or mandated, and there are people in the system who are ignoring them because they do not agree with them.*[527]

It was also suggested to the Committee that 'First Steps' was introduced to fill the gap but that this is seen as more of a stop gap measure.

> *At the moment what tends to be used and adopted as practice—this is a bit of an issue for Western Australia—is First Steps. I have had principals say to me, "We've got First Steps in Western Australia; it's the best reading program in the world." First Steps has lots of positive elements to it. First Steps grew out of the whole language movement. It grew because there was no syllabus and people were saying, "Can we have some structure? We need to have a sequence of where we're going with teaching. We need to have something clearer than the current open-ended approach." First Steps grew out of that. It has a lot of wonderful things attached to it, particularly from that top down ideology. Again, it still does do things such as encourage teachers to get kids to guess according to the first couple of letters of a word. It is not explicit enough in saying, "This is how our code works. This is the basic fundamental skill."*[528]

(b) Department of Education and Training perspective: a balanced blend of phonics and whole language

The Department of Education and Training (DET) position is that it adopts a balanced approach to literacy, encouraging attention to each child's individual needs. It sees the debate between the two pedagogical methods as a false dichotomy.

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527 Dr Steve Heath, Research and Clinical Psychologist, Child Study Centre, The University of Western Australia, *Transcript of Evidence*, 20 May 2009, p13/14.

528 Ms Mandy Nayton, Chief Executive Officer, DFS Literacy and Clinical Services, *Transcript of Evidence*, 20 May 2009, p15.

> *I want to be very careful here because there is a tendency in educational debates to set things up as a dichotomy when they are not at all. There is some ridiculous notion that there can be either learning or enjoyment. That is an absolute nonsense. There can be learning and enjoyment, and there should be in our schools. Particularly in the area of early childhood, we often get trapped into the debate about whether it is formal learning or play learning. Through play we want learning. It is not one or the other.*[529]

DET believes that there is no one method for teaching children to read and that there must be a balance between direct teaching and experience. However it acknowledges that the emphasis on phonics has been underplayed by DET.

> *The position that we have taken with respect to phonics, both recently and over the past 10 or 20 years, is that we regard phonics as an important part of, but not the sole part of, the teaching of reading. We believe that it has a place and that children must develop phonological awareness through the graphing-phoning linkage—to use that sort of terminology. We believe that there must be, as part of a balanced teaching of reading, an attention to phonics. That has been our approach for many, many years. There is some suggestion from the evidence that we have collated—some of that work has come from the work of Steve Heath and Bill Louden's research into schools—that, possibly, in recent times, if you like, the instruction of phonics has not been as well developed as it could have been. As a result of that, we have developed additional resources and supports for teachers. We have not gone, and would not go, down a line that says that phonics is the only way of teaching children to read. But phonics is an important step, and an important first step and an early step.*[530]

And again the need for a renewed focus on phonics was emphasised by DET.

> *Whilst every state and every territory and every system talks about a balanced approach and talks about the importance of phonics, maybe phonics was not given as much 'oomph' as it could have been. We have responded to that.*[531]

(c) Individualised approaches in schools

The Committee found that different schools and education districts have somewhat varying strategies to teaching phonics, in an effort to meet the challenges presented by developmentally vulnerable children. For instance:

(i) West Pilbara

In the West Pilbara there is a strong emphasis on the teaching of phonics. The District Education Office Director advised the Committee that literacy and reading has a major emphasis in every

529 Mr David Axworthy, Executive Director School Support Program, Department of Education and Training, *Transcript of Evidence*, 3 July 2009, p3,10.

530 Mr David Axworthy, Executive Director School Support Program, Department of Education and Training, *Transcript of Evidence*, 3 July 2009, p3,10.

531 Mr David Axworthy, Executive Director School Support Program, Department of Education and Training, *Transcript of Evidence*, 3 July 2009, p 15.

primary school. There are sessions in every school at 8:00 in the morning focussing on phonological awareness and then moving onto grammar.

This daily 2 hour literacy block starts in pre-primary & Year 1 through to Year 7. Most schools have opted to have their literacy block during the first session as this is seen as the optimum learning time for students. Many schools have moved towards strengthening the teaching of phonetics as well as using the NAPLAN planner, found on the DET website, to strengthen student literacy learning. All remote schools have implemented the Aboriginal Literacy Strategy (2 hrs daily), which commenced as a strategy in 2006.

(ii) Fitzroy Valley DHS

Schools have a mandated 2 hour literacy strategy and, this year, this is supported by a numeracy strategy. It's not phonics but a mix of approaches which has been established in response to the whole language approach. This is incorporated under the Fitzroy Literacy Plan which has a common approach for schools, but does not include the independent schools.[532]

(iii) Challis ECEC

Challis ECEC adopts a prescriptive approach to teaching literacy. The school has developed its own very detailed syllabus. This highly structured approach prescribes order in which children will be introduced to sounds and the relationship between the sounds of their language and the letter patterns that used to write those down in actually words.[533] The staff of Challis ECEC believe given the level of development of the children presenting that direct and very explicit instruction is imperative if the students are to reach average literacy standards. Accordingly Challis ECEC adopts a very prescriptive approach to teaching literacy.

Finding 35

Current AEDI and NAPLAN results highlight deficiencies in the existing approach taken to teaching literacy and numeracy. In response to these results and to recent research there has been a growing awareness in the Department of Education and Training of the need to place a stronger emphasis on the teaching of literacy using phonics. This increasing emphasis is in line with the findings of Australian and international inquiries into the pedagogy of literacy in the early years. However there appears to be no strong curriculum development supporting these recent moves on the teaching of phonics.

532 Mr Paul Jefferes, Fitzroy Valley DHS Briefing 5 June 2009.

533 Ms Lee Musumeci, Principal Challis ECEC, Briefing 3 June 2009.

Recommendation 28

In line with the *National Inquiry into the Teaching of Literacy* (2005), the *Independent Review of the Teaching of Early Reading* (Rose, 2006) and the *WA Literacy and Numeracy Review* (Louden 2006) the Committee recommends that students be provided with systematic direct instruction in synthetic phonics so that they can master the essential alphabetic code-breaking skills required for foundational reading proficiency. Equally, they must be provided with an integrated approach to reading that supports the development of oral language, vocabulary, grammar, reading fluency, and comprehension.

Recommendation 29

The Committee recommends that a clear, best practice, evidence based, approach be adopted to teaching literacy. Priority should be given to developing a comprehensive syllabus to ensure a consistent standard in the delivery of early years literacy. This syllabus should commence at kindergarten and be part of an integrated and coordinated program for primary school literacy.

Recommendation 30

DETWA consider imposing requirements for kindergarten and primary teachers entering the profession to have completed a mandated literacy teaching program. Ideally such a program would be developed in conjunction with tertiary institutions offering teacher training but would give DETWA a direct role in guiding course content in this important area.

APPENDIX ONE

CHILD DEVELOPMENT SERVICE PRIORITISATION FRAMEWORK

There is often a greater demand for services than resources available, largely due to a significant increase in births, an increase in population due to migration, and increasing numbers of families with complex problems.

The CDS prioritisation framework has been developed to reflect the overwhelming evidence regarding the importance of the early years and the need to intervene in the first few years of a child's life.

In developing this framework, it is acknowledged that services/action could include providing direct services within the CDS and/or facilitating access to external supports/services. Children who are not eligible for CDS services will be referred to an appropriate service/agency.

Considerations governing priority allocation

Clinical judgement

Clinical judgement plays a fundamental role in the delivery of best practice services and is one of the key principles of the CDS Strategic Intent which refers to delivering best practice through 'research, evaluation, peer review and clinical judgement; implementing ongoing quality improvement; and complying with relevant legislative requirements'[8].

The importance of clinical judgement is also highlighted by the Institute of Medicine (IOM) which refers to best practice involving the 'integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences'[9].

All decisions regarding prioritisation are informed by evidence based practice, clinical judgement, available research, and the client's context.

Age of the child

Given the evidence regarding the early years and the importance of early intervention, a child's age is a significant factor when determining prioritisation.

Safety

Where a child is at imminent risk of harm to self or others, this must be addressed as a matter of urgency. The CDS is not a crisis service and children/families should be referred to appropriate services/support to address their 'urgent' needs/issues. Once the 'urgent needs' have been

addressed, children who are eligible for the CDS may also be referred to intake for priority allocation.

Complexity/severity/timeliness

The complexity, severity and timeliness of a child's needs/issues are significant factors when determining priority status.

Complex cases can include children

- with multiple disorders/issues and/or
- involved with/receiving services from multiple agencies and/or
- presenting with multiple risk factors[10] and/or
- requiring assessment and/or treatment from a multi-disciplinary team and/or
- where extraneous factors exist for example, social /family/ environmental factors that have a significant impact on the child's developmental needs.

Severity is assessed according to

- the impact of the child's developmental concerns on their functioning in various settings.

Timeliness relates to maximising the benefits of intervention through providing services at particular point/s in time based on

- the evidence for the disorder/delay and treatment and/or
- the capacity to effect change with the child/family and/or
- the presenting developmental concerns are likely to be early symptoms of a life long developmental disability.

Priority categories

Priority One

The following children will be allocated a priority one status:

1. A child of any age requiring assessment/ diagnosis/ treatment within 4 weeks

- to enable referral to external services and/or
- due to the severity of the developmental delay/concern and/or
- due to parental anxiety/distress.

2. A child of any age where there is a risk of significant deterioration (for the child/family) if action is delayed.

3. Children 0-3 years of age with developmental concerns/needs that

- are complex and/or
- are severe and/or
- require intervention at particular point/s in time (timeliness).

Priority Two

The following children will be allocated a priority two status

1. Children 0-3 years of age with developmental concerns/needs that:

- are NOT complex and/or
- are NOT severe and/or
- do NOT require intervention at particular point/s in time (timeliness).

2. Children 4-6 years of age with developmental concerns/needs that

- are complex and/or
- are severe and/or
- require intervention at particular point/s in time (timeliness).

Priority Three

The following children will be allocated a priority three status:

1. Children 4-6 years of age with developmental concerns/needs that:

- Are NOT complex and/or
- are NOT severe and/or
- do NOT require intervention at particular point/s in time (timeliness).

3. Children 7-12 years of age with developmental concerns/needs that

- are complex and/or

- are severe and/or
- require intervention at particular point/s in time (timeliness).

Priority Four

The following children will be allocated a priority four status:

1. Children 7-12 years of age with developmental concerns/needs that:

- are NOT complex and/or
- are NOT severe and/or
- do NOT require intervention at particular point/s in time (timeliness).

2. Children over 13 years of age that are

- complex and/or
- are severe and/or
- require intervention at particular point/s in time (timeliness).

Priority Five

The following children will be allocated a priority five status:

1. Children over 13 years of age with developmental concerns/needs that:

- are NOT complex and/or
- are NOT severe and/or
- do NOT require intervention at particular point/s in time (timeliness).

Assessment

Assessment is a process that involves a face to face meeting (with parent(s) and/or the client) in order to enable diagnosis and/or the formation of a management plan for a client.

Once eligibility has been determined, referrals are presented at an intake meeting.

Once a referral has been accepted at intake, a priority category is allocated to a child with the following timeframes applying to the priority categories:

Priority Timeframe for completing the assessment

1 Within 4 weeks of intake

2 Within 3 months of intake

3 Within 4 months of intake

4 Within 5 months of intake

5 Within 6 months of intake

Allocation of priority categories is informed by a range of information including the referral form, ASQ/ ASQ-SE and PAQs. It may be necessary to obtain further

information in order to allocate an assessment priority, which could include completion of a screening tool with parents and/or the client.

It is possible that different disciplines will allocate a different priority category for a child.

If a child is allocated the same priority status across a number of disciplines, it may be appropriate to spread the appointments out to take account of family needs rather than a family attending for multiple appointments in a very short space of time. It may also be appropriate to consider undertaking a joint assessment.

Treatment

Once an assessment has been completed, a 'treatment priority' will be allocated to the client based on the assessment findings. It is possible that different disciplines will allocate a different priority category for a child and priority status can change at any time.

All treatment should commence within four weeks of the initial assessment However, there may be circumstances in which this is not appropriate due to the child's needs and/or the family's circumstances. Given resource constraints, benchmarks will be developed for each priority category in relation to the maximum waiting between the first and subsequent treatment/ intervention.

APPENDIX TWO

NATIONAL INITIATIVES IN EARLY CHILDHOOD

•National Agenda for Early Childhood

the Rudd Government has placed an strong focus on children and early childhood development. There is support for this across the Council of Australian Governments. COAG has made it clear that under the broad umbrella of the Productivity Agenda, early childhood is an area that will receive significant attention.

> *The Australian Government's agenda for early childhood education and child care focuses on providing Australian families with high-quality, accessible and affordable integrated early childhood education and child care. The agenda has a strong emphasis on connecting with schools to ensure all Australian children are fully prepared for learning and life. Investing in the health, education, development and care of our children benefits children and their families, our communities and the economy, and is critical to lifting workforce participation and delivering the Government's productivity agenda..*[534]

The progress to date is outlined below:

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between the Commonwealth and state and territory governments to pursue substantial reform in the areas of education, skills and early childhood development, to deliver significant improvements in human capital outcomes for all Australian

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between the Commonwealth and state and territory governments to pursue substantial reform in the areas of education, skills and early childhood development. COAG asked its Productivity Agenda Working Group (PAWG) to deliver these reforms in the area of early childhood education and care.

The reforms envisage a new national quality framework, comprising:

- strong national quality standards for early childhood education and care;
- a quality rating system to drive continuous improvement and provide parents with robust and relevant information about the quality of learning and care;
- streamlining or integrating licensing and accreditation arrangements; and
- a national Early Years Learning Framework.

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534 Department of Education, Training and Workplace Relations, Available at: http://www.deewr.gov.au/Pages/default.aspx. Accessed on 20 April 2009.

In bringing this about, PAWG recognises that there will be implications for the existing and future early childhood education and care workforce, as well as to the cost to parents and the broader community.

As a first step towards these reforms, PAWG published a discussion paper on 2 August 2008. This discussion paper formed the basis for an extensive first wave of public consultations in August and September 2008.

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- streamlining or integrating licensing and accreditation arrangements; and
- a national Early Years Learning Framework.

In bringing this about, PAWG recognises that there will be implications for the existing and future early childhood education and care workforce, as well as to the cost to parents and the broader community.

PAWG sought input from a wide range of people and organisations to assist in developing these broad options, through:

- the release of a discussion paper on 2 August 2008;
- a public consultation process during August and September 2008, comprising:
- 48 open public forums around Australia, involving around 2,500 people from across the early childhood education and care sector;
- 35 focus group discussions, principally involving families and service providers; and
- 34 in depth interviews with key stakeholders and people who were unable to attend a forum or focus group (e.g. isolated parents).

In addition, a public invitation was issued to provide written submissions on the issues raised in the discussion paper. Around 400 submissions were received.

Key findings from the consultations

The consultations found a diverse range of views, which was expected given the wide variety of parents and families who use early childhood education and care services, the diversity of services and settings across the early childhood education and care sector, and the variations in current practice across the nine jurisdictions involved in delivering, licensing, accrediting and funding early childhood education and care.

While acknowledging this diversity, some common themes did appear:

- there is considerable impetus for reforms across the sector, with widespread support for the general thrust of the reforms as agreed at COAG and outlined in the discussion paper;

National Quality Standards:

- there is cross-sector support for the notion of stronger quality standards, especially nationally consistent

- standards focussed on 'key drivers' of quality such as relationships between staff and children, family and community partnerships, a differentiated play-based curriculum, staff leadership and management;

- parents were particularly keen to ensure that national quality standards included reference to the health and safety/security of their children;

- there was broad agreement that there needs to be a focus on the three structural indicators of quality – staff qualifications, child-to-staff ratios and group size;

- while the sector broadly recognises the importance of having properly qualified staff delivering early childhood education and care, there was recognition of the impact this might have for the existing and future early childhood education and care workforce, and for the costs of delivering services;

- parents, especially of children 0-2 years of age, tended to place a higher emphasis on a carer's capacity for nurturing and caring rather than on formal qualifications;

Quality Ratings System

- the concept of a ratings system received a mixed response. There was some general support for a three tiered

- system that drove continuous improvement in quality delivery, and little support for an A – E rating system as set out in the discussion paper;

- an example of a three-tiered system that was expressed across each of the consultation formats was

- a 'provisional', 'operating effectively' and 'centre of excellence' model. In this model, a 'provisional' service would receive active assistance and support to address aspects of its operations that required improvement;

- it was broadly agreed by parents and providers that an A – E system would not necessarily provide useful information on the services actually being provided, and cause anxiety for parents faced with needing to place their children in a 'D' or 'E' rated service. Conversely, services receiving an 'A' rating may take the opportunity to raise fees;

Regulatory Approach

- there was strong support for a nationally consistent approach to regulation of the early childhood education and care sector;
- service providers sought a reduction in the 'cost of compliance', especially the administrative burden of meeting compliance and a reduction in the overlap between Commonwealth and state/territory licensing and accreditation requirements;
- parents supported licensing and accreditation arrangements that gave them consistency and certainty around the quality of services being provided;

Early Years Learning Framework

the first wave of consultations indicated that there was not a strong understanding of the concept of an Early Years Learning Framework, suggesting that further information on this is required. A draft Early Years Learning Framework is now available (see website link below). Further EYLF consultations were held nationally during November and December 2008;

Workforce Issues

- workforce issues were consistently raised in all consultation formats, and are widely seen as a key constraint to the successful implementation of the reform proposals;
- the interrelated issues of low wages, high turnover and difficulty attracting and retaining staff were seen as being of paramount importance;
- service providers generally expressed willingness to support the ongoing development of their existing staff, though were concerned at the cost, especially in terms of time 'off line', and the impact this could have on the continuing operation of their service;
- there was general acknowledgement of the need to raise the perceived status of early childhood education and care, including to recognise it as a profession;
- participants noted that there were likely to be cost implications to upgrading the status, and therefore salaries, of people working in early childhood education and care;

Indigenous Families and Services

The consultations found that:

- Indigenous parents valued the routine and structure child care provided and saw it as supporting the children's transition to school;
- Indigenous parents' idea of quality emphasised health, nutrition and culturally and linguistically sensitive care;
- Training local people in the local community was seen as the best way forward;

The following cultural and structural issues were raised:

- concern that aspects of a service valued by Indigenous parents may not be recognised in a ratings system;
- the regulatory system needs to be responsive to local culture, circumstances and problems, especially in remote areas;
- difficulty attracting and retaining Indigenous staff, especially young staff;
- problems in obtaining and 'upgrading' qualifications, especially in rural and remote areas;
- lack of service access and affordability, often exacerbated in remote areas by a lack of local infrastructure such as staff housing;

Culturally and Linguistically Diverse Families and Services

- families in culturally and linguistically diverse communities place a high emphasis on the appropriate
- balance between reflecting cultural values and readiness for 'mainstream' society and schooling; availability (including choice) and cost of services were also key issues for these families;

Families of Children with Disability

- families of children with disability reported finding it very difficult to access services that are able to address the particular needs of their children, and often find themselves having to 'buy in' additional support services;
- reliance on finding staff with the expertise and understanding to care for their child further highlights
- the need to consider strategies for the retention of staff;

Next steps:

The outcomes from this first wave of consultations, including copies of all written submissions, have been made available to PAWG through the Early Childhood Development Sub-group for consideration in the development of more detailed draft documents, including:

- a set of draft national quality standards;
- draft models of service quality rating systems;
- a draft Early Years Learning Framework (now available at **www.dest.gov.au/sectors/early_childhood/policy_initiatives_reviews/coag/**
- **The_Early_Years_Learning_Framework.htm**); and
- proposed regulatory arrangements.

APPENDIX THREE

SUBMISSIONS RECEIVED

Number	Name	Position	Organisation
1	Ms Cora-Ann Wilson	Secretary	Early Childhood Australia (WA Branch)
2	Ms Veronica Rodenburg	Chief Executive Officer	Yaandina Family Centre
3	Ms Susan Barrera	Director General	Department for Communities
4	Ms Emma Birch		WA Country Health
5	Mr Sharyn O'Neill	Director General	Department of Education and Training
6	Ms Debbie Karasinski	Chief Executive Officer	Senses Foundation
7	Ms Margaret Sims	Professor of Early Childhood	University of New England
8	Dr Peter Flett	Director General	Department of Health
9	Ms Rachael Fallows	Developmental Paediatric OT Interest Group	OT Australia WA
10	Dr Rob Simons	Head of Research and Evaluation	The Smith Family
11	Hon Barbara Scott, MLC	Member for South Metropolitan Region	Legislative Council
12	Ms Jenny Roberts	Private Occupational Therapist	
13	Mr Trevor Parry		NIFTeY WA
14	Ms Rae Walter	Chief Executive Officer	Ngala
15	Ms Michelle Scott	Commissioner	Commissioner for Children and Young People
16	Mr Ramdas Sankaran	President	Ethnic Communities Council of Western Australia
17	Dr Corinne Reid	Senior Lecturer	School of Psychology

18	Dr Anna Targowska	Coordinator of Children and Family Studies	School of Psychology and Social Science
19	Ms Anne West		Community Health Nurses Association WA
20	Ms Penny Chapman	Administrative Assistant - Paed Rehab	Princess Margaret Hospital
21	Ms Violet Samson	Chairperson	Roebourne Strong Womens' Group
22	Ms Helen Beaton	Paediatric Physiotherapist	Touch Move Play Physiotherapy Services
23	Ms Anne Lawson		Early Childhood Intervention Australia (WA Chapter)
24	Ms Vicki Larkins		Therapy Focus
25	Ms Margaret Allen	CEO & State Librarian	Department of Culture and the Arts
26	Ms Hilary Brakewell	Manager WA Branch	Australian Physiotherapy Association
27	Ms Helen Beaton		Paediatric Physiotherapy Services Network
28	Mr David Zarb	Chief Executive Officer	Playgroups WA Inc
29	Ms Trish Barron	Manager Social Development	Pilbara Development Commission
30	Dr John Wray	Paediatrician	
31	Mayor Glenys Godfrey	Mayor	City of Belmont
32	Ms Tricia Lee	Executive Director	Wanslea
33	Ms Sheenah Kantharatnam	Executive Assistant	CHILD Australia
34	Ms Shelly Lombardini	Project Officer	Eastern Wheatbelt Early Years Network
35	Professor Carmel Maloney		Early Childhood Studies
36	Mr Terry Murphy	Director General	Department for Child Protection
37	Dr Ron Chalmers	Director General	Disability Services Commission

APPENDIX FOUR

HEARINGS

Date	Name	Position	Organisation
11 March 2009	Ms Susan Barrera	Director General	Department for Communities
11 March 2009	Ms Helen Creed	A/Exec Director, Children and Family Services	Department for Communities
11 March 2009	Mr Terry Murphy	Director General	Department for Child Protection
25 March 2009	Mrs Margaret Abernethy	Senior Policy Officer	Child and Adolescent Community Health; Department of Health
25 March 2009	Mr David Ansell	Executive Director	Department of Education and Training
25 March 2009	Ms Susan Barrera	Director General	Department for Communities
25 March 2009	Mr Mark Crake	Director	Child and Adolescent Community Health; Department of Health
25 March 2009	Ms Helen Creed	Acting Executive Director	Children and Family Service; Department for Communities
25 March 2009	Mrs Kate Gatti	Director	WA Country Health Service
25 March 2009	Ms Erin Gauntlett	Senior Portfolio and Policy Officer	Department of Health
25 March 2009	Dr Janet Hornbuckle	Consultant Maternal Foetal Medicine & Co-Lead Womens and Newborns Health Network	King Edward Memorial Hospital
25 March 2009	Ms Fiona Lander	Executive Director	Department for Child Protection

25 March 2009	Mr Mark Morrissey	Executive Director	Child and Adolescent Community Health; Department of Health
25 March 2009	Professor Trevor Parry	Chairman	National Investment for the Early Years (WA)
25 March 2009	Dr John Wray	Doctor/Paediatrician	
25 March 2009	Ms Raelene Walter	Chief Executive Officer	Ngala
25 March 2009	Ms Elaine Bennett	Director	Early Parenting Service; Ngala
25 March 2009	Miss Helen Beaton	Paediatric Physiotherapist	Touch Move Play Physiotherapy Services
6 April 2009	Dr Martha Burns	Professor	Northwestern University Chicago
20 May 2009	Dr Steve Heath	Research and Clinical Psychologist	University of WA
20 May 2009	Ms Mandy Nayton	Chief Executive Officer	DSF Literacy & Clinical Services
10 June 2009	Ms Maureen Mears	Associate Dean	University of Notre Dame Australia
10 June 2009	Dr Yvonne Carnellor	ECE Coordinator	Curtin University of Technology
10 June 2009	Dr Libby Lee-Hammond	Senior Lecturer	Murdoch University
10 June 2009	Mr David Axworthy	Executive Director School Support Program	Department of Education and Training
10 June 2009	Dr Jenny Jay	University Lecturer	Edith Cowan University

APPENDIX FIVE

BRIEFINGS

Date	Name	Position	Organisation
9 December 2008	Ms Sally Brinkman	Epidemologist	Telethon Institute for Child Health Research
	Ms Julie Dixon	Principal Policy Officer	Commissioner for Children and Young People
	Mrs Lee Musumeci	Principal	Challis Early Childhood Education Centre
	Ms Michele Scott	Commissioner for Children and Young People	Commissioner for Children and Young People WA
	Professor Sven Silburn	Clinical Psychologist	Telethon Institute for Child Health Research
23 February 2009	Ms Sue Davies	Director Education and Care	Ocean View College Children's Centre
	Hon Jay Weatherill	Minister for Early Childhood Development	
24 February 2009	Ms Kathy Melsom	Indigenous Affairs and Early years Learning	ACT
	Pam Cahir	C.E.O.	Early Childhood Australia Inc
	Alyson Wessex	Branch Manager	FaHCSIA
25 February 2009	Professor Frank Oberklaid	Director of the Centre for Community Child Health	Centre for Community Child Health Royal Children's Hospital

	Dr Sharon Goldfeld	Paediatrician and senior fellow at the Centre for Community Child Health	Centre for Community Child Health
	Ms Sally Brinkman	Epidemiologist	Telethon Institute for Child Health Research
	Professor Steve Zubrick	Head of Population Sciences	Telethon Institute for Child Health Research
	Professor Collette Tayler	Chair of Early Childhood Education and Care	University of Melbourne
	Mr Robert Griew	Deputy Secretary	the Office for Children and Early Childhood Development
	Professor Hayes	Director	Australian Institute of Family Studies
26 February 2009	Ms Joan Gilbert	Director	Education and Care
	Ms Andrea McGuffog	Manager	Early Childhood Strategy
	Jan Andrews	Deputy Chief Executive	Schools and Children's Services
	Ms Patricia Winter	Executive Director	Early Childhood Services (DECS)
	Ms Naomi Arnold	Director	Early Childhood Development Strategy (DECS)
	Ms Liz Wilson	Director	Early Childhood Development (DECS)
	Ms Sue Barr	A/Director	Business Affairs (DFC)
	Ms Trish Strachan	Executive Director	Child, Youth & Women's Health Service (SA Health)

4 June 2009	Kim Crawford,	Principal	Karratha Educational Support Centre
	Colleen Longmore		Communities for Children
	Madge Mohi		Disability Services Commission
	Anne-Marie McLaughlin		Department for Child Protection
4 June 2009 Pilbara Early Learning Alliance:	Elaine Clifton Kathryn Moelands Marline Grogan Carol Warren Maureen Allert Cath O' Connor Janette Tuttle Carolyn Biar	Indigenous Strategies Branch, Senior Project Officer Children's Services Officer Manager Coordinator Agreements Manager, Supervisor Towns Coastal Principal Project Officer	DEEWR Social Development, Pilbara Development Commission Department for Communities Pilbara, Child Australia Pilbara Family Day Care Scheme Indigenous Coordin Centre RIO TINTO Iron Ore Pilbara Development Commission
4 June 2009	Yaandina Family Centre		
4 June 2009 Roebourne Strong Women's Group	Violet Samson, Marion Cheedy, Jane Cheedy Pansy Hicks Beth Smith		
4 June 2009	Vicki Jack	Director	District Education Office
5 June 2009	Emma White	District Director	DCP East Kimberly

	Jamie Malloch	A/Team Leader	Department for Child Protection
	Denise Cottrell	Field worker	Department for Child Protection
	Marietta Deegan	Responsible Parenting	Department for Child Protection
5 June 2009	Joanne Wraith		CAMHS-WACHS
	Julia Boyd		Fitzroy Valley Early Learning Centre
	Helen Fitzgerald		Marninwartikura Womens Resource Centre
	Bridget Miller		MWRC Family violence prevention and legal unit
	Tracy Wilkinson		Marninwartikura Womens Resource Centre
	Melissa Williams		Kimberley Population Unit
	James Brown		Kurnangki Community
	Patrick Green		Jungawa Community and Leedal P/L
	Helen Thomas		SJOG Health Care Junpuwa Community
	Marmigee Hand	Teacher	Community Education Centre
	Paul Jefferes		Fitzroy Valley DHS
	Ian Gibson		WAPOL
	Carol Erlauk		WACHS
	Rachel Hinkley	Curtin OT Student	Derby Health Services
	Lizzie Bayley	OT	Derby Health Services

	Ana Mairata		DHS (WACHS)
	Meredith Kefford		Nindilingarri ICV Volunteer
	James Fitzpatrick		WA Health Dept
	Dawn Reelor		WACHS
	Kevin Oscar		Duniba Inc
	Trish Muir		Nindilingarri CHS
	Maureen Carter	CEO	Nidilingarra CHS
5 June 2009	Megan Roseworn	Team Leader	Halls Creek Hostels Project
	Claire Weygers	Senior Case Support Worker Parent Support Service	DCP
	Sgt Tim Norrish	WA Police Officer in Charge	
	Dr David Shepherd	Senior Medical Officer	Halls Creek Hospital
	Carla Priest	Team Leader	DCP Halls Creek Office
5 June 2009	Gavin Stevens	Principal	HC District High School

Town of Kwinana 29 July 2009	*Town of Kwinana representatives:*	
	Neil Hartley	Chief Executive Officer
	Barbara Powell	Director Community Services and Development
	Lyn Devereux	Manager, Community Recreational and Cultural Services
	Grant Shipp	Strategic Projects Coordinator
	Trish Rear	Bright Futures Family Day Care Scheme Manager
	Brett Hatwell	Town Librarian

	Caroline Jones	Youth Librarian
	Leeanne King	Recquatic Dry Program Coordinator
	Kelly Brady	Personal Assistant
	Other Local Government representatives:	
	Susan Johnson	City of Rockingham
	Naomi Cathcart	City of Rockingham
	State Government Department representatives:	
	Angela Poole	Department of Health: Community Health
	Hilda Wright	Department of Health: Community Health
	Sandy Clarke	Department of Health: Child and Adolescent Mental Health Services
	Kerry Beros	Department of Health: Child and Adolescent Mental Health Services
	Julie Jones	Department Indigenous Affairs
	Beverley Rebbeck	Department Indigenous Affairs
	Joanna Filkin	Disability Services Commission
	Sandy Reed	Disability Services Commission
	Kate Darcey	Department for Communities
	Linda Wilkins	Department for Communities
Federal Government representatives:		
	Anthea Grosse	Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)
	Education representative:	
	Professor Barry Down	Murdoch University
	Community Service Organisations representatives:	
	Ronnelle Campbell	Kwinana Early Years Services (KEYS)

	Bev Jowle	South Coastal Women's Health Service
	Kristen	South Coastal Women's Health Service (student)
	Tina Dean	Ngala
	Maggie Tait	Ngala
	Helen Burgess	Communicare
	Craig Stewart	The Smith Family