

Breaking Cycles, Building Futures

Promoting inclusion of vulnerable families in antenatal and universal early childhood services

A report on the first three stages of the project

Best Start
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Brotherhood
of St Laurence
Working for an Australia free of poverty



Premier's Drug
Prevention Council

Breaking Cycles, Building Futures

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Acknowledgments

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Contents

Executive summary	v
Introduction	1
Literature review method	3
What is an inclusive service?	5
How inclusive are existing services?	7
What are the barriers to inclusion?	13
How can services be more inclusive?	21
Potential inclusion strategies	23
The community consultation	33
A framework for inclusion	71
Guiding principles	73
Ideas for action	77
Summary and conclusion	89
Next steps	95
Appendix 1: The services	97
Appendix 2: Individuals and agencies consulted	99
Appendix 3: Sample interview schedules	103
References	109

Executive summary

The Breaking Cycles, Building Futures project is an initiative of the Victorian State Government and is funded by the Premier's Drug Prevention Council. It is part of the State Government's Best Start Strategy. The project's key aim is to identify, implement and evaluate strategies to promote more inclusive antenatal and universal early childhood services, which better engage and assist vulnerable families.

The Brotherhood of St Laurence was contracted by the Department of Human Services to undertake this project. In its mission of working for an Australia free of poverty, the Brotherhood of St Laurence acknowledges the importance of efforts to better support vulnerable children and their parents, not only as an important immediate measure, but also as a strategy to prevent poverty and social exclusion in the future.

The Breaking Cycles, Building Futures project is being undertaken in four stages:

- a literature review
- consultation with parents, service providers and peak bodies
- documenting possible strategies which Best Start partnerships can adopt to help them to provide more inclusive services
- working with Best Start partnerships to implement and evaluate these strategies.

This document reports on the results of the first three stages and outlines the process for addressing the final stage.

The study started from the assumption that antenatal and universal early childhood services (Maternal and Child Health services, kindergartens and primary schools) are an important resource for promoting the wellbeing of our children and their families. As such, it is imperative these services are available to all. The study focused on answering four key questions:

- What is an inclusive service?
- How inclusive are existing antenatal and universal early childhood services?
- What are the barriers to inclusion?
- How can these services be more inclusive so that they better engage vulnerable families?

Answers to these questions were sought through a review of the national and international literature, along with an extensive community consultation process. In all, 69 parents, more than 100 service providers and more than 20 Victorian Government staff were interviewed. The vast majority of parents interviewed were experiencing a range of (often concurrent) difficulties in their lives, such as low income, unemployment, homelessness, problematic substance use, mental illness or a disability. Many were young parents (less than 20 years of age) and several were from a non-English speaking background.

To the best of our knowledge, this is the first study to provide a systematic review of these issues as they relate to the Victorian context.

What is an inclusive service?

Inclusive services are easy to reach and use and work to assist all-comers. They acknowledge people's shared humanity, celebrate diversity and promote acceptance, belonging and participation. Inclusive services also recognise people's different needs and the inequalities in people's level of power and their control over resources, and attempt to counteract these inequalities. In their ideal form, therefore, inclusive services not only ensure they engage all people within their programs, but act as agents for social change, working to overcome deprivation and disadvantage (at times through positive discrimination strategies) to promote social inclusion.

How inclusive are existing services?

Given the complex and multidimensional nature of the concept, it is difficult to provide a simple measure of 'how inclusive' existing antenatal and universal early childhood services are. Presuming that inclusive services are likely to be well used, patterns of service use offer some (rough) indication. Unfortunately, identifying current patterns of service use is not an easy task because of the lack of detail and uniformity in registration information (service user characterisers) and the limited data collection about ongoing attendance in some services. Despite these limitations, the available data suggest the majority of children and parents make good use of existing services. However, it is also clear service use varies along a continuum from very high to very low. Importantly, there appears to be a small but significant minority of families that underuse some or all of these services. Given the optional nature of these services, it is understandable that not everyone will choose to use them. While some degree of 'underuse' would therefore be expected across the population, the actual pattern is not uniform. In particular:

- certain (disadvantaged) neighbourhoods have very high rates of underuse
- certain families have very high rates of underuse.

Groups underrepresented among service users include families with low incomes, young parent families, sole parent families, Indigenous families, families from certain culturally and linguistically diverse communities, families experiencing unstable housing or homelessness, families experiencing domestic violence, families with a parent who has a disability, problematic substance use or mental health problem, and families who have been in contact with child protection services.

In most cases, it appears 'retention' rather than initial 'access' is the key issue, particularly within Maternal and Child Health services, kindergarten and primary schools. Most parents make contact with services, but some might then cease attendance, attend infrequently, or not become fully involved in the services' activities. Multiple 'potential' opportunities for engagement with children and their parents therefore exist, although unfortunately these are not always maximised.

What are the barriers to inclusion?

The observed variations in inclusion appear to reflect the impact of multiple, interacting barriers. These can be broadly grouped into service level (structural) barriers and barriers specific to children, their parents and their situation:

- Service level (structural) barriers can include lack of publicity about services, cost of services, limited availability (for example child care places), inaccessible locations, lack of public transport, limited hours of operation, inflexible appointment systems, limited access to specialist supports for children with additional needs, poor coordination between services, lack of attention to multiculturalism, and insensitive or judgmental attitudes and behaviours of staff or of other parents.
- Barriers specific to children, parents and their situation can include limited income, lack of social support, lack of private transport, unstable housing or homelessness, low literacy levels, large family size, personal preferences and individual beliefs about the necessity and value of services, lack of trust in services, fear of child protection services, physical or mental health issues or disability and day-to-day stress.

While a few barriers appear to be particularly relevant to one service type or to certain groups within the community, the majority are common across the population and across services. The most important finding is that many vulnerable families experience several concurrent barriers which impact on inclusion. Vulnerable parents might be simultaneously struggling with low incomes, inadequate or insecure housing, health or mental health problems, problematic substance use, or domestic violence. A large number have very limited social supports. Some might lack the knowledge or language to navigate the service system or the confidence and self-esteem to interact with service staff or other parents. Many vulnerable parents 'feel' different or self-conscious as a consequence of the prejudice, discrimination and rejection they encounter or of their own internalised negative self-worth. Distrust of services, or even of other parents, can be very high. Perhaps one of the greatest barriers is parents' fear they will be judged by others as 'bad' parents, or worse still, have their children taken from them by Child Protection.

Vulnerable parents have to overcome numerous obstacles and balance competing needs. It is likely that at times, 'survival' needs take priority over attendance at a service (particularly services which lack an immediate, tangible benefit) or barriers collectively become overwhelming. Without appropriate advocacy and practical support, some parents will remain unaware of services or unable to use services to their benefit.

How can services be more inclusive?

Unfortunately, there is very limited good quality empirical evidence about strategies that could be effective in Victoria in promoting more inclusive antenatal and universal early childhood services. However, there is a significant amount of ‘practice wisdom’ regarding ‘what works’.

Drawing on the limited empirical evidence and this ‘practice wisdom’ inclusive services need to:

- be affordable and well publicised
- be geographically accessible
- provide outreach and support with transport
- provide a family-friendly and culturally inclusive physical environment
- employ skilled and responsive staff working from a family-centred, culturally sensitive perspective
- promote social connectedness through informal supports
- establish strong reciprocal links with other relevant services (universal and specialist).

Among the most critical factors is workers’ ability to:

- establish a positive, non-judgmental relationship with all children and parents
- proactively engage and sensitively follow-up vulnerable children and parents who are at risk of ‘dropping out’.

It is often the little personal touches that count the most. Parents want empathetic, empowering help and are wary of criticism, interference or surveillance. They also want prompt, practical and relevant information, supports and services, preferably from the one person or the one location. Truly inclusive services are flexible and have the capacity to match assistance to each child or family’s needs and offer choice to their clientele. A ‘one-size-fits-all’ approach is not always useful. *Universal* services do not need to be *uniform* services.

Further, given the importance of social connections and the distrust some parents have of professionals, services should preferably include a blend of ‘professional’ and ‘informal’ assistance, involving volunteers, peer providers and parent groups (general and population-specific). Parents typically welcome the opportunity to meet with other parents, particularly those in similar circumstances. The physical environment of the service can also play a role in facilitating or inhibiting these connections.

Regular training, consultation support and supervision for workers in culturally sensitive and inclusive practice are essential. Improved links across universal services and between them and specialist child and adult services, whether through co-location, service integration, regular network meetings, case conferencing or reciprocal ‘in-reach’, are also required. While difficult to achieve, it is important every service is encouraged to regard itself as part of a larger system supporting children and their parents.

Considering the breadth of barriers, promoting more inclusive antenatal and universal early childhood services will inevitably require the introduction of multiple, simultaneous strategies within each service. Strategies which focus on removing only one potential barrier in isolation are unlikely to be sufficient. Inclusion could be thought of as an overarching ‘value’ adopted by a service, supported through a range of policies and practical initiatives which are subject to regular review and continuous quality improvement.

Since it is highly unlikely a service will have *no* vulnerable children and parents among its potential clients, every service needs to establish these policies and practices. As one person put it, services need to ‘act as if’ they already have particular vulnerable groups in the service. This will enable them to prepare the service to attract families, rather than waiting to change once they arrive.

In summary, to be more inclusive, services will need to implement strategies which:

- minimise the ‘practical’ (structural) access barriers and support parents to overcome their knowledge, financial, transport and time difficulties to maintain attendance
- build positive and affirming relationships with parents, which counteract distrust and stigma, and assist parents to connect with others
- ensure their programs are culturally sensitive and provide a perceived ‘value for effort’, both short term and long term, for the child and their parents
- establish strong reciprocal links with other services, particularly those targeted to vulnerable families.

Next steps

At the conclusion of the literature review and consultation phase (stages one and two of the project) there was a definite sense that more needs to be done and that the needs of vulnerable children and their parents are still not being adequately met. The next challenges for this project were clearly to more rigorously define and document what is possible and what works and to implement effective and sustainable initiatives. This challenge is being taken up by implementing specific inclusion projects at three Best Start sites—Shepparton, Whittlesea and Maribyrnong. These projects, which are now in progress, are based on the findings of the review stages of this project and build on the identified local needs and local community preferences. A report on the implementation and evaluation of the inclusion projects at the three Best Start sites will be published in 2005.

Note: There were limits to the number of service providers the researchers were able to interview during the consultation phase and there is a diversity of service types covered in this report and a lack of agreed indicators relating to inclusion. As such, this report does not provide ‘case studies’ of best practice, but rather focuses on the elements that bring about good practice.

The views expressed in this document are those of the Brotherhood of St Laurence, based on the findings of the literature review and the community consultation. The intended audience for this report is departmental staff within the Department of Human Services and the Department of Education and Training and members of the Best Start partnerships.

Introduction

... what happens during the first months and years of life absolutely does matter; not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or a fragile base for what follows. (Shonkoff & Phillips 2000, cited in Ochiltree & Moore 2001, p.12)

Early childhood is a crucial period in human development, during which the foundations for future wellbeing are established. Each child's development is a dynamic process shaped by a wide range of factors including their own characteristics, the quality of the child-caregiver relationships, as well as the nature of the broader social environment in which they are raised (Ochiltree & Moore 2001). Negative environmental influences, such as poverty, family discord, abuse or neglect, during the early years of life can delay or disrupt learning and social and emotional development, often with long term adverse consequences. It is vital that children are protected against such risk factors in these critical early years and instead experience environments which promote their wellbeing.

In recognition of this, increasing attention is being focused on supporting parents and families in the care of their children and on creating the social environments necessary for promoting positive development. Antenatal and early childhood services are a key part of this landscape. A well functioning antenatal and early childhood service system can support healthy development and minimise negative outcomes through active prevention or targeted early intervention strategies.

At present not everyone has equal access to or finds equal value in the use of these services. Often those who could most benefit from these services, to help moderate the effects of the stressful or disadvantaged environments in which they live, have less access to services or experience a service response that is insensitive or fails to meet their needs (Ochiltree 1999). Specific efforts are required to create more accessible, engaging and inclusive early childhood services which address the needs of all children and parents, particularly those who are more vulnerable. This is the key focus of the Breaking Cycles, Building Futures project.

The Breaking Cycles, Building Futures project is an initiative of the Victorian State Government and is funded by the Premier's Drug Prevention Council. It is part of the State Government's Best Start Strategy. The major aim of the Breaking Cycles, Building Futures project is to identify, implement and evaluate strategies to promote more accessible, engaging and inclusive state-funded, antenatal and universal early childhood services (that is, Maternal and Child Health, kindergarten and primary schools) (see Appendix 1).

The Brotherhood of St Laurence was contracted by the Department of Human Services to undertake this project. In its mission of working for an Australia free of poverty, the Brotherhood of St Laurence acknowledges the importance of efforts to better support vulnerable children and their parents, not only as an important immediate measure, but also as a strategy to prevent poverty and social exclusion in the future.

The Breaking Cycles, Building Futures project was undertaken in four stages:

- a literature review
- consultation with parents, service providers and peak bodies
- documenting possible strategies which Best Start partnerships can adopt to help them to provide services which are more inclusive
- working with three Best Start partnerships to implement and evaluate these strategies.

This report presents the findings of the first three stages of the Breaking Cycles, Building Futures project. A report on the implementation and evaluation of the inclusion projects at the three Best Start sites will be published in late 2004.

Note: There were limits to the number of service providers the researchers were able to interview during the consultation phase and there is a diversity of service types covered in this report and a lack of agreed indicators relating to inclusion. As such, this report does not provide 'case studies' of best practice, but rather focuses on the elements that bring about good practice.

The views expressed in this document are those of the Brotherhood of St Laurence, based on the findings of the literature review and the community consultation. The intended audience for this report is departmental staff within the Department of Human Services and the Department of Education and Training and members of the 11 Best Start partnerships.

Literature review method

During the literature review and community consultation stages of the project, the study focused on answering four key questions:

- What is an inclusive service?
- How inclusive are existing antenatal and universal early childhood services?
- What are the barriers to inclusion?
- How can these services be more inclusive?

The literature review particularly focused on examining these issues in relation to the experiences of vulnerable children and parents. Particular attention was paid to the needs of:

- families on low incomes
- sole parent families
- families with young parents (under 20 years of age)
- Indigenous families
- families from culturally and linguistically diverse backgrounds
- families experiencing unstable housing or homelessness
- families with a parent who has a disability, problematic substance use or mental health problem
- families who have had contact with child protection services or the criminal justice system
- families experiencing domestic violence.

A systematic search of the national and international literature was undertaken to address these questions. Given the wide range of services of interest to the project, this required a search of health, allied health, social sciences and education databases.

What is an inclusive service?

In striving to develop more accessible, engaging and inclusive services, some agreement needs to be reached about the meaning of these words.

Unfortunately, there are no single accepted definitions for any of these terms, although there is some general agreement. In addition, the terms are not mutually exclusive and their meanings overlap to some degree.

Perhaps the least contentious term is 'accessible', which typically refers to the ease with which something can be reached and used. From this perspective, an accessible service would be regarded as one that minimises or eliminates 'practical' barriers to its use (for example, cost).

The term 'engaging' is more complex. In contrast to the practical dimensions of service useability encompassed by the word accessible, the term 'engaging' by and large refers to some sort of relational 'bond'; in this case, between the service user and organisation or between the service user and a particular service provider. An engaging service is one with which people 'connect'. This use of the term can be found in education literature, where 'engagement' has been used to refer to a sense of 'belonging' and 'involvement' with school (Fullarton 2002).

Of the three terms, 'inclusive' (or 'inclusion') is perhaps the most contested. Within the early childhood literature the term has mainly been used to refer to the inclusion of children with disabilities into mainstream education (Fuchs & Fuchs 1994, cited in Aldredo 2003). Thus, inclusive services are those which bring children with disabilities together with children without disabilities, in contrast to segregated programs.

Over recent years, a broader meaning has emerged, encompassing other dimensions of diversity, in particular, cultural diversity (Keefe & Davis 1998). From this perspective, an inclusive service is one that responds well to children from diverse cultural backgrounds, as well as to children with diverse abilities. As with 'disability inclusion', 'cultural inclusion' is focused on service reform which emphasises accepting children as they are, rather than changing them to fit the system. An inclusive service is therefore one that promotes tolerance, acceptance of difference and creates a sense of belonging. In many ways this meaning overlaps with that of 'engaging'.

Moving beyond the field of early childhood and into social policy, the term 'inclusion' is used in a different way again, within the notion of 'social inclusion'. Arising out of European social policy discourse, this term and its opposite, 'social exclusion', have their genesis in debates about poverty (Jones & Smyth 1999). Specifically, the concept of social exclusion arose from a concern that debates about poverty had become overly focused on income, and as a consequence, understated the multidimensional nature of deprivation and disadvantage. Social exclusion was seen as a broader term which focused on people's inability to participate fully in the economic, political, social and cultural life of mainstream society (Jones & Smyth 1999).

Bradshaw (2003) distinguishes between four types of social exclusion: exclusion from adequate income or resources, labour market exclusion, service exclusion, and exclusion from social relations (the latter encompassing difficulties, such as social isolation and lack of social support).

In a slightly different vein, the United Kingdom's Social Exclusion Unit defines social exclusion as:

A shorthand term for what can happen when people or areas suffer from a combination of linked problems such as low incomes, unemployment, poor skills, poor housing, high crime environments, bad health and family breakdown. In the past governments have had policies that tried to deal with each of these problems individually, but there has been little success at tackling the complicated links between them, or preventing them from arising in the first place (Social Exclusion Unit 2000, cited in Selwyn 2002, p.4).

The key aspect of this particular definition is the recognition that many people experience multiple, interconnected and concurrent disadvantages that affect their quality life and participation in society. Further, the definition makes clear that it is not just individuals but whole communities or locations which can be impoverished and 'cut off' (Jones & Smyth 1999). Most importantly it suggests social exclusion is preventable.

Clearly, inclusion is a complex and multidimensional concept, defined as much by what it is trying to prevent, as by what it is. At a minimum, it is about acceptance, tolerance and belonging, but in its broadest sense it is also about social participation and distributive justice (Bradshaw 2003). The broader the definition of inclusion, however, the more difficult it might be to consistently achieve.

Based on the above discussion, we suggest an inclusive service is one that promotes a sense of acceptance and belonging, facilitates social participation and works to overcome deprivation and disadvantage. Truly inclusive services accept people as they are and work to assist and involve all-comers. Such services acknowledge people's shared humanity, but also recognise their differences, in particular inequalities in level of power and control over resources, and attempt to counter these inequalities. By their nature, such services would also be 'accessible' and 'engaging'. For the purposes of this project, therefore, we use the word 'inclusive' as an umbrella term that encompasses the terms accessible and engaging.

How inclusive are existing services?

Given the complex and multidimensional nature of the concept, it is difficult to provide a simple measure of 'how inclusive' existing services are. Presuming inclusive services are likely to be well used, patterns of service use offer some (rough) indication. Unfortunately, identifying patterns of service use is not an easy task because of the lack of information collected by most services about service user characteristics and the lack of detailed attendance data from many services.

Antenatal and maternity services

Antenatal and maternity services within Victoria are provided in a wide variety of ways. Services are provided through both public and private hospitals, often in various combinations with private specialists or GP obstetricians and a small number of private midwives. The latter include several 'models', including a large proportion of shared care with general practitioners (Darcy, Brown & Bruinsma 2001).

As a consequence of the diversity of service models and the lack of uniform data collection, it is extremely difficult to obtain a comprehensive picture of antenatal service use. The Victorian report on models of antenatal care, *WUDWAW: who usually delivers whom and where*, (Halliday, Ellis & Stone 1999) provides the best and most recent estimate. The results of this study suggest the uptake of antenatal care in Victoria is reasonably good, with around 80 per cent of women commencing antenatal care in the first trimester. However, around 14 per cent of women first attend between 14 and 20 weeks gestation, about 4 per cent attend for the first time between 21 and 31 weeks, and around 2 per cent attend for the first time after 31 weeks gestation (Halliday, Ellis & Stone 1999). Data about 'consistency' of attendance are also limited, although a recent South Australian study found around 78 per cent of pregnant women had the recommended number of antenatal visits (Ford, Nassar, Sullivan, Chambers & Lancaster 2003).

Even less information is available about the characteristics of women who present late in pregnancy or attend irregularly. United States data suggest significant differences exist in the use of antenatal services depending on socioeconomic status, age and ethnicity. For example, women living in poverty, mothers with little formal education and mothers under 20 years of age are less likely to use antenatal care or more likely to attend only later in their pregnancy. In addition, 'ethnic minority women are three to four times more likely to seek prenatal care late in pregnancy or not at all' (Sanders-Phillips & Davis 1998, p.16). Women who have experienced domestic violence also tend to delay the initiation of antenatal care (Campbell et al. 1992, cited in Cook et al. 1999).

In Australia, research suggests Indigenous mothers are more likely to attend later in their pregnancy (de Costa & Child 1996). For example, New South Wales data from 1997 suggest almost 40 per cent of Indigenous mothers commenced their antenatal care after 20 weeks gestation (Taylor et al. 1998). Ethnicity also appears to have some impact, with the Life Chances Study in Melbourne finding that less than a quarter of mothers from non-English speaking backgrounds attended prenatal classes, in contrast to 72 per cent of other mothers in the sample (Taylor & MacDonald 1992).

Maternal and Child Health services

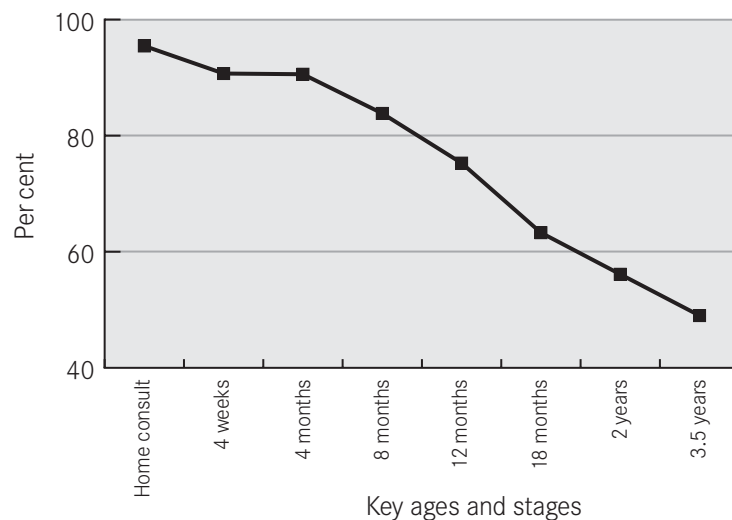
The Maternal and Child Health service is a free service for families with children aged zero to six years jointly funded by Department of Human Services and Local Government. Maternal and Child Health services provide support to parents and offer information and advice on a number of issues relating to child health and development, parenting, and maternal health and wellbeing. Maternal and Child Health services also organise groups for first-time parents that provide information and an opportunity for parents to meet other parents in the local area.

Victorian legislation requires maternity hospitals to notify a local government authority of the birth of child from their area. On receipt on this notification a local government authority will then allocate a Maternal and Child Health nurse to contact the parents so as to introduce Maternal and Child Health services to them. This contact is also supported by legislation and usually occurs within a week after the mother arrives home from hospital or earlier if there are any concerns. Maternal and Child Health service visits are typically arranged to occur at key ages and stages. These include visits at two weeks, four weeks, eight weeks, four months, eight months, 12 months, 18 months, two years and three and a half years. Additional contact with Maternal and Child Health services, whether in person or over the telephone, is also available in between these key visits.

While the majority of the service delivery is clinic-based, there is scope for home visits and a 24-hour telephone support and advice line is also available. More recently in each local municipality an enhanced home visiting service has been established. In general, this service is targeted to vulnerable parents who have children aged zero to 12 months and are experiencing significant early parenting difficulties, although it might also engage families with a child over 12 months where required. Enhanced Maternal and Child Health service support is provided for an average of up to 15 hours total per family, although the length and intensity of contact with a particular family is based on the professional judgement of the staff involved. In addition, the service has been implemented in different ways within different areas to enable support for a broader age group or a greater duration of contact. Lastly, Maternal and Child Health services also organise groups for first-time parents which provide information and an opportunity to meet other parents in the local area, as well as groups for other parents with particular needs.

Use of Maternal and Child Health services varies from neighbourhood to neighbourhood; however, a fairly consistent pattern of attendance over time can be seen. In general, participation rates are very high immediately after the child's birth and then steadily decrease over the following months and years. For example, in 2001–02, the statewide average participation rate in the first weeks of the child's life (home consultation) was around 95 per cent (see Figure 1). This contact then fell to 75 per cent at 12 months, 63 per cent at 18 months, 56 per cent at two years and 49 per cent at three and a half years (Department of Human Services 2002). In addition, however, a substantial amount of additional contact in between key age and stage visits does occur, although details about the timing of such contacts (that is, age of child) are not available (Department of Human Services 2002).

Figure 1: Statewide Maternal and Child Health contacts at key ages and stages for 2001–02



Source: Department of Human Services 2002

Only limited data exist about Maternal and Child Health service user characteristics, although it is apparent certain groups of parents and children are less likely than others to use these services. For example, Maternal and Child Health service nurses from the cities of Yarra, Hume and Moreland who were consulted during the Brotherhood of St Laurence's Early Years Project (Rogers & Martin 2002) nominated a number of groups who they believed were less likely to use their services, including:

- mothers who are stressed or unwell, particularly those experiencing depression
- families who have had contact with the Department of Human Services' Child Protection service
- people from culturally and linguistically diverse communities, especially new arrivals and victims of trauma
- families or single mothers who do not have cars or easy access to public transport
- families experiencing homelessness or with high levels of transience
- mothers with an intellectual disability
- young or adolescent mothers.

In a similar vein, the Australian Institute of Family Studies (AIFS 1991, cited in Victorian Parliament Community Development Committee 1995) found that parents on low incomes, parents from a non-English speaking background, and mothers who worked medium to long hours in the first years of the child's life were less likely to use Maternal and Child Health services. A child with a late position in the birth order was also less likely to be taken to the service. More recently, Comino and Harris (2003) examined attendance rates at a child and health service in south-west Sydney and found that women who attended the

service were more likely to be married and to have stayed in education until at least 17 years of age. In contrast to some other studies, they also found quite high attendance rates among women from non-English speaking backgrounds.

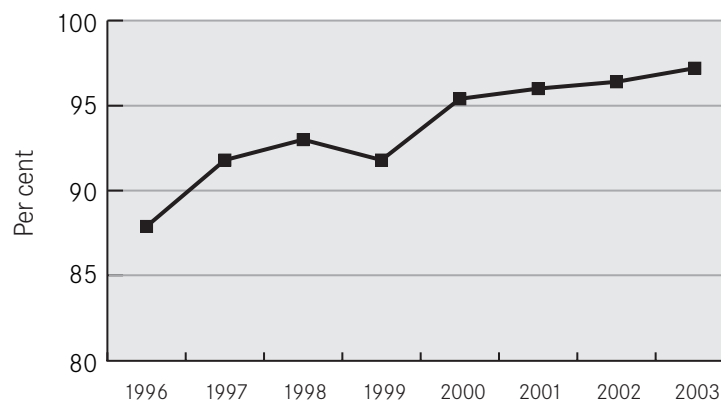
Overall, three consistent issues emerge at a statewide level:

- There is a small percentage of parents who have no contact with Maternal and Child Health services following the birth of a child.
- There is a steady decline in Maternal and Child Health attendance over the first three years, culminating in attendance rates below 50 per cent at the last scheduled age and stage visit (three and a half years).
- Vulnerable families are underrepresented in use of services, including first-time mothers' groups and other activities offered through Maternal and Child Health services.

Kindergarten services

Kindergarten is a program for children in the year before they start primary school. Kindergarten services are provided by a range of providers in standalone service settings, in child care centres or linked to schools. In Victoria, children are eligible to attend a funded kindergarten program if they turn four years of age on or before 30 April in the year of attendance. Funding is provided by the Department of Human Service on a per capita basis and attendance is on a fee-paying basis. Fees vary from service to service. The Department of Human Services also provides eligible families who have a health care card or pensioner concession card with a fee subsidy of \$250 to help reduce the cost of kindergarten. Department of Human Services data indicate Victorian kindergarten participation rates have steadily increased over the past six years and current participation rates are very high (see Figure 2). However, significant variation in kindergarten participation is apparent across local government areas in the state.

Figure 2: Victorian kindergarten participation rates 1996–2003 (per cent)



Source: Department of Human Services

Unfortunately, these data reflect enrolments only and do not provide any detail about ongoing participation through the year (retention) or hours of attendance, which can vary considerably. For example, a review of children's services in Victoria in 1992 (Department of Health and Community Services 1992b) revealed variable patterns of attendance at kindergarten among the municipalities of Melbourne, Box Hill, Berwick and Werribee. While only 11 per cent of children in Melbourne and Werribee attended less than 10 hours of kindergarten a week, about 38 per cent of children in Berwick and Box Hill attended less than 10 hours a week.

Australian Bureau of Statistics data (Commonwealth Taskforce 2003) indicate children from non-English speaking backgrounds, Indigenous children, children from single parent families and children with a disability are all substantially underrepresented among kindergarten users. A similar pattern was noted by Rogers and Martin (2002).

Primary schools

Enrolment in primary school is compulsory for children once they reach the age of six years. While 'access' is therefore not an issue in the primary school context, 'inclusion' can be a problem, particularly in relation to school attendance, arriving late for school, repeated transfers from school to school and the level of parent participation in the school. In Victoria, school absenteeism data show marked variations between local government areas and between schools. Average statewide absenteeism data from 2002 (assessed at local government area level) are presented in Table 1.

Table 1: 2002 statewide average numbers of days absent per pupil by year level

Year level	(State) average days absent	Range
Prep	13.4	8.9–18.6
Year one	12.9	8.4–15.9
Year two	12.3	7.7–15.8

*Note: averages and ranges based on local government area level data
(Source: Department of Education and Training)*

Demographic characteristics relating to absenteeism are not available. Drawing on United Kingdom data, however, a consistent and strong correlation has been found between absenteeism from primary school and poverty, with children from low socioeconomic status environments having significantly higher levels of absenteeism from school than children from high socioeconomic status environments (Zhang 2003). It is important to note, however, while attendance data (absenteeism) might indicate inclusiveness, these data could equally reflect other factors. For example, given the higher rates of illness among people living in disadvantaged environments, higher rates of absenteeism within this group might simply reflect the poorer health status of the schools' children or that of their caregivers. In relation to parent participation, it has been consistently noted families on low incomes and parents from ethnic minorities participate less frequently in schools than other parents (Abrams & Gibbs 2002).

What are the barriers to inclusion?

In investigating the barriers to inclusion within antenatal and universal early childhood services, very few studies or reviews relating to Australia (or more specifically, Victoria) were identified. The vast majority of papers and reports were from the United States and to a lesser extent the United Kingdom, neither of which has exactly the same range of services as Victoria. As such, information about the barriers relevant to certain services (for example, Maternal and Child Health) was limited. The review therefore includes information about the barriers experienced by vulnerable groups using other types of services, assuming that many of these will also be relevant to the current discussion. Studies which focus on barriers to service use tend to employ surveys or focus groups with service users and service providers and most are descriptive.

Overall, a number of interconnected barriers to inclusion were identified. While a few barriers appear to be particularly relevant to one service type or to certain groups within the community, the majority are common across the population and across services. The most important finding is that barriers tend to aggregate and many vulnerable families experience several concurrent barriers that impact on inclusion.

Barriers can be loosely grouped into service level (structural) barriers and barriers specific to the child, their parents and their situation.

Service level (structural) barriers

Knowledge of services/information about services

At the service (structural) level a number of barriers can exist. For example, services might be poorly promoted or explained. As a consequence, some parents might not be aware of their existence or what they provide, creating barriers to inclusion (Ahmed et al. 2001; Morda, Kapsalakis & Clyde 2000; Shi et al. 1996; Rosenheck & Lam 1997).

Cost barriers

Cost is frequently and extensively mentioned as a barrier to service use; however, this factor is more relevant for some services (for example, child care or kindergarten) than others (for example, Maternal and Child Health services). Clearly, cost barriers are particularly important for parents on limited income. Even modest increases in the cost of a particular service can lead to significant decline in use. A recent report by the National Centre for Social and Economic Modelling estimates that for the average Australian family to raise two children from birth to age 20 costs \$310 per week (Percival & Harding 2003). However, important cost differences exist between parents on low incomes and parents on higher incomes. Compared with families on high incomes, low income families need to spend a greater proportion of gross family income on raising their children and this proportion steadily increases with the age of the child and the number of children (Percival & Harding 2003). Costs are therefore more difficult for low income families to absorb. Costs are also a problem when payments are required 'up front'.

The impact of cost barriers on low income families is clearly seen in relation to child care (Gilley & Webb 2001; Jope 2000). The affordability of child care fell between 1991 and 1999 and this impacted most heavily on low income families (Australian Institute of Health and Welfare 2002). While government subsidies reduce the out-of-pocket expenses for families using child care, there is still a significant 'gap fee' after government assistance. For a low income family with two children in full time long centre day care, this gap fee amounts to around 15 per cent of disposable income (Powlay 2000). In addition, while cost barriers can have a direct impact on the use of child care, they can also have flow-on effects on other aspects of the parent's or child's life. Formal child care costs are a significant factor influencing female workforce participation. Higher costs lead to lower levels of workforce participation (Lokshin, Glinskaya & Garcia 2000).

Cost has also been cited as an access barrier to kindergarten services (Kirby & Harper 2001). The Kindergarten Teachers Association (Hammer 1994, cited in Taylor 1997) reported decreased enrolments and withdrawal of enrolled children during the term as a result of the fee increases which occurred following the per capita kindergarten funding introduced by the Kennett Government in 1994. Likewise, a review of kindergarten services in the Wyndham area revealed families on low incomes had more problems paying the fees and chose programs with shorter hours after the introduction of the new funding arrangements (van Moorst & Graham 1995, cited in Taylor 1997).

In the Life Chances Study (Taylor 1997), 44 per cent of the parents on low incomes reported difficulties in meeting the cost of kindergarten fees, compared with only 13 per cent of non-low income parents. While most parents were able to continue to pay the fees, they were often behind in payments or had to miss out on other things. In addition, parents on low incomes were less able to send their children to three-year-old activity groups. They also stated they were less able to afford a repeat kindergarten year if the child attended at least one term, but did not complete a full year, or if they were not 'school ready' (Taylor 1997). While the increase in the State Government rebate to \$250 for parents on health care cards appears to have improved affordability of kindergarten, for some families the cost of kindergarten services remains a barrier to full participation (Smallwood, Webster & Ayres-Wearne 2002).

Cost is also becoming a barrier to inclusion in primary school as a result of the increase in 'hidden' costs of school education, such as uniforms, books, excursion fees, elective subject fees and voluntary contributions. Such fees are placing increased burdens on some families and can cause some children to miss out on school activities (Smallwood, Webster & Ayres-Wearne 2002; Smyth, Zappala & Considine 2002). Given that around 20 per cent of all families (couple and sole parent) who have children aged zero to 14 years are jobless families (Australian Bureau of Statistics 2003), such cost barriers are clearly very important.

Location and transport

Location can be another barrier to inclusion. Services might be inconveniently located or require long travel times to access, particularly for rural residents (Gray 1998; Morda, Kapsalakis & Clyde 2000). This can interact with other factors, such as lack of vehicle ownership or driver's licence. In these instances lack of access to public transport (Ahmed et al. 2001; Miranda & Green 1999) and the cost of transport can become compounding barriers to service access (Smallwood, Webster & Ayres-Wearne 2002).

Service availability and eligibility

Lack of local services that can provide for sufficient numbers can also pose a problem for inclusion (Department of Health and Community Services 1992b). Lack of availability is often more pronounced in rural settings for a variety of reasons, including difficulty in recruiting qualified staff and higher costs of establishing services (Morda, Kapsalakis & Clyde 2000). Waiting lists for child care and kindergarten in some rural and remote areas have developed as a result of a mismatch between demand and supply. (Bergin-Seers & Breen 2002).

Restrictive eligibility is also a barrier. This has been noted in relation to child care where government guidelines prioritise access for parents already working and studying, therefore limiting access for parents seeking child care for other reasons (Bergin-Seers & Breen 2002). Narrow eligibility is also a problem in relation to specialist children's services, such as specialist early intervention services and child and adolescent mental health (Department of Human Services c.2002).

Opening hours and appointment scheduling

Opening times are another potential barrier impacting on inclusion. Services need to be responsive to the diverse needs and lifestyles of the population, including working hours. Over recent decades there have been considerable changes in patterns of workforce participation among men and women, with a much greater mix of full time, part time and casual employment and a much greater range in the number of hours worked and when they are worked (Press & Hayes 2000).

Given the diversity of working hours, the fairly limited opening hours of services such as Maternal and Child Health can limit access and contribute to underuse. Likewise, the sessional nature of kindergarten services can create significant problems for working parents (as well as for parents who lack transport). The situation becomes even more complex when parents have children of different ages, each with their own needs, or for sole parents who often have to deal with commitments without support. Inflexible or limited appointment scheduling and long waiting times are other related barriers, which have been particularly noted in relation to antenatal care services (Cook et al. 1999; Sanders-Phillips & Davis 1998).

Service quality

Service quality can impact on inclusion (Acharya & Cleland 2000). To a great extent, parents make decisions to use services based on the perceived quality of the service. Determinants of quality in early childhood education include environmental factors, such as child/staff ratios and group sizes and the appropriateness of the program, working conditions provided for staff and staff turnover, and formal early childhood training of staff (Whitebook, Howes & Phillips 1989, cited in Fler & Udy 2002). Early childhood programs need to be based on the developmental needs and interests of the children and interactions between staff and children need to be warm, responsive and reciprocal. Properly qualified and well paid staff are more likely to provide quality programs (Fler & Udy 2002).

Cultural sensitivity, service user expectations and preferences

Cultural factors can also impact on service use. Services are often designed and delivered in a manner that is insensitive to cultural difference (Gray 1998) and many services do not provide the sort of program that encourages continued attendance among children from a non-English speaking background. Lack of sensitivity to the child's first language or to the parent's cultural beliefs and practices, or overt discrimination, all pose barriers by creating distrust and negative experiences (Vose & Thurecht 1999).

Cultural factors also affect expectations and beliefs about the value of particular services. Parents have varying views about the benefits and disadvantages of particular early childhood services and what is appropriate and important for children at different ages and stages. For example, the age of the child appears an important factor affecting use of child care—the younger the child, the less likely the parents are to use formal care (Fuller et al. 2002).

In a general community survey conducted in 1992 for the Department of Human Services, the most common reasons cited by parents for using child care were to enable the parent to work and to prepare the child for school. In relation to kindergarten, the perceived benefits included assisting children to learn to get along with other children, preparing the child for school, allowing the child to mix with other adults, learning, and developing friendships (DHCS 1992a). There is a suggestion, however, that different groups in the community have different views. Where the service provided is too divergent from the preferences and beliefs of a particular group or individual, they are less likely to use it.

Service provider attitudes and behaviours

Finally, the attitudes and behaviours of service staff are possibly one of the most important factors influencing inclusion (Fuller et al. 2002). Staff attitudes can impact not only on initial access, but also on ongoing attendance and the level of parent involvement in the service. Moore and colleagues (2001) list a number of barriers to parental engagement and partnership building, which relate to the attitudes, beliefs and behaviour of staff. These barriers include:

- judgmental staff attitudes and behaviours
- staff resignation to low parental involvement
- rigid beliefs about the limited role of parents in the organisation
- poor communication methods between staff and parents
- a lack of responsiveness by staff towards parents' requests for information, support and advice.

Staff vary in their knowledge about and sensitivity towards the needs of diverse groups, some with increasingly complex problems. This might reflect the personal characteristics of the individual worker, but also significantly depends on qualifications, ongoing training and support and staff workloads (Press & Hayes 2000). Indeed, staff attitudes and behaviours are not solely a function of personal attributes and many would suggest that social exclusion is institutionalised within our social systems and services. From this perspective, exclusion is not 'caused' by the attitudes and behaviours of particular staff, but rather all staff are culture carriers of the beliefs, preferences and practices of dominant and advantaged groups in our society, which intrinsically serve to exclude less advantaged and minority groups (Abrams & Gibbs 2002).

Barriers specific to children, their parents and their situation

Children with additional needs

A number of barriers specific to children, their parents and their situation can also impact on inclusion. For example, particular barriers exist for children with additional needs because of disability, developmental delay or behavioural and emotional disorders. The *Review of the Kindergarten Field Officer Program within the context of kindergarten inclusion support* (Department of Human Services c.2002) identified a number of gaps in the service response to children with additional needs. In part this was caused by inadequate funding and in part by excessively rigid eligibility criteria. In addition, as a result of the lack of additional specialist supports for the child and the teacher from external services (for example, early intervention services, family support services and child and adolescent mental health services), some children were not able to attend or fully participate in kindergartens. Additional funding was allocated in 2002–03 following the review.

Mobility and homelessness

Parents themselves might be struggling with a number of issues. For example, lack of access to affordable, stable housing leading to frequent changes of address or homelessness can also impact on parents' use of services and make 'assertive' engagement (that is, proactive follow-up of missed appointments) difficult for workers (Katz et al. 2001).

The impact of mental health problems and stress

Having a mental illness can make it difficult at times for parents to provide for their children's needs (Australian Infant, Child, Adolescent and Family Mental Health Association 2001). Depression can create problems with motivation, anxiety can create avoidance and psychotic illnesses can lead to suspicion of others or to disorganised patterns of behaviour, which at times impacts on parenting capacity (Australian Infant, Child, Adolescent and Family Mental Health Association 2001). Problematic substance use can impair a person's memory, planning and organisational skills. Even in the absence of significant health or mental health problems, many vulnerable families' lives are characterised by chronic stress, which may be compounded by acute crises (for example, family illness) or situations of domestic or neighbourhood violence. Such stresses might occasionally or regularly interfere with attendance.

Service user attitudes and behaviours

In the same way that staff attitudes and behaviours can impact on inclusion, parents' own attitudes, beliefs and behaviour can also affect their engagement (Moore, Ochiltree & Cann 2001). These include:

- parents' sense of efficacy, experience and confidence in relating to staff
- parents' feeling of embarrassment or shame or fear
- parents' perception of being judged
- parents' perceptions of organisations as intimidating, alien, threatening and unapproachable
- previous negative experiences
- parents' belief that the staff or their children do not want them to be involved.

Some parents might lack the information or language to navigate the service system or the confidence and self-esteem to interact with service staff or other parents. Others might just 'feel' different or self-conscious as a consequence of the prejudice, discrimination, rejection and other negative experiences they encounter in their life (or hear about from others). Distrust of certain services (Cook et al. 1999) or even other parents can be very high. Perhaps one of the greatest barriers is parents' fear they will be judged by others as 'bad' parents, or worse still, have their children taken from them. Indeed, the fear of involvement with Child protection services can cause some parents to avoid services altogether (Australian Infant, Child, Adolescent and Family Mental Health Association 2001).

Clearly, vulnerable parents have to overcome numerous obstacles and balance competing needs. It is likely that at times, ‘survival’ needs take priority over attendance at a service (particularly services which lack an immediate, tangible benefit) or barriers collectively become overwhelming, preventing parents from making use of services.

In some ways, parents’ use of services could be seen as the end-point of a process of weighing up the advantages and disadvantages of attendance or participation against other priorities or demands. In this regard, the Health Belief Model and the Theory of Reasoned Action provide useful models for understanding parents’ behaviour (Caltabiano & Sarafino 2002).

Applied to this situation, the Health Belief Model suggests that in deciding whether or not to use a service, parents (consciously or unconsciously) weigh up the ‘costs’ (for example, barriers) and the benefits and also assess their own capacity to overcome the barriers. If the disadvantages outweigh the advantages or if parents do not perceive they can overcome the obstacles, then attendance or involvement is less likely. The Theory of Reasoned Action similarly suggests that people weigh up perceived benefits and costs, assess their own capacity for action, and then behave according to the outcome of their analysis. In addition, however, this theory suggests that people also take into account the opinions of others (What do other people think and how much do I want to comply with them?) or so-called social norms (Caltabiano & Sarafino, 2002). Although both these theories focus on health behaviours (particularly preventive behaviours) it is possible a similar process occurs with other non-health related behaviours.

The table below summarises the major barriers described in the literature.

Table 2: Barriers to inclusion

Service level (structural) barriers	Barriers specific to children, their parents and their situation
<ul style="list-style-type: none"> • lack of publicity about services • cost of services • limited availability of services (for example, child care and kindergartens) • inaccessible locations • lack of public transport • limited hours of operation • inflexible appointment systems and overcrowded clinics • limited access to specialist supports for children with additional needs (for example, disability) • poor coordination between services • lack of attention to multiculturalism • insensitive or judgmental attitudes and behaviours of staff or of other parents 	<ul style="list-style-type: none"> • limited income • limited support from family and friends • lack of private transport • unstable housing or homelessness creating transience • low (English) literacy levels • large family size • ambivalence about pregnancy or parenthood • personal preferences and individual beliefs about the necessity and value of services • lack of trust in services • fear of Child protection services • physical or mental health issues or disability • domestic violence • day-to-day stress

How can services be more inclusive?

Access and inclusion do not automatically result from the mere existence of a program or service. Specific attention is required to ensure these aims are realised. This is especially the case when trying to engage vulnerable families in services. This section of the review examines strategies outlined in the national and international literature, which have been adopted to enhance inclusion within antenatal and early childhood services for vulnerable families.

Surprisingly few intervention studies exist which specifically focus on improving access, engagement and inclusion in antenatal and universal early childhood services (that is, where these outcomes have been studied as dependent variables). Australian studies are particularly scarce. While local initiatives are known to exist, few have been documented in the literature.

There are, however, a number of studies with aims such as the prevention of child abuse, the enhancement of educational achievement, or the prevention of emotional and behavioural problems, in which enhancing inclusion, while not necessarily the primary purpose, was an important aspect. As such, they have been considered worthy of attention for the purpose of this project. However, in including these in the present review, it is important to be aware of a number of caveats:

- Most of these interventions have been specifically targeted rather than provided through universal services.
- A number of these interventions are delivered in a research context with well trained staff and a dedicated budget. This creates difficulty in determining the feasibility and effectiveness of delivering the program on a larger scale.
- Most of the interventions that have been trialled and evaluated originate overseas where the service environments are very different from the Australian context.
- Most have adopted multimodal approaches rather than standalone, single initiatives. As a consequence, it is difficult to determine which facet of the approach has which effects.

While intervention studies evaluating specific access and inclusion strategies are limited, there is nevertheless considerable consensus in the literature about what constitutes best practice.

For the sake of clarity, we therefore present the findings of this section of the review under two broad categories:

- examples of potential inclusion strategies, some with ‘empirical’ support
- general principles for inclusion.

Potential inclusion strategies

Overcoming the practical barriers

Subsidies

Given the importance of cost as a barrier, both the Commonwealth and state governments have introduced various subsidies to families and additional finance for services (for example, the Special Needs Subsidy Scheme and the Supplementary Services Program) to enable participation in child care and kindergarten. A comprehensive analysis of such schemes and their impact is beyond the scope of this review.

Recall and reminder systems

Recall and reminder systems have been used in health services to promote access and maintain service use. For example, mail or telephone reminders have been consistently reported as being useful in reducing missed medical appointments (Tanner & Feldman 1997), moderately successful in increasing immunisation rates among children living in families with a low income (Vivier et al. 2000) and have also been effective in increasing attendance at initial intake appointments in mental health services (McKay et al. 1998). Telephone reminders or home visits following missed appointments were also successfully used to promote attendance at an antenatal service for Indigenous women in Rockhampton (Dorman 1997).

Tanner and Feldman (1997) found that social support exit counselling (a discussion at the end of an appointment indicating the importance of attending the next and of bringing a significant other with them) was effective in improving attendance, whether combined with reminders or not.

Home visiting

Home visiting programs are increasingly being used to provide services to disadvantaged families (McLoughlin & Nagorcka 2000). While they have frequently been used in programs directed at the prevention of child abuse, they have also been used for other purposes, including educational enrichment. Providing such services means 'reaching out' to the families rather than expecting families to access services themselves (McLoughlin & Nagorcka 2000). In addition to facilitating access, home visiting allows the worker to assess the home environment and understand the specific needs of the families and to tailor services to meet their circumstances. Also, the contact with workers can decrease loneliness and isolation for parents and link families to their community (Gromby, Culross & Behrman 1999).

Such programs are not, however, a panacea for access and participation problems. Gromby and colleagues (1999) report on six home visiting programs and state that all struggled to enrol, involve and retain the low income or at-risk families in the services:

Based on the data of the Hawaii Healthy Start Program and the Nurse Home Visitation Program for example, it can be estimated that 10–25% of families that are invited to enrol in these programs choose not to participate. (Gromby, Culross & Behrman 1999, p.16)

Further, between 20 per cent and 67 per cent of families enrolled in the six home visiting programs left the programs before they were intended to end. Factors which make it difficult to engage clients include staff turnover, changes in family or work circumstances, unstable housing and parental mobility and young age of mother (Fraser et al. 2000; Gromby, Culross & Behrman 1999).

While the ultimate effectiveness of home visiting programs appears variable (Gromby, Culross & Behrman 1999), several models have produced benefits in parenting and the prevention of child abuse and neglect. However, comparison and evaluation of the effectiveness of home visiting programs is difficult given their considerable diversity in stated goals, qualifications of the provider, target group, timing of the involvement (for example, antenatal, postnatal or both), frequency and duration of contact and the actual supports and services provided. The service elements which appear to be important for success include:

- targeting the most vulnerable families
- workers experienced in working with vulnerable families
- workers provided with ongoing support, supervision and professional development
- ability for workers to link families to others who can provide case management to move beyond crisis service provision and help families achieve their specific long term goals
- retention of workers
- role play and modelling as effective engagement and change strategies (Armstrong et al. 2000; Duggan et al. 1999; Gromby, Culross & Behrman 1999; St Pierre & Layzer 1999).

Clearly, it is not just the ‘outreach’ component that is important, but rather the whole service package.

Outreach and mobile units

Outreach and mobile services have also been identified as a useful strategy, particularly for families in rural and remote settings. For example, mobile children’s services are travelling resource units, which cater to families in rural and remote areas. Mobiles offer a range of services, including child care, kindergarten, playgroups and toy libraries, depending on the community needs (Department of Family and Community Services 2002).

One-stop-shops

The concept of the ‘one-stop-shop’ has also been used to promote access to early childhood services. It is argued that co-locating or streamlining the links between services facilitates use, in part by minimising transport barriers, but also by providing a ‘joined up’ approach for the multiple simultaneous concerns experienced by many vulnerable families.

Such centres typically offer a range of formal and informal services and supports (Tomison 1997). The United Kingdom Government has adopted this principle as part of its Sure Start strategy. A number of Early Excellence Childhood Centres have been established. The Early Excellence Childhood Centres give a practical reality to ‘joined up thinking’, offering one-stop-shops where families and children have access to integrated care and education services delivered by multiagency partners within one centre or a network of centres. They are also intended to raise the quality of local early years services provision and disseminate good practice through training and modelling of integrated practice (Bertram et al. 2002). The United Kingdom government has conceptualised ‘integration’ within the Early Excellence Childhood Centres program as:

- a shared philosophy, vision and agreed principles of working with children and families
- a perception by Early Excellence Childhood Centre users of cohesive and comprehensive services
- a perception by Early Excellence Childhood Centre staff teams of a shared identity, purpose and common working practices
- a commitment by partner providers of Early Excellence Childhood Centre services to fund and facilitate integrated services.

The Victorian State Government’s proposed Children’s Centres are a further example of this type of approach. Through this initiative, funding will be provided to establish a number of Children’s Centres, which will include a range of early childhood services (both universal and specialist). The strategy’s intention is to promote ‘more integrative service delivery and collaborative professional practice, leading to better outcomes for children and their families’ (Department of Human Services 2003, p. 1).

Full-service schools are another example of the one-stop-shop concept. In its simplest form, the concept translates into ‘co-location’ or ‘in-reach’ of ‘non-education’ services into the school environment: in essence using the school as a physical base for a range of community activities and services, both during and after school hours. There is no single model for a full-service school, with different ‘versions’ evolving in different communities. Each has their own mix of ‘services’ and governance and funding arrangements, although ‘the school pays for education and the other services are supported by an array of non-school funding’ (Dryfoos 2002 p. 396). Non-government organisation involvement and local community participation in decision making are a common feature. United States’ experience suggests that ‘almost anything’ can be provided from the school (including laundromat services and a miniature-golf course) as long as it meets the needs of the community and the resources are available to support it (Dryfoos 2002).

Evaluation results are mixed and somewhat difficult to interpret given that no two initiatives are alike and many of the evaluations rely on very small, non-representative samples. Reviewing these evaluation studies, Dryfoos (2002) states that 46 of the 49 studies demonstrated some positive result (among some students) in relation to academic performance, attendance, suspensions and parent involvement, although details of measures used, significance tests and effect sizes were not included in her summary (Dryfoos 2002).

Comprehensive services

Related to the 'one-stop-shop' is the notion of comprehensive programs. A number of programs have been based on the principle of providing a suite of services relevant to the general or 'target' population. Their aim is to provide holistic support to parents and children and to focus on building connectedness and increasing informal social supports. The St Paul's Project in London provides a range of services, such as affordable child care and kindergarten education for children from low income families, training for child care workers and training and employment initiatives for disadvantaged parents. It also provides a centre for young people to come together for activities, a meeting place for the elderly and other community initiatives to assist parents to form social and religious networks (Wilkinson 2002).

However, even the most comprehensive service might not engage everyone. For example, Akinbami and colleagues (2001) note the relatively poor outcomes documented for various comprehensive services for teenage mothers and their children, which are struggling to maintain ongoing participation. The limitations of multiple simultaneous strategies are also highlighted by Katz and colleagues (2001) who outline their own efforts to maintain the participation of a group of mothers on low incomes in a parenting intervention study. Strategies included assertively tracking the mothers, providing outreach services, offering them incentives (for example, nappies, pushers and gift certificates for toys) for completing certain activities, providing culturally appropriate staff, providing transport to activities and giving parents with low literacy skills easy-to-read written project materials. However, even with such intensive strategies to enhance engagement, the program had a 41 per cent attrition rate.

'Joined up' funding

Related to both the concept of one-stop-shops and comprehensive services, a number of people argue for the importance of a more 'joined up' approach to funding, which they believe can also translate into better access. Rather than independently funding a range of discrete services, each addressing a narrowly defined 'problem' for a specific population subgroup, they argue for funding a system of broadbanded early childhood services (Oberklaid 2002; Vimpani 1996). Whether or not such an approach is adopted, it is clear the success and sustainability of access and inclusion initiatives does depend on adequate ongoing funding.

Building trust and service acceptability

Informal supports – volunteers and befriending

Most people prefer informal support from family, friends and peers to formal support from services and professionals. In addition, people have a strong preference for support through universal services rather than targeted services because of the stigma associated with the latter (Armstrong & Hill 2001). In response, various ‘structured’ approaches to informal support have been implemented as a means of providing early childhood services. These include training local community members to act as paraprofessional volunteers, recruiting service users as ‘service providers’ and recruiting established service users to provide peer support to new service users (Armstrong & Hill 2001). It is argued the involvement of non-professional volunteers or parents can enhance feelings of trust because they are perceived as less threatening and less judgmental.

One such program is the Community Mothers Program in Dublin, which recruited ‘non-professional’ experienced mothers living in low income communities to support first-time parents during the first year of their babies’ lives (Johnson & Molloy 1995). Mothers were selected on the basis of whether they were caring and sensitive, had reasonable literacy and had an interest in the community. The results of the program evaluation were positive. Parents in the program scored significantly higher on such indicators as child immunisation, child’s diet, cognitive stimulation of child, maternal self-esteem and maternal positive feelings, compared with parents who lived in the same disadvantaged area but who were not part of the program (Johnson & Molloy 1995).

In addition, such structured informal approaches have also been used for educational programs. For example, both Head Start (Head Start 2001) and the Home Instruction Program for Parents with Kindergarten Youngsters (HIPPY) engage parents as service providers to other parents (HIPPY 2003). HIPPY is a home-based early childhood enrichment program for kindergarten children, targeting communities who have experienced disadvantage. The program works by supporting parents to provide their child with the necessary skills and confidence to begin school with a positive attitude towards learning. A professional coordinator employs, trains and supports several parents in each community as home tutors. Each tutor first implements the activities with their own child, then works with a few parents. The home tutor uses role play with the parent to teach the weekly set of activities. On alternative weeks, all the parents meet as a group for the training, which is followed by an enrichment activity or workshop on topics previously decided by the parents.

‘Befriending’ has been used to assist parents with limited social supports, as well as parents with mental health problems. In one London-based program targeting chronically depressed women, volunteers were recruited to provide the women with a ‘friend’ to talk to for one hour a week. The volunteers also accompanied the women on outings and encouraged new and different

experiences. They were recruited through newspaper advertisements and local church and health centres and undertook three days of training. It was hypothesised that the knowledge the volunteer was not being paid might contribute to the women's feeling of being cared about, thus fostering trust and self-worth and acting as an alternative for women unwilling to gain professional help. Ultimately, only half of the women contacted were interested in receiving befriending; however, the women who did participate displayed greater remission from their depression (Harris, Brown & Robinson 1999).

Parent groups

Parent groups are another very common inclusion strategy. A wide variety of such groups exist. These groups can be either universal (for example, first-time mothers' groups in Maternal and Child Health services) or targeted (for example, young mothers' groups) and initiated and led by parents or facilitated by early childhood workers. The most common type of parent-initiated group is the playgroup. Playgroups provide social contact and support for parents and stimulation and socialisation for their children (see Playgrouping Victoria's web site <<http://www.playgroup.org.au>>).

Training and consultation support for early childhood service staff

Given the importance of non-judgmental staff attitudes and behaviours, various initiatives attempt to provide support for workers employed within early childhood services to help them to be more inclusive in their work with children and parents. The Department of Human Services has initiated a number of such programs over the years, in particular the Kindergarten Field Officer Service, Koori Kindergarten Assistants and Koori Early Childhood Field Officers. In addition the FKA Children's Services Multicultural Resource Centre is funded by Commonwealth and state governments to support workers in government approved child care and kindergarten programs to better include children and parents from a non-English speaking background.

While each program provides a slightly different service, the types of supports provided include:

- direct support to parents and children
- consultancy support to staff
- training for staff
- an attempt to promote a 'holistic approach' and 'whole-of-government' approach by establishing links to other local services and government initiatives
- culturally appropriate children's resources and translated material
- access to bilingual workers to provide support for children and parents.

Similarly, Phillips and Lock (1994) describe the services of the Child Care Access Support Teams and Southern Child Care Support Program in South Australia. These programs support child care staff who work with children with special needs and disabilities. Workers in the program:

- assist the children (identify their needs and encourage participation)
- assist the families (provide information on services, their child's developmental needs and other services or agencies, help parents to communicate with child care staff, maintain contact with families and support them)
- assist child care staff (provide information on other services or agencies and specific disabilities, assist them to communicate with parents, encourage positive attitudes towards children with special needs and their families, assist staff with planning and implementing inclusive programs, assist with funding so staff can attend training) (Phillips & Lock 1994).

Culturally sensitive practice

Inclusive practice is also culturally sensitive practice and substantial attention has been directed towards enhancing service access and the inclusion of people from culturally and linguistically diverse communities. Some initiatives relate to antenatal and early childhood services.

The common principle in these initiatives is the attempt to tailor program elements to take into account the child and parent's specific cultural frame of reference. Strategies that have been used in various service settings or that are recommended include:

- developing and using standards and providing 'bonus' funding for services that meet standards (Blanco 1998)
- involving ethnic community representatives on committees and in policy making (Prasad & Ebbeck 2000)
- conducting information campaigns targeted specifically at non-English speaking background communities, which promote the service and its benefits (Giglio 1997; Tsaconas 1990)
- involving members of non-English speaking background communities and important community figures (for example, religious leaders, politicians) in disseminating information because such people are well connected and appear on ethnic media, radio, newspaper, television (Giglio 1997)
- improving formal communication (for example, by using interpreters and translated written material) (Tsaconas 1990; Prasad & Ebbeck 2000)
- asking, rather than assuming, the language spoken by the family at home (Harry et al. 1995)
- selecting the most appropriate interpreters in terms of culture (not just language) and gender (Giglio 1997)
- educating workers about linguistic and cultural factors so these factors become a 'normal' consideration in the planning process and delivery of services (Tsaconas 1990)

- educating staff about different child rearing practices and acknowledging the importance of the extended family (Harry et al. 1995; Giglio 1997)
- employing bilingual service providers and bicultural workers (Blanco 1998; Riddick 1998)
- offering culturally relevant resources (for example, books and toys)
- offering culturally appropriate food (Prasad & Ebbeck 2000)
- building trust by accepting and acknowledging cultural difference (Vose & Thurecht 1999).

Riddick (1998) highlights some difficulties in achieving these objectives, such as:

- a lack of trained health care professionals who are bilingual or bicultural
- cost (and shortage) of well trained professional interpreters
- translated printed materials, such as non-English versions of pamphlets, which require the patient to be literate.

Affirmative employment policies which attempt to ensure multicultural staff mix have also been adopted in some jurisdictions. For example, the United Kingdom government has adopted a recruitment strategy and set targets to employ workers from black and minority ethnic communities in the child care profession (Wilkinson 2002).

Population-specific services

In some instances, access and inclusion can best be achieved through population-specific services, for example those provided for Indigenous communities. State and Commonwealth governments provide supports and services to facilitate access and inclusion in antenatal and early childhood services among Indigenous children and families. For example, the Daruk Aboriginal Medical Service runs an Indigenous community-managed maternity program in rural New South Wales. The program employs an Aboriginal health worker and a non-Aboriginal midwife who work with a female general practitioner, providing a 'holistic' approach to antenatal care. Preliminary findings from the evaluation suggest the program has been an important service for Aboriginal women who would usually miss out on antenatal care because of their dislike of attending hospitals for checkups. The women experienced the service as providing a trusting and non-judgmental environment (Hecker et al. 1997).

Dorman (1997) reports on the success of an Indigenous-specific antenatal and early childhood clinic in Rockhampton. The service was located in a house in a neighbourhood where most of the Indigenous population lived. It was actively promoted, especially through word-of-mouth by the Aboriginal health workers. A pamphlet outlining the program was distributed to service providers and hospital staff and a logo, posters and business cards were designed. In addition to publicising the service, efforts were made to facilitate attendance. A driver was employed to transport mothers to the clinic. If a mother could not come to the clinic, home visiting took place.

At the time Dorman wrote the article, the clinic had begun to effectively engage with the community and had achieved a number of successes, including increases in women coming to the clinic to have a health check before becoming pregnant, in fathers attending with mothers and in mothers seeking care for subsequent pregnancies (Dorman, 1997).

Another Indigenous-specific service is provided by Multifunctional Aboriginal Children's Services. Multifunctional Aboriginal Children's Services caters to Aboriginal and Torres Strait Islander children (aged zero to 12 years) and is managed by the local Aboriginal and Torres Strait Islander community. It offers services such as long day care, playgroups, outside school hours care, school holiday care and cultural programs.

A population-specific approach has also been used to engage young mothers. Reviewing one such program, Zubrzycki et al. (1991) found the young mothers liked meeting with other mothers of similar ages and this was a key reason for attending and using the service. The mothers provided several ideas for expanding the clinic's service. They suggested that to engage young mothers at their first visit, one member should introduce the new mother to all other members of the group one by one, in effect creating a 'buddy' system. Another suggestion was to engage the mothers' partners in the clinic and create a young fathers' group. Interestingly, while the young mothers thought a service for them as a group was a good idea, they did not want to be 'labelled' or treated differently because they believed they faced similar issues to other parents.

Local community participation and ownership

Frequent reference is made in the literature to the importance of local community participation and ownership. While important, this is not always easy to achieve and requires time, resources, effort and planning.

Community participation and ownership can be achieved in a number of ways. In one low income community in the United States, the important elements included establishing a partnership group involving policy makers, service providers and local community members; a comprehensive needs assessment, which included consultation with all key stakeholders and which led to the identification of specific barriers and agreed strategies to overcome these; and a community-based approach to evaluation (Shi et al. 1996).

Another way of achieving community ownership (Henly et al. 1998) was used by the antenatal clinic in Rockhampton previously described, which was developed to service the local Indigenous community. The clinic providers established a community reference group, which was given responsibility for setting program activities and was regularly consulted about service planning and development (Dorman 1997). However, community committees of management are not without problems and care needs to be taken to ensure they represent the needs of all families who use the service. Problems might arise, for example, in kindergarten parent committees of management, among which many vulnerable groups are underrepresented.

The community consultation

Given the dearth of locally relevant research, in the next stage of the project the research team set out to explore the issue of inclusion within the Victorian antenatal and universal early childhood service context through a statewide community consultation process. Individuals and groups who were consulted include:

- parents with young children
- providers of antenatal and universal early childhood services
- service providers in specialist settings, such as mental health, drug and alcohol treatment services, housing services, family/sexual violence services, disability services, multicultural support services and family support services
- early childhood peak bodies
- academics
- representatives of the Department of Human Services and the Department of Education and Training (see Appendix 2 for details).

Sampling involved a mixture of (non-random) purposive and convenience sampling of antenatal and universal early childhood service providers, specialist services and academics (with an attempt made to include services from urban, outer urban and regional areas) as well as 'snowball' sampling based on word-of-mouth referral. Parents were recruited through contact with service providers, using non-random convenience sampling. In all, 69 parents, more than 100 service providers and more than 20 government department staff were interviewed.

The vast majority of parents interviewed were female; there were only four fathers. All were experiencing a range of (often concurrent) difficulties in their lives, such as low income, unemployment, homelessness, problematic substance use, mental illness or a disability. Many were young parents (aged less than 20 years) and several were from a non-English speaking background.

Parents were interviewed face to face, either individually or in focus groups. Interviews with service providers, peak body representatives, academics and department staff were also mostly face-to-face individual and focus group interviews, with a small number of telephone interviews. The interviews were conducted by four researchers using semi-structured interview guides specific to parents, each universal service, specialist services and peak bodies or academics (see Appendix 3).

The findings presented below provide a 'summary' of the views of the parents, services providers and other key stakeholders who were consulted. Wherever possible, this synopsis is supplemented with direct quotes taken from interview transcripts.

Given the qualitative method, it is important to emphasise that while these findings represent the views of a broad cross-section of parents and providers, they may or may not be representative of the population as a whole. However, since many issues were raised over and over again, it is likely they are fairly indicative. In addition, most of the issues that emerged in the consultation are in keeping with the findings of the literature review.

Patterns of service use

When asked to reflect on their clientele, workers in antenatal, Maternal and Child Health services, kindergartens and primary schools agreed some parents accessed services less than others, had greater difficulties in maintaining regular attendance, or were less actively involved. While workers found it difficult to give details, in general they stated that sole parents, young parents, parents from some culturally and linguistically diverse communities, Indigenous parents, parents on low incomes, families experiencing homelessness or unstable housing, families experiencing violence, parents with problematic substance use, parents with a mental illness and parents who had been in contact with protective services were more likely to underuse their services. In addition to these socially excluded groups, some workers also noted certain neighbourhoods had disproportionately high numbers of parents who were not engaged with services.

Overall, the majority of workers believe they have at least some contact with most parents in their local community. However, it does appear there is a small but significant proportion of parents that does not use, or rarely uses, services.

Barriers to inclusion

The community consultation highlighted a number of barriers that can impact on inclusive practice; these are largely consistent with the findings of the literature review. As previously noted, these can be loosely grouped into service level (structural) barriers and barriers specific to the child, their parent and their environment.

Service level (structural) barriers

Knowledge about services

Clearly one of the first steps towards service access is knowledge about the availability and location of services. Unfortunately, it appears ‘knowing about’ services is not so straightforward for some families. Many vulnerable parents are uncertain about ‘what’s out there’ and do not feel confident in navigating the system. This is particularly apparent with complex service systems, such as antenatal care, which are provided in so many different ways:

I think there's a difference between really vulnerable families and families that are quite capable of knowing what's out in the community and making their way and turning up to appointments and finding out the information they need. Families that I'm talking about probably don't have access to transport, don't even know where the local community health service is or where the Maternal and Child Health nurse operates from ... I mean it's one thing being resourceful enough and seeking out your needs, there's another thing for someone who doesn't have those skills to go and find it all.

Several workers suggested young mothers, parents experiencing homelessness and parents who had recently settled in Australia were particularly subject to these knowledge barriers, because many of these parents have low English language literacy, are transient or have limited social or informal networks, and miss out on ‘word-of-mouth’ information and ‘local knowledge’:

I think that they don't know very much because they have never been within that environment, so it is not part of the general chitchat of their life experiences so they are not familiar [with what services are available].

Parents and families who are newly arrived refugees in Australia need information about our country's service system[s] because often they are very different. Even those that are well educated may not understand.

Some people living in rural or remote areas might also be less aware of the services available, particularly services in distant regional centres:

I think a lot of the time, too, some parents are isolated and remote, they aren't aware of what services are around unless they make that connection very early in the piece via a doctor or a Maternal and Child Health nurse [who] might connect them up [with a particular specialist service]. Particularly in those early years, they are very important people.

Local availability

In general, antenatal and early childhood services appear to be reasonably widely available; even small country towns are served by outreach services. However, the lack of kindergarten services and child care is an issue in some (particularly growth) areas. This has led to services establishing waiting lists, which as one parent stated, can extend ‘for months’. In addition, most child care and kindergarten services operate on a ‘first come, first served’ basis, with no priority given to children with additional needs. If these delays are too long, some vulnerable parents simply ‘give up’.

Transient families, young parents, parents with low literacy and parents from non-English speaking backgrounds appear to be most affected because they might not have had the opportunity to place their child’s name on a waiting list or did not know they needed to do so.

One group of workers in Melbourne’s north reflected that every year parents from non-English speaking backgrounds would turn up at kindergarten on the first day not realising that they needed to have placed their children on a waiting list. The kindergarten places go to more advantaged parents who often put their children’s names on the list when they are very young. Regulations about staff/child ratios might also prevent additional enrolments mid-term or mid-year, unless a place is vacated. The uninformed parent either has to find a service that is much further away and less convenient or the child misses a large part of the year, or simply misses out altogether.

Access to respite child care (or foster care) is also limited:

I asked DHS for respite care. There's no respite care unless you're in serious difficulties. They ended up taking the kids off me. But I never got the respite care. That's all I ever needed, a bit of respite care.

Just as serious is the shortage, especially in rural and regional areas, of local specialist services to support children and parents with additional needs in child care, kindergarten and primary school. Several workers commented on the overstretched early childhood intervention services, child and adolescent mental health and family support services in their area, with most workers citing lengthy delays and waiting lists for all these services.

I'm having major problems at the moment. I have a kid with special needs and the kindergarten won't accept that and we're having a lot of trouble getting him in and dealing with certain issues there.

This presents a major problem as vulnerable families often need more intensive or specialist support than can be provided by the existing universal early childhood services, which are mostly geared towards primary care or preventive care. Many workers are finding an increasing number of children and parents who have needs that are beyond the capacity of the existing universal system, yet who are deemed ineligible for assistance from specialist services because their problems are not 'severe' enough. Such families struggle. Another concern is many specialist services are only funded to provide short to medium term assistance, yet many children and parents have either recurrent or long term needs.

Cost

Most people stated cost was one the biggest barriers to service access for vulnerable families, in particular for child care and kindergarten. For some people this cost barrier might be 'episodic' while for many it is a more persistent problem. While fees pose the greatest problem, costs associated with getting to and from the centre by private car or public transport can also impact on service use by many families. The more children in a family, the greater the cost pressures:

Costs of services are particularly hard for CALD [culturally and linguistically diverse] families because in many cultures the practice is to have many children.

While a \$250 per capita subsidy exists for kindergarten and child care, many respondents perceived this to be inadequate:

It's cheaper to send them to school than it is to get them used to school by sending them to kinder.

Even though you can get the \$250 subsidy from a health care card holder [for kindergarten] there are a whole lot of families that are unable to fill the gap. There is still often a gap of \$450 a year.

Further, it was suggested some families have difficulty accessing the subsidy because they have no fixed address, which creates difficulties in obtaining a health care card. Families in the process of separation are also less likely to be able to claim the subsidy, because often neither parent has a health care card at the point of transition to separation. This is an important issue considering the high rate of family breakdown.

While the kindergarten fee policy advocates for flexibility and sensitivity in the collection of fees, the policy is a guide only and implementation is variable. In some instances, parents struggling with kindergarten payments might encounter pressure, or even hostility, from the service or parents on the committee of management. This is uncomfortable for both parties and can lead to parents deciding to take the child out of the service:

It's just a horrible [situation] that is happening out there ... Unless you pay fees by this date, your child can't come. Then there's no more communication, the parent doesn't pay the fees and the child doesn't come, and that's it.

This might then have flow-on effects for siblings. For example, if a parent fails to pay fees for one child, some kindergartens might have no further communication with them and subsequent children from that family will miss out.

While additional financial assistance with kindergarten fees is provided by several non-government organisations (for example, Kindergarten Parents Victoria), many parents (and some kindergartens) are unaware of these funds or do not apply. In addition, kindergarten teachers might be unaware of which parents need financial support and therefore cannot provide appropriate information and assistance with applications.

Cost barriers are even more apparent in relation to so-called 'three-year-old kindergarten'. While government policy provides for all eligible children to receive a year of funded kindergarten prior to school entry, many families are also choosing to enrol their children in the fee-for-service three-year-old 'activity groups' which are provided by many kindergartens. However, access to these activity groups is almost universally beyond the reach of vulnerable families because of the costs involved. In the words of one kindergarten teacher, such groups have become 'an elitist program'. Given research findings that highlight the benefits of early and sustained educational enrichment for children from disadvantaged backgrounds, it is of concern that children who need them most are least likely to have access to these groups than their more affluent peers.

Cost can also have an impact at the service level. If a large proportion of the parents using a service are on limited incomes, payment failures can become more common and can neither be absorbed nor offset by higher charges or fundraising. In many parts of Victoria, such concentration of disadvantage affects the quality of local kindergarten services.

Another cost barrier identified during the consultation relates to the provision of methadone for pregnant women who have been heroin users. At present, women are required to pay around \$35 a week for their methadone. If their partner is also on a methadone program the cost for the couple becomes \$70 a week. This represents a significant cost for parents on a low income.

School costs, such as books, uniforms, excursion fees, school photos and voluntary contributions, can also pose problems for families, in particular those with several children. These cost barriers have an impact at both a practical and an emotional level for children and parents alike:

It's not his fault that his mother doesn't have as much money as other parents do. It's not his fault, so he shouldn't have to miss out [on school activities].

My sister was getting in trouble in front of the class because my mum hadn't paid her school fees. Instead of getting in touch with the parents, they're addressing the kids.

I don't know how to describe it. I just feel absolutely guilty as if he can't have everything else the other kids are having.

Perversely, costs can be a larger hurdle for working parents on low incomes than for parents on income support, since the loss of subsidies is not made up by their net wages.

I found when I was working I was earning a lot less money because of the more stuff I had to pay out because it was a lot dearer for me. When I wasn't working because I had the pension it was a lot cheaper and I actually had more money left over. So it's really strange how it works.

Transport

Lack of transport is another major barrier for many people. Limited income can impact on vehicle ownership, vehicle maintenance and running expenses (for example, petrol, insurance, registration, car repairs):

I had a client whose child didn't go to school for two weeks because the car was off the road. So this affects a little boy or little girl with [their] schooling and puts stress and pressure on the mum. She is then thought of as a bad parent by the school and it just goes round and round and round and round. But she is not a bad parent, she just can't get them [to school].

Some young parents are not old enough to hold a driver's licence. In other instances, mothers might be dependent on their partner for transport, particularly among certain culturally and linguistically diverse communities:

A lot of the time it's because their husbands don't want them to drive, or it's just not a thing that they do, so they need to be picked up.

This can pose a problem if the partner is working during the day and not available to drive the family to appointments or sessions. It can also be a problem for one-car families in outer urban or rural areas where travel times to jobs in the city or regional centres can mean their partner is away for long stretches of the day.

For parents with problematic substance use, the suspension of their licence as a result of drink-driving or other offences, or health problems which affect their capacity to drive safely, can also create difficulties.

Car parking and road safety are other related issues that discourage attendance. Parking can be difficult (and expensive) around many services, particularly those based in hospitals or inner city areas. Some services lack basic safety infrastructure. For example, at one major public hospital in Melbourne there is no pedestrian crossing from a car park to the hospital building across the road. Parents with young children are forced to run the gauntlet of heavy traffic.

Without private transport, parents become dependent on others or reliant on public transport. This can be difficult if parents do not live close to public transport or if (available) services are not close to transport routes.

I don't have a car so I'd be catching public transport. So somehow I had to find [child care] somewhere that's close to either where I live or where I work and on top of that it's really hard to find available places.

Public transport times might not fit well with service opening times or appointments. People might have to wait outside, perhaps in the rain, until the service (for example, kindergarten) opens. Getting around can be even more difficult for parents with several children and for women who are pregnant. For one young mother, catching a train and tram for 45 minutes to get to an antenatal service during her pregnancy was not only time-consuming and costly, but also intimidating because she felt people would stare at her because she was a young mother:

Perhaps the only thing I didn't like [about accessing services] was catching the train into hospital, probably because I was pregnant because you can imagine people's faces, that was really uncomfortable, so it kind of got to me.

In rural and regional areas, waiting times and travel distances can be significant. One parent living in a large regional centre described the local bus service as running one bus an hour. Another parent living in a small rural town stated there was only one bus into the local regional centre each day and one bus back again. Public transport problems are also a major issue in outer suburban Melbourne and semi-rural metropolitan fringe areas. Such problems can be compounded if a child is unable to attend the nearest child care, kindergarten or primary school. In many areas, a shortage of child care or kindergarten places means some parents have to travel further to access a service with vacancies.

If you've got to travel half an hour and catch two buses to get to a kindergarten ... with vacancies, of course you're not going to go if it's pouring with rain.

Likewise, a parent experiencing homelessness or instability in their housing who has to move to a new area but wishes to maintain their child in the same child care service, kindergarten or primary school, can experience great difficulty with transport.

I've got one lady who buses her child daily to and from school so that she doesn't have to change her child's schooling. [She] doesn't have a car, their car was repossessed, so she buses it. So that cuts out any chances of her doing further study or doing any work ... Most of the women in my group ... none of their children go to a school near where they live. They all cart their kids all over the place to try and stop the kids from having to change schools. So consequently the kids haven't got friends in the area they live in, so parents pay lots in petrol.

In some regional areas where school buses operate, they will only take the child to the nearest primary school, otherwise the parent has to pay an extra charge. Using public transport might also be difficult for grandparents who are left with the care of their grandchildren while parents are at work or studying.

Hours of operation and appointment systems

Some people interviewed stressed the importance of 'family friendly' hours of operation, including the need for weekend services, particularly in Maternal and Child Health services. While some services had moved towards providing extended hours services or sought to link session times to parents' other responsibilities (for example, afternoon kindergarten sessions linked to school 'pick-up' times) many still operate Monday to Friday 9am to 5pm. Limited hours of operation are a particular problem for mothers from some culturally and linguistically diverse communities who prefer to attend appointments with their (working) partner and for working parents generally (fathers can be especially affected).

The sessional nature of kindergarten is very awkward for some parents. The timing of sessions can also be a problem:

The thing that drove me nuts about that was they were two-hour sessions and they were always smack in the middle of the day so it ruined your entire day. From 11 to 1 or something like that. It's completely useless.

Parents might have to pay for more child care than they need if the hours they want span sessions or they might have to find ways to get their child from kindergarten to child care (or vice versa) if they work full days. While child care services that offer kindergarten programs do exist, they are not readily available in all areas.

A related concern is scheduling of appointments. Hospital-based antenatal clinics often pose problems, particularly if the clinic uses block appointments in which women are all given the same appointment time and are then required to wait in turn to be seen.

Sometimes you're in the waiting room for ages and then they tell you to lay on the bed and wait for someone. And at other times you're done over, get the opinions and stuff that you need and then you're out.

Some local governments introduced a very structured appointment system within Maternal and Child Health services to support the provision of ten key 'ages and stages' visits. These include visits at two weeks, four weeks, eight weeks, four months, eight months, 12 months, 18 months, two years and three and a half years, with additional contact with Maternal and Child Health services in person or over the telephone in between these key visits. Concerns were raised in some areas that while nurses do not necessarily discourage attendance between key age and stage appointments, they do not explicitly encourage it.

Numerous people were critical of this shift to key milestone visits. One worker referred to an unpublished review of Maternal and Child Health services in Melbourne's north which included focus groups with parents. The review was said to have stated that in that area since the change to key age appointments, many parents had found accessing the Maternal and Child Health service difficult when in crisis or at the point of need and also complained they were not referred to other services.

So there was a particular model or approach to service delivery and as long as people fit within those parameters then the service responds effectively. Now when you get people in crisis, whether it was breastfeeding or depression, and getting to the point where they needed urgent help, they found access was extremely difficult.

[The Maternal and Child Health centre] was basically appointment only and [when] you would arrive at the door, it's 'I'm sorry, I've got clients and I can't see you'. And very, very not user-friendly at all in that area.

When I had my other three children years ago, I used to visit the health nurses regularly. Now you can't visit them regularly like that. You can only visit them at nine months, 12 months, every three months or whatever – it's ridiculous. (Note: This perception is not accurate.)

When actively promoted and readily available, the opportunity for additional contact is valued by parents.

I can call her anytime, like if [child's name] is sick ... she would tell me 'right, do this, take her to the doctors'. I'd call her for anything. It was good.

The move to an appointment system has also undermined another benefit of the drop-in model, namely the social interaction that occurred between parents sitting in the waiting room together.

When you had the drop-in there'd be other mothers waiting as well. And because they're so local and the 20 streets around the centre come to that centre, it encourages that sense of social connectedness, the getting to know your neighbours, getting to know the mum around the corner that's got a kid the same age.

The spacing of the appointments was also said to work against a feeling of continuity over the early years, given that the first seven appointments are scheduled between birth and 12 months, followed by visits at 18 months, two years and three and a half years. As a result of these ‘gaps’, any sense of ‘relationship’ can be lost.

Several workers in specialist (adult) services stated that for many vulnerable parents an appointment-based system is completely inappropriate. The parent’s lifestyle might be too chaotic and their circumstances too unstable for them to keep appointments. In addition, some parents might not see the point of preventive services when they are simply trying to make ends meet from day to day and they much prefer an immediate approach to service availability. While they might not visit a Maternal and Child Health nurse (for example) when their child is well, they might well be interested in seeing her when there is a problem. Some respondents mentioned after hours access is sometimes required (for crisis needs), but one nurse believed it was important not to foster dependency.

It should be noted, however, data from Maternal and Child Health services indicate additional contact between key age and stage visits does occur. For example, data from the 2001–02 annual report show more than 162,000 additional telephone contacts, 148,000 additional centre-based contacts and just under 20,000 additional home-based contacts took place on a statewide basis (Department of Human Services 2002).

Cultural sensitivity

Victoria has a diverse, multicultural community. Service providers need to reflect this diversity and supply information to parents about the existence, nature and value of their services:

On the one hand, there’s a lot of work to be done with families to help them understand about kindergarten and child care or whatever the program is that might best suit their needs. But by the same token the services have got to be more receptive.

It’s about services themselves being more inclusive or reflecting diversity or making an effort and not just running this traditional WASPish-type thing based on early childhood values.

Despite significant progress it appears that families from non-English speaking backgrounds continue to experience a service system which does not fully respect their traditions, preferences and needs. One agency thought some service environments were very clinical and unwelcoming or very ‘Anglo’ rather than culturally inclusive. Others suggested service delivery to culturally linguistically diverse and Indigenous families often comes from a ‘deficit model’ (that is, focusing on a problem to be fixed) rather than a strengths perspective, focusing on positive factors, such as a family’s resilience or determination. Others suggested sometimes services treat people from culturally and linguistically diverse communities as some sort of homogeneous group, rather than as individuals.

Lack of cultural sensitivity can take many forms. One worker reflected on the lack of fit between Maternal and Child Health service provision and the cultural practices of some groups. For example, within the Somali community, it is common practice for a new mother to be confined to home for 40 days after the birth of her child. This means the new mother is unable to attend the scheduled two-week visit at the Maternal and Child Health centre. If the woman has difficulty establishing breastfeeding, it might be too late by the time she attends the appointment at eight weeks or later.

Workers need to be alert to parents' concerns about the cultural 'appropriateness' of the service and proactively address them. It is not uncommon for parents from culturally and linguistically diverse and Indigenous communities to wonder, 'Will my child be all right, will the staff observe my cultural practices and will they be sensitive to the way I/we do things?'

I think, particularly if their religion and their culture are sufficiently different, they worry that certain cultural things won't happen, about things like toileting, or modesty, or food preferences – those taboos, those things. And they are perhaps suspicious of their children going into services and there are still a lot of services that don't do enough to accommodate what parents really want.

Some groups might have greater needs than others. For example, because of the dislocation and trauma they have experienced, some refugee children (and their parents) might need more time to be emotionally ready for school and to be comfortable about separation, or might need more support once at school.

While overt discrimination by service staff is rare, ignorance of how their attitudes and actions affect families is still apparent. Indeed, discrimination is often much more subtle, 'like giving each family an English newsletter and 50 per cent of the parents can't actually read English'. Services might provide translated information, but fail to choose words carefully so as to avoid confusion in translation. There might be a lack of attention to the provision of culturally appropriate meals, books or play resources.

Language barriers can affect both child and parent. Indeed, lack of confidence in English was cited as a common barrier to parent participation in schools. While many schools seek to overcome this by using interpreters, this does not always overcome the difficulties. For example, in classroom reading programs, parents would need to be able to read some English.

The predominant barrier here is that many of the parents don't believe that they have a good command of the English language. They feel that they will show up poorly ... and feel embarrassed.

Poor coordination and links

Another factor that might impact on inclusion is the lack of strong links among universal services and between these services and specialist (child and adult) services. For example, some people were critical of the poor links between maternity hospitals (and their domiciliary services) and Maternal and Child Health services, in particular the lack of information sharing between these sectors, which in some cases can lead to delays in addressing the needs of mothers and children at risk. Likewise, several workers thought kindergartens and primary schools needed to work better together, particularly for children with additional needs, to facilitate their smooth transition into primary school.

While there are some families who do not access services, it is also not uncommon for some vulnerable parents to have concurrent contact with multiple services and workers. For example, a mother with two young children might be in contact with a case manager in a mental health service, have a key worker in a psychiatric disability support service, be involved with a family support agency, have one child in kindergarten and the other in primary school—and somehow also have to stay in contact with her Maternal and Child Health nurse and general practitioner, none of whom communicate with each other. Such multiagency involvement is a barrier in itself because attending multiple appointments becomes too onerous and sometimes confusing:

There is currently no service that deals with a person as a whole. For these [vulnerable] people they have multiple problems and have to engage with different services to deal with each problem. There is a need for universal and specialised services that treats these people as a whole and deals with their problems all together.

Many vulnerable parents and children go through too many assessments. This is especially difficult when parents do not speak English as their first language, but is a strain for others too:

[One mother] added up that she had sixty-two appointments within 12 months, so I mean that is more than one a week. There is all the effort of getting there, the waiting, all of that, and when you consider and add that to everything else the family has to do that's not unusual, particularly when you don't know what the diagnosis is or there is a lot of medical problems and you tend to go from clinic to clinic to clinic.

While privacy issues and legislation can limit communication, it was suggested that sometimes workers use this as an excuse and do not even try to gain consent to communicate with other providers.

There was an overwhelming concern the system has too many component services, each with its own target group, eligibility criteria and length of involvement. Individual service providers often do not regard themselves as part of the broader system or do not have the time to forge links with other services. Case conferences to discuss individual families and 'networking' to inform service development and coordination are simply not funded within antenatal and universal early childhood services.

In addition, several specialist providers, particularly of drug and alcohol and mental health service, stated their funding was limited to working with the adult as the client and they therefore had no capacity or mandate to include their child(ren) as clients as well. As a consequence, these ‘hidden children’ of parents with problematic substance use or mental illness rarely had their needs addressed in a structured way, independently of their parents.

Lack of access to universal services for children can also impact on parents’ use of services for themselves. For example, one participant from the drug and alcohol sector commented that ‘lack of child care is the single biggest reason why women do not access drug treatment services’.

Barriers related to the child, their parents and their situation

In addition to these service level barriers, the consultation also found a number of barriers that related to the child, their parents and their situation. Perhaps the most significant of these were distrust and fear.

Distrust and fear

Workers generally agreed some vulnerable parents are reluctant to use services because they feel ‘different’ and ‘out of place’ or are concerned they will be judged to be ‘bad parents’ either by the workers or by other parents. Concerns about difference might result from age (for example, a young mother in a first-time mothers’ group with mothers in their twenties and thirties), socioeconomic circumstances, mental illness, problematic substance use, or disability. Indeed, despite improvements in community attitudes, a considerable stigma remains attached to many of these issues. For example, people with a mental illness or problematic substance use are often judged as ‘different’, arousing anger, disapproval and fear. Parents with a disability might also feel judged, particularly during their pregnancy, and might become circumspect or fearful about using services. Likewise, many of the young parents interviewed also felt judged, particularly if they were single parents.

That’s the way they see us – kids having kids.

I left her father while I was pregnant and as soon as anyone would find out that you’re not with the child’s father, you’re just another young mum who has just had the baby for the money. You’re just going to have 50 kids to 50 different fathers.

Such negative and judgmental attitudes are not confined to the lay community. They are also observed among those who provide services:

DHS welfare were on my case before and they actually said if we [partner and I] were older it wouldn’t have happened.

Negative attitudes can often be displayed unconsciously, as well as more overtly. One worker recounted the story of a parent's daughter who developed nits. The child's teacher brought her home and was preparing to 'lecture' her parents (who have disabilities), thinking they didn't or couldn't keep the child clean. When she saw how clean and tidy the house was, she changed her attitude completely and her body language changed too. In another instance, one young mother was pressured by her doctor to have an abortion after they found out the baby had a cardiac problem, thinking she was too young to handle the child's extra needs.

When you are a disabled parent sometimes you don't get treated like an equal ... by teachers, kinders and family.

This stigma can have an enormous impact on service use through the anxiety it creates in the minds of the parent. As a consequence of regular negative experiences and the fear of being judged an 'unfit' parent, vulnerable parents might become very secretive about their situation and highly sensitive to the reactions of others. Insensitive service providers might 'lose' such parents very quickly:

There's a whole lot of 'covering up' that occurs within these families. This sense of secrecy extends to their children who have learnt to 'watch out' for their parents and remain tight-lipped about their situation.

Some vulnerable parents have 'internalised' the stigma and actually think of themselves as 'bad parents'. They might therefore fail to use or quickly cease to use services through embarrassment, shame and a sense of hopelessness.

Many parents have the even bigger fear they might be reported to Child protection services and they might 'lose their kids':

The other problem is parents are very scared of child protection, very, very scared and sometimes they don't want to come to places.

They are scared to actually go and see [service providers] because they are on methadone, they're in domestic violence, so they are people who are actually going to hide. They're really private, they don't want to access the service at some level as well because they are going to get found out, the story is going to be told and so this child might be taken off them.

Social exclusion can affect more than one generation in a family. The child's experience of their own and their parents' interaction with services can have a profound effect on how they use services when they in turn become parents. Negative or traumatic experiences (such as being placed in care) in childhood or in the lives of close family and friends can prejudice their view of services in the future.

Likewise, the history of a particular organisation can be a barrier, particularly among small, tight-knit communities and cultures. Many Indigenous parents might be reluctant to use certain services which historically had a role in the forcible removal of Indigenous children or which adopted segregation practices.

Other parents might lack self-confidence or feel intimidated by the imbalance in power between the worker and themselves or be resentful of authority figures. This might particularly occur with young mothers because of the power imbalance between the mother and 'high status' workers, such as doctors or nurses. Many vulnerable parents lack the confidence to assert their needs and views, particularly in the face of authoritarian service providers. Overall, distrust can be very high:

I thought, why come around and pretend that they're [Maternal and Child Health nurses] just coming to talk to you when they're really just checking the house out? They may as well say 'I'm coming to check your house out', come look at it and go.

Expectations and value placed on the service

In some instances, failure to use a service or limited use of a service might reflect the different 'value' people place on services and their expectations about what should be provided. People need to see the service as useful to make the effort to use it, particularly in the face of numerous obstacles.

Much depends on cultural norms. For example, a group of young Somali mothers commented that in Somalia, women might not have much antenatal care, are less focused on 'how many weeks' pregnant they are, and might only present for attention once labour has commenced. Even though mothers recognise antenatal care in Australia is 'more compulsory', many mothers act from the belief that 'if they are not sick' there is no need to attend.

Just as some people prefer to use 'alternative' health practitioners over 'Western' medical services, it was suggested some parents prefer 'alternative' services for advice on Maternal and Child Health or parenting and regard Maternal and Child Health services as 'old fashioned' or operating from a 'middle class' or 'medical' paradigm.

Different values were also mentioned about kindergarten. For example, it was suggested certain cultural groups see the current model of kindergarten as 'just play' and not 'real education':

Parents might say he's not learning anything, he's just playing all the time.

Services need to better promote what they offer and explain why they offer programs in particular ways (for example, the role of play in learning and literacy and numeracy development. At present, this does not always occur:

I think there's always been this feeling that we were lucky in Australia, we had this wonderful kindergarten system and it was viewed overseas as a wonderful program based on play and initiated learning and very Anglo and Western and full of good values and everything else and I think teachers just felt that they didn't need to explain it to anybody.

Workers also mentioned that certain cultural groups are not inclined to use formal child care, preferring informal care, or perhaps might believe it is only 'valid' to use child care if they are working, rather than for 'time-out' or for the child's own benefit:

You can actually look at occasional care across Melbourne and I'm sure that [culturally and linguistically diverse groups] would be massively underrepresented. I mean, to leave your child while you went shopping would be an absolute anathema, I would think.

Some families prefer to have their children at home with the family until school age and not use services such as kindergarten:

Quite a few of the children that we have come into the school have never experienced anything outside of the home apart from contact with cousins or other extended family.

In primary school, there is often a 'clash' of attitudes, with some parents believing 'education' is the school's responsibility and they don't need to be involved and most schools trying to promote parental involvement in the child's learning. Parents' time, ability and attitudes affecting involvement can vary enormously. One principal commented:

We are trying very hard at the moment to change the community attitude from one where they expect the school, or want the school, to churn out a finished product at the end, but don't necessarily want to take part in that.

Another view held by some parents is that missing school in the early years 'isn't a problem' when compared with (say) high school. A couple of principals commented that every year they would have parents (from non-English speaking backgrounds) take their children out of school for extended periods to travel overseas, sometimes without telling the school or taking school work with them, believing it didn't matter because it was only primary school.

While promoting parent participation in schools is desirable and important, schools (and the parent community within them) need to accept that not everyone can or wants to be involved and that this should not be 'held against them'.

I know that our school absolutely relies on parent helpers and the problem is that when you're unable to do that, you're ostracised for that. And it's really difficult when you're being ostracised by the other mums. It's like, 'You never come and do reading'.

I'm in that boat now and that's what I get said to me: 'Well, why don't you come to the school and read?' I can't do it. I haven't got the confidence to get up and do it.

Value is also defined in terms of personal experience: ‘What was good enough for me is good enough for my kids’. As already alluded to, some vulnerable parents might not have been taken to services such as the Maternal and Child Health centre, child care, playgroups or kindergarten when they were children nor have seen immediate family or friends using the services. It might not be the ‘done thing’ in their experience nor be seen as offering any benefit. This impact on current perceptions was said to be particularly apparent among parents who had had negative educational experiences during their own schooling. It was suggested many of these parents subsequently do not ‘see the value’ in school.

We therefore have a situation where the intrinsic value of education is not necessarily completely understood by many parents. And so therefore in prep a lot of children have absences which are not necessary.

‘Value’ is a relative judgement. Some parents might have more pressing things to attend to:

Parents themselves often have limited education, so school to them is not always seen as an important aspect in their children’s lives. There are many other critical things on the parents’ minds, such as finding secure accommodation and a place to sleep the night. Often thinking about getting the kid off to school comes after thinking about these basic needs, therefore children living in homeless families miss out on a lot of school, they are often late or they have no lunch and turn up to school hungry which [makes it] hard for them to concentrate.

In some cases, lack of attendance might simply be a matter of parents feeling confident to provide for their children without the assistance of services. This was suggested as a common reason for the gradual decrease in attendance at Maternal and Child Health services as the child grows older and for subsequent children. Parents might simply feel more confident and not see a need to attend the service and, if they do have concerns, they might go to their general practitioner rather than the Maternal and Child Health nurse:

You learn with the first one so you don’t need to keep going.

Conversely, one worker suggested lack of access could be symptomatic of a wider pattern of neglect:

Originally the role of early childhood services was to service vulnerable families, however now they are mainly used by families where both parents are working. The vulnerable families that need the services are often jobless or are the type of people who will not access services on their own accord ... If the family can abuse the child then [why] would they have the thought to put them into early childhood services for the child’s own good?

Health and mental health problems

People's physical or mental health can also directly impact on their use of services. Several workers suggested, as a general rule, people with a serious drug or alcohol use problem tend to underuse most services:

I mean a problematic drug user doesn't access services, full stop. They don't access services unless they need to access them for really critical reasons.

This can occur for a range of reasons. Serious substance use problems often lead to a chaotic lifestyle in which routines might be difficult to establish and people might live on a day-to-day basis. Appointments or other commitments made some weeks or months ago might be displaced by an immediate pressure which takes up their focus and time. The substance use might also directly impair the person's memory, motivation, planning and organisational skills.

Likewise, mental illness might interfere with a parent's ability to access services. Depression can sap motivation and energy; anxiety can create avoidance; and psychosis can lead to disorganised behaviour, suspicion or paranoia or negative symptoms, such as loss of drive. These problems are particularly evident if the illness is untreated or during times of relapse. Prompt recognition and treatment are vital:

Because I got postnatal depression I basically withdrew from everything ... People don't access services because they don't feel they can do it. They don't feel confident enough to go and say 'I need help' ... Everyone is coping and you're not so you're a failure ... and you don't want to have to admit that there's something wrong.

In these circumstances, parents might need workers to be more proactive and 'assertive' in their contact or follow-up:

There needs to be a point where the health centre sisters are a little bit more perceptive, or I don't know, maybe forceful, to make sure that things are done.

Other barriers

Other barriers noted relating to the child, their parent and their situation include:

- Unstable housing, homelessness and family violence cause some children and parents to be unable to access or maintain contact with services because of the need to move around.
- Parents going through separation might remove their children part way through a year at kindergarten or school because they are relocating or have changed custody or access arrangements.
- Parents working odd shifts might be unable to get their children to kindergarten or school on time.
- Parents with literacy problems might find registration and application forms difficult to complete.

- Children who have not been immunised might encounter administrative barriers to kindergarten and school enrolment.
- The larger the family, the greater the practical barriers that have to be overcome. Some parents with large families simply do not have the time to use services.
- Children who have to act as family ‘interpreter’ or who have to take on a parental role, perhaps looking after younger siblings as a result of their parent’s ill health or mental health, might have a lot of absences from kindergarten or primary school.
- Children who are taken to kindergarten or school by their grandparents while their parents work might be unable to attend the service if their grandparents become unwell.

Strategies to promote access and inclusion

In addition to being asked about barriers to inclusion, parents and service providers were also asked to describe potential solutions. These discussions revealed a range of possible inclusion strategies, many of which have already been adopted by services. Overall, consultation with parents and providers confirmed the importance of most of the strategies and principles outlined in the literature review.

Inclusion strategies could be loosely grouped into:

- strategies that seek to overcome ‘practical’ barriers
- strategies that build the relationship between the service user and provider or other parents
- strategies that ensure services are culturally sensitive, relevant and useful
- strategies to build links between agencies.

Overcoming ‘practical’ barriers

The first group of strategies addresses one or more of the ‘practical’ barriers to inclusion, such as lack of information, cost and transport difficulties.

Promotion and publicity

At present, promotion of antenatal and universal early childhood services is largely left up to services at the local area level, with some additional statewide promotion and publicity from the Department of Human Services and the Department of Education and Training. In most areas, however, the active promotion of services is limited, being largely in printed form, such as pamphlets or information in council directories (hard copy and web-based). It would appear that it is largely assumed parents will know services, such as antenatal care, child care, kindergarten and primary school, exist and they will independently find out who provides what and where. The exception is Maternal and Child Health services, in which the Maternal and Child Health nurse takes responsibility for proactively contacting parents on receiving a new birth notification.

Unfortunately, it appears 'knowing about' services is not so straightforward for some vulnerable families and services might need to do more to inform potential services users about programs and their benefits, with a particular focus on 'targeting' vulnerable groups.

Information needs to be provided through a variety of media and any printed information should be simple to read, provided in relevant community languages and readily available. Information should describe the services on offer, how to access them, fees and charges and other useful information.

Some workers argued that given the 'universal' nature of services and the common issues of access and inclusion across the state, this promotion and publicity should be conducted at a statewide as well as a local community level. This could take the form of community education campaigns (similar to those used to prevent traffic accidents, smoking related illness and skin cancers) with messages about the benefits of early and regular antenatal care, the importance of age and stage visits in Maternal and Child Health services which are not presently well attended (for example, the three and a half year visit), the benefits of kindergarten and the importance of parent participation in schools. One worker also commented it is essential that free services be advertised as free so people are aware of their existence.

Services can also be promoted by being more visible. The move by one Maternal and Child Health centre to a shop-front location within a shopping area has increased opportunistic service use.

Other staff noted antenatal and universal early childhood services could play a bigger role in promoting each other's services. Existing examples include the promotion of Maternal and Child Health services by antenatal services and the promotion of playgroups, child care and kindergarten by Maternal and Child Health nurses:

New mothers are given a prenatal and postnatal information pack containing information about services, information session times, phone numbers and website addresses, books, equipment hire, nutrition information, recipes and samples of products at the Royal Women's Hospital – this works well.

Given the knowledge and other barriers already described, it is vital any worker in contact with a vulnerable family advocates on their behalf to access other parts of the service system and funded services assist one another in reaching their potential client groups. For example, there is a window of opportunity whenever a parent comes for assistance within the adult specialist service system (for example, disability, mental health or drug and alcohol services, housing support) to link their children into appropriate universal services. The reverse is also true. Workers in antenatal care spoke of the opportunity when a pregnant woman seeks antenatal care to link her with relevant specialist services.

There is a window of opportunity during pregnancy when parents are more receptive to accessing services, for the sake of their child. Most parents want to do the best for their child.

Unfortunately, these opportunities for ‘cross-promotion’ are frequently missed because workers fail to consider them.

Promotion could also occur through general practitioners, since many parents with young children will attend their local general practitioner on a number of occasions:

You could put in flyers or posters in every doctor’s surgery because they are going to visit the doctor between ages two and four.

Some councils advertise through local newspapers but not everyone—particularly people from a non-English speaking background—reads these. Advertising through ethno-specific radio programs or newspapers might be more appropriate for culturally and linguistically diverse groups. Information has to be regularly reinforced. Some councils and centres have conducted community days and expos to promote early childhood services, with some success; however, such one-off promotions are not enough on their own.

Sometimes information might best be provided visually. For example, one school produced an in-house video with the help of their Turkish speaking community worker to inform parents about a proposed school excursion. In addition to the Turkish narration, the video included footage of the location, the activities the children would be undertaking and the accommodation where the children would be staying.

Reminders can be used to promote regular attendance. One group of Maternal and Child Health nurses has adopted a computerised system to alert parents to appointments, which includes sending birthday cards to the children with appointment reminders for parents.

Unfortunately, promoting a service such as child care and kindergarten might be seen as unimportant if management believes enrolments are adequate, or pointless if the service does not have the capacity to absorb the increased demand.

Reducing costs

Given the difficulties experienced by vulnerable families in relation to kindergarten, child care and school related costs, further reducing or eliminating financial barriers to access would be an effective inclusion strategy. While both Commonwealth and state subsidies are available to support access to these various services, greater government support appears to be required to overcome this barrier:

It is essential that children from vulnerable families have access to child care and kindergarten programs as they are fantastic opportunities for both the children and the parents. In order to do this, fees must be made as easy as possible for parents and there needs to be flexible arrangements available for payment of fees.

In relation to kindergarten services, some workers suggested the simplest solution was to provide free kindergarten for all children. Others suggested free kindergarten should be provided for vulnerable children based on factors such as parental income (using a fairly high threshold), ethnicity, length of time in the country, parent or child disability, or other psychosocial factors contributing to risk. Others simply called for an increase in the current government kindergarten fee subsidy provided to parents with a health care card or pensioner concession card.

A few workers also believed vulnerable families should have free or subsidised access to so-called ‘three-year-old kindergarten’ (activity groups) as well, with the benefits likely to far outweigh the costs:

I think a good long-term strategy would be funded three-year-old kindergarten. I think that would make a significant difference from a universal point of view.

One strategy that has already helped overcome cost barriers for low income parents has been the Early Childhood Education Trust Fund organised by Kindergarten Parents Victoria. Initially funds were donated by a peak body and subsequent fundraising has taken place to maintain the fund.

The trust fund serves a twofold purpose: first of all keeping the child there [in kindergarten] but also helping to keep the kinder afloat. It's worked reasonably well. The [parent's] application generally comes through the kindergarten teacher. Some families might be reluctant to do it [apply for fee relief] and sometimes the [parent kindergarten] committees don't know [the fund is available].

To be successful, kindergartens need to be more active in promoting the fund's availability. In addition, the fund requires more financial support from government or from business and philanthropic donations.

Apart from increasing direct support to disadvantaged parents, several workers thought additional financial support also needs to be provided to services, particularly those in ‘disadvantaged’ areas. For example, kindergarten per capita grants could be further refined to include an additional ‘weighting’ for services in areas with high levels of socioeconomic disadvantage or cultural and linguistic diversity.

Support with transport, outreach and home visiting

Several suggestions were offered for overcoming barriers related to access to transport. First and foremost several workers stressed the importance of locating services close to public transport and improving the frequency of the transport. Others suggested funding antenatal and universal early childhood services to provide taxi vouchers for clients, while one worker suggested providing subsidised taxi fares directly to parents with young children. At present, subsidised taxi travel is only available for people with permanent severe disabilities.

Other options include a 'pick-up' bus for children attending the same kindergarten or primary school or recruiting volunteer drivers to drive parents or children to and from services. Parents attending kindergarten and primary school often set up informal arrangements to help one another with drop-offs and pick-ups, but these are often linked to vehicle ownership. Parents without a car might be reluctant to become involved in such arrangements because they cannot reciprocate. A driver scheme available for everyone might therefore be more acceptable.

A number of Indigenous services offer a bus service to pick up children. A few workers commented that without this 'pick-up' many families would struggle to attend regularly and it is seen as a core component of service delivery. As with most strategies to increase access, it is important the child and parent do not feel singled out or exposed as 'in need'.

By far the most common suggestion, however, was to increase services' capacity to provide outreach and home visiting. Maternal and Child Health nurses unanimously endorsed the recent introduction of enhanced home visiting as an effective strategy for reaching vulnerable families (indeed most would like to see more time and resources in this area). Home visiting allows the worker to gain a clearer picture of the family's domestic situation and is seen as a practical and non-threatening approach. Home visiting also reduces the power imbalance, as the worker 'is on the parent's turf' and the parent therefore has a greater sense of comfort and control. One worker stated parents appreciated that a worker was willing to 'make the effort' to see them. This made them feel important and 'cared about'. Parents value this approach to service delivery:

After I got out of hospital someone came to visit me, so that part was good and really organised.

When they come to your house it's more convenient, especially when I wasn't driving because you don't want to take them [the child] out, especially in winter.

Some primary schools also use home visiting to reach families. Although it is more commonly done on a 'targeted' basis to follow-up children and families who are having difficulties with school attendance, one principal described how this could also be conducted on a 'universal' basis:

One of our staff members last year set up a roster and visited every child in her grade throughout the year. You know – a couple of hours, share a coffee, have a talk. In that way you can see what are the child's living conditions and how they react with their parents at home.

It is better for home visiting to involve the child's teacher rather than just the welfare coordinator:

While I could go off and the assistant principal could go off and see family's homes and visit the family, but we can't give the teachers a perspective of what that home is like ... If they were able to go into some homes and see what the home is like they would be better able to understand why the child acts the way they act.

Such an approach takes time and funding to provide a relieving teacher, but it is worth the effort and makes it clear you are interested in the child and the family.

Increased capacity for outreach could also allow workers (or volunteers) to drive parents to attend appointments at other services, thereby facilitating referrals and links.

Unfortunately, most child and adult services are only funded to provide centre-based contact. A few services have sought to overcome such barriers by cross-subsidising outreach or home-visiting from other program areas. One worker in an antenatal service has even resorted to using her own vehicle to maintain contact with some vulnerable clients. While clearly a solution for engaging clients, providing outreach and home visiting is costly and time-consuming and cannot be achieved unless it is specifically and adequately resourced and staffed. However, it is clearly *one of the single most effective strategies* to engage vulnerable families.

Building positive relationships

The second group of strategies aims to promote inclusion by building stronger ‘relationships’ between the services user and service provider or between the service user and other parents.

Addressing staff attitudes and behaviours

Throughout the consultation, worker after worker suggested inclusion is very dependent on the personal qualities of the worker and their capacity to establish a non-judgmental relationship with the service user. As previously indicated, many vulnerable parents have very deep feelings of distrust and resentment towards government services, particularly child protection services. In addition, parents might be low in confidence and not very assertive. Many will stop attending if they perceive they are being criticised or ‘lectured’ or excluded from or overridden in decision making. Workers need to be mindful of these issues and work to alleviate distrust and build a collaborative relationship.

To do this, workers need to be sincere, accepting and respectful. They need to focus on the parents’ strengths and work ‘with them’ not ‘on them’, listening to their issues, involving parents in decision making and empowering them:

Really working with the families, wherever they are at, and really listen to what they are saying they need ... that’s really important, so it’s working together. And listening to the families and what their priorities and issues are and not making the assumption ... that the family needs this, but listening to what the families are saying.

Parents have to be empowered in the first place ... You have to support the parents first. The parents are ‘stressed out of their brains’, alienated from the culture, or – say with a child with a disability – completely stressed out about what’s happening to [their] child. The child’s not going to thrive so you’ve got to look after the parents.

Providing information about child development and care, discussing practical supports available and assisting parents to build support networks are all important ways of empowering parents:

Knowledge is power, we always say that. Getting that knowledge so that they can go on their own and pursue things. It's very daunting on your own. We try and encourage and connect parents. Support groups are a great way of connecting parents, you get great information from other parents.

A lot of parents in this area often just need to learn how to be a parent and they need assistance in a range of practical ways.

It is often a positive and warm manner that counts the most:

The first one [maternal and child health nurse] was brilliant. She treated me like a human being, she treated me like a friend, it wasn't just about [the baby] being weighed. She is still friends and we talk over the phone.

They [staff at service] don't pass judgement, they don't look at you like that.

Every worker within every service needs to develop this non-judgmental, empowering attitude:

They might be a drug-addicted person, they might be whatever, but treat them with the same compassion that they [workers] would want to be treated with, instead of acting like they are God.

The timing and intensity of the support is very important. Certain times, such as the immediate postnatal period, represent 'critical points' when things can either progress smoothly or be derailed. An individualised approach to assistance is required, matching the level of support to the level of need. Parents did not always experience this:

In hospital, they tried to get me out as soon as possible and being a first-time mum, I needed help with breastfeeding. I don't think I had enough support.

They don't understand that every person and situation is different. They treat everybody's bodies as the same.

Building trust also requires continuity with the same worker, particularly in the antenatal period:

I had different midwives. I had one for three weeks in a row who I confided in and then I got turned to one that I didn't even know.

I've been going to [antenatal service] and have had six appointments and every time I've had a different doctor.

A few people also emphasised that workers need to be proactive in following up 'at risk' children and parents and that communication between services and parents needs to improve.

We have children often coming through our service and they've got huge learning difficulties, lots of health problems and things like that, and they just don't get picked up at school or in the child care centre. And even if the child does present difficulties later on, [schools] just don't approach the parent either. I don't know if they think the parents just don't care. [The teachers] don't chase them up, they don't follow it up.

Ultimately parents want empathic, supportive help, not help that is about surveillance or being told what to do:

They [Maternal and Child Health nurses] were real friendly. You could ask them for anything and they'd just give you the advice. They don't try and push you or anything like that. And you could talk to them anytime, they say that they are there to talk to.

Others mentioned a balance has to be struck between providing for the needs of the parent and meeting the needs of the child. One worker believed services could currently be split into those that are biased towards a focus on the child (Maternal and Child Health services, child care, kindergarten and primary school) and those that focus mainly on the parent (antenatal services and family support agencies). She felt more needed to be done to promote a 'whole-of-family' focus.

However, it was acknowledged it is not always easy to get the balance right between child and parent, between being empowering and being directive, or between offering non-judgmental support and challenging abusive or dangerous behaviour. Indeed, some workers emphasised that with some vulnerable parents (for example, a pregnant mother abusing substances) the need to involve Child protection services was an ever-present possibility. Hence, several workers suggested it was important to be honest and up-front with people about their role and responsibilities. It was also important to prepare people in advance and keep them informed of any decisions that had to be made 'and not just go behind their back'. In this way the worker would hopefully come to be seen as an ally rather than a traitor.

One agency suggested employing parent advocates within universal services to help vulnerable families negotiate the system and keep parents informed of their rights. In this model, a worker could contact an advocate on the parent's behalf if difficulties emerged to assist the parent in their interactions with services. Alternatively, the system could be structured to provide parents with direct access to advocates who would be expected to provide support, advocacy and links with services and informal supports. Parents with personal experience of the difficulties that confront vulnerable families could be employed to fill such a role.

Professional development

Clearly, engaging and assisting vulnerable parents and their children is a skill—one that can be developed with time and training. Several people, therefore, commented on the importance of providing adequate professional development activities for workers, some focused on general engagement and communication skills (including broaching sensitive topics) and others designed to assist workers to better understand the specific issues that might confront particular families (for example, substance use, mental illness, disability). Providers in universal services could benefit from training by workers in specialist services with particular expertise. Wherever possible, such training should be conducted jointly by a consumer and a provider.

Within this training, early childhood professionals need to learn about the diversity of families and their experiences. They also need to review their own prejudices regarding what they believe constitutes ‘competent’ parenting.

Volunteers, peer and paraprofessional supports

Not all services and supports need to be offered by professional providers. Support and services provided by volunteers, peers or paraprofessionals could be a useful way of engaging some parents. Such workers are often regarded as less threatening and more ‘like me’.

The involvement of volunteers is particularly useful for engaging socially isolated parents who might need ‘a buddy’ as much as a service. The ‘buddy’ might also provide practical support with home duties, transport or child care, and become the person’s link with the broader community. One worker mentioned a program in the United States in which women who were pregnant had access to a volunteer support worker who provided practical and emotional support and facilitated attendance at services.

Several volunteer programs focused on providing support to children and families are also operating in Victoria; however, most are small scale, local initiatives and many have been unsustainable because they depended on short term funding. A coordinated, recurrently funded, statewide approach might provide economies of scale and greater opportunities for continuity, as well as facilitate wider availability. It might also allow more thorough screening of applicants.

While volunteer programs require resources for recruitment, training, supervision and support, they are, in the words of one worker, ‘cheap as chips’. Recruitment and retention can sometimes be a challenge, but making the commitment time-limited and the tasks required of the volunteers very practical can help to reduce these difficulties.

Another successful strategy is training and employing parents as service providers or support people. This seems to work particularly well when the parents who are trained and employed are from vulnerable families themselves. Vulnerable parents are more likely to use the service if meeting with ‘like’ people, including workers who have been through similar experiences. For example, one antenatal service has introduced peer education workers for young first-time mothers. These workers are

parents who have previously been through the service and who provide support to the new mothers and link them with the service social worker. Another example is the parent support workers (all of them parents of children with a disability) at the Association for Children with a Disability.

Our experience is the fact that we all have children with disabilities, we have similar experiences [to the parents we work with] and I think that's what parents really value when they ring up.

Informal support

When asking parents what they need during the early years of their children's life, by far the most common response was support:

Support, support people are great ... just to know you have someone there, that's always gonna be there. It makes life much easier when you've got people to support you.

Given the level of family breakdown and social isolation experienced by many vulnerable families, one worker argued universal early childhood services need to adopt more of a 'community development' approach, focusing on bringing families together, to form informal social networks and friendships. Groups could also provide and share information about parenting or universal and specialist services. Such networks can also become conduits for service access:

People have to be connected – human beings are social animals ... So that's the most important thing and the most effective thing. Because when people are with others all sorts of strengths are released and there's natural ways of resolving issues and emotional support.

Such groups do exist: Maternal and Child Health services offer first-time mothers' groups, playgroups are also very popular and several child and family services run their own groups. Despite this, more needs to be done, such as offering groups for particular 'populations' and enhancing coordination. Opinion was somewhat divided, however, in relation to population-specific groups. For example, while some favoured the suggestion of providing groups for young mothers, sole parents or mothers from a particular culturally and linguistically diverse community, others thought it was too stigmatising and labelled the parent as different. One parent who had attended a young mothers' group thought it was excellent:

[I felt] a lot more comfortable, heaps more comfortable ... Like I knew they're in the same position as me, really so I didn't need to see who's looking at me and what they were thinking, so that was good.

However, some workers said they had had trouble recruiting interested parents to population-specific groups. Others thought it was difficult to organise too many types of group. One worker suggested different local organisations could take responsibility for particular groups to which everyone could refer possible participants. She felt this would encourage resource sharing and would avoid different agencies in the same area offering groups for the same populations (for example, young mothers) while others (for example, fathers) were missing out altogether.

A mix of independent and facilitated groups was also suggested. Some parents simply lack the confidence or resources to run a group among themselves or feel uncomfortable in groups that require them to organise a session or host one in their home. Opinion was divided about whether facilitated groups should involve both parents and children or whether it was better for parents to meet separately, while the children were placed in child care at the same centre (such as a neighbourhood house). Parents and children could then perhaps come together over morning tea or lunch. This could provide much-needed respite for parents caring for children on their own and also an opportunity for the adults to mix with other adults and the children to mix with other children.

Some emphasised that social or educational group activities for children and parents should not be restricted to parents with kindergarten children, but could also be adopted as a way of involving parents in primary schools. Indeed, several people agreed primary schools need to be more active in involving parents, particularly in the first few weeks and months of school. Some suggested welcome barbecues or other fun activities. Others thought the school should allow more use of its facilities, particularly after hours, for social and recreational groups for parents.

There is no single ‘perfect’ way to achieve such informal parent participation, but rather many potential ways, as long as services are supportive of the concept and commit resources to it.

It is also worth emphasising that social connectedness is not only fostered through ‘structured’ activities, but can also occur spontaneously given the right environment, although this is not often ‘exploited’. Many early childhood services do not have a place for parents to congregate before, during or after sessions. This promotes a drop-off/pick-up arrangement and discourages informal social connections.

Providing services that are relevant and useful

The literature review points to parents’ use of services as the end-point of a process of weighing up the advantages and disadvantages of attendance or participation, and the social norms associated with the use of particular services. These norms might be part of the society in general or peculiar to a person’s particular sub-culture.

In general, the more relevant and useful a service, the more likely it is parents will use it. Therefore, in addition to overcoming practical barriers and building positive relationship, services also need to provide culturally sensitive services that offer something of perceived short term and long term value for effort. The latter might be achieved by enhancing the services of each program area for everyone or for particular groups or particular individuals.

Promoting cultural sensitivity

There are a number of strategies that can be used to promote cultural sensitivity. These include:

- promoting uniform standards for culturally sensitive practice within services
- providing easy access to appropriately trained and qualified interpreters and to translating services
- employing full time, part time or casual bicultural and bilingual workers
- promoting the use of multicultural written resources and play equipment
- providing staff training and consultation support.

Workers said that uniform standards need to be comprehensive and enforced to be effective. While detailed guidelines do exist, current systems such as the Quality Improvement and Accreditation System in child care are fairly general and the requirements are not rigorously enforced. One worker suggested that since the Quality Improvement and Accreditation System is a peer review process, operators are reluctant to set the bar too high for others for fear of having to meet the same criteria themselves. In addition, providers might not have sufficient understanding of multiculturalism to be able to enforce the standards.

It is also too easy for people to make only a token effort by borrowing multicultural resources for a day or by arranging for bicultural workers to be present when the review team is scheduled to visit their centre. On the other hand, some operators complain the 'gold standard' proposed by multicultural advocacy groups is too onerous and too expensive to implement.

One of these agencies, the Free Kindergarten Association Multicultural Resource Centre supports child care and kindergarten services to promote the inclusion of children from culturally and linguistically diverse communities. Funded by a mixture of Commonwealth and state sources, Free Kindergarten Association Multicultural Resource Centre provides a wide range of services, including consultancy support (in person and by telephone), access to bilingual workers, training for staff, development and distribution of culturally relevant parent information and educational resources (books and toys), a library service and a mobile unit. By and large, child care services and kindergartens make effective use of these services, though some organisations do not use them at all. The greatest problem, however, is meeting demand and the Free Kindergarten Association Multicultural Resource Centre has had to establish waiting lists for some of its services.

Promoting cultural sensitivity requires a skilled workforce. Staff training is essential and governments need to allocate resources to assist staff to develop culturally appropriate programs:

Services really need to ... actively seek out to improve their cross-cultural understanding, as well as their cross-cultural communication skills. So the staff need training, they need to engage with parents who come to them in a different way ... And then when they have a child in their care I think the staff need to take additional strategies to make sure the child is participating; just being physically present doesn't mean that child is feeling included.

While training of staff in cultural issues is carried out, it's really not enough to have a couple of hours at night after a long day talking to workers about a particular culture, I mean that's just giving people a taste of what's involved. To move away from ethnocentrism services have to understand that diversity is normal, it's not on the fringe.

Given the history of this country and the level of disadvantage experienced by Indigenous people, some workers argued there needs to be a policy of affirmative action to entrench Aboriginal cultural studies and priority for Indigenous families within all services, above all other cultural groups or other disadvantaged groups.

Flexibility and responsiveness

The more the service can meet the person's needs, the more likely they are to use it. These needs are often very practical:

There was a counsellor there [at the antenatal clinic] that was good as well. She helped me with like anything that I need – housing, nappy services for example. If I had any questions I would just go to her and that was good.

Attending the service must be worth the effort:

Hospitals need to make longer appointment times when you're pregnant. There's no time if you've got questions to ask, they don't have time to stop and listen. It takes you two hours to get there for that five minute [appointment] – it's pointless.

The timing of the service response is also crucial. School holidays can be another stressful period. As one worker explained:

I find that with parents with just that little bit of extra special need, the school holidays is actually quite a problem because this [support] group closes and all of women's support groups, playgroups, anything that they're doing to get out of the house so they don't go stir-crazy.

Every mum coming home from hospital, I reckon – I know there probably isn't the funding – but they all need to have some sort of support for the first six weeks, because that's when it's crucial.

Adding value for parents

In some settings, particularly kindergartens and primary schools, services have intentionally included activities in the service of direct benefit to parents, as well as their children. These include social activities, such as playgroups or cultural events (for example, lunches), information for parents about child development or services, including talks by well regarded members of the local community, and vocational programs for parents (for example, computer courses). In some instances, services (for example, schools) have offered assistance with transport or taken other practical measures to encourage attendance.

While progress can be slow and perhaps only a limited number of parents will ever take up the opportunity, successes do occur. It is important that opportunities for parent involvement are culturally inclusive (for example, use interpreters, provide training courses in community languages). For some services, space might be a limiting factor to providing such activities, however it is certainly a developing trend, particularly in schools.

In addition, a number of schools have headed down the ‘full service school’ pathway, bringing services, such as family support and mental health services, into the school. This draws parents into the school environment and eases the burden for children and parents who need to access multiple agencies.

Services might require a coordinator to develop and implement these initiatives. Such a position might be full time or part time, focused on including all parents, or perhaps targeted to particular parents. For example, one school servicing a community with a very high Turkish population has employed a part time Turkish community liaison worker in a community development role to ensure the school is better engaging parents.

Indeed, a few workers suggested that employing ‘different’ staff (such as community development workers) could further enhance service delivery within universal services by creating mini multidisciplinary teams.

Services for specific groups

Ultimately, providing a *universal* service does not mean providing a *uniform* service. A number of workers commented on the benefits of providing ‘services within services’ for particular population groups. In antenatal services, this has led to the development of specialist ‘sub-clinics’ (for example, for young mothers, mothers with a mental illness, mothers with problematic substance use) within the universal service. These allow women to be given a specialised service by someone who understands their issues and also provides parents with an opportunity to meet other parents in similar circumstances. As far as possible this care is provided in local community settings rather than in the hospital. Many parents prefer such services and the sense of ‘fitting-in’ they create:

You meet new people your own age and they have kids as well. Even if you don't get to know them, just walking in there and being able to feel confident. Not be scared like you're some kind of freak.

The clinic that I did my antenatal check-ups with was specifically for young women who were pregnant, so that made me a lot more comfortable ... I knew they were in the same position as me, really, so I didn't need to see who was looking at me and what they were thinking, so that was good.

Some parents, particularly Indigenous parents, prefer to use community-operated services, rather than mainstream services. These ‘population’-specific services might be standalone or part of a mainstream service (for example, Koori Open Door Education programs within schools). Indeed, while cultural sensitivity in mainstream services is important so too is a ‘familiar face’. As a result, many Indigenous people prefer to attend Indigenous services since they are ‘more like a family, where everyone knows everyone else’.

Likewise, ethno-specific services for certain culturally and linguistically diverse groups might sometimes be appropriate. For example, an ethno-specific playgroup for parents who have recently settled in Australia might be a less threatening and useful way of bringing children and parents together. In addition, a couple of workers suggested there is a small but significant proportion of people in culturally and linguistically diverse communities who will always prefer an ethno-specific service.

Comprehensive assessment

While it is important some ‘valued-added’ initiatives are provided broadly, it is also important to tailor activities or services to benefit particular children and their parents. A comprehensive assessment is vital in achieving this and several workers stressed the importance of conducting a thorough biopsychosocial assessment of risk and protective factors, particularly during the antenatal period:

For example, when the mother is drug-addicted, the problems must be dealt with at the time of pregnancy in order to help both the mother and the infant that will be born.

This assessment needs to be extremely sensitive and clearly explained. It might need to be conducted over a couple or more appointments to establish rapport and trust. The proper ‘identification’ of additional needs not only assists with antenatal care but can also enable workers to set up links with services that will provide support after the child is born.

Arguably, similar holistic assessment and care should occur within all universal early childhood services, including kindergartens and primary schools, perhaps through the employment of staff specifically to undertake this role. Other respondents thought existing staff could provide such assessments, provided they had appropriate training. Whatever the model, a consistent approach to assessment through early childhood services is required:

MCH [Maternal and Child Health] nurses identify vulnerable families differently to how kindergarten teachers would, so there need to be guidelines established around how to identify such families.

Perhaps training staff [in universal services] to do more psychosocial assessments so that they can pick up stuff [problems/issues] and then refer clients on to other [specialist] services.

However, comprehensive assessment must be balanced with respect for parents' and children's privacy. Sometimes people just want to leave the past behind and make a fresh start or are fearful of how information will be used:

Services need to be flexible in the questions that they ask. Often generalist services ask questions that they are required to ask but may be irrelevant and inappropriate in certain circumstances.

I have certainly had people say things like 'They don't understand' ... they often don't want to tell the full details of what has happened to their child. They do get discriminated against at the school.

A central issue is how to ensure it is made clear that the questions are asked of everyone to enable appropriate support to be provided and not just asked of one family because the worker thinks 'they have problems'. If parents perceive they are being 'monitored', they will quickly disengage.

Strategies for enhancing coordination

While it is important that workers in universal services become more familiar with the issues that confront particular vulnerable families, they cannot be all things to all people. Many vulnerable families experience multiple simultaneous difficulties.

Vulnerable families tend to have a cluster of vulnerabilities, such as financial, low skills, housing, transport. We don't often find a family that has one strike against it.

Accordingly, many vulnerable families will need assistance that is beyond the time or skills of a generalist, universal system. At present, however, a number of difficulties occur in linking children and parents into specialist services from the universal service platform. Some workers might lack the confidence or skill to raise concerns with parents or might feel they will be seen to be 'interfering':

These families are already feeling vulnerable, and [the service providers] need to be honest and up-front about what's going on and what they're doing and who they're referring to. My experience is that some workers will not let the client know because there might be lack of training about how to respond to a situation of fear.

Some parents might be uncomfortable about going to a specialist service for themselves or their children, might deny there is a problem, and might not accept or follow through on the referral. More commonly, the parent might be agreeable, but specialist services are already overloaded or the parent or child does not fit within restrictive eligibility criteria.

Another major stumbling block is the lack of coordination between universal and specialist services. How coordination can be improved remains unclear and several different ideas were proposed. Examples include:

- co-location of universal and specialist services
- workers in universal and specialist services attending case conferences together
- regular network meetings between senior staff from specialist and universal services to promote intersectoral collaboration
- workers in universal services to provide 'in-reach' to specialist service settings
- workers in specialist services to provide 'in-reach' to universal settings.

Others advocate removing the universal/specialist distinction and pooling resources to create a comprehensive early childhood system in each municipality.

Whatever the approach adopted, attention to information sharing is required. Inevitably some families will require support from more than one worker or more than one service at the same time. Consequently, services need to develop a process to allow different workers and agencies to access relevant information (with parental consent) to avoid confusion or assessment 'overload'.

It is often overwhelming for the families because they have contact with so many different people from different services. For example, there is one of us from [Service] for their housing needs, a counsellor, etc., etc., so this may lead to them dropping out because the whole process is overwhelming.

Likewise, services need to have some protocol for linking people within a team or to other services. While encouraging personal responsibility is an important aspect of service provision, this should not be translated into a 'hands-off' approach. Leaving it up to parents to contact other services might not always work. Many vulnerable parents lack the knowledge or confidence to navigate the service system. Unless someone acts as advocate for the parent and child, service use might not occur.

Finally, workers also agreed a longer term approach to support is required for vulnerable families. Indeed, many people were of the opinion a sustained relationship with a key worker is crucial to achieving better outcomes for vulnerable children and parents and the current short term approach to intervention is merely a 'band-aid'.

A seamless universal base

Apart from the need to improve links between universal and specialist services, several people also mentioned the need to improve links between the various universal services to create a more 'seamless' system of services from the antenatal period to school.

The number of families who have no contact with Maternal and Child Health services is presently unclear. While for some workers this situation represents the exercise of free choice in a voluntary system, others argue attention is required to encourage more continuous use of universal services from birth to start of school.

A few people thought Maternal and Child Health services were in the best position to fill the gap between birth and start of school since they are ostensibly funded to support children from zero to six years and the Maternal and Child Health nurses should do more to stay in touch with vulnerable families until they start school. Several workers also suggested their involvement should actually commence in the antenatal period. Such contact could assist in introducing the nurse and be the first step towards establishing a relationship with the parent(s).

Others argued for the introduction of free or subsidised 'three-year-old kindergarten' to fill 'the gap' and to provide earlier opportunity to identify children with special needs.

Finally, one agency suggested the current lack of continuity reflected the fragmented 'silo' approach to service planning and funding within the Department of Human Services and Department of Education and Training and called for the introduction of an Office for the Early Years, with responsibility for all child and family services and the creation of regional early childhood networks.

Change management

Whatever the strategies adopted it was agreed that change will not be easy. Many people commented Maternal and Child Health nurses and kindergarten teachers are used to working as sole practitioners and doing things 'their own way'. They might not see themselves as part of a team or broader system. Many work part time, which makes organising meetings and providing shared training difficult. Further, not everyone is interested in change. Comment was also made that certain services, such as antenatal care, were beset by professional rivalries and 'power struggles', making change slow or impossible. This would require attention to change management and leadership. It could be useful to second senior staff from services and agencies that had successfully achieved change to act as 'consultants' for 'like' organisations and services attempting change.

Resourcing

The most consistent theme to emerge so far from the consultation relates to policy development and funding. There was almost unanimous agreement that the major problems affecting early childhood services at the moment were the inadequate funding and resources and the short term, poorly coordinated, 'three steps forward, two steps backward' approach to service development:

How to improve access for vulnerable families? I suppose acknowledgment that there is a problem out there. We need extra services and more money, more flexible guidelines.

Just [by] the mere fact of letting them know the kindergarten program exists ... you wouldn't increase the attendance much at all, because most people know it's there and most people value it ... so the group we're talking about – why don't they access it? – normally you will find it's a resourcing issue.

The bottom line for most respondents was that promoting access and inclusion would require more money for services:

Basically I think this whole area [of welfare] is underfunded and underresourced. We [the workers] are stretched! Recently there has been an influx of disadvantaged families coming to us, especially refugees. There is simply not enough resources to help these families. Overall workers dealing with disadvantaged families are overworked and underpaid.

This funding must be long term to be effective. People were highly critical of the short term, pilot or demonstration project approach:

Funding for certain programs seems to come and go ... The government needs to not just run pilot programs for short, unrealistic periods of time (such as one year), as the programs are not given a chance to get up and running or be evaluated fairly. Currently such an approach is leading to a waste of resources.

On the other hand, a limited amount of short term project funding might have some merits:

It has been a boon in enabling us to look at the needs and find ways to meet them. It is a [frustration] when a great project comes to an end, leaving a gap in service delivery in the community and unfulfilled expectation[s] ... The short-term projects have not gained long-term results but they have given us the experience to know how to go forward.

Increased funding for one area should not cause a reduction of funds for another:

Assisting vulnerable families requires additional resources in universal services and targeted specialist services because stealing from one to fund the other will not work in the long term.

Workers felt services were already stretched and suggested there was no time to devote to new or additional activities beyond their current workloads to promote access and inclusion and no way they could cope with the increased service demand anyway.

A framework for inclusion

Considering the breadth of barriers, promoting more inclusive antenatal and universal early childhood services will inevitably require the introduction of multiple, simultaneous strategies within each service. More specifically, it appears that promoting inclusion in antenatal and universal early childhood services will depend on the introduction of one or more initiatives in *each* of the four key areas outlined below:

- strategies to minimise the ‘practical’ (structural) access barriers and to support parents to overcome their knowledge, financial, transport and time difficulties to maintain attendance
- strategies to build positive and affirming relationships with parents, which counteract distrust and stigma and assist parents to build positive relationships with others
- strategies to ensure services are culturally sensitive and provide ‘value for effort’ for the child and their parents, both in the short term and the long term
- strategies to establish strong reciprocal links with other services, particularly those targeted to vulnerable families.

Ultimately, the findings indicate there is no single, ‘magic bullet’ solution for promoting inclusion. Rather, inclusion could be thought of as an overarching ‘value’ adopted by a service, supported through a range of policies and practical initiatives that are subject to regular review and continuous quality improvement, involving service users and service providers.

In the remainder of this report, the Brotherhood of St Laurence project team presents a number of examples of possible inclusion strategies, some based on existing practice in certain services or areas, others offered by the project team for consideration. These examples are organised under the key headings of the inclusion framework described above. While comprehensive, these suggestions are clearly not exhaustive and are provided merely as ‘concrete’ examples to assist early years services in their deliberations and discussions.

Guiding principles

Despite the limited availability of good quality empirical evidence, there is a significant amount of ‘practice wisdom’ about ‘what works’. The following general inclusion principles have been identified as important based on the contributions of a range of authors (Alcorn & Grant 1994; Victorian Parliament 1995; Dawson & Berry 2002; Dorman 1997; Grenot-Scheyer, Schwartz & Meyer 1998; Mackay 2001; McLoughlin & Nagorcka 2000; Jackiewicz, Lincoln & Brockman 1997; Moore, Ochiltree & Cann 2001; Ochiltree & Moore 2001; Tomison 1997; Victorian Government 1983).

Since it is highly unlikely a service will have no vulnerable children and parents among its potential client group, every service needs to establish these policies and practices. Services need to ‘act as if’ they already have particular vulnerable groups in the service. This will enable them to prepare the service to attract families, rather than waiting to change once they are there.

Drawing on the ‘practice wisdom’ of experienced providers, it is suggested that promoting more inclusive services will require attention to the following issues. These issues reiterate the findings of the literature review and community consultation.

Commitment

Inclusion requires a commitment to accepting people as they are and working to assist and involve all-comers. This commitment has to be expressed by the whole organisation. While some agencies and workers are naturally more inclusive than others, this is a principle that needs to be built into the culture of all organisations through operational plans and support to workers.

Adequate resourcing

Providing inclusive services is not an easy task and can also be time- and resource-intensive. Moreover, providing such services is difficult if workers feel emotionally stretched or underresourced. Inclusion therefore requires sufficient, appropriately qualified staff with the time and resources to involve all families and to manage the increased service demand or complexity that might occur. Adequate funding is also required to ensure services are affordable. In addition, it is essential that available resources are used effectively and services need to be willing to ‘experiment’ with new ways of using their existing capacity.

Knowing and involving the community

Inclusion requires organisations and workers to:

- know their local community and the issues that confront them
- seek out parents’ perspectives about the strengths and limitations of the service.

Inclusive services involve parents in service planning or service delivery activities. This requires the introduction of appropriate community-focused service planning, monitoring and review processes, which proactively seek

to engage the potential client group not merely as passive recipients, but as collaborators. Services might need to facilitate parent involvement by providing interpreters, child care and assistance with transport. Parents also need training and support in these roles.

Proactive focus

Inclusive services adopt a proactive focus in reaching out to vulnerable parents. Services therefore need to track who is and is not using their services and initiate contact with underrepresented groups. This can be achieved through links with other services that might be able to refer parents to them or more directly through liaison activities with community leaders or other marketing strategies. Indeed, services need to actively promote themselves and the supports they offer. This information needs to be culturally sensitive and appropriate to the needs of Indigenous families and families from non-English speaking backgrounds. Once contact has been initiated, services might also need to be sensitive yet 'assertive' in following up missed appointments or repeated absenteeism.

Family-friendly environment

Inclusive services are 'family-friendly', being presented in ways which reduce both practical and psychological barriers to engagement. For example, services need to be conducted in appropriate locations close to public transport, use clear signs, have an allocated space for parents to meet with other parents and have waiting areas that are safe for children. The physical environment should also reflect the cultural diversity of the community and the diversity of family structures.

Flexibility and relevance

Ongoing service use depends on the provision of assistance that is seen as relevant and useful. Prompt information, advice, and practical and emotional support are vital. 'Time out' is also very welcome. The timing, intensity, complexity and duration of this support need to match the intensity, complexity and duration of the issues being addressed. There are also certain times when more help might be required, particularly at transition points (for example, immediate postnatal period, post-hospitalisation for physical or mental health crises, post-separation). Flexibility is therefore very important. A 'one-size-fits-all' approach is not always useful. Inclusive services have the capacity to match assistance to each child or family's needs and are able to offer choice to their clientele.

Family-centred practice

Positive staff attitudes and behaviours are pivotal to inclusion. Staff need to be non-judgmental and approachable and adopt a 'family-centred' approach to practice. Services become family-centred when they have skilled workers who have an holistic view of child development and a good understanding of family dynamics and behave positively towards parents (for example, are warm, empathetic, respectful and good listeners).

Good practice, however, involves more than just being a good listener. The provision of very practical supports and services is often required to engage parents or to help them to maintain attendance. At a ‘helping’ level, behavioural strategies and ‘strengths-based’ and ‘solution-focused’ approaches are among the most useful approaches to working with vulnerable families. The last two approaches are based on a collaborative relationship with children and their parents and focus on the family’s potential for change, rather than on their problems. The underlying belief is all families have strengths and capabilities. This does not deny there might also be shortcomings; however, continually or exclusively focusing on families’ shortcomings is not the most helpful way to address them. At a behavioural level, workers might need to work with families using a variety of approaches, such as role play or modelling, rather than merely didactic approaches.

While parents should be maximally supported in their role as caregivers, it is important children are regarded as citizens with rights independent of their caregivers. Children’s needs cannot always be ‘put on hold’ while their parents receive help with their own issues. Accordingly, inclusive services are based on a whole-of-family focus. This whole-of-family focus needs to extend throughout services, in particular so-called adult services, such as specialist mental health services, drug and alcohol treatment services and housing support services. These services, which are typically targeted to vulnerable individuals, need to be resourced and given the mandate to consider the adults’ children as clients in their own right, given that such children are at higher risk of adverse outcomes and might need particular assistance or at least preventive support.

Professional development

Developing inclusive services requires a skilled workforce. Workers need access to professional development and supervision to increase their skills. Training should include engagement and communication skills. In addition, staff might benefit from training around cultural sensitivity and specific issues that confront some families, such as mental health problems and problematic substance use. Training also needs to suit the service context (for example, by addressing rural issues) and be provided in collaboration with consumers.

Promoting a team approach

In many instances, a multidisciplinary team approach to working with vulnerable families with complex needs is required. It is therefore important to promote a sense of collaboration between workers and agencies, which breaks down the ‘silo’ mentality. While this can be difficult, ultimately it is important that each service is assisted and encouraged to regard itself as part of a larger system.

Providing a blend of professional and informal supports

Given the importance of social connections and parents' distrust of some professionals, every service should seek to provide a blend of 'professional' and 'informal' assistance to enable parents to develop their own social support networks. Involving volunteers or other parents as peer support workers or family liaison workers can have numerous benefits.

Providing opportunities for group activities is also very important. Using the service base as an 'activity hub' can draw parents into the service (for example, by providing activities for parents in a primary school) and bring parents together. This requires a 'community development' focus which seeks to involve people and to promote the use of facilities for a range of social and support activities.

The physical environment of the service can also play a role in facilitating this sense of informality and connection between parents and children. Waiting areas and meeting spaces for parents can promote spontaneous and relaxed social interaction and counteract the 'drop-off/pick-up' mentality which works against family involvement in some children's services.

Ideas for action

The following section provides more practical examples of how these guiding principles can be translated into specific strategies. In keeping with the findings of stages one and two, we present these ideas under four key headings:

- overcoming ‘practical’ (structural) barriers
- building positive relationships
- providing acceptable, relevant and useful services
- strengthening service coordination and links.

Overcoming ‘practical’ (structural) barriers

Promotion and publicity

Promotion and publicity can be used to:

- increase parents’ knowledge about the existence of services and how to access them
- increase parents’ knowledge about the importance or potential benefits of services.

At present the promotion of antenatal and universal early childhood services differs from service to service. Individual antenatal care services are largely promoted through word-of-mouth and general practitioner referrals to private or public antenatal services. In addition, the Department of Human Services has established the ‘Having a baby in Victoria’ web site to provide information about antenatal care in Victoria. The current Maternal and Child Health service strategy of proactive contact with newborn children and their parents on receipt of a birth notification has led to very high rates of initial contact and is a key strength of the Maternal and Child Health services. Kindergartens are also largely promoted through word-of-mouth and by advertisements in local newspapers, council directories (printed and web-based) or pamphlets produced by local government and other providers, supplemented by an annual media campaign in January and February each year. Formal promotion of primary schools varies from school to school. Most have open days and orientation sessions.

While it is suggested that services should continue and extend their own independent promotional efforts, a focus on coordinated ‘cross-promotion’ of services also needs to occur. Cross-promotion of universal services could occur through a range of services, including:

- universal services themselves
- general practitioners, given that most families take their children to see a general practitioner on a number of occasions during the child’s early years
- accident and emergency departments in the local hospitals
- specialist adult and children’s services.

One option is to promote antenatal, Maternal and Child Health and kindergarten services and primary schools as the ‘Big Four’ group of services for all children and families in Victoria, rather than promoting each of them individually. This would help to bring the services together in parents’ (and providers’) minds as one system, with each component being equally important. Posters, pamphlets and media advertising could be used to promote this core quartet of universal services as one system.

To support this option, the Best Start logo could be used to brand those services which belong to the ‘Big Four’ group. A sign bearing the logo could be placed within each antenatal, Maternal and Child Health and kindergarten service and each primary school to indicate they are all part of this ‘Best Start’ group of early childhood services to emphasise the link between these services. Ultimately, ‘Best Start Services’ could become the overarching name for the universal service system, rather than just being the name for a time- and location-limited government initiative.

Another option is to trial ‘showbags’ containing culturally inclusive information about family services and supports. These could be made available to all parents at first contact with Maternal and Child Health services and again at the 12 month, two years and three and a half years visits, as well as through kindergartens and primary schools. Specialist children’s and adult services and general practices could also be used to distribute these showbags.

At a regional level, an early childhood free-call information number could be introduced. This would allow parents to find out about early childhood services available in their local community. The information line could be funded by pooled contributions from each early childhood service that wishes to be included.

Another initiative borrows from the ‘active script’ strategy currently being implemented through general practice. In this scheme, patients are given ‘a script’ for exercise or dietary advice, in addition to any relevant medication. In a similar vein, Maternal and Child Health nurses could hand out a ‘script’ with instructions such as, ‘Now’s a good time to enrol your child in kindergarten’, or ‘Have you considered joining a playgroup?’, or even something unrelated to service use such as, ‘Reading to your child helps them to learn’, or affirmations such as, ‘Parenting can be stressful—it’s OK to ask for help’. The scripts would need to be simple to read and understand and culturally appropriate.

While services need to ensure regularly updated information about their service is available to the general public, targeting of population sub-groups or geographic areas that are underrepresented in service use should also occur. Further research is required to identify the characteristics of ‘excluded’ children and parents to allow more relevant messages to be developed and to enable advertising budgets to be better targeted.

Reducing costs

One characteristic that many vulnerable families have in common is that they are living in poverty. As such, service costs can often be a barrier. Indeed, the more a service costs, the greater the risk some users (however small a number) will not use the service, will underuse it, or will discontinue using it. Governments and services can reduce costs, or minimise their impact, in various ways, such as by:

- providing free access to a greater range of services or essential items
- increasing the level of subsidies (for example, kindergarten subsidy and Educational Maintenance Allowance) currently provided for people on low incomes
- capping fees and charges
- further encouraging schemes to allow parents to pay fees or charges by instalments, rather than as a lump sum
- providing extra funding to all early childhood services in disadvantaged areas (by weighted population formulas)
- providing financial assistance to non-government organisations' kindergarten support funds and developing similar funds for other service costs, such as primary school expenses.

Transport, outreach and home visiting

Lack of transport is another major barrier. It can impact on all services. Once again, a number of possible options exist for assisting children and parents with transport. These include:

- paying greater attention during the planning of new capital projects to locating early childhood services near public transport
- increasing the availability and regularity of public transport, particularly in outer urban, regional and rural areas
- increasing concessions for travel on public transport
- increasing funding for services to provide 'taxi vouchers'
- providing subsidies for taxi use to pregnant women and parents with children under eight years
- establishing 'volunteer' driver programs
- expanding outreach and home visiting within antenatal and early childhood services.

Among these options, home visiting is widely regarded as an extremely valuable way of engaging vulnerable families. This is not only a useful solution for transport related barriers, but also:

- assists workers to build rapport and trust
- provides an opportunity to get to know parents and children 'on their own turf'

- provides a means for proactive follow-up of children or parents having difficulties in regular attendance
- allows workers and volunteers to deliver practical services in the home
- allows workers or volunteers to drive parents and children to other activities and services.

These benefits are likely to be of value in supporting vulnerable families in all antenatal and early childhood services as they have been, for example, in Maternal and Child Health services. Therefore, it is suggested that all antenatal and early childhood services be resourced to provide home-based and outreach services.

Appointment scheduling and reminders

Reminder letters can be a very low cost, useful tool for maintaining contact with children and parents to encourage them to attend appointments that are spread over time. Clearly, this method could be usefully applied in antenatal care and particularly in Maternal and Child Health services. Computerised systems that automatically generate personalised advance reminders, missed appointment reminders or both, are likely to be most practical. As much as possible, these should be presented in a ‘fun’ manner (for example, the birthday cards that are sent by one Maternal and Child Health service).

Another potential obstacle to attendance in Maternal and Child Health services is the focus on key age and stage visits, the last two of which are 18 months apart. A change in scheduling or a return to more flexible ‘drop-in’ arrangements or both for selected clients might improve attendance.

Hours of operation

Limited hours of operation can create problems for some parents, as can the sessional nature of child care and kindergarten. A number of services have already attempted to address these difficulties by extending their hours (evening and weekend sessions) or, in the case of kindergarten, by providing longer session times. However, to the best of our knowledge, none of these approaches has been evaluated to determine ‘what works best’. Wherever possible, services should provide a range of options, in some cases through partnerships with other providers that enable them to cooperatively extend the range of options, taking advantage of economies of scale.

Being proactive

Clearly, the onus is on each service to proactively engage ‘excluded’ groups. This means services must be prepared to ‘reach out’ to groups that are known to be at risk, rather than wait for them to attend. In addition, services need to establish mechanisms for retaining connections with children and parents following their initial contact.

One strategy to address this latter priority could involve the routine provision of an ‘information sheet’ at first contact with Maternal and Child Health services, kindergartens and primary schools, outlining the types of assistance available to parents who experience difficulties with costs or transport or

other barriers to ongoing attendance. This information needs to make clear that these barriers ‘can happen to any family’ and these additional supports are offered to everyone, for the ‘sake of the child’. In addition, posters with messages such as, ‘Keep your kid in kinder – ask your kindergarten teacher for advice’ could also be developed and displayed.

Building positive relationships

Consultation support, training and supervision of workers

Engaging and assisting vulnerable parents and children requires specific skills which can be developed with time and training. Professional development for workers is therefore essential.

Training should focus on general engagement and communication skills (including broaching sensitive topics) and on assisting workers to better understand the specific issues that might confront some families (for example, substance use, mental illness, disability). It is important that expertise is shared. For example, providers in universal services could benefit from training by workers in specialist services (such as family support agencies), who could in turn benefit from the knowledge and skills of their ‘universal’ peers. In addition, wherever possible, training should be conducted jointly by a ‘consumer’ and a provider. Training should preferably be provided through small group interactive sessions with opportunities for workers to practice their skills with ‘simulated’ clients. Videotaping and feedback are other key ingredients for successful skills development.

While profession-specific education and training sessions are important, so are intersectoral, multidisciplinary training sessions. The Integrated Early Years Professional Development initiative currently being provided as a joint initiative between the Department of Human Services’ Community Care Division and the Centre for Community Child Health is an excellent example of such training. It is important, however, such training opportunities are not limited to ‘once-off’ initiatives but are available on a recurrent basis. One way to avoid this would be for the Commonwealth and state and local governments to fund and auspice regular regional early childhood services seminars and workshops in each Department of Human Services and Department of Education and Training region, involving local services, professionals and parents with an interest in the early years. Cross-sectoral training could also be facilitated by providing opportunities for early childhood workers to spend time or undertake a placement within a specialist children’s or adult service (or vice versa) to understand the needs of vulnerable families.

Factsheets and booklets on various issues confronting vulnerable families are another important resource for antenatal and early childhood workers. Such resources include material written by professional groups (for example, mental health, drug and alcohol, family violence groups), as well as by parents themselves, explaining what they want and prefer from service providers. While a range of such resources already exists, their dissemination is often poorly organised, some topics are covered less well than others and their uptake is variable.

In order to overcome these problems and to ensure the perspectives of a wide variety of groups and individuals are represented, it is suggested the development, production and dissemination of these educational materials should be coordinated statewide. This could involve an expression of interest or tender process, seeking applications from suitable organisations or consortia. An alternative would be to establish a multidisciplinary ‘Centre for Early Years Education and Training’, responsible for providing educational services for workers in antenatal and early childhood services. Such a centre could also be funded to provide secondary consultation to workers on a range of issues, including inclusive practice.

Finally, while education and training opportunities and access to educational resources are key to promoting service quality and inclusive practice, ensuring professional supervision is also vital. Working with vulnerable families can be personally very challenging and advice and support from experienced practitioners and peers can be beneficial.

Enhancing service entry pathways

At times people need to establish a trusting relationship with one key person before they can come to trust and engage with a larger group or a more abstract entity such as a ‘service’. Indeed, given the high levels of distrust and fear among some parents, at times engagement with a service might need to be graded slowly. One option is to establish expanded service entry pathways which are graded through the following sequence:

- informal home-based contact with a respected member of the local community or ‘peer’
- above, combined with professional (service provider) outreach to the family
- combined professional and informal centre-based services.

Using graded options rather than all-or-nothing centre-based approaches could allow parents to negotiate the system at their own pace, ensuring they are not taken too far out of their comfort zone too quickly. This could lead to three ‘levels’ of service provision in the kindergarten years:

- informal and home-based
- mixed informal and professional, home-based
- mixed informal and professional, centre-based.

While the service provision in the home-based model would clearly be much less comprehensive than that of centre-based services, particularly in relation to socialisation opportunities for the child and the parent, some sort of early childhood service contact, albeit limited, is better than nothing. At any rate, the idea would be to use this ‘level’ as a stepping-stone towards more comprehensive centre-based support, rather than as a replacement.

Enhancing the service entry pathway will require services to identify, train and support ‘community leaders’ or ‘peers’ who can act as the bridge between the service and very ‘hard to reach’ parents. As such, this model could become part of a broader strategy to develop the extent of informal supports provided by each service as discussed below.

Paraprofessional, peer and volunteer programs and informal supports

Many antenatal and early childhood services have successfully introduced paraprofessional, peer and volunteer programs. Such programs are invaluable and have been used to provide assistance with child care, transport, shopping and household duties; social and emotional support; children's education; and skill building.

In addition, many services offer structured and unstructured social and support groups. These informal groups (such as first time mothers' groups and playgroups) are very popular and assist in overcoming social isolation. Some programs have been developed to meet the needs of a specific group (e.g. young mothers), while others are more generic.

At present major issues confronting paraprofessional/volunteer programs and informal groups include:

- availability
- sustainability (for various reasons including limited resourcing)
- recruitment and retention (of participants, volunteers, staff)
- promotion and coordination (to avoid gaps in some areas and duplication in others).

In spite of these challenges, the benefits of informal service provision and support remain. It is important that all antenatal and universal early childhood services are encouraged and assisted to include these in their service model and provide a blend of professional and informal input. It is not clear that any single model for involving paraprofessionals, peers or volunteers or for running parent groups is superior; rather services may need to provide one or more types of informal program in order to become more inclusive.

Changing attitudes

In addition to the host of practical barriers, a number of attitudinal barriers among service users and service providers can also impact on inclusion. In the same way promotion and publicity can be used to increase parents' knowledge about the existence of services, how to access them and the importance or potential benefits of services, such activities can also be used to challenge negative attitudes.

In relation to service users, two requirements for promoting inclusion are challenging people's distrust of providers and the shame some experience associated with conditions such as mental illness or problematic substance abuse. Specific beliefs that might need to be challenged include:

- 'I should be able to look after my child(ren) on my own, everyone else does.'
- 'It's my fault.'
- 'I won't fit in.'
- 'They just think that I am a bad parent'.
- 'They're out to take away my children.'

In addition to challenging these concerns, it might also be useful to promote the ‘acceptability’ of seeking assistance or of getting involved in services as a social norm.

A combination of mass media strategies and local community development ‘awareness campaigns’ could be one way of counteracting these attitudinal barriers and promoting the acceptability of antenatal and universal early childhood services. Success requires careful planning, adequate resourcing and continuity over time. Successful campaigns are clear about the specific attitudes, beliefs and behaviours that need to change or be encouraged, and involve the local community in action. In addition, they are based on appropriate theories of behaviour change.

Similarly, activities are also required to target service providers’ attitudes and behaviours. While such changes might be best promoted through education, training, consultation and supervision activities described above, they could also be the focus of an awareness campaign. Challenging judgmental attitudes and behaviours appear to be two key requirements. Specific beliefs that might need to be challenged include:

- ‘Some people will never make good parents.’
- ‘Some families never change.’
- ‘Some parents are just not interested in being involved.’
- ‘I’m a nurse [or teacher] not a social worker.’

Providing acceptable, relevant and useful services

Cultural sensitivity

A variety of strategies can be used to promote cultural sensitivity. These include:

- promoting uniform standards for culturally sensitive practice within service types
- advertising services through Indigenous or ethno-specific media
- providing easy access to appropriately trained and qualified interpreters and to translating services
- employing full time, part time or casual bicultural, bilingual and Indigenous staff
- providing Indigenous and ethno-specific groups and services
- promoting the use of multicultural written resources and play equipment
- displaying signage, artwork and other cultural items which acknowledge and celebrate cultural diversity
- providing staff training and consultation support.

It is recommended that each Best Start partnership consult with culturally and linguistically diverse and Indigenous peak agencies for advice on culturally sensitive ‘best practice’ principles. Consideration should also be given to enhancing multicultural support services and Indigenous services within antenatal and universal early childhood services.

Standardised assessment

Parents want empathetic, empowering help and are wary of criticism, interference or surveillance. In addition, they also want prompt, practical and relevant information, supports and services.

A comprehensive assessment is pivotal to providing appropriate assistance. Ideally, this would involve conducting a thorough biopsychosocial assessment of each family's strengths and needs, particularly during the antenatal period. Arguably, however, holistic assessment should also occur within all universal early childhood services. A standardised approach to assessment to routinely identify risk and protective factors would be preferable.

The creation of a framework to support such a process is already underway as part of the Department of Human Services' Wellbeing Enhancement Framework project. It is anticipated that the Wellbeing Enhancement Framework will lead to a consistent approach to assessing wellbeing and risk across child, youth and family services.

A critical issue in developing such a framework, or possibly a common assessment tool, is how to ensure it is made clear to parents that the same questions are asked of everyone to enable appropriate support to be provided and not just asked of one family because the worker thinks 'they have problems'. If parents perceive they are being 'monitored' they will quickly disengage. This assessment therefore needs to be done extremely sensitively and be clearly explained.

Enhancing the universal base

While improved assessment processes would enable universal services to better tailor their services to each child and parent's needs, it is inevitable there will be some vulnerable families who require a level of support that is beyond the time or skills of a generalist, universal system to provide. Improving access to universal services will therefore in itself not be enough to improve outcomes for some families unless some sort of 'step-up' enhancement is also provided through these services.

At present, almost every family in Victoria has at least one contact with the Maternal and Child Health service system and many have several contacts. This provides an enormous opportunity for commencing positive relationships with vulnerable families and providing appropriate prevention and early intervention initiatives.

Given this very broad coverage and the scope to see children up to age six, it is suggested that the Maternal and Child Health service system is ideally placed to be further developed as the cornerstone of the early childhood service system for all children from birth to school commencement. Several key changes might be considered to achieve this:

- change the name to encourage a whole-of-family focus which includes fathers
- enhance staffing and funding
- increase capacity for outreach and home-visiting
- return to 'drop-in' appointments on a targeted basis

- create an opportunity for service contact until school entry
- develop a mini multidisciplinary team within Maternal and Child Health services to include groups of nurses, rather than solo practitioners, working with family counsellors, other early childhood workers and family advocacy and support workers (described below)
- increase the range of informal supports and activities (for example, universal access to playgroups)
- enhance access to ‘day-stay’ services which provide parenting skills and personal support services
- provide a range of specialist children’s services from Maternal and Child Health service centres either on a visiting sessional basis or by permanently co-locating them with Maternal and Child Health nurses
- further promote Maternal and Child Health nurses (and other practitioners who might become part of their ‘team’) to provide outreach into other services, such as kindergartens and adult services, including housing support, drug and alcohol and psychiatric disability support services.

It is also suggested that for vulnerable families, Maternal and Child Health service contact should preferably commence some time in the late antenatal period. Such antenatal contact would provide:

- an opportunity to establish rapport
- a bridge between hospital and community services
- improved information sharing between hospital and Maternal and Child Health nurses
- greater support to at-risk families.

In addition, consideration also needs to be given to how Maternal and Child Health services can be better linked to the other major universal primary care service—general practice.

Advocacy and support

Building on these suggestions, another important improvement to the Maternal and Child Health services would be to increase capacity for practical, social and emotional support to be available for parents. Such an enhancement might require recruitment of more diverse personnel. It is suggested that this recruitment should proactively target parents with personal experience of the difficulties that confront vulnerable families. Such an arrangement would then deliver the dual benefits of enhancing the ‘informal’ aspects of Maternal and Child Health service delivery and providing greater value for effort for families when they attend services.

The focus of such an enhancement would be to:

- provide continuity of contact between antenatal care and universal services
- provide increased practical, in-home support to vulnerable parents and parents-to-be
- assist families to link into and maintain contact with other children’s services

- assist families to expand their social supports
- be available to provide transitional support to connect parents who move with services in their new neighbourhood
- be available to support the family until the child starts school.

As discussed, many vulnerable parents have limited social supports and experience multiple practical barriers to service use. Parents often require very practical assistance and advocacy to overcome these barriers. While some agencies (particularly family support services) provide such support, universal services have been less able to do so. This type of assistance needs to be more readily available through the universal base.

This enhancement would also require an increased capacity for Maternal and Child Health services to provide outreach and brokerage funding to Maternal and Child Health services to enable staff to purchase other necessary supports and services (for example, respite child care) for children and parents.

Should this enhancement be provided through the recruitment of 'experienced' parents, then intensive supervision and ongoing professional development would be essential. A senior social worker within a local family support service could provide training and supervision to such workers. This would assist in building links between Maternal and Child Health services and 'specialist' family support providers. In addition, caseloads would need to be suitably low to allow intensive, long term contact with families.

Service coordination and links

Improved links with specialist services

Many argue that one of the greatest problems with the early childhood service system is that it is too fragmented. There are too many component services, each with their own target group, eligibility criteria and length of involvement. In addition, many individual service providers do not regard themselves as part of the broader system or do not have the time to forge links with other services. Links between children's services and adult services, such as mental health, drug and alcohol services and housing support, are also very poor.

A greater degree of coordination and even co-location might be required to promote inclusion. Developing 'multifunction' children's centres and 'one-stop-shops', which bring together a range of community, vocational and recreational services, has been proposed. Other strategies to promote coordination and improved links between services include:

- supporting workers in universal and specialist services to attend case conferences together
- supporting regular network meetings between senior staff from specialist and universal services to promote intersectoral collaboration
- enabling workers in universal services to provide 'in-reach' to specialist service settings
- enabling workers in specialist services to provide 'in-reach' to universal settings.

Once again, it is not clear that any single approach to service coordination is outstanding; however, it is highly likely that greater coordination will impact positively on access. Piloting various options would be advantageous.

Promoting innovation

Just as services need to be promoted to potential service users, action is required to promote examples of good practice among service providers. During the community consultation for the Breaking Cycles, Building Futures project, the project staff from the Brotherhood of St Laurence was repeatedly told about this service or that service ‘doing good work’. However, finding details about such services and projects was extremely difficult. Greater efforts are required in documenting and disseminating local ‘ideas that work’.

Case studies can sometimes be a useful way of documenting this best practice and providing other practitioners and organisations with a tangible example to learn from or emulate. It is therefore suggested that an intentional and ongoing emphasis on the promotion of good ideas needs to be instituted at an interdepartmental level.

One possibility could be the production of a biannual (or even quarterly) electronic newsletter jointly auspiced by the Department of Human Services and the Department of Education and Training, which could showcase new or good ideas across antenatal and early childhood services. Peak bodies or other groups with specific expertise around particular issues (for example, children of a parent with a mental illness) could also be invited to contribute.

Another useful way of sharing and disseminating good practice, research findings or the results of service evaluations could be to establish an electronic database. The database could contain examples of new and good ideas about access and inclusion, prevention and early intervention, partnerships and collaborations or any other relevant topic. This would encourage a ‘whole system’ approach to early childhood services and also promote information sharing.

In addition, greater formal support should be given to staff from antenatal and universal early childhood services who have achieved positive changes to act as ‘consultants’ for other organisations attempting similar changes. These key ‘change agents’ would be asked to share their knowledge and experience so that success in one ‘site’ can be more quickly disseminated through the system. Such an arrangement might require these workers to be allocated a ‘higher duties’ allowance and their employing services remunerated for any ‘back-fill’ that is required.

Taken together, these approaches seek to create a greater focus on intersectoral knowledge sharing and the accumulation of learning so that individual services do not keep ‘reinventing the wheel’. Providing more funding for service evaluation—particularly to those services with existing ‘good’ models—would also greatly assist this process because most services are currently not able to achieve this.

Public acknowledgment and awards for individual services and workers are other initiatives worth considering. These awards could be jointly auspiced by state and local government.

Summary and conclusion

This study started from the assumption that antenatal and universal early childhood services are an important resource for promoting the wellbeing of our children and their families. As such, it is imperative these services are inclusive and available to all.

The study addressed four key questions:

- What is an inclusive service?
- How inclusive are existing services?
- What are the barriers to inclusion?
- How can services be more inclusive so that they better engage vulnerable families?

To the best of our knowledge, this is the first study to provide a systematic review of these issues as they relate to the Victorian context.

What is an inclusive service?

Inclusive services are easy to reach and use and work to assist all-comers. They acknowledge people's shared humanity, celebrate diversity and promote acceptance, belonging and participation. Inclusive services also recognise people's different needs and the inequalities in people's level of power and their control over resources and attempt to counteract these inequalities. In their ideal form, therefore, inclusive services not only ensure they engage all people within their programs, they are also agents for social change, working to overcome deprivation and disadvantage (at times through positive discrimination strategies) to promote social inclusion.

How inclusive are existing services?

Given the complex and multidimensional nature of the concept, it is difficult to provide a simple measure of 'how inclusive' existing antenatal and universal early childhood services are. Presuming inclusive services are likely to be well used, patterns of service use offer some (rough) indication. Unfortunately, identifying current patterns of service use is not an easy task because of the lack of detail and uniformity in registration information (service user characterisers) and the limited data collection about ongoing attendance in some services. Despite these limitations the available data suggest the majority of children and parents make good use of these services. However, it is also clear service use varies along a continuum from very high to very low. Importantly, there appears to be a small but significant minority of families that underuse some or all of these services. Given the optional nature of these services, it is understandable that not everyone will choose to use them. While some degree of 'underuse' would therefore be expected across the population, the actual pattern is not uniform. In particular:

- certain (disadvantaged) neighbourhoods have very high rates of underuse
- certain families have very high rates of underuse.

Groups underrepresented among service users include families with low incomes, young parent families, sole parent families, Indigenous families, families from certain culturally and linguistically diverse communities, families experiencing unstable housing or homelessness, families experiencing domestic violence, families with a parent who has a disability, problematic substance use or mental health problem, and families who had been in contact with child protection services.

In most cases, it appears ‘retention’ rather than initial ‘access’ is the key issue, particularly within Maternal and Child Health services, kindergarten and primary schools. Indeed, it is uncommon for families to have absolutely no contact with an (optional) universal service before attending (compulsory) schooling, although this has been observed. Rather, parents generally make contact with services, but some might then cease attendance, attend infrequently, or not become fully involved in the services’ activities. Multiple ‘potential’ opportunities for engagement with children and their parents therefore exist, although unfortunately these are not always maximised.

Patterns of service use only tell part of the story, however, and multidimensional measures of inclusion are required, including subjective ratings from children and parents. Likewise, more detailed information is required about service user characteristics, preferably using standardised registration forms across each service. This registration information should include details about children and parents, the latter including age, marital status, employment status and ethnicity. De-identified data could then be compared with local demographics to establish whether particular groups use the service less than others and enable better targeting of new initiatives. It is therefore suggested that the Department of Human Services and the Department of Education and Training work together to improve the quality of the data collected to help services keep abreast of who is and who is not using their services to enable better proactive targeting of vulnerable groups.

What are the barriers to inclusion?

The observed variations in inclusion appear to reflect the impact of multiple, interacting barriers. These can be broadly grouped into service level (structural) barriers and barriers specific to children, their parents and their situation:

- Service level (structural) barriers can include lack of publicity about services, cost of services, limited availability (for example, child care and kindergartens), inaccessible locations, lack of public transport, limited hours of operation, inflexible appointment systems, limited access to specialist supports for children with additional needs, poor coordination between services, lack of attention to multiculturalism, and insensitive or judgmental attitudes and behaviours of staff or of other parents.
- Barriers specific to children, parents and their situation can include limited income, lack of social support, lack of private transport, unstable housing or homelessness, low literacy levels, large family size, personal preferences and individual beliefs about the necessity and value of services, lack of trust in services, fear of Child protection services, physical or mental health issues or disability and day-to-day stress.

While a few barriers appear to be particularly relevant to one service type or to certain groups within the community, the majority are common across the population and across services. The most important finding is that many vulnerable families experience several concurrent barriers which impact on inclusion.

Vulnerable parents might be simultaneously struggling with low incomes, inadequate or insecure housing, health or mental health problems, problematic substance use, or domestic violence. A large number have very limited social supports. Some might lack the knowledge or language to navigate the service system or the confidence and self-esteem to interact with service staff or other parents. Many vulnerable parents ‘feel’ different or self-conscious as a consequence of the prejudice, discrimination and rejection they encounter or their own internalised negative self-worth. Distrust of services, or even of other parents, can be very high. Perhaps one of the greatest barriers is parents’ fear that they will be judged by others as ‘bad’ parents, or worse still, become involved with Child protection services.

Vulnerable parents have to overcome numerous obstacles and balance competing needs. It is likely that at times, ‘survival’ needs take priority over attendance at a service (particularly services which lack an immediate, tangible benefit) or barriers collectively become overwhelming. Without appropriate advocacy and practical support, some parents will remain unaware of services or unable to use services to their benefit.

Given its descriptive focus, the research is limited in how confidently it can ‘rank’ the relative impact of the various barriers experienced by each vulnerable population or affecting each service type. It is also limited in its capacity to state how barriers correlate with each other and with actual service use. Future research should therefore include survey-based, correlation studies in relation to each service type as the next step towards setting priorities for inclusion strategies. These surveys could be conducted in known areas of poor service use.

How can services be more inclusive?

Unfortunately, there is very limited good quality empirical evidence about strategies that could be effective in Victoria in promoting more inclusive antenatal and universal early childhood services. However, there is a significant amount of ‘practice wisdom’ regarding ‘what works’.

Drawing on the limited empirical evidence and this ‘practice wisdom’, it appears that to be inclusive services need to:

- be affordable and well publicised
- be geographically accessible
- provide outreach and support with transport
- provide a family-friendly and culturally inclusive physical environment

- employ skilled and responsive staff working from a family-centred, culturally sensitive perspective
- promote social connectedness through informal supports
- establish strong reciprocal links with other relevant services (universal and specialist).

Among the most critical factors is workers' ability to:

- establish a positive, non-judgmental relationship with all children and parents
- proactively engage and sensitively follow-up with vulnerable children and parents who are at risk of 'dropping out'.

It is often the little personal touches that count the most. Parents want empathetic, empowering help and are wary of criticism, interference or surveillance. They also want prompt, practical and relevant information, supports and services. Truly inclusive services are flexible and have the capacity to match assistance to each child or family's needs and offer choice to their clientele. A 'one-size-fits-all' approach is not always useful. Universal services do not need to be uniform services.

Further, given the importance of social connections and the distrust some parents have of professionals, services should preferably include a blend of 'professional' and 'informal' assistance, involving volunteers, peer providers and parent groups (general and population-specific). Parents typically welcome the opportunity to meet with other parents, particularly those in similar circumstances. The physical environment of the service can also play a role in facilitating or inhibiting these connections.

In light of the importance of positive relationships, regular consultation support, training and supervision for workers in culturally sensitive and inclusive practice are essential.

Improved links across universal services and between them and specialist child and adult services, whether through co-location, service integration, regular network meetings, case conferencing or reciprocal 'in-reach', are also required. While difficult to achieve, it is important every service is encouraged to regard itself as part of a larger system supporting children and their parents. A 'whole-of-family' focus is needed across all human services, in particular so-called adult services, such as mental health services, drug and alcohol treatment services and housing support services. These services, which are typically targeted to vulnerable individuals, need to be resourced and given the mandate to consider the adult's children as clients in their own right, given that children in these circumstances are at higher risk of adverse outcomes. Indeed, while parents should be strongly supported in their role as caregivers, children must also be regarded as citizens with rights independent of their caregivers. Children's needs cannot be 'put on hold' while their parents receive help with their own issues.

Considering the breadth of barriers, promoting more inclusive antenatal and universal early childhood services will inevitably require the introduction of multiple, simultaneous strategies within each service. Strategies which focus on removing only one potential barrier in isolation are unlikely to be sufficient.

Inclusion could be thought of as an overarching ‘value’ adopted by a service, supported through a range of policies and practical initiatives which are subject to regular review and continuous quality improvement.

Since it is highly unlikely a service will have no vulnerable children and parents among its potential clients, every service needs to establish these policies and practices. As one person put it, services need to ‘act as if’ they already have particular vulnerable groups in the service. This will enable them to prepare the service to attract families, rather than waiting to change once they arrive.

In addition, it is important that services are not simply left to decide what ‘inclusion’ means to them because this is likely to vary considerably from service to service. One of the most significant findings of this review was that despite the considerable rhetoric about ‘wanting to make services more inclusive’, neither the Department of Human Services nor the Department of Education and Training could offer a clear definition for this term or information about how it should be operationalised, benchmarked and measured. The State Government therefore needs to state how it intends to define ‘inclusive’ and the minimum acceptable standard, otherwise inclusion will remain a ‘feel good’ abstract notion and services can claim they are inclusive, when they are not.

To be more inclusive, services will need to implement strategies which:

- minimise the ‘practical’ (structural) access barriers and support parents to overcome their knowledge, financial, transport and time difficulties to maintain attendance
- build positive and affirming relationships with parents, which counteract distrust and stigma and assist parents to connect with others
- ensure their programs are culturally sensitive and provide a perceived value for effort, both short term and long term, for the child and their parents. The more a service has to offer, the more attractive it becomes
- establish strong reciprocal links with other services, particularly those targeted to vulnerable families.

It is clear there is no single, ‘magic bullet’ solution for promoting inclusion and attempts to find the perfect strategy are doomed to failure. Rather, inclusion needs to be thought of as an overarching ‘value’ adopted by services, which is supported by a range of policies and practical initiatives that are subject to regular review and continuous quality improvement.

It is proposed that promoting more inclusive services, which better engage vulnerable families, requires services to undertake the following key steps:

- Establish a planning group involving parents, service providers and other key stakeholders.
- Develop a clear and agreed definition of inclusive practice.
- Develop clear and agreed indicators (qualitative and quantitative) for monitoring performance.

It is hoped that by using this process, services will be in a better position to more clearly articulate and trial specific inclusion strategies.

What else needs to occur?

Two final points need to be made. First, it is inevitable there will be some vulnerable families who require a level of support that is beyond the time or skills of a generalist, universal system to provide. Improving access to the current suite of universal services will therefore not be sufficient for some families. At present, many of these families have poor access to specialist services. This 'specialist access gap' also needs urgent attention. This could be achieved by broadening the eligibility for specialist services and increasing their availability or by introducing 'step-up' alternatives linked to universal services. Given the chronic and complex difficulties confronting vulnerable families, a longer term focus to support and change is also required, preferably through ongoing support by a single key worker.

Second, it must also be stressed that while improvement in early childhood services is important, it is not sufficient. Improving outcomes for children will require simultaneous efforts on a number of fronts. The life chances of vulnerable children will not improve unless their parents have greater access to ongoing, adequately paid employment or fairer levels of income support, and to more stable and affordable housing. In order for them to give priority to attending an early childhood service, parents' more immediate 'survival' needs must be addressed first. While these issues remain unresolved, attendance will remain haphazard.

Improved outcomes will also be less likely unless there is better access to specialist services for parents with a mental illness (not just serious mental illness), problematic substance use, or a physical, sensory or intellectual disability. Good outcomes will also be less likely unless there is tolerance, acceptance and a sense of connectedness within the community. Change in one system is not enough.

Next steps

At present, there is a definite sense that more needs to be done and that the needs of vulnerable children and their parents are still not being adequately met. Achieving inclusion will require funding and policy support, combined with program-level and site-level initiatives. The challenge ahead is to more rigorously define and document what is possible and what works and to implement effective and sustainable initiatives.

While some strategies might require additional resources, some changes might instead require creative allocation of existing funds.

Inclusion projects

The first stages of this project were the starting point for more conversations between the Brotherhood of St Laurence, the Department of Human Services, the Department of Education and Training and Best Start partnerships to define specific inclusion projects which could be implemented in selected Best Start areas over the coming years, as well as changes that were required to promote inclusion at a statewide or program level.

Following these conversations, three Best Start partnerships were selected as the sites for these Breaking Cycles, Building Future implementation projects: Shepparton, Whittlesea and Maribyrnong. The Brotherhood of St Laurence worked with these three partnerships to define the specific inclusion projects that were to be implemented and evaluated in the next stage of the Breaking Cycles, Building Futures study. While these projects were to be based on the findings of this review, they were also to build on the identified local needs and local community preferences.

Projects could focus on a particular service area (for example, antenatal, Maternal and Child Health services, kindergarten or primary schools) or on the interface between services. Alternatively, projects could focus on a particular target group, such as parents with a mental illness or problematic substance use or from certain culturally and linguistically diverse communities. Projects involving a particular target group were to endeavour to cross the span of the universal services rather than concentrate on one service type. Ultimately, it was anticipated the projects would involve a substantial reshaping of services or the development and implementation of a comprehensive package of strategies to engage vulnerable families.

Implementation of these inclusion projects commenced in October 2003 and will continue until December 2004. A report on their implementation and evaluation is due to be released in late 2004.

Appendix 1: The services

Antenatal and maternity services

Within Victoria, antenatal and maternity services are provided in a wide variety of ways. Services might be provided through private specialists linked with private maternity hospitals or through public antenatal services. The latter include several 'models', including a large proportion of shared care with general practitioners (Darcy, Brown & Bruinsma 2001).

Maternal and Child Health services

Maternal and Child Health services are free services for families with children aged zero to six years, which are funded jointly by state and local government. They provide support to parents and offer information and advice on issues relating to child health and development, parenting, and maternal health and wellbeing. Maternal and Child Health services also organise groups for first-time parents which provide information and an opportunity to meet other parents in the local area.

Following a child's birth, the maternity hospital notifies the local municipality of the birth and requests that the Maternal and Child Health nurse contact the parents. This contact usually occurs within a week after the mother arrives home from hospital or earlier if there are any concerns. Maternal and Child Health service visits are typically arranged to occur at key ages and stages. These include visits at two weeks, four weeks, eight weeks, four months, eight months, 12 months, 18 months, two years and three and a half years. Additional contact with Maternal and Child Health services in person or over the telephone is also available in between these key visits.

Local government determines the service delivery model provided, for example, clinic-based, home visits or a drop-in service. There is also a 24-hour telephone support and advice line. More recently in each local municipality, an enhanced home visiting service has been established. In general, this service is targeted to vulnerable parents who have children aged zero to 12 months and are experiencing significant early parenting difficulties, although it might also engage families with a child over 12 months where required. Enhanced Maternal and Child Health service support is provided for an average of up to 15 hours per family, although the length and intensity of contact with a particular family is based on professional judgement of the nurse(s) involved. In addition, the service has been implemented in slightly different ways in different areas to enable support for a broader age group or a greater duration of contact.

The Department of Human Services and the Municipal Association of Victoria have jointly undertaken the Maternal and Child Health Improvement Project, which has developed a raft of new initiatives to improve the Maternal and Child Health service at the local level. An enhanced Maternal and Child Health service will provide additional services to children who have been identified as being 'at risk', in the form of a more intensive level of in-home family support. Other improvements in the service include the integration of planning for services for young children at the local government level, improved coordination between services and quality improvement processes.

Kindergarten services

Kindergarten is a program for children in the year before they start primary school. Kindergarten services aim to develop children's social, emotional, intellectual and physical abilities and prepare them for school attendance. Kindergarten services are offered by a range of providers as standalone services, in child care centres or linked to schools. In Victoria, children are eligible to attend a funded kindergarten program if they turn four years of age on or before 30 April in the year of attendance. Attendance is on a fee-paying basis. Fees vary from service to service. At present the Victorian State Government provides eligible families who have a health care card or pensioner concession card with a fee subsidy of \$250 to help reduce the cost of kindergarten.

Primary schools

Education in Victoria is compulsory for children from ages six to 15 years. The first year at school is known as the preparatory or 'prep' year. To enter the prep year, children must be at least five years of age by 30 April of the year they start school. Children spend their first seven years of schooling at a primary school. A complete secondary education then takes a further six years.

Appendix 2: Individuals and agencies consulted

Parents

69 parents

Antenatal services

Royal Women's Hospital Social Support Services

Monash Medical Centre Women's Health Service

Ballarat Health Services

Sunshine Hospital

Maternal and Child Health services

25 Maternal and Child Health nurses

One Maternal and Child Health service manager

Child care centres

Five child care workers

Kindergartens

20 kindergarten teachers

Primary schools

Nine principals

Ballarat school nurses

Child protection services

Six Department of Human Services Child Protection workers (Western Region)

Disability services

Action on Disability within Ethnic Communities (ADEC)

Association for Children with a Disability (ACD)

PINARC Support Services (Ballarat)

Playworks

Victorian Advocacy League for People with Disability (VALID)

Drug and alcohol services

Goulburn Valley Health Community Health Service (A and D team)

Odyssey Institute of Studies (Odyssey House)

Royal Women's Hospital Alcohol and Drug Service

Turning Point

Victorian Association of Alcohol and Drug Agencies (VAADA)

Family/sexual violence services

Gatehouse Centre, Royal Children's Hospital

South Eastern Centre Against Sexual Assault (SECASA)

Family support services

Anglicare Victoria
Brotherhood of St Laurence (Early Childhood Practice Group)
Centacare (Ballarat)
Centacare (Footscray)
Child and Family Services Ballarat Inc.
Children's Protection Society (CPS)
Good Shepherd Youth and Family Services (St Albans)
Good Shepherd Youth and Family Services (Hastings)
Oz Child

Housing support services

Hanover Family Services
Lisa Lodge (Ballarat)
Melbourne Citymission (Footscray)
Whittlesea Housing

Indigenous services

Burri Family Preservation and Extended Care (Shepparton)
Royal Women's Hospital Aboriginal Women's Unit
Rumbalara Health Co-operative
Victorian Aboriginal Education Association Inc. (VAEAI)
Yappera Children's Services

Mental health services

Austin and Repatriation Medical Centre Mother Baby Unit
Ballarat Health Psychiatric Services
Eastern Health Adult Mental Health Program
Family and Mental Health Network (FAMHN)
Mercy Hospital Mother Baby Unit
Prahran Mission Mothers Support Program

Services for young mothers

Young Mothers' Clinic, Royal Women's Hospital
Young Women's Clinic, Mercy Public Hospital (Werribee)

Services for culturally and linguistically diverse and refugee communities

Action on Disability within Ethnic Communities (ADEC)

Asylum Seekers Resource Centre (Thornbury)

Ecumenical Migration Centre (EMC)

Free Kindergarten Association – Multicultural Resource Centre (FKA-MRC)

Victorian Cooperative on Children's Services for Ethnic Groups (VICSEG)

Victorian Foundation for Survivors of Torture

Peak bodies

Australians Against Child Abuse (AACA)

Australian Early Childhood Association (AECA)

Child Care Centres Association of Victoria

Children's Welfare Association of Victoria (CWAV)

Early Childhood Management Services (ECMS)

Family Day Care Victoria

Kindergarten Parents Victoria (KPV)

Municipal Association of Victoria (MAV)

National Association for the Prevention of Child Abuse and Neglect (NAPCAN)

Playgrouping Victoria

Victorian Private Child Care Association

Academics in the early childhood field

Two university lecturers

Department representatives

Department of Human Services and Department of Education and Training workers from the nine regions

Appendix 3: Sample interview schedules

Parents

Question 1

If you were speaking to someone that had never had kids and they asked you what it's like being a parent, what would you tell them?

Hard? Easy? Fun?

Question 2

I'd now like to ask you some questions about the different times in parents' and children's lives, starting from when a mother is pregnant.

Thinking about your own experiences or those of family and friends, what sort of help or advice do you think mothers might need when they are pregnant? What about their partners? What about other family members?

Question 3

I would now like to ask some questions about some of the services that people use during pregnancy, such as GPs, midwives, obstetricians, community health services, antenatal clinics and hospitals.

Firstly, I wonder if you could tell me:

- Which of them have you used?
- What were some of the things that you liked about these services?
- What were some of the things that you didn't like?
- Did you experience any difficulties in trying to use them?
- If you didn't use them, what were some of the reasons for this?
- What would make you more/less likely to use these services?

Question 4

Next I would like to ask some questions regarding the period of time after a mother leaves hospital and then I'd like to ask about the first few years of their child's life.

Thinking about your own experiences or those of family and friends, what do you think parents and children might need at this stage?

- support from family and friends
- information about child development
- health checks
- time out.

Question 5

Thinking about some of the services for parents and children that are available for this stage, I wonder if you could tell me:

- Did you use Maternal and Child Health services? How often?
- If so, what were some of the things that you liked about this service?
- What were some of the things that you didn't like?
- Did you experience any problems in trying to use the Maternal and Child Health services?
- If you didn't use Maternal and Child Health services or only went once or twice, what were some of the reasons for this?
- What would make you more/less likely to use this service?
- Did you use any other services, such as child care or playgroups?
- If so, what were some of the things that you liked about these services?
- What were some of the things that you didn't like?
- Did you experience any problems in trying to use any of these services?
- If you didn't use them or only once or twice, what were some of the reasons for this?
- What would make you more/less likely to use these services?

Question 6

OK, next I'd like to move on to talk about when kids are a little bit older, say when they are between three and five [years], just before school age.

What do you think parents and children might need during this stage?

Question 7

Turning back to the services that are available, I wonder if you could tell me:

- Would you continue to use Maternal and Child Health during this stage? Why/why not?
- What about child care or playgroups at this stage?
- Would you send your kids to kindergarten? At what age?
- If you would send them, why? If not, why not?
- If your kids have been to kindergarten, what are some of the things that you or your children liked about the kinder?
- What were some of the things that you/they didn't like?
- Did you experience any problems in trying to use kindergartens?
- If you didn't use them, what were some of the reasons for this?
- What would make you more/less likely to use these services?

Question 8

OK, lastly I'd like to move on to talk about when kids are older and are at school in prep, grade one and grade two.

What do you think mothers and children might need during this stage?

Question 9

Thinking about primary school:

- What are the good things about primary schools?
- What are some of the things that aren't so good?
- Did you or your kids experience any problems with the primary school?
- What could schools do to involve parents more in the school?
- Apart from teaching kids, what else would be useful for schools to provide?

Question 10

Finally, the Victorian Government and local services are keen to find out how they can improve services for parents and children from pregnancy to age eight, so that people find them easier to use and more useful for their needs. What do you think they should do?

Universal service providers – Maternal and Child Health services

Question 1

Could you please describe to me the role of the Maternal and Child Health services in Victoria?

- services offered
- hours of operation

Question 2

How are children and parents referred to your service?

- links between Maternal and Child Health services and maternity services
- new parents who move into the area

Question 3

Are there any groups in your local community that are less likely to use Maternal and Child Health services (for example, young mothers, sole parents, non-English speaking background families)?

Question 4

In your opinion, what are some of the reasons why people may not use your service or might stop coming after a few visits? *Prompt with examples of possible barriers (for example, transport; don't see the value).*

Question 5

In your opinion, what can Maternal and Child Health services do to improve access and maintain ongoing contact with more vulnerable parents and children? *Possible areas for prompt include:*

- *publicity*
- *outreach*
- *flexible appointments*
- *links with specialist children's services such as early intervention, child protection, family support services and child and adolescent mental health services*
- *links with specialist adult services such as drug and alcohol services and mental health services.*

Question 6

Are any of these activities to improve access/maintain contact currently happening? If so, how successful have they been?

Question 7

Overall, what sort of changes do you think need to occur within antenatal and universal early childhood services in order to improve outcomes for vulnerable children and parents?

Question 8

Other thoughts/comments?

Specialist services – drug and alcohol services

Question 1

What is the role of your organisation in relation to parents with problematic substance use who have dependent children?

Question 2

What do you think is (or should be) the role of universal services like Maternal and Child Health services, kindergarten and primary schools in relation to parents with problematic substance use who have dependent children?

Question 3

What is (or should be) the relationship between these universal services and drug and alcohol services?

Question 4

Thinking about the families that drug and alcohol services work with, do you think that there are any parents and children that are currently missing out on the universal services or dropping out early or not getting value from these services?

Question 5

What do you think are some of the factors that lead to this situation?

Question 6

What strategies are you aware of that have been tried over the years to address this?

Question 7

Which do you think have worked? Which haven't?

Question 8

In your opinion, what needs to be done to improve access and better engage parents with problematic substance use within antenatal and universal early childhood services?

Possible areas for prompt include:

- *role of government*
- *role of services*
- *others.*

Question 9

Other thoughts/comments?

Peak bodies and key individuals

Question 1

What are some of the day-to-day issues that confront the vulnerable families and children that you work with or represent?

Question 2

What are some of the issues that confront these families when they use services?

Question 3

Thinking about universal services like Maternal and Child Health services, kindergarten and primary schools overall, what do you think their role should be in relation to vulnerable families?

Question 4

What do you think should be the relationship between these services and more specialist services like child and family support, early intervention and child protection services?

Question 5

Thinking about the vulnerable families that you work with or represent, do you think that there are any parents and children that are currently missing out on the universal services or dropping out early or not getting value from these services?

Question 6

What do you think are some of the factors that lead to this situation?

Question 7

What strategies are you are aware of that have been tried over the years to address this?

Question 8

Which do you think have worked? Which haven't?

Question 9

In your opinion, what needs to be done to improve access and better engage vulnerable kids and parents?

Possible areas for prompt include:

- *role of government*
- *role of services*
- *others.*

Question 10

Other thoughts/comments?

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