Helping shape the Education State

Response to the Victorian Government consultation – July 2015

Centre for Community Child Health

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The Centre for Community Child Health welcomes the opportunity to contribute to the consultation process on how to best build the Education State in Victoria. We view the Education State strategy as an opportunity to transform Victorian systems relating to children's health, development and wellbeing. Education is the most powerful public health intervention available to children. They spend 7 hours a day, 5 days a week, 40 weeks a year and, in general, 12-13 years of their lives in schools. We are deeply concerned that despite the potential of this platform, there is continuing evidence showing the widening gap in outcomes between children from disadvantaged families and children from more advantaged families.

We believe now is the time to challenge the status quo, to look to the evidence for what is needed to improve outcomes for children and families, and to not be limited by current systems, programs and initiatives. In our response, we will outline what we perceive are some of the major challenges within the current service system, and provide recommendations and options for change.

Current challenges

- Approximately 1 in 5 children arrive at school vulnerable on at least one developmental domain (Australian Early Development Census [AEDC] 2012).
- In some communities, 1 in 2 children are developmentally at risk (AEDC 2012).
- There are no entitlements to care or education until a child reaches the year before formal schooling commences. At that point, there is an 'agreed goal' that every child should have 15 hours per week of preschool education – but this is not guaranteed with substantial financial barriers for some families, compounded by an inequitable distribution of quality services.
- Evidence shows that high quality early learning is beneficial for all children in the two years before formal schooling, and that an earlier commencement (from two years of age or even earlier in some circumstances) is particularly beneficial for children from disadvantaged families (Sylva et al. 2010). Conversely, children who spend long periods of time in poor quality early childhood education and care show poorer outcomes in the later years.
- About 4% of children arrive at school with an identified special health care need already diagnosed. A further 15-20% are identified by classroom teachers as having a serious problem that interferes with their learning (Goldfeld et al. 2012). While the 4% of children with significant problems receive some funding, the additional 15-20% of children with other problems do not receive financial support.
- Victorian schools are therefore trying to help around 15,000 children starting the first year of school with health, behavioural and other developmental problems that will impact on their learning and wellbeing (Goldfeld et al. 2015); potentially over the life of their schooling.
- The three most common problems for children arriving at school are: speech impairment, behavioural problems and home environment difficulties.

- Teachers are not currently equipped with the skills and knowledge about how children with different needs learn or the barriers to learning, and schools are ill-equipped to support teachers in this endeavour (O'Keeffe & McDowell 2004, Oberklaid 2004).

- Often, developmental or learning problems manifest in behavioural problems, particularly when a child's problems are not understood or supported. Labelling a child as 'difficult' not only denies them further support but also creates further disengagement of that child with schooling.

Most significantly:

- **There is no systematic way of identifying or responding to those children who are struggling with learning or behaviour in the early years of school.**

- **The Department of Education and Training's Student Support Services Officers are chronically under-resourced, inefficiently utilised and disconnected from the rest of the local health care system.**

- **Referral for assessment and support is ad hoc, and often delayed. Where external support is sought and is available, there is often poor communication between the support agency and the school.**

- **Publicly funded health services for school aged children with learning or behavioural problems are almost non-existent.**

Education as a true life course continuum

Education should be viewed as a continuum from birth into adulthood. One of the significant challenges to be addressed in order for reform to take place is the division of responsibility for early learning and schooling between the federal and state and territory governments, with the system subsequently being fragmented into 'care' and 'education'. Not only does this serve to reinforce unhelpful public perceptions that learning does not occur prior to formal schooling, but it also directly contributes to the problems facing schools in having to cope with an influx of previously unidentified developmental problems, at a point in time when intervention will be less effective.

If we are going to view education as a continuum that starts from birth, the following needs to occur:

- Ensure all educators (early years and primary) are qualified, with appropriate knowledge about how children develop, how children learn, what some of the key 'red flags' are for developmental vulnerability and risk, and how to engage well with families, services and the community.

- Increase internal supports for all educators in the areas of inclusion and early identification of problems.

- Ensure families have a better understanding of child development and are supported to promote positive development. This can only be achieved if all early years services (health and education) are better equipped to engage with families.
- Promote positive, seamless transitions between early learning and school services.
- Increase external supports for all educators and families by redesigning the existing service system to enable more efficient referral pathways, better sharing of information, shared ownership of complex cases and enhanced peer-to-peer learning opportunities.

We will expand on each of these points below.

The health/education interface

Education and health are inextricably linked in the life course development from childhood to adulthood. If health is compromised, education is compromised. Approximately 4% of Australian children will arrive at school with an identified health need/diagnosis. Another 15-20% of children will be identified by primary school educators as having serious problems (special health care needs) that interfere with learning (Goldfeld et al. 2012).

Children with special health care needs (SHCN) are those who 'have or are at increased risk for a chronic physical, developmental, behavioural or emotional condition and who also require health and related services of a type or amount beyond that required by children generally' (Newacheck et al. 1998).

Describing children more broadly as having SHCN rather than focusing on specific diagnoses has a number of advantages, including that it is inclusive and can be applied both to children with severe conditions, and to children experiencing emerging issues who may not have a formal diagnosis (Goldfeld et al. 2012). Research tells us that this latter group is at high risk of missing out on services (McDowell & O'Keeffe 2012). In addition, broadening the definition of children with additional needs recognises that needs may change over time. For these reasons SHCN has emerged as a useful and valid concept for exploring developmental issues in children (Bethell et al. 2002; Davis & Brosco 2007).

The following is an excerpt from a paper* published by CCCH researchers, examining the impact of SHCN on early school functioning:

> From the time they begin school, children with SHCN are at risk for academic difficulties and poorer adjustment to this new setting. Goldfeld and colleagues (2012) drew on data from over 260 000 students in their first year of compulsory schooling in Australia in 2009 and found that children with SHCN were more likely to be rated by their teachers in the bottom 10th percentile in pre-literacy and numeracy skills.

* O'Connor M, Howell-Meurs S, Kvalsvig A and Goldfeld S. (2014). Understanding the impact of special health care needs on early school functioning: a conceptual model. *Child: care, health and development.* John Wiley & Sons Ltd.

Perhaps not surprisingly, children with SHCN also show higher levels of disengagement with the school setting, including lower levels of motivation and willingness to achieve academically (Forrest et al. 2011; Bethell et al. 2012). Given that the most recent prevalence estimates of SHCN in the USA range between 13% and 19% for 0- to 17-year-olds (Bethell et al. 2008; Forrest et al. 2011), and Australian data similarly suggest that around a fifth of children in their first year of schooling experience SHCN (Goldfeld et al. 2012), these problematic school experiences are likely to incur significant costs to society over the life course (Belfield 2008).

At the individual level, the nature, severity and complexity of the child's condition has been consistently identified as an important factor in shaping their school experience (Forrest et al. 2011; Bethell et al. 2012). This is often compounded by the child's perceptions of school and themselves as learners. Feelings of competency as a learner and positive attitudes towards school have been shown to be predictive of later mathematical achievement and literacy outcomes for children with SHCN (Hauser-Cram et al. 2007). Similarly, social bonds to peers and teachers have been associated with higher levels of behavioural and emotional adjustment among children with SHCN in the later elementary years (Reed-Victor 2004; Murray & Greenberg 2006).

Beyond the transition window, a comprehensive and coordinated system of care continues to be a critical factor in supporting positive outcomes for students with SHCN. Policies on inclusiveness and the extent to which they are enacted, physical dimensions of the school environment, the provision of a coordinated multidisciplinary approach, and information sharing within and between schools, have all been highlighted as impacting on the experiences of students and their parents (Mukherjee et al. 2000; DEEWR 2012; Coster et al. 2013; Hopkins et al. 2013).

We propose that SHCN can impact on four interrelated domains of a child's functioning at school: body functions and structures (e.g. intellectual capacities), activities of daily living (e.g. ability to manage self-care skills such as toileting independently), social participation (e.g. interactions between the child and their peers) and educational participation (e.g. school attendance). These domains are overlapping and interrelated.

Funding to support children with SHCN in Australia is currently distributed along diagnostic lines (McDowell & O'Keeffe 2012). Yet the complexity and heterogeneity of ways in which children's school experiences can be impacted by SHCN suggests that a broader classificatory framework centred on children's functioning is likely to be far more effective in shifting developmental trajectories over their schooling (Janus 2011).

An approach that considers the child's needs in relation to the four domains outlined (body function, daily living skills, social participation and educational participation), as well as surrounding risk factors and positive resources, would allow appropriate matching of services to needs. In taking such an approach, it is important to not only describe and respond to children's limitations, but also to acknowledge the child's capabilities and surrounding protective factors so that these can be leveraged to help the child succeed (A. Kvalsvig, unpublished). In addition, children with SHCN are likely to benefit from a multidisciplinary approach to intervention that can flexibly respond to their difficulties (Janus et al. 2008; Janus 2011).

In line with this thinking, newer service delivery models are emerging that emphasize purpose built multidisciplinary approaches, often lead by a health practitioner (see the 'medical home' framework: Medical Home Initiatives for Children with Special Needs Project Advisory Committee 2002). The Healthy Learner Model of school-based intervention is another example that places a health practitioner (school nurses) as the coordinator of care and bridge between the school, the child and their family, and other service providers; this model has been trialled with promising results in relation to asthma (Erickson et al. 2006).

We know that coordinated and effective interventions to promote better school outcomes for children with SHCN should begin well before children enter the formal educational system. Not only does this not happen systematically or comprehensively, but those who are identified will most often find that they *lose* resources upon entering the formal education system.

Student support services officers (SSSOs) and school nurses are valuable resources that are critical to the ability of schools to support educators, families and children dealing with all children, but particularly those with SHCN. However, the SSSOs in particular are significantly under-resourced, vary substantially in the quality of service they provide and are failing to meet the needs of many children and families requiring support. SSSOs and school nurses play a vital role at the health/education interface, but need appropriate resourcing, training and linking to other professionals and the community to have the impact that is required in Victoria.

The health/education interface offers the best opportunity to influence inequalities through the substantive universal platforms from birth through to schooling, but radical reform is required to identify and support children and families in need.

Improving educator training

Educators must develop the skills to teach children with intellectual and language abilities across the normal range. They must also develop the skills to teach children with health, mental health, developmental and learning problems. Many such children have a number of problems.

Even in settings where staff are eager to support children with developmental or learning problems, educators often lack an understanding of a child's particular difficulties, or of specific strategies to assist that child (O'Keeffe & McDowell 2004, Oberklaid 2004). Academic failure can lead to discouragement, which may manifest as withdrawn behaviour or antisocial, disruptive behaviour, school refusal or (in older children) truancy. Outcomes in all domains of life — vocational, social, emotional — depend to a large extent on academic success.

There are opportunities for professionals with skills in developmental and behavioural problems to contribute to educator training, including:

- contribution to curriculum development, in the areas of normal and abnormal child development, social and emotional development, and common developmental and behavioural disorders
- formal teaching at pre service and professional development levels
- learning experiences for educators (e.g. in specialist learning/behaviour paediatric clinics)
- promotion of new or updated research in relevant areas.

This contribution to educator training would promote mutual understanding of descriptive formulation of problems, diagnostic labels used and treatments recommended across disciplines involved in helping children with developmental and learning problems. Positive outcomes would include shared understandings of the developmental model of learning disabilities, leading to greater coherence and more coordinated implementation of programs for children with special health care needs.

We must improve educator training so that educators are better equipped to identify learning and development problems, to know how to support children with different learning and development needs, and to know where to seek additional support when required.

Engaging with families

In a visit to Australia in 2009, Dr Margy Whalley stated that *"…instead of asking what is wrong with these people that they don't use our services, we should be asking what is wrong with our services that people don't want to use them."*

Traditionally, the focus for educators has understandably been on children's educational outcomes. However, as we come to understand more about how children develop (shaped by their relationships and environments), we have come to realise that we cannot separate families and communities from the education equation. To thrive in early learning settings or at school, children need to be thriving in the home environment. If families have had a poor school experience or little formal schooling, are generally mistrustful of service providers and those seen as authority figures, or if they are otherwise disengaged from education due to other life stresses, they will not be in a position to provide the necessary supports or rich learning environments for their children.

Genuine family engagement can be difficult. Educators and health professionals have often been trained to practice from an expert model that implies a hierarchical relationship between the professional and the family. The 'expert' instructs or prescribes solutions, while families are seen as recipients or beneficiaries of the expertise. The cultural shift from an expert model to a model of partnership with families is complex, but entirely possible.

There are a number of ways we can assist educators and health professionals to better engage with families. Some of these include:

- focused training for educators and health professionals (e.g. in the Family Partnership Model, which is an evidence-based approach to working in partnership with families [Davis et al. 2002; see also http://www.cpcs.org.uk/index.php?page=about-family-partnership-model])
- the use of an evidence-based framework or method of inquiry for educators and health professionals to elicit psychosocial concerns from families about their children in a manner that is acceptable to families (e.g. the Parent Engagement Resource developed by CCCH [Moore et al. 2012])
- establishing a culture of inclusion within health and education services where families feel welcome to attend and that their contribution is valued
- establishing more formalised programs or initiatives that enable family and community engagement on school grounds (e.g. Community Hubs)
- co-locating health and education services to form 'one-stop-shops' for families.

We must ensure all early years service providers, including educators, have the skills to engage with families, to develop mutually respectful relationships and to work in partnership.

Improving transitions

Starting school is one of the key transition points during childhood. All such transitions are known to be times of particular vulnerability for young children, and difficulties at this time are predictive of poorer long-term health and educational outcomes (Forrest et al. 2011; Ryan 2011). Conversely, a successful transition to school results in children who like school, look forward to going each day, and show steady growth in academic and social skills. Successful transitions are also more likely to lead to families being actively involved in their children's education, as well as educators and families valuing each other.

How easy or difficult children find the transition between early years services and school settings partly depends upon the degree of discontinuity they have to negotiate. Discontinuities include changes in the physical environment of buildings and classrooms, differences in curricula and teaching strategies, differences in the number, gender and role of staff, changes to the peer group, and most significant of all, changes in the relationships between children and the adults responsible for their education and care (CCCH, 2008).

One of the major sources of discontinuity is that between the curriculum and teaching approaches used in early learning settings and those used in schools. Whereas programs in early learning settings use developmentally appropriate play-based learning approaches, traditional school curricula tend to be more structured and teacher-directed. There is a strong rationale for seeking greater alignment between early learning settings and school curricula, with a more gradual introduction to structured learning.

At the service systems level, the interface between educational and health service providers appears critical in promoting positive transitions for all children, particularly those with special health care needs. Poor information exchange on the nature and degree of the impairment and the child's functioning, lengthy and delayed assessment procedures, and limited communication between the educational and supporting institutions can all hamper children's transition to the school settings. Some communication practices (e.g. sending the school a copy of a preschool report) are simply inadequate, and do not provide school teachers with useful or important information about the child and family.

As noted under 'Engaging with families', families whose own experiences of school were poor may have little understanding of or support for the school. Successful transition depends in part upon how well the school culture is understood by the parents and family, and how trusting and respectful families are of the school. Children make better progress academically and socially when their families are actively and positively involved in their children's learning activities at home, in early childhood settings and at school.

Transition strategies need to involve early years educators, other early years professionals and primary school educators, as well as parents. They should encompass a wide time span, starting well before school commences and continuing well afterwards, and should be built into educator roles. Examples of transition activities include:

- home visits before and after children enter school
- visits to early learning settings and schools
- family meetings to discuss teacher expectations
- connecting new families with families currently enrolled in the school
- dissemination of information to families on the transition to school
- family support groups (CCCH 2008).

Stronger linkages between services can be achieved by dedicating funding for schools to work with families and early years services before the children reach school. The benefits of this model are that schools develop prior knowledge about the needs of the particular children who are commencing, put in place a range of appropriate classroom and support strategies to meet their needs, encourage family involvement, and are able to build strong links with other relevant services as required.

We need better coordination between early years services, schools and families in the years leading up to school, so that problems can be detected earlier and information can be shared. This will lead to more seamless transitions to school for children and families, which in turn leads to better child and family outcomes.

Taking a place-based approach

As illustrated by the recommendations for reform outlined above, there is growing recognition that addressing complex, entrenched problems requires integrated, interagency and interdepartmental approaches (Moore and Fry 2011). Over the last decade, place-based approaches focusing on the early childhood years have been implemented in a number of disadvantaged communities around Australia. These community-based collaborations focus on child and family outcomes, often adopt a multi-level approach, involve a wide range of stakeholders and place rigour around attempts to align and coordinate stakeholder efforts (Moore et al. 2014). For the purpose of this submission, we define place-based approaches as: 'stakeholders engaging in a collaborative process to address issues as they are experienced within a geographic space, be it a neighbourhood, a region or an ecosystem' (Bellefontaine & Wisener 2011).

Place-based collaborations should be understood as providing a mechanism or platform through which action can be taken to address the needs of children and families more effectively so as to achieve better outcomes. A simplified program logic for a place-based initiative looks like this:

- If we build a partnership with all stakeholders and gain a collective commitment to an agreed set of goals for the community
- and if we develop an action plan that improves the conditions under which families are raising young children, and provide families with direct services that address their needs
- and if we implement the action plan in partnership with the families themselves and in a way that continuously adapts to emerging child and family needs
- and if the strategies succeed in building the capacity of families, services and communities to provide children with the care and experiences they need to flourish
- then we will see improved outcomes for children (Moore 2014).

What this program logic makes clear is that building a place-based collaboration is only the first step, and the efficacy of the partnership-building process and structures and efficacy of the action plan and ongoing monitoring and improvement of interventions need to be determined separately.

In developing the Platforms Service Redevelopment Framework (CCCH 2010), we identified the need for place-based approaches to take action on three fronts:

1. Building more supportive communities. This includes ensuring that all families have positive personal support networks, regular opportunities to interact with other parents and young children, easy access to family-friendly settings and services, and urban environments that are easy to navigate and that provide

numerous opportunities for encounters between people in the community (Moore 2004).

2. Creating a better coordinated and more effective service system. An ideal service system would be one that is based on a strong and inclusive universal set of services, has well-developed 'horizontal' linkages between the various forms of services that directly or indirectly support families of young children, and also has well-developed 'vertical' linkages with secondary and tertiary services that enable varying levels of additional support to be provided to those with particular needs.

3. Improving the interface between communities and services. This means developing ways in which service providers/systems can be more attuned to the emerging needs of communities (see 'Engaging with families').

A key feature of effective place-based initiatives is that they can translate state and national evidence-based policy and programs into local practice by adapting interventions to local circumstances and needs.

Department of Education and Training services play a critical role in enabling a place-based approach. However, policy platforms need to be nuanced to allow this to occur, including creating incentives to bring schools together (balancing autonomy against collective good) and encouraging the idea of joint metrics, accountability and innovation that can respond to local needs.

Place-based approaches can enable the implementation of localised solutions to broader policy objectives.

Summary and overall recommendations

We congratulate the Victorian government on making education the priority it needs to be. It is only through a sustained focus on promoting positive learning and development for all children that Victoria will continue to thrive. We believe education is the fundamental and critical platform to improve outcomes for children (and their families). We also know it will take significant reform in the areas of policy, practice and service delivery to make this possible. Despite the best intentions and efforts of those working in research, policy and practice, the system is currently failing our children.

In summary, we make the following recommendations:

- Education must be conceptualised as a life course continuum that starts at birth and continues into adulthood.

- Policy must reflect this conceptualisation by joining up the currently fragmented systems of 'care' and 'education' before children start school.

- We must strengthen the health/education interface in the years leading up to school and during schooling. While additional investment may be required in

the short-term, the ability to identify concerns earlier and intervene earlier will lead to cost-savings in the longer-term.

- It is vital that we improve educator training so that educators are better equipped to identify learning and development problems, to know how to support children with different learning and development needs, and to know where to seek additional support when required.
- All early years service providers, including educators, need the skills to engage with families, to develop mutually respectful relationships and to work in partnership.
- We need better coordination between early years services, schools and families in the years leading up to school, so that problems can be detected earlier and information can be shared. This will lead to more seamless transitions to school for children and families, which in turn leads to better child and family outcomes.
- We must introduce a robust, evidence informed strategy to identify those children struggling with learning and behaviour in the early years of school, together with a systematic way of supporting these children within schools and referring them to external professionals when appropriate.
- We should look to place-based approaches as a locally responsive and efficient means to implement solutions to these broader policy objectives.

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