Investing in Futures: A Critical View of Options for Early Intervention and Prevention in Indigenous Communities.

Abstract
Current thinking about intervention increasingly accepts the premise that early childhood experience crucially determines health and wellbeing and the attainment of competences at later ages, and that investment in the early years will be reflected in improved education, employment, and even national productivity. While this logic in itself appears unassailable, and is for many outcomes backed by strong research evidence, decisions about just what deserves public investment are complex. For indigenous societies, sources of early risk are situated in family contexts whose potentials for resilience are often not well understood and where languages for intervention have not been created.

This paper outlines aspects of an early intervention project in progress on the Tiwi Islands to highlight themes in indigenous parenting and to examine the prospects for developing culturally competent interventions which can help alleviate some sources of early childhood risk. It illustrates the families and the problems they face and considers how intervention can be approached through engagement of community members within strategies for development of new services.

The paper will examine three main themes:
- General propositions concerning the need for investment in early intervention research
- Outline of an intervention currently under way on the Tiwi Islands
- Aspects of Tiwi family life.

In the health and welfare sectors there has been a cumulative shift to acknowledge the early childhood determinants of health and psycho-social wellbeing. This is leading to an increasing concern to direct resources to childhood, families and youth, including interventions to reduce risk, enhance early development and child wellbeing and to support families. Following examples like the Ontario Early Years study (McCain and Mustard 1999) – and with increasingly prominent advocacy nationwide -
there is a policy shift in Australia which now seeks to redirect and expand public investment in childhood beyond traditional education and welfare to coordinated, comprehensive and evidence-backed strategies.

The idea of early intervention as investment (like notions of investment in human and social capital), necessarily represents a utilitarian view, according to which intervention should be guided by the cost of achieving measurable population outcomes. These include reduction of the costs to the nation through failing education and employment outcomes, reduction of the direct costs of treatment, policing and ameliorative welfare (Hertzman 2002). The notion of public investment demands that questions of the cost-effectiveness of intervention at the population level, relative to current practice, be answered. The response to individual need, the improvement of the life chances of individuals and their families, is inevitably seen in terms of the greater good, aggregate gain within populations. In practice, this can produce a narrowing of the scope of possibilities for research, a skewing in favour of products amenable to implementation without disturbing current practices of delivery, and a reluctance to support research and development in depth. Where such products fail – as in most remote and many urban indigenous settings – the answer is seen to be in community development, in “community participation” without rhyme or reason, as though both solution and problem were bound up together in ways which do not need explanation.

In terms of the desired policy shift, the Northern Territory faces a number of distinct problems. The Learning Lessons report has highlighted the apparent degree of “failure” produced by the educational system. Similarly, the apparent “failure” of health care systems to reduce the burdens of indigenous ill health, violence and premature mortality has guided attempts to increase spending and improve access to health services, including a willingness to fund early intervention and prevention.

The NT is seriously under-spending in child and family services. In 2000-2001, it spent 25% of the Commonwealth Grants Commission’s recommended standardized expenditure assessment, the lowest in Australia, and appears over the last 6-7 seven years to have both absolutely and relatively declined in this area of expenditure. Despite some efforts to shift the focus, health and welfare services alike remain overwhelmingly oriented to “acute”, curative and remedial care, and, in child welfare, to statutory child protection functions (NTCOSS 2003). Early intervention and
prevention in the area of child developmental wellbeing – while perhaps now somewhat better supported in policy – are seriously under-resourced.

Assuming there is money to spend, in what should the state invest, and how should it be managed? Managing growth in services expenditure is a vexing question, highlighted by the difficulties evident with the Coordinated Care Trials and the “roll-out” of Health Zones. There are two issues here: what kinds of programs and what kinds of capacities are needed? How can they be managed and sustained over time?

Firstly, most family-focused interventions developed for indigenous peoples, particularly in remote areas are either more or less loosely structured programs of talk and activity largely untheorized in terms of therapeutic rationale; or reactive, individualized crisis interventions – e.g. child protection casework or, sometimes, mental health counseling – on the other. Lacking are programs with both firm professional input and culturally well-grounded methods and practices, each component with a basis in theory. The objective must be to achieve greater intensity of effort both in the application of professional expertise, and in development of the cultural salience of interventions and services, commensurate with the social and cultural diversity of the NT. This does not simply apply to remote areas, but also to the NT’s urban populations which today are both socio-economically and culturally differentiated and complex. In respect of some areas of need, they may be as under-serviced as remote areas.

Secondly, evaluations of the CCT found that even well funded regional health care systems needed access to research and evaluation capacity, to assist them to maintain the structure and direction of clinical programs.

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1 This no doubt reflects a complex historical legacy. Not simply of under-spending in welfare as opposed to economic pump-priming, nor simply of shifts in policy in Aboriginal affairs, and the tacit abandonment of post-welfarist assumptions about the self-reproducing nature of Aboriginal societies; but also of real transitions in the nature of social relationships and arrangements, the cumulative growth of demand for investment in services and interventions in remote and regional NT, and growing problems encountered by societies increasingly interacting with the mainstream economy and education systems etc. Suffice it to point to the diseconomies of scale and remoteness and general underdevelopment of the service sector, compared with increasingly visible need. The real effects of social change within Aboriginal societies are autonomous drivers of need. However, demand for intervention will also continue to grow as formerly separate indigenous social systems are more pervasively counted as part of the output of state activity.

2 Investment is now focused at the regional level – so that the notion of community control shifts towards the idea of regional management and control - because of the inability of centralized departments to build and deliver a denser layer of services at the level of the individual community. “Region” brings the strategic population focus on aggregate outcomes into closer alignment with social groupings with commonalities of experience, culture and with commonalities in the social determinants of ill health.
(Robinson 2002). The problem is equally, if not more acute for family- or child-focused psycho-social interventions. More intensive family and parenting interventions with professional input and theoretically grounded methodologies demand the managerial capacity to recruit at the appropriate level and to maintain program structure with consistency over time. Research and development partnerships are needed to sponsor the development work both to anchor interventions in the cultures and practices of remote indigenous contexts, and to establish the basic frameworks for the management of structured programs.

At present in social welfare, significant amounts of Commonwealth funds are spent on community programs of limited duration, with indifferent or unmeasured outcomes, and with little prospect of real impact on the adequacy of services in the communities, and limited ability to achieve the professional competence and the cultural competence which should inform their delivery. New service models can not be inserted on this basis, nor, more importantly, sustained, if their effectiveness is not demonstrated or explained, or if they are not developed in conjunction with a reorientation of existing state- or territory-managed service provision arrangements (esp. education, primary health care, policing). This problem is of key concern for intervention research and program evaluation, with the added complication that the research effort is often a key element of the intervention whose outcomes are to be evaluated or trailed. Research and evaluation provides organization, direction and structure (and usually a standard of professional recruitment) which the health or educational services themselves will not automatically be able to replace to ensure a sustainable program (cf Robinson, et al, 2003). This is all the more true if service providers can not replace the funding of the research component.

What kinds of research are needed? Epidemiological, population-level analysis of risk, morbidity, underachievement etc. has mapped a certain terrain and provided evidence or supported inference about the potential population benefits of early intervention to improve child developmental health. Risk analysis has been well criticized over the years in public health, and is now increasingly criticized in education, welfare and community services: it demarcates the “mainstream” from the rest (Connell 1994; Wyn 3

3 The CCTs aimed to develop improved systems to treat and prevent chronic disease at the regional/population level. It is now clear that increased spending on generalized capacity needs to be accompanied by well-targeted research to establish evidence for the effectiveness of community-based clinical programs and to establish the capacity to monitor and sustain them (Robinson, et al, 2001).
the resilient from the vulnerable, the self-reliant from the passive and needy and as a result, condemns all the latter to be recipients of interventions and messages premised on their insufficient, deficient or deviant agency. Attempts to counteract the focus on negative risk with an epidemiology of resilience, “what works”, do not overcome the basic limitations of experience-distant research. They respond to what is there as a result of measurement, reconstruct outcomes, but can not serve to initiate or sustain models for intervention.

Intervention research must work at the level of explanation grounded in experience and resonate with the meanings of action among subjects, that is, children and families, their social and cultural values and their diverse contexts of life. This especially includes ideas and motivations underpinning the tricky areas of responsibility for dependents. What is needed perhaps is a stronger partnership between contextualized intervention level research, the development of service delivery, and the careful study of outcomes in groups and populations. In other words: the study of outcomes in populations and social groups needs to be informed by and to inform explanation of causal pathways at the level of action and meaning. However, even that is perhaps not the point. The level of theory and observation needed to support intervention research is that of therapeutic process and outcome, beginning with individuals and small groups and based on understanding of family and group processes, in the context of culturally shaped patterns of interaction.

**The Intervention:**

The Tiwi project is called Ngaripirliga’ajirri and was based on Exploring Together, an intervention developed by the Victorian Parenting Association. It is an initiative of the Tiwi Health Board and is one of a number of innovative outcomes of the Tiwi Coordinated Care Trial. The program was initially funded as one of a number of suicide prevention initiatives, and has

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4 At a general level, what is perhaps missing is a more effective partnership between epidemiological research and explanatory research underpinning interventions rather than the displacement of the latter by the former. However, such partnerships aside, intervention research should not wait until epidemiology can sanction the appropriateness of its concerns. The investment of effort in terms of the future outcomes of action is an act requiring a different order of imagination, drawing on different sources of conviction, other than notions of risk and deficit. It draws on the communicative competences of the researcher and expects that the meanings of communication are not indifferent to causality in relation to identified problems. In other words epidemiology is not about action or meaning, nor therefore about the process of therapeutic intervention. Epidemiology has a retrospective importance.
evolved into a research and development partnership between THB, NTU, and the chief sponsors, NT DHCS, Beyondblue inc., the Commonwealth Dept of Health and Ageing, and CRCAH which sponsored the first stages of research.

**Program process.**

There are four components to the overall research project:

1. the redevelopment of program and content for Tiwi circumstances, including development of groupwork practices for parents’, children’s and combined groups
2. testing and validation of referral, assessment and evaluation methods & instruments
3. measurement and interpretation of treatment outcomes
4. development of an appropriate service model which is sustainable in Tiwi setting and comparable contexts.

![Program process](image)

Participation: from 94 referrals, 59 families have participated in program to term 2 this year. Qualitative reports have indicated that over 80% of children
show a decline of problem behaviours and/or some other improvement both according to teachers and parents. Feedback from parents about the program is positive – with a steady trend towards families referring their own children - but at interview tends to be a little more ambiguous about specific behaviour outcomes than teachers’ reports of change. Even so over 50% of program participants indicate clearcut improvement in observed behaviour, substantially sustained at 6 months. A small number of children for whom some or no improvement was noted by parents during the program itself have been reported to have shown improvement at six month follow-up.

Preliminary findings based on psychometric instruments developed for the program suggest that there may be reductions in both aggressive-oppositional behaviour and withdrawn behaviour among boys, with reductions in attention deficit among girls. However, the development of the capacity to measure outcomes is itself a major ongoing project.

**Ngaripirliga’ajirri: talking with parents and children**

*Ngaripirliga’ajirri* involves selection of a group of around eight 7-12 year old children with behavioural problems, broadly defined, from a list of children referred to the program by teachers. Consenting parents and children participate in the program over ten weeks, attending separate groups for one hour, followed by a combined parent-child group for a second hour during school time. Each of the two groups is led by a minimum of two facilitators, one Tiwi and one non-Tiwi.

Although most referrals are made by teachers, some parents now seek to enrol children. Children come willingly, enthusiastically, even when it means they miss out on school excursions or other desirable activity; only one child has refused to participate in the program once started. Parental attendance is more uncertain, with the result that, on average, of seven or eight families who at first agree to participate in a term, around five or six complete the program (attend 75% or more of sessions). Even for those parents, persistence on the part of program workers is needed to secure attendance each session.

*Ngaripirliga’ajirri* is based on the assumption that the chief points of intervention in the Tiwi context are in the combination of group work and parent-child interaction. It aims to assist parents by eliciting conversation about individual children, facilitating communication with the children, and encouraging development of insight about parenting and family issues.
through work in groups. As the group work proceeds, the focus is on eliciting a picture of the family group, and how it works and how some processes may be affecting the child. Discussion of parenting draws contrasts between passive, avoidant strategies as well as aggressive responses to child behaviour, and positive, assertive strategies in the interests of outcomes for the child. The parallel groups of parents and children enable exploratory work with each, while the combined group focuses on dyadic interaction between parent and child in the presence of other adults.

The majority of children identified for the program experience multiple sources of difficulty to some degree, including current family violence, overt abuse of alcohol and other substances. They often witness suicide, conflict between parents, sibling conflict, recent deaths including suicides in close family, separations and fostering, and situations in which the child lives apart from parents with tenuous commitment from any resident caregiver. The pervasiveness of these problems provides an extra barrier to participation for many parents uneasy with disclosure of issues concerning say, their drinking or marijuana use, conflict with spouse or prospective spouses or other matters.

For the children, parental attendance (or attendance of an adoptive or other care-giver) is important. The program offers the chance for one-to-one contact in a group with a parent, without competition from other family members, or indeed without competition from the parent’s other adult preoccupations. Those children whose parents do not attend are returned to class, while the others join the parents’ group for an additional hour. This element of the program structure risks confirming some children’s fears about their worthiness of parental response. It is something the team pays attention to, and despite making adjustments from case to case, can not entirely avert as a risk.

A given child’s behaviour may reflect:

a) present tensions, patterns in family relationships which may be related to the child’s location in these relationships; these can be referred to as transitions in relationships related to deaths, parental separations, fostering or age-related transitions, or as family system issues, in which particular relationships have the effect of causing stress on the child
b) specific sources of explicit or severe trauma; for example, marital violence, deaths of parents or family members by suicide or homicide; chronic substance misuse
c) longer term, withdrawn or externalising behaviours, sometimes antisocial behaviours, reflecting possible disorders of varying origins; these interact with current family transitions and family processes, but are not explained by them.

The model is currently best able to recognize and talk with parents about the issues in a), which can usually be elicited for discussion. For b), families may have clear needs for professional assistance: for example, where child is coping with the suicide of a parent (four cases to date); serious relationship tensions, violence and suicide threats involving parents or other family members (12 cases). This assistance is possible to some extent within the existing model. However, there are grounds for a variation of the basic model to allow for more focused work – marital or family counselling - with these parents and children. It should be noted that even in a high stress family environment in which suicide, violence or other acute trauma has affected members, these always occur in the context of family processes and transitions which shape individual and collective responses and which need to be understood, as in a).

For c), there is need for further understanding of developmental processes in the Tiwi context, with some attention to developing the team’s assessment skills, its ability to read the developmental antecedents of children’s presenting behaviour. There may be need for variations on the treatment model for some children. This extends to some children who have been the subject of persistent marginalisation or neglect, have virtually no parent or adult willing to exert control or responsibility and who are therefore not likely to draw gain from the program in its present form.

Parents, Active and Passive
Tiwi parenting commonly involves delegation of responsibilities for children from early in childhood within groups or networks of people who express relationship to parents through action towards their children. This produces some significant differences from the assumptions underlying parenting interventions like Exploring Together. In the Tiwi situation, the authority of the parent may be no more emphasized than that of many others in the family network, even if they are the chief resource providers and nurterers.
One often sees parents defer to interventions by others concerning their child (teasing, taking the child somewhere), even in contravention of the parent’s wishes.

Over 25% of children referred to the program reside with persons apart from their biological parent or parents, and many of these are more or less formally fostered to a grandmother, a mother’s sister or paternal aunt. These arrangements may be permanent or last for a number of years, before a child reverts to co-residence with a birth parent. In another 10-15% of cases seen, children may live in a common household with a parent, but have been made the permanent responsibility of another household member (usually a mother’s mother or parent’s sister). However, actual fostering out of a child is just one in a range of potentials which involve parents handing over or sharing some degree of responsibility for their children within a social network of related persons. A number of parents could be regarded as “single mothers”, who live with their children together with other kin, including brothers, sisters or parents. Almost all children in the program live in households which include kin other than their parents, including foster-children as well as actual siblings, as well as aunts and uncles and grandparents.

A regularly occurring reality is that, while parents can draw on the support of others in the family network as an important resource, these others also often constitute an often powerful limitation on parent’s readiness and ability to act in recognition of the needs of individual children. The pressure of many layers of demand acting within a large household, along with the alliances, separations and informal adoptions which shape a child’s place in it, can amount to substantial social and emotional distance between parents and children. In some cases isolation or emotional deprivation experienced by a certain child may not be obvious because of the ready availability of kin and children in the household and beyond.

Within Tiwi families, it is not possible to work with the assumption that child discipline is the sole preserve of parents. While parents tacitly initiate many acts of “discipline”, this is always exercised in a matrix of relationships within which the parent is dependent on many others. “Discipline” may be an indirect consequence of parental behaviour, but is
very often enacted by others. Some of the discipline makes the parents uncomfortable: the program encounters some parents who are not happy with the treatment of their children by kin (e.g. a mother’s brother), but who, when this is raised in discussion, may feel helpless to change anything or challenge others.

A Tiwi child is generally seen as having a high degree of responsibility for his own response to actions of the parents and others, and this may include decisions about where and with whom to live. Many parents see child relocation solely as an expression of the child’s wishes. However, facilitators and others may well see this as something initiated directly or indirectly by parental behaviour or caused by some other issues in family relationships. Kids may be left, or indeed sometimes may be pushed to take decisions upon themselves.

Some parents seen may appear ready to withdraw or give up, perhaps out of a sense of not having control of the family situation, or because active assertion of responsibility over the child’s situation is not compatible with their own relationship choices. A frequently encountered source of tension revolves around parents renegotiating marriages and partnerships following death or separation. These kids may be left floating. Such parents are a flight risk in the program.

It is sometimes the case that parenting in the narrow sense is less an issue than is the functionality of an entire group, in which lines of authority, protection and care with respect to children are weak, inconsistent or disrupted. In this context, a style of parenting is frequently observed which can be referred to as passive-avoidant parenting and which we contrast with assertive forms of parenting in the Tiwi context.

What does a parent do in response to a child’s distress, demands or disruptiveness? Two options are parental withdrawal and dyadic intensification: in other words, an intensified direct response to the child’s demands or behaviours, is contrasted with avoidance of them or passive non-response. Aggressive parental responses may occur on both sides, in active

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5 A grandmother whose grandson was referred to the program was head of a household with ten of her grandchildren, and some of her sister’s children as well as her own sons. She wanted a seventeen year-old son to act as the parent for the grandchild. The team resisted this and she herself attended. However, later in the program, it turned out that the teenager was the chief disciplinarian of the household, managed most of its resources, kept the food locked in his bedroom and was the authority over the many grandchildren, his nephews.
and passive modes. Desirable parental assertiveness is distinguished from aggressive or hostile responses to the child, and may consist of elements of both intensification and withdrawal/delegation. Delegation of responsibility for a child to others might be active and authoritative, or passive and based on retreat from a child’s demands.

Parental assertiveness may involve action to support a child in response to the child’s needs, distress or discomfort, taken by the parent against distractions, impingements and difficulties arising in or around the household group. Correspondingly, avoidant parenting often means letting the child cope, that is, react to his or her own distress and find solutions more or less without parental assistance. Many parents will not intervene against pressures on a child, unless the child has been physically hurt by an older person or even unless blood is evident. More importantly, (coping with aggression, teasing and threats is after all something expected of all Tiwi to some degree), tensions or conflicts may displace a child almost entirely, so that the child shifts, leaves his or her parents, lives elsewhere, without parental intervention (albeit often after some testing of alternatives by the child, for example periods spent with grandparents, aunts, etc.). The child is in this case usually also reacting to the failure of the parent to respond, to some hostility or criticism, or some degree of collusion by the parent in the reasons for the shift.

Patterns of parenting have complex origins in Tiwi culture and the Tiwi family system which can not be further explored here. Two examples will be given which contrast parental passivity and assertiveness, and will allow a brief outline of important foci of the program.

**Mack:**
A boy named Mack lived with his father and stepmother, his birth mother having left them over a year before. Mack and his father attended the program together, with the stepmother attending for the first two weeks, although with seeming reluctance. Mack’s father seemed more difficult to find on program days, and when he did attend, Mack and he sat at opposite ends of the room, Mack sometimes preferring to sit with one of the Ngari-P team members, D., whom his father called a “brother” and who was married to Mack’s mother’s eldest sister. Mack in fact spent a lot of time at D’s house, playing with D’s sons, whom he called his “brothers”.
Mack’s mother was number 3 in the group of his “mothers”. Their mother was with a new partner who was, if not hostile to Mack and his brothers, then at least not welcoming. Mack’s father stopped attending the program altogether. Mack aligned himself closely with D, and before the end of the program, he and his two brothers moved into D’s home to live with their “brothers”. Mack’s father withdrew, avoided confrontation with his son, and tacitly encouraged him to make this shift – in effect aligning himself with his new spouse over the wishes of the boy.

After break-up of Mack’s parents, departure of the mother and re-marriage of the father, does the father strengthen his efforts to respond to his young son, or does he passively ‘let go’, ignore the son’s behaviour and thus allow the son to move away to all but live with the boy’s mother’s sister and her children? What should the program’s response be to choices being made in this manner? Was the shift to D’s house indeed the best option, to allow both of Mack’s parents to renegotiate life with their new partners and eventually allow their children to seek out contact when things have “settled down”? Mack’s behaviour at school improved considerably during the program.
However, it deteriorated occasionally after the program ended, although he was still living at D’s place. He now had occasional access to his mother for visits, and his father would sometimes visit to see him and take him out for a trip; however, the effects of these major shifts were still a source of unhappiness.

Ngaripirliiga-ajirri often faces parents who appear ready to withdraw or give up, perhaps out of a sense of not having control over circumstances of their relationship with their child, or because active assertion of responsibility over the child’s situation might not be perceived as sustainable given their own relationship choices.

The outcomes of Mack’s transition appeared uncertain, in part because his father seemed to use the opportunity of the program to withdraw further from his son. In other cases parents have responded actively to problems expressed by their child during the course of the program, drawing closer to rather than distancing from their child.

**Russ:**
A parent who does not live with the child may remain the person most interested in his or her welfare and – from the standpoint of issues affecting the child and the child’s medium term prospects for adjustment - may prove to be the most important person to attend. On the other hand, if a child’s position among adoptive kin appears settled, and is at the same time related to underlying causes of referred behaviour, an adoptive parent or uncle/aunt from the current household is undoubtedly the most appropriate choice.

At referral, a child was living with a grandparent, and the mother expressed the intention that this remain permanent. However, on further discussion, it became clear that the mother was the person most interested in understanding the child and, after discussion, she decided to participate, “to see what makes him like that”. During the course of the program, the two quite openly began to criticize each other. The mother then actively asserted herself by moving into the grandparent’s house where the boy had been living. She took charge, had her younger brother and his spouse move out, allowed her eldest son to move out with them and made the decision to keep the referred child with her. Teachers spontaneously reported that the child’s behaviour at school improved dramatically during this period.

It is clear that attendance of the grandparent in the program rather than the boy’s mother could not have had the effect described, but would have
prolonged a problematic and possibly unworkable arrangement. In other words, it is of great importance that issues underpinning adult attendance be discerned as far as possible at group selection. These issues often go to the heart of transitions in family arrangements to which children are subject and which may be a significant component of a child’s difficulty and hence symptomatic behaviour.

It appears that selection for participation in the program constitutes a relatively powerful source of acknowledgement which is reinforced in the group work. It appears to be able to insulate the children from strains in their environment and even to facilitate their attempts to negotiate transitions which involve alternatives to parents as sources of care and support, as in the case of Mack and other boys like him. That is, the program may not only assist parents and children, but also support children by themselves to achieve positive self-reliance with reduced antisocial tendencies.

The question must be asked, however, whether this beneficial effect of participation is sustainable. Two “strong boys” (so called by the Principal of their school), had improved greatly after participation in the program, even though their parents had failed to attend. In the following months, they were certainly reported by teachers to have at least partially slipped back to their old ways. Mack too appeared to return to being somewhat angry and grumbling and occasionally disruptive at school (although reportedly not as bad as at referral) as his relations with his separated natural parents did not improve. Nevertheless, the principal of MCS has recently and emphatically stated, “All the boys who have been in the program are no trouble any more”. The sustainability of effects of the program is a complex matter, and, like the resilience of children generally, not reducible to a single factor, such as parental participation or support, important though this may be for most children.

From the two cases briefly outlined, it appears possible to work effectively with children who are doing things on their own, coping with difficulty in maintaining consistent parental or family support. It is also possible to work with parents and children together, to facilitate improved communication between them, and support adjustments in the family situation.
**Intervention or Service?**

_Ngaripirliga’ajirri_ leaves many questions yet to be resolved. The political, organizational and professional pressure towards intervention need to be both supported and constrained by evidence. It is necessary to question the value of even seemingly successful interventions. Positive reported outcomes and support from organizations and members of the community may mean that such a program generates conviction in the interaction between the team and participants in a particular community which is, if not more important than specific treatment effects, then a precondition for effectiveness of specific components of the program. That is, effects of treatment may not be independent of that interaction, and may not be sustainable over time without it. This is not necessarily a criticism of the program, but points to the need to couch such interventions in effective communication and engagement with community members, their values and concerns. It certainly does not preclude a contribution to cumulative outcomes in addition to specific treatment outcomes.

As a final comment on the possibility of measurement of aggregate gains: population gains do not automatically flow from individual gains. Even where treatment benefits are sustained for individuals and their families, processes may occur over time in communities which negate gains at the population level. The cumulative benefit of early intervention in the context of general community activity and longer terms trends may therefore be difficult to assess. However, the demonstration of the ability to contribute to substantial gains for groups of individuals through intervention of itself demonstrates the need to confront the challenge of incorporating its practices on a sustainable basis in the delivery of community services. A new program of research and development based on an integration of the program in school support and health services is currently being developed.

**References**
