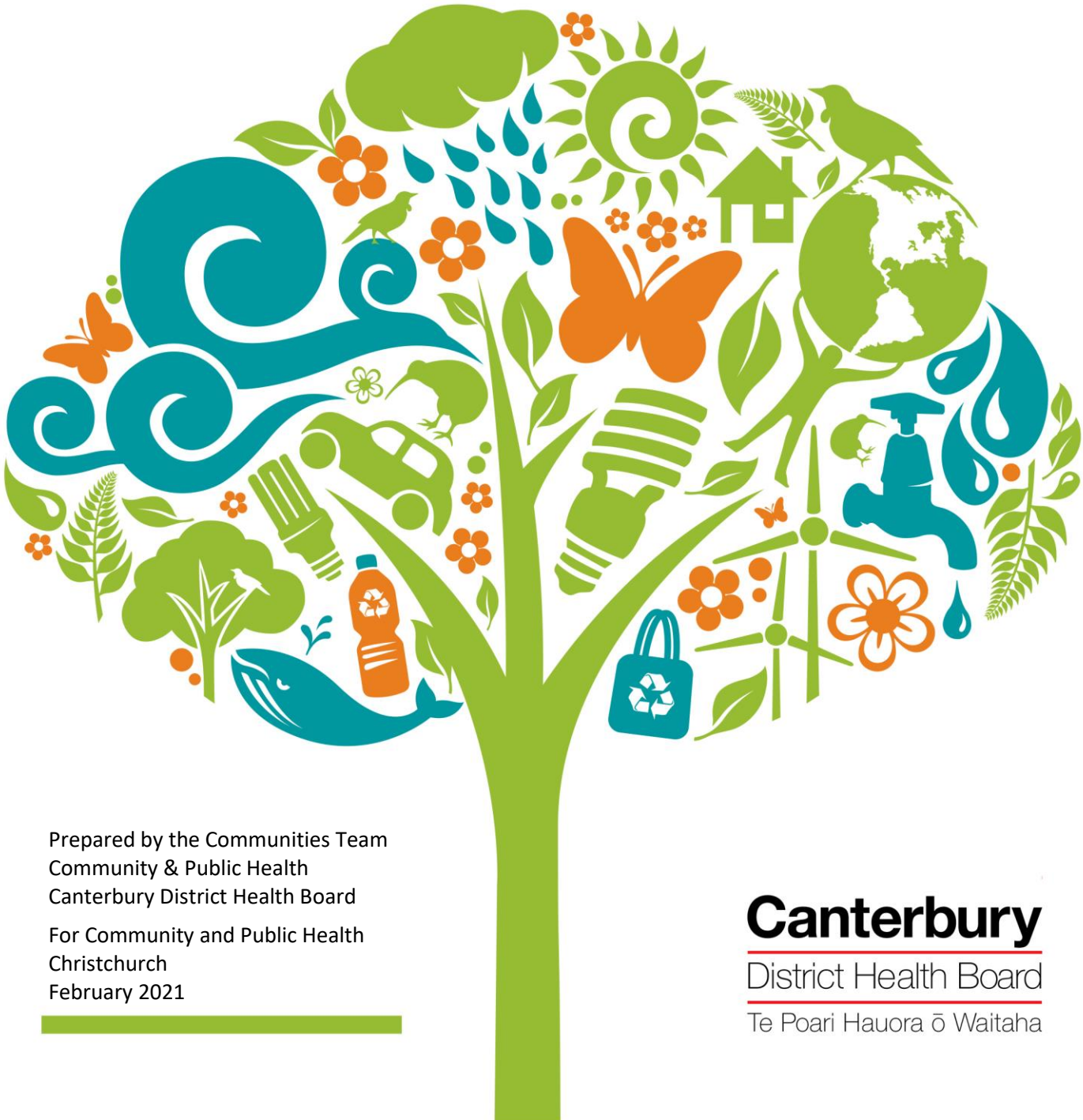
Preschoolers missing the opportunity to thrive: A case study



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Te Pae Māhutonga graphics courtesy of Healthy Christchurch.

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Summary

Thriving preschoolers are much more likely to become thriving adults. Participating in quality early childhood education (ECE) is one significant intervention that can make a difference to tamariki experiencing socioeconomic disadvantage. However, many non-privatised Christchurch ECE settings in low socioeconomic neighbourhoods are not adequately resourced to support preschoolers and their families to thrive. Competition from private ECE settings exacerbates the situation.

This case study seeks to illustrate the urgency and complexity of these issues.

Introduction

The importance of early childhood development and education

"Development during early childhood lays the foundation for health, education, social, employment and economic outcomes throughout the life course." (Community and Public Health, 2018a). Early childhood is **the** critical time of life for a person's whole future life trajectory. Investing in prevention and intervention strategies in the early childhood years provides greater savings over the life course as the need for remedial or punitive actions later in life are reduced (Community and Public Health, 2018b).

Adverse childhood experiences such as violence, poor parental mental health, parental substance abuse, parental imprisonment, and divorce/separation are highly correlated with worse physical and mental health during childhood, and limit opportunities for employment and community participation in adulthood (Ministry of Social Development, 2019a).

ECE is a critical social determinant of health. Investment in and participation in **quality** ECE has positive outcomes for learners (Ministry of Social Development, 2019b; Mitchell et al., 2008)[1]. The first goal of the Mana Atua/Wellbeing strand of Te Whāriki, the New Zealand early childhood curriculum, is that "children experience an environment where their health is promoted" (Ministry of Education, 2017, page 24).

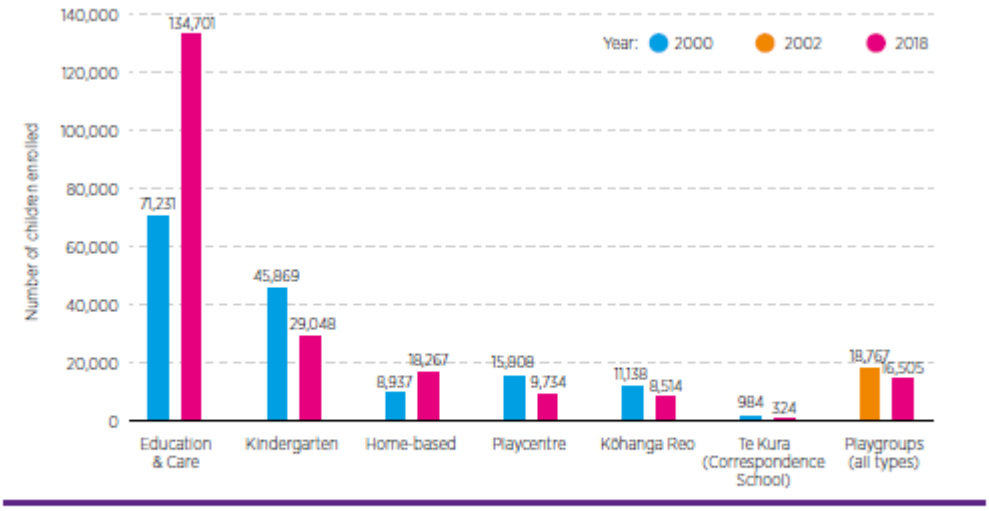
Trends in early childhood education – Christchurch and New Zealand

In 2018, there were over 5,400 early learning services in New Zealand – an increase of over 30 percent since 2000 (Ministry of Education, 2019). Since 2000, the number of children participating in community-run ECE settings has decreased, while the number attending (privatised) "Education and Care" settings has increased (see Figure 1 below). Growing numbers of ECE centres, an oversupply of ECE centres, and little regulation of new builds (in

[1] "These were most evident in centres rated as good quality in respect to responsive and stimulating adult–child interactions and rich learning environments, and in centres employing qualified teachers, with adult: child ratios and group sizes that enabled teachers to work with small groups of children or interact one on one with individual children" (Mitchell et al., 2008).

the main, business ventures) has led to a decline in **quality** (including remuneration for staff, physical space per child, heating, lighting, cleaning, and teacher: child ratios) and an increase in **competition** (for children, families, and teachers) (Bedford, 2020; Neuwelt-Kearns & Ritchie, 2020). In Christchurch it is not unusual to find six or more ECE settings within a 1 km radius of another ECE setting, with new private centres opening every month.

Figure 1. Number of children in early learning services by type in 2000, 2002 and 2018



Source: Ministry of Education annual ECE census. There will be some overlap as children may be enrolled in more than one service type. Playgroup enrolment data is not available for 2000 so 2002 has been used instead. Hospital-based service enrolment data is not available.

Trends in child wellbeing – New Zealand

The annual UNICEF Worlds of Influence Report Card, which ranks OECD and European Union countries in terms of child wellbeing, has placed New Zealand near the bottom of the 41 countries surveyed: 38th in terms of child mental health, 33rd in physical health and 23rd in children's academic and social skills, averaging to an overall ranking of 35th (UNICEF, 2020). New Zealand is also ranked second worst for child obesity.

Further, these poor outcomes are not distributed evenly across the New Zealand population, and significant inequities in health, behavioural, and learning outcomes persist. Children who are Māori, Pacific and/or living in areas of high deprivation are significantly more likely to have limited access to the social determinants of health and subsequently experience poor health outcomes (Duncanson et al., 2019). For example, in the 20-year period between 1990-2009, the national rate of preventable dental hospital admissions in New Zealand had increased nearly four-fold from 0.76 per 1000 to 3.00 per 1000 (Whyman et al., 2014). The rate of admission was highest in children aged 3-4 years, those living in areas of high deprivation, and Māori and Pacific people. The majority of those presenting with dental disease had complications arising from dental caries.

Looking at the South Island, a recent report from Community and Public Health (CPH, the public health division of the CDHB) on The First Thousand Days (Community and Public Health, 2018b) paints a worrying picture of inequities in health-related outcomes for Māori and Pacific children (see Figure 2 overleaf).

Figure 2. Selected health status indicators for South Island children 0-5 years

Source: Community and Public Health (2018c)

Focusing on Christchurch City and the Canterbury region in particular, a picture emerges of a very difficult decade, with the population experiencing shocks from the 2010/2011 earthquakes, Port Hills fires, and the mosque shootings, all taking a toll on the health and mental wellbeing of residents.

Available resources, however, are not keeping pace with the need in low-income family ECE settings, let alone to turn the curve of outcomes for child wellbeing. Although the Ministry of Education provides funding and support to ECE settings in communities of social disadvantage and for particular children (primarily through 'equity funding', 'targeted funding', and 'learning support' staff time), discussions between CPH staff and ECE leaders describe systemic gaps for both the level of funding/support and the time it takes to access the needed support.[2] A similar story of long waiting times and narrow acceptance criteria for services has been anecdotally reported for Oranga Tamariki (Ministry of Social Development).

[2] A child who does qualify for learning support (with the Ministry of Education) often receives around 2 hours a week of expert care.

This case study

Staff from kindergartens, community-based preschools, and indeed many ECE settings have expressed concern on numerous occasions to CPH, about their serious and ongoing challenges sourcing adequate and timely support for children and whānau.

This case study was developed by staff from CPH working in the Communities Team. Sources of information include years of work by health promoters in education settings as well as notes from multiple conversations with ECE sector leaders with over 30 years' experience, including with staff in one particular ECE setting attended by children experiencing high levels of socioeconomic deprivation in Christchurch. We have focused on this setting as it profiles the many acute and ongoing challenges experienced by ECE settings in low socioeconomic areas.

The objective of this case study is to highlight these challenges that can summarise significant issues for dialogue with key stakeholders to support change.

The children

Twenty nine tamariki are enrolled at the ECE setting that is the focus of this case study, representing a diverse and significantly disadvantaged mix of preschoolers. Most tamariki attend full time (8:30am to 2:30pm 5 days a week - 30 hours a week). Half of the children are 2 years old and still use nappies. Half of the children speak little or no English, and only 40 percent have functional language of any kind. These children come from a mix of ethnic backgrounds and all come from homes that are socioeconomically deprived; in addition, all children are described by the Ministry of Education as 'priority learners'[3] . Adverse childhood experiences (ACEs)[4] are prevalent. Fifteen of the 29 tamariki (over 50%) experience two or more ACEs, while 25 percent experience four or five ACEs meaning they are at very high risk of poor outcomes in education, health, employment and life. Two full-time and two part-time teachers work with these children over the course of the week, a total of 120 hours. The staff ratio for the children (2-6 years) is one teacher per 10 children (1:10). One child receives 2 hours of learning support a week. The stories of three representative preschoolers are described below.

[3] "Priority learners are groups of students who have been identified as historically not experiencing success in the New Zealand schooling system. These include many Māori and Pacific learners, those from low socio-economic backgrounds, and students with special education needs." (Education Review Office, 2012)

[4] Adverse childhood experiences (ACEs) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life. Such experiences include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence." (World Health Organization, 2020).

Stories of three tamariki

Priya

Priya is a petite and cheerful three-year-old who was born in India. She and her family arrived in New Zealand as recent migrants 2 years ago. Her father is working as a cleaner in a motel chain and is the only income earner in the household of three adults and two children. He speaks some English although others in the house predominantly speak Punjabi. Priya is not meeting developmental milestones for language or learning although she is good at fine motor skills and likes to make animals with playdough. Priya often arrives late, and staff have learned that this is because she usually goes to bed at the same time as the adults. Staff sense cultural expectations that they are expected to 'sort' any developmental needs.

Priya speaks around fifty words in her home language of Punjabi and around ten words in English which underlines her significant challenges with speaking and perhaps learning. She struggles with comprehending or following instructions and tries to avoid group activities, usually playing alone. She joined the preschool 8 months ago and staff noted her limited language skills and at that point referred her for learning support. She has not been assessed or supported to date. While the ECE staff team spend time supporting oral language development by talking to Priya they are thinly spread and can give her limited attention meaning her progress with speaking is slow. Talking to her grandmother or mother who drop off and pick her up is challenging as both women also have very limited English.

Sammy

Sammy, a 2-year old Pākehā boy, loves the outdoor environment at the centre, particularly the large trees and outdoor play equipment, and is an adept climber. However, he often displays rough behaviour, and hits other children. He shows poor social and problem-solving skills, and will often hit, bite, scream or cry in his attempts to communicate. Sometimes he appears very hungry, reaching for any available food. His father is unemployed and family violence occurs often. In weekends, the father drinks heavily, and the mother struggles with mental health challenges including anxiety and depression. There are three older siblings in this family. Staff made a referral to Learning Support and have been waiting for an assessment for the last 7 months. They also made a referral to Oranga Tamariki who were not able to provide support as the situation falls outside their criteria. The mother doesn't want to take legal action regarding family violence.

Pita

Pita is 3½ years old, and is a quiet, anxious child, who lacks interest socially, but who can show kindness and caring. Pita is not yet toilet-trained and staff need to change his nappies during the day. They also notice he has some development delays, including poor oral language skills. Staff find it difficult to understand what Pita is saying. When Pita joined the centre 9 months ago, his Dad had just come out of prison, however his parents have now separated. Pita's mother now has sole custody and is on a sole parent support benefit, and she finds it challenging to make ends meet. With limited education herself, Pita's mother struggles to read and budget. Pita's attendance is becoming irregular, and staff are aware that a regular home routine has not been established for Pita. Pita's mother clearly wants to do her best for Pita, and talks to staff about some of her parenting challenges.

Conclusion

Resources for learning support, child welfare, and for ECE settings with highly disadvantaged tamariki are too little (and come late). The children and ECE setting described here are representative of many other ECE settings and young tamariki. There are tamariki attending ECE settings from families who experience significant deprivation, with multiple forms of childhood adversity which we know negatively impacts their ability to thrive and which will lead to poor health, education and social outcomes. Problems for public ECE providers (and the children who attend them) that are exemplified in these case studies include:

1. learning support is poorly resourced with large delays in responding to referrals
2. social and welfare requirements of children and whole-of-family care are poorly coordinated and under-resourced
3. ratios of qualified teachers to children are too low for children with multiple compounding forms of disadvantage, and
4. children with behavioural challenges, limited English and diverse and varied cultural expectations require additional resourcing with better staff to child ratios.

This short paper and case study illustrates that the larger system for ECE fails to meet the needs of the most disadvantaged children, is under-resourced, and needs better coordination across service providers and sectors. These problems are complex and need dialogue, intersectoral coordination, collaboration, and resourcing.

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