School readiness program for Aboriginal children with additional needs

Working with children, families, communities and service providers

Final evaluation report
The Social Policy Research Centre is based in the Faculty of Arts and Social Sciences at UNSW Australia. This final evaluation report is an output of the Evaluation capacity development for the Aboriginal child and family disability therapy research project, funded by Northcott. The views expressed in this publication do not represent any official position on the part of Ageing, Disability and Home Care, NSW Department of Family and Community Services.

Suggested citation
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ABBREVIATIONS

ADHC    Ageing, Disability and Home Care
ADHD    Attention Deficit Hyperactivity Disorder
AMS     Aboriginal Medical Service
GP      General practitioner
LGA     Local Government Area
OT      Occupational therapy
SPRC    Social Policy Research Centre
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ACKNOWLEDGMENTS

We wish to acknowledge the contributions from the following individuals and organisations:

FAMILIES, COMMUNITIES, TEACHERS AND SERVICE PROVIDERS

for their participation, advice and comments

SPRC RESEARCH TEAM

Karen R Fisher, Christiane Purcal, B J Newton, Christine Eastman, Andrew Griffiths, Rosemary Kayess, Darryl Cronin, Margaret Raven, Iva Strnadova, Terry Cumming, Marianne Rajkovic, Kylie Valentine, Marie Delaney, Abigail Powell

NORTHCOTT RESEARCH TEAM

Terri Mears, Mariann Smith, Sally Gibson, Fiona Oudenryn, Wayne Nagle, Kim Slabon, Sarina Mahony, Kyla Thurtell, Jenny McIntosh, Kate Hanley, Megen Towney, Tricia Daley, Merle May

AGEING, DISABILITY AND HOME CARE, NSW DEPARTMENT OF FAMILY AND COMMUNITY SERVICES

for funding the project.
EXECUTIVE SUMMARY

Northcott in partnership with the Social Policy Research Centre (SPRC) evaluated Northcott’s school readiness program for Aboriginal children with additional needs (the Program). The Program worked with Aboriginal children with developmental delays or disabilities and their families to support school readiness and successful transition to school.

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

This report presents the methodology and findings of the evaluation. An interim evaluation report was published in May 2013 (Purcal et al. 2013). The evaluation was conducted over eighteen months to June 2013, concurrent with service provision.

EVALUATION METHODOLOGY

Northcott conducted the evaluation with advice and assistance from 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.

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

The evaluation included a literature review; interviews with preschool and school staff, service providers and families; and program data analysis about changes in the capacity of children, families and communities.

Northcott staff had a generally positive experience with data collection and it enhanced their research and service capacity. They appreciated the training and analysis workshops, and they enjoyed participating and reflecting on their practice through the interviews. Future projects need to consider allocating staff time to ensure that research tasks do not conflict with service delivery.

Successful methods for engaging families in the evaluation were clarifying the purpose of the evaluation, considering community events with the timing of interviews, and explaining and modifying interview questions and styles.

PROGRAM DELIVERY

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. During the Program some services ended when children transitioned to preschool or school, two playgroups were amalgamated, and new schools joined the Program. At the end of service delivery, in Term 2/2013, there were five preschool- and school-based services and two playgroups.
A total of 93 children entered the Program, and 45 children left before the Program finished. Reasons for leaving included medical needs, attending other services and no longer needing Program support.

Program attendance fluctuated between weeks and school terms. Towards the end of service delivery, about 20 children participated regularly in the preschool- and school-based services, and 0–10 children attended the playgroup services in any given week.

Of the children entering the Program, 70 per cent were boys and 30 per cent were girls. Ages of the children ranged from 0–8 years, consistent with the Program criteria, and Northcott included some toddlers in preschool-based services. Transport assistance was provided primarily to families attending playgroup and those from the rural site.

Of all children entering the Program, 18 per cent had a previous disability diagnosis. The most common diagnoses were autism spectrum disorder and ADHD. Twenty-one per cent had existing therapy support.

The main concerns that families had for their children when entering the Program were child behaviour and speech delays. Overall, concerns spread across intellectual, physical and emotional aspects of children’s development.

Factors that contributed to successful recruitment of families were the Aboriginal-specific focus of the Program, having Aboriginal staff members as contacts 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, preschools and other services and, as the Program became established, increasingly through word of mouth.

Staff built trusting relationships with families by helping them fill out enrolment forms and by spending time to get to know them. Support plans for the children and families were developed individually and focused on short term goals such as child developmental and health assessments, so that families could see and achieve outcomes quickly.

During the Program, 13 information and training sessions were organised for teachers, service providers and families. Most participants liked the sessions, and some asked for more. Attendance was higher at the teacher/provider sessions than the family sessions, as families preferred one-on-one conversations. Discussions with groups of Aboriginal families, called yarn-ups, were trialled in the Program but were unsuccessful, as most families preferred one-on-one conversations.

When planning information sessions and training for preschool and school staff it was important to plan well in advance as schools had busy schedules. The optimal time to plan with the school was towards the end of one school year in preparation for the next year. This enabled schools to allocate sufficient time for staff to attend training. Allocating funds to schools to allow staff to be released from face to face teaching for intensive individual education would also have helped facilitate their participation. Future projects might consider additional ways of providing information and training and provide this support to teachers’ aides and parent helpers.

The Program included speech pathology, psychology and occupational therapy services from Northcott for the children. Due to caseloads and location of the therapists, children in the rural site had infrequent face-to-face access to the therapists, who travelled from Sydney. In the urban site, the closer proximity of the therapists meant that children had easier, more frequent access to support.
To arrange some ongoing support in the rural site, therapists built the capacity of the local team, parents, preschool and school staff and other service providers by providing them with strategies and resources and consulted over the phone. Therapy support was most effective when the therapist had close collaboration with other Program staff, such as a joint visit with the family, so that they could all learn from each other about the family preferences.

Collaboration with school and preschool staff worked best where teachers were proactive and internal school communication functioned well. This helped with engaging families and supporting children. Collaboration was challenging in schools and preschools that were short-staffed and where staff had little experience and training about child disability.

OUTCOMES FOR CHILDREN AND FAMILIES

The findings about outcomes address the evaluation questions.

1. What support can assist Aboriginal families to identify their children’s potential need for disability support and obtain that support for their child earlier?

   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 were comfortable to start talking about their concerns for their child.

   Support needs were related to the child’s disability or developmental delay; and also family issues such as accommodation or financial support. Northcott staff found that working with the families around their broader situation 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 identifying and supporting children with disability, particularly in the rural site.

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?

   Most staff and families were pleased that 86 per cent of the high and medium priority goals established with the families were achieved during the course of the Program. During the Program, 77 physical and behavioural assessments were conducted for the children, 20 of which were speech assessments.

   Therapy and specialist medical support was easier to arrange in the urban than the rural site due to availability of therapists and specialists. Service coordination meetings were a successful method for obtaining effective support for some families who were involved with other health and community services.

3. What empowers Aboriginal families to effectively advocate for services and support where their child has learning disabilities or a developmental delay?

   Families with several children or without extended family support had less capacity to talk to staff about their children and implement strategies at home. These families required more intensive, longer term support.

   Staff successfully transitioned several children to and between schools during the course of the Program, by developing individual transition strategies, by having Program support follow the child to the new school, and by addressing issues early that would make transition difficult in the future.
Staff observed that parents became more empowered during the Program through receiving information about disability and their children’s needs, learning strategies to use with their child at home, and having trusted workers who they could talk with openly. As parents felt more confident, they also started asking medical specialists questions about their children and communicating with schools and service providers. Opportunities for family empowerment were restricted where contact with Program staff was infrequent, as with many preschool and school parents.

The Program also empowered parents to support other families, by calling them to attend playgroup, informing them about other services and helping to run playgroup sessions. Northcott believed that a longer Program timeframe could have increased this peer support at the community level.

4. What format of service support can provide a sustainable model for ongoing support to Aboriginal communities for families of children with additional needs?

Northcott staff took steps to make the support sustainable after the end of the Program. They provided strategies and resources to school and preschool staff to use in the classroom and informed them about disability services. Parents were referred to other services for ongoing support, and they learned strategies to meet their children’s specific needs after the Program ended. Northcott conducted playgroups in collaboration with other organisations so that the playgroups might continue.

Northcott expected that the empowerment many parents felt, the information they had received and the connections they had built with other families in the Program would sustain the outcomes achieved.

**IMPLICATIONS FOR SIMILAR PROGRAMS**

**Timeframe**

Similar programs need a lead time of at least one year to build trusting relationships with local service providers and the Aboriginal community. Prior relationships help. Obtaining approval from community leaders may require time and persistence but is essential.

In planning a similar program, the local service system needs to be considered. New services have to fill a gap rather than duplicate existing services. A service delivery time longer than 18 months could help to improve outcomes such as school readiness and family empowerment, and it could avoid possible disappointment and disengagement of Aboriginal families and communities.

**Staffing and logistics**

Good communication among the program team is essential and facilitated by regular team meetings and modelling of skills among workers. A project coordinator is needed on the ground in each program site to develop and support the relationships internal and external to the program.

Children in each site need regular, face to face contact with therapists. This could be arranged by using local therapists or regular travel to the sites, or alternatively by video-conferencing. Service delivery in rural sites requires long travel times and therefore more staff hours.

Recruitment of Aboriginal staff can be facilitated by liaising with job networks and simplifying the application process. Strategies for successful retention of Aboriginal staff include: organisational
Structures for culturally appropriate workplaces; improving cultural awareness among non-Aboriginal staff within the project team; continuing cooperation with job networks; safe practices that protect both the organisation and the worker; creating a flexible, family-centred workplace; training and assisting Aboriginal workers to fulfil administrative duties; pairing Aboriginal staff with more and less experience; providing supervision, debriefing and mentoring opportunities for Aboriginal and non-Aboriginal staff; and considering possible divisions within the local Aboriginal community when hiring Aboriginal workers.

**Engaging families and communities**

When engaging families and communities, a program approach that emphasises general early childhood development rather than disability-specific intervention helps, as do flexible eligibility criteria. Not requiring a previous disability diagnosis engaged families who would otherwise not have received support for their children’s disability or developmental delay.

Building trusting relationships with families requires time, as well as flexible work arrangements for staff to accommodate parent preferences. Maintaining contact with families during the program is important for child outcomes and sustainability. It requires cooperation with schools and preschools to engage families, and extended travel time for staff in a rural area.

Involving extended families and communities helps to raise awareness about how to meet the needs of children with disability or delay. Community elders are good initial points of contact. Programs provided within an Aboriginal community need to have understanding and awareness that the families have community commitments and responsibilities.

**Partnerships with schools and service providers**

Similar programs would benefit from early contact with local providers, a regular presence in the area and flexibility to accommodate the needs of providers. Programs need to enlist the support of key people in local organisations and work within existing communication structures. Building partnerships with local Aboriginal providers is essential and may require flexibility and time for many points of contact.

**Delivering this program model to Aboriginal communities**

Staff may need to explain to local Aboriginal and non-Aboriginal community members why this kind of program is specifically for Aboriginal families, to dispel possible notions of unfairness.

Lack of previous information about disability in Aboriginal communities may be addressed by talking generally about the child’s development, by focusing on school readiness and by informing community members about disability generally.

Culturally appropriate service delivery needs to consider staff training for interaction with families, flexibility using formal assessment tools, and sensitive responses to community trauma. Non-Aboriginal staff can work successfully with families if they have cultural sensitivity and cooperate with local Aboriginal leaders and the Aboriginal staff.
THE PROGRAM

Northcott’s school readiness program for Aboriginal children with additional needs (the Program) provided 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 was to support Aboriginal children during their transition to school, ready to learn and participate in the school environment and to identify children with undiagnosed disabilities prior to starting school or in their first year of school.

Ageing, Disability and Home Care (ADHC), NSW Department of Family and Community Services funded Northcott to develop a program with therapy, family support and early education services to Aboriginal children and their families. The Program delivery included: inclusive playgroups; preschool- and school-based support; family information, training and support; information and training for preschool and school staff; and therapy.

The locations for the Program were one urban and one rural Local Government Area (LGA). The urban LGA is in metropolitan Sydney, and the rural LGA consists of small towns and remote areas. In both sites, Program services were delivered in several locations.

In addition to delivering services in these areas from January 2012 to June 2013, the Program built community capacity by partnering with relevant local organisations, including Aboriginal community organisations, health centres and schools.

The Program aimed to:

- provide a comprehensive therapy program to Aboriginal children who had undiagnosed disabilities or developmental delay and limited school readiness skills
- enhance the capacity of Aboriginal families, community members and preschool and 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 intended 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 enhanced the transition to school, promoted skill development and learning, facilitated access to the curriculum and enhanced 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 was 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 included an evaluation component (the evaluation). The evaluation assessed the benefits of the Program for Aboriginal children, their families and communities as well as local service providers. 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. This report presents the evaluation methodology and findings.
2 EVALUATION METHODOLOGY

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

The evaluation used mixed methods to answer the evaluation questions outlined below. It observed the ongoing Program activities to determine whether the Program was conducted as planned (process evaluation), and it assessed whether the Program met its goals (outcomes evaluation).

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

2.1 EVALUATION QUESTIONS

The evaluation questions were:

1. What support can assist Aboriginal families to identify their children’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 included the number of:

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

Some outcomes could not be measured in numbers, but were assessed by looking at indicators of Program success. These included the following.

For families: felt supported, less isolated; communication improved, e.g. with other services/therapists; accessed support as soon as concerns developed – not waiting until crisis happens; engaged more with other services plus playgroups/ pre-school/ school activities; improved life skills (e.g. driving); received practical support from Northcott (e.g. transport to
hospital appointments); unmet needs and service gaps identified; strengthened 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:** felt more confident, more empowered; used new strategies in the classroom; engaged 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. SPRC supported 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 SPRC used an action research process for the evaluation. This involved Northcott staff actively participating in all stages of the evaluation, collaborating with SPRC, and engaging with Program participants and communities during the research process.

Frequent meetings and a series of workshops were held between Northcott and SPRC staff about:

- training on evaluation and research methodology – general training, 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 SPRC
- interview training – SPRC researchers modelling the 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 the evaluation findings.

In the two service delivery areas, Northcott staff engaged 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 were a literature review, qualitative and quantitative data collection.

### LITERATURE REVIEW

This was 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 SPRC and a report was provided to Northcott in November 2011.
QUALITATIVE DATA COLLECTION

Qualitative data collection included:

- 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 recorded about the Program
- staff reflections during team workshops; and
- minutes of Northcott staff meetings.

Three waves of interviews were conducted with families as well as teachers and service providers: close to the start of service delivery (March/April 2012), around the mid-point (October/November 2012) and near the end (May 2013). The purpose of repeated interviews was twofold: to provide information about the effectiveness of the Program while it was operating and adjust it accordingly; and to provide a longitudinal perspective on the impact of the Program on participants. A total of 75 interviews were conducted for the evaluation: 34 with families, and 41 with teachers and service providers (Table 1).

Staff tried to include families and teachers/service providers in multiple interview rounds, to obtain longitudinal perspectives. This was not always possible, due to the turnover of both families and school and service staff, and people’s availability (for example, some families were not able to participate in repeat interviews due to Sorry Business). In the urban site, four parents and one service provider participated in all three interview rounds, and no-one in the rural site participated in all three rounds. Two interviews were completed with four family members and four teachers/service providers in the urban site, and one parent and six teachers/service providers in the rural site.

The interview questions for families and teachers/service providers used in the first and subsequent waves of data collection are in the Appendices. Interviews were voice-recorded and transcribed. Interviews and other qualitative data were analysed thematically by Northcott staff using a template developed by SPRC, and during collaborative workshops. The findings are presented in this report.

Table 1: Evaluation interviews

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<th>Wave 2</th>
<th>Wave 3</th>
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<td>34</td>
<td>23</td>
<td>18</td>
<td>75</td>
</tr>
</tbody>
</table>
Quantitative data collection

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

- 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 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).

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

2.5 REFLECTIONS ON THE RESEARCH EXPERIENCE

As part of the action research process for the evaluation, SPRC organised three workshops where Northcott staff reflected on their experiences regarding data collection and analysis, and where they discussed how the research process could be improved for the remainder of the evaluation and for future projects. Staff identified experiences and recommendations about combining Program delivery and research, and conducting interviews.

COMBINING PROGRAM DELIVERY AND RESEARCH

- As the evaluation progressed, staff became increasingly comfortable with their role as researchers. Through modelling by SPRC researchers and Northcott colleagues they learnt how to conduct interviews, how to complete the program data forms and how to analyse the data. In this way research capacity among Northcott staff was enhanced.
- Staff members enjoyed the interviews as they gave them opportunities to get feedback from the participants, a chance for reflection on their practice, and suggestions for how to improve service provision.
- The repeated change in Program staff meant that research skills were lost and training new colleagues was an added responsibility for staff.
- Over time, staff worked out how to fit their evaluation tasks around the service delivery. For example, program data collection was organised during the school holidays when staff were not engaged in service delivery. However, staff felt that some additional time allocation specifically for research tasks would have helped.
- The joint workshops with SPRC were considered valuable and necessary as they gave the entire Northcott team opportunities to get together and discuss the Program, research findings and lessons for program improvement.
CONDUCTING INTERVIEWS WITH FAMILIES AND TEACHERS/SERVICE PROVIDERS

- Staff engaged families in the evaluation by letting them know about an evaluation component from the start; by explaining that the aim of the evaluation was to improve service access and delivery for the community; and by explaining the term ‘evaluation’.

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

- Community events could impact on evaluation plans. In the rural site, Sorry Business at the time of wave 3 interviews made it inappropriate to ask parents to participate.

- In the interviews some parents were initially shy, especially of the voice recorder. Staff found that it helped to:
  - go through the questions with the parents prior to the interview
  - modify the wording of questions to make them appropriate to each family and local area
  - play the recording back to parents. Staff found this empowering for the parents as some did not realise how professionally they spoke until they heard themselves, and
  - after playing the recording, asking parents to respond again. This gave them the opportunity to reflect on the questions and their answers.

2.6 SUMMARY OF THE EVALUATION METHODOLOGY

Northcott conducted the evaluation with advice and assistance from 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.

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

The evaluation included a literature review; interviews with preschool and school staff, service providers and families; and program data analysis about changes in the capacity of children, families and communities.

Northcott staff had a generally positive experience with data collection and it enhanced their research and service capacity. They appreciated the training and analysis workshops, and they enjoyed participating and reflecting on their practice through the interviews. Future projects need to consider allocating staff time to ensure that research tasks do not conflict with service delivery.

Successful methods for engaging families in the evaluation were clarifying the purpose of the evaluation, considering community events with the timing of interviews, and explaining and modifying interview questions and styles.
3 PROGRAM DELIVERY

This section presents evaluation findings about the different components of service delivery: the playgroups and preschool- and school-based services, recruitment of families, support plans, information and training sessions, therapy support, yarn-ups, and communication with preschool and school staff. The findings are based on the qualitative and quantitative data described above.

Due to incomplete quantitative data received from some services, the numbers reported here may not be complete. Where possible, we have indicated that data is missing, but in some cases it is unclear whether data are incomplete or the value is zero.

3.1 PLAYGROUPS AND PRESCHOOL- AND SCHOOL-BASED SERVICES

3.1.1 SERVICE DESCRIPTION

The Program consisted of preschool- and school-based services and playgroup services. In the preschool- and school-based services, Northcott staff formed partnerships with existing preschools and primary schools, attended classes and observed children. Staff at the preschools, schools and Northcott identified children who might benefit from the Program and tried to recruit the families. Once children joined the Program, Northcott staff worked with the children and families individually, organised therapy and provided other support.

In the playgroup services, Northcott worked with community organisations and set up new supported playgroups for children or supported existing playgroups. Northcott staff either ran the playgroups or co-facilitated with other service providers and, alongside the group work, assisted children and families individually. Northcott provided transport assistance for children in both types of services.

In the two sites, a total of ten services were established initially in Term 1/2012 (Table 2): six preschool- and school-based services located in primary schools and early childhood education centres; and four playgroups, three of which were located on the grounds of community organisations. The rural and urban sites each had five services.

One of the primary schools in the rural site withdrew from the Program at the end of school Term 1/2012. One playgroup in the urban site was disbanded towards the end of Term 1/2012 due to consistently low numbers. The families who attended this playgroup then attended the other playgroup in the urban site.

Two urban primary schools joined the Program later, as participating children transitioned from the playgroup into these schools and service provision continued. Services ended after Term 4/2012 in one of the urban and one of the rural preschools, as well as in one of the rural playgroups, because all children participating in the Program transitioned to primary school and preschool respectively. At the end of service delivery, in Term 2/2013, there were five preschool- and school-based services and two playgroups.
Table 2: Number of services per site and service type, beginning and end of service delivery

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Urban site</th>
<th>Rural site</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beginning</td>
<td>End</td>
<td>Beginning</td>
</tr>
<tr>
<td>Preschool- and school-based services</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Playgroup services</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

The services were available to Aboriginal families who had children aged 0–8 years and who had concerns about their children’s development and/or learning. This included:

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

The types of support offered by the Program were:

- individual child or group programs with skilled workers to meet the child and family needs
- family support through individual case management and development of parent networks
- assistance in accessing resources and services in the community
- 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 to three weeks, and a speech pathologist, a psychologist and an occupational therapist visited both sites.

Frequent staff changes occurred during 2012. Staff left in both sites, and during recruitment, the remaining staff took on extra Program tasks. This involved working additional hours and travelling between the urban and rural sites. Several staff were recruited in the rural site but left, and at the close of service delivery in Term 2/2013, the rural site was staffed by a local coordinator and an early childhood educator. In the urban site, the initial project coordinator took on the roles of local coordinator and Aboriginal community development worker, working with an early childhood educator.

3.1.2 PARTICIPANT CHARACTERISTICS

This section analyses the demographic characteristics of the children attending the Program, as well as their disability diagnoses, parental concerns and patterns of Program attendance.

Number, age and gender of the children

A total of 93 children started in the Program during the six school terms in which it operated, Term 1/2012 to Term 2/2013: 56 in the preschool- and school-based services and 37 in the playgroup services (Table 3). Across both types of services, there were 41 children in the urban
site and 52 in the rural site. The three children in rural playgroup 2 started in Term 3/2012 and left the Program at the end of the year because they transitioned to preschool. No demographic data was provided for these children, and therefore they are not included in the following tables and analysis.

Table 3: Number of children entering the Program during 2012 and 2013

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool- and school-based services</td>
<td></td>
</tr>
<tr>
<td>Urban primary school 1</td>
<td>15</td>
</tr>
<tr>
<td>Urban primary school 2</td>
<td>2</td>
</tr>
<tr>
<td>Urban primary school 3</td>
<td>2</td>
</tr>
<tr>
<td>Urban preschool 1</td>
<td>3</td>
</tr>
<tr>
<td>Urban preschool 2</td>
<td>12</td>
</tr>
<tr>
<td>Rural primary school 1</td>
<td>9</td>
</tr>
<tr>
<td>Rural primary school 2</td>
<td>6</td>
</tr>
<tr>
<td>Rural preschool</td>
<td>7</td>
</tr>
<tr>
<td><strong>Subtotal, preschool- and school-based services</strong></td>
<td><strong>56</strong></td>
</tr>
<tr>
<td>Playgroups</td>
<td></td>
</tr>
<tr>
<td>Urban playgroup</td>
<td>7</td>
</tr>
<tr>
<td>Rural playgroup 1</td>
<td>27</td>
</tr>
<tr>
<td>Rural playgroup 2*</td>
<td>3</td>
</tr>
<tr>
<td><strong>Subtotal, playgroup services</strong></td>
<td><strong>37</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
</tr>
</tbody>
</table>

* These children left after two terms and no demographic data about them was available. They are not included in the following tables and analysis.

After each term, Northcott staff recorded the numbers of children who did not regularly attend or had left the Program, although a clear distinction between those two groups was not possible at the time, as children might return later. Altogether, 40 children in the preschool- and school-based services and 43 in the playgroup services were recorded as absent. If children were regularly absent across terms, they were recorded more than once. Over the course of the Program, the most common reason for children’s temporary absence or permanent withdrawal from the Program was medical, which applied to 14 children in the preschool and school services and eight children in the playgroup services.

According to the reasons recorded for absences, a total of 45 children appear to have left the Program altogether: 26 children from the preschool- and school-based services, mostly because they changed schools or no longer needed Program support; and 19 children from the playgroup services, mostly because the playgroup closed, the child started attending day care on the same day as playgroup, or family issues. Reasons for withdrawal were unknown for 12 children (six each from both service types) because staff were unable to contact the family.

At entry to the Program, the most common age for children in the preschool- and school-based services was four years, but the entire group of participants was a little older, with about half the children aged six or more (Table 4).
When children entered the playgroup services, almost one-half (16 children) were two years old. Another 12 children (35 per cent) were older, and 6 children (18 per cent) were younger than two years (Table 5).

<table>
<thead>
<tr>
<th>Age of children</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>3</td>
</tr>
<tr>
<td>1 year</td>
<td>3</td>
</tr>
<tr>
<td>2 years</td>
<td>16</td>
</tr>
<tr>
<td>3 years</td>
<td>4</td>
</tr>
<tr>
<td>4 years</td>
<td>7</td>
</tr>
<tr>
<td>5 years</td>
<td>0</td>
</tr>
<tr>
<td>Over 5 years</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>34*</td>
</tr>
</tbody>
</table>

* Excluding the 3 children from rural playgroup 2, for whom no demographic data was available.

Overall, more than twice as many boys as girls were in the Program (Table 6). Most of this difference is due to the preschool- and school-based services, where 77 per cent of entrants were boys. In the playgroup services, the distribution between girls and boys was more even.

<table>
<thead>
<tr>
<th>Gender of children</th>
<th>Playgroup</th>
<th>Preschool and school</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children</td>
<td>Per cent</td>
<td>Children</td>
</tr>
<tr>
<td>Boy</td>
<td>20</td>
<td>59</td>
<td>43</td>
</tr>
<tr>
<td>Girl</td>
<td>14</td>
<td>41</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>100</td>
<td>56</td>
</tr>
</tbody>
</table>

Schooling

The majority of the children entering the preschool- and school-based services were in school (Table 7), with 18 of the 28 children enrolled, and just over one-third in preschool (10 children).
Table 7: School enrolment of children entering the preschool- and school-based services

<table>
<thead>
<tr>
<th>Preschool or school year</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool</td>
<td>20</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>5</td>
</tr>
<tr>
<td>Year 1</td>
<td>8</td>
</tr>
<tr>
<td>Year 2</td>
<td>11</td>
</tr>
<tr>
<td>Unknown</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
</tr>
</tbody>
</table>

Disability diagnoses

Almost one in five children had a disability diagnosis when they joined the Program (Table 8). In other words, 82 per cent of the children (74 children) entered without a disability diagnosis. Proportions were similar in the playgroup and preschool- and school-based services, and the children came from both Program sites.

Table 8: Children in the Program with a previous disability diagnosis

<table>
<thead>
<tr>
<th>Number of children</th>
<th>Per cent of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Playgroup services</td>
<td>6</td>
</tr>
<tr>
<td>Number diagnosed</td>
<td>34</td>
</tr>
<tr>
<td>Preschool- and school-based services</td>
<td>10</td>
</tr>
<tr>
<td>Number of children</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
</tr>
<tr>
<td>Per cent of children</td>
<td>18</td>
</tr>
</tbody>
</table>

The type of previous disability diagnosis differed between the two service types (Table 9). Among the playgroup children, autism spectrum disorder was the most common diagnosis, whereas in the preschool- and school-based group, it was ADHD. Some children had more than one diagnosis.

Table 9: Number of children with type of previous disability diagnosis by service

<table>
<thead>
<tr>
<th>Disability diagnosis</th>
<th>Playgroup services</th>
<th>Preschool- and school-based services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism spectrum disorder</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Partial epileptic</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Moderate global developmental delay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Severe language delay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mild global developmental delay</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>T2/T3 vertebral anomaly &amp; associated scoliosis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Profound hearing impairment</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Executive function disorder</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Dyspraxia</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Intellectual disability-non specific</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Seizure syndrome</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Northcott staff also recorded any disability diagnoses that were made during the course of the Program. Over the six terms of service provision, six children received diagnoses. These children were in both the preschool- and school-based services and playgroups. The children were diagnosed with Autism Spectrum Disorder (one child), mild intellectual disability (one child), severe (one child) or moderate (two children) language delay and one diagnosis was unknown.

Most children in the Program did not have a diagnosed disability and were therefore not eligible for many funded disability services. Especially in the rural area, the scarcity of medical specialists limited the opportunity for children to receive a diagnosis even if it was identified that they might need one. Obtaining a diagnosis for some families was not their priority. Instead, their focus was to get assistance for their child about a particular issue, for example positive behaviour strategies in the home.

Most children were not receiving any specialist support, and for several families the Program was the first time they accessed support from a social service provider. Northcott felt that the Program’s flexible entry criteria helped to support children who had no formal disability diagnosis but who could benefit from the service. Some children were affected by multiple disadvantages and benefited from an accessible service for any Aboriginal families who wanted support for their children’s development.

**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, and many parents listed more than one concern (Table 10).

The concern expressed by the most parents was related to behaviour (44 mentions, representing almost one-half of all entrants). This was followed by concerns about speech or expressive language, which was reported by 43 parents (also almost one-half of all entrants). Overall, concerns spread across intellectual, physical and emotional aspects of children’s development.

Some families had difficulty with specifically naming any or further concerns they had for their child. However, they were aware that their children might have 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.

Parents’ main concerns for their children related to behaviour and speech delays that were affecting their children’s social interactions in formal settings, such as at school, or informal settings, such as with other children in a local park or shopping. Some parents had difficulty detailing their concerns for their children beyond these larger impacts. Therapists assisted them to identify more specific needs, such as for an OT to assist with self-regulation and sensory integration and/or fine motor skills, handwriting.
Table 10: Parental concerns for their children at Program entry

<table>
<thead>
<tr>
<th>Concern</th>
<th>Playgroup services</th>
<th>Preschool- and school-based services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour (home or school)</td>
<td>12</td>
<td>32</td>
</tr>
<tr>
<td>Speech / expressive language</td>
<td>12</td>
<td>31</td>
</tr>
<tr>
<td>Literacy / reading / writing / learning</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Motor skills / gross motor / fine motor / clumsiness / coordination</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Social inclusion</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Attention / concentration</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Hearing</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Social skills / Interactions with other children</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>School readiness / coping with school</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Concerns with weight</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Dealing with grief</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Listening</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Stiff/painful joints</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Confidence</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Dribbling</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Receptive language</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Appropriate development</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Independence</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge of disabilities</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Physical development</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Concerns about drug/alcohol use during pregnancy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Toilet training</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Using visual aids</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Family outings</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Note: Parents could record more than one concern

Existing support from therapists

Most children had no existing support in place on entering the Program (Table 11), although the preschool- and school-based group had a larger proportion of children with existing support (25 per cent) compared to the playgroup children (15 per cent). Each child was accessing only one type of support upon entering the Program. Among the playgroup children, five (two rural and three urban) out of the 34 entrants had existing support: occupational therapy, speech pathology and audiology. Within the preschool- and school-based group, four children had accessed a speech pathologist, and ten had seen their school counsellor. These children were all from the rural site.

Table 11: Access to support upon entering the Program

<table>
<thead>
<tr>
<th>Support type</th>
<th>Playgroup services</th>
<th>Preschool- and school-based services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational therapist</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Speech pathologist</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Audiologist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>School counsellor</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Per cent of children with support</td>
<td>15 per cent</td>
<td>25 per cent</td>
</tr>
</tbody>
</table>
3.1.3 PROGRAM ATTENDANCE

Attendance information was provided only for some services and terms. It is unclear whether this was due to a lack of attendance or data not recorded. Figure 1 to Figure 4 below are based on the available data. Figure 1 shows the number of children attending all preschool- and school-based services per week, across the six terms. Attendance remained quite constant across the 10 weeks of the terms, varying between 92 and 100 children.

**Figure 1:** Preschool- and school-based services total attendance by week across all terms 2012–2013

Fluctuation between terms was greater. Figure 2 shows the sums of each week’s attendance across the preschool- and school-based services. Attendance rose initially and peaked in Term 3/2012, with 255 children attending. It remained fairly constant afterwards. The drop to 30 in Term 2/2013 is due to missing data and some children were referred to other services to connect them to a service that could provide ongoing support. Actual attendance numbers are unknown.
Figure 2: Preschool- and school-based services total attendance by term across all terms 2012-2013

Note: Numbers for each term are a sum of the children who attended each week that term

Compared with the preschool- and school-based services, attendance in the playgroup services fluctuated more from week to week (Figure 3). Across the two playgroups that provided attendance data, the smallest number of children attended in the first and last weeks of the term, while attendance was more than double in weeks two and three.

The Program was originally set up to provide services for a total of 70 children: 30 in preschool- and school-based services (15 in each site) and 40 in four playgroups (10 per playgroup). The actual number of children who entered during the course of the Program was higher, totalling 93, while the numbers participating at any one time were lower, particularly in the playgroups.

Playgroups in both sites were fewer and smaller than expected. In the urban site, Northcott presumed that this was due to the large number of already existing playgroups and the lack of awareness of Northcott services in the area. The small size of the playgroups led to a rethink of service delivery: the two playgroups were amalgamated, and the number of children who could access the preschool- and school-based services was increased.

Similarly in the rural site, only one of the planned two playgroups flourished. The relatively large number of children entering the playgroup (27) does not reflect regular attendance but a turnover of playgroup participants. Several families left when staff changed in Term 3/2012. Northcott felt that this was partly because families had built relationships with the previous workers. The new staff recruited other families to the playgroup so that numbers increased again in Term 1/2013.

The second playgroup in the rural site was a pre-existing supported playgroup for Aboriginal families and not specifically for children with a disability or delay. Northcott staff only visited this playgroup but did not run it and had no influence on recruitment. The three participating children transferred to preschool at the end of 2012, and Northcott provided support to attempt to rebuild the playgroup in Term 1, 2013. Intake into the preschool- and school-based services was nearer capacity, 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. During the interviews parents confirmed there was limited access to services in the rural site. One parent said:
Just being [an] isolated town and little opportunities to see the specialist that he needs.

The higher fluctuation in attendance at the playgroups compared to the preschool- and school-based services was expected by Northcott, as children generally attend the structured educational environments of preschools and schools more regularly than they do voluntary playgroups. In addition, families were affected by illness, Sorry Business and other community commitments, which prevented parents from taking their children to playgroup every week. The programs in the Aboriginal communities incorporated an understanding and awareness that the families had community commitments and responsibilities. In response, the program provided services differently at times. For example, families could still receive weekly contact, through flexible means such as via the telephone or a visit to a local park.

**Figure 3: Playgroup total attendance by week across all terms 2012–2013**

Like in the preschool- and school-based services, attendance in the two playgroups peaked in Term 3/2012, with each week’s attendance numbers adding up to 54 children (Figure 4). Attendance dropped to almost half in Term 4, before rising again in 2013. The pattern was similar in both the rural and the urban playgroup.
Attendance data, although incomplete, indicates that towards the end of the Program in Term 1/2013, about 20 children participated regularly in the preschool- and school-based services. Participation in the playgroups fluctuated from week to week, and towards the end of the Program, between zero and ten children came to the playgroup services in any given week.

### 3.1.4 TRANSPORT ASSISTANCE

More children needed transport assistance in the playgroup services than the preschool and school services (Table 12), despite the smaller total number of children in the playgroup services (Table 3). Transport assistance was needed more in the rural than the urban site: 25 of the 28 playgroup attendees who required transport assistance were from the rural area, as were 12 of the 15 preschool- and school-based children who required transport assistance.

<table>
<thead>
<tr>
<th>Table 12: Children needing transport assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool- and school-based services</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Term</td>
</tr>
<tr>
<td>Preschool- and school-based services</td>
</tr>
<tr>
<td>Playgroup services</td>
</tr>
</tbody>
</table>

Most of the children who needed transport assistance were from the rural site and the playgroups. Some of the families in the urban site walked to the playgroup, preschool and school and requested assistance only when they needed to go to medical or therapy appointments. One rural mother commented: ‘I wouldn’t have been able to get there without the pick-up service.’ A teacher also commented in an interview:

> The fact that the services came into the schools, so that the families didn’t have to go to them or travel [was important], because, obviously transport can be an issue.
The need for transport assistance was lower than anticipated. Northcott expected that the Aboriginal community development worker would need to provide a lot of transport support to families, and a Northcott van and staff time were made available for this purpose.

The planning stage of the program needed to consider assistance with transport as it can vary depending on the location of the community. Staff time and vehicles had to be budgeted. The type of assistance provided could vary from budgeting for a van/people mover to transport a number of families to a playgroup to transporting individual families to medical appointments which would require a car with a car seat or the provision of taxi vouchers. The time required to transport families was also considered when planning services such as playgroups.
3.2 RECRUITMENT OF FAMILIES

ABORIGINAL FAMILY PROGRAM

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 an Aboriginal person as the first point of contact was essential for engaging families. This Aboriginal contact could be one of the staff members, as in the urban site, or staff and at the same time a trusted member of the local Aboriginal community, as was the case in the rural site. Northcott observed that having an Aboriginal contact person enabled families to enter the Program with a feeling of cultural safety. After the initial recruitment had occurred with an Aboriginal staff member, non-Aboriginal staff were introduced and built relationships with the families.

Northcott workers found that they had more success 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 children’s development. Northcott staff in that site concluded that it was most effective if they included anyone who was interested and then discussed any disability needs only after they had engaged the family and established trust. In the urban site, workers found that some families were also referred because they specifically wanted a program for children with disabilities.

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, the general service approach was more appropriate as it identified 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 seek a service to meet their children’s specific disability or developmental needs for school readiness.

Referral to the Program

Referral of families to the Program was mainly through schools, preschools, health services and other providers at both sites. Northcott obtained permission from the director or principal to provide a service in the preschool or school. The preschool and school staff were then responsible for identifying children they could benefit from the Program. Teachers and other service provider 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 and actively promoting the Program.
Self-referral of families to the Program was rare initially, 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 children’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. As the Program became established, referrals increasingly happened through word of mouth, especially in the rural site.

**Building a relationship between the family and Program**

Once parents had agreed to join the program, they were asked to fill out an enrolment form. If families requested assistance, staff would read the form to them and complete it together with them. An Aboriginal staff member recommended encouraging families to fill out the form themselves if at all possible, so that they felt empowered.

After the initial recruitment, staff needed to engage families in the Program long term, and they found that this required considerable time. In order to build trust and develop relationships, staff needed to sit with the families and talk, spend time to get to know them and eventually learn about the family circumstances and child needs. It was important to Northcott that this time investment was recognised as a vital part of the Program. Ideally, more staff time would be allocated in the recruitment phase so that staff could also talk to families about the importance of early intervention generally, of consent, and of being involved in their children’s services and therapy, because they know their child best. An Aboriginal Education officer commented in an interview:

> I’m happy to hear stories about how well the families are doing … because I know that ….it takes a long time for people to trust somebody … because they’ve got this stigma about certain organisations, that it’s a DOCS … and I think what happens to the families is they get scared, that it’s like an invasion of their privacy. But I think your service, like Northcott just came in and they didn’t look at anything like that, they just looked at what they could do for the family. So and built relationships and I think that’s what been fabulous about your program.

**3.3 SUPPORT PLANS**

Each participating family worked with Northcott staff to develop a support plan to guide their progress while they were 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 family experiences, school reports, medical reports and observing a child in the preschool, school or playgroup environment. Support plans for children in playgroups generally focused on developmental milestones relevant to school readiness, and talking with parents about these milestones. Support plans for preschool and primary school children concentrated more on the learning curriculum. Developing strategies for the teacher to work with children in the classroom were also part of the plan.

Northcott felt that all Program staff should participate in developing the support plans, including the community workers, early childhood educators and therapists. However, as this project was relatively small, therapists were engaged for only one or two days a week, restricting face to face communication and meetings among the team. Staff suggested that if this was the case in a future project, staff could communicate more via phone and email. They could relay family priorities between each other, thus empowering families to make decisions based on the recommendations of various practitioners.

Support plans contained a variety of goals that the family would like to accomplish while participating in the Program. Goals included practical issues for the child, such as undergoing an eye exam, hearing test or speech assessment. Other goals involved linking the family with services, such as family violence counselling or drug and alcohol counselling, Centrelink and housing. Goals also addressed concerns such as custody matters or the child protection system.

For example, one parent talked about her alcohol use and domestic violence she had committed against her partner. The team discussed with her how her parenting was influenced by her alcohol use. They spoke about services she could go to for assistance, and staff also took her to a health expo, where she could find information about local services and supports. Staff reported that it was difficult for this mother to enter the health expo, but after a time she walked around talking to services on her own. She subsequently brought other children to the playgroup.

Northcott staff emphasised that identifying support for parent and family needs was essential for some families before they could focus on their children’s school readiness and disability. Other families resolved such issues concurrently, and some did not ask for any support other than with their children’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. Fewer medium term and very few 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 timeframe of the Program.

The most common high priority goals for children in the preschool- and school-based services were developmental and health assessments, while many medium priority goals concerned behaviour improvement, child development and service access (Table 13). Total numbers were too low for a valid comparison between the urban and rural services. The high number of goals reflects the individualisation of the plans.
### Table 13: Goals for children in the preschool- and school-based services

<table>
<thead>
<tr>
<th>Type of goal</th>
<th>High priority</th>
<th>Medium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech assessments</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>Manage behaviour</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Vision test</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Psychological assessments</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Hearing test</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>OT assessments</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>General assessments</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Obtain diagnosis</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Strategies from assessments given to parents</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Improve reading and writing skills</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Increase focus and concentration</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Gathering Reports</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Identify Support Services</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Therapy assessments</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Alternative accommodation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Difficulty sharing with peers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Physical aggression towards other children</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Getting 2nd opinion for a diagnosis</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Give therapy assessments to SP at new school after Program</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Fine motor development</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Strategies to support family &amp; school</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Transport to therapy</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Housing assistance</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Referral to diagnosis support service</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>School holiday activities</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Counselling sessions</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Make contact with speech pathologist post-program</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Meeting with therapists</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Give OT/Speech reports to family</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Listening; parent not too clear on the actual goal</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Provision of information about child’s disability</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Collaborative approach with therapists</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Developmental assessments</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Communication with the school</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Incorporating home strategies into classroom</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Individual emotional/social skills</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Information and referral for custody issues</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Mental health assessments</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Parent information on ODD</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Participate in group playground activities</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Referral to psychologist</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Service coordination</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Emotional development – dealing with grief</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Stop thumb sucking</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>58</td>
</tr>
</tbody>
</table>
Note: Parents could record more than one goal per child.

In the two playgroup services, high priority goals were often related to assessments (speech, hearing and vision), developing and using visual aids, and accessing other services (Table 14). Medium priority goals were about giving information to the family, and about behaviour and learning strategies. No low priority goals were recorded.

Table 14: Goals for children in the playgroup services

<table>
<thead>
<tr>
<th>Type of goal</th>
<th>High priority</th>
<th>Medium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing assessment</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Transport to medical appointments</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Vision assessment</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Speech assessment</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Behaviour assessment</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>To develop &amp; implement using visual aids for communication</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Preparing for cochlear implant</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Listening to and following instructions</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Meeting with public school (transitioning)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Service coordination meetings</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Enrolment in preschool</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Housing assistance</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Toilet training</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Transition to School</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Transition to another School Readiness Program</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Give families information on disability support services</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Wanting craft ideas for home</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Wanting cooking ideas for home</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Obtain Diagnosis</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Name recognition</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Gross motor skills</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Stop thumb sucking</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pencil grip</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Physical development</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>To find suitable accommodation to ensure safe living environment for child.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>To obtain information about funding for child after diagnosis.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Give family information on respite services</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>To find a suitable preschool or school for child for next year.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Developing communication/interaction</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Independent learning habits</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Provide family with case management</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Developmental assessment</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Positive behaviour strategies for behaviour at home</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Second opinion on diagnosis</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Interactions with other people</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Follow instructions</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
The large number of different goals in the Program and the various wording used for similar goals indicates that support plans were developed individually with each family, in response to their particular concerns, and using terms with which the family was comfortable. Northcott staff emphasised that they saw ‘parents as partners’: they developed support plans together with the parents, to arrive at a plan that the family would truly engage with. In addition, support plans were reviewed periodically with parents so they could see that goals were achieved and could feel part of the process. One mother, when asked about the support plans, said:

They were all good too because they [her children] are doing so good at what they are doing. Yeah we did, very much to achieve them. I pat myself on the back, I’m very proud of myself!

3.4 INFORMATION AND TRAINING SESSIONS

Information and training sessions for families, teachers and service providers were planned as part of the Program, to provide families with information and resources to support children with disabilities at home, to give teachers and service providers skills and resources to support children with disabilities in their learning environment, and to build community capacity by educating families, community members, teachers and service provider staff.

Information and training sessions began in school Term 2/2012, after Northcott staff, parents and preschool and school staff had discussed the types of sessions that would be useful in each site. Other sessions were added as the Program progressed and more information and training needs became apparent. Over the course of the Program, 13 sessions were conducted: nine in the urban and four in the rural site (Table 15). Northcott Program staff facilitated the sessions, and sometimes external professionals gave presentations. More than half the sessions were about behaviour management, while others gave information about child development and the role of therapists. Northcott Program staff also supported families to attend two other sessions, one in each site, facilitated by other Northcott staff.

Participants were asked to fill out a feedback form so that Northcott could gauge which types of professionals and family members attended and how the sessions were received (Appendix E and Appendix F). A total of 114 feedback forms were returned to the facilitators (Table 15). In a few teacher and service provider sessions, the feedback form for families was mistakenly distributed, so that some information is missing from the analysis below. No information was provided on how many people attended the sessions, but Northcott staff confirmed that most participants completed feedback forms.
Table 15: Information and training session attendance

<table>
<thead>
<tr>
<th>Site</th>
<th>Title of session</th>
<th>Target group</th>
<th>Date</th>
<th>Feedback forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Speech Therapy</td>
<td>Teachers</td>
<td>Jun 2012</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Sensory Processing</td>
<td>Teachers</td>
<td>Jul 2012</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Play &amp; Language</td>
<td>Families</td>
<td>Sep 2012</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fussy Eaters</td>
<td>Families</td>
<td>Sep 2012</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Psychology / Behaviour Management</td>
<td>Teachers</td>
<td>Oct 2012</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Positive Behaviour Support</td>
<td>Teachers</td>
<td>Oct 2012</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Handwriting</td>
<td>Teachers</td>
<td>Mar 2013</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Positive Behaviours</td>
<td>Teachers</td>
<td>Apr 2013</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Managing Challenging Behaviours</td>
<td>Teachers</td>
<td>May 2013</td>
<td>8</td>
</tr>
<tr>
<td>Rural</td>
<td>Positive Behaviour Support</td>
<td>Service providers</td>
<td>Nov 2012</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Positive Behaviour Support</td>
<td>Families</td>
<td>Nov 2012</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Keyword Signs</td>
<td>Parents service providers/teachers</td>
<td>Jun 2013</td>
<td>3 14</td>
</tr>
<tr>
<td></td>
<td>Managing Challenging Behaviours</td>
<td>Teachers</td>
<td>Jun 2013</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>114</td>
</tr>
</tbody>
</table>

Most sessions (9) were provided to teachers and service providers (Table 15). Three sessions were for families, and one for both target groups combined. Family sessions were attended by relatively few people. Northcott staff commented that this was due to the high demand by teachers and providers for information sessions, and the observation that such sessions were not the way in which most parents wanted to find out about disability and strategies. One-on-one conversations with staff were preferred. Northcott workers felt that families could be provided individually with more information about the value of therapies and diagnosis and would then be more likely to attend sessions about behaviour management.

Participants at the training sessions were asked to indicate their profession (Table 16). The majority of participants (59 per cent) indicated they were teachers in a preschool, primary school or secondary school. Various people named specialist service provider roles. One person said that they performed a number of professional roles: librarian, preschool teacher and primary school teacher. In the group of teachers and service providers who were given the parent forms, seven individuals indicated their profession as ‘carer who is not a family member’. Some data was missing due to incomplete or incorrect forms.

Table 16: Profession of training participants

<table>
<thead>
<tr>
<th>Profession</th>
<th>Participant</th>
<th>Valid per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary school teacher</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>Teacher</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Teacher's aide</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Unknown</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Preschool teacher</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Aboriginal education officer</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Thirty-six respondents indicated they had direct contact with children in the Program, and twenty-six indicated they did not (Table 17). Contact was unknown for 29 respondents, including those who were given the parent feedback form. Of the 36 respondents who specified they had contact with children in the Program, 17 gave further context as to where this contact occurred. This was generally related to class or support contact: ‘two children in my class’, ‘early intervention preschool’, ‘special ed. class’, ‘during RFF sessions’, ‘speech therapy’, ‘support classes’, ‘work with different children throughout the day some of which are participating in the Northcott program’, ‘deaf’, ‘child with autism’.

### Table 17: Direct contact with children in the Program

<table>
<thead>
<tr>
<th>Direct contact</th>
<th>N</th>
<th>Valid per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36</td>
<td>40</td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Unknown</td>
<td>29</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>100</td>
</tr>
</tbody>
</table>

Participants also provided feedback on the quality and usefulness of the training. They were asked whether they found it interesting, whether they learnt new information and would use it, and whether they liked the facilitator, the language and the length of the session. Response options were on a five-point scale: strongly agree, agree, neutral, disagree, and strongly disagree. Feedback was overwhelmingly positive for all sessions. Between 80 and 100 per cent of participants said they strongly agreed or agreed with the positive statements above. Examples of positive comments on the assessment forms are: ‘Well organised and presented, ‘Great ideas and tools’, ‘Very useful’, ‘I loved all the resources and being able to see them and touch them’, ‘It was really worth the time’. One parent commented in an interview:

> I liked the one where the psychiatrist came, it was good that session! It was different but it was interesting. Yeah it was good, I liked that.

One teacher commented:

> I think that having the professional development sessions has been fantastic. The resources that were provided from that are really good in terms of finding out more information and also for use in the classroom.

The lowest approval ratings (67 per cent) concerned the length of the sessions. Several people commented they would have preferred longer sessions, which indicates unmet need for this
type of information provision and training. Similarly, the other participants’ suggestions for improving the sessions revolved around extending the training, for example adding activities on how to manage children with different behaviours, case studies, more strategies, and generally more training on various aspects of disabilities and behaviour support.

Staff found that timing the session and choosing the venue around the needs of the target group increased their participation and engagement. Teacher sessions were often held straight after school and parent sessions, in the evenings. Venues with air-conditioning on hot days also helped.

Overall Northcott staff would have preferred to provide more information and training sessions to both target groups and families. Barriers for the teacher/service provider sessions were time constraints, competing priorities in schools and inability of schools to release teachers. An important barrier for parent training was the necessity to liaise with parents indirectly, through the schools. Parent sessions had more attendance in the rural site, where they were opened up to community members.

Northcott therapists supported, Aboriginal Education Officers (AEO) and teachers in one school by modelling in-class strategies, for example for handwriting. One AEO commented in an interview:

> Because I’ve been in those workshops with the OT and with the kids out of the other classes and it’s been marvellous. And I’ve seen the growth with the kids you know … how they hold the pencil … and trying to … do the letters, the control and everything else and the little exercise that we do. That’s what we do on the Monday and Tuesday, yes so I got a lot of strategies that I can bring back into the preschool.

When planning information sessions/training for preschool and school staff it was important to plan well in advance as schools had busy schedules. The optimal time to plan with the school was towards the end of one school year in preparation for the next year. This enabled schools to allocate sufficient time for staff to attend training. Allocating funds to schools to allow staff to be released from face to face teaching for intensive individual education would also have helped facilitate their participation. Future projects might consider additional ways of providing information and training and provide this support to teachers’ aides and parent helpers.

### 3.5 THERAPY SUPPORT

As described in section 3.1.2 above, the majority of children were not receiving any therapy support related to disability or developmental concerns when entering the Program. Of the total 90 children participating in the Program, 19 (21 per cent) were receiving support upon joining: by school counsellors, speech pathologists, occupational therapists 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 local therapy support varied greatly between the two sites, which appeared largely due to the diversity of geographic locations. The rural area was more isolated than the urban site, and therefore access to specialists and therapists in the rural site was limited. For example, the only local psychologist had months-long waiting lists, and there were no constant therapy services available.
In response to the shortage of local specialist support, Northcott arranged for an occupational therapist, a consultant psychologist and a speech pathologist from the Sydney Northcott office to visit the rural site once a month. Their time was split between two different locations in the rural site, and extended travel times between the locations meant that the specialists could visit only one location per month, or two of the four services in the rural site. Therefore children received face-to-face therapy support every two months, and less if the children were unable to attend their allocated session.

To arrange some form of ongoing therapy support, the Northcott early childhood educator in the rural site implemented strategies from the therapists to support children and families in-between visits. In addition, the therapists provided 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. Finally, therapists provided strategies to the parents that they could use at home.

Northcott would have preferred to have the therapists see children and families more often, but given the restricted therapists’ availability, staff developed other ways to support children and families in the rural site. For example, Northcott staff built bridges 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 meant that there were multiple and various external therapists available for participant families. However, Northcott used their own staff therapists to provide therapy to participants, as their cost was covered by the Program. External therapists would have had to be paid for by the parents. The Northcott therapist offices were located close to the urban site, so travel was easy.

The Northcott speech pathologists visited the site twice a week, attending each service location weekly or fortnightly. Northcott occupational therapists visited the site once per week, and each school, preschool and playgroup received occupational therapy on a fortnightly basis.

Parents in both sites appreciated the support they received from therapists, as they said during the interviews:

Therapy is excellent – lovely easy-going people too; that makes it very approachable, you know.

Well it helps me and [my child]. He’s better because we’re starting to understand what [he] is saying and he is starting to be independent with himself and slowly showing me the things he needs.

Helping me assist with […] the girls’ speech and with [my other child] in the classroom with his concentration. And with behavioural skills at home and stuff like that – behaviour charts and other things.

Therapy support provided through the Program also helped to improve connections between families and schools. One school staff member said in the interviews:

I know that just that the couple of parents that are involved with you, you know, they are happy to come talk about what you guys have been doing and keep us up to date, so I think it has strengthened the link with the parents from the school perspective.

In both sites, Northcott staff observed that families appreciated therapists coming to them rather than having to go and seek support. From a therapeutic perspective, Northcott therapists felt
that the amount of therapy provided was sufficient to support the children and families to achieve many of their goals. Most parents and teachers were motivated to work with the therapists to implement strategies for individual children. This was assisted by the therapists attending classrooms regularly. One school staff member said in an interview:

Well again working with the OT, the speech therapist as well as the behavioural strategies we were given, it’s given us as a staff a lot of tools and strategies that we can try and that’s been really good because we have been able to use those strategies for all the children in the classes and not just the ones that have been targeted for the program, so it has had a flow on effect across the school

Sometimes therapy support was not as effective as possible because therapists were unable to contact the families or unable to see the child on the allocated therapy days. Northcott staff reported:

We have had difficulty getting in contact with the parents in the Program [at one of the urban schools], it has been difficult to keep the families updated with what therapy we have given the participants and have not achieved other goals due to lack of contact with the families.

[The child] will be changing days at the child care centre. Due to the therapists working one day per week, [the child] will not be able to access the Program from Term 1/2013.

Another barrier to effective therapy support was limited collaboration among the therapists. The expertise of psychologists, OTs and speech therapists overlaps, and staff felt that more communication between the therapists would have enabled more coordinated therapy support for families. Coordination occurred more in the rural than the urban site, possibly because therapists had time to talk as they travelled to the rural site together on the same days. Future projects might consider organisational and staffing structures that facilitate team cooperation.

3.6 YARN-UPS

Yarn-ups were informal group discussions among Aboriginal families participating in the Program and Northcott staff. They were planned as an additional, culturally appropriate way to engage Aboriginal families in the Program, and to have conversations about family concerns and strategies. Staff in both sites tried repeatedly to organise yarn-ups, but parents did not appear interested. Instead, staff observed that parents were more likely to talk about family and community issues in one-on-one conversations with the workers. Two yarn-up sessions were held, both in the urban site, and attended by two families each.

3.7 COMMUNICATION WITH PRESCHOOL AND SCHOOL STAFF

Northcott workers in both sites identified that a main facilitator for effectiveness was a school that supported the Program and had 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 identified concerns with children more easily, 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 relationships 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. Teachers were willing to consult with Northcott staff during their recess and lunch breaks. One urban school staff member said:

Well, I think that the Northcott Project has offered a unique opportunity for communication because the therapy was done with the child at the school and often in the classrooms. Even though you were busy with other things, you could observe what was going on in that session and take that on board and, also, because they were on site, you had an opportunity to, even informally, communicate.

Northcott staff in the rural site 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. Northcott staff were able to develop good working relationships with the principal and counsellor in the primary school, who took time to talk with the therapists after their sessions.

Communication with the rural preschool staff was more difficult. Northcott reported that due to staff shortages in the preschool, staff were not able to take time out of the classroom. Therefore, consulting with them about preschool students, e.g. gathering information or providing strategies, was restricted to a few minutes, and even then the staff had to keep an eye on the children. The strategies that therapists suggested for supporting positive behaviour tended to be rejected by preschool staff as being “too hard” to implement due to reduced staff numbers. Northcott tried to communicate with preschool staff via email, but that was unsuccessful.

In response to these difficulties, the idea of a staff training day for the preschool was developed, where the staff could give full attention to professional learning targeted to their individual needs. This was supported by the preschool staff, but by the time the Program ended, preschool management had not approved a training day.

In the interviews conducted for this evaluation, a few preschool and school teachers in both sites commented there was not enough communication with Northcott. Program staff communicated with at least one staff member in each organisation but did not have the capacity to communicate with all staff and needed to rely on the contact person to forward information to other staff. Future projects need to emphasise to their contacts the importance of passing on Program and student information. One teacher suggested:

Since it is such a busy environment in the classroom, particularly in the younger years, it would be really lovely if there was sort of […] a workbook or communication book, so that if they are completing work with Northcott therapists, it gets pasted in and then we have a record that it is very easy to go back to and see progress; it is very easy for parents to see the value as well.
The preschool and 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 in Wave 2 interviews:

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.

At the end of the project some staff had a greater knowledge of the range of services available for families and reported in Wave 3 interviews:

I’m a lot more confident in regard to advising families that there are other sources of funding and directing them in the right direction of who to contact to access that.

Yes I have become more aware of what sort of facilities and services are out there that we are able to access to support children, yeah. And be able to again advise families that are not necessarily in the program of what they can do to access support.

Some of the school staff reported an increased communication with the families as a result of their involvement in the project. One teacher said in an interview:

Yes I think often the families sort of the school’s there and they are there & there’s this wall. But I think that they have been made aware that there is so much support out there for them & that we are there for the kids. And we all want the best for their kids. I think it has helped to break down some of those barriers, sort of promoted the lines of communication

3.8 SUMMARY OF PROGRAM IMPLEMENTATION

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. During the Program some services ended when children transitioned to preschool or school, two playgroups were amalgamated, and new schools joined the Program. At the end of service delivery, in Term 2/2013, there were five preschool- and school-based services and two playgroups.

A total of 93 children entered the Program, and 45 children left before the Program finished. Reasons for leaving included medical needs, attending other services and no longer needing Program support.

Program attendance fluctuated between weeks and school terms. Towards the end of service delivery, about 20 children participated regularly in the preschool- and school-based services, and 0-10 children attended the playgroup services in any given week.

Of the children entering the Program, 70 per cent were boys and 30 per cent were girls. Ages of the children ranged from 0-8 years, consistent with the Program criteria, and Northcott included some toddlers in preschool-based services. Transport assistance was provided primarily to families attending playgroup and those from the rural site.
Of all children entering the Program, 18 per cent had a previous disability diagnosis. The most common diagnoses were autism spectrum disorder and ADHD. Twenty-one per cent had existing therapy support.

The main concerns that families had for their children when entering the Program were child behaviour and speech delays. Overall, concerns spread across intellectual, physical and emotional aspects of children’s development.

Factors that contributed to successful recruitment of families were the Aboriginal-specific focus of the Program, having Aboriginal staff members as contacts 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, preschools and other services and, as the Program became established, increasingly through word of mouth.

Staff built trusting relationships with families by helping them fill out enrolment forms and by spending time to get to know them. Support plans for the children and families were developed individually and focused on short term goals such as child developmental and health assessments, so that families could see and achieve outcomes quickly.

During the Program, 13 information and training sessions were organised for teachers, service providers and families. Most participants liked the sessions, and some asked for more.

Attendance was higher at the teacher/provider sessions than the family sessions, as families preferred one-on-one conversations. Discussions with groups of Aboriginal families, called yarn-ups, were trialled in the Program but were unsuccessful, as most families preferred one-on-one conversations.

When planning information sessions and training for preschool and school staff it was important to plan well in advance as schools had busy schedules. The optimal time to plan with the school was towards the end of one school year in preparation for the next year. This enabled schools to allocate sufficient time for staff to attend training. Allocating funds to schools to allow staff to be released from face to face teaching for intensive individual education would also have helped facilitate their participation. Future projects might consider additional ways of providing information and training and provide this support to teachers’ aides and parent helpers.

The Program included speech pathology, psychology and occupational therapy services from Northcott for the children. Due to caseloads and location of the therapists, children in the rural site had infrequent face-to-face access to the therapists, who travelled from Sydney. In the urban site, the closer proximity of the therapists meant that children had easier, more frequent access to support.

To arrange some ongoing support in the rural site, therapists built the capacity of the local team, parents, preschool and school staff and other service providers by providing them with strategies and resources and consulted over the phone. Therapy support was most effective when the therapist had close collaboration with other Program staff, such as a joint visit with the family, so that they could all learn from each other about the family preferences.

Collaboration with school and preschool staff worked best where teachers were proactive and internal school communication functioned well. This helped with engaging families and supporting children. Collaboration was challenging in schools and preschools that were short-staffed and where staff had little experience and training about child disability.
4 OUTCOMES FOR CHILDREN AND FAMILIES

The findings about outcomes are ordered according to the evaluation questions:

1. What support can assist Aboriginal families to identify their children’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?

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 children’s learning needs. Staff also invited people who the parents trusted to meetings (e.g. school teacher, preschool staff and 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 general family support (e.g. accommodation or financial issues), but Northcott staff felt that identifying support for these concerns could contribute to the child’s other support needs.

Northcott staff reported that many families found it difficult to identify their children’s needs or express their concerns, and they might rely on prompts from staff. For instance, parents mentioned that they were concerned about their children’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 provided services, community members had previously received limited information about disability. If a person had a physical disability, the local communities were generally accepting of this difference and understood how it might impact on the person and their carers’ lives. However, if a person had a disability such as autism or an intellectual disability and a community member did not have any experience of that disability in their own lives or family, then the community member was often not sure how to interact with the person or how the person’s disability impacted upon their lives.
In general, the communities did not tend to label someone as having a disability – this would make them seem different from everyone else – rather they saw the person as a whole and the disability as part of who they were. If a family had concerns about their children’s development, the family had often not had information about what services were available to support them. They would know that a GP might help them, but they might 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. It could also be due to limited awareness because of a shortage of disability services in the rural community.

One parent said:

> There’s nothing else in [this town] for young parents or for young kids and especially for kids with disabilities, [and also] for other parents to come and socialise with parents that’s going through the same thing.

Many parents in the Program asked for information about their children’s disabilities and challenging behaviour, or for a diagnosis or developmental assessments so that they could better understand their children’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 (Table 18). The most frequent were speech assessments for 17 children in the preschool- and school-based services and hearing tests for 7 children in the playgroups.

<table>
<thead>
<tr>
<th>Type of assessment</th>
<th>Number of assessments conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preschool- and school-based services</td>
</tr>
<tr>
<td>Speech assessment</td>
<td>17</td>
</tr>
<tr>
<td>OT assessment</td>
<td>9</td>
</tr>
<tr>
<td>Vision test</td>
<td>5</td>
</tr>
<tr>
<td>General assessment</td>
<td>5</td>
</tr>
<tr>
<td>Hearing test</td>
<td>4</td>
</tr>
<tr>
<td>Obtain diagnosis</td>
<td>4</td>
</tr>
<tr>
<td>Academic assessment</td>
<td>3</td>
</tr>
<tr>
<td>Cognitive assessment</td>
<td>3</td>
</tr>
<tr>
<td>Therapy assessment</td>
<td>3</td>
</tr>
<tr>
<td>Behavioural assessment</td>
<td>3</td>
</tr>
<tr>
<td>Getting second opinion for a diagnosis</td>
<td>2</td>
</tr>
<tr>
<td>Psychological assessment</td>
<td>2</td>
</tr>
<tr>
<td>Developmental assessment</td>
<td>1</td>
</tr>
<tr>
<td>Mental health assessment</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>

Assessments sometimes led to the development of other goals for the child. When the therapists discussed the outcomes of the assessment, some parents found out their child had difficulty with a specific skill and then included a corresponding goal in their support plan. For
example, when one school child's OT assessment showed they had difficulty with writing, the child's support plan was updated and the OT worked with the child's teacher to develop this skill in class.

Among the total 116 high priority goals established for preschool and school participants (Table 13), 98 were achieved during the six school terms of the Program; this represents an 84 per cent achievement rate. Eight assessments (five vision tests and three hearing tests) and three goals to obtain diagnoses remained outstanding at the conclusion of the Program. Of the medium priority goals established for preschool and school participants, 90 per cent were achieved (52 out of 58 goals). Among the outstanding goals were two to obtain diagnoses, and two concerned reading.

Out of the 33 high priority goals established amongst the playgroup children, 28 (85 per cent) had been achieved by the end of the Program, as well as 25 of the 28 medium priority goals (89 per cent). Two of the three outstanding medium priority goals were due to clients leaving the playgroup, and one was for an unknown reason.

Most Northcott staff and parents were pleased with the goals achieved. Two parents in the preschool-school-based services commented:

It has been fabulous; it has helped him extremely well. His behaviour, his report, it’s just phenomenal how much he improved in the last year. So, he got an award for ‘Excellent Attitude Towards Learning’. He got a special award for his class last year.

His attitude – [...] he always wants to go school now. Not that he loves it, but he doesn’t hate going to school. He doesn’t give you the ‘Oh, I’m sick’ or ‘I don’t want to go to school’. He is quite happy to go to school. It has made a big difference because he knows he can. You know, it’s having people there to support him and encouragement.

A parent of a playgroup child said:

Yeah I feel it’s helped [my child]. Seeing her, she attends the playgroup every week, so definitely in seeing the progress in her development from where at the start she wasn’t even looking at anyone, didn’t even know anyone else was around to now really engaging with other people and with us at home. [...] And just, as well as being here, having you guys to talk to, to ask questions to, you know about what we can do at home and giving us ideas, and that’s been a massive help!

One parent would have preferred more frequent reviews of support plans to see progress:

If we could have looked at [the support plan] probably each week or whatever or fortnight whatever, ongoing, then that would have helped a bit more to see what we were achieving.

Several service providers commented in the interviews that they had seen positive outcomes for children, for example:

The families that I’ve known that have been involved have had very positive outcomes, whether it is watching their children progress and, you know, hit those smaller milestones along the way with fine motor or speech. Being able to communicate, the children are less frustrated at home and at school. They are able to form better peer relationships. I think that there have been a lot of personal success stories out of the Program.
Some of our families are actually involved, they are actually more open to come into other playgroups that they probably, and then these playgroups are open to all the community. And they’re more open to come into those playgroups now and being confident knowing that it’s for their child and the wellbeing of their children’s development.

Yes again within the project you might have only been working with a particular child but within the family situation so not only the one child in the family has benefited it has had a flow on affect to you being able to provide family support for them so that the family as a whole have gained from the experience.

Much of the support obtained for the children was the therapy provided by the Program. Comparing the two sites, Northcott staff felt that therapy support had been more successful for children in the urban site, as there were fortnightly to monthly therapy sessions. However, it was difficult to get in touch with some parents of the preschool and school children.

Therapists’ contact with children in the rural preschools and schools was monthly at best, and therefore mainly assessments were completed rather than providing ongoing intervention. It was also more difficult than in the urban preschools and schools to engage parents and teachers to implement therapy ideas. Therapy support in the rural playgroup was more successful with the implementation of therapy strategies within the group structure and consistent monthly visits from therapy staff.

In addition to providing therapy, Northcott staff worked with families to achieve other goals, including family support needs. For example, staff assisted families to complete forms for Centrelink to receive carers’ payment and to find suitable housing.

In both sites, Northcott staff organised service coordination meetings for some families who received support from other health and community services. The aim was to provide coordinated case management, avoid service duplication and deliver fast, effective support to the families. Among the providers involved were local Aboriginal community organisations, government disability and housing providers, and Centrelink. The focus of these meetings, as requested by the families, was to resolve immediate family issues that were getting in the way of addressing disability needs for the child.

Northcott staff felt these meetings were successful not only in addressing family needs, but also in developing trust among service providers and between families and providers. Meetings happened about once a month, when needed, and Northcott staff followed up with services by phone. In the urban Program site, meetings were generally face to face, and more services were involved than in the rural site, where meetings were often informal and occurred via phone calls. Northcott staff observed that this difference reflected different service cultures, with the urban services more used to working in collaboration than their rural counterparts.

Northcott staff observed that goal achievement was related to family size. The Program had families ranging from one to five children, and workers reported that parents of smaller families generally had more time and capacity to discuss information, implement strategies at home and meet up with staff. Similarly, parents who had extended family support were often able to take in the strategies they were shown by therapists in the playgroup, while parents with limited or no family support appeared more stressed and exhausted and tended to treat playgroup as a respite opportunity rather than participating. The implication for future programs is that larger families and those with limited social networks need more intensive, longer term support that fits in with their other responsibilities.
Northcott Program staff commented that it had taken longer than expected to obtain support and achieve outcomes for children and families. This was partly due to time constraints of the therapists, as described above, but also due to the time required for engaging families and building trust between the workers, families and other service providers. However, staff regarded the process of engagement and building trust as a vital part of successful service delivery.

The following two case studies illustrate how the Program worked flexibly with individual families to identify child support needs and help the family to obtain support, in the playgroup and the school-based services.

CASE STUDY

PLAYGROUP

The child came to playgroup not interacting with others, was not aware of others, made no eye contact, showed no facial expressions, was consistently hand flapping and running in circles. The child did not engage in activities, only to pick things up and throw them on the floor. The child had never played in sand and did not like to play in it, and had visual perception difficulties.

Through the Program the child was diagnosed with autism spectrum disorder, and parents had difficulty accepting it. They knew ‘she was different’ but did not think she was autistic. The workers discussed the recommendations from the paediatrician with the family and referred the family into an early diagnosis team to give intensive support. The child continued to come to the playgroup every week.

Staff from the Program organised a case conference, a monthly meeting to discuss what services were doing for the family. It was a chance for the family to talk to all services at the same time, and avoid service duplication. The family used five services for almost a year.

Within a year, the child was interacting with others (mostly adults) and making eye contact. She was beginning to smile and frown and respond to her parents saying her name. The child was playing in the sandpit and engaging in many of the play activities for up to five minutes at a time, including painting, bubble blowing, play dough, ball games and climbing the play gym.

The speech pathologist had begun to give the parents visuals to use in the home with the child. Her parents had a good understanding of funding and services available after the Program was to finish.
CASE STUDY

SCHOOL

The family was referred into the Program by an executive staff member at the school, who explained to Program staff that the parents did not trust services and had very little communication with the school. The family had five children, four of whom were referred into the Program (the fifth was too old). Two of the children were in the preschool; one was in a mainstream primary school class and the other in a support class. After being assessed, the therapists found that the student in the mainstream class was age appropriate in all areas except concentration. The psychologist gave the teacher strategies to work with that child. The two children in preschool were given frequent therapy and transitioned into kindergarten with another school. The children continued to see the therapists at their new school.

For several months the Program’s early educator worked with Community Services to give the parents behavioural strategies during home visits. The support class teacher expressed concern that the child may need a mental health check. Though it was difficult getting an appointment, the psychologist and early educator succeeded, and the child had a mental health assessment. The psychologist worked with the parents and teacher to develop strategies to help the child with his anxiety/depression/explosive behaviour. The parent was not happy with the progress in the classroom and decided to send the student to another school. The Program helped transition the child to the other school. The child was most comfortable with the early educator, so the early educator went to each morning session in the classroom for two weeks. The child settled in and was showing great progress in the classroom.

At the end of the Program, the child was happy at his new school. His mother was much happier with the teacher and school and felt comfortable talking to them. The mother called the Program staff regularly to check in and catch up. She expressed in the interview that she would like to go to a parenting program for behaviour. The family has been referred to an Aboriginal case management service.

4.2 SUCCESSFUL TRANSITION TO SCHOOL

During the Program, several participating children transitioned from playgroup to preschool, from preschool to primary school, or from one primary school to another. Together with the
families, Northcott developed transition strategies for each individual child. One staff member explained:

We assess what the appropriate support needs are for the child to achieve a smooth transition. It is about planning the steps to make transition to school easy, not stressful, invite the transition-to-school teacher to meet parents, discuss what is available for the family and child, if funding is needed for a support person at the school, and other options.

In some cases, where the child did not require much support, or staff were familiar with school teachers and support available at the school, the transition process was less involved and just entailed a meeting with the teacher and a handover of the child’s file.

Staff recounted examples of successful transitions to school during the course of the Program:

- One child from the rural playgroup found it initially difficult to engage and follow routines and instructions in playgroup. Through the structure of the playgroup and implementation of a range of strategies and support, the child started to respond positively. She transitioned to school and the teacher reported she had no concerns with her. A handover of strategies was provided to the school teacher in a meeting, and the teacher was responsive to these strategies.

- Two children from an urban preschool in the Program, who were receiving speech therapy, transitioned to a local public school. The teacher reported that they had settled in well but did have some literacy concerns, which were the focus of speech therapy for the remainder of the Program.

- A child who transitioned from one school to another was in an Emotional Disturbance/Behaviour Disorder class at the new school. Northcott had meetings with the new school staff, and the Program’s early educator went to morning sessions in the class for two weeks at the start of the year (the child was most comfortable with the early educator). The child showed good progress in the new school.

These examples show that the Program support sometimes followed the children to their new school. In some cases this was not possible, either because the new school or the parents declined continued service or because of logistical difficulties: Program staff did not have enough work hours to travel regularly to each of the schools involved in the urban site.

Early in the Program, Northcott staff identified a number of factors that would make a child’s successful transition to school difficult, and they addressed these factors straight away. First, many parents were unsure about what was meant by the term ‘school readiness’, or they believed that it was relevant only 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 site, 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 groups within the community. Northcott staff felt that their playgroup was important in filling a gap in this community.
Northcott staff reported that they had seen families becoming empowered through the Program. This had happened mostly through providing families with information and support. Staff gave families information about school readiness, developed support plans together with the families, helped them get child assessments and diagnoses, 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. Staff also talked with families about relevant local service providers. When talking to the parents, staff tried to empower them by giving choices about strategies rather than prescribing interventions.

Northcott staff noticed that after several weeks in the Program, parents trusted them enough to ask them questions or request assistance, for example when seeing teachers or specialists. Some parents became confident enough to reject labels bestowed on their child. For instance, they questioned what the school staff suggested was ‘wrong’ with their child if they misbehaved in class. Others felt empowered to question their children'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 became 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.

As the Program progressed, increasing numbers of parents began communicating directly and independently with schools and services, without Northcott's support. Staff observed significant changes in some families who previously had no communication with schools and no involvement with services, and who, after involvement with the Program, felt comfortable talking to teachers and service providers. Staff said families were ‘fantastic’ in initiating contact. For example, a parent went on their own to a specialist medical appointment for their child without the support of a worker, and families started organising their own transport. Another parent said in an interview:

Oh yeah you’re really good with helping me with that! Yeah really good! I've, I can, more open with them now and just as you say, just keep yourself calm and just go and talk to them and work it all out.

I’m really good at my parenting skills now. Very much so! I, let’s say less stress and more progress in the house. Which is really good.

Parents enjoyed the contact with other families with children with disability. One parent commented in an interview:

It got us to interact with other families with children with disabilities and other children with disabilities as well. And seeing how all children are different and with other therapists I think that was the best part about it. You were able to go and talk to therapists one on one about any issues that you had with your children and doing the cooking and things like that, which are easy to do, and you can bring them home and easily do at home.

Parents also became empowered to support other families in the Program. The grandmother of one of the playgroup children took charge of calling participants on the day of playgroup to attend. During the playgroup sessions, she engaged families to help with cleaning and cooking duties. Another parent, once they were established in the Program, became a mentor for newer parents: talking about other services and programs, and discussing opinions on different schools. Staff said:
This is a big change since this parent first came on the Program, and therefore it is not just children, but families and parents benefiting from the Program and passing this knowledge on to other families.

An Aboriginal Education officer said in an interview:

So they’ve contacted, they’re feel confident enough that they can talk you up because they’ve had that support from you. And they’re thinking about their friend down the road whose got a similar, going through a similar thing, well maybe these people, I’ll give you a number, here.

Some parents asked specific questions about identifying delays in children who were not their own, 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 to the community. Staff believed that a longer timeframe for future programs would increase empowerment at the community level.

In the preschool- and school-based services, Northcott staff, in particular the therapists, had little contact with the parents and felt this restricted opportunities for family empowerment. Future programs need to devise strategies and include resources for engaging parents of preschool and school children.

4.4 SUSTAINABLE SUPPORT

Since this was a relatively short-term project, Northcott staff considered from the beginning how to make support to children and families sustainable beyond the end of service delivery in June 2013.

In both sites, Northcott therapists aimed to empower teachers with strategies to use with children in the classroom. This worked well in some schools, where teachers were particularly eager to learn and alter their practice to better meet the needs of children with a disability or delay. Teachers would, for example, make time during their lunch breaks to talk to the therapists, and dozens of teachers and service providers in both sites participated in the Program’s information and training sessions (section 3.4). Northcott hoped that new classroom strategies would become part of regular teaching methods in the schools and benefit other children in the future. 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 the interviews, school and preschool staff described how the Program had helped teachers:

I think it has probably assisted the teachers to be aware of more signs to look for in the children, so that we can identify them that way.

I also think it is probably easier, as a result of the Program, to have that initial conversation with the parents because we are more aware of the support services out in the community separate from the school system to provide assistance.

I think particularly after the staff in-services the teachers have been able to use those strategies not just for the children in the program but just generally for other students in the class that you know haven’t got a specific diagnosis but would benefit from those strategies. And even staff in the higher grades who haven’t got a tie with the children in your program,
The biggest thing is my staff have a greater awareness of reporting and avenues of reporting for students with additional needs. Teachers are more confident in identifying these needs and legitimately identifying them. Without putting down my staff as a natural human thing you are sometimes second guessing what the child’s needs are. I think your program has actually developed my staff to a point where they can legitimately know where to go and who to go and see. It’s actually fed back into our learning support team more so. It’s actually getting the children support from all avenues.

Northcott staff thought that the impact of similar, future programs in schools would be even higher if the service provider consulted with relevant staff in the schools as well as the main contact person, with a wrap-around service approach. In particular, the schools’ social worker, school counsellor and Aboriginal Education Officer could help with engaging children and families during the project and continue to assist them afterwards. However, such collaborations would have to fit within the school’s structures and processes, and, as mentioned previously, would require additional staff time.

Another suggestion for future programs was to offer school staff members that they can shadow therapists as they work with children, learn those skills and transfer them to other school staff.

In each site, Northcott conducted playgroups in collaboration with a local organisation. Northcott staff considered from the beginning how the playgroups might continue. In the rural site, the playgroup parents were empowered through the Program to run the playgroup once the Program finished. Northcott sourced funding to supply transport for the families as well as staff and therapy support for an additional twelve months and are continuing to look for funding on an ongoing basis.

The playgroup in the urban site was set to continue with assistance from the host organisation, although without therapy support. Northcott felt that the assessments and awareness of support needs that parents and playgroup staff had gained through the Program would continue to benefit the families. Also, an early diagnosis worker recently employed by the host organisation would help to identify children’s difficulties and delays, and refer them to appropriate services.

As mentioned above, parents in both sites learned strategies to meet their children’s specific needs. Staff felt this had significant implications for sustainability, as parents could integrate these practices into their everyday lives. Northcott staff anticipated that in-home strategies taught to the parents were more likely to continue in playgroup families, because in the playgroup settings families could observe changes in their children’s behaviour and development directly, and therapists interacted directly with families. In contrast, in the preschools and schools parents were not present during sessions, and therapists did not have direct contact with many parents. One of the Northcott therapists commented:

There is little contact with parents [in schools and preschools] so it is difficult to get any follow up of therapy at home – this is a major issue as I don’t believe we can make a huge impact without support and follow-up of parents at home.

As reported above, by the end of the Program some parents felt comfortable to talk to teachers and other service providers. The Northcott team expected that families would be able to continue doing so, as they were now educated about their children's needs and disability and were confident to approach services.
To facilitate these connections and ongoing support, Northcott gave families information about other services and referred them to those that were culturally appropriate. One staff member commented:

Parents have been told about a range of services they can use. We referred families to other services that they did not know about, and could help. These services included Aboriginal services, community health, AMS, a therapy service, speech therapists, the hospital, an Aboriginal preschool, a parent workshop for children with autism, Centrelink and housing.

In the urban site, where a multitude of support services existed, staff also developed a local service directory for families.

It was easier to refer families who had been well engaged with the Program: workers suggested appropriate support agencies, discussed them with the parents and obtained permission for the transfer. Sometimes it helped when staff filled in the referral forms so parents just had to sign.

Parents who had not had regular contact with Program staff, particularly those of preschool and school children, were less likely to discuss a transfer and give permission. Staff handed them a summary report of the services the child had received through the Program and of suggested ongoing types of support and agencies, thus giving the parents information if they chose to follow up. Staff suggested that referral forms be simplified, to make the process easier in the future.

Finally, Northcott staff expected that relationships built among participating families, particularly in the playgroups, were likely to continue and remain a source of support as their children would start school together.

4.5 SUMMARY OF OUTCOMES

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 were comfortable to start talking about their concerns for their child.

Support needs were related to the child’s disability or developmental delay; and also family issues such as accommodation or financial support. Northcott staff found that working with the families around their broader situation 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 identifying and supporting children with disability, particularly in the rural site.

Most staff and families were pleased that 86 per cent of the high and medium priority goals established with the families were achieved during the course of the Program. During the Program, 77 physical and behavioural assessments were conducted for the children, 20 of which were speech assessments.

Therapy and specialist medical support was easier to arrange in the urban than the rural site due to availability of therapists and specialists. Service coordination meetings were a successful method for obtaining effective support for some families who were involved with other health and community services.

Families with several children or without extended family support had less capacity to talk to staff about their children and implement strategies at home. These families required more intensive, longer term support.
Staff successfully transitioned several children to and between schools during the course of the Program, by developing individual transition strategies, by having Program support follow the child to the new school, and by addressing issues early that would make transition difficult in the future.

Staff observed that parents became more empowered during the Program through receiving information about disability and their children's needs, learning strategies to use with their child at home, and having trusted workers who they could talk with openly. As parents felt more confident, they also started asking medical specialists questions about their children and communicating with schools and service providers. Opportunities for family empowerment were restricted where contact with Program staff was infrequent, as with many preschool and school parents.

The Program also empowered parents to support other families, by calling them to attend playgroup, informing them about other services and helping to run playgroup sessions. Northcott believed that a longer Program timeframe could have increased this peer support at the community level.

Northcott staff took steps to make the support sustainable after the end of the Program. They provided strategies and resources to school and preschool staff to use in the classroom and informed them about disability services. Parents were referred to other services for ongoing support, and they learned strategies to meet their children's specific needs after the Program ended. Northcott conducted playgroups in collaboration with other organisations so that the playgroups might continue.

Northcott expected that the empowerment many parents felt, the information they had received and the connections they had built with other families in the Program would sustain the outcomes achieved.
This section draws implications for similar programs in the future, in the following areas that Northcott found important for the implementation and success of this program model: timeframe, staffing and logistics, engaging families and communities, working with schools and service providers, and delivering this program model in Aboriginal communities.

### 5.1 TIMEFRAME OF THE PROGRAM

Northcott staff recommended that similar projects—which support Aboriginal families with children with additional needs and rely heavily on relationships with other service providers—include a lead up time of 12 to 18 months 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 more than one year of regular appearances at meetings and community events to develop relationships with Aboriginal families, communities and services. The process was 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.

Once service provision had started, staff observed that it took another year to establish the Program in the community as a presence and a known element of the local service system. Towards the end of service provision Northcott staff said:

> Other service providers now know the project as it has a greater presence in the community, particularly since the therapists have begun running workshops. There is now a big turnout at workshops, very different from a year and a half ago, because previously no one knew the point of the Program or why the therapists were there. While it is crucial to develop trust and relationships prior to the project starting, faith in the Program and credibility only happen once it has shown what services and support it offers.

Program planning for similar projects needs to include awareness of related services in the community. In the urban Program site, Northcott set up two playgroups, but only one flourished. Staff assumed this was because numerous playgroups already existed in the area.

The planning cycles of other services also need to be considered. As schools plan a year ahead, it helped to meet with the principal in the year prior to service provision to ensure the Program is incorporated into the school calendar.

Once the Program was established, Northcott staff felt that a longer service delivery time than 18 months would have been beneficial. As mentioned before, it took months for parents to feel comfortable talking to staff about family concerns or needs for their child. This shortened the period of effective 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, and in Northcott’s view ongoing funding for these types of projects is the preferred option. A number of families, preschool and school staff
and other service providers also commented in interviews that the children could benefit from ongoing support:

Keep it going, be an ongoing support system.

We got used to you for the last two years. I know this is going to be our last year, but I would like for you to do this, because really it is only half way through the year and, sadly, to me it is only half the work done.

Also we have a high turnover of families in here. You know we have sort of started off with particular families and they have left half way through the program. New families have come in and it is a very transient thing. It would be really good if there was this kind of project to support families as they keep coming and going kind of thing.

In addition, Northcott is concerned that repeated short-term interventions in vulnerable Aboriginal communities may have damaging consequences, as they may lead to disappointment among participants and a loss of trust in mainstream services that may impede their engagement in future projects.

5.2 STAFFING AND LOGISTICS

Due to the Program’s specific target group, service scope and geographical location, there were particular staffing and logistical requirements. Northcott needed to recruit appropriate professional staff including Aboriginal workers; to deliver a range of professional therapy services as well as training; to ensure collaboration among a professionally diverse team of workers; and to achieve this in two distinct areas several hundred kilometres apart.

Northcott experienced challenges related to all these aspects. Staff recruitment was difficult, particularly for Aboriginal staff, because of a shortage of qualified workers. Staff turnover was high, partly due to Northcott work structures and practices, hindering consistent service delivery. Local therapists were not available in the rural site to provide Program services. The team had little opportunity for regular, face to face communication. Finally, service provision was more difficult in the rural site due to distance.

Northcott had not encountered this combination of challenges before. Management addressed issues as they emerged and worked towards structural adjustment within the organisation. A variety of measures were tried and put in place during the course of the Program, limited by budget and time constraints. This section lists suggestions for similar projects.

Effective program delivery in two distinct locations, including a rural site, might be helped by:

- a project coordinator in each of the sites, who lives in the area and is available on an ongoing basis to build and maintain relationships with local communities and services
- availability of therapists for regular, face to face contact with children and parents. Preferably, local therapists in each site should be employed. If this is unfeasible and therapists need to travel between sites, face to face contact with families should be arranged at least every fortnight, either through visits or video conferencing, and
- in a rural site, additional staff hours need to be allocated for travel. In this Program, the two main rural service locations were 100 kilometres apart, and travel between the locations took considerable time away from contact with families and services.
Recruitment of Aboriginal staff, particularly in rural communities, could be assisted by:

- liaising with job networks to access potential applicants, including Aboriginal-specific networks such as the Aboriginal Employment Strategy (AES) and the National Disability Services (NDS) Aboriginal Jobs Together project
- consultation with job networks to assist applicants with interview preparation and pre-employment probity processes, for example obtaining documentation such as birth and professional qualification certificates and working with children checks
- simplified application forms
- including Aboriginal staff on interview panels and
- conducting job interviews in an informal, conversational way.

Once Aboriginal staff members have been recruited, an employer’s aim is to retain them, at least for the duration of the project. In this Program there was high staff turnover, which made ongoing service provision difficult and impacted on Program outcomes. It became evident that families would remain engaged with services for longer periods of time when they were interacting with the same worker. The following strategies could be useful to retain Aboriginal workers, drawing from Northcott’s experience:

- organisational structures that ensure culturally appropriate workplaces. Northcott formed an internal Reconciliation Action Committee to advance cultural change within Northcott about training and supporting Aboriginal staff. Northcott has conducted manager training and linked its Aboriginal family and community worker roles to traineeships offered via the NDS Aboriginal Jobs Together project
- improving cultural awareness among non-Aboriginal staff within the project team, for example through cultural training, regular team meetings, and modelling of culturally appropriate communication and service provision to Aboriginal families
- continuing to work with job networks, particularly Aboriginal-specific agencies, during the initial phase of employment to help address any workplace issues
- ensuring safe practices that protect both the organisation and the worker, especially where the worker is a community member. For example, workers need support to set boundaries with clients about use of organisational resources such as mobile phones, and the workers’ confidentiality around mandatory reporting requirements needs to be protected
- supporting staff reliability by creating a flexible, family-centred workplace. For example, structuring workers’ duties around their physical capabilities and schedule preferences, organising back-up staff so that regular service provision such as playgroups can continue when staff are unable to work, and being flexible to Aboriginal working practices such as driving families to appointments and buying them lunch to engage them in the Program
- training and assisting Aboriginal workers to fulfil administrative duties. Suggestions were: minimising paperwork, training the worker in administration and computer skills while on the job, using voice recognition software for administrative reporting tasks, providing additional administrative support, and partnerships between workers, where one takes responsibilities for administrative tasks. It was acknowledged by Northcott staff that many of these suggestions require additional funding
- developing the job skills of less experienced Aboriginal community workers by pairing them up with more experienced Aboriginal colleagues
- providing supervision, debriefing and mentoring opportunities for Aboriginal staff, according to their preferences. This may be with other Aboriginal workers in the organisation or externally. Supervision is also important for the project manager and needs to be arranged according to their preferences, and
- considering possible divisions within the local Aboriginal community when hiring Aboriginal workers. Due to these divisions some families may prefer workers who are either from, or have been accepted by, their area of the community. This may require the recruitment of additional staff in order to cover the entire Aboriginal community.
Delivering a complex project in diverse locations requires good communication among team members. Organisational management structures in similar projects need to consider:

- regular team meetings among community workers, early educators, therapists and management to clarify roles and responsibilities, and to communicate about participating families, their goals and progress, and
- conducting family visits in pairs so that team members can model their specialised skills to colleagues, such as therapy skills to non-therapists, and Aboriginal cultural knowledge to non-Aboriginal staff. In this Program, for example, when a non-Aboriginal therapist conducted an assessment, an Aboriginal staff member reframed questions in a culturally sensitive way—such as changing questions about the child’s ‘soccer’ playing to ‘league’ in the rural site—and asked the therapist for explanations, to ensure that the parent understood the questions by modelling how to ask for clearer information.

Northcott staff acknowledged that regular communication and collaboration among the team would take additional time and funding, but they considered it essential for effective, coordinated service delivery.

5.3 ENGAGING FAMILIES AND COMMUNITIES

When trying to engage families and communities in similar programs, service providers need to be mindful of community and cultural preferences. As mentioned before, families in the two Program communities had previously received little information about disability. Northcott workers found that some parents did not want to label their children as having a delay or disability. Other parents were hesitant to join a disability program because their child had not been diagnosed with a disability, or the family did not view their children’s needs as a disability or delay. Staff found it useful to explain to parents that this was not just a disability-specific program but also a school readiness and general support program.

Northcott 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 families built trusting relationships with the workers, they became comfortable talking about their children’s needs. To get to this point, workers needed time to sit and talk to the parents about any issues that concerned them, be it housing, financial struggles or their children’s behaviour. This process could take weeks or months, and future projects need to allocate staff time for this engagement period.

Some families continued to feel uneasy about the concept of disability. Staff found it helpful to avoid the term disability and talk instead about the children’s development in general, as well as particular developmental and behavioural issues, and to give options for problem solving.

Families have different preferences for how, when and where to talk with program staff. They may want to meet in the school, the local park, outside their house or inside, or they may talk to the worker while having lunch together or while the worker gives them transport to a doctor’s appointment. Program management needs to be flexible to enable workers to accommodate different family preferences.

In addition, employing a range of staff members helps with engaging clients, including staff of various ages and levels of experience, as well as Aboriginal and non-Aboriginal staff. In this
Program, for example, a young non-Aboriginal mother was more comfortable to engage with a young non-Aboriginal worker, and a single Aboriginal father was at first more comfortable with a more experienced Aboriginal worker.

Once children are enrolled in the Program, maintaining contact with the family can 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. This program model needs to incorporate staff hours for visiting families, according to travel times within the Program site.

Maintaining contact with parents was easier in the playgroup services than in the preschool and school services, as parents participated in the playgroups together with their children. Future programs need to work with schools and preschools to contact parents and encourage them to get involved in the program so that outcomes can be sustained, for example by parents talking with program workers and therapists and by learning strategies to use at home with the child. However, it is important to wait and give parents time until they feel comfortable to engage. In the playgroups some parents initially needed to sit back and observe rather than take part. Playgroup was an important respite time for them, when they could take a break from looking after their children. Staff were patient, which enabled parents to engage at their own pace.

Achieving outcomes for children in similar programs requires engaging extended families and the communities. Where parents are hesitant or unable to participate, a grandparent or other relative might take the child to program services or encourage the parents to join. However, it is important to wait and give parents time until they feel comfortable to engage. In the playgroups some parents initially needed to sit back and observe rather than take part. Playgroup was an important respite time for them, when they could take a break from looking after their children. Staff were patient, which enabled parents to engage at their own pace.

Achieving outcomes for children in similar programs requires engaging extended families and the communities. Where parents are hesitant or unable to participate, a grandparent or other relative might take the child to program services or encourage the parents to join. This happened in both Program sites. Community elders are good initial points of contact, first out of respect for their position, and second because they know families and can advise workers on how to engage them. Elders may also have knowledge about disability through participating in interagency meetings and can help workers to inform community members about disability. Staff suggested that community education about disability issues be wide so that everyone becomes 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.

5.4 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 achieve outcomes for participating children. Therefore close partnerships are essential for these programs to succeed.

Successful partnerships depend on a regular program presence in the community. As mentioned before, a coordinator located in each program site would help to build and maintain contacts with staff from other services.

Local service providers need to be approached and involved early, in the program planning phase, in order to establish trust in the community. Once service provision starts, service providers can then refer families to the program and have coordinated service provision, otherwise there is a risk of duplicating services and using resources inefficiently.

In the playgroup component of future programs, preference should be given to working with existing playgroups rather than starting new groups. The program can provide education and
training to the existing playgroup’s staff and families so they can acquire skills to identify and support children with additional needs after the program finishes, thus improving sustainability of program outcomes.

To build successful partnerships, Northcott tailored the Program to the needs of different services. For example, a school and preschool in the rural site preferred therapists to spend their time providing training for staff rather than therapy for individual children.

Northcott found that the support of key people in local organisations was crucial to establishing this kind of program. For example, one rural school withdrew from the Program after one term, but a new principal who started later in the year re-engaged with the Program. Future programs need to work with at least one key person who has disability and cultural awareness in each organisation, and transition to a replacement if that person leaves.

Northcott staff concluded that it was important to identify existing communication structures in partner organisations early and work within those structures to maintain successful partnerships. The aim is for program staff to communicate with all relevant workers in participating organisations so that children can be supported well. In schools, for example, relevant staff would include the principal, classroom teachers, school counsellors, the Aboriginal Education Officers (AEOs) and possibly others. Communication can happen in various forms, according to the preference of the organisation – either via one key contact who transmits information to colleagues, or via group meetings.

Northcott experienced communication challenges in this Program due to high staff turnover in participating organisations including Northcott, part-time staff, or staff with limited experience or training, time pressures and competing priorities. These difficulties were more accentuated in the rural site. Communication worked best via one key contact, provided this person supported the Program, relayed information and facilitated Program services such as therapy sessions, for example by informing classroom teachers when therapists visit and scheduling therapy sessions for participating children. Future projects need to review communication arrangements regularly and adjust if necessary.

As Aboriginal children and families are the target group for this program model, partnerships with local Aboriginal service providers are essential. Northcott observed differences between the two Program sites in how these service providers engaged, and Northcott adapted its approach accordingly. 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.

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 the main Aboriginal organisation, and it delayed service delivery to families. Staff used other ways to connect with the community, such as talking to people and services and attending interagency meetings. Over time, relationships were formed, and towards the end of Term 1, 2012 the Aboriginal organisation started referring families to the Program. The implication for similar programs is a need for flexibility and persistence.

In addition to schools, preschools and Aboriginal organisations, the wider local service system also needs 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 incentive to engage with another provider; in addition, Northcott was not well known. Program staff engaged in community activities such as preschool fun days, community fairs, Aboriginal forums and community meetings. Gradually, other service providers became familiar with Northcott and the Program, and they increasingly worked together and referred clients. In an area with fewer services, such as the rural Program site, Northcott staff observed that any new service was warmly welcomed.

5.5 DELIVERING THIS PROGRAM MODEL TO ABORIGINAL COMMUNITIES

When delivering this kind of program, specific Aboriginal cultural issues need to be considered and are discussed below: restrictions of the program target group, attitudes towards disability, culturally appropriate service delivery, the Aboriginality of staff and community approval.

The Northcott Program was specifically designed for Aboriginal children and families, as Aboriginal people with disabilities can be a disadvantaged population group who benefit from early intervention. Evidence shows that Aboriginal families are less likely than non-Aboriginal families to access services due to personal, social and cultural reasons. As the Program was situated in two areas with a relatively high proportion of Aboriginal residents, service providers and families were receptive to culturally appropriate services that were specific to the local Aboriginal communities.

Some families and service providers asked to include non-Aboriginal families who they felt would benefit from the Program. This was especially pertinent in the rural site, where all families were affected by a shortage of social services. Northcott staff observed that this type of program might create a perception of segregation or unfair advantage. It is therefore important to emphasise the reasons for the program being Aboriginal-specific.

As mentioned previously, few Aboriginal families have received information about disability in the past. This can be a barrier for similar programs, but Northcott’s experience shows that it can be overcome by:

- not using the word ‘disability’ in the beginning, but having a general conversation about the family and concerns about the child, talking to families in a descriptive way about the child’s development, for example the child not talking as well as other children of that age
- focusing on early intervention support and school readiness
- talking to families one-to-one rather than in a group
- opening the program up to all Aboriginal families who have concerns about their children’s development, not just those with an obvious disability
- excluding the word ‘disability’ from the title of the program and
- raising community awareness and information about disability.

Culturally appropriate service delivery involves staff interaction with participating families and staff training. As the therapists’ formal assessment tools are often not culturally appropriate, similar programs need to ensure that therapists can conduct child assessments in a culturally sensitive manner. Northcott staff found the following strategies useful:

- using flexible assessment methods, for example child observations, play based assessments and conversations with parents, whenever possible, and
if formal, paper based assessments have to be used (for example to obtain a disability diagnosis), an Aboriginal worker can give information to the parent about the importance and benefit of the assessment, they can be present during the assessment and rephrase questions or ask the therapist for clarification, as described earlier.

This approach also helps to train non-Aboriginal therapists, because it uses modelling of culturally appropriate service delivery. Other training methods are: pairing Aboriginal and non-Aboriginal staff during therapy and playgroup sessions; and cultural training courses provided by the organisation. When staff change, the transition process needs to include transfer of cultural knowledge to new staff members. A non-Aboriginal Northcott therapist commented:

I have learnt a lot both personally and professionally about Aboriginal culture as a result of working with the targeted families via this Northcott project.

Culturally appropriate service delivery also involves acknowledging community events and responding flexibly in how the program is delivered. For example, during one Program term the community in the rural site was affected by repeated Sorry Business. The Northcott team responded by running only three playgroup meetings and focusing on home visits and supporting the families.

Whenever services are implemented in Aboriginal communities, workers need to be aware of any trauma that is potentially being experienced, its history and its intergenerational and collective nature. Service providers need to be equipped with the skills and strategies to work with traumatised communities in a sensitive and appropriate way so they do not add further harm or distress to families. Training and workshops for trauma-informed support are available to assist in recognising the impact of trauma on the family and community, trying to minimise further trauma, acknowledging and validating the family’s experiences, encouraging community participation in service planning, and promoting empowerment and self-determination.

Employing Aboriginal workers in this type of program is important in order to facilitate community and family engagement. However, if recruitment is unsuccessful, Northcott Program staff recommended that non-Aboriginal workers with a good standing in the wider community, cultural sensitivity and disability awareness be employed, and that they work with local Aboriginal elders to set up the program. Once non-Aboriginal staff have established trusting relationships with families, they could continue service delivery.

Obtaining approval from Aboriginal community leaders to deliver this program model can be a lengthy process. Future programs need to anticipate and navigate challenges encountered by Northcott:

- during the planning phase, finding out which people and organisations to approach within the Aboriginal community without causing friction among local groups or services
- exploring alternative ways of community approval other than the main Aboriginal service provider and
- learning about the local community and existing funding and services, to target the program most effectively.

Northcott staff observed that it was essential to develop good personal relationships and establish the organisation as credible within the Aboriginal community and among service providers. This required time and financial resources but is critical for this program model to succeed, now and in the future.
5.6 SUMMARY OF IMPLICATIONS FOR SIMILAR PROGRAMS

TIMEFRAME
Similar programs need a lead time of at least one year to build trusting relationships with local service providers and the Aboriginal community. Prior relationships help. Obtaining approval from community leaders may require time and persistence but is essential.

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

A service delivery time longer than 18 months could help to improve outcomes such as school readiness and family empowerment, and it could avoid possible disappointment and disengagement of Aboriginal families and communities.

STAFFING AND LOGISTICS
Good communication among the program team is essential and facilitated by regular team meetings and modelling of skills among workers. A project coordinator is needed on the ground in each program site to develop and support the relationships internal and external to the program.

Children in each site need regular, face to face contact with therapists. This could be arranged by using local therapists or regular travel to the sites, or alternatively by video-conferencing.

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

Recruitment of Aboriginal staff can be facilitated by liaising with job networks and simplifying the application process. Strategies for successful retention of Aboriginal staff include: organisational structures for culturally appropriate workplaces; improving cultural awareness among non-Aboriginal staff within the project team; continuing cooperation with job networks; safe practices that protect both the organisation and the worker; creating a flexible, family-centred workplace; training and assisting Aboriginal workers to fulfil administrative duties; pairing Aboriginal staff with more and less experience; providing supervision, debriefing and mentoring opportunities for Aboriginal and non-Aboriginal staff; and considering possible divisions within the local Aboriginal community when hiring Aboriginal workers.

ENGAGING FAMILIES AND COMMUNITIES
When engaging families and communities, a program approach that emphasises general early childhood development rather than disability-specific intervention helps, as do flexible eligibility criteria. Not requiring a previous disability diagnosis engaged families who would otherwise not have received support for their children’s disability or developmental delay.

Building trusting relationships with families needs time, as well as flexible work arrangements for staff to accommodate parent preferences. Maintaining contact with families during the program is important for child outcomes and sustainability. It requires cooperation with schools and preschools to engage families, and extended travel time for staff in a rural area.

Involving extended families and communities helps to raise awareness about how to meet the needs of children with disability or delay. Community elders are good initial points of contact.
Programs provided within an Aboriginal community need to have understanding and awareness that the families have community commitments and responsibilities.

PARTNERSHIPS WITH SCHOOLS AND SERVICE PROVIDERS

Similar programs would benefit from early contact with local providers, a regular presence in the area and flexibility to the needs of providers. Programs need to enlist the support of key people in local organisations and work within existing communication structures. Building partnerships with local Aboriginal providers is essential and may require flexibility and time for many points of contact.

DELIVERING THIS PROGRAM MODEL TO ABORIGINAL COMMUNITIES

Staff may need to explain to local Aboriginal and non-Aboriginal community members why this kind of program is specifically for Aboriginal families, to dispel possible notions of unfairness.

Lack of previous information about disability in Aboriginal communities may be addressed by talking generally about the child’s development, by focusing on school readiness and by informing community members about disability generally.

Culturally appropriate service delivery needs to consider staff training for interaction with families, flexibility using formal assessment tools, and sensitive responses to community trauma. Non-Aboriginal staff can work successfully with families if they have cultural sensitivity and cooperate with local Aboriginal leaders and the Aboriginal staff.
6 REFERENCES

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 and third rounds

Family interview – Waves 2 and 3

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?
  o Therapy support
  o Playgroups / school readiness program
  o Training sessions
  o Yarn-ups
  o Support plans
  o 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:
  o Information about disabilities, strategies, services and funding
  o Communication with the management of your school or preschool
  o 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 and third rounds

Teacher/Service provider interview – Waves 2 and 3

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):
   o 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 –
Appendix E  Training assessment survey for professionals

Title of training session: _____________________________________________________
Location: _______________________________ Date: ____________________________

1. What is your professional role?
   □ Preschool teacher
   □ Primary school teacher
   □ Teacher’s aide
   □ Aboriginal Education Officer
   □ Other (please specify): _______________________________________________

2. In your work, do you have direct contact with children participating in the Northcott program?
   □ No
   □ Yes (please specify): __________________________________________________

3. How did you find the training?

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<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
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</thead>
<tbody>
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<td></td>
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<tr>
<td>I learnt new information</td>
<td></td>
<td></td>
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<tr>
<td>I will be able to incorporate the</td>
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<tr>
<td>information into my daily work</td>
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<tr>
<td>The facilitator was good</td>
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<tr>
<td>The length of the session was right</td>
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</table>

Other comments about the presentation:


4. How do you think the training could be improved?


5. What other training would be useful?


   – Thank you very much for completing this survey. –
Appendix F  Training assessment survey for families

Title of training session: ____________________________________________

Date: ____________________________________________________________

1.  Are you:  □ Male         □ Female

2.  How old are you?  □ under 20  □ 30 – 39  □ 50 – 59
               □ 20 – 29  □ 40 – 49  □ 60 and over

3.  Age of the child participating in the program: ____________ years

4.  Which program is the child participating in?
    □ playgroup  □ school readiness

5.  What is your relationship to the child?
    □ parent         □ extended family  □ carer who is not a family member

6.  Did you invite someone to come to the training with you?
    □ No   Yes:  □ a friend  □ a family member  □ other ________________

7.  How did you find the training?

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was interesting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I will use the information</td>
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<tr>
<td>It was in plain English</td>
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<tr>
<td>The length of the session was</td>
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<td>right</td>
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</tbody>
</table>

Other comments about the presentation:

8.  How do you think the training could be improved?


9.  What other training would be useful?


- Thank you very much for completing this survey.  –