Australian Childcare Alliance

Early Years Strategy Submission

#BestStartInLife

May 2023

Contents

Introduction

This submission was developed by the Australian Childcare Alliance (ACA) in response to the Australian Government's call for submissions to provide feedback on the draft Early Years Strategy.

The ACA is gratified that the Australian Government is committed to developing a long-term strategy as a framework for action and reform in the Early Childhood Education and Care (ECEC) sector and we welcome the opportunity to contribute our views and experiences to this discussion.

As the national peak body in the Australian Early Childhood Education and Care (ECEC) sector, the Australian Childcare Alliance (ACA) represents more than 2,500 members and approximately 360,000 families throughout Australia. We work on behalf of long day care service owners and operators, predominantly private, to ensure families have an opportunity to access affordable, quality ECEC throughout Australia.

The ACA has existed in various forms for more than 30 years. Our experience means that we understand the critical role a quality ECEC program plays in the life of families and the importance of a viable long day care sector in preparing children for the best start in life and learning.

This submission paper reviews the draft Early Years Strategy to identify any areas that we believe may be improved or clarified, to set the foundation for the best outcomes for the early learning sector, thus ensuring that **every child in Australia** has access to high quality, affordable and sustainable early learning services, and therefore the **best start in life**.

Yours sincerely,

Paul Mondo
President
Australian Childcare Alliance

Structure of the Strategy

The Australian Childcare Alliance (ACA) would like to see the proposed structure of the Early Years Strategy ("the Strategy") adjusted to reflect a nationally consistent approach held by existing early year's strategies reviewed across Australia and internationally[1]. This format is the basis of ACA's recommendations for greater attention, focus and consistency that is not currently reflected in the structure.

Further to this initial work on the Strategy, we understand that it will be supported with an Implementation Action Plan, a clear set of deliverables and an Outcomes and Evaluation Framework. Whilst these are both essential components to support the Strategy, they do not however discount the need to have clear strategies and other core aspects included in the Strategy structure. The level of detail of actions to be taken and measuring the impact comes from the Action Plan and Outcomes and Evaluation Framework.

ACA recommends the structure of the strategy should adopt:

- A clear purpose

  The Purpose should sit under the Vision to set out the overarching aim of the Strategy in clear, simple terms. It should support the Vision and speak in meaningful terms to the diverse Early Years stakeholders (including different government departments, community services, ECEC services, peaks, health providers, etc.) who work with children and families in varying capacities. Having a clear purpose provides an anchor – a common goal for the whole sector - in terms of why the work is being done. It also sets the foundation for a meaningful evaluation of the strategy in the coming years, so that there are clear, identifiable measures of success.

- A set of clearly defined goals[2].

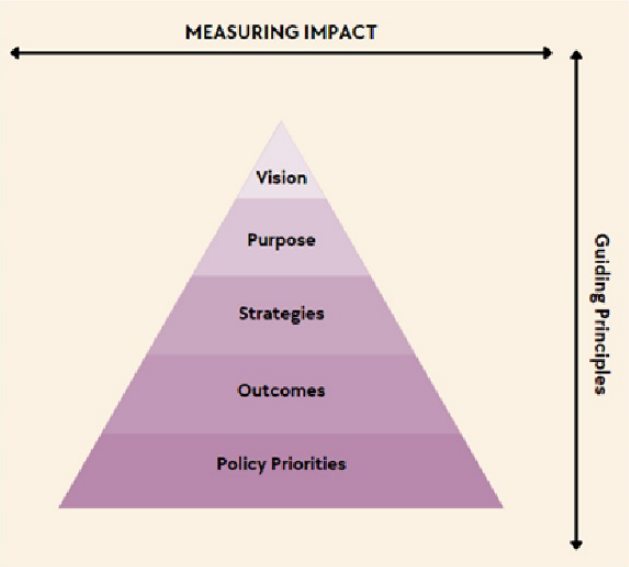

Figure 1 - ACA's recommended revised structure.

[1] First Five: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019-2028, Government of Ireland , https://assets.gov.ie/31184/62acc54f4bdf4405b74e53a4afb8e71b.pdf

[2] Opportunity to link goals to the *OECD Aspirational Child Wellbeing Measurement Framework*, Measuring What Matters for Child Well-being and Policies, OECD (2021)

- Strategies with Strategic Priorities
  We recommend that these can be taken from the Early Years Compact[3] as per the suggestions below:
  - driving better outcomes
  - a more coherent and empowering early childhood system
  - stronger place-based governance and planning
  - promoting early childhood
  - supporting service quality
  - more inclusive services.

- Guiding principles to wrap around the entire strategy structure to foster an intention of how each aspect within the Strategy will operate embedding commitment with accountability.

[3] *The Early Years Compact (2017-2027)* is a ten-year agreement between Victorian Government State Departments (Department of Education, and the Department of Families, Fairness and Housing) and local government (represented by the Municipal Association of Victoria). This was part of the *Supporting Children and Families in the Early Years (2017-2027).*

Vision

ACA believes the Vision needs to reflect the need for **all Australian families** - from all backgrounds, cultures, demographics, geographics and individual circumstances - to have access to affordable, high-quality early learning services.

It should reflect an aspirational future for Australia's children and families from birth to five years, that cultivates a sense of responsibility, action, and importance from all those engaged with the Strategy. A clear, national Vision will help to motivate and inspire others around a concept and important work for the next ten years.

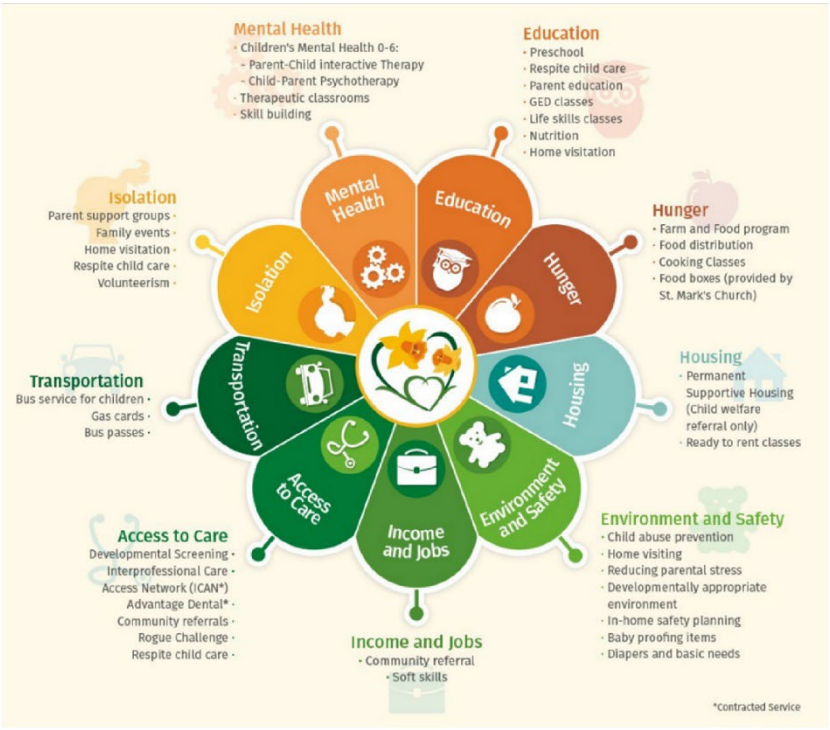

Figure 2 - Example of Social Determinants in Health - how it operates in an ECEC and children's services lens in America Sourced from the Family Nurturing Centre

"[If] children are seen as a collective national responsibility or as a moral charge upon all of us to whom they are vulnerable, the state has potentially a much greater role in promoting the well-being of children." [4]

SOCIAL DETERMINANTS OF HEALTH

The Social Determinants of Health and Wellbeing[5] with a ECEC lens has been used to inform this submission. Early childhood teachers and educators work with children on a daily basis and build awareness of each child's unique characteristics, strengths, challenges and development.

[4] Goodin, R. E. (2003), *Responsibilities for Children's Well-Being* cited in S. Richardson & W. Prior, *No Time to Lose: The Wellbeing of Australia's Children* (pp. 60–83), Melbourne University Press citied in, *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health, P10

[5] World Health Organisation Commission used the Social Determinants of Health to explore how to reduce inequities in power, money and resources and people's daily living conditions to improve health equity.
World Health Organisation (2008), *Closing the Gap in a Generation: Health Equity Through Action on The Social Determinants of Health, Final report of the Commission on Social Determinants of Health*, World Health Organisation Commission

These educators talk to the parents almost every day. They observe the children closely - how they play, how they interact with each other. They provide them with their early learning stepping stones.

Evidence indicates that birth to five years is a critical period of brain growth and development for a child. These early years are the foundation of a child's health, wellbeing and overall the life path which can be measured through what are known as "Social Determinants of Health". Social Determinants of Health are a range of factors that are non-medical factors that contribute to and influence health.

> *"One way of reducing inequities during early childhood at the daily living conditions level is through the provision of high-quality early childhood education and care... learning and development are cumulative – the skills acquired early form the basis for later skill development."* [6]

Following on from considering Social Determinants of Health, ACA strongly believes the 'Rights of the Child' as listed in the United Nations (UN) Convention on the Rights of the Child[7] are highly relevant and therefore also need to be embedded in the Vision and overall Strategy. This should inform a national Vision for all Australia's youngest children to:

- have access to services such as health and education;
- be protected from abuse, exploitation, and harm; and
- participate, have their voices heard in the community and in relation to the decisions that affect them. [8]

A clearly communicated Early Year's Vision should be a critical collaborative commitment from diverse stakeholders working with a child from birth to five years and their families across education, health, social care, and Commonwealth departments for better outcomes. This requires a holistic lens of what contributes to all areas of life, education, health and wellbeing and safety to grow our children now and into the future.

> *"The need for a national policy on general services to the family is a matter of pressing concern... …. A child care policy must be set in a broader context; one which takes account of housing, income maintenance, health, legal protection and education policies for the community as a whole."* [9]

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[6] Alexander et al., 2001; Cunha et al., 2006; Field, 2010; Meisels, 1998; Rigney, 2010; Stipek, 2001, 2005, cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health p 47

[7] https://www.unicef.org.au/united-nations-convention-on-the-rights-of-the-child?&mkwid=&pcrid=&pkw=&pmt=&pdv=c&plid=&gclid=CjwKCAjwxr2iBhBJEiwAdXECw2BcfpIIZRf-eIaKdOI-deo4ocCsueBdMau33vr4EJmCwn1f0vqe0BoCJAwQAvD_BwE&gclsrc=aw.ds

[8] Wong and F. Press (2012), *Integrated services in Australian early childhood education and care: what can we learn from our past?* Australian Journal of Social Issues Vol.47 No.2

[9] *SWC 1974: 13,* 165, cited in S. Wong and F. Press (2012), *Integrated services in Australian early childhood education and care: what can we learn from our past?* Australian Journal of Social Issues Vol.47 No.2

ACA'S RECOMMENDATIONS FOR THE WORDING OF THE VISION:

"Creating strong foundations for a child's success now and into the future into adulthood – good outcomes in the early years will lead to a better future."

Outcomes

Each outcome needs to place the child at the centre, with the underlying question considered being "What do children and families need to access to succeed?":

- Every child born and raised in Australia has access to resources to support their physical and mental wellbeing to flourish
- Every child has access to health and care support that responds to their individual circumstances
- Every child has the right to feel nurtured, safe, and secure within their families, learning, care, and healthcare environments.
- Every child has access to high quality ECEC learning and care that is simple and affordable regardless of the child's background
- Strengthening the current service delivery to existing ecosystem of Allied Health clinicians and other child focused practitioners
- Cultivating a strong workforce to respond to the needs of the child and family

Policy Priorities

WHAT SPECIFIC AREAS/POLICY PRIORITIES SHOULD BE INCLUDED IN THE STRATEGY AND WHY?

The core policy priorities for the government to focus its efforts through the national Strategy with further reasons why these should be included are elaborated in the following section relating to vulnerable populations.

- **Equity** through needs based funding and universal proportionality.
- **Access** by streamline services without delay, make systems easier to navigate and invest in integrated family and children services.
- Affordability with investment in different funding models, Inclusion Support and CCS.
  Existing policies that relate to affordability in ECEC is the Cheaper Child Care for Working Families, Preschool Reform Agreement 2022-2025 and National Strategy to Achieve Gender Equality. These are important commitments by the Commonwealth to support families, however, there are still significant gaps that are barriers to families accessing affordable ECEC, particularly those with children who have additional support needs.
- **Quality** with investment in workforce, national consistency of training and regulations. Existing policy that relates to quality is the National Quality Framework (NQF) Review, Early Childhood Education & Care framework, and Shaping Our Future: National Children's Education and Care Workforce Strategy.
- **Culturally safe and responsive** practices embedded in all services (across education, health, and care) which a child and family may interact with. Existing policies that relate to culturally safe learning environments is the National Aboriginal and Torres Strait Islander Early Childhood Strategy National Agreement on Closing the Gap.
- Commitment to a **whole government collaboration** at every level (Federal, State and Local), across departments and systems for accountable, clear responsibilities and roles for greater outcomes for our youngest children. Unless this Strategy is supported by each jurisdiction, it will likely fail.

  The success of this Strategy comes from all levels of government, with agreeance that this Strategy is fit for purpose. There needs to be a commitment to support the implementation and link future policy decisions back to Strategy on a state level.

  One step towards this whole government coordination is the development of the National ECEC Vision that aims to create and unify a holistic approach that breaks down silos and addresses systems challenges.
- Research and **data collection** to better understand issues and inform policy from an evidence basis. The current use of the AEDC data helps to identify a problem. Now we need to ask and move towards what does success look like from AEDC perspective?

  The ideal outcome is that there are no children experiencing developmental vulnerability in the future. This would be the ultimate outcome and success would look like improvements incrementally proven in AEDC data, with focus on a cohort level (children who identify as Indigenous) and on a global level (Australia).

WHAT COULD THE COMMONWEALTH DO TO IMPROVE OUTCOMES FOR CHILDREN — PARTICULARLY THOSE WHO ARE BORN OR RAISED IN MORE VULNERABLE AND/OR DISADVANTAGED CIRCUMSTANCES?

One in ten preschool aged children in Australia are exposed to multiple factors that put them at increased risk of mental illness in adulthood. Examples of risk factors include[10] :

1. poor physical health, particularly among children who spend a long time in hospitals
2. personal trauma, experienced either by the child or by a family member
3. socio economic disadvantage
4. lack of access to services, for example, for children living in remote areas
5. being in out of home care or in the child protection system, and in particular Aboriginal and Torres Strait Islander children in out of home care.

For some children, these factors compound to put them at risk of severe mental illness. For example, Aboriginal and Torres Strait Islander children in remote communities are often affected by entrenched disadvantage, exposure to trauma and poor physical health. By the age of three, Aboriginal and Torres Strait Islander children tend to have higher rates of social and emotional difficulties, compared with other children, and the gap continues to expand as children grow[11].

Some of these risk factors can be ameliorated through early intervention. Numerous studies and trials have shown that early intervention for vulnerable children can significantly improve outcomes[12].

Many of these children at risk are in childcare and/or early childhood education settings. As a key service for families and children, long day early learning centres are, therefore, ideally placed to contribute to the early detection of risk factors for family violence, neglect, health or developmental vulnerabilities or other concerns that require additional support. Indeed, everyday 360,000 families walk through the doors of ACA centres and the children from 0-5 years spend up to 11 hours within the embrace of the nurturing educators.

[10] Jordana K, Obioha C, Ukoumunne, Nina Lucas, Melissa Wake, Katherine Scalzo and Jan M. Nicholson, (2011) *Risk Factors for Childhood Mental Health Symptoms: National Longitudinal Study of Australian Children*, Centre for Community Child Health, Royal Children's Hospital https://www.rch.org.au/uploadedFiles/Main/Content/ccch/Risk_factors_for_childhood_mental_health_symptoms_Bayer.pdf

[11] Milbank Q (2017), *Risks for Mental Illness in Indigenous Australian Children: A Descriptive Study Demonstrating High Levels of Vulnerability*, National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5461394/

[12] Wise, (2013*) Improving the early life outcomes of Indigenous children: implementing early childhood development at the local level*, Issues paper no. 6 produced for the Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, and the Australian Institute of Family Studies - https://www.aihw.gov.au/getmedia/b46de39b-eeb5-4a98-87e8-44dad29f99b9/ctgc-ip06.pdf.aspx?inline=t rue

Equity and Access: Universal Proportionality and Needs Based Funding

Proportionate universality responds to the needs and level of disadvantage of each child and family, based on their individual circumstances. The existing ECEC structure has a 'one-size-fits-all' approach which fails to respond to the diverse needs of a child and family. We know that some communities - as supported by Socio-Economic Indicators For Areas (SEIFA) data and Australian Early Development Census (AEDC) data - are at greater risk of financial and developmental disadvantage.

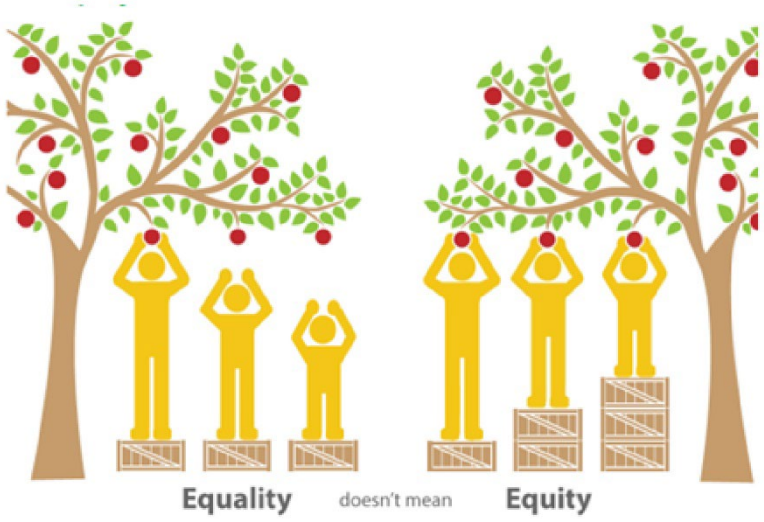

Figure 3 - A visual representation of the difference between equality and equity

The current funding model takes a general approach for the whole population. The effect is that it magnifies the disadvantage from one to another, fails to consider different circumstances and contextual challenges (like remote vs metro communities). In highlighting these current issues based on the existing funding model, it raises the need for a more responsive approach, with community led solutions and appropriate funding that is unique and represents individual needs.

ECEC can be a disruptor to affect intergenerational poverty. Participation rates to get greater outcomes in a child's life – we know that more hours of ECEC at an earlier age will benefit long term into a child's lifelong learning.

> *"Obstacles children encounter early in life can set off a negative chain of events so hard to break that they can transcend generations. Poor education leads to limited job options, which lead to lower income, living in poor neighbourhoods with poor housing, higher crime, more violence, limited access to nutritious foods, safe places to exercise or medical care—all of which leads to poorer physical and mental health."*[13]

The National Strategy needs to place greater focus to explore how to access local community knowledge, from the ground up, to inform policy, responds to need, measuring, documenting, and giving opportunities for children and families to have a voice.

[13] Risa Lavizzo-Mourey, President and CEO, Robert Wood Johnson Foundation cited in Heather Dubiel, Alyson Shupe, Rickey Tolliver, (2010*) The Connection between Health Disparities and the Social Determinants of Health in Early Childhood*, Health Watch. https://www.cohealthdata.dphe.state.co.us/chd/Resources/pubs/ECHealthDisparities2.pdf

Questions of consideration:

As part of addressing inequities experienced by family and children from vulnerable backgrounds, it is important that we reflect on the following questions:

- Where is funding best placed to support on a local, state, and federal level that is responsive and proportionate to the individual needs of children and families?
- Where can government review the existing funding streams, and modify to target funding streams that respond to local context, community, families, and their needs?
- What mechanisms and levers could the Commonwealth activate to adapt proportionate universality into the Strategy and practically?
- How can government make a greater commitment and investment for communities where more is needed?

Integrated Family and Children Services

The early years of a child's life can shape and influence their lifeline health and wellbeing outcomes. Evidence suggests that in Australia, a higher proportion of children with special health-care needs were from low SES communities.[14]

Health inequalities are more likely to impact a child from a lower socio economic, Indigenous and CALD communities. Long term impacts include chronic health implications, extra cost, and the burden on the health systems.

> *"...the **social gradient in health actually emerges in childhood**. Consequently, it is argued that interventions designed to reduce health inequalities early in childhood, and those that seek to create equal opportunities in childhood and adolescence, may help move children onto healthier trajectories, with the hope of maximising health across the life course... ... such interventions may not only have a positive impact on health, but may also assist in addressing inter-generational inequalities in health."* [15]

The investment in early childhood years has the greatest potential for leveling up the gradient to create and facilitate long term positive health outcomes.

[14] Goldfeld et al., (2012), cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health, p7

[15] Chen, (2004); Chen et al., (2007) cited in Professor John Kenneth Davies & Dr Nigel Sherriff (2012), *The Gradient Evaluation Framework: A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families*, University of Brighton

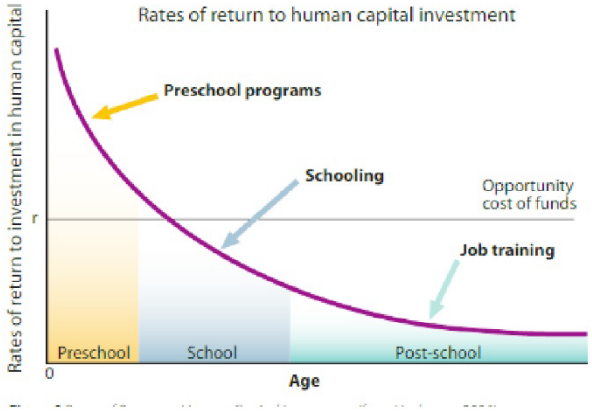

Figure 4 Source: The Social and Health Gradient, from the Gradient Evaluation Framework (Heckman, 2006)

There needs to be greater commitment to streamline services for a cohesive approach to supporting families of young children, especially those with multiple and complex needs without delay. Particularly as good service integration is a valuable method to meet the holistic needs of children and families while reducing disadvantage. [16]

An example of one of the many areas that participating in ECEC affects lifelong health and positive habits of a child is with nutrition.

The health and wellbeing of a child is influenced by the environment they live, their parent's attitudes and behaviours towards things like diet and nutrition. Effectively the intergenerational transmission of values around food within families flows onto their child's eating habits and impact their long-term health.[17]

Case Study: Child with speech difficulties

A recent example of an early learning service's early intervention highlights the positive health impact that early intervention and integrated family and children services can bring about in early learning settings.

At one of ACA's member services in Townsville, Queensland, the early childhood educators observed that a two-year old child in their care was experiencing speech difficulties. The observation was raised and discussed with the child's parents. The parents were encouraged to take their child to an audiologist to get a hearing test. After some delays, a year later when the child was three years old, he was tested and diagnosed with fluid in the ears. This condition had impacted his ability to hear, learn and develop his speech.

The child's parents took great comfort in gaining an understanding of the evolving health problem, having it diagnosed and being given the correct medical advice and general steps to support him.

The child is now seven years old and has weekly speech therapy for half an hour at a cost of $150 through the private system and is not eligible for NDIS funding.

In almost all cases, hearing loss can be prevented or minimised by early detection. However the delay in diagnosis - caused by the wait lists to see specialists - and interventions at key developmental milestones led to more intensive, high-cost and ongoing speech therapy treatment for the child.

[16] Wong, S., & Press, F. (2012). Integrated services in Australian early childhood education and care: What can we learn from our past? Australian Journal of Social Issues, 47(2), 153–173

[17] Green et al., (2003); Roden (2003), cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health p 32

With even earlier intervention, supported by less wait times for medical attention and access to treatments, it is likely the child would have experienced better outcomes even earlier, with his speech and learning outcomes improved and his overall mental and emotional wellbeing less impacted in terms of positive experiences, self-confidence and identity.

Investment in health assessments and responses at an earlier age can generate many long-term cost and health savings for the child, their family and government.

This family is paying for the private weekly speech pathology sessions, but not all families can afford this level of support, with the same frequency and cost.

This example raises the long-term implications of what happens to children from families who cannot afford higher levels of support that was not accessed or available in early childhood years.

Questions of consideration:

As part of integrated family and children services to ensure greater early years outcomes across the service delivery of education, health, and care:

- How can existing ECEC infrastructure be utilized, expanded and invested to create better health and wellbeing outcomes for all children?
- How can integrated family and children services work across the different Commonwealth, State and Local government contexts, funding models and systems?
- How could greater Integrated family and children services look for families?

Trust, consistency, and ease of systems' navigation

The knowledge, attitudes, and behaviours of health professionals can both directly and indirectly impact a child's health and the families' experience, perception and ongoing engagement of the health system. This may be based on assumptions a practitioner may have on a child and family based on their background with conscious and unconscious bias. A negative encounter or series of encounters with health professionals may result in the family feeling mistrust and disengaging from these systems.

"Child development is also influenced by the quality of community social capital – including sense of safety, norms of reciprocity, social engagement, participation, cohesion and trust."[18]

Furthermore, some people (Indigenous peoples, people from refugee backgrounds, those affected by domestic violence or abuse from people in position of power) have experienced institutional trauma and mistrust. This becomes a barrier to accessing systems as they may not feel safe to engage which flows onto their child being able to access additional support.

For a child to access the services needed to support their education, health and social needs there needs to be trust in the system, empathy, and cultural safety:

"...access involves people being able to identify health-care needs, to seek health-care services, to reach the health-care resources, to obtain or use health-care services, and to actually be offered services appropriate to the needs for care."[19]

For those already in and confident to navigate the system, they can receive the benefits better than others who struggle to understand the system, or who have not had positive experiences with the system. This includes people from non-English speaking backgrounds who are less inclined to seek support and have challenges navigating complex systems.

"Families from culturally and linguistically diverse (CALD) backgrounds may be reluctant, or feel alienated, uncomfortable or disrespected when interacting with health professionals; similarly, health professionals may struggle to identify the needs of families from CALD backgrounds"[20]

ECEC services are well placed to support families through the strong rapport and relationships built, as they are seeing them almost daily. These relationships create trust and openness to work together to understand a child's needs and what additional support or services would benefit. Trusted ECEC and family relationships also result in a greater follow through with actions by parents to engage with wider health and other services, that would see interventions for the child and family sought out sooner and creating better outcomes for the child.[21]

Building ECEC's Workforce Capacity to Respond

ECEC plays an important role as often the first responders and soft engagement for a child and family into additional support needs. This comes through the support and investment in the ECEC workforce to build the transferrable skills for educators to support all children through high quality safe learning environments.

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[18] Hertzman, (2010) cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health p24

[19] Levesque et al., (2013) cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health p26

[20] Arlidge et al.,(2009); Bolitho & Huntington (2006); Edge, (2008), (2010), (2011); Henderson & Kendall, (2011); Hoang et al., (2009); Smith et al., (2006); Towle et al., (2006), cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health p27

[21] Hertzman, C., & Power, C. (2003). Health and human development: Understandings from life-course research. Developmental Neuropsychology, 24(2–3), 719–744

According to the Royal Commission's *Family Violence Report* in 2015, ECEC services can fulfil three important roles:

- High quality ECEC services provide healthy environments for children that can promote their social and emotional wellbeing.
- Trained staff can focus on child development, identify early signs of concern, and communicate these to parents.
- ECEC services can act as a gateway into the broader mental health system or provide parents with information and education on social and emotional development and the support services available in the community[22].

Questions of consideration:

As part of workforce considerations, that work across education, health and care services:

- Has innovative approaches that respond to vulnerable populations been explored, costed and piloted?
- How could an Allied Health professional (like social worker, OT, Speech Pathologist, etc.) be funded, coordinated, and accessed for local connection of services?
- How could the State and Federal Departments of Health work together to integrate these outcomes in an ECEC place based setting?

ACA recommends that the Strategy invests in an early learning sector that is equipped with the training, skills, resources, and support to respond immediately and appropriately, providing the best and safest outcomes for children and families.

This includes training for educators that is trauma informed and culturally responsive. This training is needed urgently, to build the capacity of educators to respond and support children and families.

[22] Oberklaid, F., Baird, G., Blair, M., Melhuish, E. & Hall, D. (2013), *Children's Health and Development: Approaches to Early Identification and Intervention*, University of Wollongong https://ro.uow.edu.au/sspapers/1205/

Inclusion Support

Families who have a child with additional needs may also experience difficulties firstly identifying or understanding the nature of their child's challenge. This is where ECEC teachers and educators as first responders are best placed to observe, identify and measure if the child is tracking to key developmental milestones, then communicate concerns to parents.

ECEC services have strong relationships with both the child and their family, in which trust and rapport are built over the frequency of the engagement in the service. These relationships open more difficult conversations about what additional needs a child may need, and supporting the parents to understand this, the importance of early interventions and the systems to start to navigate.

> *"...the mechanisms that determine eligibility for disability services for children are typically complex, inconsistent and subject to change, thereby placing additional stress on parents."*[23]

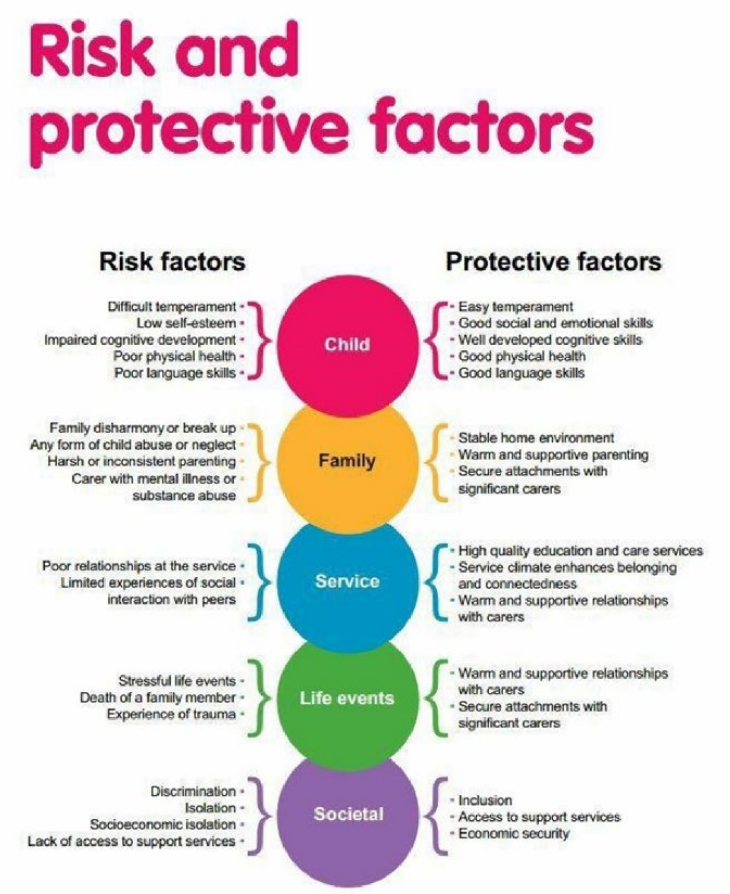

Figure 5 Sourced from Infant Parent & Early Childhood Mental Health Services

When inclusion in the ECEC environment is done well, the ECEC can be the centre of an ecosystem of additional support. This would look like a child having access and attending ECEC three, four or five days a week, child who can have learning from peers from this program, access to additional education and curriculum support.

Inclusion done well in an ECEC setting would also allow environment for allied health professionals to observe and to provide strategies for better outcomes for the child. These outcomes could be cultivated and embedded into the ECEC's program to support the child through structure and consistency. Furthermore, the educators would continue to make observations of the child's developments and identify areas of additional support needed to assist with tracking and measuring their outcomes.

[23] Ray, (2005) cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health P6

Case Study: Children with Additional Needs

Below is a recent example of an early learning service making an enormous effort to work closely with one of their families experiencing social disadvantage to achieve "every day inclusion" and bring about the most positive outcomes for the child.

The owner/operator of one of ACA's member services in Melbourne's eastern suburbs, has kindly provided the following overview:

Little Charlie started at one of our services as a three-year-old, attending 4 days per week. It became evident quite quickly that he was exposed to domestic violence in the home and that whilst his mother was not the perpetrator, she was still in denial about the severity of the situation.

Charlie's hours of attendance were quicky increased to five days a week, with very long hours per day. His behaviour indicated that he experienced separation anxiety as a result of the increased attendance at our service, and this quickly moved into aggressive, violent behaviours towards our educators as his mother was leaving and for about one hour after her departure. Throughout the day he was unable to regulate his emotions and regularly had emotional outbursts, often throwing furniture, swearing and making threats to the educators.

Unfortunately, we started to see a resistance from our team and educators as they began requesting not to go into Charlie's room unless there was additional support. We knew we needed to put some supports in place immediately to address Charlie's needs, as well as the needs and wellbeing of our team of educators and the other children.

The first step was talking honestly and openly with Charlie's mother and explaining Charlie's behaviour throughout the day to her, what his emotional triggers seemed to be and, the behavioural patterns we were seeing throughout the day. We made a commitment that, as long as she agreed to engage with external support networks, we would continue to support Charlie and their family.

Over the coming weeks we made multiple phone calls to identify all of the relevant support that was available to us as a service provider, and then implemented the following:

1. A behavioural plan was created in collaboration with the Kindergarten teacher, Charlie's mother, the Centre Director and the owner/operator.
2. We applied for Inclusion Support – This eventually came through but unfortunately it took a very long time.
3. Our service paid for the initial assessment for Charlie to find out whether he did have any additional needs so we could best understand how to help him.
4. We sourced a local paediatrician and paid for the appointments for the mother and child to attend. We also had open communication between the three of us so we could update both the parent and paediatrician on Charlie's behaviour and track his progress together.

5. We set up our staff arrangements so that additional educators were always in Charlie's immediate proximity in his learning environment while he was at the service.
6. We held weekly meetings with Charlie's mother to track his progress and see if any adjustments needed to be made.
7. We engaged a speech pathologist who attended the service to work one-on-one with Charlie.
8. Very early on we contacted the primary school that Charlie's mother intended for him to eventually attend, and we worked together to get Charlie as school-ready as possible whilst the school worked at their end to make sure they had the resources and the planning in place for Charlie's school commencement.

The improvements in Charlie's behaviour and his emotional state were slow but continuous.
After a few months:

- Charlie could walk into the service and separate from mum without any anxiety.
- His emotional outbursts had decreased and our team were able to help him happily engage in play with other children.
- A diagnosis was given of ASD and ADHD and Charlie started on the appropriate medication
- A comprehensive plan was put together for Charlie's primary school placement and the school was well prepared with their funding application ready prior to his first school year, to ensure that he would have a teaching aid when he started prep.
- Our relationship with Charlie's mother became a very positive, collaborative relationship and she thanked us immensely for all of our support when he finished up and commenced primary school.

The end result of our efforts to address Charlie's very specific needs was extremely positive due to our collaborative approach and our commitment to the best outcomes for children in our services.

However, addressing these needs in the first instance took up a lot of our resources and required a significant financial commitment on our behalf. Fortunately, we were in a position to do so but sadly many services are not.

There are many other children attending early learning services who are experiencing problematic home environments similar to Charlie's, who urgently need greater support. In the absence of this support, these children may experience ongoing behavioural repercussions from these problems for many years and sometimes for the rest of their lives.

Targeted additional resources and financial commitment from the government for would mean that children from disadvantaged and vulnerable backgrounds could receive the support they need. The ultimate outcome of this targeted support for the individual children would be a better education and in turn better work opportunities, a more predictable adulthood and less reliance on government welfare and support services.

WHAT AREAS DO YOU THINK THE COMMONWEALTH COULD FOCUS ON TO IMPROVE COORDINATION AND COLLABORATION IN DEVELOPING POLICIES FOR CHILDREN AND FAMILIES?

- Engagement with all layers of government (State and Local), peaks and industry bodies across all the early years – creating consistency of policy, design and structure. Commonwealth's role as a facilitator, through National Cabinet – consistent policy application across the entire country. For example, ECEC to create consistency of regulatory structure

- Ensure there is a common understanding of the shared goals of the Strategy through policies and well communicated across all services and providers, for effective implementation:

  "...even when new policies are introduced, they may not necessarily be implemented as intended 'on the ground' by services and/or practitioners.

  In some cases, policy directives may not be clearly understood by the people who are required to implement them, they may be interpreted in different ways by different people, particularly when the resources available to deliver services are insufficient to implement a specific policy – all of these factors potentially dilute the effects of the policy."[24]

- When working with communities, check that the spokesperson is truly representative of the community and their needs.

  For example, when working with Indigenous communities, ensure there is a culturally safe environment created to support engagement with one of several Elders or persons of respect. The community should agree with the person of respect to speak on their behalf, and checking with the community to verify this.

- Through regular and consistent data collection that reflects families and children moving through different education, health and care systems.

- Integrated child and family centred approach for designing and evaluating systems.

[24] Smith & Wilmott, (2008); Condon et al., (2011), and (Condon, 2011; Grant et al., (2013) cited in *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014*), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities*, Vic Health p11

Principles

- Placing the child's needs, views, and rights with their best interests at the core[25]
- embedding an approach that supports a child's identity, values and culture
- commitment to action for investment in early action, for long term impacts and benefits
- supporting pathways for children and families of all abilities and needs in an inclusive and responsive way
- Child and family centred systems navigation and support
- accountability in measurable actions
- giving a child the best start to life is everyone's responsibility[26]

[25] *The United Nations Convention on the Rights of the Child (1989)*

[26] Adopted from *Starting Early for a Better Future, Early Childhood Development in the Northern Territory 2018-2028,* Northern Territory Government (2018)

Evidence-based approach

- **Are there gaps in existing frameworks or other research or evidence that need to be considered for the development of the Strategy?**

Davies, J & Sherriff, N. (2012), The Gradient Evaluation Framework: A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families, University of Brighton

World Health Organisation (2008), *Closing the Gap in a Generation: Health Equity Through Action on The Social Determinants of Health, Final report of the Commission on Social Determinants of Health*, World Health Organisation Commission

References

- Arlidge, B., Abel, S., Asiasiga, L., Milne, S. L., Crengle, S., & Ameratunga, S. N. (2009). Experiences of whanau/families when injured children are admitted to hospital: A multi-ethnic qualitative study from Aotearoa/New Zealand. Ethnicity and Health, 14(2), 169–183
- Bolitho, S., & Huntington, A. (2006). Experiences of Maori families accessing health care for their unwell children: A pilot study. Nursing praxis in New Zealand, 22(1), 23–32.
- Chen, E. (2004) Why socioeconomic status affects the health of children: a psychosocial perspective, Current Directions in Psychological Science, 13, 112–115.
- Chen, E., Martin, A. & Matthews, K. (2007) Trajectories of socio-economic status across children's lifetime predict health, Pediatrics, 120(2), 297-30.
- Condon, L. (2011). Do targeted child health promotion services meet the needs of the most disadvantaged? A qualitative study of the views of health visitors working in inner-city and urban areas in England. Journal of Advanced Nursing, 67(10), 2209–2219.
- Cunha, F., Heckman, J. J., Lochner, L. J., & Masterov, D. V. (2006). Interpreting the evidence on life cycle skill formation. In E. Hanushek & F. Welch (Eds.), Handbook of the Economics of Education (pp. 697–812). Amsterdam: North-Holland
- Davies, J & Sherriff, N. (2012), The Gradient Evaluation Framework: A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families, University of Brighton
- Dubiel, H., Shupe, A, Tolliver R, (2010*) The Connection between Health Disparities and the Social Determinants of Health in Early Childhood*, Health Watch. https://www.cohealthdata.dphe.state.co.us/chd/Resources/pubs/ECHealthDisparities2.pdf
- Edge, D. (2008). 'We don't see Black women here': an exploration of the absence of Black Caribbean women from clinical and epidemiological data on perinatal depression in the UK. Midwifery, 24(4), 379–389.
- Edge, D. (2010), Falling through the net – Black and minority ethnic women and perinatal mental healthcare: health professionals' views. General Hospital Psychiatry, 32(1), 17–25.
- Edge, D. (2011), 'It's leaflet, leaflet, leaflet then, "see you later"': Black Caribbean women's perceptions of perinatal mental health care. British Journal of General Practice, 61(585), 256–262
- Field, F. (2010). The Foundation Years: Preventing poor children becoming poor adults. Retrieved from: www.bristol.ac.uk/ifssoca/outputs/ffreport.pdf

- Grant, J., Parry, Y., & Guerin, P. (2013). An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. Australian and New Zealand Journal of Public Health, 37(3), 250–256
- Green, J., Waters, E., Haikerwal, A., O'Neill, C., Raman, S., Booth, M. L., & Gibbons, K. (2003). Social, cultural and environmental influences on child activity and eating in Australian migrant communities. Child: Care, Health and Development, 29(6), 441–448.
- Goldfeld, S., O'Connor, M., Sayers, M., Moore, T., & Oberklaid, F. (2012). Prevalence and correlates of special health care needs in a population cohort of Australian children at school entry. Journal of Developmental & Behavioral Pediatrics, 33(4), 319–327
- Goodin, R. E. (2005). Responsibilities for Children's Well-Being. In S. Richardson & M. Prior (Eds.), No Time to Lose: The Wellbeing of Australia's Children (pp. 60–83). Melbourne, Victoria: Melbourne University Press
- Henderson, S., & Kendall, E. (2011). Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: Exploring the need for improvement in health service delivery. Australian Journal of Primary Health, 17(2), 195–201.
- Hertzman, C. (2010). Framework for the social determinants of early child development. In R. E. Tremblay, M. Boivin & R. DeV. Peters (Eds.), Encyclopedia on Early Childhood Development. Montreal, Quebec: Centre of Excellence for Early Childhood Development. Retrieved from: www.child-encyclopedia.com/documents/HertzmanANGxp.pdf.
- Hertzman, C., & Boyce, T. (2010). How experience gets under the skin to create gradients in developmental health. Annual Review of Public Health, 31, 329.
- Hertzman, C., & Power, C. (2003). Health and human development: Understandings from life-course research. Developmental Neuropsychology, 24(2–3), 719–744
- Hoang, H. T., Le, Q., & Kilpatrick, S. (2009). Having a baby in the new land: A qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia. Rural and Remote Health, 9(1), 1084.
- Infant Parent & Early Childhood Mental Health Services (2021), *Risk and Protective Factors*, https://www.ipemh.com/amp/risk-protective-factors
- Jordana K, Obioha C, Ukoumunne, Nina Lucas, Melissa Wake, Katherine Scalzo and Jan M. Nicholson, (2011) *Risk Factors for Childhood Mental Health Symptoms: National Longitudinal Study of Australian Children*, Centre for Community Child Health, Royal Children's Hospital https://www.rch.org.au/uploadedFiles/Main/Content/ccch/Risk_factors_for_childhood_mental_health_symptoms_Bayer.pdf
- Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. International Journal for Equity in Health, 12, 18. Retrieved from: http://www.equityhealthj.com/content/12/1/18

- Meisels, S. J. (1998). Assessing readiness (Report No. 3-002). Ann Arbor, Michigan: Center for the Improvement of Early Reading Achievement. Retrieved from: http://www.ciera.org/library/reports/inquiry-3/3-002/3-002.pdf.
- Milbank Q (2017), *Risks for Mental Illness in Indigenous Australian Children: A Descriptive Study Demonstrating High Levels of Vulnerability*, National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5461394/
- *Moore*, T., *McDonald*, M. & *McHugh-Dillon*, H. (2014), Evidence Review: Early Childhood Development and The Social Determinants of Health Inequities, Vic Health
- Northern Territory Government (2018), Starting Early for a Better Future, Early Childhood Development in the Northern Territory 2018-2028
- Oberklaid, F., Baird, G., Blair, M., Melhuish, E. & Hall, D. (2013) Children's health and development: approaches to early identification and intervention by, https://ro.uow.edu.au/sspapers/1205/
- OECD Aspirational Child Wellbeing Measurement Framework
- https://www.oecd.org/wise/measuring-what-matters-for-child-well-being-and-policies-e82fded1-en.htm
- Kenneth Davies, J and Sherriff, N, (2017) The Gradient Evaluation Framework: A European framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families,
- Ray, L. D. (2005). Categorical service allocation and barriers to care for children with chronic conditions. Canadian Journal of Nursing Research, 37(3), 86–103.
- Risa Lavizzo-Mourey, MD, MBA President and CEO, Robert Wood Johnson Foundation
- Rigney, D. (2010). The Matthew Effect: How Advantage Begets Further Advantage. New York: Columbia University Press
- Roden, J. (2003). Capturing parents' understanding about the health behaviors they practice with their preschool-aged children. Issues in Comprehensive Pediatric Nursing, 26(1), 23–44
- Smith, D., Edwards, N., Varcoe, C., Martens, P. J., & Davies, B. (2006). Bringing safety and responsiveness into the forefront of care for pregnant and parenting Aboriginal people. Advances in Nursing Science, 29(2), E27–E44
- Smith, C. A., & Wilmott, D. (2008). Inequalities in child health up to five years: A supradistrict audit. Community Practitioner: the Journal of the Community Practitioners' & Health Visitors' Association, 81(12), 26–29
- Social Determinants of Health, 2019, The Family Nurturing Centre, https://familynurturingcenter.org/social-determinants-for-health/
- Stipek, D. (2001). Pathways to constructive lives: The importance of early school success. In C. Bohart & D. Stipek (Eds.), Constructive and Destructive Behaviour: Implications for family, school and society (pp. 291–315). Washington, DC: American Psychological Association.

- Stipek, D. (2005). Children as unwitting agents in their developmental pathways. In C. R. Cooper, C. T. Garcia-Coll, W. T. Bartko, H. Davis & C. Chatman (Eds.), Developmental pathways through middle childhood: Rethinking contexts and diversity as resources (pp. 91–120). Mahwah, New Jersey: Lawrence
- Supporting Children and Families in the Early Years (2017-2027), A Compact between DET, DHHS and Local Government (represented by MAV)
- SWC (Social Welfare Commission) (1974) Project Care: Children, Parents, Community, Canberra, Australian Government Publishing Service.
- S. Wise, (2013*) Improving the early life outcomes of Indigenous children: implementing early childhood development at the local level*, Issues paper no. 6 produced for the Closing the Gap Clearinghouse, Australian Institute of Health and Welfare, and the Australian Institute of Family Studies - https://www.aihw.gov.au/getmedia/b46de39b-eeb5-4a98-87e8-44dad29f99b9/ctgc-ip06.pdf.aspx?inline=true
- S. Wong and F. Press (2012), Integrated services in Australian early childhood education and care: what can we learn from our past? Australian Journal of Social Issues Vol.47 No.2,
- The United Nations Convention on the Rights of the Child (1989)
- Towle, A., Godolphin, W., & Alexander, T. (2006). Doctor-patient communications in the Aboriginal community: Towards the development of educational programs. Patient Education and Counseling, 62(3), 340–346.
- World Health Organisation (2008), Closing the Gap in a Generation: Health Equity Through Action on The Social Determinants of Health, Final report of the Commission on Social Determinants of Health, World Health Organisation Commission

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