



The Early Years Project: Refocusing community based services for young children and their families:

A Literature Review

**Prepared by the Centre for Community Child Health,
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WORKING TOWARDS COMPREHENSIVE AND MORE COORDINATED EARLY CHILDHOOD SERVICE SYSTEMS: A LITERATURE REVIEW

This literature review was conducted at the beginning of the Community Partnerships Project, funded by The R.E. Ross Trust and undertaken by the Centre for Community Child Health in partnership with *Good Beginnings* Australia. The project provides the opportunity for communities to take up the challenge of exploring new and more effective ways of working with young children and their families. The literature review has provided a strong evidence base for **why** and **how** services need to move towards a more comprehensive and coordinated service system, at a local level. The Project will use this evidence to resource local communities in embarking the pathway towards this new way of working in order to achieve better outcomes for young children and their families.

Please note: The Glossary of Terms (at the end of this document) provides definitions explaining the way we are using some of the important terms in this document. We also explain in the body of the main document the ways we are using the terms “coordination” and “integration”, but their usage by other authors may be variable.

1. BACKGROUND

The Community Partnerships Project provides an opportunity to embark on a pathway to new ways of working with young children and their families. The literature and experience from a number of overseas countries suggest that there is a need for the development of a more comprehensive and coordinated early childhood service delivery systems, at a local community level. Victoria has an existing infrastructure of accessible and generally affordable health, educational and other community based services, such as child health services, general practitioners, childcare and family day care, preschools and schools. Also, networks of professional and community agencies provide some level of secondary services to this strong primary care platform to which children and their families, can be referred for further assessment and intervention. However, there are also problems with these existing services including, an often fragmented service system with different sectors, different funding sources and different professional cultures. In addition, there can be a lack of coordination between services, an absence of a consistent preventive focus, a failure to detect problems early, a lack of appreciation of the importance of family-centred practice and often inadequate training and professional support (Oberklaid, 2000).

The message about the evidence for, and importance of, the early years of life has been well received internationally. It is also now clear that many problems in adolescence and adult life have their roots in early childhood. World-wide, people are motivated to find more effective ways of supporting young children and their families, and many countries are choosing to make significant investment in working towards better outcomes for children and families, and long-term national economic benefits. There is mounting evidence that the most likely way to make a difference is through a comprehensive, more coordinated (or integrated) service system response, and the focus of service delivery should be on prevention, early detection and early intervention. In addition, there is a compelling argument that services should embrace family-centred practice.

No “best” way of working as a more coordinated (or integrated) service system has yet been identified but important elements and principles have emerged. Several countries, including USA, Canada, and the UK, are endeavouring to explore a range of possibilities. Our Community Partnerships Project provides the opportunity to explore some possibilities for working towards a broad, coordinated early childhood system in the Australian context.

2. RATIONALE FOR NEW WAYS OF WORKING

2.1. The early years evidence

“There is powerful new evidence from neuroscience that the early years of development from conception to age six, particularly for the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life” (McCain and Mustard, 1999: 5). There is encouraging evidence that good nutrition, nurturing and responsive caregiving in the first years of life, linked with good early child development programs, improve the outcomes for all children’s learning, behaviour, and physical and mental health throughout life (ib id:6; Shore, 1997). Good early child development programs, that involve parents or other primary caregivers of young children, can influence how they relate to and care for children in the home, and can vastly improve children’s outcomes in later life. The earlier in a child’s life these programs begin, the better.

Given that the brain’s development is a seamless continuum, initiatives for early child development and learning should also be a continuum.
(McCain and Mustard, 1999:7)

Only recently has much of the scientifically persuasive evidence emerged that interventions in life can have long term impacts on crime and other social problems such as substance abuse (National Crime Prevention, 1999). “We now have a growing body of research on vulnerability and resilience, much of it based on sound longitudinal studies. This is complemented by a growing body of research on the evaluation of prevention strategies” (Scott, 2001:76). A recent meta-analysis of 1200 outcome studies of prevention programs in the USA (Durlak, 1998):

demonstrates that the same set of risk factors at the levels of the child, family, peer group, school environment, and the broader community is associated with major negative outcomes. These include child behavioural and mental health problems, school failure, drug use, and child abuse. The same set of protective factors, including the availability of social support, and connectedness to school and family, is associated with positive outcomes.
(Scott, 2001:77)

2.2. The need for better coordination of services

Durlak (1998) concludes from his review of prevention programs that those working with prevention in different fields must realise that the convergence of their approaches in targeting common risk factors are likely to overlap.

Categorical approaches to prevention that focus on single domains of functioning should be expanded to more comprehensive programs with multiple goals. Future prevention programs, therefore, will need to be more multidisciplinary and collaborative”. (Durlak, 1998:518)

Scott (2001) concludes from this research that: “the separate silos of health, mental health, education and welfare need to be bridged at the policy creation, program development and service delivery levels” (p.77). Greater coordination and collaboration between services and programs is required. In addition, the universal services available cannot always meet all the needs of families, especially those who have been made more vulnerable by current and recent social, economic and demographic changes. The needs of particularly vulnerable families often cluster and are often greater than simple health or education difficulties. These families often need additional supports that enable them to use existing services. Also, services

need to be able to respond to or know where families might gain assistance for multiple needs.

3. COMMUNITY DEVELOPMENT

3.1. Communities supporting families to raise their children

Child-rearing is by no means an easy task, and many people consider that it has been made increasingly difficult by social changes such as increased family mobility (Ochiltree, 1998); increasing rates of unemployment and poverty; both parents in the workforce and working longer hours; higher divorce rates, more single parents and fewer informal support networks (Shonkoff and Phillips, 2000). These and other social changes in western societies have often resulted in government and administration of services becoming increasingly incapable of meeting families' support needs.

A number of studies have shown, it is quite common for women to experience increased isolation in the first year of parenting (Brown and Harris, 1978; Brown, Lumley, Small, and Astbury, 1994; Oakley, 1992), in some cases associated with post-natal depression. Other groups at increased risk of social isolation and depression are migrant families who are often separated from their relatives and in very different socio-cultural environments.

There is now mounting international evidence that the well-being of individuals and families is linked to the nature of the social relations that exist in their communities.

Most people ... locate well-being in a sense of belonging, of connectedness, of being part of a whole larger than themselves, whether that is a family, a workplace, a friendship group, a football club or some wider community.
(Edgar, 2001:xi)

This characteristic of communities is known as **social capital**, which has been defined by Eva Cox (1995) as "the processes between people which establish networks, norms and social trust and facilitate coordination and cooperation for mutual benefit". Robert Putnam (1995) defines social capital as the norms and networks of civil society that enable groups of individuals to co-operate for mutual benefit (and perhaps for the broader social benefit) and may allow social institutions to perform more productively. Social capital is embodied in such forms as civic and religious groups, bonds of family, informal community networks, kinship and friendship, and norms of reciprocity, volunteerism, altruism, and trust. Social capital has been the subject of much interest in recent years (World Bank, 1998; Organisation for Economic Cooperation and Development - OECD, 2001; and the Australian Institute of Family Studies (Winter, 2000; Stone, 2001; Stone and Hughes, 2001).

The level of social capital in societies and individual access to such capital, is often measured through participation rates in different types of associational life and self-reported levels of trust. Studies of this nature show a decline in social capital in the United States and Australia. Research links social capital and access to such capital with a number of factors including, improved health, greater well-being according to self-reported survey measures, better care for children and lower crime rates.

According to Stone (2001), the key elements of social capital are trust and reciprocity. When the social capital of a community is high, children and families benefit in a number of direct and indirect ways. These include information networks that are seen as accessible and helpful, as well as relatively clear cut norms and sanctions about parental and child behaviour (Coleman, 1988). However, Fegan and Bowes (1999) note that when families are isolated from the community, these

benefits are not available to them. Such isolation can be the result of geographic isolation; poor health, disability or special needs; cultural or language differences; social isolation; lack of education and lack of transport.

All families, including those living in urban areas, need access to information that helps them gain a realistic understanding of their child's development and of the possible impact of developmental changes on family life. Families living in isolated circumstances, but particularly geographical isolation, are often deprived of incidental encounters with other children and other parents within the local neighbourhood, encounters that can provide such information, reduce the intensity of uncertainty and alleviate parental anxiety.
(Fegan and Bowes, 1999:122)

The desire to promote social capital arises out of concern about the erosion of community networks and social engagement. Governments are being urged to design programs to enhance social capital, or at the very least, to avoid undermining existing networks and norms of trust and reciprocity. The Australian Institute of Family Studies' *Families, Social Capital and Citizenship* project (Stone, 2001) is currently exploring the relative importance of different elements of social capital (trust, reciprocity, and networks) to different sorts of family engagement outcomes.

3.2. Community development approach to improve service systems

Building social capital at a local level usually takes the form of community development or community building. A number of people have been calling for more of this, both overseas (Etzioni, 1993, 1996; Schorr, 1997) and in Australia (Edgar, 2001). Raysmith (2001) describes the four principles of community building: participation/empowerment; inclusion/accessibility; tolerance/diversity; and sustainability. Evidence shows that successful community building initiatives rely on a community's own resources and strengths as the foundation for designing change initiatives. Community development "is one traditional model for community action that explicitly attempts to resist the tendency to top down approaches and the collection of data that are not grounded in the life histories of local people" (Homel, Elias, and Hay, 2001:274).

The role of governments is increasingly becoming one of facilitating community-building, with a combination of top-down (ie. "higher level" of government) guidelines and locally-autonomous decision-making about how guidelines will be implemented. The Victorian Government now has a Community Building initiative, aimed at improving the ways Government works in partnership with communities, to support their aspirations. The Office of Community Building has been established in the Department of Premier and Cabinet to strengthen this initiative. A key feature is local family and community participation in defining service needs and programs of action. Communities that are the recipients of services need to be consulted far more widely than currently occurs in many municipalities – consulted not only about their needs but also about the appropriateness of both existing and new service delivery models.

However, Tucker (2001) warns that:

... community development should not be seen as a panacea for all social ills. Structural inequalities such as poverty, poor housing and inadequate health services, or the experience of racism and discrimination, will not be swept away merely by raising the level of local participation. (p. 112)

Nevertheless, Tucker believes that "some level of social change can be achieved through the implementation of community development approaches that attempt positively to engage families in the wider issues that face the communities in which they live" (p. 112). One example of the potential of this approach for improving early childhood services occurred in two minority communities in North Carolina. These

communities used a community development framework to improve the quality and accessibility of local childcare and early intervention services (Buysse, Wesley and Skinner, 1999).

Scott, Brady and Glynn (2001) emphasise that initiatives involved in community building need to generate social support for families with young children. They refer to a growing body of research that indicates a correlation between a lack of social support and quality of child-rearing, maternal depression, child abuse and neglect (Brown and Harris, 1978; Quittner, Glueckouff and Jackson, 1990; Beeman, 1997). Numerous studies of children and families, both at risk and not, have shown that social support directly influences the well-being of children and families (Oakley 1992; Crnic and Stormshak, 1997; Dunst, Trivette and Jodry, 1997; Sloper, 1999; Tomison and Wise, 1999).

Scott (2001) concludes that the various ways in which supportive social networks may operate to reduce risk are not yet understood, but it could be through:

- provision of child care to alleviate situational stress;
- defining and reinforcing normative parenting practices;
- meeting parental needs for affirmation which then enhances emotional well-being.

One of the four elements of successful community-rebuilding initiatives in the USA, identified by Schorr (1997), is to rely on a community's own resources and strengths as the foundation for designing change initiatives.

3.3. The role of government in supporting communities

The economic and social changes that have occurred over the past quarter of a century have been profound, and have major implications for the role of governments. Western societies have become more diverse and more complex, and many forms of government and administration of services are no longer capable of providing families with the supports they need. Edgar (2001) argues that:

The essence of postmodern society is complexity and diversity, where no lumbering, centrally controlled system can cope. Adaptability is the name of the game... One size will no longer fit all. Government will have to allow for tailor-made solutions to widely different regional circumstances. (p.2)

This means reconceptualising the role of government, as one of "facilitating community-building through a range of genuine partnerships with business and community organisations, not as providing (or even purchasing) services top-down" (Edgar, 2001:107). What this would involve is a combination of top-down guidelines and locally autonomous decision-making about how these guidelines would be implemented. A key feature of this approach is local family and community participation in defining service needs and programs of action, based on existing resources and community strengths.

4. EVIDENCE FOR A COMPREHENSIVE, MORE COORDINATED SERVICE SYSTEM TO SUPPORT YOUNG CHILDREN AND THEIR FAMILIES

There is mounting evidence that the most likely way to make a difference, in terms of better outcomes for children, families and the broad community, is through a comprehensive, coordinated service system response, and the focus of service delivery should be on prevention, early detection and early intervention.

4.1. Evidence for comprehensive, more coordinated service systems

A paradigm shift in beliefs and service delivery around early intervention for young children with disabilities, resulted from research and advocacy leading up to the implementation, in the 1980s, of early intervention legislation in the USA – The Individuals with Disabilities Education Act (IDEA), P.L. 102-119 (Harbin, McWilliam & Gallagher, 2000). In 1997, the law was amended to contain provisions for services to infants and toddlers, requiring major shifts in public policy and service provision.

One of the changes has been recognition that children and family needs cannot be fully met through the traditional stand-alone early childhood intervention (ECI) programs. Harbin et al (2000) consider there are at least two reasons for this:

- Families often need a wider range of services (not all of them specialist ones) than any single program can provide
- There are many learning opportunities for children that occur outside the ECI program and even the home, and full exploitation of these opportunities requires collaboration between a wide range of specialist and generic agencies.

The development of a comprehensive and coordinated system of services utilising all relevant resources requires several key elements:

- The identification of all relevant resources and programs, including broad categories of community resources such as parent education and information, housing and legal services
- The knowledge of the services provided by each of these, including the manner in which services are provided
- A plan describing how the various services form a holistic system (Harbin et al, 2000)

Studies conducted by Harbin and West (1998), identified a continuum of six qualitatively different organisational models for early childhood intervention service delivery:

1. **Single, stand-alone programs** operating autonomously and without links to other programs
2. **Network of programs** largely operating autonomously but beginning to coordinate their services
3. **Loosely-coupled coordinated system**, with primary coordination of services between two or more programs within an otherwise networked system
4. **Moderately-coupled coordinated system**, with a lead agency or core group of agencies coordinating planning and service delivery among a multi-agency group
5. **Strongly-coupled coordinated system**, with leadership and decision-making shared among a multi-agency group which delivers services cooperatively

6. **Comprehensive system for all children**, provided through a local inter-agency coordinating council composed of a broad array of child and family services.

This continuum of service models varies not only in the degree of coordination but also the populations served and the nature of the services provided. In other words, there are two distinct dimensions along which services (or service systems) may fit:

- a. the dimension of **coordination** (or **linkage**), where extreme coordination represents integration, and
- b. the dimension of **comprehensiveness**.

a. The dimension of coordination (or linkage)

There is considerable confusion in the literature concerning ways in which the terms of “integration” and “coordination” are used. Integration can be defined as “the state in which all services are linked to one another and using common procedures and practices”. It may be useful to consider that links between services can be described as a continuum, that ranges from loosely structured linkages (eg. the information-sharing and communication level), through more highly structured linkages (ie. more coordinated), to highly structured linkages between all services using common procedures and practices (“integrated”). For the purposes of this literature review, it is useful to think of a dimension of “coordination” or “**linkage**” along which services will range from stand-alone agencies to fully integrated service systems.

Konrad (1996) explains that the word “integration” is commonly used as both a catch-all term and a representation of an ideal state. Leutz (1999) claims that there are three levels of integration: linkage, coordination and full integration. Konrad explains her view of an integrated system as follows:

A fully integrated activity or system has a single authority, is comprehensive in scope, operates collectively, addresses client needs in an individualized fashion, and is multipurpose and cross-cutting. Categorical lines are transparent, activities are fully blended, and funding is pooled. Eligibility requirements for all services are simple and uniform. Clients’ problems are treated as a whole and individuals are treated as part of family and community systems. (Konrad, 1996:11)

Examples of fully integrated activities (or systems) might be one-stop shops, unified intake and assessment, case management and many services provided in one location, with one entity taking sole responsibility for management and operational decisions. Integration can occur at the policy, finance, management and clinical levels (Leutz, 1999). The means of integration include joint planning, training, decision-making, instrumentation, information systems, purchasing, screening and referral, care planning, service delivery, monitoring and feedback (ib id).

b. The dimension of comprehensiveness

The dimension of comprehensiveness refers to the extent to which all children’s and families’ needs can be addressed. At one extreme, stand-alone programs cater only for children with disabilities and provide a relatively narrow range of disability-focused services, while at the other extreme, the **comprehensive system** caters for **all needs of children** and provides a wide range of specialised and natural community programs and resources, which may be as diverse as child development programs to housing support.

Results of the cross-site analysis of six qualitatively different organisational models for early intervention service delivery were summarised by Harbin and West (1998):

In general, the more comprehensive and cohesive the system, the better the results for children and families. The more cohesive the system, the broader the array of services and the better the linkages among programs in the

public sector, as well between the public and private sectors. In cohesive service system models, staff tend to use practices more frequently that are identified as desirable by experts in the field (e.g., family-centered and inclusion). Conversely, the service delivery models that were generally associated with less positive results (e.g., not meeting needs of children and families and families frustrated by the system) were usually more insular, having a narrower array of services and weaker linkages with other programs and resources. These programs did not employ nationally recognised best practices in their policy and procedures and were often described as more bureaucratic and rigid. (pp. 403-4)

4.2. The need for shared understandings in a more coordinated service system

For service systems to be effective and more coordinated, they need to be based on a shared understanding within and between services, of:

- what the ultimate aims are ie. what long-term outcomes are being sought?
- how these are to be achieved ie. what the underlying 'theory of change' is?
- how progress towards the long-term outcomes will be measured ie. what indicators or markers of development or functioning will serve as short-term goals?

4.2.1. Long-term aims / outcomes

Clear statements of the long-term outcomes being sought by child and family services are important but currently not easy to find. Long-term outcomes must be agreed on by services. Schorr (1997) identified conditions that must be met for an outcomes-based approach:

- **We must choose the right outcomes** – all stakeholders must agree on a set of outcomes that are considered important, achievable, and measurable.
- **Goals may be ambitious but outcomes must be measurable** – goals represent what the community is striving for, while outcome measures represent its accountability.
- **Outcomes should be easy to understand and persuasive to sceptics** - not just experts or existing supporters.
- **Outcomes should authentically reflect the purposes to be achieved** – for better or for worse, what gets measured affects what gets done so careful thought is needed.
- **Outcomes and processes should be clearly distinguished** – failing to distinguish between process measures and outcome measures results in confusion between means and ends, and a loss of focus on what actually happens to people as a result of the intervention.
- **Outcomes should be understood in a broader accountability context** – all stakeholders should have access to a shared body of credible outcomes information.

4.2.2. Rationale or theory of change

A key feature of effective services or service systems is having a clearly articulated and widely shared understanding of the rationale or "theory of change" ie. of how the services being provided achieve the desired outcomes (Davis, Martin, Kosky and O'Hanlon, 2000; Halpern, 2000; Schorr, 1997).

4.2.3. Monitoring children's well-being

A system is needed for collecting data to document the effects of intentional interventions on the well-being of children, families and communities ie. a set of short-term indicators of development, health and well-being known to be associated with the desired long-term outcomes. Work is being undertaken on such a system in several countries (Ben-Arieh, Hevener, Bowers, George, Lee and Aber, 2001; and Janus and Offord, 2000). McCain & Mustard (1999) also recommended the development of a new outcome measure for the early childhood years, to help communities to know how they are handling the early years. They stated that:

Outcomes of early child development are as important as school achievement measures if we are going to improve education performance.
(p. 99)

The Centre for Community Child Health has recently produced a comprehensive summary of indicators that "span the spectrum of domains in which the evidence suggests positive child outcomes are more likely to occur as a result of their improvement" (2002: 5).

4.3. Typologies of service delivery

Various typologies have been used to describe different levels of service, each with different distinct aims. Dunst, Trivette and Thompson (1990) distinguish between three modes of **intervention** – treatment, prevention and promotion. A common way of classifying types of **prevention strategies** is to distinguish between primary, secondary and tertiary prevention (Huntington, Lima and Zipper, 1994; Offord, Kraemer, Kazdin, Jensen, Harrington and Gardner, 1999; Simeonsson, 1991, 1994; Simeonsson and Covington, 1994; Statham, 1997):

- **Primary prevention:** The focus is on reducing the incidence (ie. the number of cases) of an identified problem or condition. In a complementary manner, it can also be defined as the primary promotion of health, development, and adaptation.
- **Secondary prevention:** The focus is on reducing the existing number of cases and lowering the prevalence of the manifested problems or condition in the population. From a promotion perspective, the emphasis is on the acquisition of compensatory skills and behaviour.
- **Tertiary prevention:** The aim is to reduce the expression of the sequelae and complications of the diagnosed or identified condition. Programs and services of this kind have a rehabilitative and remedial focus.

Evidence for the effectiveness of primary prevention programs has been summarised by Schorr (1991). Among the characteristics of effective prevention programs are that they are interdisciplinary in nature; they minimise bureaucratic boundaries; they have a strong family and community orientation and they ensure convenient and ready access to a wide array of services.

Four service models which are based on the main typologies for services, according to their **availability and focus**, are:

- **Universal services** which are available everywhere and to everyone.
- **Targeted / universal services** which are targeted to particular at-risk areas (eg. high poverty areas) but available to everyone in that area.
- **Targeted / eligible services** which are targeted to particular at-risk groups and available only to those who meet certain specified criteria (eg. income level).

- **Clinical services** which are available to those who meet certain criteria (eg. children with disabilities) wherever they live.

4.4. Inclusion

A number of people (Harbin and West, 1998; Statham, 1997) are considering the benefits gained from catering for children at-risk or with delays or disabilities, along with all other children, through a **single integrated universal system**. Increasingly, it is argued that children with developmental problems or disabilities have many needs in common with other children and should therefore be regarded as **children** above all. The underlying presumption should be families also have universal needs that they share with all families, plus some additional needs unique to particular subsets of families. This contrasts with thinking of them as a different class of family altogether, with needs being met via a specialist system of services. Thus the aims of early childhood services for the community at large apply to **all** children.

In the comprehensive system model, participants plan a system of services for all young children and their families within the community. This philosophy of universal services recognises all children and families belong to the community, and thus it is the community's responsibility to support and facilitate the development of **all children** and support **all families** in this endeavour.

Harbin et al (2000) believe that providing **universal** services will result in four important consequences:

1. Children in need will be identified and receive services as soon as possible (**early identification**).
2. Because all children receive services, developmental problems can be minimised or avoided (**prevention**).
3. Stigma for receiving service is eliminated, because it is viewed as natural for the community to take advantage of resources; help-seeking is their right and to their advantage.
4. This model makes it easier to access natural settings, resources and activities.

This inclusive approach marks a paradigm shift that has important consequences for how supports and services are delivered. Statham (1997) argues that it should be possible to meet additional or specialist needs from within a universal service (eg. by greatly extending the role of mainstream services such as schools), without stigma attaching to either the services or the users.

Shonkoff and Meisels (2000), in their authoritative *Handbook of Early Childhood Intervention (2nd Ed.)*, define early childhood intervention and its goals as follows:

Early childhood intervention consists of multidisciplinary services provided to children from birth to 5 years of age to promote child health and well-being, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning. (ib id: p.xvii)

Thus early childhood intervention encompasses not only programs for children with disabilities, but also those aimed at infants and toddlers who are considered to be at risk. Risk factors may be due to some condition of birth or circumstance (eg. prematurity, poverty, being born to parents who are chemically dependent or mentally ill), and even poor experience in childcare programs. The grouping together of such a broad array of so-called early intervention services is supported by the striking convergence of findings from studies of various groups of children. These findings demonstrate that factors associated with positive child outcomes, and

strategies for helping families promote these, appear to be much the same across varied groups and settings.

Catering for all children implies a dramatically changed relationship between specialist and universal services. A comprehensive system for all children is based on the philosophy that all children and families belong to the community, and thus it is the community's responsibility to support and facilitate the development of all children. These comprehensive service systems are considered to have a number of important benefits for vulnerable families. Statham (1997) cites UK studies suggesting that family centres which offered a wide range of services and which had an open door policy were particularly successful in attracting large numbers of vulnerable families eg. toy libraries and coffee mornings.

5. HOW CAN GREATER COORDINATION OF SERVICES BE ACHIEVED?

5.1. Barriers

Statham (1997), in addressing the need for a more comprehensive and coordinated (integrated) system, argues that:

In order to move to a more integrated system, it will be important to break down the current fragmentation of early childhood services into care, education, play, health, family support (including the promotion of equal opportunities for women) and child protection, and consider how the different functions can be met in a more co-ordinated way within an overall policy and framework for service to young children. (p. 2)

Achieving true interdepartmental and inter-agency coordination has been difficult, and Harbin and McNulty (1990) have identified six dimensions that influence the extent and quality of inter-agency service coordination:

- history of and climate for cooperative service delivery;
- availability of fiscal and personnel resources to support coordination;
- policies that support coordination;
- leadership and the involvement of key people from relevant constituencies;
- an informal and formal process for communication and decision-making;
- an administrative structure and mechanisms to facilitate coordination.

Barriers to inter-agency coordination include:

- differing models of service eg. traditional medical model versus family-centred early intervention approach (Harbin and Feinberg, 1997);
- lack of leadership and involvement from high level decision makers;
- protection of boundaries;
- agency rigidity;
- competition for financial resources;
- conflicting state and federal policies (Harbin, 1996);
- bureaucratic rules and regulations (Schorr, 1997).

Harbin (1996) considers what is required is the establishment of an inter-agency entity that understands the differences between agencies, but is committed to a broader agenda. The success of such an entity would depend upon involvement of all key people; provision of leadership and facilitation; development of a shared mission and vision; development of a structure and process for joint planning; existence of a positive climate for coordination; shared knowledge of policies and politics; resources to facilitate coordination; shared information about best practices; and successful management of the change process.

Achieving all these conditions is not easy and most service systems are not truly coordinated or integrated. Halpern (2000) comments on the situation in the USA as follows:

Not a single state or city has developed a coherent system of birth-to-3 services or has provided adequate funding for the services that are available... Services for birth-to-3 poor children do not so much constitute a system as a patchwork of categorical purposes and programs. (p.362)

However, several countries are pouring substantial resources into re-shaping and adding value to local services for families and to provide better and more coordinated support for them in bringing up their children. The following are some examples.

5.2. International examples of more comprehensive and more coordinated initiatives

5.2.1. Sure Start, UK

In the UK, the Sure Start initiative is a radical cross-departmental strategy to raise the physical, social, emotional and intellectual status of young children through improved services. It is part of the UK Government's policy to prevent social exclusion and aims to improve the life chances of younger children through better access to early education and play, health services for children and their parents, family support and advice on nurturing. It is designed to particularly address poverty as a risk factor where local communities are identified, specifically because they are at risk due to poverty. It involves people outside central government in designing policy, and maintains participation and ownership by various groups by inclusion of local government, the voluntary sector and the research community. It is being locally led and delivered but will be based on evidence from the UK and elsewhere on "what works". In each region, locally-based programs, building on what already exists, will ensure the integrated delivery of a range of core services:

- outreach and home visiting
- support for families and parents
- good quality play, learning and child care
- primary and community healthcare and advice about child health and development
- support for those with special needs.

5.2.2. Proposition 10 (California, USA)

Funded by an increase in tobacco taxes in California, Proposition 10 (the California Children and Families First Act) provides a large infusion of new resources (eg. \$690 million in 1999-2000) to expand and improve availability of health and developmental services across the state for young children and their families. It is envisaged that in every community, collaboration among services will optimise each child's preparation for school and help ensure the fullest use of each child's capacities in adulthood. Building bridges for young children involves strengthening relationships and building networks between community-based resources. County commissions are responsible for developing strategic plans. Communities will be encouraged to engage in broad-based problem-solving approaches. Assumptions guiding the initiative include:

- The central role of the family.
- All families need help.
- Developmental optimisation for all children.
- Shared public responsibility for child development.
- "Developmentally informed" public policy.
- Cultural diversity means diversity of approaches.
- A new and innovative multi-stakeholder leadership.

5.2.3. Child Development and Parenting Program (Canada)

The Early Years Study (McCain and Mustard, 1999) in Canada outlined a vision for an Early Child Development and Parenting Program to support children from conception to formal school entry. This appears to have impacted on policy such that

in Ontario, the development of these Centres is seen to be an important direction, providing childcare and parenting services together.

5.2.4. Integrating services through co-location

Integrating services through co-location is a strategy being used in some countries. Examples include the USA's focus on schools as a base for the provision of a range of services, including childcare, health and family support through the Schools of the 21st Century scheme (Zigler, Finn-Stevenson, and Marshland, 1995). The Labor government in the UK has a strong policy direction for integrated services, as a means to give children the best start possible in life and as a way to counter disadvantage eg. poverty or ethnicity. Their National Childcare strategy has funded over 25 new Early Excellence Centres to provide models of good quality integrated education and childcare to children under five and support services for parents in a "one stop shop". A commissioned evaluation on eight of these Centres (Bertram and Pascal, 1999) highlights the savings made by this early intervention / prevention approach compared with the cost of tertiary services.

5.3. More coordinated service systems in Australia

Australia is not nearly as advanced in its acknowledgment of the critical importance of investing in the early years of life, and the need for locally-driven more coordinated service systems. Oberklaid (2000) asks, when evidence for the effectiveness of interventions that focus on a single issue or single risk factor is poor or non-existent:

Why are we still funding, and even expanding, individual services and programs which work in isolation and have a narrow focus?

Vimpani (1996) proposes that, in the Australian context, re-organising the system would include the following steps:

- The organising focus for primary care services needs to shift to a neighbourhood level;
- The total range of primary care services needs to be involved in restructuring;
- Restructuring needs to be done in conjunction with members of the local community;
- The principles of primary care should be 'something for everyone and more for those in special need';
- The network of primary care services should be backed up by a range of more specialised support services which serve a number of neighbourhoods.

Vimpani (1996), also considers that this network of services should include prevention, treatment and support services, delivered in an atmosphere of mutual respect which focus where possible, on the whole family and aim to achieve improved outcomes for children and families. He considers that a comprehensive list of these services would include:

- health monitoring of young children;
- emotional and practical support for families;
- participatory case management for helping children and families with special needs;
- early childhood educational experiences;
- childcare / respite care;
- faith communities;

- community spaces for meeting - schools, faith communities, neighbourhood centres;
- adult education, including literacy training;
- job training and employment services;
- transport services;
- flexible operating hours for many services;
- information and referral.

It must be stated there are some risks in adopting a universal approach to service delivery, the main one being that the additional needs of some children might not be met. To prevent this, Statham (1997) considers there must be effective systems for:

1. **Identifying children and families with additional needs** – through early screening for disabilities and developmental monitoring, or surveillance of at risk populations as well as all children.
2. **Establishing the nature and extent of the services children with additional needs require** – which means agreeing about what outcomes are to be most valued, thus first reaching agreement on underlying values. There are three main outcome areas to consider: those for children, parents and families, and the balance between these. For children, issues concerning choice of appropriate outcomes include decisions about developmental versus functional goals, and short-term versus long-term goals. It is difficult for service providers to reach consensus on outcomes for parents and families (Bailey, McWilliam, Darkes, Hebbeler, Simeonsson, Spiker and Wagner, 1998). In considering the balance between child and family outcomes, the key issues are what balance of outcomes is being sought and how has this been determined.
3. **Deploying specialist resources to support them in mainstream services.** Early childhood intervention takes many forms, and is more a concept or process than a specific program. There is also a wide range of service formats and target groups. Some recommended practices based on research evidence are summarised below.

6. RECOMMENDED PRACTICES AND ESSENTIAL SERVICE FEATURES

6.1. Recommended practices in early childhood intervention

Recommended practices in early childhood intervention have been identified in the USA by The Council for Exceptional Children's Division of Early Childhood (McLean and Odom, 1996; Sandall, McLean and Smith, 2000) and the Committee on the Integration of the Science of Early Childhood (Shonkoff and Phillips, 2000). In Australia, Wendi Beamish from Griffith University has surveyed Australian early childhood intervention practitioners to identify recommended practices (Beamish, 1998; Beamish and Bryer, 1999).

The Council for Exceptional Children's Division of Early Childhood identified a number of recommended practices for early childhood intervention services (McLean and Odom, 1996). Services should be research-based or value-based; be family-centred; be multicultural; involve cross-disciplinary collaboration; be developmentally and chronologically age-appropriate and be normalising.

The Committee on the Integration of the Science of Early Childhood (Shonkoff and Phillips, 2000) identified a number of essential features of effective early interventions, which include:

- *Individualisation of service delivery*, that matches well-defined goals to the specific needs and resources of the children and families who are served; and
- *Family-centred, community-based, coordinated orientation*: These three concepts or principles are firmly embedded in the professional philosophies that guide most early childhood programs.

Twelve principles of early childhood programs have been developed by the Centre for Community Child Health. They state that programs:

1. build on existing structures
2. are sustainable
3. encourage partnerships
4. are multi-disciplinary
5. are flexible
6. are evidence-based
7. have a quality framework
8. can be evaluated
9. are replicable
10. involve practice informing policy and vice versa
11. are family-centred
12. are delivered in universal primary care settings (Oberklaid, 2000).

Family-centred practice is mentioned as an essential feature of effective early intervention in a number of the most recent literature summaries of key service delivery principles and recommended practices. It is described in more detail below.

6.2. Family-centred practice

Family-centred practice is a key strategy known to be effective in supporting families, which describes **how** service providers should relate to parents rather than **what** they should provide. Rosenbaum, King, Law, King and Evans (1998) conducted a review of efficacy studies of family-centred practice with paediatric populations. Five of the studies involved randomised control trials, the most powerful method of

evaluating effectiveness, and these studies demonstrate the effectiveness of a family-centred approach to service delivery in positively influencing both child and family outcomes.

More is now known about the elements of family-centred practice that make it effective. Dunst and Trivette (1996) conclude that there are three elements of effective help giving:

1. **Technical knowledge and skill:** This refers to the help-giver's specialist knowledge and skills, resulting in the implementation of appropriate educational, therapeutic and medical interventions.
2. **Help-giver behaviours and attributions:** Help-giver behaviours which positively influence psychological well-being include good listening, empathy and warmth. Help-giver attributions that have positive outcomes include beliefs in the person or family's competencies and capabilities. Positive help-giver behaviours and attributions result in (a) greater parental satisfaction with and acceptance of helping, and (b) greater psychological and emotional well-being.

Help-giving behaviours and attributions are a necessary but not sufficient condition for strengthening family competencies and developing new capabilities. To achieve that, the third element of effective help giving is necessary.

3. **Participatory involvement:** This entails the recipients of help being offered information about intervention options, sharing decision making, and being directly involved in acting on decisions. Effective participatory involvement results in: (a) parents feeling more in control, and (b) strengthening of parental competencies.

The principles of family-centred practice have been successfully applied in a number of human services, including:

- early childhood intervention (Dunst, 1997; Dunst, Trivette and Deal, 1989, 1994; Dunst, Trivette and Jodry, 1997; Turnbull, Turbiville and Turnbull, 2000; Viscardis, 1998; Rosenbaum et al, 1998; Trivette, Dunst and Hamby, 1996).
- welfare and family support (Statham, 2000; Darling, 2000; Dunst, 1995; Scott, 2000; Scott and O'Neill, 1998).

Properly understood, the family-centred approach incorporates both empowerment and strengths-building strategies, both of which are approaches in their own right. **Empowerment** can be understood as a process, as an outcome, and/or as a philosophy:

- At the personal level, people become empowered through the development of personal competencies (empowerment as a **process**).
- At the social level, people become empowered through gaining influence or control over resources or policies (empowerment as an **outcome**).
- As a **philosophy**, the strengths perspective posits that "the strengths and resources of people and their environments, rather than their problems and pathologies, should be the central focus of the helping process" (Chapin, 1995: 507).

The **strength-based approach** has been used effectively with both families and individuals (Berg, 1994; Silberberg, 2001). Berg (1994) describes a family-based service approach to child welfare that focuses on the family as the target of intervention, rather than the child or the parents separately:

By involving the family as a partner in the decision-making and goal-setting process and using the family's existing resources, family-based service strives to enhance the family members' sense of control over their own lives. The result is that family members feel an increased sense of competency in conducting their lives and can create a safe and nurturing environment for the children while maintaining the unique cultural and ethnic characteristics of their family unit. With such help, families are able to live independently with a minimum of outside interference. (p.2)

Chapin (1995), describes the implications of adopting a strength-based approach for policy formation:

Social policy that reflects the reality of its intended recipients is more likely if the policymakers are also the people directly affected by the policy. If the fundamental purpose of social policy is to determine how scarce resources will be allocated ... and clients are viewed as people with strengths rather than as deficient or pathological, then the absolute necessity of their inclusion in problem definition and policy-making cannot be denied. (p.509)

Silberberg (2001) advocates that we seek to strengthen families and communities through “a strengths-based approach in which we focus on the available resources and skills within the family and community, and empower the family and community to use those assets in building resilience” (p.57).

6.3. A coherent continuum of services

Halpern (2000) describes the ongoing challenge of developing service systems that are comprehensive, continuous or seamless, and provide a continuum of services:

- Comprehensive services – based on the principle that vulnerable families have multiple needs and that services, individually or in conjunction, should be able to address them;
- Continuous or ‘seamless’ services from birth to 5 years – based on the principle that there should be no gaps in service from birth to when children enter school, and services to particular families should evolve in relation to their changing support needs;
- Continuum of local services – based on the principle that, at any time, there should be a variety of types of service available to young families.

A fourth challenge identified by Halpern (1999), is that of achieving greater coherence in terms of the system of service delivery.

Early childhood intervention service systems are typically diverse and highly fragmented in their policies, programs and funding sources. There are also many gaps in services, such as the limited availability of mental health assistance for children under 6 years.

As a basis for designing social policies based on current child development research, Hertzman (2000) identifies a number of ‘strategic conclusions’, including:

1. Improving child development will occur by improving the environments in which children grow up. The challenge is one of adopting an environmental perspective when agencies have traditionally understood their role to be the provision of one-on-one client services. The fact that health, well-being and competence all have essentially the same principal determinants means the objectives of a wide variety of government departments can be met through intersectoral action for child development.

2. Determinants of child development have an impact at all levels: family, neighbourhood, community and economy. This underlines the importance of a strategy that is not only intersectoral, but also multi-level, and has strong local leadership.

In seeking to translate these strategic conclusions into a practical early childhood development strategy, Hertzman (2000) proposes that federal and state governments should offer to fund early childhood development initiatives in local jurisdictions that fulfil the following principles:

- **Comprehensive:** Early childhood development programs must incorporate three basic components: early childhood education, childcare, parenting/care-giving support; and meet the needs of parents at home and in the paid labour force.
- **Universally available and accessible:** All families should have the opportunity to participate and should not be overly compromised by prohibitive financial costs or targeted eligibility requirements.
- **Integrated:** Integrated early childhood development programs should create holistic environments for young children and their families. They should integrate existing programs and policies across education, social services and health sectors; and also combine programs and resources from federal, provincial and local governments.
- **Community-driven:** The design of early childhood development environments, the allocation of resources, and the delivery of programs should rest with intersectoral authorities in communities. They are more likely to be sensitive to community cultural values and geographic realities. Legally established local authorities should include representation from public health, education, municipal government, childcare, voluntary sector and recreation to ensure that the environments of childhood are fully covered.
- **Quality:** Governments should establish standards of practice that reflect current knowledge and understanding of child development.
- **Accountability:** Early childhood development initiatives should be accountable to governments and the public in terms of finances, administration and performance. This will require ongoing monitoring and an outcome orientation. Local communities should be able to use outcome information to measure their progress and allocate resources.

In addition, a recurrent theme from the literature is the need for a shared philosophy and operating guidelines eg. family-centred practice.

7. CONCLUSIONS FOR A COMMUNITY DEVELOPMENT APPROACH TO THE RE-DESIGN OF SERVICES FOR FAMILIES AND YOUNG CHILDREN

Powerful new evidence of the importance of the early years of life requires a re-think about current services for families and young children. Existing universal services cannot meet the needs of all families, and families with diverse and complex needs often require additional supports. Problems with existing services include:

- often fragmented service delivery eg. different sectors, different funding streams, different professional backgrounds and cultures;
- lack of coordination between services and even within the same program;
- no universal services for children from infancy to school entry, and their families
- lack of focus on prevention, with most resources going to families in crisis leaving agencies little capacity to plan and engage in primary or secondary prevention activities;
- an absence of family-centred practice – a general lack of understanding and capacity of professionals to work in true partnerships with families.

There is a need to strengthen and refocus services and programs in early childhood toward prevention and early identification and intervention, through:

- service and program flexibility, recognising that the “one size fits all” approach fails to recognise the differing needs and available resources in different areas;
- service delivery models being developed in consultation and partnership with local communities, and reflecting not only local parent/child needs and community needs and expectations, but also research evidence;
- a comprehensive universal system to meet the needs of **all** young children and their families, with additional specialist support added to the extent required;
- improved coordination at an individual and system level (including individual case management as well as service system coordination).

There is also mounting evidence that the well-being of individuals and families is linked to the nature of social relationships that exist in their communities (ie. “social capital”). Building social capital usually utilises community development or community building. The role of governments is increasingly becoming one of facilitating community-building with a combination of top-down guidelines and locally-autonomous decision-making about how guidelines will be implemented.

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9. GLOSSARY OF TERMS

The following definitions clarify how the terms are used throughout this document.

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| Community | A group of individuals or families that share certain values, services, institutions, interests, or geographic proximity (Barker, 1991). |
| Community development | Efforts made by professionals and community residents to enhance the social bonds among members of the community, motivate the citizens for self-help, develop responsible local leadership, and create or revitalize local institutions (Barker, 1991). |
| Comprehensive | Able to address all needs of children and families (Centre for Community Child Health, 2002) |
| Coordination | Acting in combined order for the production of a result (The Shorter Oxford English Dictionary, 1973). A more structured form of integration than linkage, but it still operates largely through the separate structures of current systems (Leutz, 1999). |
| Early childhood intervention | Early childhood intervention consists of multi-disciplinary services provided to children from birth to 5 years of age to promote child health and well-being, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration, and promote adaptive parenting and overall family functioning (Shonkoff & Meisels, 2000). |
| Empowerment | The process of helping individuals, families, groups, and communities increase their personal, interpersonal, socioeconomic, and political strength and influence toward improving their circumstances (Barker, 1991). |
| Family-centred practice | 'Family-centred practice, across disciplines and settings, recognizes the centrality of the family in the lives of individuals. It is guided by fully informed choices made by the family and focuses upon the strengths and capabilities of these families' (Allen and Petr, 1996: 68). It involves 4 dimensions of principles, policies and practices: <ol style="list-style-type: none"> 1. Responding to family priorities; 2. Empowering family members; 3. Employing a holistic (ecological) approach to the family; and 4. Demonstrating insight and sensitivity to families (McWilliam, Tocci & Harbin, (1995), in Harbin, McWilliam & Gallagher, 2000). |
| Inclusive | Willing and able to cater for the needs of all children, including those with disabilities and from different ethnic and cultural backgrounds (Centre for Community Child Health, 2002). |
| Integration | The process of bringing together components into a unified |

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| | <p>whole (Barker, 1991). The state in which all services are linked to one another and using common procedures and practices (Centre for Community Child Health, 2002). On an integration continuum, linkage precedes coordination which precedes full integration (Leutz, 1999).</p> |
| Intervention | An activity implemented by a professional (or other individual outside the family) intended to deal with a problem affecting health or development (McLoughlin & Nagorcka, 2000). |
| Risk factors | Biological, psychosocial or environmental factors that increase chance of sub-optimal developmental outcome (Oberklaid, 2000). |
| Resilience | Successful adaptation following exposure to stressful life events (McLoughlin & Nagorcka, 2000). Good outcome despite vulnerability and presence of risk factors (Oberklaid, 2000). |
| Prevention | Activities implemented to avoid development of problems before they arise (McLoughlin & Nagorcka, 2000). Involves efforts to deter or forestall the occurrence of disorder, disease or problem. Preventive interventions occur prior to the onset of negative functioning and seek to reduce the incidence or prevalence of negative outcomes (Dunst et al, 1990). |
| Protective factors | Factors that modify or ameliorate individual's response to factors that predispose to poor outcomes (Oberklaid, 2000). |
| System | A combination of elements with mutual reciprocity and identifiable <i>boundaries</i> that form a complex or unitary whole. Systems may be physical and mechanical, or combinations of these. Examples of social systems include individual families, groups, a specific <i>social welfare</i> agency, or a nation's entire organizational process of education (Barker, 1991). |
| Vulnerability | Susceptibility to negative developmental outcomes (McLoughlin & Nagorcka, 2000). |

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10. APPENDICES

10.1. Appendix 1: Project Flier

An opportunity to explore new ways of working

THE COMMUNITY PARTNERSHIPS PROJECT

The Community Partnerships Project is a wonderful opportunity to embark on the pathway towards new ways of working with young children and their families. The Centre for Community Child Health, Royal Children's Hospital, in partnership with Good Beginnings Australia has received funding from The R.E. Ross Trust to develop a framework and accompanying resources that can be used in the development of comprehensive coordinated early childhood service delivery systems at a local level. The resultant structures, processes and tools will be aimed at improving outcomes for children (0-8 years) and their families in communities that take up the challenge to explore more effective ways to work from a comprehensive coordinated service system basis.

Why do things differently?

Australia has an existing infrastructure of health, educational and other community services that are accessible, affordable, and generally of good quality. Young children and their families have access to a range of community based services such as child health, general practitioners, childcare and family day care, playgroups, preschools, and schools. Furthermore there is an established network of professional and community agencies which provide some level of secondary services to this strong primary care platform, to which children and their families can be referred for further assessment and intervention.

Despite the many strengths and quality initiatives we can all identify in and between services known to us, there can be a number of problems with existing services for young children and their families. These include an often fragmented service delivery system, with different sectors (health, education, welfare); different funding streams (federal, state and local government, private, charitable) and different cultures (because of differing professional backgrounds and service providers). In addition there can be a lack of coordination between services, an absence of a consistent preventive focus, a failure to detect problems early, sometimes a lack of appreciation of the importance of family-centred practice, and often inadequate training and professional support.

The message about the importance and evidence base for the early years of life has been well received internationally. People all around the world are motivated to find more effective ways of supporting young children and their families. Many countries are choosing to make significant investment in working towards better outcomes with young children and their families. Because it has become clear that many problems in adolescence and adult life have their roots much earlier during childhood, a focus on early childhood is suggested to be both clinically effective and cost effective, and to have long term economic benefits.

What would this new way of working be?

While the evidence base on how to do this is scant, there is mounting consensus that the most likely way to make a difference is through a comprehensive coordinated service system response as opposed to a single service response. There is no solid evidence to suggest that the single issue basis on which most services have been historically conceptualised and funded makes any real difference to outcomes. There

is also compelling argument that services should embrace family-centred practice and the focus of service delivery should be on prevention, early detection and early intervention based on the effectiveness of such approaches for the community.

No one 'best' way of working as a coordinated service system has been identified although important elements and principles have emerged. Projects such as Sure Start in the UK, Proposition 10 in California, USA and programs in Canada are endeavouring to explore a range of possibilities. The opportunity afforded by The Community Partnerships Project is to have knowledgeable service providers and community members think through some possibilities for working in a broad, coordinated early childhood system in the Australian context. This will also provide them with the opportunity to nominate appropriate supports and resources that would aid these new ways of working. Additionally, it will support the development and trial of a range of tools and resources.

What is the purpose of The Community Partnerships Project?

The purpose of the Community Partnerships Project simply is to develop and support the implementation of a methodology for local communities to:

- (a) re-focus existing family and children's services in their local area so that they provide an emphasis on prevention, early detection and early intervention;
- (b) establish processes and structures at a local community level so that family and children's services collaborate to provide a coordinated network of family-centred services.

Who will be involved in The Community Partnerships Project?

Along with the Centre for Community Child Health, three local government areas – Port Phillip, Knox and Wodonga - have agreed to participate in this project. These three areas were chosen to represent a range of situations in both urban and rural Australian contexts. Councils, service providers and community members will be involved in activities including focus groups, and trialing and providing feedback on supports and resources developed in the course of the project.

What is the time frame for The Community Partnerships Project?

The project will evolve in two phases over a 24 month period. Phase One entails the scoping of information about what is involved in moving to this new way of working and what could be provided to assist service providers to work in this way. Phase Two will be the period when resource and training materials/activities are developed by the Centre for Community Child Health and tested by participating LGAs.

The involvement of LGAs will place them in a good position to consider at the local level whether they wish at some later date to go further down the pathway of implementing the processes with the assistance of background information and tools developed in this project.