Brotherhood
of St Laurence

Connecting with Frankston families

Examining service use for families in Frankston North, Karingal and Carrum Downs

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Summary

This report is part of a focus by Communities for Children Frankston North to strengthen the provision of services to 'hard to reach' families in Frankston North, Karingal and Carrum Downs, suburbs on Melbourne's outer metropolitan fringe. Communities for Children (CfC) is an initiative funded by the Australian Government under the Stronger Families and Communities Strategy. It is a locality-based program running in 45 geographic areas across Australia, including this site in Frankston North. Under the CfC initiative, community organisations are funded to focus on the health and early development needs of children aged 0–5 years of age.

The low participation in services of 'hard to reach' families is a central concern of the overall CfC initiative. Staff at the Frankston North site are acutely aware of this issue, but community partners indicated at an early stage that they tend to rely on traditional methods of contact with these families. The Brotherhood of St Laurence was contracted to prepare this report to inform improved service delivery.

Identifying hard to reach families is complex, and there are many overlapping meanings to the term 'hard to reach'. For example, Jackson identifies three groups who are referred to as 'hard to reach': first, people who do not want a service; second, people who cannot access a service; and finally, people for whom the service does not present what they perceive they need (Jackson 2004).

No single strategy will solve the problem of engaging hard to reach families in services. Various strategies, however, have been identified in the literature as useful. These include using assertive outreach, building partnerships with agencies already talking with the target groups, responding to feedback from these target groups and adopting a holistic approach to service provision.

This small study is based on interviews completed between late 2006 and early 2007 with parents and service providers in the Frankston North, Karingal and Carrum Downs area. Fourteen parents with young children were interviewed. They were asked open-ended questions about the barriers to service use, the factors that facilitated their use of services, and how they found out about services. They were also asked to respond to a questionnaire detailing their service use. Five service providers were interviewed. They were asked to discuss the barriers and facilitating factors in service use, with a particular emphasis on the needs of hard to reach families, and families with complex needs.

Eight of the 14 parents reported that there were barriers that prevented them from using services, and all 14 said that there were barriers which made service use difficult for them. The barriers related to transport and the location of services, the cost of services, the length of service waiting lists, limited childcare, the behaviour of staff at services, poor coordination between services and not knowing what services were available.

These parents identified two main factors which facilitated access to services. These were, first, that they felt comfortable with the service and supported by the staff, and second, that the service was located close to home.

Parents most commonly found out about services through family and friends. Some found out about services by speaking to a 'key' service worker, that is a service provider who was familiar with a range of services and who they knew would be able to link them to other services. Others mentioned learning about services through the Bounty Bag or the booklet they got in hospital, from flyers, television, the internet or the phonebook.

Service providers also spoke of service unavailability, infrastructure issues (such as limited public transport), cultural differences between service users and providers and a range of family-specific

factors (such as a family member's disability, or a family not yet acknowledging that they need help).

As factors that facilitated service use, service providers raised a variety of issues around communication strategies, the importance of developing relationships and trust, locating services conveniently and providing transport, and ensuring services were affordable. Service providers also highlighted strategies to assist hard to reach families and connect new families with the community. They suggested ways to approach and engage with families, and processes that assist families to be involved with services. Suggestions included to strengthen their community education so that parents are aware of the services they offer, and to provide multiple agency partnerships with a single entry point to make it easier to connect with multiple services.

Services were promoted in a range of different ways. Suggestions included various advertising strategies, linking between services, and making services accessible (including drop-in services and open days), and making sure that programs delivered what they said they would so that people would recommend the services to others.

A workshop was held with local service providers to discuss strategies that could be implemented in Frankston North, Karingal and Carrum Downs to make early childhood services more accessible to hard to reach families. Participants reviewed a summary of strategies from the literature and determined which of these would be very useful to implement in this locality. The strategies considered to be very useful were grouped according to how difficult they would be to implement. Several strategies were felt to be relatively easy to achieve: these tended to relate to the way information is communicated and to the location of services and activities. Strategies that were moderately difficult to achieve usually required a broader strategy, such as inter-agency collaborations. Strategies in this category were mainly concerned with the provision of low-cost services and services that would support families to access services. Finally some strategies were considered to be very useful, but hard to achieve. These tended to be services that required significant funding and inter-agency collaborations, such as mobile multi-disciplinary teams and more affordable childcare.

1 Introduction

Connecting Frankston Families is one of the Communities for Children (CfC) Frankston North activities funded by the Australian Government as part of the Stronger Families and Communities Strategy. Communities for Children in the Frankston North site aims to provide a coordinated and systemic approach to working collaboratively to improve outcomes in health, well-being, early learning and development and support for families, parents and children 0–5. (FaCS 2005, p.4).

The Brotherhood of St Laurence was contracted by Anglicare Victoria, the Communities for Children Frankston North facilitating partner, to undertake an action-oriented project that identifies strategies for targeting hard to reach families in the Frankston community, specifically in Frankston North, Karingal and Carrum Downs.

From research and practice knowledge, most vulnerable and hardest to reach families are those who have a low income; are young parents; are sole parents; have poor health, with mental health or substance abuse problems; have physical, sensory or intellectual disabilities; are homeless or have inadequate or insecure housing; are in contact with child protection or the criminal justice system; have CALD backgrounds (particularly newly arrived migrants or refugees); and are Indigenous (Hydon et al. 2005). However identifying which groups are hard to reach is complex.

The rationale behind this research is that identifying factors that lead to low participation by hard to reach families will help to develop services that are inclusive of all the community.

2 Aim

The purpose of this study is to identify the needs of parents in Frankston North, Karingal and Carrum Downs, particularly around service use. Through interviews, the study will provide a snapshot of parents' knowledge of services and of barriers that might exist in accessing services and what has worked in making services accessible, as well as seeking suggestions of services that would assist them in their parenting role.

3 Literature review

Developing strategies to ensure that early childhood services are accessible to families who are considered hard to reach is complex. The literature surveyed below draws attention to the difficulties associated with defining families as hard to reach. Designing services to be inclusive of such families needs to take into account the local context and the local reasons why families are hard to reach. However the literature also points to general issues and to strategies that have worked elsewhere, such as using peer educators or ensuring that parents are contacted quickly if they are referred to the service. Strategies reported by programs as a way of engaging and retaining hard to reach families are discussed below. Central to this is ensuring that the real needs of the local community are addressed and that that preventative strategies are put in place to avoid families becoming hard to reach.

Defining 'hard to reach'

In 2005, Watson surveyed literature on strategies to increase service participation by vulnerable families for the Department of Community Services (NSW). She noted the paucity of relevant international and local literature and the lack of rigorous program evaluation. She further noted::

> Where enrolment or engagement were the primary focus, often only one or two strategies were examined, resulting in a collection of small scale studies offering single factor, often contradictory explanations for participants' decisions (Watson 2005, p.1).

Our own search of literature confirms this lack of quality evaluations and some conflicting evidence of 'what works'. However, what emerges is a list of strategies that may assist services to expand their repertoire to reach and engage the hard to reach.

In 2004, UK researchers Doherty, Stott and Kinder evaluated the UK *On Track* early intervention crime prevention program targeting children aged four to twelve years and their families. They found service providers often made unsubstantiated assumptions about who should be targeted in hard to reach programming.

Challenging loose definitions, they defined three 'types of definitions' of hard to reach populations:

- 'minority groups' which are 'marginalised, disadvantaged or socially excluded' including ethnic groups, people with disabilities, itinerants and asylum seekers
- the 'overlooked' or invisible clients 'who are unable to articulate their needs': those caring for others, those with mental health issues, and 'service users who fall just outside the statutory or usual remit of a provider'
- 'the service resistant' group whose members may have had significant involvement with services, may be 'known to agencies' and may now have lasting distrust, suspicion or hostility towards agencies. This group may also have been 'over targeted' by service providers and by researchers. (Doherty, Stott & Kinder 2004, p.4)

Jackson has defined the hard to reach using three other categories that overlap with those above: people who *do not want* a service, people who *cannot access* a service and people for whom the service does not present what they *perceive that they need* in terms of content or process (Jackson 2004, p.79).

Other researchers urge care in identifying groups as hard to reach. For example, King (2007) distinguishes between 'hard to find' and 'hard to engage' populations. She argues that some hard to engage groups, such as offenders, may be in frequent contact with services, either voluntarily or under mandate, but may be unwilling to actively engage. Watson (2005) also argues that at risk families may be well known to services but hard to engage. She notes that as many as 70 per cent

of an identified target group refuse or drop out of service contact (Watson 2005, p.2, citing Naughton & Heath 2001, Katz et al. 2001, Dar et al. 2003). Drop-out rates appear to be particularly high when service participation is involuntary or court-ordered (Watson 2005, citing Dawson & Berry 2002). However it is important to note that some groups are classified as hard to reach because they do not know services exist. Such lack of awareness of services tends to be overlooked in the literature. Stanley and Kovacs (2003) found that many overloaded services did not advertise for fear they would be flooded with requests.

Similarly 'hard to reach' is often used to define groups without much explanation for the use of this term. Brackertz (2007) argued that it is often used with regard to minority groups without reference to any criteria: CALD communities, for example, may be relatively easy to reach and identifiable, but may be hard to engage in programs other than those generated by their own community. Similarly it emerged in consultations for the Department of Human Services' Rural Migrant Women's Project that CALD communities, and emerging communities in particular, may be wary of contact with government services because of traumatic experiences in their country of origin (SuccessWorks 2005). However these groups generally have close intra-community networks that can be activated to meet community needs (SuccessWorks 2005). Program planners and services need to work with key community representatives to develop programs that speak directly to those interests. Certain groups within these CALD communities may still be particularly hard to contact and engage, even with the assistance of community networkers. These groups might include young people, outworkers, and people who are on temporary visas.

Groups may be 'service resistant' for a number of reasons. The service may not be required because the potential service users are well supported by family, friends and private networks. The group may determine that the available services do not meet their needs. Some people may choose to remain 'hidden' because of previous negative experiences with services. Brackertz (2007) warned that services should be wary of '[defining] the problem as one within the group itself, not with your approach to them' (p.1), and take care to avoid unwittingly using stigmatising terminology that names groups who consider themselves capable and independent as 'in need of services'. She asserted that the 'problem' of hard to reach may in part be a matter of inappropriate service design and service provider projections as to who constitutes the outcast, marginalised or dysfunctional—projections which may not be shared by the 'target' group. Brackertz went on to argue that there is ample research and practice wisdom to suggest that 'few of [those defined as hard to reach] are hard to reach if the right approach is used' (p.2). Watson similarly concluded that the quality of the services, and whether they directly addressed barriers to participation, was a better predictor of service drop-out rates than the characteristics of the families they serve (Watson 2005, pp.iii, 2).

In a Victorian study, Thomas et al. (2004) argued that local communities themselves 'had no problem identifying the group[s] who are hard to reach and the causes of their social disconnection'. Hence, they concluded 'identification of those who are hard to reach, by local service providers and local community, is achievable' when community networks are utilised (p.11).

In practice, however, engaging the 'hard to reach' is complex. As one recent example of this, researchers at a New Zealand diabetes health promotion project found that despite the application of sound practice—including assertive outreach and networking through the community 'marae' (forum or meeting space)—they were unable to get resistant clients to take up health services. The researchers concluded that:

> There is no single solution to the challenge of getting the 'hard to reach' to avail themselves of health services (Simmons & Voyle 2003, p.48).

Watson similarly found that even programs that appear to adhere to best practice may still have high drop-out rates (Watson 2005, p.2).

Reaching the hard to reach

Engaging families in prevention programs is difficult and attrition is often high (Dawson & Berry 2002; Webster-Stratton 1998), as little research has been done on what factors predict or correlate with participation and retention in services. Recommendations on how to engage the hard to reach do offer some useful insights but also result in 'a laundry list of factors' offering little direction about the relative importance of individual determinants or clusters of factors (McCurdy & Daro 2001, p.113).

Removing barriers to participation

Barriers to participation can be viewed in terms of factors associated with potential program participants, factors associated with the program, including the service providers, and infrastructure failures (Stanley & Kovacs 2003). Services with lower drop-out rates directly address the multiple barriers to service use (Watson 2005). The Brotherhood of St Laurence (BSL) developed a model to address this issue in work undertaken with the Breaking Cycles Building Futures project which aimed to engage vulnerable families with young children with universal services (Hydon et al. 2005). This framework had four key principles to facilitate engagement:

- Principle 1 – Overcoming structural and practical barriers. This related to factors such as ensuring knowledge about services, reducing costs, ensuring transport and providing flexible hours of operation
- Principle 2 – Building positive relationships. This included addressing staff attitudes, professional development and use of peer support and volunteer programs.
- Principle 3 – Cultural sensitivity and value for effort. The latter related to providing multiple services at the one access point.
- Principle 4 – Services coordination and linkages.

Although the project was short-term, results from the use of this framework were becoming apparent. Certain structural and practical barriers were the easiest to overcome, while it was acknowledged that time was needed to build relationships. It was the combination of a number of strategies, rather than specific ones, that proved to be important.

The particular circumstances of the participants also should be taken into account. This includes a wide range of issues, such as language needs of parents, or the conditions of their visa. Parental lack of confidence also discourages attendance at programs. Watson found that parental lack of confidence related to vulnerability, family violence, poverty, cultural minority status, English language difficulties and feeling of failure. For example, some mothers who experienced family violence reported that they were afraid to seek assistance from children's services lest their child be removed (Watson 2005, p.4). Watson argued that when services target disadvantage this can increase feelings of failure families might feel.

Approaches that promote a sense of competence rather than deficit, and promote community partnerships, are more likely to be effective in engaging hard to reach groups. An example of such an approach is a child household safety program in the US which engaged community elders as field networkers and used culturally sensitive home visiting techniques (Hendrickson 2005). Questioning techniques were designed to promote a sense of expertise and competence amongst mothers. For example mothers were asked 'What do you worry about most that could happen to your child?', because it homed in on their sense of primary interest and primary expertise in the wellbeing of their own children. This drew confident responses and engaged interest in doing more to promote child safety. Home visiting was considered a key to the success of this program. This is supported by Watson's survey of literature which indicated that refusal rates are considerable lower when families are supported in their participation by home visiting services (Watson 2005, citing Olds et al. 2002). However as Hendrickson (2005) noted home visiting does not always lead to higher sustained engagement rates.

Watson reviewed the literature around strategies services used to increase the uptake of services by vulnerable families.

At the caseworker level, strategies employed included that the caseworker:
- visits the family *before* the birth of the child. Studies suggest retention rates are higher, possibly because the service is seen as supporting the mother rather than implying that the mother is incapable
- contacts families within 48 hours of a crisis referral or initial post-partum referral, as this is when the incentive to participate is strongest
- follows up the initial contact quickly—within a week—and continue contact weekly. Longer intervals between contacts are associated with higher rates of drop-out.
- follows up with families if there is no initial response or they drop out. Case workers should persist at least three or four times.
- is accompanied by a worker known to the family when visiting a family for the first time.
- visits the family's last known address, which may provide leads to follow up highly mobile families
- provides home visiting services (assertive outreach) (Watson 2005, pp.5–6)

At the agency level, Watson found strong evidence that initial uptake is supported when agencies:
- allow time to recruit participants. In one study, case managers at an agency working with pregnant, substance-abusing women spent 50 per cent of their time recruiting participants.
- are non-stigmatising. One study Watson cited recommends that caseworkers take on the role of a friendly visitor (Watson 2005, p.7, citing Tomison 1998)
- recruit through an agency not seen as representing an authority: suitable agencies might include a needle exchange or a food charity. These services, Watson suggested, may be less threatening and may attract families not accessing 'traditional' social and health services
- use other agencies as 'ambassadors'. That is, a worker from a service could promote other more stigmatised services.
- offer services during periods of transition. Pregnancy is one such transition. One study found that nearly all parents take up antenatal care, providing a key opportunity for broader service engagement (Watson 2005, p.7, citing Naughton & Heath 2001)

Retention rates can be maintained or improved when the case worker builds a relationship of trust with the family, but, as Watson noted, exactly how this is done is not clear from the available research. The strongest evidence points to the importance of communication style and content, practical and material support, and facilitating service access. For example, various studies highlight the need for case workers to confirm appointments, not to break appointments, to use non-threatening language and to include parents in decision making (Watson 2005, citing Senturai et al. 1998, Daro et al. 2003, Gomby 1999). Caseworkers who promote a sense of parenting competence also enable their client to admit to difficulties, thereby opening discussion about ways of addressing those difficulties without the client feeling judged.

Other studies surveyed by Watson pointed to the importance of practical support that meets immediate need as ways of engaging families. Supports may include childcare, transport to services, and provision of food at sessions. Agencies might also address housing and income issues (Watson 2005, citing Spice 2002). Providing material aid assists families to meet their immediate needs and shows an understanding of these, shows they have "positive intent" and that they can find solutions (Watson 2005, p.9).

Agency-level factors that support caseworkers in retaining client engagement include community promotion of programs, and referral between agencies. A number of studies found that services sometimes sought permission to trace mobile families by accessing addresses through government departments (e.g. health or education), but the legalities of such processes need to be considered (Watson 2005).

Agencies should also ensure that caseworkers have adequate training (including cultural training), manageable case loads and supervision, access to brokerage funds and clear working protocols when interagency work is involved. Long-term case workers provide families with stable support and can develop relationships of trust (Watson 2005, p.12).

Peer educators

Peer assistants, or peer educators, are a strategy used with some success in a number of programs. It has multiple layers of capacity building benefits. Peer education is a principal component of both the mothers' clinic at the Royal Women's Hospital and the young parents' program run by Greater Dandenong Council.

The Royal Women's program has trained enthusiastic 'students' as peer educators to engage young pregnant teenagers in the hospital's pre and postnatal clinics and wards. These young peers provide a different service focus from the Maternal and Child Health (MCH) Service, but work alongside it, and there is close supervision and debriefing of the peer team. They assist in childbirth education classes and visit these mothers at home in the weeks following the birth. They also support young mothers through learn-to-drive classes and arrange twice-yearly reunions so that the initial networking flows into other aspects of these young women's lives, with both a capacity-building and community-building agenda.

The Greater Dandenong Young Parents Project, Babes and All, similarly deploys peer education strategies to engage teenage mothers (City of Greater Dandenong 2005). The Young Parents' Group enables young mothers to access support and information about parenting, health, welfare and education services and to make contacts with other young parents and prospective parents. The Young Parents Group has become a referral point for young parents identified by services as isolated and in need of support. Service providers considered the peer educator aspect of the program to be a key to its success. In four years, it provided support to a total of 55 young parents, mostly females, and many of these have reconnected with education and training opportunities (Success Works 2005, pp.21–7). The program deployed a series of strategies to reach and engage an identified hard to reach or hard to engage population. Isolated young parents were located through assertive outreach when they attended antenatal groups at Monash Medical Centre and Dandenong Hospital with peer educators playing a significant role. Isolated young parents were also located through mail-outs to all young parents on the MCHS and Centrelink databases. Free transport and free childcare were provided for the group's activities and education programs. A major part of the program coordinator's role was to link young parents to services.

Snowball or chain referral networking

Two strategies used to access hard to reach groups for consultation purposes are snowball research strategies, also called chain referral sampling (Platt et al. 2006; Atkinson & Flint 2004), and 'opportunistic' contacting. These strategies can also be used as a strategy in service provision.

Snowball or chain referral sampling is based on respondents 'being asked to mention other people in the same situation to extend the sample', and relies on linkages between people and social networks within a population (DHS 2002, p.13). It involves working with initial 'key informants' to gather information on cultural sensitivities or expectations that may be otherwise unknown to the researcher, and to negotiate contacts with the informant's contacts chain (Grupetta 2006). In service delivery, rather than requiring a quorum of participants, this method enables a program to

begin with a minimal number of participants whose own capacities are built up so that they quickly become active field networkers and ambassadors for programs within their own communities.

'Opportunistic sampling' for research involves contacting people at services they do use, even if only intermittently, such as Centrelink, health services, and food aid centres. Opportunistic contacting is effectively another name for assertive outreach. Ethical issues and partnership protocols need detailed consideration in such processes and workers need to be flexible. Contact may be fleeting so the message needs to be targeted, sensitive, discreet and concise.

Learning from strategies around HIV/AIDS

HIV/AIDS is one area in which there has been a concerted effort by programs to contact the hard to reach, and Jackson (2004) considers much of the learning from these programs as transferable to other hard to reach populations. For example, such programs use 'multi-strand strategies' that include delivering services where people go; assuming a heterogeneity of experience and need; understanding the need for individually responsive services; conducting extensive and well-directed media campaigns; using peer education; and paying particular attention to reinforcing messages to prevent relapse into 'unsafe' behaviours (Jackson, cited in Thomas et al. 2004, p.80). Effective HIV/AIDS programs emphasise an open door to welcome returning program 'drop-outs'. They have also recognised that responding to 'the often conflicting realities of … clients' lives is just the first step towards offering effective and quality programming' and that addressing practical barriers such as transport and income security is also necessary (Strauss, Allende & Indyk 2002).

Analysing real needs

Addressing the real needs of hard to reach individuals and communities is difficult. To assist with this process, Doherty, Stott and Kinder (2004) produced a 'checklist' of questions for service to consider when designing services for hard to reach groups:

Minority groups:
- Is the population information that is available, and on which the service is based, complete and appropriate?
- Is it appropriate to define need according to population characteristics, such as ethnicity or physical ability?
- What evidence is there for the under-representation, disadvantage or exclusion of some groups?
- Does meeting the needs of one marginalised group disadvantage another?
- Can those targeted equally access the service, or are some excluded by physical ability, poverty, mental health problems, caring obligations or geographic isolation?
- Who speaks for those excluded from current provision and do they equally represent all members of that community?
- Who speaks for the service provider?

Slipping the net:
- What evidence exists for gaps in existing services?
- Does provision take account of any informal networks, possibly specific to the group?
- How are those outside existing provision made visible: for example, are others advocating on their behalf?
- Do any replacement target criteria improve existing one, or simply displace the disadvantage to other groups?
- Are needs projected onto service users or expressed by them?
- Is the information that is provided to potential service users accessible? What and how is it provided?

Service resistant:
- Is it ethical to engage those who refuse to participate?
- Are the proposed solutions to 'problems' (such as criminal behaviour) shared by service users?

- Does the service offered carry any negative social consequences, or stigmatise the service user?
- How do providers co-ordinate services in initiative-rich environments, are you 'fishing in the same pond' as numerous other providers?
- How are negative experiences of services overcome within a single agency and across providers? (Doherty, Stott & Kinder 2004, pp.5–6).

Doherty, Stott and Kinder also found that many services which expressed an intention to consult with their 'hard to reach' target populations did not actually do so, falling back on the road-tested formulas for programs, which suggests that service providers are reluctant to take up the challenge of outreach and engagement. Effective outreach may literally involve 'banging on doors' sometimes, which may present challenges for staff. The UK's Health and Safety Executive (2004) suggests that services make use of 'intervention mentors': staff who have experience in contacting the hard to reach through assertive outreach. Community consultation needs to reach out beyond 'the usual suspects' of sometimes over-consulted groups if programs are to reach the under-served. The message from researchers is the need to be creative in program design (Doherty, Stott & Kinder 2004).

Preventative strategies

Finally, preventing families from becoming 'hard to reach' in the first place is central. Jackson (2004) points out that a focus on prevention assists with developing better services because

> … it requires attention to risk and protective factors and strategies for breaking the chains of risk that lead to developmental problems. It also prompts reflection on patterns of need and service provision, so providing a platform for achieving a better match between the two, and encourages agencies to measure their performance against common outcome-orientated indicators. (Jackson 2004, p.81).

In practice, preventative programming invites planners to view the needs of a population broadly with best outcomes in mind, rather than focusing narrowly on 'errant' groups whose needs or outlets for community connectedness may have already been ignored by planners.

The following report seeks to throw some light on the barriers to service use for families in Frankston North, Karingal and Carrum Downs, to highlight factors that facilitate service use, and thus to suggest ways that services could be made more readily available to all parents in this area, including those who are currently considered 'hard to reach'.

4 Method

The *Connecting Frankston Families Project* was undertaken by staff from the Brotherhood of St Laurence (Carmelita Davies, Jenny Lang, Lucy Nelms, Janet Stanley and Nicole Oke), who designed and coordinated the study in association with the Communities for Children Frankston North Facilitating Partner, Anglicare Victoria. This research was conducted as part of the Communities for Children Initiative in Frankston North.

Information on family's service needs was gathered from residents of Frankston North, Karingal and Carrum Downs who care for a young child, as well as service providers working in this area.

A total of 19 participants were recruited for the study; of these 14 were parents and 5 were service providers. All the parents that participated in this research were utilising at least one local service. Interviews were also conducted with service providers in the Frankston region who were working with hard to reach and disadvantaged families in some capacity.

15 service providers contributed to a workshop discussing strategies to make services accessible to hard to reach families.

Parents

An initial meeting was conducted with a maternal and child health nurse, whose assistance was essential in recruiting clients for the project and spreading the word across MCH centres. The majority of participants were referred to the project by their MCH nurse.

Workers from key agencies in Frankston were contacted by phone and email and attempts were made to recruit clients accessing these services. The following agencies were approached and invited to assist in identifying hard to reach clients:

- Salvation Army – Peninsula Youth & Family Service
- Frankston Community Support and Information Service
- Youth Resource Centre
- Frankston Community Health Service
- Maternal and Child Health Centres in Frankston North, Karingal and Carrum Downs
- Enhanced Maternal Health
- Peninsula Health

One of the main services where disadvantaged families present is the Salvation Army Peninsula Youth and Family Service. Contact with the managers resulted in their workers recruiting appropriate families as they dropped in or came to meet case managers. A research officer spent time at the crisis centre so as to interview any suitable presenting clients. However, it was the week after Christmas and few clients attended. One client was recruited and interviewed at the Crisis Centre, where she felt comfortable.

Fourteen service users were interviewed—12 in person and two by phone. All participants were accessing one or more services in their area. Five had one child, six had two children, and three had three children. The age range of children was from five weeks to seven years. While an emphasis was placed on interviewing parents with babies up to the age of 12 months, four research participants only had children above this age.

Parents were given the choice to be interviewed at a service they accessed or at home. Six parents were interviewed in their own home, five at the Brotherhood's Frankston site in Wells Street and

one Salvation Army Peninsula Youth and Family Service in Frankston. The other two were interviewed by phone.

Participants were asked to describe their current and past service use. They were asked to list the services they currently used and to identify what allowed them to use these, and to describe what was good and bad about them. They were also asked to identify services they had used in the past or had needed but could not access. Finally, participants were asked to talk about their ideas about services that would be useful for them in the future, and what factors would make a service ideal.

Each interview took between 15 and 30 minutes, depending on the willingness of the participant to talk about these issues.

Service providers

Five service providers were then formally interviewed over the phone. They were asked to describe their organisation's services, and to assess the main barriers families have in accessing services, and the main facilitating factors. They were also asked how they would define a 'hard to reach' family and how their service targeted such families in Frankston North, Karingal and Carrum Downs.

Reflections on the process

Making contact with 'hard to reach' families in Frankston was very difficult. There were several reasons for this:

- Service providers struggled to identify such families.
- These families, when identified, often have transient and chaotic lives. Service providers identify this as a reason some families have trouble keeping appointments. The researchers needed to be flexible and responsive to meet the needs of these families and often had to recontact families several times. Half the interview appointments had to be rescheduled because people missed appointments.
- Making contact with families through service providers imposed a burden on service providers, and some were reluctant to take on the extra work of informing their clients about the project. The research relied heavily on one MCH nurse who recruited most of the respondents.
- Some services that might have provided important information were very difficult to access. For example, to speak with staff of the Peninsula Hospital we needed to apply to their ethics committee. This application could not be finalised in the project timeframes.
- This research was completed in a short timeframe and most of the interviews were completed close to Christmas. This was a difficult time because people were finishing for the year, and completing end-of-year reports.

5 Participants – Parents

While both service users and service providers were interviewed, demographic information was only collected about the service users. This is described below. The aim was to interview service users whose characteristics might match those of others regarded as 'hard to reach'.

Gender

As the study is about families with newborn babies, and many participants were recruited through their MCH nurse, most were women, as mothers tend to attend such services more frequently than fathers. Of the service users, 13 participants were female and one was male.

Age

Participants ranged in age between 20 and 39, with more than half under 25. All had dependent children, whose ages ranged from five weeks to seven years.

Country of birth

Thirteen out of the 14 people that we spoke to said they were born in Australia. Of these, two identified themselves as Aboriginal. One respondent was born in New Zealand.

Place of living

All of the participants lived within three suburbs in the City of Frankston: ten lived in Frankston North, two in Karingal and two in Carrum Downs. Most lived in private rental accommodation, two with family and friends, one in transitional accommodation and one in her own home. The length of time that participants had lived in their particular suburb varied. One-third of the participants had been residing in the Frankston area for less than two years, another third had been living in the Frankston area for six to ten years and the remaining third had lived in the Frankston area all their lives.

Family unit

Eight participants were living with a partner, two were in a partnership but not living with their partner (the partner of one was in prison and the other had mental health issues) and four did not have a partner. All four of the sole parents were women.

Nine parents had no formal childcare arrangements, the children of four of the parents went to a childcare or family day care centre, and one single mother relied on her parents to assist with childminding occasionally.

Income

Eleven of the 14 participants relied on government pensions and benefits as their main source of income.

Transport

Of the 14 service users interviewed six had a usable car; five did not have a car; and three had a car but were not using it because it did not work or was unsafe to drive. For the participants that did not rely on a car, the main form of public transport used was buses and trains. Other ways of getting around were walking, getting a lift from friends, partner and parents-in-law. One person interviewed, who had a disability, used taxis.

Parents' opinions about their neighbourhood

In uncovering the needs of families in these target areas, it is important to understand how people perceive the area where they live. Participants were asked how they viewed their area as a place to raise children (see Table 1.1).

Table 1.1 Parents' rating of neighbourhood as a place to raise children

Rating	Frankston North	Karingal	Carrum Downs
Very good	1		1
Fair	7	2	
Poor	1		
Very poor	1		1
Total	**10**	**2**	**2**

The reasons for rating their neighbourhood as a very good, fair, poor or very poor place to raise children were varied. However, the safety was the biggest concern due to the perceived increase of crime, violence, drug use and drug dealing.

> It's just everywhere you go there are drug users. In Frankston it's a nice area but there are just drugs everywhere.

Noise generated by speeding cars was another reason why people rated their suburb poorly. Of the 14 respondents, six people mentioned cars 'hooning' as a problem which contributed to not feeling safe.

> The noise is bad; there's motorbikes, parties, yelling and cars burning up and down.

One mother living in Karingal rated it as a fair place to raise children, but felt that due to younger people moving into the area, it was not as safe as it used to be. She still felt that Karingal was a safer place than Frankston North and Carrum Downs.

> I've heard some things that have been happening at Carrum Downs lately, like the police actually patrolling and looking for parties to confiscate alcohol or something because of the teenagers getting out of control and things … and Frankston North I've never really liked Frankston North, it hasn't had very much of a good reputation, although I have heard lately that it has gotten better, but that may be because they're (young people) all moving to different areas.

However, some people experienced their neighbourhood differently and positive aspects of living in these areas were reported. For example, one resident from Frankston North rated this suburb highly because it was quiet and there wasn't a lot of violence. Another resident from Frankston North had spent all her life there and felt she knew the area well and that there were plenty of parks and walking tracks. A resident from Karingal felt it was a 'nice' area that was safe with 'not many rowdy people', while the interviewee from Carrum Downs who felt it was a very good area to raise children attributed it to lots of children being around and having parks and shops nearby.

6 Services used

Parents indicated that they used a range of services, either for themselves, their children, or other members of their household. We took a holistic view and adopted a social model of health that incorporates parent's social, emotional, physical, spiritual and mental needs, and so considered services addressing various needs.

Table 6.1 lists all the services accessed by the families interviewed, as well as the services that parents used the most (keeping in mind that some parents identified more than one service that they used the most). The most commonly used services were the MCH nurse, a general practitioner and Centrelink, which were used by almost all respondents. All respondents said they saw a MCH nurse. Only one respondent reported not using a general practitioner; similarly all but one respondent used Centrelink.

As shown in Table 6.1, the services used by the most respondents (each accessed by more than five families) were:

- maternal and child health centres
- GP
- Centrelink
- hospital (emergency ward)
- dental services
- emergency relief (material aid)
- paediatrician
- hospital (outpatients clinic)
- child and family support services
- libraries.

Families' actual experience of accessing these services was mixed, as discussed further in chapters 7 to 9.

Table 6.1 Services used by parents interviewed (n=14)

Type of service	Number of interviewees using the service	Number of interviewees using this service the most
Playgroup	5	1
Parenting education programs	3	
New parents group	3	1
Parents support group	3	1
Occasional care	1	
Family day care	2	
Kindergartens	1	
Schools	1	
Childcare centres	4	1
Before & after school care	1	
Maternal & child health centre	14	7
Hospital (emergency ward)	11	1
Hospital (outpatients clinic)	7	1
GP	13	4
Medical specialist	4	
Speech therapy	2	
Paediatrician	8	
Dental services	8	
Community health service	2	
Child & family support services	6	1
Disability services	2	1
Drug or alcohol services		
Counselling services	4	1
Mental health services	1	
Housing services	4	1
Migrant or ethnic resource services		
Church or religious groups	3	
Charities	4	1
Department of Human Services	5	2
Police	5	
Emergency relief (material aid)	8	
Centrelink	13	1
Libraries	5	1
TAFE/uni or higher education	2	
Local council	3	
Neighbourhood houses	2	
Other	5	

7 Barriers to access

Respondents identified barriers that prevented them from accessing and using services altogether and identified barriers which made it difficult for them to access services. Eight of the service users, that is about half of the respondents, said there were services that they were unable to access because of particular barriers. All of the service users said there were significant barriers which made it difficult for them to access certain services.

The services that were unavailable to some respondents varied. Two participants had been unable to access specific medical services (speech pathology and an ADHD service). A further two had been unable to access dental services. Two parents could not get public housing. One respondent said she was unable to get the police to respond to her phone calls or to access counselling and mental health services. A parent said a service that provided guidance with budgeting and other financial issues was required. Another said there was no support group for older mothers (aged over 35 years) in her locality. Not all respondents, however, felt that there were additional services they needed. One man, for example, said 'I can get other services if I want but I just don't want to'.

All the respondents said there were significant barriers which made it difficult for them to use particular services. The most common difficulties related to transport or the location of services. Other reasons given were the cost of using services; the lengthy delays getting into services caused by long waiting lists; not having childcare, the behaviour of some services staff; a lack of coordination between services and not knowing about services. These issues are examined below.

Transport and location

The most common barrier to service use, mentioned by 10 respondents, was that services were not close to where they lived, or there was no public transport linking them to the service. Most of the parents did not have a working car. Respondents usually said that transport or location were a barrier to some services, but specifically mentioned that they were able to access other services because of their location the transport that the services provided. Two said the only reason they did not use more services was the difficulty of getting there. A mother wanting to access a SIDS support group found it difficult because the closest service was in Malvern.

One respondent explained how a lack of transport compounded other problems of accessing services. This woman said it was difficult to get in to see the dentist, a service with a very long waiting list. She believed that you could go in and make an appointment to be seen on the same day, but that it was difficult with children to 'jump in, fly down, and come back' on the bus.

Another barrier is not knowing how to get to services by public transport. Two respondents said they did not always know if they would be able to access services, and so did not try to use them. One said it would help to know if they would be able to take public transport to get to services. The other said it would be useful to have this information because she was new to the area.

These families with young children faced the extra difficulty of getting prams on some buses. One mother said that transport was the main barrier to service access. It was very difficult for her to get on some of the buses with a pram and she received little help from the driver or other passengers. She said:

> It's a bit hard to get that pram on a bus and everyone complains about it and now they expect you to fold the pram before you get on and they're not very helpful anymore … they won't really help you on the bus if you've got a pram, they just make you try and carry the thing yourself up the stairs … When I was pregnant with his sister I ended up hurting myself because the bus driver wouldn't get up and help, and I nearly fell back down the stairs with the pram. So they're not very helpful getting on and off the bus, some of them are helpful but most of them aren't.

This woman reported another transport difficulty is that sometimes taxis will not drive her and her kids, saying there is a need for:

> Better transport and buses need to be wider … With the taxis … when you call them you shouldn't have to wait half an hour to two hours and if you have got kids. I don't reckon they should turn around and say they can't … go in the car … I've got two kids and I've got to try and put him in the seat and keep him in the seat and also hold my daughter. Sometimes when I call them they just turn around and say no, it's not all the time but sometimes. It depends on the distance like where I'm going, if it's a long distance they won't do it.

One participant suggested that, while possibly unfeasible, it would be useful to have a community bus to pick people up and take them to the services.

Finally, one man was disinclined to use public transport, but could not afford petrol for his car. He said:

> I don't believe in public transport. I don't rely on it … I don't catch it. I never have and I never will.

Cost of services

Five of the service users named cost as a barrier to participation in services. Two respondents referred to the cost of dental treatment, one respondent to the cost of childcare, and one to the cost of seeing a paediatrician. Another said there were services that cost more than she could afford, but she did not specify particular services.

Even when the cost of services was covered by Medicare, the need to pay for the health service and later get a reimbursement from Medicare meant that some respondents had difficulty accessing services because they did not have the money to pay up front. One respondent, whose health was impacting on her ability to care for her child, could not afford the upfront cost of an essential operation, even though she would get the money back from Medicare. She explained: 'I don't normally have a hundred dollars spare'. This woman also described how she needed to get all her teeth out, and would be waiting 'forever'. In the meantime, when abscesses developed in her mouth she attended the public dental services as an emergency but each time worried about how to pay $20. She was embarrassed about the state of her teeth, and would avoid taking her daughter to places such as playgroup, because of this.

Not knowing in advance whether you needed to pay or not was also a barrier. One mother unexpectedly found that she needed to pay when she took her daughter to see a paediatrician. This meant that she did not go back, even though she had booked a follow-up appointment. Another mother said that she did not use some services, such as a paediatrician, because she was unsure whether people with a health care card need to pay for the consultation.

While perhaps fewer than expected respondents mentioned cost, many mentioned lengthy waiting lists for essential services, particularly dentistry and housing. Had they been able to afford to see a private dentist, they could have avoided long delays, in most cases.

Waiting lists

Half the parents who participated in this research said that they faced long waiting lists for services. The services mentioned were public housing, dentistry, general practitioners, specialist medical services and social workers.

Three respondents said they had trouble accessing dental services because of the waiting list. For example one respondent said:

> Dental services aren't good either … No, they are expensive too. They have this community dental thing but you have to wait months.

Four respondents mentioned their difficulty accessing DHS housing. One woman said there was about a five-year waiting list; another said she was unable to even get on the waiting list. When asked if there was anything that would help her to use services one respondent said:

> Housing. It is all I really need from the services, is just housing.

Two women said the waiting list to see a general practitioner was long. One of these said she sometimes had to wait six weeks to get in. The other woman had been unable to get a doctor to examine her baby who had developed a bad rash:

> They were all booked out … I'm like 'Can you just squeeze me in?' and I wasn't just going to the bulk billing places, I was going everywhere, but I couldn't get him in anywhere. Yeah, maybe just waiting lists.. Money wise, I don't think it's a barrier because they're all pretty feasible.

Another mother had had been waiting for twelve months to getting her son with ADHD seen by a specialist service, due to the waiting list. Finally, one woman had to wait three months to see a social worker.

Childcare

A need for childcare was not mentioned frequently. One woman who wanted to do an aged care course next year, was not sure if she would be able to because of the cost of childcare. She said that childcare is important, so that mothers can go back to work:

> It's got to be cheaper. I mean they want to encourage mums to go back to work but that's not till the youngest baby's five when they start school and I am just like I can't sit around for that long. I need a job. And it's hard to get a job if you don't have experience and if you don't have like all this stuff behind you, so childcare is a must.

Another woman said that it was difficult to line up for emergency relief with young children because you had to wait for two hours. She said childcare might be useful in this situation. While the main issue is that such a wait for an emergency relief service is unacceptable, this comment also indicates that lack of childcare can compound other barriers.

Staff behaviour

Eight of the 14 parents indicated that staff attitudes or behaviour put them off using services.

Four respondents said staff did not listen to them, or did not adequately respond to their needs. One woman, whose child requires specialist medical care, described having to keep ringing services because they would not return her calls. When asked what an ideal service would be like, she said

> They would call you, and not treat you as a number.

Another woman described how housing services did not adequately respond to her needs. She had to give up her DHS housing and her belongings that were in the flat because of the trouble her ex-partner was causing after he was charged with a criminal offence. He was refusing to leave the flat. Even though the flat was in her name, she was fearful of his behaviour. She asked the housing workers for a transfer but nothing happened. She left the flat but had to pay for the damage he had done.

Another two parents said they felt they were not being listened to in regard to child custody matters. One felt the DHS was not listening to her point of view, but taking her mother's side

instead. The other felt her partner had not been given an adequate explanation when his children were taken away, and that their confidentiality was not maintained by service providers.

Four parents felt that some staff members were prescriptive or pushy when they gave advice, or found the service provider difficult to relate to. One woman described some nurses not listening to what she was saying about her child but instead taking the approach of what she called a 'book mother':

> You know, they all go by the books and stuff, and I don't know go by anything like that, I just go by what my children want, you know what I mean, like what my children want to do. I am not a book mother really … some parents, all they will do is go by what the book says and if you say to them you're giving your baby solids at three months, 'No the book says you have to do it at six months so you have to do it at six months'. I gave my daughter solids at three months and, look, she is fine …

She felt that the nurses were pushy:

> Like if you don't make the bottles up the way they say and if you don't do what they say they sit there and they give you a lecture and they tell you that you should take your child to the doctor now because you know. Yeah just silly things, they are just a bit pushy sometimes.

Another mother said some hospitals were unresponsive to her family's needs, saying they 'need an attitude adjustment'. This was because they wouldn't let families maintain their normal routines, such as make their babies' bottles:

> …they wouldn't let us do what we would normally do at home, like if we would fall asleep just cuddling they would go sick and if we didn't have him wrapped they cut sick.

She felt this was unnecessarily restrictive, because when she went to another hospital:

> … I was allowed to make his bed and change his sheets and all that sort of stuff, and because he was on formula because my milk dried up I was allowed to go and get him a bottle and didn't have to have him wrapped.

She says this helped because:

> … it made me feel I could get back into my routine again.

Another woman said she stopped going to the counselling service she had been referred to because they made her feel worse:

> … I didn't really get along with them, I thought they made things worse [rather] than made things good … They would ask you the same question over and over again and yeah I just got frustrated and more depressed than what I was. So yeah it wasn't really much help to me, so I stopped going there and I stopped taking antidepressants and that sort of stuff, and now I'm a lot happier.

Finally, one woman described some maternal and child health nurses as disconnected from the community and 'stuck up' so it was hard to relate to them. They lacked a sense of humour:

> Even if you tell them a normal joke they are just like 'Oh'. I don't like them.

A third issue to do with staff behaviour was that some participants felt some staff were dismissive of them. One woman felt that Centrelink workers looked down on single parents, and this meant she did not want to go there. She also mentioned the difficulty of feeding a young baby and holding a place in the queue at Centrelink:

> Like one time I needed to feed him and I didn't want to do it there, so I ended up leaving and lost my spot in the queue. Like I couldn't feed in that place anyway. Some of the people that go there … it's not a good place. I don't like going there. [They need] just somewhere easier for parents just to hand in forms because pretty much once you have started you don't have to go in there too much.

Two women said they were put off by the attitude of hospital midwives during their pregnancy, which these mothers described as rude. One woman said the nurse running the young mothers' antenatal classes at the hospital framed the information in terms of how the young women had made a big mistake by getting pregnant—yet she was happy to be pregnant. She explained:

> …I ended up being put into a young mums' antenatal class … I thought it was a bit strange because there were only three or four girls and they were all quite young and like I was 18 and I was still young and everything but they were just very 'Oh you're children and you've done this, so now that's it and you have to deal with it and these are all the horrible things that are going to happen'.

> And they were saying things like 'After you have the baby, that'll be it, just don't have sex for a few months afterwards because you'll get pregnant again and you don't want to get pregnant again'. It was very much 'You're pregnant and it's a bad thing and you're going to suffer'. Whereas I wasn't like that; I was like 'Wow I didn't think I'd ever get pregnant and now I'm pregnant and having a baby' and everyone was really happy about it.

In addition she felt the advice given in the course was not helpful because it was very superficial and did not go into details:

> Yeah it was very toned down …

She changed to a general antenatal class where she found that more detail was provided. This woman also described her stay in hospital after she had her baby as frustrating. She said a nurse told her off when she went out to smoke a cigarette, saying sarcastically: 'Oh, I didn't know you were allowed to smoke under the age of 18' even though she was over 18. Another nurse came in and told her the other nurses thought she was 13 or 14 but then said:

> 'Oh it doesn't really matter how old you are love, they shouldn't be treating you like that'. They still thought I was 15 and I got dumped in a room by myself and didn't even get a look in. They tried to keep me in for an extra week and I said 'No way, you're not even doing anything'.

A second woman complained about the attitude of nurses at the hospital. She said she stopped going to the parenting education classes because the woman running the program was 'terrible' and that she gave very prescriptive advice:

> First she started by saying that caesarean is the easy way out when my mum was there with me and she's had three caesareans and she was like 'No, it's not easy', and she was pretty much saying that you'd be a failure if you took medication during labour, which I'm glad I didn't listen because you need medication, but yeah she was making out that if you used it you're failing your baby and you're not giving your baby the best start in life … I couldn't handle hearing that because when you are heavily pregnant you do start thinking maybe it isn't the best thing for my baby. I had planned on using pethidine and I just started to doubt it and some of the stuff she was saying in the classes was a bit weird …

Even though she had the support of her mother during her labour, the nurse's advice panicked her during the labour:

> Yeah I was panicked. No-one could offer help. If my mum wasn't there I would've panicked. Like with the epidural, she really emphasised things that could go wrong with the epidural … I know they're meant to touch base on 'maybe 10% get paralysed' or whatever,

> but she was emphasising all the bad things that can happen with epidurals and all the drugs. So if my mum wasn't there or I didn't have a support person I would've been freaking, I'd be like 'I'm not having that and I'm not having that'.

This woman put in a complaint about the parenting education course but asked that this not be discussed with the nurse who ran the course until she had given birth, in case the same nurse attended to her during labour. However she was told at one of her antenatal appointments that the nurse had been told.

Coordination between services

Three respondents said that the lack of coordination between services made it difficult for them to access services. One woman said she kept being sent from one support group to another, and that her support from specialist children's services would stop when the child reaches school age. Another respondent said it was hard to access housing because she kept being sent to different services:

> They help you but they don't help you at all, they just send you on your way really. They are like 'Go to this place or go to this place'.

One woman said that services for young people (under 18) were poor because young people 'get told to go somewhere else and then somewhere else'.

Not knowing about services

Three respondents said that a barrier to accessing services was not knowing whether a service existed. For example, one parent said the problem was:

> …even not knowing how to access them or not knowing they're there. I wouldn't say embarrassment or anything like that because you can always ring up over the phone and they don't know who you are anyway.

8 Ways of finding out about services

Whilst all the service users interviewed identified barriers, all were using some services. They had a variety of ways of finding out about services they needed.

Most commonly, respondents found out about services by talking to friends or family. Six respondents found out about services this way. One said:

> I will just ask different mums and look around myself, or go in and meet everyone and whichever one I feel comfortable with is the one that she [daughter] will go to.

Two respondents said they found out about services through other mothers in their play group or mothers' group.

Seven service users said they found out about services through key service providers—staff who they knew would be able to link them to other services. Such providers included their MCH nurse, playgroup facilitator, disability worker, midwife and the young mums' group facilitator. For example, one woman talked about the MCH nurse giving her useful contact numbers regarding postnatal depression, and another said her MCH nurse helped her by driving her to look at flats. Another respondent said her playgroup coordinator would link people to services they need and would drive them to these services, if need be.

One woman, who had moved from interstate after her baby was born, said that they were linked in with the MCH nurse in Frankston because her MCH nurse interstate had given her the contact details of the Frankston service.

Four respondents found out about services by asking around at services. Of these, two respondents said they found out about services through DHS. Another said she would ask at City Life (a church-based service) and the Salvation Army when she needed additional services. One woman said she would walk around and when she went past a service she would go in and ask them what they provided:

> … taking a good old walk to have a look at places. Go in there and find out what their services are and then I know if I need their help in the future.

This woman then checked this information by asking other people's opinion of that service.

The 'Bounty Bag', the bag given to women through the hospital system (at antenatal appointments or after the birth), and a booklet of services given out by the hospital were mentioned three times— but generally as places they thought services should advertise in rather than where respondents had actually found out about services. One woman said she used the book of services she was given. Two women said services should advertise in the Bounty Bag and one suggested an improved booklet of services. This respondent said that while she was given a booklet of services, it was like a 'dictionary going through services' and she gave up reading it.

Some respondents also mentioned finding information from flyers. One woman said she learned about services by picking up flyers in the MCH nurse's office. Another said she got family services brochures through the young mums' group, or 'on a wall somewhere'.

Two women preferred to find out about services by looking on the internet, and one of these women would go to the library to do this. Others found out about services by looking in the phone book and at television advertisements.

9 Facilitating inclusion

Among the factors that helped them to access a particular service, two main issues were mentioned by almost all the respondents. These were that they felt comfortable with the workers at the service, and found them to be supportive; and that the service was located close to home. These themes recurred when people talked about their 'ideal' service.

Comfortable and supportive services

The overwhelming reason (given by nine people) for using a service was that they felt comfortable with the workers and the service itself, or that a worker was particularly supportive.

Six respondents said they felt comfortable with the service or the service worker, but often also indicated that their service worker was supportive. This, they explained, helped them to access the service.

Two of these respondents talked about how they liked the MCH nurse because they could relate to her, and felt she knew how to relate to them. They felt their nurse would give them advice, but would not lecture them. One said of her nurse:

> She knew her job but she also knew how to joke … She's just, she knows how to make you feel comfortable and stuff like that. She doesn't just sit there and go you need to do this, you need to do this.

The other said she went to her MCH nurse because she was 'really lovely'. She would go to the nurse when she had a problem, especially with her baby's routines, and the nurse would sit down with her and work out a new routine. She was now able to work out new routines for her daughter by herself, having been taught by the nurse. She explained what she appreciated:

> I wouldn't say young, but she's got a younger approach, she's not aggro, she kinda makes you feel comfortable. [The MCH nurse] is very 'Oh I don't really care, I'll tell ya and I'll tell ya straight'. Like she'll tell me off if there's something she doesn't like me doing, but in the end I know I can say to her 'She's my daughter' and she'll go 'That's right she is, but I'm trying to help you make it easier for you'.

A respondent explained how she felt comfortable with the service she visited because the workers were nice and helpful and also knew her as an individual. She said:

> They get to know you personally, yeah like I know them personally now, which is really good … [This] makes you feel good, so that you're not just, you know, someone else.

Another mother commented that a staff member at the agency she visited made her feel comfortable because they knew how to 'get along with her children'. Another said that the service provided her with a space that she felt comfortable in:

> It's a good place to go and have coffee and I didn't know anybody, so I didn't have any accommodation, things like that … It's a good place to chat. And they're good people, yeah, the people that run it … they are helpful and nice.

A parent commented that she used the library because the library staff 'really understand children':

> They're like perfect, like they understand kids, they don't, you know, they are really good. They make it really easy … I can relax there. There is nothing much [my daughter] can get in trouble with, it is just books everywhere. She really enjoys herself. It's a good time for both of us.

One respondent had initially been upset about the service she was required to use—home visits from a nurse to teach her parenting skills:

> I was a bit upset to start with like when I had to bath him … and watch a stranger do it.

But she said that by the end she felt comfortable and it was a good experience:

> Because I learnt a lot and I grew as a person.

Finally, one parent said she liked one agency because they didn't 'hound' her:

> [The agency] is not too bad because they don't hound you with things. If you want to do something then they do it, if you don't then they don't hound you too much.

Two respondents talked about the way some services were particularly supportive (without mentioning that it made them feel comfortable) and that this helped them to use the service. One person's doctor had taken time to speak to her husband when he was suffering from depression. Another said his caseworker had been very accessible:

> Yeah the worker because he said anything I need just call him, day or night, it doesn't matter what time it is.

Accessible services

Seven respondents said that their use of a service was helped if the service was accessible. Two of these respondents said such services were easy to get to using public transport; one said the workers paid home visits; and one said the service was close to home. One mother mentioned the 'nurse on call' line because it was easy to access and a useful service. Another respondent said she still used a service close to where she had previously lived, because the workers were very supportive and assisted her with transport when she needed to go somewhere.

Ideal services

Respondents were asked to describe their ideal service, as a way of determining what facilitated access. They raised a variety of ideas. Suggestions about the features of the ideal service were:

- A range of services in the one location (mentioned by four respondents). One woman described her vision of this service in terms of a 'big playgroup':

> I would like a big centre, sort of like a playgroup centre thing, just where you can go and relax, like the parents and children, and sort of like a kindergarten where parents are welcome as well, sort of like a day-care where you are welcome as well.
> Yeah something like that in its own place … I suppose I would go to one of them nearly every day if I could go with her and watch her learn and grow and play with the kids.
> Something like that kid-friendly place where you can't break the windows or anything.

- Specific services. Services mentioned were doctors (GPs), counselling, drug and alcohol services, parents' groups, story time, and books to borrow. Counselling was the service mentioned most frequently, with four respondents nominating this.

- Opening hours (mentioned by six respondents). One person said the service would be open just during 'normal hours' but four parents felt that services would ideally be open 24 hours a day or at least have long hours. Another respondent who wanted the service to be open during the night explained:

> …and if I knew there was a place for me to go to in the night just for someone else to take the baby, but like you have to have a coffee and talk to someone because everyone I know

is asleep after midnight. Sometimes you just need to talk when like you're just a bit stressed and you need someone else to talk to.

- Low cost or free (two respondents)
- Free tea and coffee
- A worker to look after children while parents accessed services
- Centrally located (two respondents)
- Transport: wider buses and better transport; a bus to take people to services or shopping
- Home visits
- The health nurse providing information by writing in the local paper.
- Friendly workers. One woman said the workers would be 'nice, hopefully'. Another said they would need to be: 'at least nice and funny and caring'. Another described how the ideal service would have a friendly atmosphere. She said they would help with things like counselling and 'help you to feel better than you are' and it would be 'like the bar *Cheers*, where everyone knows your name'. One respondent said the workers would need to ask the community what they wanted and suggested that they:

    … would have to be from the community themselves in order to know what the community wants.

10 Service providers

Service providers were asked to share their knowledge of how services could be more accessible to hard to reach families, and families with complex needs, and to reflect on what facilitates inclusion. Five service providers agreed to be interviewed[1]. They represented four different programs.

Identifying hard to reach and disadvantaged groups

Service providers were asked both to define a hard to reach family and to identify groups in the community with particular disadvantage regarding access to services.

Hard to reach families were described by service providers in a variety of ways. For one service provider, hard to reach families had a pattern of multigenerational welfare dependence, minimal work skills, low aspirations and low self-esteem. These families were likely to have minimal access to health and dental care, be socially isolated and not seek help because of the attached stigma. Another service provider focused more on the issue of isolation in defining a hard to reach family. This person said that the hard to reach families are often families that move house after the first child has been born, thus losing the link with the MCH Centre. These families often have a limited network of family and friends and do not know how to look for services. Another service provider noted three main groups as being hard to reach: first, families with mental health or disability issues, because it can be hard for them to see why they need a service; second, other families who are not yet ready to acknowledge that there is a problem 'because the first barrier to overcome is why they might benefit from accessing your service'; third, families who have high anxiety about the outcome of an intervention, such as families who are fearful of a child being removed.

When discussing which groups or localities are particularly disadvantaged when accessing services, again varied responses were elicited. Groups mentioned were young mothers, CALD communities, residents of localities with poor public transport, residents who are ineligible to use nearby services located just across administrative boundaries, families in which there is a disability or a mental health issue, and men needing anger management services. Service providers gave the following reasons for particular disadvantage:

- *Young mothers:* Young mothers are often discouraged from continuing with their schooling.
- *CALD communities*: One service provider said CALD communities, such as the Sri Lankan community, were disadvantaged by not 'even understanding the first step of accessing services'. Another said that the Sudanese community were culturally isolated and had different cultural practices, for example relating to parenting. This service provider commented 'We don't understand them, they don't understand us' and said it was difficult for service providers to engage with this group.
- *Residents of particular localities*: One service provider said people living in areas poorly serviced by public transport are disadvantaged. Another identified the Pines as one area with poor public transport, and also geographically isolated, meaning that residents tend to leave the area less frequently. Residents of Carrum Downs/Skye were identified as disadvantaged because they are sometimes included within the borders of the municipality and sometimes considered to be outside the municipal boundaries.
- *Family member with a disability*: Children with a disability are disadvantaged, said one service provider, because appropriate services do not exist. Another service provider said that parents with an intellectual disability are particularly disadvantaged, because:

    They need services that are quite tailored to meeting their needs. Some of the parenting groups don't hit the mark for them in the way they are delivered. But they also don't want to be identified as different. So there is that inherent challenge.

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[1] There were only four interviews as two providers were interviewed together.

- *Families needing mental health services*: People needing mental health services faced a long waiting list. This group includes many women with psychiatric illness during pregnancy and postnatal depression.

- *Men needing anger management services*: This is because there is a stigma attached to identifying as needing to deal with violence. When these groups are run at night there are also personal safety and transport issues.

Barriers to accessing services

Barriers to service access suggested by service providers related to service unavailability, poor infrastructure, cost, lack of information, cultural differences between service providers and service users, and family-specific factors. These barriers are presented below as a list.

Service unavailability

- Basic services are lacking. Health and dental services are non-existent.
- Long waiting lists for services.
- There is currently an upheaval in service provision, creating a sense of flux.
- Suburbs are 'like islands off Frankston where the major services are located' and due to housing costs more families are being pushed out to areas with fewer services.
- The three tiers of government don't always talk to each other about service provision.

Infrastructure

- There is limited public transport.
- Infrastructure in the locality is poor. For example, many parks are without toilets.

Cost

- Some services cost more than parents can pay.
- Childcare is costly, more than what many families can afford, and there is a long waiting list, including for occasional care.

Lack of information

- There is a lack of information regarding the services that are available.

Cultural differences between parents and service staff

- There are cultural barriers between service users and service providers. It may for example be unreasonable to expect parents who live lives of chaos to attend services.
- Services need to be culturally appropriate: 'We predominantly see families from an Anglo culture and I think culture is a barrier to people accessing services.' This service provider explained that for some cultures the idea of services providing support to families is foreign so 'it's about how do we explain in a way that makes sense to cultural groups around what we do'.
- Language and cultural barriers make it more difficult to access services. However, this service provider added that the Sri Lankan community was starting to use the services more, so barriers were being broken down.

Family-specific factors

- There are some families who do not yet acknowledge that they need support.
- Partners can be barriers to women's service use:

> … particularly for some of the women [the barrier is related to] around letting people know what's happening in their family or not having permission to seek that. Being very much limited in their opportunity to have access with other people where information about their family may become known.

Another service provider also said that husbands or partners could be a barrier and added that sometimes women would not attend a service if their husbands had the day off.

- Families where a family member has a mental health issue.
- Families where a family member has a disability.
- Drug and alcohol issues within families may mean they lack the energy to focus on family needs.

Facilitating factors

Service providers suggested factors that currently facilitate access to services for families in these suburbs. These related to communication strategies, relationship building, location and transport and the cost of services. Some respondents' comments were quite general and brief. Responses are presented as a collection of ideas rather than a prioritised list.

Communication strategies

- Breaking down the stigma of being a DHS client. Some families are very frightened about notifications of at risk children, causing them to stay away from authorities.

- Encouraging positive word-of-mouth messages from friends or family. This is important because families are 'looking for someone to tell them the service is okay'.

- Increasing communication between services. This is being aided by CfC and other Commonwealth funding.

- Enhancing community education to make people aware of the service.

Developing relationships and trust

- Developing trust through the MCH system to show 'we're there to support them and listen to them. A positive experience would encourage further use'. This is a slow process of relationship building which starts by listening to families.

- Providing peer mentoring and support, because it takes strength and confidence to come to a group and talk about what is happening in your life.

- Providing access to brokerage of flexible funding. This is a way to engage with some families. While they may have multiple problems, the first can be that they are about to be evicted, or have no food this week. So a food voucher within case management facilitates engagement.

Location and transport

- Locating services centrally.

- Offering transport but also support to get to services, such as a worker or trained volunteer being available to attend a first meeting with a parent.

- Using the neighbourhood house because 'it's known to be friendly, it's not a scary place to go'.

Cost of service

- Providing low-cost programs.

Strategies to target hard to reach families

Some of the programs currently use a variety of strategies to target hard to reach families. Some respondents gave quite brief descriptions of these strategies. They are listed below.

Strategies used by program one

- Provides transport to services

- Provides food

- Creates a safe place where DHS is not present

- Offers childcare

- Offers attractive activities (e.g. belly dancing, dietician, Body Shop) alongside the main activities

- Offers the chance to meet other new or young mothers and begin social networks

- Has set up a room at the community centre so that people become familiar with their service.

Strategies used by program two

- Provides services at low cost
- Provides a drop-in service
- Has a facilitator who makes a personal connection, and visits MCH centres and new mothers groups to promote service, providing a 'friendly face' to make it easier to make the initial contact and come through the door
- Makes their facilities available for programs for families in crisis and to programs for parents of children with autism.

Strategies used by program three

- Publicises their service through word of mouth, kindergartens, and the community centre.

Strategies used by program four

- Offers transport and support
- Provides peer mentoring and support to introduce a family to the service
- Has an intake team with expertise in linking a family to a service. As well as practical support, the intake team knows about the services available in the Frankston area and offers a brokerage service. This gives families a positive experience of service delivery, so that they might reach out in the future.
- Maintains an 'open door': if a family is not interested in engaging at the moment they offer information and support in the future.
- Provides a strengths-based approach—focusing on the client's strengths and expertise as a parent rather than their needs.

Ways to better engage with families

Service providers were asked to think about the way services could improve the access of hard to reach families and increase the connection of new families in the community. A number of suggestions were made of ways to approach and engage these families so they would become involved in services. These are presented as a collection of ideas below.

Approaching and engaging with families

- Provide outreach services that go to the client.
- Form groups for parents of second and third children through MCH Centre.
- Increase efforts to encourage parents to have their child's general health checked at immunisation times.
- Break the stigma and fear of the DHS around child protection notifications. The Child-First system, which tries to work with the family, may assist with this.
- Engage with families. 'However this is a challenge because it involves questioning the service models as we are funded to target a certain group.'
- Engage with the community. There have been fewer DHS notifications since the CfC program began because the community is feeling 'looked after'.

Processes that assist ongoing family involvement

- 'Mother the mother' and encourage mothers to engage in play with their children.
- Provide multiple agency partnerships with a single entry point so families do not have to tell their story several times:

    We are doing the joining the jigsaw bits, not asking them to. Because once you put barriers such as 'You need to go through another intake process to get that' … you increase the

> chance of disengagement very quickly. So it's around how we strategically do those things around families that demonstrate seamlessness for them … but that is not easy.

- Modify services by responding to feedback from hard to reach families.
- Be flexible in service delivery.

Ways to promote services

Service providers were asked to think specifically about how to promote services to new families with complex needs, and to think about what has and had not worked in the past. Their suggestions related to ensuring that programs delivered what they promised, advertising services, encouraging service linkages and increasing service accessibility.

Advertising

- Advertise in local papers, in school newsletters and in cafes.
- Create flyers or brochures.
- Design brochures for families and place them where families are likely to go, such as GP, MCH Centres and neighbourhood houses, so that if families are in touch with a universal service they can get information about the service there.
- Hold open days and festivals and promote through these events.
- Target the young grandmothers group.

Service linkages

- Encourage linkages between services so that referrals are made between different agencies. For example, get school welfare workers or Centrelink to promote another agency's program.
- Promote your program to other professionals. Other professionals in the catchment need to be aware of your service, and ready to refer to your service.
- Make sure to deliver on the promises you make to other service providers and parents: 'What hasn't worked is when we've said things and not delivered'. This refers to service providers as well as parents because 'If you haven't got other professionals saying they're a good service … that is really tricky'.
- Create partnerships with other organisations and networks with other services.
- Provide a shared caseworker who would be the 'hub' of community information.
- Make clear, in services that support families where there has been a child protection notification, that your service not responsible for the notification.
- Target the young grandmothers' group.

Service accessibility

- Have drop-in services.
- Go to the location where people are, don't expect them to come to you. For example hold a sausage sizzle in the park for young people.
- Make greater use of local facilities, such as the community centre as venues for programs.

11 Discussion

Changing service provision to diminish barriers to service use is challenging. Some changes are within the control of services. Others are more difficult because they involve working around infrastructural and resource issues which are created outside their organisations, or are a heavy drain on existing resources, like reducing waiting lists for dental services. Most are complex: that is, services can do something about the issue, but it is not entirely within their control. This is seen, for example, with transport and housing problems, substance abuse and mental illness. These issues present as barriers to engagement but their solution may require other forms of intervention, such as community action and linking with other services. It was evident that services directed at young families in the Frankston area are actively engaging with the question of how to facilitate inclusion.

The parents who were interviewed for this research were not necessarily the most hard to reach, since they were willing to be interviewed and talk about their experience of service use. Certainly all reported that they were linked to at least one service, indicating that they were willing to engage with services at some level. But demographic analysis of the participants also indicated that they were members of groups who are routinely labelled 'hard to reach'.

The aim of this project was to address the barriers to service use, particularly for hard to reach families. The group of parents who took part may have been resistant to using services in some instances, but they were able to identify reasons for this. They reported that there were barriers to their use of services. These barriers included lack of transport or service inaccessibility; services being too expensive; lack of childcare; long waiting lists; being put off by the behaviour of some staff; lack of coordination between the services; and not knowing that certain services existed.

As the literature attests, these barriers to service uptake are not unique to the Frankston area (Watson 2005; Hydon et al. 2005). Earlier Victorian research, the *Breaking Cycles, Building Futures* (BCBF) study developed four principles to address service inclusion (Hydon et al. 2005):

(1) overcome structural and practical barriers
(2) build positive relationships
(3) ensure cultural sensitivity and value for effort
(4) develop links.

In the following section the barriers to service use identified by parents and service providers in Frankston North, Karingal and Carrum Downs are discussed in terms of these principles for inclusion. The strategies service providers have implemented to facilitate inclusion are also discussed.

Overcome structural and practical barriers

The first principle in the BCBF framework is the need to:

> Minimise the practical and structural access barriers and support parents to overcome their knowledge, financial, transport and time difficulties to maintain attendance. (Hydon et al. 2005)

Often, Hydon et al. argue, these barriers are the easiest to identify. This was the case for respondents in this research. Structural and practical barriers were identified by almost all respondents. Such barriers included difficulty getting to services because of their location or a lack of transport, the cost of services, lengthy waiting lists and not knowing what services exist.

If a service is not accessible to potential service users because it is not close to where they live and cannot be reached by public transport, this presents a major barrier to service use. Ten of the 14 parents reported that this was a barrier for them. Some parents said they did not use certain services because they were located too far away. Others said they were unsure whether they would be able

to access services on public transport, so did not always try to do so. Negotiating public transport with a pram and children can be difficult for young families, as one respondent pointed out. Transport difficulties can make other barriers to service use even more difficult.

Service providers also said transport and accessibility were a significant barrier and some services had attempted to address it. At least two provided transport to their services. Another provider spoke of the importance of locating services centrally. Service providers also mentioned the need to go to where potential service users already are, such as local parks.

Service cost was another barrier to service use, as has been found in other studies (Henricson et al. 2001). Five of the parents talked about this barrier. Service users highlighted the importance of advertising whether a service had a cost, required an up-front payment that would later be reimbursed through Medicare, was bulk billed, or was free. For some people, coming up with a sum of money up front was a barrier, even if the fee could later be claimed from Medicare.

Most of the services represented in this research provided low cost or free. Some services also considered the associated costs, and for example provided service users with food, or with free tea and coffee. At one service food vouchers could be given in a case management visit, recognising the multiple difficulties experienced by some families.

Waiting lists present a significant barrier to service use. Some services are unable to meet the demand. Parents said waiting lists were a barrier when they tried to access dental, housing, counselling and medical services. Waiting lists also have a significant impact on families and other services. For example, one woman was hesitant to take her daughter to playgroup because of the state of her own teeth. Another mother sought assistance from nurses when she could not find affordable housing. Resolving waiting list problems is difficult at the service level because it usually requires increased funding: the only strategy reported by service providers was to provide a drop-in service to run alongside the regular appointment system, and one parent mentioned that the dental service had some sort of a drop-in clinic.

Another barrier reported by a couple of parents was the need for childcare. It was reported by some parents and service providers that there are long waiting lists for childcare and the cost is prohibitive for many families. At least two of the services provided childcare for service users.

Not knowing what services existed was the final structural and practical barrier reported by service users. Service providers suggested ways to make more people aware of their services. These included initiating community education, advertising in local papers, creating flyers to leave at locations that families visit (such as MCH Centres), advertising at cafes, holding open days and going to the locations where parents are, such as the local parks, and the community centres. Related to this is the issue of adequate resourcing of services.

Build positive relationships

The second principle in the BCBF is the necessity to:

> Build positive and affirming relationships with parents, which counteract distrust and stigma, and assist parents to build positive relationships with others. (Hydon et al. 2005)

Respondents in the *Connecting Frankston families* research also reported that relationship building is very important. Strategies to address this principle may be more difficult to develop than those around practical and structural barriers, given they relate to attitudinal issues and require ongoing action (Hydon et al. 2005). The relationship begins with the way services advertise. It is suggested in the literature that service providers should advertise their programs in a positive light, where they assist in raising healthy, happy and intelligent children (Dumka et al. 1997).

The behaviour of some staff was mentioned as a barrier for many of the parents. Some parents felt that some staff did not listen to them or respond to their needs, or were dismissive of them. Certainly many of those interviewed were choosing which services they used, based on how comfortable they felt with the service and staff. Others indicated that they would continue using a service they felt less comfortable with, but would not engage fully.

Conversely, feeling comfortable with, and supported by, a service and its workers was the parents' most common reason for being able to use a service. Various explanations were given of what made them feel comfortable, including the sense that the service provider had a straightforward attitude, or knew them by name.

Service providers also reported the need to develop relationships and trust with families, and to work on ways to help families feel comfortable. They noted that this is a slow process. Their ideas for developing relationships and trust included providing peer mentoring and support, and providing food vouchers as part of case management to recognise the multiple problems families face and to encourage engagement with the service. For some hard to reach parents, the challenge of trust building may be compounded by feelings of low self-esteem or fear of loss of control over their lives. Other research has found that these factors are related to low levels of engagement in programs (McCurdy et al. 1996).

Ensure cultural sensitivity and value for effort

The third principle in the BCBF framework is the need to:

> Change attitudinal barriers amongst service users and service providers to ensure that services are culturally sensitive and provide 'value for effort' for the child and the child's parents both in the short term and the long term. (Hydon et al. 2005)

One important component of this principle is the need to develop strategies to increase cultural sensitivity. This issue was reported by some of the service providers in this research. One person gave the example of the problem of service providers expecting families who have lives in chaos to attend appointments at agencies.

This service provider also indicated the need to provide culturally sensitive services for parents from CALD communities. She described the situation between service providers and some CALD communities as one of mutual incomprehension:

> We don't understand them, they don't understand us.

Such a comment suggests the need for services to reflect on cultural sensitivity with regard to recently arrived CALD communities. Care is needed, however, not to overestimate the cultural barriers between service users and providers. To illustrate scope for change, another service provider also reported barriers between service providers and CALD communities, but she described how these barriers were being broken down as staff worked to include this community in the service. The success of this was evidenced by more members using their service.

The other aspect of this third principle relates to providing 'value for effort' when parents engage with a service. One way this was being addressed was by developing links between services. In one service, a multiple-agency partnership with a single entry point had been put in place. Another service provider reported that they try to tailor their services based on feedback from hard to reach families. This would encourage responsiveness and cultural sensitivity.

Develop links

Finally, the fourth principle of the BCBF framework is to:

> Establish strong reciprocal links with other services, particularly those targeted to vulnerable children and families. (Hydon et al. 2005)

Both parents and service providers in this research commented on a lack of coordination between services. Three parents said services would keep sending them on to another service, or tell them to try another service. One service provider said the three tiers of government (federal, state, local) were not talking to each other about service provision.

Both parents and service providers suggested ways to improve service coordination. When asked to describe their ideal service some parents talked about locating a range of services together. One service provider noted that their service is attempting to 'join the jigsaw pieces' of service provision. Another said it would be useful to have a shared caseworker to act as the 'hub' of community information. The literature around service coordination suggests that the co-location of related services has been one solution to this type of problem, and one which avoids the problems of amalgamation (Weeks n.d.).

Conclusion

This research indicates that care needs to be taken when defining people as 'hard to reach'. Respondents indicated that they were willing to use services when they felt comfortable and supported. For example, one mother described how she initially felt upset when she was required to have a nurse home visit to explain to her how to look after her own baby. Afterwards, however, she was extremely positive about the experience, saying 'I learnt a lot and I grew as a person'. This seems to accord with Brackertz's comment that we need to work to avoid 'defining the problem as one within the group itself, not with your approach to them' (2007, p.1).

This research confirms what is reported in the literature, that there are multiple dimensions that need to be taken into account in order to meet the needs of those most difficult to engage in services (Stanley & Kovacs 2003). Some of these issues are beyond the capacity of a single service agency to address. However many of these barriers can be addressed, at least in part, at the services level. Providing services to these families who are the most disadvantaged, will result in children with improved well-being, who are able to take better advantage of future opportunities.

12 Workshop with service providers

A workshop for service providers was held to outline the findings of this research and to discuss strategies that should be implemented in Frankston North, Karingal and Carrum Downs, in order to make services more accessible to hard to reach families. Fifteen service providers attended this workshop in November 2007. They represented different agencies that work in early childhood sector in this area.

Participants at this workshop were asked to comment on a summary of the strategies of engagement with hard to reach families that are recommended in the literature. In groups, participants assessed the utility of these strategies in this locality, according to how valuable they would be, and how difficult they would be to implement.

Many strategies were identified as very valuable. Some of these were already implemented at some agencies and others were new strategies which would take a greater effort to implement. Some were strategies that could be implemented by individual agencies and others would require inter-agency collaboration and might include a broader strategy such as advocating for further government funding to be made available.

The strategies that participants regarded as very valuable are listed below, and have been grouped according to whether participants regarded these strategies as easy to achieve, moderately difficult to achieve or hard to achieve. Most of the strategies discussed need to be pursued both at the agency level and in a broader context. However, the strategies that were moderately difficult or difficult to achieve usually were those that required a greater emphasis on developing a broader community strategy, including through developing inter-agency collaborations. It is indicated below where strategies require a particularly strong emphasis on a broader strategy.

Easy to achieve

A number of strategies were considered relatively easy to achieve. This tended to mean that they could be put in place by agencies or even by individuals within the agency, and required little additional external funding. These strategies related mainly to the way information was communicated and the location of services and activities.

A number of strategies related to the need to provide appropriate information to families in an accessible way. It was noted that an important strategy is to make information available during key life transition points, such as at the time a baby is born. Providing information to families verbally is an important way to provide useful and relevant information. It was suggested that this is easy to achieve, but only if you are already in contact with the families you want to inform. Related to this, participants reported that word of mouth is a very significant way of communicating to people about services. This is a useful source of referrals and families will become the best advocates of community services. It was noted that information should be simple, relevant and useful to families. It is important to have the time available to show an interest in families and to listen. The ability to do this often depends on time constraints.

Other local service providers also need information about services. It was suggested that is quite easy to achieve in this Frankston North, Karingal and Carrum Downs because the Frankston Partnership and Frankston Integrated Family Support (FIFS) are already working on developing an internet-based registry of services, called an 'e-registry'. Participants expressed the need to have a strong early years representation in this initiative.

One strategy to provide information to both families and other service providers is to visit community events. It was suggested that this is not difficult because there are many community events organised in this locality. However there is a need to be proactive at these events and not just sit inside a booth waiting for people to approach. Instead it is necessary to try to actively

engage people, for example to go up and introduce yourself, and to offer something, such as an activity, at the event.

Other strategies which were considered to be easy to achieve related to locating services in places families (or targeted groups) already visited. One way this is being approached is to try to develop an integrated services hub. This is currently being worked on by Community Renewal. More immediate and achievable ways to do this include running activities in community centres or houses. This was considered to be a useful strategy because many families are already using these centres. Families can also be recruited through community centres or houses.

The value of a source of emergency relief, such as a food bank or vouchers, was noted. This brought those who are highly disadvantage to the agency and, as well as assisting in a practical way, facilitated a point of contact with the client which could be used to develop trust and a positive relationship. Similarly, the use of community kitchens, where families gathered to make a communal meal, was found to be a successful way of reaching clients.

Moderately difficult to achieve

Other strategies were considered moderately difficult to achieve. These were strategies which would not present too much difficulty at some agencies but would be more difficult at others, depending on the way the service is set up and their funding structure. The moderately difficult to achieve strategies mainly related to the provision of low-cost services and the provision of support to allow families to attend services. These strategies could be considered at the agency level, but most also needed to be considered more broadly, including at the inter-agency level and through advocating for further government funding.

Several strategies related to the need to provide additional support to make services accessible to all the community. Ensuring that interpreters and translators are available was one such strategy. This is an agency-level cost (budget line item) but it also involves broader community consultation because there is the need to think about the accessibility of interpreters in the community. Participants reported mixed results from home visiting programs, but it was felt that at some programs employing home visiting programs made services more accessible. Facilitating transport is another way to make services more accessible to some vulnerable families. This might include strategies such as ongoing communication with the local bus operator to tailor schedules and routes to better meet local needs. Another strategy suggested was to get funding for a community bus, although concern was expressed that community buses are frequently an ineffective solution.

Other strategies related to providing services at a price families can afford. It was noted that it is important to cap fees, and to waive fees for families where necessary. Some services would be able to waive or cap the cost of some services, but for other services this would be very difficult.

One strategy around costs that was discussed at some length was for agencies to internally cross subsidise the fees for occasional care for vulnerable families. Such cross-subsidising would ensure that parents are able to attend appointments and activities without always having to attend to their children at the same time. It was noted that there is no dedicated government funding for occasional care and this makes it costly for some parents, and difficult for agencies to waive this expense. An idea put forward at the workshop was that agencies make a dedicated number of childcare places available, funded from the budgets of their different programs.

Other suggestions were made about how to make childcare more accessible. One idea was to develop a system where families who cannot afford to pay for occasional care can volunteer their time in the occasional care centre. By doing so these parents are also learning new skills and making links in the community while getting a break from their own children. Another suggestion was to support the development of babysitting clubs. This might involve making venues available and explaining how a voucher system could work in a babysitting club. Such a club could help to

develop relationships between parents in the area. Finally, it was noted that agency volunteers are might be willing to babysit, but there was a lack of clarity about the legal situation if parents were not present.

Working through these ideas about caring for children requires a coordinated approach and it was recommended that an inter-agency working group be set up. Finding solutions also requires a broader strategy of community advocacy to make government funds available for occasional care.

Hard to achieve

Several strategies were considered to be very valuable but hard to achieve. All but one required significant funding to provide a greater access to costly services, such as multi-disciplinary outreach teams and childcare. These were generally strategies that required inter-agency cooperation and an increase in existing funding.

Some of these valuable but hard to achieve strategies were around the coordination of inter-agency services requiring collaborations between a number of agencies. Participants felt that providing mobile outreach with multi-disciplinary teams was very important. Related to this it was felt that services should come to where children and families already are to provide information and services. This should occur especially at key life transition points. The key transition points suggested at the workshop were: pre-natal, post-natal, playgroup, three-year-old kindergarten, four-year-old kindergarten, and primary school. Services would come to kindergartens, schools and other venues children and families attend. Another strategy that would require inter-agency coordination was to provide a toll-free line with information about local services. It was recommended that this be an inter-agency level strategy because it would be valuable to have the line staffed 24 hours a day, which is costly.

Two other strategies were noted as very hard to achieve, but very valuable. One was empowering families: it was suggested that this could start with incremental change such as empowering families to keep appointments for their child. The other was providing free access to more services.

Where to now?

It was recommended that participants take away ideas from the workshop to work on individually and that a working group, or groups, be convened to develop detailed plans around some of the strategies which were more difficult to achieve. Some of these required inter-agency coordination and lobbying of government to make funds available. It was determined that there are two strategies that this working group should pursue as a starting point. The first is to develop models by which childcare could be made less costly. The second is to consider the availability of multi-disciplinary teams, including professionals such as speech therapists, to which services can make referrals. It was suggested that the Early Years' Partnership is a good forum to develop these ideas further and that the working group could feed into the partnership.

Suggestions to facilitate process

The following suggestions are made to facilitate the development and adoption of strategies to engage difficult to reach families. The strategies recommended above are likely to require the formation of a group comprising agencies, local government, state and federal government and other parties, to respond. Where such a group exists, the issue could be placed on the meeting's agenda and resources allocated to the development of the strategy.

Other strategies will require an individual or intra-agency response. It is suggested that workshop participants select a strategy, set themselves a period of time in which it would be feasible to initiate the strategy, and report back to a relevant local strategic or coordinating committee on progress. The researchers also suggest that, where relevant, individuals put in place a supportive process to facilitate progress. The following are some suggested options:

- Learn about the strategy from another agency which undertakes the strategy in a successful way.
- Link up with a peer support person to discuss the strategy and implementation process.
- Form a clients' or volunteers' group to work on the strategy and its implementation.
- Work on the issue at an agency level to spread the task load.
- Where the strategy relates to interpersonal style, ask a colleague to attend a client interview, suggest modifications or improvements and assist the practitioner to make the changes.

Sharing the process and progress, as well as the facilitating factors and barriers which are specific to the local community, is likely to be very important to the development of local knowledge and the building of capacities within the community.

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