Brotherhood of St Laurence

Working for an Australia free of poverty

Breaking Cycles, Building Futures

Promoting access and inclusion in antenatal and early childhood services

A review of the literature

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Acronyms

AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and linguistically diverse
DFaCS	Department of Family and Community Services (Commonwealth)
DHCS	Department of Health and Community Services (Victoria)
DHS	Department of Human Services (Victoria)
EEC	Early Excellence Childhood [Centre]
MCHS	Maternal and Child Health Services
NESB	Non-English speaking background

Introduction

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

Early childhood is increasingly recognised as a crucial period in human development, during which the foundations for future wellbeing are established. Each child's development is a dynamic process shaped by a wide range of factors including their own characteristics, the quality of the child/primary-caregiver and family relationships, as well as the nature of the broader social environment in which they are raised (Ochiltree & Moore 2001).

Negative environmental influences such as poverty, poor nutrition, understimulation, family discord, abuse or neglect during the early years of life have been shown to have a direct impact on growth and brain development, which can delay or disrupt learning and social and emotional development, often with long term adverse consequences. It is vital that children are protected against such risk factors in these critical early years and instead experience environments which promote their wellbeing.

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

At present not everyone has equal access to, or finds equal value in the use of these services. Often those who could most benefit from these services, to help moderate the effects of the stressful or disadvantaged environments in which they live, have less access to services, or experience a service response that is insensitive, or fails to meet their needs (Ochiltree 1999). Specific efforts are required to create more accessible and inclusive early childhood services, which better address the needs of *all* children and parents, particularly those who are more vulnerable. It is also vital that these services are better linked to each other and to other service systems.

Furthermore, it is essential that these promotion, prevention and early intervention efforts begin as early as possible, particularly for vulnerable children and families. It is well established that children growing up in poverty are significantly more likely to experience future health, learning, emotional and behavioural problems than other children. These differences emerge very early (Hertzman 2002). In Canada, 'by the time children reach school there are large, yet modifiable, differences between children dependent on urban neighbourhood, rural region, ethnicity and socioeconomic status that tend to track forward in time, limiting the life chances of the vulnerable' (Hertzman 2002, p.1). By kindergarten age, a socioeconomic gradient in readiness for school is evident in Canada, with children in low-income families 4.5 times more likely to have delayed vocabulary development (Ross & Roberts 1999 cited in Hertzman 2002). Early and comprehensive efforts are required to address this imbalance.

The Breaking Cycles, Building Futures project

The Breaking Cycles, Building Futures (BCBF) Project is an initiative of the Victorian State Government and is funded by the Premier's Drug Prevention Council. The Project is part of the State Government's Best Start Strategy. Best Start is a whole of government strategy, which aims to improve the health, development, learning and wellbeing of all young children across Victoria from pregnancy through transition to school.

The BCBF Project is designed to support the aims of Best Start by developing antenatal and universal early childhood services that better support parents in their role of caring for their children. In particular the Project seeks to ensure that these services engage vulnerable children and their parents/families, especially those who do not use, or disengage prematurely from, these services. The main focus of the BCBF project is on state-funded antenatal and universal early childhood services such as maternal and child health services (MCHS), preschools and the early years of primary school.

The Brotherhood of St Laurence has been contracted by the Victorian Government to undertake this project. In its mission of working for an Australia free of poverty, the Brotherhood of St Laurence acknowledges the importance of efforts to better support vulnerable children and their parents, not only as an important immediate measure, but also as a poverty prevention strategy.

The BCBF Project will be undertaken in four stages:

- a literature review focused on understanding the barriers that children and their parents/families encounter in the use of early childhood services and the potential strategies to overcome these
- consultation with service users, service providers and peak bodies in relation to these issues
- documenting possible strategies, which can be adopted by Best Start Partnerships to assist them to provide services, which are more inclusive of vulnerable children and their parents/families
- working with Best Start Partnerships to implement these strategies.

This document presents the results of stage one of the Project – the literature review.

Method

A systematic search of the literature was undertaken to identify the barriers to access and ongoing participation in antenatal and early childhood services and the strategies that have been used to address these barriers and promote better access and more inclusive service delivery. Given the wide range of services of interest to the Best Start strategy, this required a search of health, allied health, family, social sciences and education databases.

The key questions posed were:

- What are the current patterns of use of antenatal and early childhood services?
- What are the barriers to access and/or ongoing participation in relation to these services?
- What are some of the strategies that have been identified which promote access and create more inclusive service delivery?

The literature review particularly focused on examining these issues in relation to the experiences of vulnerable children and parents. This was taken to mean the following groups within our community:

- parents/families on low incomes
- sole parent families
- families with young parents (under 20 years)
- Indigenous families
- families from culturally and linguistically diverse (CALD) backgrounds
- families that are homeless or at risk of homelessness
- families in which a parent has a physical, sensory and/or intellectual disability
- families in which a parent has a mental illness, or substance abuse disorder
- families who have had contact with child protection services, or the justice system.

Unfortunately, very few studies or reviews relating to Australia (or more specifically Victoria) were identified. The vast majority were from the United States and some were from the United Kingdom.

Current patterns of service use

Antenatal and maternity services

Antenatal and maternity services are provided in a wide variety of ways. These services may be provided through private midwives and medical specialists linked with private maternity hospitals, or through public antenatal clinics and maternity hospitals on a shared care basis with GPs and/or community midwives, hospital outreach midwives, team midwives or through birth centres (Darcy, Brown & Bruisma 2001).

Data from the Victorian report on models of antenatal care (*WUDWAW: Who usually delivers whom and where)* suggest that the uptake of antenatal care in Victoria is reasonably good. Indeed, 81.5% of women commence antenatal care in the first trimester; however, there are still around 14% who first attend between 14–30 weeks' gestation, about 4% who attend for the first time between 21 and 31 weeks and around 2% who attend for the first time after 31 weeks' gestation (Halliday, Ellis & Stone 1999).

Less information is available about service user characteristics. US data suggests significant differences exist in the utilisation of antenatal services based on socioeconomic status and ethnicity. For example, women living in poverty, mothers under 20 and mothers with little formal education are less likely to use antenatal care or attend later in their pregnancy. In addition, 'ethnic minority women are three to four times more likely to seek prenatal care late in pregnancy or not at all and fewer African American women commence care in the first trimester compared with white women' (Sanders-Phillips & Davis 1998, p.16). Women who have experienced domestic violence also tend to delay the initiation of antenatal care (Campbell et al. 1992 cited in Cook et al. 1999). In Australia, Indigenous mothers are more likely to attend later in their pregnancy (de Costa & Child 1996).

In addition, the Life Chances Study in Melbourne found that less than a quarter of mothers from a non-English speaking background (NESB) attended pre-natal classes in contrast to 72% of other families in the sample (Taylor & MacDonald 1992).

Maternal and child health services

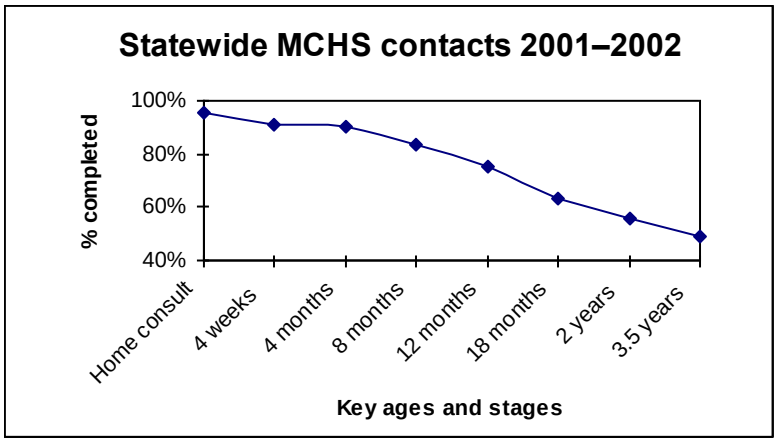
Maternal and child health services (MCHS) are free services for families with children aged 0–6 years. They provide support to parents and offer information and advice on a number of issues relating to child health and development, parenting and maternal health and well-being. MCHS also organise groups for first time parents that provide health information and an opportunity for parents to meet other parents in the local area.

Following a child's birth, the maternity hospital will notify the local municipality of the birth and request that the maternal and child health nurse contact the parents. This contact usually occurs within a few days after the mother arrives home from hospital, or earlier if there are any concerns. MCHS visits are typically arranged to occur at key ages and stages. These include visits at 2 weeks, 4 weeks, 8 weeks, 4 months, 8 months, 12 months, 18 months, 2 years and 3.5 years. The majority of the service delivery is clinic-based, although there is some scope for outreach home visits and a 24-hour telephone support and advice line is also available. More recently in each local municipality an enhanced home visiting service has been developed. This is targeted at parents who have children aged 0–12 months and are experiencing significant early parenting difficulties. Support is provided on an 'as required' basis for up to 15 hours' total per family.

Service use for maternal and child health services (MCHS) varies from region to region and from neighbourhood to neighbourhood. However, a fairly consistent pattern of attendance can be seen during the early years of a child's life. In general, participation rates are very high immediately after the child's birth and then steadily decrease over the following months and years. For example

in 2001–2002, the state-wide average participation rate in the first weeks of the child's life (home consultation) was around 95% (see Figure 1). This contact then fell to 75% at 12 months, 63% at 18 months, 56% at 2 years and 49% at 3.5 years (DHS, 2002). This pattern has been consistent for some time.

Figure 1 Maternal and child health contacts at key ages and stages for 2001–2002



Source: DHS Statewide MCHS Data Report 2001–2002

Unfortunately only limited publicly available data exists in relation to MCHS user characteristics. It appears that certain groups of parents and children are less likely to use these services than others. For example, MCHS nurses from the cities of Yarra, Hume and Moreland, who were consulted during the Brotherhood of St Laurence's First Three Years Project (Rogers & Martin 2002) identified a number of groups who were less likely to use these services including:

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

In a similar vein, the Australian Institute of Family Studies (AIFS 1991 cited in Victorian Parliament Community Development Committee 1995) found that parents on low incomes, parents from a non-English speaking background (NESB) and mothers who worked medium to long hours in the first years of the child's life were less likely to use MCHS and that a child with a late position in the birth order was less likely to be taken to the MCHS.

Child-care services

Child-care services are typically defined as either formal or informal. Formal day care includes centre-based long day care, family day care, occasional care and out of hours school care. Informal child-care includes care from family, friends, neighbours and babysitters.

Increasing numbers of children are now involved in some form of child-care, whether formal or informal. Figures compiled by the Australian Bureau of Statistics (ABS) indicate that in 1999, 40% of children aged 0–4 years used Commonwealth approved child-care services, while 43% of children 0–4 years used some form of informal child-care and many children experienced both types of child-care. In relation to formal child-care, the majority is centre-based long day care, followed by family day care and occasional care (ABS 1999 cited in Commonwealth Taskforce 2003).

Demographic data on parents and children using child-care is limited. However data from the *Report on government services 2003* (SCRCSSP 2003) suggests that children from single parent families and children with disabilities are substantially under-represented in their use of child-care services in Victoria.

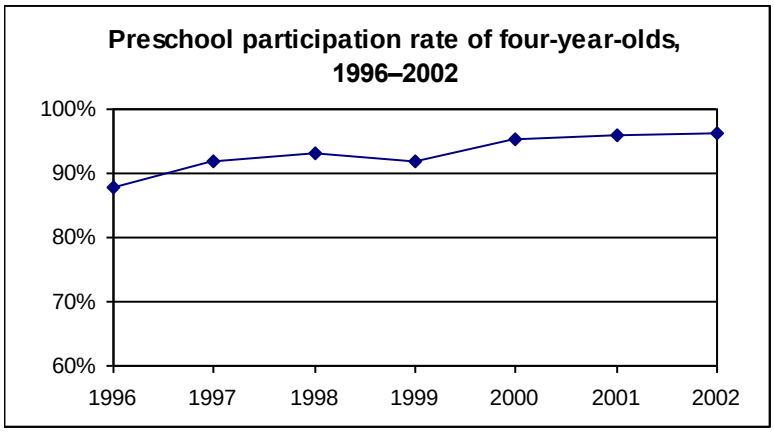
Consultation with service providers for the First Three Years Project (Rogers & Martin 2002) found that low-income families are more likely to use family day care and less likely to use centre-based long day care. Families from CALD communities were more likely to use informal care. A review by the Department of Health and Community Services in 1992 found that parents in metropolitan areas were more likely to use formal child-care than were parents in regional/rural areas. In addition, formal child-care was more commonly used for older children (over 2 years) compared with younger children and more commonly by those with higher education and working parents, than parents with less formal education or those parents who were not working (DHCS 1992a).

Preschool (kindergarten) services

Preschool (or kindergarten) is a program for children in the year before they start primary school. Preschool services aim to develop children's social, emotional, intellectual, physical and language abilities and prepare them for school attendance. Preschool services are provided by a range of providers in stand-alone service settings, in child-care centres or linked to schools. In Victoria, children are eligible to attend a funded preschool program if they turn 4 years of age on or before 30 April in the year of attendance. Attendance is on a fee-paying basis. Fees vary from service to service. At present the Victorian Government provides eligible families, who have a Health Care Card or Pensioner Concession Card, with a fee subsidy of $250 to help reduce the cost of preschool.

Data from the Department of Human Services indicates that Victorian preschool participation rates have steadily increased over the past six years and that current participation rates are very high (see Figure 2).

Figure 2 Victorian preschool participation rates 1996–2002 (%)



Source: DHS Fact sheet

Unfortunately, this data reflects enrolment data only and lacks detail regarding ongoing participation throughout the year and hours of attendance, which are known to vary considerably. For example the review of children's services in Victoria in 1992 (DHCS 1992b) revealed variable attendance rates at preschool between the municipalities of Melbourne, Box Hill, Berwick and Werribee. While about 38% of children in Berwick and Box Hill attended less than 10 hours of preschool a week, only 11% of children in Melbourne and Werribee attended less than 10 hours a week.

ABS data (Commonwealth Taskforce 2003) indicates that children from a NESB, Indigenous children, children from single parent families and children with a disability are all substantially under-represented among preschool users. A similar pattern was noted by Rogers and Martin 2002).

Primary schools

Enrolment in primary school is compulsory for children once they reach the age of 6 years. While 'access' is therefore not an issue in the primary school context, 'participation' can be a problem particularly in relation to school attendance, arriving late for school and repeated transfers from to school to school.

Marked variations exist from school to school. For example while the average absenteeism rate for the state in the first year of primary school is around 12 days, in one education subregion absenteeism in the prep year ranged from 9 days to 25 days across the 10 schools, with an average absenteeism of 17 days (Best Start 2003). Unfortunately, demographic characteristics relating to absenteeism and data on school lateness and school mobility are not publicly available.

Barriers to access and inclusion

In discussing barriers, it is important to highlight barriers to access as well as barriers to ongoing participation in a service. Access barriers may affect a parent's ability to obtain a service on behalf of their child(ren) (Newacheck et al. 2002), while barriers to participation can affect parent/child involvement in the service over time, because they may not engage with, or feel included by, the service. An inclusive service is one in which all are welcomed and feel that they belong, are accepted and valued (Madden 1998).

Barriers have been documented through the use of surveys and focus groups with service users and occasionally with service providers. While the present review was mainly focused on examining the barriers in relation to antenatal and early childhood services, in some cases such information was not available. The review therefore also includes information about the barriers experienced by vulnerable groups in using other types of services.

Antenatal services

A number of factors have been shown to influence the uptake of antenatal care (Cook et al. 1999; Sanders-Phillips & Davis 1998). These include:

- aspects of the service environment such as inflexible/limited appointment scheduling, crowded clinics, long waiting times
- practical barriers such as cost, lack of child-care, limited support from family and friends, lack of transport, language barriers and unstable housing leading to mobility/transience
- personal barriers such as lack of awareness of the pregnancy, ambivalence about the pregnancy, stressful life events, psychological distress and/or depression.

It appears that immediate stressors at any one point in time have a substantial compounding influence. Thus, 'For many women it is likely that the daily stress and immediate demands associated with poverty take priority over the immediate perceived need to attend a clinic appointment' (Cook et al. 1999, p.136).

The health professional's ability to establish a supportive, non-judgmental relationship, their availability to discuss both medical and psychosocial issues and how rushed they appear are also important determinants of women's satisfaction with and use of prenatal services (Bruisma, Brown & Darcy 2000; Sanders-Phillips & Davis 1998). Negative previous experiences (or the experience of others) and a general lack of trust in medical services are common (Cook et al. 1999).

Barriers tend to aggregate. In their study into the barriers to antenatal care experienced by 115 inner city women on low incomes, Cook and colleagues (1999) found that the mean number of access barriers experienced per woman was 4.5.

Early childhood services

At present, early childhood services across Australia are characterised by a lack of integration and coordination (OECD 2001). Three levels of government, operating through a number of program areas (e.g. child and family services, education, health) are involved in policy, funding and regulation and a range of providers are responsible for services. This has led to a service system that is fragmented and hard to navigate. A number of barriers to access and inclusion have been identified.

Cost barriers

Cost is frequently and extensively mentioned as a barrier to service use; however this factor is more relevant for some services (e.g. child-care/preschool) than others (e.g. maternal and child health services).

Clearly, cost barriers are particularly important for parents on limited income. Even modest increases in the cost of a particular service can lead to significant decline in use. A recent report by the National Centre for Social and Economic Modelling (NATSEM) estimates that for the average Australian family to raise two children from birth to age 20 costs $310 per week (Percival & Harding 2003). However, important cost differences exist between parents on low incomes and parents on higher incomes. Compared with families on high incomes, low-income families need to spend a greater proportion of gross family income in raising their children and this proportion steadily increases with the age of the child and the number of children (Percival & Harding 2003). Costs are therefore harder for low-income families to absorb. Costs are also a problem when payments are required 'up front'.

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

Cost has also been cited as an access barrier to preschool services (Kirby & Harper 2001). The Kindergarten Teachers Association (Hammer 1994 cited in Taylor 1997) reported decreased enrolments and withdrawal of enrolled children during the term as a result of the fee increases, which occurred following the shift to per capita kindergarten funding introduced by the Kennett government in 1994. Likewise, a review of kindergarten services in the Wyndham area revealed that families on low income had more problems paying the fees and chose programs with shorter hours after the introduction of the new funding arrangements (van Moorst & Graham 1995 cited in Taylor 1997). Cost was also identified as a barrier to access to preschool services in the Life Chances Study (Taylor 1997) in which 44% of the parents on low incomes reported difficulties in meeting the cost of preschool fees compared with only 13% of non low-income parents. While most parents were able to continue to pay the fees, they were often behind in payments or had to miss out on other things. In addition, parents on low incomes were less able to send their children to 3-year-old kindergarten. They also stated they were less able to afford a repeat kindergarten year if the child attended at least one term, but did not complete a full year or if they were not 'school ready' (Taylor 1997). While the increase in the state government rebate to $250 for parents on health care cards appears to have improved affordability of preschool, for some families cost of preschool services remains a barrier to full participation (Smallwood, Webster & Ayres-Wearne 2002).

Cost is also becoming a barrier to full participation in primary school due to the increase in 'hidden' costs of school education, such as excursion fees and so called 'voluntary' contributions. Such fees are placing increased burdens on some families and limit children's ability to attend certain school activities (Smallwood, Webster & Ayres-Wearne 2002).

Knowledge of services/information about services

In order to use a service people need to be aware both of its existence and of what it provides. Lack of information about services is therefore an acknowledged barrier to access (Ahmed et al. 2001; Morda, Kapsalakis & Clyde 2000; Shi et al. 1996; Rosenheck & Lam 1997).

Availability and eligibility

Another barrier to access is the lack of services which are local and can provide for sufficient numbers (DHCS, 1992b). Lack of availability is often more pronounced in rural settings, for a

variety of reasons including difficulty in recruiting qualified staff and higher costs of establishing services (Morda, Kapsalakis & Clyde 2000). Waiting lists for child-care have developed in a number of areas, due to a mismatch between demand and supply, thereby affecting access (Bergin-Seers & Breen 2002).

Overly targeted eligibility is also a problem. This has been noted in relation to child-care where government guidelines prioritise child-care for parents already working and studying, therefore limiting access for parents seeking child-care for other reasons (Bergin-Seers & Breen 2002). Having to make a formal application to extend the limit of hours for non work-related child-care can act as a barrier if parents feel self-conscious about needing extra support (Jope 2000).

Narrow eligibility is also a problem in relation to specialist children's services, such as specialist early intervention services and child and adolescent mental health (DHS, undated).

Location and transport

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

Flexibility and changing needs

Services also need to fit with the changing and diverse needs and lifestyles of the population. Australian families have changed considerably over recent decades. Since the 1970s there have been a steady increase in the number of sole parent families (mostly as a consequence of increasing parental relationship breakdown), a decrease in the number of children that parents have and a steady increase in the age when women have their first child (Press & Hayes 2000). There has also been a considerable change in patterns of workforce participation. Women account for 43% of the workforce and approximately 70% of women are in some kind of paid employment either full time or part time. There is a much greater mix of full-time, part-time and casual employment and a much greater range in the number of hours worked and when they are worked.

Lack of flexibility and the restrictive opening hours of services such as maternal and child health and preschool can therefore limit access and contribute to under-utilisation. While there has been some shift towards integrated service delivery and extended hours, a number of MCHS and preschool services are provided through stand-alone facilities, during office hours. Furthermore, preschool is often provided on a sessional basis, a few times a week. This can create significant problems for parents who lack transport and/or working parents. The situation becomes even more complex when parents have children of different ages, each with their own needs.

Service quality

Service quality can impact on service use (Acharya & Cleland 2000). Parents make decisions to use services, in part based on the perceived quality of the service.

> Determinants of quality in early childhood education have been well documented and include: environmental factors such as child/staff ratios and group sizes and the appropriateness of the program; working conditions provided for staff and staff turnover; and formal early childhood training of staff (Whitebook, Howes & Phillips 1989 cited in Fleer & Udy 2002, p 5)

Early childhood programs need to be based on the developmental needs and interests of the children and be culturally sensitive; and interactions between staff and children need to be warm, responsive and reciprocal. Properly qualified and well-paid staff are more likely to provide quality programs (Fleer & Udy 2002).

Cultural sensitivity, service user expectations and preferences

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

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

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

Care versus education

Service providers have developed a conceptual distinction between care (to enable workforce participation, provide respite for parents, particularly for families at risk) and education (directed at the child's learning and developmental needs). This may further contribute to the confusion around the benefits of particular early childhood services and create barriers to their use. A number of people argue that the distinction is unhelpful and call for a greater alignment of these two foci, through a system that is able to meet children's needs for quality early years education as well as parents' needs for child-care while they work, study or rest (Fleer & Udy 2002).

Children with additional needs

Particular barriers exist for children with additional needs. The *Review of the Preschool Field Officer Program within the context of preschool inclusion support* (DHS, undated), identified a number of gaps in the service response to children with additional needs. In part this was caused by inadequate funding and in part by excessively rigid eligibility criteria. Due to the lack of additional supports for the child and the teacher, some children were not able to attend or fully participate in preschools. Likewise, the continued participation of some children was limited by the absence of external specialist supports (e.g. early intervention services, family support services and child and adolescent mental health services).

The impact of stress and mental health problems

Many vulnerable families' lives are characterised by chronic stress, which is commonly compounded by acute crises (e.g. worsening of marital conflict or domestic violence). Such crises and the stresses of everyday life may occasionally or regularly interfere with attendance.

Likewise mental illness can create barriers to attendance at services. Having a mental illness can make it difficult at times for parents to provide for their children's needs (Australian Infant, Child, Adolescent and Family Mental Health Association 2001). Depression may create problems with motivation, anxiety can create avoidance and psychotic illnesses can lead to suspicion of others, or disorganised patterns of behaviour. In addition, for some parents with a mental illness, the fear of losing their children causes them to avoid services (Australian Infant, Child, Adolescent and Family Mental Health Association 2001).

Mobility and homelessness

Homelessness, or the need to move house can also impact on parents' use of services and make 'assertive' engagement—that is, proactive follow-up of missed appointments—difficult for workers (Katz et al. 2001).

Service provider attitudes and behaviours

Perhaps most significantly, the attitude of service staff is an important factor influencing parents' use of early childhood services (Fuller et al. 2002). Staff attitudes can impact not only on initial access, but also on ongoing participation. Moore and colleagues (2001) list a number of barriers to parental engagement and partnership building, which relate to the attitudes, beliefs and behaviour of staff. These barriers include:

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

In addition, staff may vary in their knowledge about and sensitivity towards the needs of diverse groups, some with increasing complex problems. This may reflect the personal characteristics of the individual worker, but it also significantly depends on qualifications, ongoing training and support and workloads. The early childhood service system is characterised by a wide variety of employment conditions and staff profiles, which impacts on quality (Press & Hayes 2000).

Service user attitudes and behaviours

'Perception' and 'behavioural' barriers are usually bi-directional. The attitudes, beliefs and behaviour of parents can also have an impact on their engagement (Moore, Ochiltree & Cann 2001). These include:

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

Given the personal histories of many vulnerable people in the community and the discrimination they regularly experience, a lack of trust in others can be a major barrier to service use.

Strategies to promote access and inclusion

Access and inclusion do not automatically result from the mere existence of a program or service. Specific attention is required to ensure that these aims are realised. This is especially the case when trying to engage vulnerable families in services.

This section of the review examines strategies outlined in the national and international literature, which have been adopted to improve access and the responsiveness of antenatal and early childhood services for vulnerable families.

Overview of the literature

Surprisingly few initiatives specifically focus on improving access and ongoing participation in antenatal and early childhood services – that is there are few studies in which access and inclusion have been defined and measured as dependent variables. Australian studies are particularly scarce. While a number of local initiatives that attempt to enhance access and inclusion are known to exist, few have been documented in the literature.

There are however, a number of programs with aims such as the prevention of child abuse, the enhancement of educational achievement, or the prevention of emotional and behavioural problems, in which enhancing access and participation, while not necessarily the primary purpose, is still an important aspect. As such, they have been considered worthy of attention for the purpose of the Breaking Cycles Building Futures project.

For the present review it is important to be aware of a number of caveats:

- Most of these programs have been specifically targeted to particular vulnerable families, rather than provided through universal services, which need to engage with all children and their parents.

- A number of these programs are delivered in a research context, with well-trained staff and a dedicated budget. This creates difficulty in determining the feasibility or effectiveness of delivering the program on a larger scale.

- The majority of services or interventions that have been trialed and evaluated originate overseas where the service environments are very different from to the Australian context.

Specific access and inclusion strategies

While a range of strategies have been used to address barriers to inclusion and participation in services, multi-focal approaches are more common than stand-alone measures. As a consequence it is difficult to determine which facet of the approach has which effects.

For the sake of clarity, however, the various strategies are discussed here separately.

Subsidies

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

Recall and reminders

Recall systems and reminders have been used in health services to promote access and maintain service use. Both mail and telephone reminders have been consistently reported as useful in reducing missed medical appointments (Tanner & Feldman 1997) and have been found to be moderately successful in increasing immunisation rates amongst children living in families with a low income (Vivier et al. 2000). Tanner and Feldman (1997) also found that social support exit counselling (a discussion at the end of an appointment indicating the importance of attending the next and indicating to the person the importance of bringing a significant other with them), was effective in improving attendance, whether combined with reminders or not. Telephone reminders were also found to be effective in increasing attendance at initial intake appointments in child and adolescent mental health services (McKay et al. 1998). Telephone reminders and/or home visits following missed appointments were also used to promote attendance at an antenatal service for Indigenous women in Rockhampton (Dorman 1997).

Outreach or home visiting

Outreach or home visiting programs are a good example of multi-dimensional approaches. Such programs are increasingly being used to provide services to disadvantaged families (McLoughlin & Nagorcka 2000) and have recently been introduced through MCHS in Victoria. They have been often been used in programs directed at the prevention of child abuse, but have also been used for other purposes, including educational enrichment.

Providing such services means ‘reaching out’ to the families rather than expecting families to access services themselves (McLoughlin & Nagorcka 2000). In addition to facilitating access, home visiting also allows the worker to assess the home environment and understand the specific needs of the families and tailor services to meet their circumstances. Also, the contact with workers can decrease loneliness and isolation for parents and link families to their community (Gromby, Culross & Behrman 1999).

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

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

Furthermore, between 20% and 67% of families enrolled in the six home visiting programs left the programs before they were intended to end. Factors which make it difficult to engage clients

include staff turnover, changes in family or work circumstances, unstable housing and parental mobility and young age of mother (Fraser et al. 2000; Gromby, Culross & Behrman 1999).

The ultimate benefits of home visiting programs appear mixed. Gromby and colleagues (1999) concluded that no home visiting model has produced impressive or consistent outcomes in child health or development, although several models produce some benefits in parenting and the prevention of child abuse and neglect (only on some of the measures used). However, comparison and evaluation of the effectiveness of home visiting programs is difficult given their considerable diversity in stated goals, qualifications of the provider, target group, timing of the involvement (e.g. antenatal, postnatal, or both), frequency and duration of contact and the actual supports and services provided. The service elements that appear to be important for success include:

- targeting the most vulnerable families
- workers experienced in working with vulnerable families
- workers provided with ongoing support, supervision and professional development
- ability for workers to link families to others who can provide case management, in order to move beyond crisis service provision and help families achieve their specific long-term goals
- retention of workers
- role-play and modelling as effective engagement and change strategies.

(Armstrong et al. 2000; Duggan et al. 1999; Gromby, Culross & Behrman 1999; St Pierre & Layzer 1999).

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

Mobile units

In a similar vein to home visiting services, mobile services have also been identified as a useful strategy, particularly for families in rural and remote settings. For example, Mobile Children's Services are travelling resource units, which cater to families in rural and remote areas. Mobiles offer a range of services including child-care, preschool, playgroups and toy libraries depending on the community needs (DFaCS 2002).

Informal supports – volunteers and befriending

Most people prefer informal support from family, friends and peers to formal support from services and professionals. In addition, people have a strong preference for support through universal services, rather than targeted services, because of the stigma associated with the latter (Armstrong & Hill 2001).

In response to this, various 'structured' approaches to informal support have been implemented as a means of providing early childhood services. These include training local community members to act as paraprofessional volunteers; recruiting service users as 'service providers' and recruiting established service users to provide peer support to new service users (Armstrong & Hill 2001). It is argued that the involvement of non-professional volunteers and/or parents can enhance feelings of trust, as they are perceived as less threatening and less judgemental.

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

'Befriending' is based on similar principles and has been used to assist parents with limited social supports, as well as parents with mental health problems. In one London-based program, targeting chronically depressed women, volunteers were recruited to provide the women with a 'friend' to talk to, for one hour a week. The volunteers also accompanied the women on outings and encouraged new and different experiences. They were recruited through newspaper advertisements and local church and health centres, and undertook three days of training. It was hypothesised that the knowledge that the volunteer was not being paid might contribute to the women's feeling of being cared about, thus fostering trust and self-worth and acting as an alternative for women unwilling to gain professional help. Ultimately, only half of the women contacted were interested in receiving befriending; however, the women who did participate displayed greater remission from their depression (Harris, Brown & Robinson 1999).

In addition, such structured informal approaches have also been used for educational programs. For example, both Head Start (Head Start 2001) and the Home Instruction Program for Parents with Preschool Youngsters (HIPPY) engage parents as service providers to other parents (HIPPY 2003). Playgroups are another kind of informal program which provide social contact and support for parents and stimulation and socialisation for their children. While most playgroups are run by parents, playgroups facilitated by professionals also exist (see <http://www.playgroup.org.au>).

Local community participation and ownership

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

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

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

Training and consultation support for early childhood service staff

Various initiatives attempt to provide support for workers employed within early childhood services, to help them to be more inclusive in their work with children and parents.

The Victorian government has initiated a number of such programs over the years, in particular the Preschool Field Officer Service, Koori Preschool Assistants and Koori Early Childhood Field Officers. In addition the Free Kindergarten Association of Victoria Multicultural Resource Centre is funded by Commonwealth and state governments to support workers in government approved child-care and preschool programs, to better include children and parents from a non-English speaking background.

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

- direct support to parents and children
- consultancy support to staff

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

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

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

One-stop-shops

The concept of the 'one-stop-shop' has also been used in to promote access to early childhood services. It is argued that co-locating or streamlining the links between services facilitates use and also provides opportunities for professional development for staff.

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

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

Comprehensive services

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

However, even the most comprehensive service may not engage everyone. For example, Akinbami and colleagues (2001) note the relatively poor outcomes documented for various comprehensive services for teenage mothers and their children, struggling to maintain ongoing participation. The limitations of multiple simultaneous strategies are also highlighted by Katz and colleagues (2001) who outline their own efforts to maintain the participation of a group of mothers on low-incomes,

in a parenting intervention study. Strategies included assertively tracking the mothers, providing outreach services, offering them incentives (e.g. nappies, pushers, gift certificates for toys) for completing certain activities, providing culturally appropriate staff, providing transport to activities and giving parents with low literacy skills easy-to-read written project materials. However, even with such intensive strategies to enhance engagement, the program had a 41% attrition rate.

Culturally sensitive practice

Substantial attention has been directed towards enhancing service access and the inclusion of people from culturally and linguistically diverse communities. Some initiatives relate to antenatal and early childhood services.

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

- developing and using standards and providing 'bonus' funding for services that meet standards (Blanco 1998)
- including ethnic community representatives on committees and in policy-making (Prasad & Ebbeck 2000)
- conducting information campaigns targeted specifically at NESB communities, which promote the service and its benefits (Giglio1997; Tsaconas 1990)
- involving members of NESB communities and important community figures (e.g. religious leaders, politicians) in dissemination of information, as such people are well-connected and appear on ethnic media, radio, newspaper, television (Giglio 1997)
- improving formal communication (e.g. by using interpreters and translated written material) (Tsaconas 1990; (Prasad & Ebbeck 2000)
- asking, rather than assuming, the language spoken by the family at home (Harry et al. 1995)
- selecting the most appropriate interpreters in terms of culture (not just language) and gender (Giglio1997)
- educating workers about linguistic and cultural factors so these factors become a 'normal' consideration in the planning process and delivery of services (Tsaconas 1990)
- educating staff about different child rearing practices and acknowledging the importance of the extended family (Harry et al. 1995; Giglio 1997)
- employing bilingual service providers and bicultural workers (Blanco 1998; Riddick 1998)
- offering culturally relevant resources (e.g. books and toys)
- offering culturally appropriate food (Prasad & Ebbeck 2000)
- building trust by accepting and acknowledging cultural difference (Vose & Thurecht 1999).

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

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

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

Population-specific services

In some instances, access and inclusion can best be achieved through population-specific services, for example those provided for Indigenous communities. Both state and Commonwealth governments provide supports and services to facilitate access and inclusion in antenatal and early childhood services amongst Indigenous children and families.

For example, the Daruk Aboriginal Medical Service runs an Indigenous community-managed maternity program in rural NSW. The program employs an Aboriginal health worker and a non-Aboriginal midwife who work with a female GP, providing a 'holistic' approach to antenatal care. Preliminary findings from the evaluation suggest that the program has been an important service for Aboriginal women who would usually miss out on antenatal care because of their dislike of attending hospitals for checkups. The women experienced the service as providing a trusting and non-judgemental environment (Hecker et al. 1997).

Dorman (1997) reports on the success of an Indigenous-specific antenatal and early childhood clinic in Rockhampton. The service was located in a house in a neighbourhood where most of the Indigenous population lived. It was actively promoted, especially through word of mouth by the Aboriginal health workers. A pamphlet outlining the program was distributed to service providers and hospital staff and a logo, posters and business cards were designed. In addition to publicising the service, efforts were made to facilitate attendance. A driver was employed to transport mothers to the clinic. If a mother could not come to the clinic, home visiting took place. At the time the article was written, the clinic had begun to effectively engage with the community and had achieved a number of successes, including increases in women coming to the clinic to have a health check before becoming pregnant, in fathers attending with mothers and in mothers seeking care for subsequent pregnancies (Dorman, 1997).

Another Indigenous specific service are the Multifunctional Aboriginal Children's Services (MACS). MACS cater to Aboriginal and Torres Strait Islander children (0–12 years) and are managed by the local ATSI community. They offer services such as long day care, playgroups, outside school hours care, school holiday care and cultural programs.

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

Funding

As with the concept of one-stop-shops, there are a number of people who argue for the importance of a more 'joined-up' approach to funding, which they believe can also translate into better access. Rather than independently funding a range of discrete services, each addressing a narrowly defined 'problem' for a specific population subgroup, they argue for funding a system of broadbanded early childhood services (Oberklaid 2002; Vimpani 1996).

Whether or not such an approach is adopted, it is clear that the success and sustainability of access and inclusion initiatives does depend on adequate ongoing funding.

Learning from experience

In addition, the extent to which successful initiatives become generalised depends on information sharing and communication. At present, this process seems to be inadequate. For example, the literature search revealed that a number of local initiatives related to increase access and participation in early childhood services had been undertaken in recent years. However, several of these initiatives have been discontinued due to cessation of funding. While this may have been due to a demonstrated lack of impact, the actual reasons for such decisions remain unclear, because information on these initiatives is not yet publicly available.

General principles for access and inclusion

While intervention studies evaluating specific access and inclusion strategies are limited, there is nevertheless considerable consensus in the literature regarding what constitutes best practice. The following factors have been identified as important by a range of authors (Alcorn & Grant 1994; Victorian Parliament 1995; Dorman 1997; Grenot-Scheyer, Schwartz & Meyer 1998; Mackay 2001; McLoughlin & Nagorcka 2000; Murdoch & Wood 1997; Moore, Ochiltree & Cann 2001; Ochiltree & Moore 2002; Tomison 1997; Victorian Government 1983).

Funding

Firstly, there is a need to provide sufficient funding to support inclusion strategies. Many strategies, such as nurse home visiting, are time and labour-intensive and require appropriate funding to meet the local level of need.

Proactive targeting

Secondly, universal services should develop policies and specific, concrete goals to promote inclusion. This means that services may also need to adopt a deliberate, proactive focus in targeting parents/caregivers considered to be 'at risk', rather than waiting for them to attend. Services may need to forge links with other services which may provide 'referrals', and may need to follow-up missed appointments assertively. Such a proactive stance also requires knowledge of local demographics and the regular monitoring of service use patterns, to identify groups who are under-represented or locations that are under-utilised.

Community involvement and service linkages

Services should involve parents in planning and development. The various early childhood services available to families in the community should also work together to create networks and a sense of community which involves parents, children and service providers. Particular attention needs to be paid to ensuring continuity of contact across transition points (e.g. maternity hospital to community, preschool to school).

Family-friendly environment

Services should be 'family-friendly' and be presented in ways which reduce both practical and psychological barriers to engagement. For example, services need to be affordable, be conducted in appropriate locations close to public transport, have hours that suit families, include after-hours telephone access in some cases, use clear signage, have an allocated space for parents to meet with other parents and have waiting areas that are safe for children. In some instances, services may need to provide an outreach response to families, or provide assistance with transport. The physical environment should also reflect the cultural diversity of the community and the diversity of family structures and the program should be culturally relevant. A family-friendly service should include an orientation program for new families, which can be a useful strategy to engage 'up and coming' service users, for example in the transition from preschool to primary school.

Active promotion

Services need to promote themselves and the supports that they offer, along with general information about child development. This information should be easy to read and well presented. Information should be translated into different languages for families from a non-English speaking background.

Family-centred practice

Staff need to be non-judgmental and approachable and adopt a 'family-centred' approach to practice. Services become family-centred when they have skilled workers who posses technical knowledge, have a holistic view of child development, behave positively towards parents (for

example, are empathetic and good listeners) and have a reflective approach to learning. Parents need to feel they are able to participate in the service provision and be involved in decision making.

Workers may need to work with families using a variety of approaches such as role-play or modelling, rather than merely didactic approaches, and to encourage the active involvement of parents as partners in the development of their children, both as caregivers and teachers. Workers should actively involve interpreters or include bilingual workers as required.

Professional development

A family-centred approach also requires that staff have the opportunity to attend professional training and development courses to increase their skills. Training should include communication skills, problem solving and conflict resolution. In addition staff may benefit from training around cultural sensitivity and the specific issues that confront some families, such as mental health problems. Training also needs to suit the service context (for example by addressing rural specific issues).

Managing change

Key change strategies include involving the whole organisation (top to bottom) in developing inclusive practice; starting with simple initiatives that can be expanded and monitored; running pilots and trials to demonstrate inclusive practice in certain areas and developing inclusive practice performance monitoring processes (Mackay 2001).

Conclusion

While most parents and children have access to antenatal and early childhood services, differences in frequency or consistency of use are apparent between some groups in society.

Tracking the service use patterns of particular vulnerable populations is not an easy task, given privacy issues. However, data collected by maternal and child health services, preschools and primary schools can be used to map neighbourhoods and even specific service sites that have patterns of low attendance. This can enable strategic targeting of access and inclusion strategies to these high need areas.

The observed variation in access and participation appears to reflect the impact of multiple and interacting barriers. These include structural barriers, service level barriers and barriers unique to the parent and their environment:

- Cost, local availability, location (in particular accessibility to transport and other services), inadequate staffing levels and limited access to specialist supports are potential structural barriers.
- Hours of operation, rigid appointments, insensitive or judgmental staff attitudes and behaviours, lack of professional development and poor attention to multiculturalism are amongst the service level barriers which can impact on access and participation.
- Expectations, preferences and beliefs about the necessity and value of services, confidence and trust in individual workers and day-to-day stress are some of the personal barriers which also affect access and attendance.

Many vulnerable parents have a number of concurrent stressors in their lives. They may be struggling with low incomes, inadequate or insecure housing, health or mental ill health problems, domestic and/or neighbourhood violence. Furthermore, they may lack the knowledge or language to navigate the service system or the confidence and self-esteem to interact assertively with service staff. Many have limited social supports. Without appropriate advocacy, some parents will remain unaware of or unable to use services to their benefit. Perhaps one of the greatest barriers is the fear that they will be judged by others as ‘bad’ parents, or worse still, have their children taken from them.

Vulnerable parents have to overcome more obstacles and balance competing needs (Giambruno et al. 1997). It is likely that at times these barriers collectively become overwhelming, and prevent the parents from making use of services.

Multiple concurrent strategies are required to address these barriers and to maximise the benefits of existing antenatal and early childhood services.

Universal antenatal and early childhood services are a key resource for promoting the health and well-being of children and their parents and for active prevention or targeted early intervention strategies. Such services need to be available to the whole community and be able to meet the needs of children and parents from a range of backgrounds. Services are required for each and every child, not just those regarded at risk (Raban 2000).

However, it is especially important that such services are able to meet the additional and specific needs of vulnerable children and their parents/families. In this vein, Harris (1990) argues for positive discrimination strategies to engage children from low-income families. Positive discrimination strategies ‘need to challenge inequalities rather than to compensate the poor for their disadvantage’ (Harris 1990, p.41).

Inclusive services are affordable and well publicised, have appropriate opening times, are geographically accessible, provide outreach or support with transport, are family-friendly, employ skilled and responsive staff with a family-centred approach and seek to establish links with other relevant services. Critical amongst these factors is the worker's ability to establish a positive and non-judgemental relationship with the parents. Access and inclusion and quality service provision are intimately linked.

Achieving improved access and inclusion will require a blend of funding and policy support and improvements in data collection, combined with program-level and service-level initiatives which are locally developed. There may be potential for local initiatives to include parent-led activities, which will require funding and practical or in-kind support but which need not be run by the service. Even if they only function for short periods of time, they are still worth supporting.

Ultimately, most of these strategies and 'best practice' principles that have been documented in this review are intuitively self-evident. The more important question is therefore not 'What works?', but rather 'How do you make it happen and sustain it?'.

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