



# Social Policy Research Centre Report Series

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Faculty of Arts and Social Sciences

**School readiness program for Aboriginal children with additional needs: working with children, families, communities and service providers**

**Interim evaluation report**

**Christiane Purcal, BJ Newton, Karen R. Fisher, Christine Eastman, Terri Mears**

**For Northcott Disability Services NSW**

**Social Policy Research Centre**

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## **Executive summary**

Northcott Disability Services in partnership with the Social Policy Research Centre (SPRC) is evaluating Northcott's school readiness program for Aboriginal children with additional needs (the Program), which works with Aboriginal children with developmental delays or disabilities and their families to support school readiness and successful transition to school.

In the Program, Northcott provides inclusive playgroups; preschool and school based support; family information, training and support; information and training for preschool and school teachers; and therapy. The Program is in two sites in NSW: one urban and one rural Local Government Area (LGA). The urban LGA is located in metropolitan Sydney, and the rural LGA consists of small towns and remote areas. In both sites, Program services are delivered in several locations from January 2012 to June 2013. The Program is funded by Ageing, Disability and Home Care (ADHC), Department of Family and Community Services NSW.

This interim report presents the findings of the first round of data collection for the evaluation. Data were collected close to the beginning of service provision, from February to April 2012. The evaluation applies participatory research principles and includes a literature review; interviews with teachers, service providers and families; and program data about changes in the capacity of children, families and communities. It is conducted over eighteen months to June 2013, concurrent with service provision.

## **Evaluation methodology**

The evaluation questions are:

1. What support can assist Aboriginal families to identify their child's potential need for disability support and obtain that support for their child earlier?
2. What comprises effective early intervention to contribute to successful school readiness by supporting Aboriginal families where a child has a disability or challenging behaviour? Is this different in urban and rural areas?
3. What empowers Aboriginal families to effectively advocate for services and support where their child has learning disabilities or a developmental delay?
4. What format of service support can provide a sustainable model for ongoing support to Aboriginal communities for families of children with additional needs?

Data collection methods are:

- a literature review
- interviews with families, teachers and service providers participating in the project, and notes and observations by Northcott staff and
- program data gathered by Northcott staff, in the course of service delivery, from participating Aboriginal families and service providers (enrolment forms, support plans, progress notes and training assessment surveys).

Northcott is conducting the evaluation using participatory action research with Northcott Program staff to enhance their research capacity. The SPRC provides evaluation advice through workshops, identifying data sources, developing data collection tools, interview training and data analysis.

Northcott staff had a generally positive experience with the first round of data collection. However, they found it difficult to juggle service delivery and evaluation interviews. Data collection meetings among the Northcott team were changed to a more suitable time in the next round. Staff engaged families and service providers in the interviews by explaining that the aim of the evaluation is to improve service access and delivery for the community.

### **Program delivery**

Northcott established ten services as part of this Program: six services based in schools and preschools, and four playgroups. Five of the ten services are in the rural site and five in the urban site. Two playgroups in the urban site were amalgamated due to low participation in one of the groups. The number of participants in the preschool/school services in the urban site was increased when the second playgroup stopped.

Evaluation data for the interim report shows that a total of 40 children entered the Program in Term 1, 2012, which was lower than expected due to recruitment difficulties. About two-thirds were boys (26) and one-third was girls (14). Ages of the children ranged from 0–8 years, consistent with the Program criteria, and some toddlers participated in the preschool-based services. Transport was provided primarily to the families attending playgroup.

The preschool/school services in the rural site had a waiting list. Northcott staff presumed that this waiting list reflected a shortage of therapy and support services in the rural area.

Factors that helped recruitment of families were:

- the Aboriginal-specific focus of the Program
- having a trusted community member on staff, which is the case in the rural site and
- explaining that the Program could provide support to Aboriginal families concerning a range of issues as well as disability-specific support.

Referral of families to the Program was mainly through schools and preschools, and less often through other services or self-referral.

The main concerns that families had for their children were speech delays and child behaviour. Some families had difficulty naming any or further concerns they had for their child.

Support plans for the children and families focussed on short term goals such as child developmental and health assessments, so that families could achieve outcomes quickly.

Of the 40 children entering the Program in Term 1, seven children (18 per cent) had a previous disability diagnosis, and 12 (30 per cent) accessed support from other services.

Northcott provides speech pathology, occupational therapy and psychology services for the children. Due to caseloads and location of the therapists, children in the rural site have less frequent face-to-face access to the therapists, who travel from Sydney. In the urban site, the closer proximity of the therapists means that children have easier, more frequent access to support.

Collaboration with school and preschool staff worked well in the urban site, where teachers were proactive and internal school communication functioned well. This helped with engaging families and supporting children.

### **Outcomes for children and families**

The evaluation found that Northcott staff first developed a trust relationship with the parents, before they jointly identified a child's support needs. It took several weeks before some parents were ready to talk about concerns for their child. Parents were given information and encouraged to discuss their concerns and explore various options for their child.

Support needs related to the child's disability or developmental delay and other family needs such as accommodation and financial support. Northcott staff felt that working with the family about their broader situation and helping them to identify solutions was important for indirectly supporting the child.

Identifying the particular needs of a child was difficult for many parents, and also for some preschool and school staff who had little experience identifying or supporting children with learning difficulties or disabilities, particularly in the rural Program site.

In Term 1, 2012, speech, hearing or occupational assessments were obtained for 27 of the 40 children in the Program (68 per cent). A shortage of specialist services (e.g. paediatricians) in the rural site made it difficult to obtain adequate support for the children.

Northcott staff supported families to understand how school readiness could be best achieved if support started earlier than in the year before school. In some remote communities in the rural site, many children do not attend early education services, due to a lack of transport, transience, tensions in the community and a shortage of early education services.

Staff observed that by building trust with parents and talking with them about disability, school readiness and strategies to use with their child at home, the parents became more empowered. Parents started asking questions and requesting assistance in communicating with schools.

To make support sustainable beyond the end of the Program, Northcott staff provided training for the school and preschool staff about practical strategies to use in the classroom and information about disability services. In both sites Northcott conducted one playgroup in collaboration with another organisation, and in the rural site they explored handing over the other playgroup to the parents to run, but transport needed to be arranged. Parents in both sites were learning strategies to meet their child's specific needs after the Program would end.



## **Implications for similar programs**

The Program needed a lead up time of at least one year to build trusting relationships with local service providers and the Aboriginal community. Prior relationships helped.

In planning a program, the local service system needs to be considered. New services have to fill a gap rather than duplicate existing services.

A longer service delivery time would help to achieve outcomes such as school readiness and family empowerment.

The recruitment of staff for the rural site was difficult due to the smaller pool of potential qualified applicants. Flexibility with the staffing model helped to compensate. Strategies that could be used to assist with recruitment and retention of Aboriginal staff are: training for managers to support staff in culturally appropriate ways, developing relationships with job networks, and assisting staff to obtain qualifications on the job.

Service delivery in rural sites requires long travel times and therefore more staff hours.

A project coordinator is needed on the ground in each site.

A shortage of available therapy services in rural sites can be partly compensated for by arranging therapists to visit, support via telephone, and staff training to provide some therapy strategies.

Successful partnerships with schools and preschools are facilitated by disability awareness among teaching staff and openness to engage with the Program, and by good internal communication within schools and preschools.

Partnerships with other local service providers are easier to establish if the program provider organisation (in this case Northcott) is well-known and staff have personal connections in the Aboriginal community.

Flexibility of service provision and repeated communication between Program staff and service providers can build rapport to become engaged.

Similar programs could benefit from equally flexible eligibility criteria. Not requiring a previous disability diagnosis helped to engage families who would otherwise not have received support for their child's disability or developmental delay.

Disability awareness and education should be provided widely to extended families and communities to best meet the needs of participating children.

## **Conclusions**

The interim analysis for the evaluation raised a number of issues for the remainder of the Program, for similar programs, and for research methodology:

- In the rural Program site, staff recruitment and retention were difficult, travelling took considerable proportions of staff time, and a shortage of health specialist and therapy services impeded Program implementation.

- The Program needed a set up time of more than one year to build trust within communities, and it would benefit from longer service delivery times of more than one year to achieve sustainable outcomes. The Program was extended by six months to June 2013.
- Engaging Aboriginal families in the Program required time to build trust with the families and communities, identifying support for general needs of the family in addition to the child's disability needs, and achieving some short-term goals.
- Collaboration with schools and preschools was facilitated by existing experience with disability issues among teaching staff, and by good internal communication within schools and preschools.
- Partnerships with other local service providers were easier to establish in locations where Northcott was well-known and staff had personal connections in the community.
- The participatory action research methodology used in the evaluation gave Northcott staff the opportunity to gain research and evaluation experience and to improve the Program as it progressed.

# 1 The Program

Northcott's school readiness program for Aboriginal children with additional needs (the Program) provides a range of therapy and early education based services to Aboriginal children with disabilities and their families, prior to and in their first years of school. The purpose is to support Aboriginal children during their transition into the more formal arena of school, ready to learn and participate in the school environment.

Ageing, Disability and Home Care (ADHC), Department of Family and Community Services NSW, provides the Program funding to Northcott to develop therapy, family support and early education services to Aboriginal children and their families, including: inclusive playgroups; preschool and school based support; family information, training and support; information and training for preschool and school teachers; and therapy.

The locations identified for these services are one urban and one rural LGA. The urban LGA is located in metropolitan Sydney, and the rural LGA consists of small towns and remote areas. In both sites, Program services are delivered in several locations. In addition to delivering services in these areas from January 2012 to June 2013, the Program intends to build community capacity by partnering with appropriate local organisations, including Aboriginal community organisations, health centres and schools.

The Program aims to:

- provide a comprehensive therapy program to Aboriginal children who have undiagnosed disabilities or developmental delay and limited school readiness skills
- enhance the capacity of Aboriginal families, community members, and preschool/school staff to support children in an ongoing way and
- evaluate the outcomes achieved by participants in the Program, with particular emphasis on successfully starting, and staying at school.

The Program intends to assist Aboriginal children, their families and the community by:

- identifying children with undiagnosed disabilities prior to starting school and/or in their first years of school, and providing additional support to these children and families
- providing the opportunity for Aboriginal children to develop skills necessary for starting and staying at school
- providing therapy which enhances the transition to school, promotes skill development and learning, facilitates access to the curriculum and enhances participation and integration
- managing challenging behaviours in the school and other environments
- providing families/parents with the information and resources to support the children with disabilities
- providing teachers and other professionals with skills and resources to support children with disabilities within their learning environment

- linking families with local and mainstream services and resources to build support networks and enhance resilience and
- building community capacity by educating families/community members, teachers and support staff.

The Program is designed to support preschool-aged Aboriginal children with a developmental delay or disability (as defined in the Disability Services Act); and Aboriginal children in the first two years of school with a developmental delay or disability (as defined in the Disability Services Act).

In addition to service delivery in two LGAs, the Program includes an evaluation component (the evaluation). The evaluation assesses the benefits of the Program for Aboriginal children, their families and communities as well as local service providers, and the outcomes of the evaluation may be useful when considering future service models to support Aboriginal families of children with disabilities, developmental delay or challenging behaviours.

## **2 Evaluation methodology**

Northcott engaged the Social Policy Research Centre (SPRC) to provide evaluation capacity development to the Program. Northcott is conducting the evaluation with advice and assistance from the SPRC. The evaluation methodology uses participatory action research with Northcott Program staff.

The evaluation uses mixed methods to answer the evaluation questions outlined below. It observes the ongoing Program activities to determine whether the Program is being conducted as planned (process evaluation), and it assesses whether the Program is meeting its goals (outcomes evaluation).

Ethics approval for the evaluation was granted by the Aboriginal Health and Medical Research Committee (AHMRC) and the University of New South Wales Human Research Ethics Committee (HREC), which is registered with the National Health and Medical Research Council (NHMRC).

### **2.1 Evaluation questions**

The evaluation questions are:

1. What support can assist Aboriginal families to identify their child's potential need for disability support and obtain that support for their child earlier?
2. What comprises effective early intervention to contribute to successful school readiness by supporting Aboriginal families where a child has a disability or challenging behaviour? Is this different in urban and rural areas?
3. What empowers Aboriginal families to effectively advocate for services and support where their child has learning disabilities or a developmental delay?
4. What format of service support can provide a sustainable model for ongoing support to Aboriginal communities for families of children with additional needs?

### **2.2 Program outcomes and indicators**

The types of Program outcomes measured in the evaluation include:

- the number of Aboriginal children and families attending playgroups
- the number of children identified as having a disability/developmental delay through the Program
- the number of information sessions provided to families and teachers
- the number of Aboriginal children participating regularly in school
- the number of referrals and subsequent access to external supports and
- the number of Program goals achieved for children and families.

Some outcomes cannot be measured in numbers, but are assessed by looking at indicators of Program success. These include the following.

*For families –*

- feel supported, less isolation; communication improves, e.g. with other services/therapists; accessing support as soon as concerns develop – not waiting until crisis happens; engaging more with other services plus playgroups/ pre-school/ school activities; improved life skills (e.g. driving); receiving practical support from Northcott (e.g. transport to hospital appointments); unmet needs and service gaps identified; strengthening of family relationships

*For children –*

- fewer suspensions and exclusions from school; more engagement in the classroom; improved learning skills; individual education plans developed

*For school teachers and preschool staff –*

- feel more confident, more empowered; use new strategies in the classroom; engage more with parents; more tools and resources available to teachers.

### **2.3 Evaluation process**

Northcott employed a project manager to conduct the Program, including the evaluation. The SPRC supports the project manager and Northcott to increase their research and evaluation capacity by providing advice and support in the evaluation throughout the Program.

Northcott and the SPRC use an action research process for the evaluation. This involves Northcott staff actively participating in all stages of the evaluation, collaborating with the SPRC, and engaging with Program participants and communities during the research process.

Frequent meetings and a series of workshops are held between Northcott and SPRC staff regarding:

- training on evaluation and research methodology – general training, and concerning working with Aboriginal communities and evaluating programs in culturally appropriate ways (e.g. engaging Aboriginal families; Aboriginal Program staff as community researchers)
- identifying data sources for the evaluation – selection of program data (data collected in the process of Program delivery), and agreement on additional data specifically collected for the evaluation
- data collection – development of data collection tools (interview schedules and data tables), and feedback on tools drafted by the SPRC
- interview training – SPRC researchers modelling interview technique, then shadowing Northcott staff conducting interviews, and subsequently Northcott staff conducting interviews on their own and
- data analysis – reflection on experiences in the data collection process, refining data collection tools, discussion of evaluation findings.

In the two service delivery areas, Northcott staff engages Program participants and communities in the evaluation through meetings, informal discussions and interviews.

## 2.4 Data collection methods

The key data collection methods for the evaluation are the literature review, qualitative and quantitative data collection.

### Literature review

This is a review of literature and current early intervention programs specifically regarding school readiness, partnership strategies around school readiness, and ongoing support at school for teachers and Aboriginal children and their families. The literature review was conducted by the SPRC and a report provided to Northcott in November 2011.

### Qualitative data collection

Qualitative data collection includes:

- interviews with families and carers of children participating in the Program (about expectations and experiences regarding the Program, and suggestions for improvement)
- interviews with teachers and service providers (about knowledge and professional support regarding children with additional needs, experiences with the Program, and suggestions for improvement)
- journal/diary notes and any other observations that Northcott staff record about the Program and
- minutes of Northcott staff meetings.

Three rounds of qualitative data collection are planned: near the beginning of service delivery (March/April 2012), at the end of the first year (October/November 2012); and near the end of the Program (May 2013), after the extension of the Program to June 2013. In the first round, a total of 31 interviews were conducted (Table 1).

**Table 1: Number of evaluation interviews, first round**

Type of interview	Urban site	Rural site	Total
Families	6	8	14
Teachers/service providers	9	8	17
Total	15	16	31

The interview questions for families and teachers/service providers used in the first round of data collection, as well as drafts for the repeat rounds, are in the Appendices. Interviews were voice-recorded and transcribed. First-round interviews were analysed by Northcott staff using a form developed by the

SPRC, and during a collaborative workshop. The results are presented in this interim report.

### Quantitative data collection

Quantitative data used for this evaluation are the program data gathered by Northcott staff, in the course of service delivery, from the participating Aboriginal families and service providers:

- enrolment forms (demographic information about participating children; parent concerns)
- support plans (individual family service plans developed with the family – goals for the child; strategies and types of support; child health, therapy and behaviour assessments)
- progress notes (observations and comments recorded by Northcott staff after contact with participants – including family concerns, observations of child behaviour, conversations with parents etc.) and
- training assessment surveys (satisfaction surveys completed by parents and teachers/service providers after training and information sessions).

The SPRC developed forms for Northcott staff to collect program data at the end of each school term. Data are collected for each service separately. The SPRC analysed the data, and findings from Term 1, 2012 are presented in this interim report.

## **2.5 Reflections on data collection**

As part of the action research process for the evaluation, the SPRC organised a workshop in May 2012, where Northcott staff reflected on their experiences in the data collection process so far, and discussed how this process could be improved for the remainder of the evaluation. The workshop identified the following evaluation issues and recommendations:

### Timing of data collection

- It was difficult for Northcott staff to juggle service delivery and evaluation interviews.
- The timing for the first stage of program data collection was unsuitable due to school holidays and leave for staff.
- A data collection meeting among the team during school holidays would have been more helpful – in the next round, Northcott planned the data collection meetings well ahead of time.

### Data collection forms

- Northcott staff found the process for data collection and analysis simple.
- A suggestion for improving data collection forms was incorporated, to add prompts at the side of each section to explain what is needed.

### Conducting interviews with parents

- Some participants were shy at first, but interview prompts helped.



- Some parents were initially nervous about the voice recorder, but then spoke freely.

#### What worked well in approaching parents/carers to participate

The staff engaged parents and carers in the evaluation by

- letting families know about an evaluation component from the start
- explaining that the aim of the evaluation is to improve service access and delivery for the community and
- explaining the term 'evaluation'.

#### Approaching services to participate

- Some services were hesitant to participate.
- In one of the preschools, it helped to clarify the Program and evaluation primarily as supporting children to be ready to transition to school rather than assisting families to get diagnosis or therapy.

## **2.6 Summary**

Northcott conducted the interim evaluation with advice and assistance from the SPRC. The evaluation methodology was based on participatory action research with Northcott Program staff, and it involved input from families and organisations that supported the Program.

The SPRC provided evaluation advice and training to Northcott staff, through workshops, identifying data sources, developing data collection tools, interview training and data analysis.

Data collection methods were a literature review, qualitative data collection (interviews) and quantitative data collection (program data). Northcott staff had a generally positive experience with the first round of data collection.

### 3 Program delivery

This section presents the interim evaluation findings about the different parts of the service delivery: the playgroups and preschool/school-based programs, information and training sessions, therapy support, yarn-ups and communication with preschool and school staff. Evaluation data were collected in March and April 2012, shortly after the start of service delivery.

#### 3.1 Playgroups and preschool/school-based services

##### 3.1.1 Description

The Program consists of preschool/school-based services and playgroup services. In the preschool/school-based services, Northcott staff form partnerships with existing preschools and primary schools, attend classes and observe children. Both school staff and Northcott staff identify children who might benefit from the Program and try to recruit the families. Once children join the Program, Northcott staff work with the children and families individually, organise therapy and provide other support. In the playgroup services, Northcott works with community organisations and sets up new supported playgroups for children or supports existing playgroups. Northcott staff either run the playgroups or co-facilitate with other service providers and, alongside the group work, assist children and families individually. Northcott provides transport assistance for children in both types of services.

In the two geographic areas of the Program, a total of ten services were established initially (Table 2): six preschool/school-based services located in primary schools and early childhood education centres; and four playgroups, two of which were located on the grounds of community organisations. The rural site had five services altogether, as did the urban site.

One of the primary schools in the rural site withdrew from the Program at the end of school Term 1, and Program staff are exploring alternative ways to assist families in the area. One playgroup in the urban site was disbanded towards the end of Term 1 due to consistently low numbers. The families who did attend this playgroup now attend the other playgroup in the urban site.

**Table 2: Number of initial services per site and service type**

Type of service	Urban site	Rural site	Total
Preschool/school-based services	3	3	6
Playgroup services	2	2	4
Total	5	5	10

The services are available to Aboriginal families who have children aged 0–8 years and who have concerns about their child’s development and/or learning. This includes:

- families who have a child with a recently diagnosed disability
- families who have a child with an identified developmental delay and are in the process of obtaining a diagnosis and
- families who have a concern about their child’s development and are seeking support.

The types of support offered by the Program are:

- individual child or group programs with skilled workers to meet the child and family needs
- family support through individual conversations with a community development worker or in parent support/education groups
- assistance in accessing resources in the community, including pre-schools and other services
- advocacy and
- therapy assessments and supports, including occupational therapy, speech pathology, physiotherapy and psychology services.

At the beginning of 2012, Program staff at each site consisted of an early childhood educator and an Aboriginal community development worker. A project coordinator travelled between the two sites every fortnight or three weeks, and a speech pathologist, a psychologist and an occupational therapist visited both sites. In the urban site the Aboriginal community development worker resigned early in the year, and the early childhood educator worked an extra eight hours per week to assist with some of the community development worker tasks while recruitment took place.

### **3.1.2 Participant characteristics – Preschool/school-based services**

This section describes demographic characteristics of the children entering the preschool/school-based services in school Term 1, 2012, the first term of service delivery.

#### Number, age and gender of the children

A total of 28 children started in the preschool/school-based services in Term 1, 2012: 13 in the urban site and 15 in the rural site (Table 3).

**Table 3: Number of children entering the preschool/school-based services during Term 1, 2012**

Service	Number of children
Urban primary school	7
Urban preschool 1	3
Urban preschool 2	3
Rural primary school 1	5
Rural primary school 2	6
Rural preschool	4
Total	28

The most common age at entry in Term 1 was four years, but the entire group was a little older, with half of the children aged six or more (Table 4).

**Table 4: Age of children entering the preschool/school-based services**

Age of children	Number of children
Under 3 years	2
3 years	0
4 years	8
5 years	3
6 years	7
7 years	4
8 years	4
Over 8 years	0
Total	28

Table 5 below shows the gender distribution of the children who entered the preschool/school-based services. Almost two-thirds of the 28 children were boys: there were 18 boys and 10 girls.

**Table 5: Gender of children entering the preschool/school-based services**

Gender	Number
Girls	10
Boys	18
Total	28

### Schooling

The majority of the children entering during Term 1 were in school (Table 6), with 18 of the 28 children enrolled, and just over one-third were in preschool (10 children).

**Table 6: School enrolment of children entering the preschool/school-based services**

Preschool or school year	Number of children
Preschool	10
Kindergarten	3
Year 1	6
Year 2	9
Total	28

### Program attendance

Three services provided information about attendance during this semester. Attendance was consistent throughout the semester, with 13 children attending each week between weeks one and 9. Three children did not attend in week 10: two due to illness, and one child after being referred by the preschool director to other services.

### Transport assistance

Six of the 28 children who started in Term 1 needed transport assistance (21 per cent). These children were from both urban and rural services.

### Previous disability diagnosis

Of the 28 children who started this term, five entered with a diagnosis of a disability; this represents 18 per cent of the children (Table 7). In other words, 82 per cent of the children (23 children) entered without a disability diagnosis.

**Table 7: Children entering the preschool/school-based services with a disability diagnosis**

Disability diagnosis	Number
Previous disability diagnosis	5
No previous disability diagnosis	23
Total	28

Each of the five children with a diagnosis had a different disability. These were (in alphabetical order): ADHD, dyspraxia, executive functioning disorder, intellectual disability non-specific, and seizure syndrome. These children

came from two services only, one urban (one child) and one rural (four children).

### Parental concerns

On entering the Program, parents were asked to list their concerns about their children's development and behaviour. Parents could list as many concerns as they wanted. The majority of answers in the preschool/school-based services were related to speech/expressive language (19 children) and behaviour (18 children). All concerns and frequencies are listed in Table 8 below.

**Table 8: Parental concerns in the preschool/school-based services**

Type of concern	Number of children
Speech / expressive language	19
Behaviour (including at home and school)	18
Hearing	5
Literacy skills (including reading and writing)	5
Emotional	2
Interaction with other children / social skills	3
Concentration / attention span	2
Concerns with weight	1
Listening	1
Stiff / painful joints	1

### Existing support from therapists

Almost two-thirds of the children had no existing support from therapists prior to joining the Program (Table 9). Of the ten children that were accessing support, seven were supported by school counsellors, and three were seeing a speech pathologist.

**Table 9: Type of support children were already receiving when entering the preschool/school-based services**

Support type	Number
Speech pathology	3
School counsellor	7
No existing support	18
Total	28

### 3.1.3 Participant characteristics – Playgroup services

This section describes demographic characteristics of the children entering the playgroup services in school Term 1, 2012, the first term of service delivery. Information for Term 1 was provided for two playgroups, one urban and one rural. The third playgroup, in the rural LGA, started operating at the end of Term 1 and did not provide data, and neither did the fourth playgroup in the urban site that was disbanded.

#### Number, age and gender of the children

A total of 12 children entered the playgroup services in these two locations; nine in the rural and three in the urban site. Of these, there were eight boys and four girls. The most common age at entry was two years (Table 10).

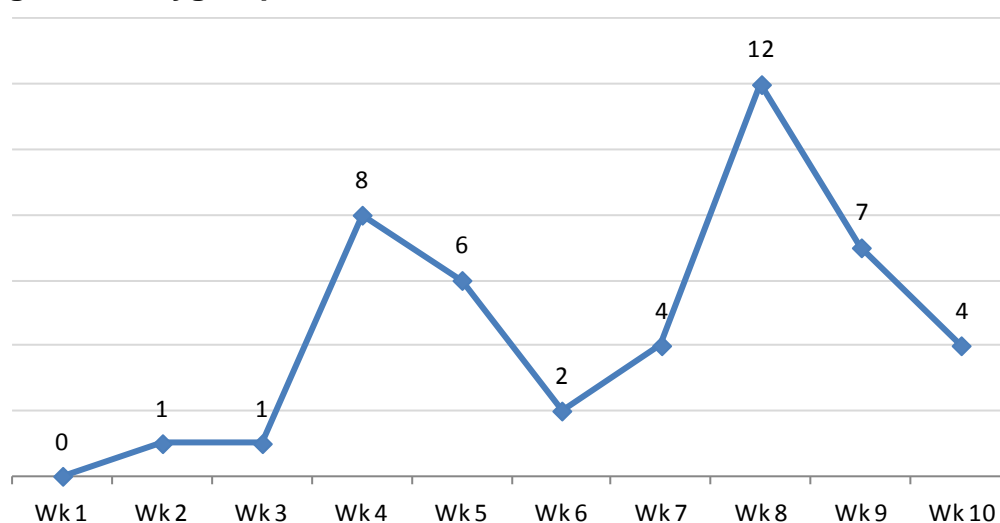
**Table 10: Age of children entering the playgroup services during Term 1**

Age of children	Number of children
Under 1 year	2
1 year	1
2 years	4
3 years	2
4 years	2
5 years	0
Over 5 years	1
Total	12

#### Program attendance

Attendance for the playgroup services varied across the term (Figure 1); week 8 had the highest attendance with 12 children attending that week. It was noted that attendance varied due to childcare and school attendance, illness and appointments.

**Figure 1: Playgroup attendance**



Transport assistance

Most of the children in this group – 10 out of 12 – needed assistance with transport.

Previous disability diagnosis

Two children who entered the playgroup services had been previously diagnosed with a disability. One child had a profound hearing impairment; the second child had Autism Spectrum Disorder - Pervasive Developmental Disorder - not otherwise specified, and T2/T3 vertebral anomaly and associated scoliosis.

Parental concerns

As in the preschool/school-based services, parents were asked to list their concerns about their children’s development and behaviour. The most common concerns were the same in both types of services: speech/expressive language and behaviour (Table 11).

**Table 11: Parental concerns in the playgroup services**

Type of concern	Number of children
Speech / expressive language	6
Behaviour	4
Receptive language	2
Appropriate development	1
Hearing	1
Independence	1
Lack of knowledge of disabilities	1



### Existing support from therapists

When joining the playgroup services, two of the 12 children (17 per cent) were receiving specialist support related to disability or developmental concerns. One child was accessing speech pathology, and one was seeing an audiologist.

### **3.1.4 Assessment of participant characteristics**

This is a relatively small project, with a limited number of children participating: by the end of Term 1, 2012, 40 children had entered the Program. It is therefore not possible to conduct meaningful statistical analysis of demographic characteristics.

The number of children starting in Term 1 was lower than Northcott expected in some of the Program services. The Program was originally set up to provide services for 15 children in preschool/school settings in each location and 10 children (inclusive of siblings) in each of the four playgroups.

The preschool/school numbers were close to the allocated positions, and in the rural area the team had a waiting list. Northcott staff presumed that this waiting list reflected a shortage of therapy and support services in the rural area. During the interviews one parent also reported there was limited access to services:

Just being [an] isolated town and little opportunities to see the specialist that he needs.

The playgroup numbers in the urban area were lower than expected. Northcott presumed that this might be due to the large number of playgroups already in the area (both community and supported playgroups), and the general lack of awareness of Northcott services in the area. The small numbers in the playgroups in the urban area led to a rethink of service delivery: the two playgroups were amalgamated, and the numbers of children that could access the preschool/school program was increased.

The numbers attending the rural playgroup varied due to illness and other family commitments. Families also provided feedback about the starting time of the playgroup, and this was changed to accommodate their needs, which may impact on the numbers attending in future school terms. The second playgroup in the more remote area of the rural site had a number of children who did not access the Program, as the playgroup was a supported playgroup for Aboriginal families and not specifically for children with a disability or delay.

The lower numbers in the urban playgroup were ascribed to difficulties in recruiting families to the Program, possibly due to the availability of many other playgroups in the area.

The majority of the children accessing the Program did not have a diagnosed disability. These children and their families therefore were not eligible for the majority of funded disability services. This was the first time a number of families had accessed support from a service provider.

There was an expectation that the Aboriginal community development worker would provide a lot of transport support to families. However, transport was not a large part of service provision in the Program. It was primarily provided to families attending playgroups.

The main concerns that families had for their children were speech delays and child behaviour. Some families had difficulty with specifically naming any or further concerns they had for their child. They were aware that their children might have other delays, as they compared them to their siblings or other family members at the same age. For example, one parent reported:

He's just quiet, his reading and writing is slow compared to other kids, like in his year.

The Program staff referred the children to the speech pathologist and psychologist to address the parental concerns, and during these assessments the need for occupational therapy assistance was raised.

### **3.2 Recruitment of families**

A main asset of the Program identified by Northcott staff in both sites was that the Program was intended specifically for Aboriginal families and communities; for this reason many families were open to trialling the services. However, the process of engaging families and getting them to participate in the Program could be lengthy.

Staff felt that having a trusted member of the Aboriginal community working in the Program in the rural site enabled families to enter the Program with a feeling of cultural safety. In the urban site, which did not have this benefit, a number of families initially requested a support person to be present during interactions with Program workers. Northcott staff reported that, after a few weeks, parents in this site had developed trust and no longer requested a support person.

Northcott workers found that they had more success in recruiting some families to the Program when they explained that it could provide support to Aboriginal families concerning a range of issues, as well as disability-specific support. This was particularly true in the rural site, where families used the Northcott playgroup services for general school preparation, social interaction and family support, as well as assistance with concerns about their child's development. Northcott staff in that site concluded that it was most effective if they included everyone who was interested and discussed any disability needs after they had engaged the family and established trust. In the urban site, workers found that some families were referred because it was a program for children with a disability.

According to Northcott staff, this discrepancy between the two sites might be due to differences in general availability of child and family services. In the rural site, with a smaller population and shortage of many types of human services, a generalist approach might be more appropriate to avoid stigma within the community, and to provide families with a go-to service to identify support for a variety of needs. In the urban site, where many different services are available, targeting families with children with disabilities might be more

effective because parents are seeking a service for meeting their child's specific disability or developmental needs for school readiness.

Referral of families to the Program was mainly through schools and preschools at both sites. School staff observed children who might meet the program criteria and then approached families to see if they were interested in participating in the Program. In the rural site, the early childhood educator liaised with preschool staff to see which children could potentially benefit from the Program. Some referrals also came from within Northcott, or from other organisations in the community as a result of Northcott staff networking with local service providers.

Self-referral of families to the Program was very rare, as was referral from a family member who had learned about the Program. Northcott staff suggested that this may be due to reasons including: some families had not previously received information or support that might increase their knowledge about their child's needs, which led to parents having difficulty identifying how their child could benefit from support; or the Program was new and not yet well-known and trusted in the community. In one instance a child entered the Program through their older sibling who was already participating. Northcott staff spoke to the parents about developmental concerns about one child, and subsequently the parents identified a similar need for the younger sibling.

### **3.3 Support plans**

Each participating family worked with Northcott staff to develop a support plan to guide their progress while involved in the Program. These support plans were generally devised after several weeks of participating, once trust had been established with the worker. The purpose and content of the support plan were explained verbally to families before developing the plan. Staff found that, for many of the families, developing and committing to a support plan was a significant achievement in itself, as this was the first type of formal planning they had been involved with for their child.

Families and Program staff identified a child's needs based on school reports, medical reports, observing a child in the school/preschool environment and family experiences. Support plans for children in playgroup generally focus on developmental milestones relevant to school readiness, and talking with parents about these milestones. Support plans for preschool and primary school children concentrate more on the learning curriculum. Developing strategies for the teacher to work with children in the classroom environment are also part of the plan.

Support plans contain a variety of goals that the family would like to accomplish while participating in the Program. Goals include practical issues for the child, such as undergoing an eye exam, hearing test or speech assessment. Other goals involve linking the family in with services, such as family violence counselling or drug and alcohol counselling, Centrelink and housing. Goals also address concerns relevant for individual families, for example talking with the parents/carers about issues such as custody matters or the child protection system. Northcott staff emphasised that identifying support for these needs was essential for some families before they could

focus on their child's school readiness and disability. Other families resolved such issues concurrently, and some did not ask for any support other than with their child's delay or disability.

Goals were rated as high priority (to be completed within three months), medium (six months) and low priority (12 months). Workers emphasised the importance of concentrating on short term goals with achievable outcomes so families could see results quickly. Few medium or long term goals were recorded, not because children and families did not need longer term assistance, but because Program staff felt these issues were unlikely to be resolved within the short timeframe of the Program.

The most common short term goals for children in the preschool/school-based program were developmental and health assessments, while medium priority goals concerned behaviour improvement and service access (Table 12). Total numbers were too low for a valid comparison between the urban and rural services.

**Table 12: Goals for children in the preschool/school-based services**

Type of goal	Number of children
<b>High priority goals</b>	
Vision assessment	10
Speech assessment	9
Hearing test	7
Improve reading / writing	3
Communication	2
Accommodation	2
Transport	1
Support strategies	1
Providing information about disability	1
Listening	1
Get diagnosis	1
<b>Medium priority goals</b>	
Develop positive behaviour strategies at home	3
Collaborative approach with therapists	1
Information and referral for custody issues	1
Participate in group playground activities	1
Small muscle strength and manipulation	1
<b>Low priority goals</b>	
Independent work habits	1

In the playgroup services, information about goals was received from one service, the urban playgroup. High priority goals were mainly related to assessments (speech, hearing, vision), and developing and using visual aids to assist with communication. Medium term goals were finding accommodation, obtaining a diagnosis, obtaining information about funding, childcare, and communication and learning. No low priority goals were recorded.

### **3.4 Information and training sessions**

Information and training sessions were anticipated to begin in school Term 2, 2012. At the end of Term 1, Northcott staff, preschool and school staff and parents were discussing the types of information and training sessions that would be useful in each Program site.

### **3.5 Therapy support**

As described in section 3.1 above, the majority of children entering the Program were not receiving any therapy support related to disability or developmental concerns. Of the total 40 children participating in Term 1, 12 children (30 per cent) were receiving support: by school counsellors, speech pathologists or an audiologist. According to Northcott staff, many parents in both sites had not previously been provided with appropriate and accessible information about the purpose of therapy and how it may help their child. Through participating in the Program, parents in the urban site in particular became eager for their children to use therapy services and requested strategies from therapists to use at home.

Access to therapy support varies greatly between the two sites, which appears largely due to the diversity of geographic locations. The rural area is more isolated than the urban site, and therefore access to specialists and therapists in the rural site is very limited. For example, the only local psychologist has months-long waiting lists.

In response to the shortage of local specialist support, Northcott arranged for an occupational therapist, a psychologist (consultant) and a speech pathologist from the Sydney Northcott office to visit the rural site once a month. Their time is split between two different locations in the rural site, and extended travel times between the locations mean that the specialists can visit only one location per month, or two of the four services in the rural site. Therefore children receive face-to-face therapy support every two months, and less if the children are unable to attend their allocated session.

To arrange some form of ongoing therapy support, the Northcott early childhood educator in the rural site learns strategies from the therapists to support children and families in-between visits. The therapists also provide indirect support to the families in the rural site by being available for phone consultations, by attending teleconference meetings with school staff, and by writing reports and therapy plans.

Northcott would find it preferable to have the therapists see children and families more often, but given the restricted therapists' availability, staff are

developing other ways to support children and families in the rural site. For example, Northcott staff see it as part of their role to build a bridge between community health services and families. They observed that many of the families in the area did not access these services because the families did not travel to the premises. Northcott staff negotiated with community health workers to come to the Program's playgroup to provide services to children and their parents.

The metropolitan location of the urban Program site means that there are multiple and various external therapists available for participant families. As part of the Program the Northcott speech pathologists visits the site twice a week, giving the school weekly speech pathology and attending the other services either weekly or fortnightly. Northcott occupational therapists visit the site once per week, and each school, preschool and playgroup receives occupational therapy on a fortnightly basis. From a therapeutic perspective, Northcott therapists feel that the amount of therapy provided is sufficient to support the children and families to achieve their goals. Parents and teachers alike are motivated to work with the therapists to implement strategies for individual children. This is assisted by the therapists attending classrooms/preschools weekly or fortnightly, enabling the preschool/school staff and therapists to work together in the classroom environment.

### **3.6 Yarn-ups**

Yarn-ups are informal group discussions among Aboriginal families participating in the Program and Northcott staff. They will commence in both sites in school Term 2, rather than in Term 1 as planned. The main reason identified by Northcott staff for the delay in starting the yarn-ups was that families seemed fully occupied with engaging in the other aspects of the Program. However, staff and parents had ongoing discussions in anticipation of the yarn-ups.

### **3.7 Communication with preschool and school staff**

Northcott workers in both sites identified that a main asset to the effectiveness of the program is a school that is supportive to the Program and has good internal communication structures at all levels, from principals to teachers, parents and children. This seemed to occur more in the urban than the rural site. Northcott Program staff commented that schools in the urban site more easily identified concerns with children, possibly because teachers tended to be proactive in communicating with parents and Program staff. Also, teachers assisted communication between parents and Program staff by setting up meetings, as Program staff found it difficult to reach parents over the phone or contact them during school pick-up and drop-off times. The established relationship between parents and teachers also proved helpful, as positive reinforcement from a trusted teacher to join the Program assisted in the recruitment process.

Program staff found it essential that communication between therapists, teaching staff and parents was open and ongoing to best meet the needs of the child. In the urban site, staff found this was happening regularly, and that

school and preschool teachers were eager to liaise with therapists and implement therapy strategies into their classrooms.

Northcott staff in the rural site, however, found that some teachers were hesitant to assist with implementing therapy services or with the Program more generally. This might be due to less experience or resources among school staff, as outlined in section 4.1 below.

The preschool/school staff working directly with the children were sometimes not aware of all the services in the community that families could access. Rather, executive staff or management appeared to have that knowledge. For example, staff reported:

I don't know about the rest of them, I wouldn't even know where to start to ring anyone to come and assess some of the kids.

I think executives would have more understanding of that one than I do, and if there's some support available in terms of funding.

### **3.8 Summary**

Northcott initially established ten services as part of this Program: six services based in schools and preschools, and four playgroups. Five of the ten services were in the rural site and five, in the urban site. One of the primary schools in the rural site withdrew from the Program at the end of school Term 1, and two playgroups in the urban site were amalgamated due to low attendance at one of the groups.

A total of 40 children entered the Program in Term 1, 2012, which was lower than expected due to recruitment difficulties. About two-thirds were boys (26) and one-third was girls (14). Ages of the children ranged from 0–8 years, consistent with the Program criteria, and Northcott included some toddlers in preschool-based services.

The main concerns that families had for their children were speech delays and child behaviour. Some families had difficulty naming any or further concerns they had for their child.

Transport was provided primarily to the families attending playgroup.

There was a waiting list for the preschool/school services in the rural site. Northcott staff presumed that this waiting list reflected a shortage of therapy and support services in the rural area.

The numbers for the preschool/school services in the urban site were increased following the disbandment of the second playgroup.

Factors that contributed to recruitment of families were:

- the Aboriginal-specific focus of the Program
- having a trusted community member on staff, which was the case in the rural site and

- explaining that the Program could provide support to Aboriginal families about a range of needs as well as disability-specific support.

Referral of families to the Program was mainly through schools and preschools, and less often through other services or self-referral.

Support plans for the children and families focussed on short term goals such as child developmental and health assessments, so that families would see and achieve outcomes quickly.

Of the 40 children entering the Program in Term 1, seven children (18 per cent) had a previous disability diagnosis, and 12 (30 per cent) accessed support from other services.

Northcott provides speech pathology, psychology and occupational therapy services for the children. Due to caseloads and location of the therapists, children in the rural site have less frequent face-to-face access to the therapists, who travel from Sydney. In the urban site, the closer proximity of the therapists means that children have easier, more frequent access to support.

Collaboration with school and preschool staff worked well in the urban site, where teachers were proactive and internal school communication functioned well. This helped with engaging families and supporting children.



## **4 Outcomes for children and families**

### **4.1 Identifying child support needs and obtaining support**

Northcott staff reported that it took several weeks for some parents to feel comfortable to talk to them about their families' concerns or needs of their child, as they might not have wanted to discuss personal information before they had established trust with the worker.

Staff talked with parents without labelling their child as having a disability or delay. This approach was sensitive to the family's opinions, so that together they could work out how to identify their child's learning needs. Staff also invited people who the parents trusted to meetings (e.g. school teacher, preschool staff, service provider staff). After several weeks, Northcott staff felt they had developed trusting relationships with the parents and reported that parents came to them when they needed assistance.

In many cases the support required by families was not just specific to a child's delay or disability, but rather general family support (e.g. accommodation or finance issues), but Northcott staff felt that identifying support for these concerns could also contribute to the child's other support needs.

Northcott staff reported that many families found it difficult to identify their child's needs or express their concerns, and might rely on prompts from staff. For instance, parents mentioned that they were concerned about their child's speech, but they had not previously received information or support to understand their child's needs and how they could be supported. This also led to misconceptions about children's behaviour. For example, difficulties with receptive language were often seen as a child not listening to instructions and being 'naughty'.

In both communities where the program provides services, community members have previously received limited information about disability. If a person has a physical disability, the local communities are generally accepting of this difference and have an understanding of how it may impact on the person and their carers' lives. However, if a person has a disability such as autism or an intellectual disability and a community member does not have any experience of that disability in their own lives or family, then the community member is often not sure how to interact with the person or how the person's disability impacts upon their lives.

In general, the communities do not tend to label someone as having a disability – this would make them seem different from everyone else – rather they see the person as a whole and the disability as part of who they are. If a family has concerns about their child's development, the family has often not had information about what services are available to support them. They will know that a GP may help them, but they may not have had contact with specialist services such as paediatricians, therapists and psychologists.

This issue was more common in the rural site, where Northcott staff also found that some preschool and school staff had difficulty identifying the support needs of the children in their classrooms. Northcott workers

suggested this might be due to less experience, as schools in remote Aboriginal communities in the site were partly staffed by new graduates.

Northcott staff commented that after several weeks in the Program some parents became confident enough to reject labels bestowed on their child. For instance, some parents questioned what the school staff suggested was 'wrong' with their child if they misbehaved in class. Some parents felt empowered to question their child's specialist diagnosis. For example, a paediatrician in one of the sites reportedly diagnosed many behavioural issues as ADHD, and some families participating in the Program felt strong enough to ask for a second opinion. Other parents asked Northcott staff for support to access appropriate service provision or speak to the school about concerns regarding their child.

Many parents in the Program asked for information about their child's disabilities and challenging behaviour, or for a diagnosis or developmental assessments so that they could better understand their child's situation and needs.

This is reflected in the support plans (section 3.3). Consistent with the most common high priority goals established in the support plans, various assessments were conducted for the children during Term 1. In the preschool/school-based services, speech assessments were obtained for nine children and hearing assessments, for seven. In the two playgroups that provided data, seven children (of a total 12 participating) received speech assessments, and four were assessed by an occupational therapist. None of the children participating in the Program was diagnosed with a disability during Term 1.

Once a child's support needs were identified, many parents in the rural site were not able to access enough therapy and services to meet their needs, due to a shortage of service availability in the site.

Northcott Program staff commented that it was taking longer than they had expected to obtain support and achieve outcomes for children and families. This was largely due to the time required for engaging families and building trust between the workers and families. However, staff regarded this process as a vital part of the success of service delivery.

## **4.2 Successful transition to school**

While it was early in the evaluation to comment on the Program outcome of successful transition to school, Northcott staff identified a number of factors that were making the transition difficult, and they started to address these factors. First, many parents were unsure about what was meant by the term 'school readiness', or they believed that it was only relevant for children in the year prior to school. However, Northcott staff noticed that most children of any age in the Program needed to develop their communication and interaction skills to be ready for school, and this could best be achieved if support started as early as possible. Staff felt they were successful in communicating this to the parents.

Second, in the rural LGA, Northcott found that many children did not access early education services such as preschool or playgroup before starting school, making transition to school more challenging. Staff identified that the reasons included a lack of transport, families' transient lifestyles, and tensions between some groups within the community. The latter point becomes an issue when there is only one Aboriginal-specific service in an isolated community. This is the case in the rural Program site, where there is only one Aboriginal-specific playgroup in one of the remote communities, and the alternative for families who do not wish to attend this playgroup is to travel to the town more than 100 km away to access therapy and early education support. Northcott staff felt that their playgroup was important in filling a gap in this community.

### **4.3 Empowering Aboriginal families**

Northcott staff reported that, by the end of Term 1, they were starting to see families becoming more empowered through the Program. This had come about mostly through providing families with information and support. Staff gave families information about school readiness, worked with parents to improve interaction with their child, and provided them with strategies to use at home with their child along with explanations as to why these strategies might be useful to them. Staff also talked with families about relevant local service providers.

Northcott staff felt that parents now trusted them enough to ask them questions or request assistance, for example when seeing teachers or specialists. Some parents had asked specific questions about identifying delays in children, which might not be about their own children, but those of relatives or friends. Northcott staff believed that this helped to develop a culture of disability awareness that extended beyond the participant families, and thus promoted empowerment at both the family and community levels.

### **4.4 Sustainable support**

Although service delivery was in its early stages, Northcott staff considered how to make support to children and families sustainable beyond the end of the Program in June 2013. Strategies differed to some extent between the sites, given the different geographical and service conditions, and the strengths identified in each site.

In both areas, Northcott therapists were empowering teachers with strategies to use with the children in the classroom. As some teachers were particularly eager to learn and alter their practice to better meet the needs of children with a disability or delay, these strategies will potentially become part of the normal teaching methods in the schools. Program staff also informed teachers about services that families could utilise, so that teachers became a source of knowledge and referral for families beyond the life of the Program.

In both sites, Northcott conducted one playgroup in collaboration with a local organisation, providing hope that the playgroups may continue. In the rural site, one of the playgroups was attended by a close group of parents, who

were exploring the possibility of continuing the playgroup informally after the Program finished. This would provide ongoing community based support for these families. The difficulty with this plan, however, is the lack of transport in the town. A local service or organisation would have to take on the role of providing transport. Staff in the rural site also linked families into existing services with staff they trusted, to assist in the sustainability of support.

As mentioned above, parents in both sites were learning strategies to meet their child's specific needs. Staff felt this had significant implications for sustainability, as parents could integrate these practices into their future everyday lives. Additionally, as families were now confident to talk to Program staff about family issues, this might transfer to interactions with other service providers. In some instances, family relationships with other support services had already developed.

Northcott staff felt that sustainability in both sites could be facilitated by securing the support of people at an executive level in local organisations, schools and services.

#### **4.5 Summary**

In order to identify a child's support needs, Northcott staff first needed to develop a trust relationship with the parents. It could take several weeks before parents started talking about concerns for their child. Parents were provided with information and encouraged to discuss their concerns and explore various options for their child.

Support needs were related to the child's disability or developmental delay but also family issues such as accommodation or financial support. Northcott staff felt that working with the family around their broader situation and identifying support was important as it indirectly supported the child.

Identifying the particular needs of a child was difficult for many parents, but also for some preschool and school staff who had little experience in identifying and supporting children with disability, particularly in the rural Program site.

In Term 1, 2012, speech, hearing or occupational assessments were obtained for 27 of the 40 children in the Program (68 per cent).

A shortage of specialist services (e.g. paediatricians) in the rural site made it difficult to obtain adequate support for the children.

Northcott staff supported families to understand that school readiness could best be achieved if support started earlier than in the year before school.

In some remote communities in the rural site, many children did not attend early education services, due to lack of transport, transience, tensions in the community and a shortage of early education services.

Staff observed that by building trust with parents and talking with them about disability, school readiness and strategies to use with their child at home, parents became more empowered. Parents started asking questions and requesting assistance in communicating with schools.

To make support sustainable beyond the end of the Program, Northcott staff started teaching school and preschool staff strategies to use in the classroom, and informed them about disability services. In both sites, Northcott conducted one playgroup in collaboration with another organisation, and in the rural site they explored handing over a playgroup to the parents to run, but transport needed to be arranged. Parents in both sites were learning strategies to meet their child's specific needs after the Program would end.

## **5 Implications for similar programs**

This section is based on the experiences of Northcott staff with the Program so far. It describes challenges that staff faced and their responses to these challenges, it identifies factors that helped the implementation of the Program, and it draws out implications for similar programs.

### **5.1 Timeframe of the Program**

Northcott staff believed that programs such as this – which support Aboriginal families with children with specific needs and rely heavily on external supports – need a generous lead up time of at least one year before commencement of service provision. This time is needed to build trust in the local Aboriginal community and with preschools and schools; and to thoroughly plan the program to ensure that services are tailored to community needs.

Building trusting relationships in the service locations was identified by Northcott staff as a key element to success in this type of program model. Staff commented that it took a considerable amount of time – more than one year – of regular appearances at meetings and community events to develop relationships with Aboriginal families, communities and services. The process was greatly assisted when staff, or the organisation as a whole, had prior relationships with local services and communities. This occurred in the rural site, where the program coordinator was originally from the area, the community development worker currently lived in the community and was well connected, and Northcott as an organisation was highly regarded.

Program planning needs to include awareness of the dynamics in the community between different family groups and services, both Aboriginal and non-Aboriginal. Awareness of similar services in the community is also essential. In the urban Program site, few parents attended the two Northcott playgroups. Staff assumed this was because numerous playgroups already existed in the area. In response Northcott amalgamated the two playgroups into one, which made the remaining playgroup viable and freed up staff resources to provide Program services to more children in schools and preschools.

Once the program was established, Northcott staff felt that a longer service delivery time than one year would be helpful. As mentioned before, Program staff found it took months for parents to feel comfortable talking to them about family concerns or needs for their child. This shortened the period of service delivery for children and parents. Northcott staff believed that intended Program outcomes for children and families, such as school readiness and family empowerment, generally need longer-term support. The Program has since been extended by six months to June 2013.

### **5.2 Staffing and logistics**

Recruiting staff to the Program was difficult in both sites, particularly in the rural site. There were limited numbers of applicants, and some of these had little or no experience and/or qualifications for the roles. The staffing model for

the Program changed a number of times to accommodate recruitment problems. This included flying a coordinator between two sites, increasing the early educators' hours, modifying their roles for a short period, and utilising therapy staff from other Northcott programs.

The rural site was in an isolated area, where recruitment was difficult due to a smaller pool of potential qualified applicants. Potential applicants for the roles were also unaware of vacancies.

To enable recruitment of Aboriginal staff, Northcott liaised with job networks, including Aboriginal-specific networks and the National Disability Services (NDS) Aboriginal Jobs Together project, to advertise roles. This did increase the number of applicants. However, applicants experienced difficulty with the recruitment and interview process, including the documentation required for the application process and pre-employment probity checks. An application form was developed to simplify the recruitment process, and an Aboriginal staff member was on the interview panel where possible. Northcott felt that further consultation is required with job networks to assist applicants to be ready for interviews and pre-employment probity processes.

On commencement of employment within the Program, some Aboriginal staff had difficulty adapting to the work environment. Northcott has identified that for some Aboriginal staff the organisation may not have culturally appropriate work practices and environments. To begin addressing this issue, Northcott held a two-day training course for all executive, senior and some middle managers on policy development and guidelines for supporting Aboriginal staff. An action plan was developed and the first steps taken. Northcott formed an internal Reconciliation Action Plan (RAP) Working Group. The purpose of the group is to develop a business plan which formalises Northcott's contribution to reconciliation by identifying clear actions with realistic targets in consultation with Aboriginal and Torres Strait Islander communities, organisations and leaders. The RAP is also about embedding cultural change within Northcott, through building good relationships, creating meaningful opportunities and respecting the contribution of Aboriginal and Torres Strait Islander communities. For example, Northcott linked its Aboriginal family and community worker roles to traineeships offered via the NDS Aboriginal Jobs Together project.

In addition to recruitment difficulties, a shortage of available staff hours for Program work was an issue in the rural LGA, as all Program staff were employed part-time. The two main service locations are more than 100 km apart, so that a roundtrip to run a playgroup takes three hours' travel time. Program staff in this site also highlighted the importance of communicating with families in person; however visiting families is often not practical due to the long distances. Staff suggested that if a program was located in a rural area and attempted to service outlying communities, an increase of staff hours, possibly to full-time, should be considered.

Northcott staff also felt that a project coordinator is needed in each site where the program is conducted, as dividing this role between two sites is difficult for both the coordinator and other program staff. The Program does have funding for two part-time project coordinators but had to amalgamate the positions due to recruitment difficulties. It is preferable that workers on the ground live

close to where the program is situated, otherwise long commuting times may cause strain.

A shortage of available therapy services in the rural site initially seemed a barrier to Program success. This was addressed by Northcott through organising therapists based in Sydney to travel to the site. However, the location and caseload of the therapists mean that children in the rural site receive only one therapy session per month, and less if children cannot attend on the allocated day. Northcott staff compensated by developing alternative ways of providing therapy support in the interim, such as arranging telephone contact between parents and therapists, and learning therapy strategies to implement with the children, their families and the preschool/school staff.

### **5.3 Partnerships with schools and service providers**

Programs such as this rely heavily on the support and involvement of local schools, preschools and service providers to meet the specific needs of participating children. Therefore close partnerships are essential for these programs to succeed.

Northcott staff had different partnership experiences in the two Program sites. In the urban schools and preschools, many teachers had experience with disability issues and seemed keen to learn from the therapists about how to best work with children with additional needs, and to attend training or information sessions associated with the program. Teachers worked well with Program staff and other services, and this was a key facilitator in communicating with parents and setting Program goals. In contrast, many school and preschool staff in the rural site appeared to have less experience with disability support, and they seemed unsure of what training they needed.

Northcott staff believed that the reasons for such differences were related to school staffing and internal communication issues. In the urban site teachers seemed highly experienced, and communication from preschool and school management down to classroom teachers appeared to work well, which helped service provision. In the rural site, Program staff stated that their communication with preschool and school staff was problematic or challenging for reasons such as high staff turn-over, part-time staff, or staff with limited experience or training due to the fact that they had only recently graduated.

Northcott staff in the rural site also observed that communication within schools and preschools was limited, with negative impacts on the Program. For example, when the first visit from Northcott occupational therapists and speech pathologists occurred, the classroom teachers in one primary school were unaware of it. The therapists arrived in the afternoon, as they had been advised by school management, but the teacher felt that the visit should have been conducted in the morning. Additionally, the management of the preschool participating in the Program had not organised the children to be present on the day of the therapists' visit.

Forming partnerships with local Aboriginal service providers also evolved differently in both sites. In the rural site, the main local organisation was highly supportive of the Program. Northcott staff thought this was because Northcott



was already well known to the Aboriginal organisation, and established relationships existed. In addition, the Northcott project coordinator was originally from the area and helped Program staff to make initial contact. The local Aboriginal organisation facilitated contact with Aboriginal families and provided practical support to the Program, by allowing staff to garage their van on their premises and letting them use their community hall for the playgroup for free. Program staff were in constant contact with the organisation.

In the urban site, however, Northcott was not well known, and previous relationships with Aboriginal organisations were limited. This created a barrier for workers trying to engage some Aboriginal services, and it delayed service delivery to families because the Program needed more time to become established within the community. Over time, relationships were formed, which Northcott staff attributed to continuing to communicate with people and organisations in the community. When they were initially not able to engage one of the main local Aboriginal organisations, staff used other ways to connect with the community, through attending interagency meetings in the local area. This process engaged the Aboriginal organisation indirectly, and towards the end of Term 1 the organisation started referring families to the Program.

In addition to schools, preschools and Aboriginal organisations, the wider local service system also needed to be considered. In the urban site, a number of services initially appeared to be hesitant to refer clients and work with the Northcott Program. Staff thought this was because a large number of early intervention supports and programs already existed in the area, so services felt little need to engage with another provider; in addition, Northcott was not well known. In contrast, in an area with fewer services, such as the rural Program site, Northcott staff observed that any new service was warmly welcomed.

#### **5.4 Engaging families and communities**

Northcott staff found that when engaging some families to participate in the Program, it seemed effective to explain that it was a school readiness and support program generally as well as a disability-specific program. In doing so, parents who were fearful of stigma or who did not want to label their child as having a delay or disability felt more comfortable participating. Other parents would be hesitant to join a disability program because their child had not been diagnosed with a disability, or the family did not view their child's needs as a disability or delay. Northcott staff felt that the flexible eligibility criteria for the Program helped. Not requiring a previous disability diagnosis was a key facilitator in recruiting families. It also helped engage children who would otherwise not have received support, and it responded to practical considerations: the shortage of health specialists in the rural site made it difficult for families to obtain a diagnosis.

Once children were enrolled in the Program, maintaining contact with the family could be difficult. Northcott staff in both sites found it hard to reach some families by phone. This posed issues particularly for the rural site due to the need to travel long distances to visit a family.

Achieving outcomes for children in similar programs requires engagement of extended families and entire communities. Northcott staff reported that in some cases extended family members participated in the program, rather than the parents. Staff suggested that community education about disability issues needed to be wide so that everyone was aware of how best to meet the needs of children with disability or delay. This would also help to overcome another challenge that Northcott staff faced in the rural site: many children were not accessing early childhood education services such as playgroup and preschool, and these were especially difficult to reach.

## **5.5 Summary**

The Program needed a lead up time of at least one year to build trusting relationships with local service providers and the Aboriginal community. Prior relationships helped.

In planning a program, the local service system needs to be considered. New services have to fill a gap rather than duplicate existing services.

A longer service delivery time would help to achieve outcomes such as school readiness and family empowerment.

The recruitment of staff for the rural site was difficult due to the smaller pool of potential qualified applicants. Flexibility with the staffing model helped to compensate.

Strategies that could be used to assist with recruitment and retention of Aboriginal staff are: an investment in training for managers to support staff in culturally appropriate ways, developing relationships with job networks, and assisting staff to access qualifications whilst on the job.

Service delivery in rural sites requires long travel times and therefore more staff hours.

A project coordinator is needed on the ground in each site.

A shortage of available therapy services in rural sites can be partly compensated for by arranging therapists to visit, support via telephone, and staff training to provide some therapy strategies.

Successful partnerships with schools and preschools are facilitated by existing disability awareness among teaching staff and their openness to engage with the program, and by good internal communication within schools and preschools.

Partnerships with other local service providers are easier to establish if the program provider organisation (in this case Northcott) is well-known and staff have personal connections in the Aboriginal community.

Flexibility of service provision and continued communication between Program staff and service providers can build rapport for engagement.

Similar programs could benefit from equally flexible eligibility criteria. Not requiring a previous disability diagnosis helped to engage families who would otherwise not have received support for their child's disability or developmental delay.

Disability awareness and education should be provided widely to extended families and communities to best meet the needs of participating children.

## 6 Conclusions

The interim analysis for the evaluation raises a number of issues for the remainder of the Program, for similar programs, and for research methodology.

### Program locations

Implementation of the Program differed considerably between urban and rural locations.

- Staff recruitment and retention were more difficult in the rural than in the urban site.
- In the rural site, travelling long distances between spread-out communities took substantial proportions of staff time, which reduced the hours available for service delivery.
- A shortage of health specialist and therapy services in the rural site initially made Program implementation difficult. Northcott compensated by sending therapists from Sydney.

### Timeframes

- Establishing the Program took a lead up time of more than one year, to build trusting relationships with local service providers and Aboriginal communities.
- Service delivery times of more than one year were needed to address wider family issues and achieve sustainable outcomes for children.

### Engagement of Aboriginal families, communities and local service providers

- Northcott staff were able to engage Aboriginal families in the Program by explaining that it was a general support program as well as disability-specific; by allowing families time to build trust with Northcott staff; by identifying support for the family, in addition to the child's disability needs; and by achieving some short-term goals for the children, such as developmental assessments.
- Collaboration with schools and preschools was facilitated by experience with disability support among teaching staff, and by good internal communication.
- Partnerships with other local service providers were easier to establish where Northcott was well established and staff had personal connections in the Aboriginal community. Initial hesitance by service providers could be addressed by Northcott staff's continued communication with the community.

## **Research methodology**

- Participatory action research gave Northcott staff the opportunity to learn about evaluation, to collect and analyse data, and to improve the Program as it progressed.
- Staff found the process of data collection and analysis straightforward. They learned to manage the time required for both evaluation activities and service delivery.

## Appendices

### Appendix A Family interview schedule first round

## Family interview – Wave 1

Name of interviewer: \_\_\_\_\_

Name of person being interviewed: \_\_\_\_\_

Date of interview: \_\_\_\_\_

This program is about supporting your child and your family. We want to know how it is helping you and how it could be improved.

- First, can you please tell me a little bit about your child and your family?

Interviewer's notes:

- Now, at the beginning of the program, what are you hoping it can do for your child and your family?

Interviewer prompts:

1. Find support services and funding?
2. Get your child ready for school / support your child to stay in school?
3. Help with concerns in your home?
4. Give you ways of supporting your child?

5. Help your communication with the school / preschool?
6. Help with your child's additional needs?
7. Provide therapy sessions for your child?

If needed, use alternative prompts:

1. Therapy support
2. Playgroups / preschool and school support
3. Information sessions
4. Yarn-ups
5. Support plans
6. Case management

Interviewer's notes:

Thank you for taking part in this interview.

– End of interview –

**Appendix B Family interview schedule second round (draft)**

**Family interview – Wave 2**

Name of interviewer: \_\_\_\_\_

Name of person being interviewed: \_\_\_\_\_

Date of interview: \_\_\_\_\_

This program is about supporting your child and your family. We want to know how it has helped you and how it could be improved.

- Overall, have you found the program has helped your child and your family?

Interviewer's notes:

- What has the program helped you with most, and where has it not helped so much?

Interviewer prompts:

- Find support services and funding?
- Get the child ready for school / support the child to stay in school?
- Help with concerns in your home?
- Give you ways of supporting your child?
- Help your communication with the school / preschool?
- Help with your child's additional needs?
- Provide therapy sessions for your child?

Interviewer's notes:



- How did you like the various parts of the program?

Interviewer prompts:

What was good or not so good about them?

- Therapy support
- Playgroups / school readiness program
- Training sessions
- Yarn-ups
- Support plans
- Case management

Interviewer's notes:

- What could be improved?

Interviewer's notes:

- What other support would you have liked to get through the program?

Interviewer's notes:

- Do you have any other suggestions for future ways of supporting children with additional needs and their families?

Interviewer's notes:

Thank you for taking part in this interview.

– End of interview –

**Appendix C Interview schedule for teachers and service providers first round**

**Teacher/Service provider interview – Wave 1**

Name of interviewer: \_\_\_\_\_

Name of person being interviewed: \_\_\_\_\_

Date of interview: \_\_\_\_\_

This project is about helping you to support children with additional needs and their families. We want to know how the project is helping you and how it could be improved.

- What is your role here?

Interviewer's notes:

- How do you identify that a child has additional needs?

Interviewer's notes:

- What strategies do you use to support a child with additional needs?

Interviewer's notes:

- How do you know what services exist in your community for a child with additional needs and their family?

Interviewer's notes:

- How do you know what funding exists for a child with additional needs and their family?

Interviewer's notes:

- What communication do you have with parents and families of children with additional needs?

Interviewer's notes:

- What communication do you have with support services?

Interviewer's notes:

- What support are you currently provided with to assist children with additional needs?

Interviewer's notes:

- How would you like the project to help you in supporting children with additional needs?

Interviewer prompts:

- Information about disabilities, strategies, services and funding
- Communication with the management of your school or preschool
- Helping to set up a parent support group

Interviewer's notes:

- Do you have any other suggestions for the project?

Interviewer's notes:

Thank you for taking part in this interview.

– End of interview –

**Appendix D Interview schedule for teachers and service providers  
second round (draft)**

**Teacher/Service provider interview – Wave 2**

Name of interviewer: \_\_\_\_\_

Name of person being interviewed: \_\_\_\_\_

Date of interview: \_\_\_\_\_

This project is about helping you to support children with additional needs and their families. We want to know how the project has helped you and how it could be improved.

- What has changed because of the project in the way you identify that a child has additional needs?

Interviewer's notes:

- Have the strategies changed that you use to support a child with additional needs? If so, how?

Interviewer's notes:

- How has your knowledge changed of services in your community for a child with additional needs and their family?

Interviewer's notes:

- How has your knowledge changed of funding for a child with additional needs and their family?

Interviewer's notes:

- How has your communication changed with parents and families of children with additional needs?

Interviewer's notes:

- How has your communication with support services changed?  
Interviewer prompt (if appropriate):
  - Communication with their school's/preschool's management

Interviewer's notes:

- Do you have any other suggestions for future ways of helping teachers and preschool staff to support children with additional needs and their families?

Interviewer's notes:

Thank you for taking part in this interview.

– End of interview –