Australian
Early
Development
Census
An Australian Government Initiative

Our **Children**
Our **Communities**
Our **Future**

AEDC User Guide: Policy Makers & Government Executive

This AEDC user guide leads policy makers through the steps they might take when thinking about how to respond to AEDC data for their jurisdiction. It provides an example of a policy response in order to illustrate how the concepts can be applied to real-world situations. Before reading this guide, readers should be familiar with the AEDC and what it measures. For more information about what the AEDC measures visit www.aedc.gov.au/about-the-aedc/about-the-aedc-domains

A state government education department commissioned a review of the distribution of early childhood services across its jurisdiction to determine whether the service mix was best placed to meet the needs of children and families.

The AEDC was considered to be a good starting point for identifying the needs of children and families because it is:

- a nationwide census

- evidence based

- predictive of later health and educational outcomes and

- reflects the environments and cumulative experiences of children in the first five years of life.

The AEDC data for the jurisdiction demonstrated that there was a relationship between the Socio-Economic Indexes for Areas (SEIFA) and the proportion of children who were developmentally vulnerable on one or more of the AEDC domains in their first year of full-time school. The highest proportions of vulnerable children were residing in the most socio-economically disadvantaged areas of the jurisdiction. This relationship reflects inequality in outcomes for children across the socio-economic spectrum. The department noted, however, that the largest numbers of vulnerable children resided in areas in the middle of the SEIFA range. The department considered that any redistribution of services needed to address the needs of children across the entire population while reducing inequality in developmental outcomes.

It was noted that although the AEDC language and cognitive development domain was strongly associated with SEIFA, the social competence and emotional maturity domains were not as strongly socio-economically patterned across the region.

To better understand which services and supports were needed and where they were needed, more information was required.

SEIFA alone was not considered to be a good indicator of need, as redistributing services based only on SEIFA would result in the largest numbers of vulnerable children missing out on supports and services. However, using AEDC data in conjunction with SEIFA to inform the redistribution of services and supports was considered to be superior to using SEIFA alone.

The department initiated a review of the services and supports currently available for families and children, from conception through to school age, and then mapped against the AEDC data. Mapped services included:

- child health nurse clinics

- general practitioners

- allied health services (speech pathology, occupational therapy, psychology)

- child care

- preschools

- playgroups

The intensity of each service or support and how it was delivered to children and families was catalogued.

Tips for identifying the need

Think about what factors may be contributing to the proportion and number of children who are developmentally vulnerable in the community. These could include:

- limited services or supports

- available to families

- many families face barriers to accessing any available services or supports

- parents are isolated and not well connected to family and friends locally

- a general lack of awareness and understanding around the importance of early childhood development

- parents face a large number of additional challenges that are preventing them from providing optimal environments for children

- there are service shortages – not all families are able to access services, there may be long waiting lists

- the mix of services and supports available may not be well suited to the needs of children and families

- families face barriers to accessing services and supports

- any combination of the above.

It is important to note that these are not exhaustive possibilities. This list is intended as a starting point for thinking about the needs of families.

Some services and supports were considered to be beneficial for all families (e.g., community health nurse visits, playgroup, immunisations, parenting advice/ information) while others were considered to be targeted supports and services for families with additional needs (e.g., home visiting health nurses, speech therapy, occupation therapy, psychological services, disability services, financial management advice, parenting support, child protection services).

Figure 1. Estimated distribution of parenting support needs
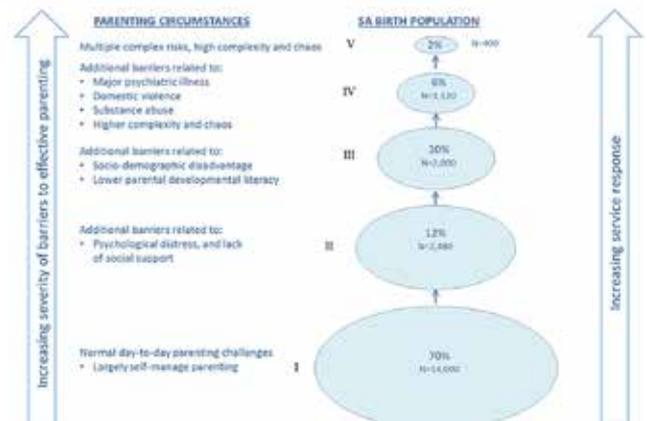
(Five by Five: A supporting Systems Framework for Child Health and Development. Better Start, 2014)

Services and supports were then categorised against a scale of parenting support needs within the population to identify service gaps, oversupply or undersupply in the service mix.

The department considered how it could reach all families and how it could identify and reach those families who required additional supports. The department noted that only through universal contact points (times at which every family would present themselves) could families requiring additional supports be identified. In education, all children eventually presented at school, however earlier universal contact points were not evident in the education department's service mix. Thus, contact points for all services to children and families, delivered by the departments of health and social services, were plotted on a timeline.

Tips for examining support needs

Consider barriers to accessing services such as:

- not knowing what services are available (lack of easily available information, no internet, inability to find information, new to the community)

- poor access to transport (no vehicle and lack of convenient public transport)

- inconvenient opening times or parent time pressures

- cost of the service is prohibitive

- language barriers (low literacy or English as a second language)

- chronic health conditions of parents

- chronic health conditions of children

- poor parental mental health (postnatal depression, anxiety disorders, etc.)

- disability of parents (physical or intellectual)

- disability of children

- stigma associated with accessing help (e.g., young mums, generational cycles of disadvantage, etc.)

- domestic violence

- homelessness

- substance abuse

- service alienates a subgroup of parents or carers (dads, single parents, foster parents, grandparents, unemployed parents, unconventional families).

This identified the points in time at which families were most easily engaged, screened for support needs and delivered a service proportionate to need. Universal service points were considered, including:

- antenatal/postnatal services

- health services (e.g., immunisations – 98% population coverage)

- family registrations (Centrelink)

Based on this information, it was evident that an interdepartmental approach was required to effectively reach all children and families in their earliest years.

Figure 2. Adjusting the mix of targeted and universal services based on community needs
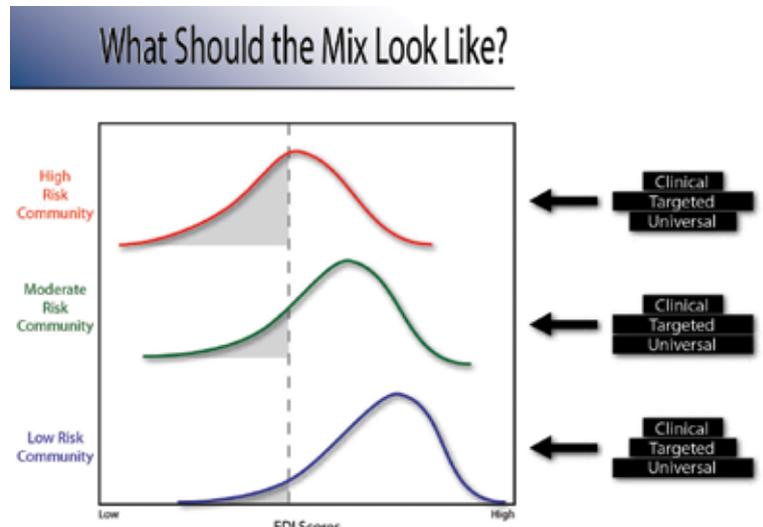
(Presentation of the Early Development Instrument results, Hertzman, 2004)

Key personnel in the relevant state departments responsible for the delivery of health services and social services were approached to discuss the ways in which a coordinated approach could be developed to reach families across the jurisdiction. The education department presented the proposed universal contact points that had been identified, along with how these could potentially be used to direct families to the services and supports that were offered from birth to school age.

To establish a joint initiative, the departments produced a report that collated administrative data and acted as a starting point for assessing the needs of children and planning a coordinated response.

A coordinated action group, tasked with developing a service delivery model, was established. The model was to conform to best practice by:

- having a strong universal service base that offers supports to all families

- utilising universal contact points for screening for additional needs

- providing more intensive supports to families who face additional barriers to providing optimal environments for children.

The coordinated action group documented:

- contact points

- services available across all departments

- current capacity of each service and whether this capacity was proportionate to need.

Services were categorised as:

1. Universal and high population coverage. For example: antenatal services, first universal child health nurse visit, 4 year old health check by GPs, immunisation, preschool, school.

2. Universal but lower population coverage: playgroups, parenting advice, children's centres, child health services post the first universal scheduled check, library story book sessions.

3. Targeted. For example: social work, speech therapy, occupational therapy, psychologists, in-home support.

Using programme logic, the coordinated action group then mapped the proposed approach. They defined the expected outcomes if a reconfigured service system was not only better placed to reach and meet the needs of all families with the aim of reducing vulnerability across the whole region, but also to reduce inequality in child development across the socio-economic spectrum.

Once all the resources were identified, an action plan was developed which documented what would be done, when, by whom and at what cost.

A list of stakeholders was developed that detailed who needed to be kept informed and what information they needed so that the initiative would have the best chance of reaching as many families as possible.

The coordinated action group agreed on ways they would measure the efficacy of the service mix and agreed to develop a coordinated administrative database that enabled more effective tracking of service usage.

The group included the AEDC as an outcomes indicator and looked forward to tracking population outcomes with AEDC data in 2015 and 2018.

About the Australian Early Development Census

The Australian Early Development Census (AEDC) provides a national snapshot of early childhood development for children in their first year of full-time school. The AEDC is held every three years and measures five key areas or domains of development. The AEDC measures how well children are doing across five key areas of development referred to as domains. The domains are: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills; communication skills and general knowledge. Taken together, these domains provide a holistic picture of children's development and are important predictors of later health, wellbeing, and academic achievement. In 2012, 78% of children were assessed as being developmentally on track and one in five children across Australia were developmentally vulnerable on one or more domains of the AEDC.

The environments and experiences children are exposed to from pregnancy shape their development. Policies and services at a national, state and local level each play a pivotal role in supporting children and families. Recognising these influences on children's development can provide policy makers with the opportunity to consider what is working well and what needs to be improved or developed to better support children and their families.

The AEDC is the national progress measure of child development in Australia. Research shows that investing time, effort and resources in children's early years, when their brains are developing rapidly, benefits children and the whole community. Early developmental gains support children through their school years and beyond. Investing in the early years can reduce social inequalities in children's outcomes, has long lasting impacts on communities, and can increase national productivity by improving the skills of the workforce, reducing disadvantage and strengthening the global competitiveness of the economy.

At a government level, the AEDC provides a sound basis for strategic planning, policy creation and policy evaluation. Policy makers can use AEDC results to allocate resources and services to more effectively meet the needs of children and families. Governments can use the AEDC data to inform their strategic plans, to monitor the progress of communities over time, and to assess the impact of policy changes.

Best practice

Identify need

State level AEDC microdata is available to government departments.

The AEDC Data Protocol sets out the principles and protocols governing the collection, management, access, use and dissemination of AEDC data for the period 2015 – 2017.

To find out more about how to access AEDC microdata speak to your State or Territory AEDC Coordinator (www.aedc.gov.au/communities/states-and-territories) or visit www.aedc.gov.au/researchers/resources-for-researchers/aedc-data-protocol-2015-2017

Demographic data can add additional context about the challenges facing communities. Demographic data is freely available online form a number of sources. For example, the Social Health Atlas presents extensive data for every community in Australia via: www.adelaide.edu.au/phidu/maps-data/maps/

Examine support needs

To identify the support needs of children and families and any potential response it is important to gather information on:

- supports and services currently available
- broader factors impacting upon children and families ability to access available services and supports.

To better understand what groups are and aren't accessing services, consider comparing administrative data to census data. This can help to identify whether particular sections of the community are not engaged with services.

Hard to reach families are often those who could benefit the most from services and supports. Engaging these families requires consideration of the barriers they face.

Identify and bringing together stakeholders to respond to the AEDC

In bringing together stakeholders to respond to the AEDC it is worth considering who could or should be involved in bringing about better outcomes for children.

Agencies who work directly with children may include:

- early childhood education and child care providers
- public health units
- child health nurses
- schools
- not-for profits
- local businesses.

Agencies who do not work directly with children but who nonetheless support families include:

- transport providers
- housing services
- training and employment agencies
- local police.

Bringing together stakeholders to respond to the AEDC is likely to generate a response that reaches more families. A collaborative approach is better placed to identify service gaps and barriers to access and address these than a single service provider might achieve working alone.

Plan a coordinated approach to service delivery

A good plan starts with a clear and actionable set of objectives that are based on sound information about a situation.

Document the service plan

Take into account the resources available and the activities that will be conducted to achieve the objectives.

Action planning

An action plan can support funding applications, it also clearly documents the steps agreed for implementation and is a useful tool to ensure that all collaborating stakeholders are working to the same information.

Best practice for monitoring programme efficacy

A well thought out evaluation should form part of any implementation process. How to evaluate an initiative should be factored into each stage of the process.

What to include as measures of success should be a reflection of what you set about to change.