# CHILDREN AT RISK

## Strengthening Communities

### A Future Pathway – a discussion document

NEW ZEALAND PRINCIPALS' FEDERATION

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## Introduction

The New Zealand Principals Federation (NZPF) is strongly supportive of the notion that school success is not predicted by a child's fund of facts or a precocious ability to read so much as by emotional and social measures: being self assured and interested; knowing what kind of behaviour is expected and how to rein in the impulse to misbehave; being able to wait, to follow directions and to turn to teachers for help; and expressing needs while getting along with other children.

Improving teacher pedagogy is important but on its own will not affect the desired outcomes. Russell Bishop's research indicates that the quality of the relationship between teacher and child is integral to maximizing each child's learning potential. This is supported by the work of Daniel Goleman. Whilst supportive of this notion there is tension around any individual teachers ability or willingness to give so readily from their emotional reservoir. Each teacher's "emotional cup" must be refilled.

We are aware of the need to focus on the "long tail" of underachievers, disproportionately maori and pasifika peoples. Schools alone will not address the disparity.

**Based on all the evidence it is clear that to affect meaningful change, coordinated interventions need to occur in the early years (birth – 8years).** The NZPF contends that there needs to be systemic change. **Functional interagency protocols are urgently required.**

**Communities can and do make a difference**

# It takes a village to raise a child

# It takes a nation to create a village

# NZPF wants to help create the villages

The influences of families / whanau and communities are identified as key levers for high quality outcomes for diverse children. It is the view of the NZPF that the social and academic factors influencing learning outcomes are interconnected.

The Ministry of Education alone is spending $680 million (2003) on Student Support Interventions and Prevention Approaches. When allied with the expenditure from other social agencies (CYF, Health etc) there are obviously significant social issues, which are negatively impacting on the future of our nation, the tamiriki. All of these interventions from an end users point of view (i.e. the schools) lack connectivity. It is time to review whether the resources are meeting the needs of both the school and community.

It is time to develop and resource models that "best fit" school and community need. This will mean that there will not be a "one size fits all" model.

Given that the school is both the nucleus of community and the last bastion of compulsory attendance it makes sense to focus resources at the school/s. Our model (see Figure 1.1) is proposing that communities of schools (including pre-schools) would have access to ready

reaction teams. These teams, comprising of Health, Social Services and Education, would have judicial power to positively intervene on behalf of children at risk.

**The New Zealand Principals' Federation believes that a child's physical, mental, emotional, social and cultural well-being is integral to their future success.**

**Children have a right to live in a safe, nurturing environment that maximises their potential.**

**Our Goals are:**

1. To ensure that our social system functions so that interventions are responsive to the child's needs.

2. To ensure that effective coordinated intervention occurs at the earliest sign of dysfunction

3. To ensure that interventions look at the whole family and its needs in order to provide long term change.

4. To ensure that our principals and teachers are provided with the skills and resources to engage and empower all learners within a community of learners.

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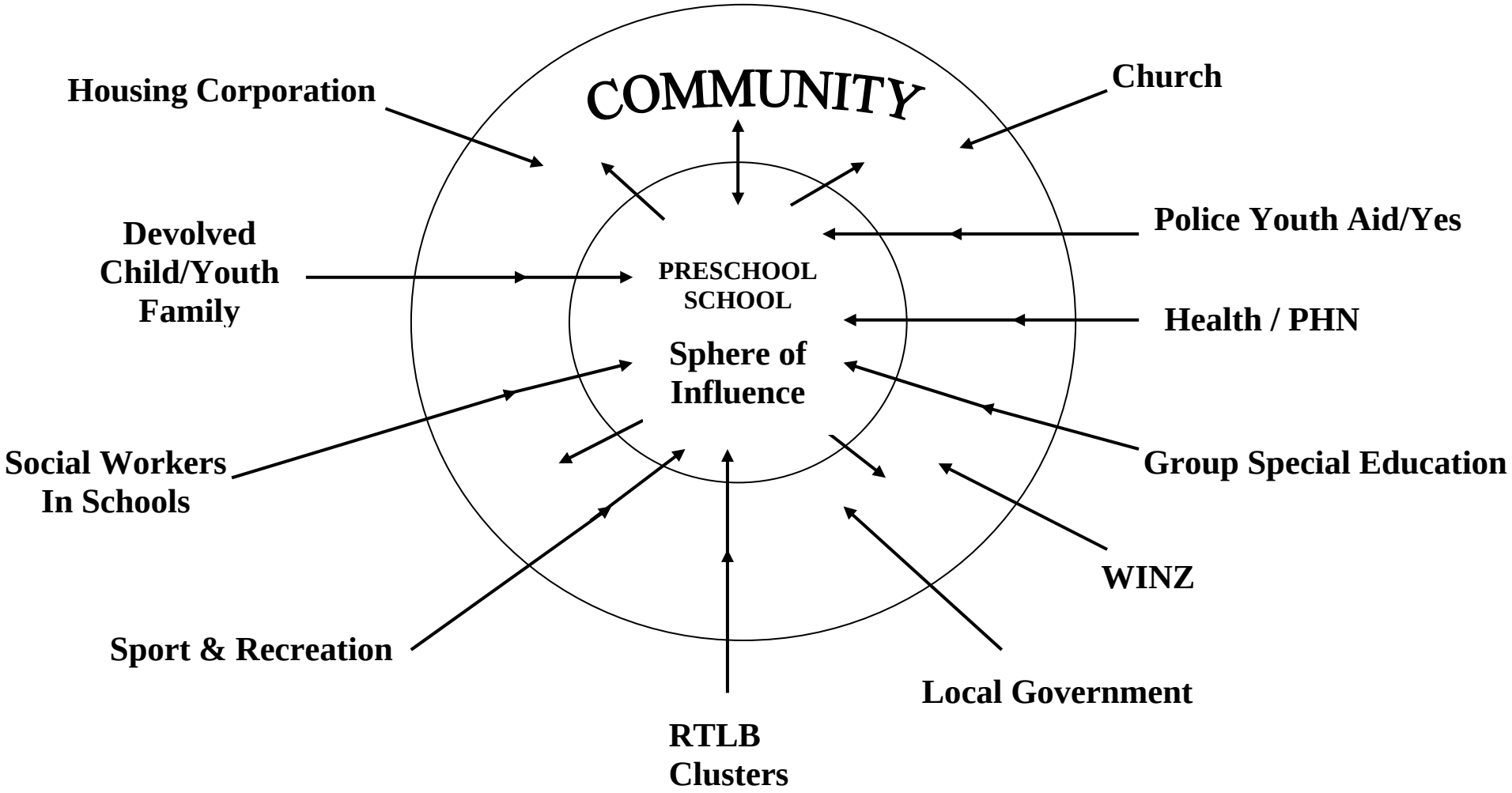
# STRENGTHENING ALL COMMUNITIES

## Focus on Vulnerable Communities – Figure 1.1



# UNDERPINNING BELIEFS

1. That individuals be provided with a ‘tool kit’ that will equip them for their life’s journey. Central to which are ‘values’

2. **Education** is the ‘key’ to any door.

3. Comfort with change.

4. Empowerment rather than rescue.

5. Long term change rather short-term solution. ‘Systemic’ change rather than ‘event’

6. The child is at the heart – “Find the matriarch”

7. Every child is born with ‘magic.’

8. Every child has the right to be treated with dignity

# ISSUES WITH 'STRENGTHENING COMMUNITIES' MODEL

1. Lack of Vision
2. Resourcing
3. Coordination of Interventions - Resourcing
4. Legal 'teeth'
5. Professional Jealousy
6. Blame Culture

# STRATEGIES TO MAXIMISE PUBLICITY/NETWORKING

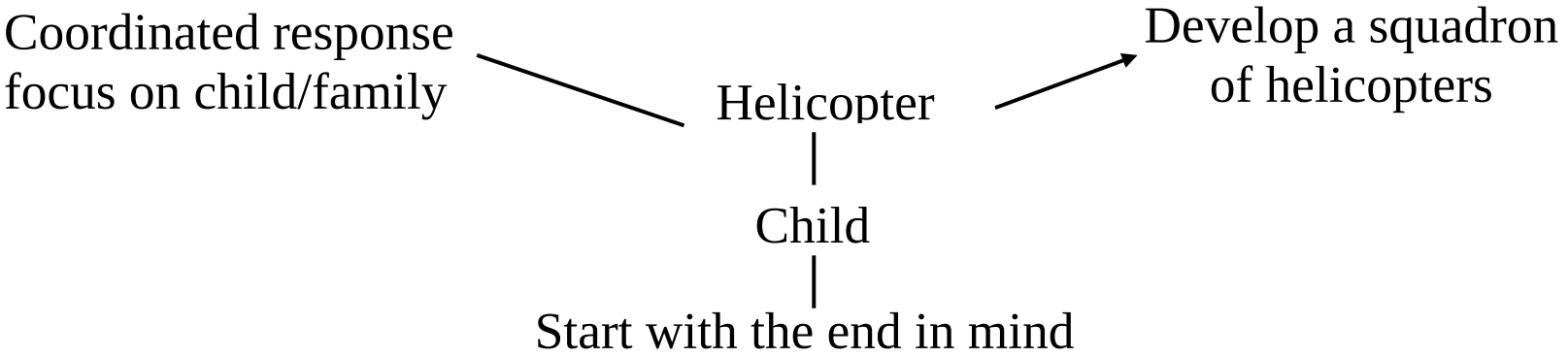
**1. Share/sell model with regions**
- **refine model**
- **Gain sector 'buy in'**

**2. External buy in**
- **MoE First**
- **CYFS**
- **Commissioner for Children**
- **Justice**
  - **Pat Maloney (Chief Family Court & Judge)**
  - **Andrew Beecroft**

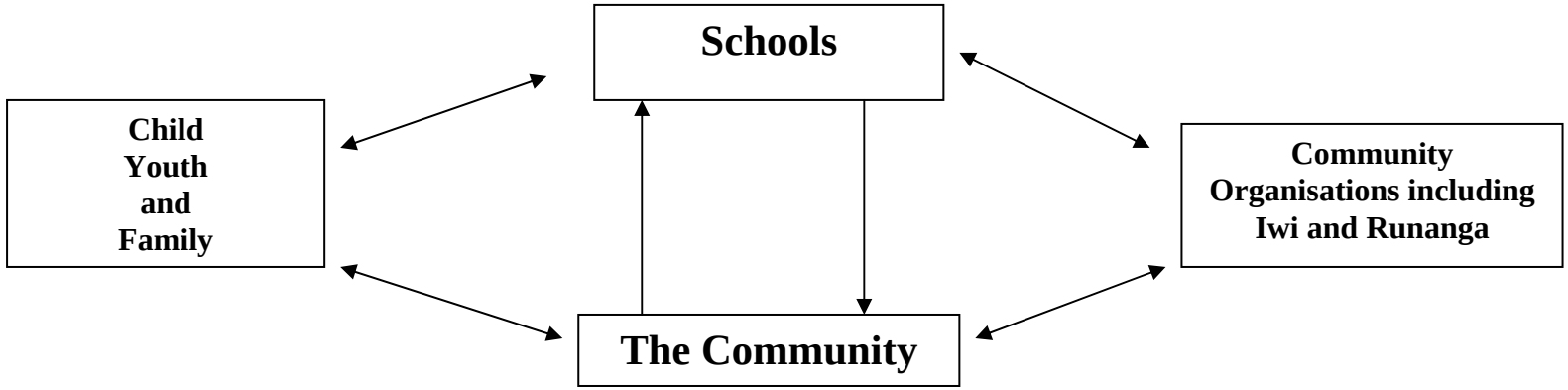
## SELLING POINTS

1. **Present system doesn't work – we know that – we spend hours, wasting time/effort trying to get help for our vulnerable kids and families**
2. **Who knows their children/families/ communities best – us or CYF?**
3. **It's not a matter of increasing workload, we're already doing it. It is a matter of lessening them.**
4. **Resourcing is the key – money/people**
5. **The RTLB Model (with modifications) is a way of resourcing communities**

# VULNERABLE FAMILIES – BUILDING RELATIONSHIPS



# How the Model Would Work

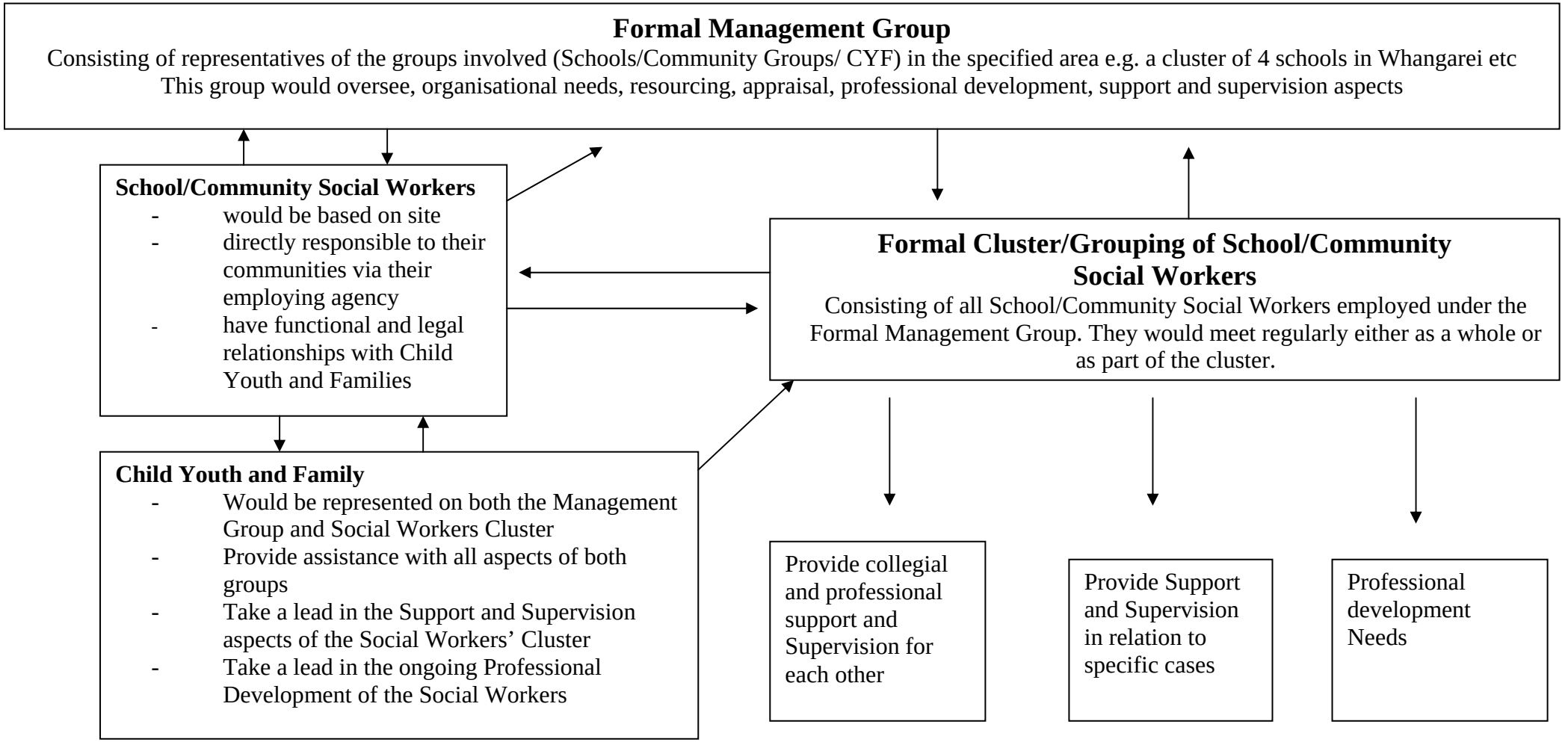



**Child Youth and Family would be responsible for**:

1. 24 Hour and under emergency referrals (acute needs)
2. Funding, monitoring and training of school / community social workers
3. Providing resources such as housing, foster homes, secure facilities etc
4. Working with the Management Group for the Social Worker Cluster and involved organisations

**Schools and Community groups who opt into the system would be responsible for**:

1. All cases of children and families at risk that they become aware of within their community area, except for the 24 hour emergency response ones
2. Follow up to the 24 hour emergency response cases once the initial action had been taken by CYF or Police
3. The emphasis will be on ongoing, support and assistance with the aim of making long term effective change to the whole family
4. The main vehicle for this change will be based around the educational needs of the *whole family*, to cover immediate needs and also to ensure the long term needs of the family are able to be met.
5. Minimising boundaries between educational facilities (Open Polytechnic, Correspondence School, local schools,) and using technology, to assist with whole family support and development.


Formal Management Group
Consisting of representatives of the groups involved (Schools/Community Groups/ CYF) in the specified area e.g. a cluster of 4 schools in Whangarei etc
This group would oversee, organisational needs, resourcing, appraisal, professional development, support and supervision aspects
School/Community Social Workers
- would be based on site
- directly responsible to their communities via their employing agency
- have functional and legal relationships with Child Youth and Families
Formal Cluster/Grouping of School/Community Social Workers
Consisting of all School/Community Social Workers employed under the Formal Management Group. They would meet regularly either as a whole or as part of the cluster.
Child Youth and Family
- Would be represented on both the Management Group and Social Workers Cluster
- Provide assistance with all aspects of both groups
- Take a lead in the Support and Supervision aspects of the Social Workers' Cluster
- Take a lead in the ongoing Professional Development of the Social Workers
Provide collegial and professional support and Supervision for each other
Provide Support and Supervision in relation to specific cases
Professional development Needs

# APPENDIX 1

## Supporting Children at Risk
## A Discussion paper

**Presented to the Schools Consultative Committee**
**On 3 November, 2003**

***"School success is predicted not by a child's fund of facts or a precocious ability to read as much as by emotional and social measures: being self assured and interested; knowing what kind of behaviour is expected and how to rein in the impulse to misbehave; being able to wait, to follow directions, and turn to teachers for help; and expressing needs while getting along with other children." Goleman, Daniel. "Emotional Intelligence – Why it can matter more than IQ." P.193***

**Underpinning Beliefs**

"A view of human nature that ignores the power of emotions is sadly shortsighted. The very name **Homo sapiens**, the thinking species, is misleading in light of the new appreciation and vision of the place of emotions in our lives that science now offers. As we all know from experience, when it comes to shaping our decisions and our actions, feeling counts every bit as much – and often more – than thought. We have gone too far in emphasizing the value and import of purely rational – of what IQ measures – in human life. Intelligence can come to nothing when the emotions hold sway." p.4 Emotional Intelligence

"In a sense we have two brains, two minds – and two different kinds of intelligence: rational and emotional. How we do in life is determined by both – it is not just IQ, but **emotional** intelligence that matters. Indeed, intellect cannot work at its best without emotional intelligence. Ordinarily the complementary limbic system and neocortex, amygdala and prefrontal lobes, means each is a full partner in mental life. When these partners interact well, emotional intelligence rises – as does intellectual ability." p. 28 Emotional Intelligence

Dr. T. Berry Brazelton, the eminent Harvard pediatrician says that parents "need to understand how their actions can help generate the confidence, the curiosity, the pleasure in learning and the understanding of limits" that help children succeed in life. Brazelton's view is informed by a growing body of evidence showing that success in school depends to a surprising extent on emotional characteristics formed in the years before a child enters school.

A report from the National Centre for Clinical Infant Programmes makes the point that school success is not predicted by a child's fund of facts or a precocious ability to read so much as by emotional and social measures: being self-assured and interested; knowing what kind of behaviour is expected and how to rein in the impulse to misbehave; being able to wait, to follow directions and to turn to teachers for help; and expressing needs while getting long with other children. Emotional predictors of school success – Heart Start.

The report goes on to say that almost all students who do poorly in school lack one or more of the above elements of emotional intelligence (regardless of whether they have cognitive difficulties such as learning disabilities). A child readiness for school depends on the most basic of all knowledge, **how to learn.**

The report lists the 7 key ingredients key to the capacity of how to learn, all related to emotional intelligence.
They are:

1. **Confidence** – a sense of self control and mastery of one's body, behaviour, and world; the child's sense that he or she is more likely than not to succeed at what he undertakes, and that adults will be helpful.
2. **Curiosity**. The sense that finding out about things is positive and leads to pleasure.
3. **Intentionality**. The wish and capacity to have an impact, and to act upon that with persistence. This is related to a sense of competence, of being effective.
4. **Self-control**. The ability to modulate and control one's own actions in age-appropriate ways; a sense of inner control.
5. **Relatedness**. The ability to engage with others based on the sense of being understood by and understanding others.
6. **Capacity to communicate**. The wish and ability to verbally exchange ideas, feelings, and concepts with others. This is related to a sense of trust in others and of pleasure in engaging with others, including adults.
7. **Cooperativeness**. The ability to balance one's own needs with those of others in the group activity.

The new paradigm requires us to harmonise head and heart.

## A Synthesis of the Synthesis

### 1. "The Complexity of Community and Family Influences on Children's Achievement in New Zealand"

The Ministry of Education's Best Evidence Synthesis "The Complexity of Community and Family Influences on Children's Achievement in New Zealand" gives weight to the notion that the influences of whanau and community are core to improving the learning outcomes for children. This is supported by Goleman's notion of harmonising EQ and IQ ….. or Hearts and Heads. **If a child's emotional hauora is unstable then it is difficult to see how they can maximise their intellectual capability within a community of learners.**

**Key statements from the Complexity of Community and Family Influences Best Evidence are:**

- Ethnicity and culture are linked to children's achievement.
- Low SES children have significantly lower achievement than middle and high SES children.
- Levels of human and material resources are linked to children's achievement.
- Home language is related to children's achievement where English is both spoken at home as well as being the medium for instruction at school.
- The quality of the environment (loving, nurturing) within which a child is raised is more important than family structures.
- Transience / Truancy **may** be detrimental. (NZPF would argue that the **may** should be replaced with **is**)
- Lower SES children are much more likely to experience chronic health problems.

- Shared educational expectation by significant others has a direct influence on learning outcomes.
- Dysfunctional family processes can affect performance and behaviour. There is some evidence that by age 15 20% of NZ children have experienced some kind of mental health disorder.
- Over exposure to television can impact negatively on learning outcomes.
- The "richness" of home environments is associated with higher achievement.
- Positive social networks (church, marae) impact positively on children
- Peer groups (especially at secondary school) have profound influence, both positive and negative, on learning outcomes.
- Access to local community facilities (library, medical) and social services can enhance children's learning outcomes beyond the level which schools can accomplish.
- Comprehensive, integrated programmes focused in the early years (Year 0-5) can significantly improve learning outcomes for children.
- Developing parent pedagogical knowledge through positive school links can have dramatic impacts on children's achievement – developing collaborative partnerships.
- Having access

2. **"The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties: A Review of Research."** **John Church, Education Department, University of Canterbury**

- Detailed analyses of the interactions of antisocial children with their parents, teachers and peers suggest that children who are raised in environments in which polite and friendly responses pay off more frequently than coercive and antisocial responses learn to interact with others in polite and friendly ways while children who are raised in environments where coercive and antisocial responses pay off more frequently learn to interact with others in coercive and antisocial ways.
- To prevent antisocial children growing up to be antisocial adults it is desirable that interventions occur at the first sign of antisocial development.
- There is a lack of standardised screening procedures suitable for NZ use.
- It is estimated that the proportion of antisocial children in NZ school is between 4.5 and 5% however this percentage can increase between 3 and 6 fold in lower decile schools.

***Three conclusions were drawn from the research**:*

1. Children who do not engage in antisocial behaviour during childhood do not engage in antisocial behaviour during adolescence and adulthood.
2. Children identified during childhood as engaging in high rates of antisocial behaviour are at considerable risk as adults. (unemployment, psychiatric disorders, alcoholism, substance abuse, early pregnancy, early fatherhood, drunk driving, criminal offending, domestic violence, higher rates of injury and hospitalisation).
3. Current social conditions appear to be producing a group of life-course persistent antisocial children who go on to become delinquent youth and then adult offenders. For boys raised in the 1970's, this group numbered about 7% of all boys.

Children with severe antisocial behaviour difficulties are likely to have **four** major types of special teaching need.

1. The need to respond in prosocial ways to the behaviour of other people.
2. The need to learn that other people can be trusted and that how other people react to one's behaviour is important and needs to be taken into account.
3. The need to learn and to practice age-appropriate social skills, especially those which are necessary for the development of and maintenance of positive relationships with peers and with adults.
4. The need to catch up as quickly as possible in the core learning areas. i.e. reading, writing and maths.

**The research reviewed in this report shows that the task of halting the behaviourally challenged becomes more complex, more costly and less likely to succeed the older the child becomes**. Further the longer the intervention is left the less chance of affecting a successful outcome. Pre-school interventions have the most success (75 – 80%), between the ages of 5 -7 years, 65 – 70%, between 8 – 12 years, 45 – 50%)

Further it goes on to say that it appears extremely unlikely, on the basis of the research reviewed that antisocial development can be halted and prosocial development accelerated using just a school-based intervention on its own.

## 3. Our Children's Health – key findings on the Health of NZ Children

*The following statistics are taken from the Ministry of Health publication "Our Children's Health" available on www.moh.govt.nz*

*Please note that I have not reported all key points*

Growing up in NZ

- In 1996, 11% of children had a least one parent who claimed the unemployment benefit
- In 1996, 23% of children did not have a parent participating in the labour force
- In July 1996, 93% of four-year-olds were enrolled in an early childhood service
- In 1996, mothers of 62% of children from two-parent families were participating in full or part-time work. In 1991, the corresponding figure was 53%. In 1981, it was 46%.
- In 1996, 23% of children were living in one-parent families, compare to 22% in 1991 and 12% in 1981.

Mortality and Morbidity in Children

- The NZ mortality rate for children aged 0-4 years currently ranks 15$^{th}$ out of 21 OECD countries. This is a fall from a position of sixth out of 21 countries in 1960.
- The death rate for Maori children aged 0-14 years is consistently higher than for non-Maori.
- Children are being hospitalised at an increasing rate. Over the period 1988-95, there was an average annual increase of 5% in the hospitalisation rate of 0-14 year olds.

Infant Health

- Internationally, the NZ infant death rate remains comparatively high with a current ranking of 17th out of 21 OECD countries for which information is available.
- The Maori infant death rate is consistently higher than the rate for Pacific and European children.
- Maternal smoking is strongly correlated with SIDS (Sudden Infant Death Syndrome), with over half of all SID deaths each year attributable to maternal smoking. One-third of all women smoke during pregnancy. For Maori women the proportion is two-thirds.

Children with Disabilities

- About 11% of NZ children aged 0-14 years have a physical, intellectual, sensory, psychiatric disability or a long term-term disease or illness.
- School-age children, boys and Maori children are more likely to have a disability than pre-school children, girls and European children.
- In 1995/96, 7.6% of three-year olds and 8.5% of new school entrants (5 year olds) failed hearing screening tests. Maori and Pacific children were twice as likely as children from other ethnic groups to fail these hearing tests.
- It is estimated that 2.5% of 0-14 year olds have disabilities related to long term emotional, behavioural, psychological, nervous, or mental health problems.

Tamiriki Maori Hauora

- Tamariki Maori are more likely than European children to live in social circumstances associated with an increased risk of serious ill-health.
- Tamariki are also much more likely than non-Maori children to be admitted to hospital. This is particularly so in the first five years of life.
- Tamiriki, especially girls aged 12-15 years, are continuing to take up smoking and become committed smokers at rates well above those of young teenagers form other ethnic groups.

Nutrition

- The prevalence of obesity in NZ children has not been accurately determined. However, overseas data suggest a large increase in child obesity is occurring and predicts significant ill-health during childhood (including psychological and social consequences), in many cases progressing to numerous serious diseases in adults. ***"The reality of the obesity epidemic means that many parents will outlive their children." Annette King. According to Annette 1:7 children suffers from obesity and this percentage is increasing.***

- Food security covers issues of hunger, food quality, food quantity, and cultural appropriateness of foods. The prevalence of food insecurity is unknown in NZ children, but there is significant anecdotal evidence suggesting a serious problem.

- The major risk factor for food insecurity in families is low socioeconomic status, especially housing tenure, education, employment, and car ownership, which all impact on the ability to procure and store food.

Tobacco, Alcohol, Cannabis & other substances

- Tobacco smoke damages children's health when:
  - Pregnant women smoke
  - Children are exposed to environmental tobacco (passive smoking)
  - Children themselves become regular or committed smokers

- About a third of NZ women smoke when they are pregnant. Smoking during pregnancy is especially common among Maori women, teenage girls and women with lower educational levels.
- Children from less-advantaged backgrounds are more likely to be exposed to cigarette smoke in the home.
- As teenagers grow older, increasing proportions become committed smokers. In 1996, over 30% of 20 – 24 year olds were smokers.
- In the Christchurch Health and Development Study, 7 percent of young people were drinking alcohol at least once a week by age 15. Around a quarter of 15 year olds did not drink alcohol and another quarter drank only once or twice a year. 12% of 15 year olds reported drinking more than the equivalent of three standard – sized bottles of beer at their last big drinking session. About 5% met criteria for alcohol abuse.

**From a principal's perspective …. a few thoughts!!!**

As a general statement children whose needs fit within the ORRS criteria are reasonably well catered for in a school setting however there are still tensions surrounding levels of mainstream support.

a. Inclusive v exclusive education. There is evidence that certain groups of special needs students are best met in an exclusive setting. e.g. Deaf Education. Is it in the best interests of special needs students to be educated in the mainstream 100% of the time?
b. From a principals grading perspective ORRS students generate additional numbers but to the teacher in the classroom the same does not apply. The additional staffing (0.2 and 0.1) does not offset the fact that in many cases the teacher is required to differentiate programme delivery 25 hours per week.
c. Many schools still have to make up the short fall in funding for ORRS from other sources within their Operational Funds.
d. There are significant numbers of children whose needs are critical but do not fit into any category. They are in the "too hard" category.
e. TFEA and SEG Funds need to be funded at the level required to meet actual employment costs and be indexed to the inflation and CEA rates. A review of levels of resourcing is urgently needed.
f. LSF funding managed by RTLB clusters tries to address long-term behavioural needs because of the shortfall in other funding pools. The tension here is that the resource is allocated on short-term basis. The model of schools working together is sound.
g. It is worth discussing why another "special needs" funding pool would be created when there are apparent short falls in existing pools of funding.e.g Supplementary Learning Support.

h. The system's (Health, CYF and Education) lack of coordinated responsiveness to child need.
i. Clearly the groups of children who are providing the most angst in a conventional school setting are those "behaviourally challenged" individuals who emotionally and physically blackmail teachers and fellow students.
j. There is evidence of "culture clash" in the mid-decile schools. Central to this clash are values and beliefs.
k. Human Resources are taxed to the point where those whose focus should be on teaching and learning are consumed with issues around the "special needs" of children. In a class of 30 children differentiating curriculum to meet such a wide spectrum of needs as well as connecting emotionally is too hard.
l. There are institutionalised barriers for many of our "at risk" children. Some of these may include pedagogical shortfall, lack of relevant context for learning, inability to connect emotionally, physical structures – Industrial paradigm versus Information Age paradigm.

# Discussion points

**What are the priority areas for policy and professional focus if we are to progressively develop earlier and more effective ways of supporting children at risk?**

*Some starters:*

- *Student management as a compulsory aspect of pre-service training.*
- *Emotional Intelligence development for all teachers pre and in-service and actively taught in preschool and the first three years at primary.*
- *Engaging teachers in discussions around teaching within meaningful learning contexts – integration / interdisciplinary.*
- *Utilisation of technology to share best practice.*
- Developing cross ministry procedures (that work at the grassroots) to identify children "at risk" before they reach school and instituting appropriate long term "wrap around" support mechanisms for both the school and the family.
- Give the Strengthening Families process some legal standing – some teeth. Recognise the time and energy required for schools to be involved and resource appropriately.
- Enhancing transitions between pre, primary and secondary schools. The focus clearly on the child.
- Investigating alternative models of schooling for those who do not fit mainstream delivery.
- Modifying the Education Act so that it allows schools flexibility. e.g. What constitutes attendance needs to looked at. A look at the school year etc.
- Investigating the ergonomic aspects of school structures from both Health and Learning aspects.
- Mechanisms for connecting and sharing good practice in and between schools for "Kids at Risk."
- Funding professional development so that it is "doomed to succeed" - doing less better!
- Fully funding schools that wish to participate in the Peace Foundation's Peer Mediation Programme.
- Ensuring that there is linkage between pre-service teacher training and in-service practice for all teachers. e.g. literacy initiatives, numeracy initiatives,

classroom management, ICT initiatives. A balance of pedagogy, knowledge and practicalities of teaching diverse students.

- Developing connections between Universities / Colleges of Education in terms of developing good practice in Action Research.
- Build on RTLB model for social and medical needs – a ready action "Hauora Team" made up of a field staff from each of the agencies attached to each cluster.
- Bring preschool providers into RTLB clusters.
- A media campaign is needed to affirm the wonderful job that our schools do, the importance of education in the widest sense, and that the parents / caregivers' role as first teachers is crucial. We need to share the notion of "heart start" and what that actually means in practice. **Refer 7 key ingredients in page 2 of paper**

**Changing Role and expectation of schools. Is there a place for schools to be points of intervention?**

Some starters:

- The school is one of the last places of compulsory attendance therefore it is already a point of intervention. The tension currently is that schools are trying to carry out these interventions without the necessary resources (both fiscal and human). If we wish schools to play this role then we must resource them appropriately. This may not necessarily be in all schools – medical, social, pre-school, etc. If the expectation is that schools should work with the whole child then make the school a ***"centre of learning and well-being"*** and resource accordingly. Extend social workers in schools by developing interagency agreements, base Health workers in schools, reinforce the community constable concept, make counsellors accessible for primary and intermediate schools.
- If schools provided a "one stop" shop for Heath, Education etc then it would provide a means to "engage" families.
- The changing nature of work has placed demands on schools that are not historically core to their existence. Pre and After School Care centres have been developed. For many the ability to pay is an issue. How can we make better use of school property to enhance learning outcomes for "at risk" children?
- Should children need to always be physically at school? Given the development of technology is it a possibility that children carry out their study on line for part of the week thus releasing school resources for those in greatest need?
- There must be a single key case worker (not a school principal or teacher) that all can contact (could be based in the school), there must be teeth in decisions made. Currently people – professionals and families do not do as they agreed and there are no consequences.

**Summary**

**Based on all the evidence it is clear that to affect meaningful change, coordinated interventions need to occur in the early years (birth - 8). This will require systemic change and a need to further develop functional interagency protocols.**

**How many of our school underachievers, the "long tail" that we have been repeatedly told about, fit into the group of children with multiple emotional and health deficits?**

**Kelvin Squire**
**President**
**New Zealand Principals' Federation**