Inquiry Submission

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

Committee Name: **Community Development and Justice Committee**

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The following submission is made by Dr. Corinne Reid, a clinical psychologist and Dr. Libby Lee, an Early Childhood Education specialist. Both Dr. Lee and I are practitioners and academics and currently hold a joint grant from the Aboriginal Education and Training Commission and the Department of Education and Training to evaluate the Best Start program being run at Mungullah Aboriginal community in Carnarvon. This program caters for children aged 0-5 years and their carers. We would like to share with the Committee some of the issues that have been highlighted in the process of gathering evidence as to the effectiveness of the Best Start program. These points are outlined below. Both Dr. Lee and I would be happy to appear before the committee to present this case more fully.

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

We believe that Best Start offers a unique opportunity to provide early intervention and prevention for children at high risk of social and cognitive impairment. Moreover, its philosophy of involving both parent and child in the program is best practice and offers an opportunity for systemic enhancement rather than merely individual remediation – it is clear to us that the latter is bound to fail in the absence of familial engagement, education and support.

We have found that all Best Start staff are committed to assisting the kids and families. However, they have repeatedly expressed to us their need for more training and support. Parents also consistently report that Best Start offers an important opportunity for their kids but feel that it is an unreliable source of support in this instance.

In considering these findings, we feel that the following improvements would assist Best Start to fulfil its potential in this community (i) ensuring that the program runs

consistently and is not allowed to succumb to the vagaries of staff contracts (ii) that at least one indigenous staff member is employed to facilitate the development of trusting relationships between families and staff (iii) staff be provided with training in child development, early childhood education and working with indigenous communities (iv) staff be provided with accessible and regular support in their ongoing management of the program (v) staff be provided with the opportunity for ongoing professional development (vi) that a process be implemented (and resources provided) for assessing the needs of individual children and their families so that there is an evidence-base for identifying vulnerability in particular cases and to assist in making referrals to appropriate services (viii) resources and support be provided such that the program is linked with other relevant service providers, particularly schools. These links are imperative if the purpose of the program is to be fulfilled in the longer term. While some of these issues are particular to this Best Start in this community, others seem to be relevant to services in other Indigenous communities and still other issues are true for all Best Start programs and also for other early intervention programs.

In sum, Best Start in our experience offers great potential but requires the above changes to allow it to address the social and developmental needs of children aged 0 to 3 years. We would like to see resources committed to this program and a more evidence-based, informed approach to developing programs that meet the needs of local communities. Most importantly, this should include some form of assessment of vulnerability and resourcefulness of each client (or potential client) to underpin a preventative and/or early intervention model of service.

(b) how to appropriately identify developmentally vulnerable children;

Identifying developmentally vulnerable children is a sensitive task and one that is the focus of our current research. It is optimized under the following conditions:

(i) Parental support and co-operation is a priority and as such is accorded relevant time and resources to establish relationships of trust and collaboration. If such support is not forthcoming, it makes early intervention more difficult and less likely to succeed

(ii) It is targeted at both the individual and systemic level. Each individual child is, to a large extent, at the mercy of his or her life context. Understanding what resources and obstacles exist in that life context both assists in assessing vulnerability and potential sources of resilience and robustness

(iii) It utilizes the gathered information to inform intervention decisions and where intervention is desired, to plan intervention. No assessment process should be undertaken without being utilized in furthering the care of the child

(iv) It should use a comprehensive developmental profiling approach which incorporates: observation of the child(ren)'s abilities, observation of the parent(s)/child dynamic , parental report about the child and family, self-report of the child where appropriate (these can often be quite illuminating), and formal testing of cognitive potential *and* achievement (both are important) as well as social and functional behavioural capacity and achievement. Each aspect of this profiling process is imperative and informs the other. Relying on any one test or any single observation or report is unlikely to provide sufficient evidence upon which to plan and implement a lasting intervention. There is a large evidence base on risk and vulnerability in children and families which should provide guidance in the selection of relevant tools for a given community. Currently for example we are using a combination of structured and unstructured observation,

parental and self-report, formal cognitive assessment (including the Bayleys, WPPSI and for older children the WISC-IV), formal assessment of activities of daily living (including the Vineland) and social development (including the Strengths and Difficulties Questionnaire).

Some argue that such tests are not sensitive enough or have sufficient predictive validity to be useful. However, we have found that when taken together, an informative profile of consistencies and discrepancies, strengths and weaknesses, can be developed which, in the large majority of cases, maps very well with the reports of children, parents and teachers. Further, insensitivity to cultural differences is also often cited as a reason *not* to test. Obviously care and careful selection is required but we have found this view is often based on fear rather than evidence. Our current study is showing that, contrary to current government policy, the sole use of non verbal cognitive assessments for indigenous children disadvantages some of the children we are assessing though it is intended to do the opposite. As with non-indigenous children, some of these children show relative strengths in verbal ability which is neither assessed nor catered for. In these cases, a lower level of overall ability is inferred on the basis of a restricted assessment process.

(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;

While it may be argued that in each community, the relevant person to provide this role may be different, we have noticed that role uncertainty can lead to the breakdown of collaborative relationships. In our view, schools have a powerful presence in every child's learning life which offers unparalleled potential for schools to take the lead in engaging and supporting children and families during these earliest years of life. It seems that schools and the educational system have the 'reach' and the relevant educational training though perhaps not currently the relational training nor the staffing capacity to undertake this role successfully. An attitudinal re-orientation and goal re-prioritisation would need to occur as part of a cultural shift to support the educational system in working collaboratively to engage, support and integrate children and families into an ethic and practice of collaborative lifelong learning.

It is also worth noting that we have found in our study 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 insurmountable obstacle at the age when schooling becomes compulsory.

A final point to make is that, in the community we are working with, it is invaluable to have an indigenous person supporting this process of early engagement with learning and then supporting the transition into the school system. Their presence and their example offers a powerful yet unspoken impetus to the process. The trust inherent in this relationship can circumvent many concerns that are difficult to address verbally.

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

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' behavior to observe in the first instance. In these instances, what must be captured are changes in understanding and attitude rather than necessarily in behavior.

Even when there are identifiable and measureable behavioural goals, change can be idiosyncratic in nature, timing and value for each child and each family. Our approach to evaluation must accommodate this. As outlined in response to an earlier point, comprehensive profiling of children and families provides a strong baseline for individually responsive intervention planning, implementation and then, finally, for measuring outcome against this baseline. Profiling is a powerful tool in individual case management as well as service evaluation.

Careful evaluation also requires both quantitative and qualitative information that also includes evidence of such things as attendance, client satisfaction ratings and snowballing referrals. It also requires long term follow-up, the perspective of multiple participants including parent, service provider, related agencies and, most importantly, the child. Children are often overlooked as a source of credible information , yet even young children are capable of indicating verbally and/or in their behaviour what their strengths and weaknesses are as well as what their concerns, wishes, hopes and preferences are.