# Review of Best Practice in Early Childhood Intervention

## PRECI Round 2 Consultation Report

Version 1.0, December 2024

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PROFESSIONALS & RESEARCHERS IN EARLY CHILDHOOD INTERVENTION

THE UNIVERSITY OF MELBOURNE

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Two online consultations were facilitated by Denise Luscombe and Kerry Bull in December 2024 as part of the Review of Best Practice in Early Childhood Intervention (ECI). Professionals who had participated in the first round of consultations in July-August were invited to this second round. 124 professionals including allied health practitioners, early childhood educators and teachers, academics, managers and paediatricians attended. They represented service providers (private, not-for-profit, government), early childhood education and care services, peak bodies, professional bodies, advocacy organisations (disability-specific, family, siblings), health (hospital and community health) and education departments.

Participants received pre-reading material that included a draft version of the Practice Framework's vision, aims, outcomes and principles, and two templates of principles and practices to support the consultation. Participants also received a discussion paper on terminology and completed an online poll on the terms 'intervention' and 'best practice' at the end of the consultation. Results of the poll will be collated and analysed following the closure of a survey disseminated widely to the broader sector, parents and other interested stakeholders from December 2024 to January 2025.

The following is a summary of what we heard at the two December consultations.

## 1. Vision

Participants supported the "clear and purposeful" vision that *'All children with developmental concerns, delay or disability, and their families, thrive in their early years'* and that it falls clearly within the vision for all children - '*That all children thrive in their early years'* from The Early Years Strategy (2024-2034). They endorsed the addition of families in the proposed vision for children with developmental concerns, delay or disability.

## 2. Aims and outcomes

Participants approved of the proposed overall aim for ECI services: '*To promote the capabilities of parents/carers, communities and service providers to be able to provide children with developmental concerns, delay or disability with the experiences and opportunities that build their capacity, agency and meaningful participation in home, community and ECEC/school settings'*. Many supported the focus on capacity building and were pleased to see agency and participation included.

Participants endorsed the need for specific outcomes for children, families and the community. They were supportive of further work on aims and outcomes for service

providers that had been recommended in the first round of consultations. They discussed the need to consider how outcomes are measured and the need for accountability and guidance around measurement.

Specific recommendations were provided on the wording of some outcomes.

- **Child outcomes** recommendations related to nutrition, self-care, emotional regulation, opportunities for communication and child safety.
- **Family outcomes** related to family quality of life, capacity building, parents with disability, understanding of child identity and supporting social connections, advocacy, and recognition that parenting begins before the child is born. There were comments about the scope of ECI in relation to participation in the social and economic life of the community.
- **Community outcomes** recommendations broadly revolved around concern about the final proposed outcome being beyond ECI practitioner ability or scope. There were recommendations about additional outcomes related to peer connection and support.

Participants sought definitions of key words such as ‘families’, ‘parents/carers’, and ‘ECI practitioners. This led to an important discussion about how participants defined ECI practitioners. Responses included:

a) ECI therapists include speech pathologists, occupational therapists, physiotherapists, music therapists, educators, keyworkers, psychologists, dietitians, continence nurses
b) ECI represents the important work of allied health professionals and specialised therapists
c) ECI is the provision of specialist support to young children and their circles of support and this could come from a range of places and individuals and must not be siloed to be provided by a select group of providers
d) ECI includes all practitioners who provide support
e) All those who work with children, each bringing their own expertise to support the development of the child and/or support of family-collaboration and connection
f) Broaden our idea of what makes a practitioner - across the community - teachers, doctors, grandparents, peer workers, neighbours

The majority agreed with a combination of the first three (3) points.

## 3. Core care conditions

Whilst some participants were really pleased to see the core care conditions included in the Practice Framework, others were confused about what it meant and whether it was within the scope of an ECI service or practitioners. There were

suggestions about changing this new terminology to ‘social determinants’ or ‘supportive conditions’. Many found the draft graphic that included the core care conditions helpful and suggested it be adapted for future use.

## 4. Fundamental elements

Participants largely endorsed the three fundamental elements: ‘rights’, ‘relationships’ and ‘context’. There was overwhelming support for adding ‘strengths’ as a fourth fundamental element. There was discussion about ‘capacity building’ and where it needed to be included within the Practice Framework – as a fundamental element, a principle, or a practice.

Many participants were unsure about the term ‘context’ and offered alternatives such as ‘environmental’, ‘social and physical environment’, ‘child and family ecology’, ‘child’s ecosystem’ and ‘ecological’. Many suggested that fundamental elements also be titled differently with alternatives provided such as ‘overarching principles’, ‘approaches’ or ‘underpinning values’ or ‘considerations’. Some commented that the idea of fundamental elements was initially confusing and that the current National Guidelines for Best Practice were clearer in relation to quality areas.

## 5. Principles

Overall, participants were positive about the proposed principles and were enthusiastic about the changes from the current National Guidelines. Many indicated that the draft diagram provided clarity about the interaction between the five principles and suggested that the fundamental elements could be represented as encircling the principles with the child and family in the middle.

Participants indicated that the clusters of principles worked well and more specifically noted the following:

a) Child and family-centred
   - Both are necessary inclusions
   - Child-centred is a welcome addition to the current guidelines
   - Ensure a broad definition of family is provided

b) Culture and diversity
   - Capturing diversity within families and the community is welcome
   - Ensure diversity affirming includes Deaf-Deafness and Deaf culture
   - Ensure diversity includes neuro-affirming practice
   - Consider that cultural safety remains central to other culturally diverse communities
   - Suggested ‘Culturally Sensitive’ as an alternative term

c) Connection and collaboration
   - Enthusiasm for the community-focused principle as an addition to the current guidelines
   - Include capacity building under collaboration
   - Replace teamwork with ‘joined up services and settings’ or ‘working together’
   - Consider the need for teamwork to include cross-sector collaboration and various models of practice (e.g. therapist working in collaboration with other services but not necessarily under the same roof)

d) Inclusion and participation
   - Review the main heading of inclusion and participation and subheadings of participation and everyday opportunities because of duplication of terms
   - Ensure definitions of inclusion and participation are provided
   - Include natural or everyday environments or settings

e) Outcomes and evidence
   - Consider adding implementation in this principle
   - Consider providing guidance on measuring outcomes

## 6. Practices

There was overwhelming approval for the draft template that provided a rationale of the principles, associated practices and a ‘looks like/doesn’t look like’ table. They found it “exciting” and “refreshing”. Participants liked the clear language, support with implementation and a solution to the “risks of misinterpretation” that the template provided.

Recommendations included:

a) Continue to ensure the practices flow directly from the principles
b) Don’t be concerned about ‘doubling-up’ of practices across the principles
c) Add a section at the bottom of the table that highlights the interactions between practices and principles
d) Don’t add outcomes to each practice because there may be many intended outcomes from a single practice
e) Continue to use the term practitioners rather than therapists
f) Provide a self-reflection tool for principles and practices
g) Develop fidelity tools and resources, including video modelling examples
h) Consider different wording within the ‘looks like/doesn’t look like’ practices to avoid misinterpretation
i) Add *‘We know this is working when’* to the template

j) Consider re-wording of ‘looks like/doesn’t look like’ to ‘it looks like/it doesn’t look like’, ‘what we do/don’t want to see’, ‘appropriate/inappropriate’ or something more strength-based or neuro-affirming (Note: majority approved of ‘looks like/doesn’t look like’)
k) Consider a table that includes ‘what are we working on’ and the current progress as ‘not achieved’, ‘emerging skills’ or ‘achieved’, and align with outcome measures.

Further considerations

a) Visual representation of the framework
b) Further consultation with stakeholders such as dietitians about specific areas related to their expertise (e.g. health and nutrition)
c) Continued alignment with other frameworks
d) Implementation support through resources and professional development
e) Workforce issues including accountability, credentialing, capability framework and worker registration
f) Embedding best practice in pre-service tertiary education
g) Systemic barriers
h) Referral pathways
i) Resources for families, educators, medical staff etc.

Finally, when asked if we were on the right track, there was overwhelming support for the current direction being taken.

The project team will consider all the comments and questions for the final Practice Framework.

Further professional consultations, led by PRECI, will be held in January and February 2025. They will focus on topics/areas such as:

a) service provider/service aims and outcomes
b) frequency, intensity and duration of ECI supports and services
c) teamwork
d) natural learning environments (including practices)
e) working in rural, regional and remote/very remote locations
f) working with school-aged children

# Contact us

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