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**THE INCLUSION AGENDA IN EARLY CHILDHOOD SERVICES:
EVIDENCE, POLICY AND PRACTICE**

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This paper draws on a resource developed by the Centre for Community Child Health at the request of the Office for Children and Early Childhood Development (OCECD) of the Victorian Department of Education and Early Childhood Development. The initiative forms part of *Victoria's Plan for Improving Access and Participation in a Kindergarten Program for Children At Risk of or Experiencing Disadvantage*.

1. OUTLINE

This paper begins by outlining changing social ideas and values relating to the inclusion of marginalised groups within society, including disadvantaged and vulnerable populations, culturally and ethnically diverse populations, and those with disabilities. It then explores what is known about the use made of early childhood and family support services by vulnerable families, and the most effective ways of overcoming the barriers to them accessing such services.

The paper then focuses on inclusion in early childhood services, examining current assumptions about the nature and purposes of early childhood services, and describing an alternative set of ideas and assumptions that is emerging. This sees early childhood education and care programs as providing care and education programs for *all* children, regardless of their abilities, backgrounds and needs. Three general ways of supporting this emerging service paradigm are explored: strengthening universal early childhood services, building a tiered system of universal, secondary and tertiary services, and using progressive or hierarchical intervening processes.

The paper concludes with a discussion of the respective roles of early childhood and other services in supporting vulnerable families. The aim of such support is to help the parents ensure that their children attend early childhood services regularly and that they are able to support their children's learning effectively.

2. CHANGING SOCIAL IDEAS AND VALUES

The recent social changes experienced by developed nations have been accompanied by a growing awareness of the ways in which some people within

society are failing to benefit from the changed social and economic conditions and are therefore achieving poorer outcomes (Freiler & Zarnke, 2002; Hertzman, 2002; Keating & Hertzman, 1999; Richardson & Prior, 2005; Stanley, Prior & Richardson, 2005; Vinson, 2009a). This has, in turn, led to general public policy initiatives in Australia and elsewhere (eg. UK) to address social exclusion and promote a truly inclusive society (Hayes, Gray & Edwards, 2008).

These initiatives include the establishment of a Social Exclusion Task Force in the UK (http://www.cabinetoffice.gov.uk/social_exclusion_task_force), and its counterparts in Australia, the Australian Social Inclusion Board (www.socialinclusion.gov.au) and the South Australian Social Inclusion Initiative (<http://www.socialinclusion.sa.gov.au>). The focus of the UK Task Force has been on the 2% of families which it sees as being most at risk (Buchanan, 2007; Social Exclusion Task Force, 2007, 2008). Similarly one of the first priorities of the Australian Social Inclusion Board (which was only established last year) has been to identify the actions or services that it sees as necessary to address the needs of children at greatest risk of long-term disadvantage (Australian Social Inclusion Board, 2008; Vinson, 2009b).

According to Daly (2006), a risk of social exclusion arises when children suffer from multiple disadvantages that make it difficult for them to actively participate in society. Children in jobless households, sole parent families and members of minority groups face the greatest risk of living in poverty, and therefore being socially excluded.

Freiler & Zarnke (2002) argue that social inclusion is not, however, just a response to exclusion. It is about making sure that all children and adults are able to participate as valued, respected and contributing members of society. Social inclusion reflects a proactive, human development approach to social well-being that calls for more than the removal of barriers or risks, but requires investments and action to bring about the conditions for inclusion. Thus, social inclusion extends beyond bringing the 'outsiders' in; instead it is about closing physical, social and economic distances separating people, rather than only about eliminating boundaries or barriers between *us* and *them* (Freiler & Zarnke, 2002).

These qualities are captured in the following definition of inclusive services (Carbone, Fraser, Ramburuth & Nelms, 2004):

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

times through positive discrimination strategies) to promote social inclusion.

Despite their prosperity, developed nations have difficulty providing such services. For example, Hertzman (2002) maintains that Canadian society systematically denies identifiable groups of children the opportunity for healthy development by letting socioeconomic circumstances govern children's access to environments that support early child development.

One of the key environments that all children need access to are early childhood education and care programs. Friendly & Lero (2002) suggest that, under the right conditions, such programs can make a significant contribution to social inclusion by supporting children's development, family well-being, community cohesion and equity.

In order to understand what inclusion means for early childhood services, we need to understand changing ideas about disadvantaged and vulnerable populations, cultural and ethnic diversity, and ability / disability. Each of these will now be examined briefly.

Changing ideas about disadvantaged and vulnerable populations

Among those who are the focus of social inclusion initiatives are families who make limited use of available services, sometimes referred to as 'hard to reach' families. Increasingly, the validity of this term has been challenged (eg. Brackertz & Meredyth, 2008). One problem with the term is the lack of clarity about exactly who or what it refers to. The term is employed inconsistently, sometimes referring to minority groups (such as the homeless) or to 'hidden populations' (those who do not wish to be found or contacted, such as illicit drug users or gang members). In the service context, 'hard to reach' often refers to the 'underserved', those slipping through the net, who are not known to services or do not wish to use services.

Another problem with the term 'hard to reach' is that it implies that the problem exists in the 'hard to reach' themselves, rather than in the services provided for them. There is a growing consensus that, rather than thinking about certain sections of the community as being hard to reach, it is more useful to think of them as being people whom services find difficult to engage and retain in their services. As Slee (2006) argues,

In order to achieve improved outcomes for families at risk, a paradigm shift is required, so that unequal outcomes are seen as social injustices, rather than as products of individual dysfunction or deficit.

This new perspective shifts the burden of responsibility from being totally that of those who do not make use of the services available to those who provide the services. Instead of marginalised families being seen as at fault for failing to

make full use of the early childhood services that are available, the services themselves might be held to account for failing to reach out to and engage such families effectively. Adopting this perspective is challenging for all parties involved: those seeking to involve marginalised families need to overcome their own prejudices about the people they wish to contact, while at the same time having to work to address the prejudices and preconceptions (often misconceptions) of the families themselves (Brackertz, 2007). An alternative way of framing the 'disinterest' or 'lack of motivation' often attributed to marginalised groups is to emphasise differences rather than deficits, that is, to act on the assumption that when people are motivated to acquire information and that information is functional in their lives, they will make use of it (Brackertz, 2007).

Changing ideas about cultural and ethnic diversity

Another area that has been reconceptualised is the issue of cultural and ethnic diversity. Over the past few decades, Western societies (including Australia) have become progressively more diverse – in the composition and size of families, in the cultural and ethnic backgrounds of families – and the circumstances in which families are raising young children have become increasingly complex (Moore, 2008a). This increasing diversity has challenged old certainties about parenting and child development, as well as traditional early childhood practices.

The models of child development upon which much early childhood practice are based have needed to be modified to take account of the cultural influences on children's development (Huang & Isaacs, 2007; Rogoff, 2003). There is now clear evidence that universal assumptions about development do not equally explain all processes and pathways of development for all populations (García Coll & Magnuson, 2000).

In addition, there has been a growing awareness of the way that culture shapes our perceptions of what child qualities and behaviours are of value and should be encouraged, and defines what is 'disabled, delayed, and non-normative in contrast to what is abled, advanced, and normative' (García Coll & Magnuson, 2000). As Gonzalez-Mena (2004) notes, everyone has their own cultural framework, although many people of the dominant culture in any country may be unaware that they even have a culture. They may think their way of doing things is just normal or regular. Gonzalez-Mena argues that, in today's more diverse world, early childhood practitioners need to expand their definitions of what is normal to include a greater variety of people, ideas, and behaviours. She advocates the idea of *cultural pluralism* as a goal for society:

Cultural pluralism is the notion that groups and individuals should be allowed, even encouraged, to hold on to what gives them their unique identities while maintaining their membership in the larger social framework. Mutual respect is the goal, though it isn't easy because, at least in the human development / education fields, we've been taught a

deficit model where intellectual, family, and mental health practices that differ from the mainstream, middle-class norm are not viewed as cultural differences but as defects or inadequacies. Similarly viewed were behaviours that are competent and adaptive responses to a history of bias and misunderstanding in a society that has always had first- and second-class citizens.

Similarly, Goodnow (1999) argues that ‘... a truly multicultural or ‘pluralist’ society is one where people from different cultural groups can negotiate, maintain or change lifestyles from positions of equal power, visibility and respect’ (p. 50). Goodnow considers that Australia has not reached that ideal state, although it is moving towards it.

Changing ideas about ability / disability

There has also been what amounts to a paradigm shift in the way that we conceptualise disability (Odom, Horner, Snell & Blacher, 2007; Turnbull & Turnbull, 2003; World Health Organisation, 2001, 2002).

The World Health Organisation (2002) describes two major conceptual models of disability:

- The *medical model* which views disability as a feature of the person, directly caused by disease, trauma or other health condition, which requires treatment or intervention, to 'correct' the problem with the individual.

This model represents the deficit view that has historically framed ‘disability’ (Turnbull & Turnbull, 2003).

- The *social model* of disability, which sees disability as a socially created problem rather than an attribute of an individual. In this model the problem is the unaccommodating physical environment brought about by attitudes and other features of the social environment.

This model represents the contemporary view of disability that has replaced the medical model (Turnbull & Turnbull, 2003; World Health Organisation, 2001, 2002).

In recognition that neither of these models is adequate on their own the WHO International Classification of Functioning, Disability and Health (2002) distinguishes between impairment, activity and participation. **Impairments** refer to the actual body functions and structure within the child, **activity** to the impact of the impairment on the child’s ability to do certain activities, and **participation** on the child’s ability to participate as they would like within family and community settings. By taking into account the social aspects of disability and the impact of the environment on a person’s functioning, this re-frames the notions of ‘health’ and ‘disability – recognising that every human being can experience a decrease in health or functioning and thereby experience some degree of disability. Thus, disability is a universal human experience.

Considering disability as a universal experience is consistent with the growing understanding of the attributes those with and without disabilities share, and the lack of a clear dividing line between the two groups. In discussing diagnoses of psychopathologies, Pennington (2002) makes some observations that are equally relevant to diagnoses of children with disabilities;

For some mental health practitioners, diagnoses are aversive because they do not capture the individuality of the patient's problems. Robin Morris (1984) has said, "Every child is like all other children, like some other children, and like no other children"; that is, some characteristics are species-typical, others are typical of groups within the species, and still others are unique to individuals. It is important for diagnosticians and therapists to have a good handle on which characteristics fall into which category.

Further, there is a developing understanding that many, if not all disabilities, are points randomly placed on a continuum of normality. This is obviously true of intellectual disabilities as measured or defined by IQ scores, but it is also true of other conditions such as autism. For instance, Skuse, Mandy, Steer, Miller, Goodman, Lawrence, Emond & Golding (2009) have shown that the social and communication disorders characteristic of autism are continuously distributed in the general population, although boys have mean scores 30% higher than girls. This shows that many children have mild autistic 'symptoms' without ever having enough problems to attract specialist attention.

These developments in thinking require appropriate levels of support to be provided to enhance the lives of people with disabilities, rather than requiring them to develop certain skills and behaviours in order to participate inclusively in relationships and community settings (Turnbull & Turnbull, 2003). The 'equal opportunities' model reflects these developments, aiming to give everyone, irrespective of differences, equal opportunity to succeed within society as it exists; as well as removing the barriers that exist in policy and practice which prevent children from participating in early childhood programs (MacNaughton, 2006).

Common features of the changing context

Our conceptualisations of inclusion and diversity are continuing to evolve. Currently, we appear to be transitioning from one set of ideas about difference, disability and exclusion to an emerging set of ideas about diversity, capability and inclusion. As a result, there is a spread of opinion regarding the rationale, definition, and practice of inclusion, both within the early childhood service sector, and the wider community. However there are common features of the evolving ideas about inclusion and diversity:

- It is evident that there is considerable commonality in the evolving ideas emerging from discussions of social inclusion, disability, and diversity.

- This confluence of ideas reflects a gradual ‘sea change’ in societal thinking about difference and diversity, inclusion and exclusion.
- There is no single factor or movement driving this change – it is an emerging set of ideas that represents a shared response to changing community and global conditions.

The old and new paradigms can be summarised as follows:

Old paradigm	New paradigm
‘Blaming the victim’ – holding the person responsible for the problem	Recognising that the system is the problem (or part of the problem)
Deficit-based approach	Strength-based approach
Treatment-based service system	Whole-of-population prevention approach
‘Top-down’ professionally-driven system	System based on partnerships and mutual respect
Risk-based or category-based service system	Response-based or needs-based system
Compartmentalised system of services – each service only responsible for its own service brief	Integrated service system – based on recognition that the responsibility for outcomes for those who have difficulty participating fully is a shared one
Reliance on specialist services to meet most or all of the needs of children with additional needs	Strengthening the universal service system’s capacity to be fully inclusive and cater for all children
Differences are perceived as absolute rather than relative	Recognising that every child is like all other children in some respects, like some other children in other respects, and like no other children in yet more respects.

These changing ideas about inclusion and diversity have major implications for human services, including early childhood and family support services. The Federal and State governments are concerned to increase the use made of early childhood services by vulnerable children so as to ensure that they are provided with the learning experiences and opportunities that are vital for optimal development during the early years. However, the existing system of services and the assumptions underlying current practices are not consistent with the

emerging paradigm regarding inclusion and diversity: these services and practices continue to meet the needs of many young children and families, but are failing to meet the needs of the most vulnerable. As a result, significant numbers of children arrive at school poorly prepared to benefit from the learning and social opportunities that schools provide.

Meeting the needs of these disadvantaged children involves two challenges:

- First, learning how to engage the families of these children so that they make full use of the services available to them and their children
- Second, learning how to provide fully inclusive services that are capable of meeting the needs of children with a wide range of interests, abilities and backgrounds

In the next section, we examine the first of these challenges: learning how to engage vulnerable families.

3. ENGAGING VULNERABLE FAMILIES

Engaging vulnerable families involves two steps:

- The first is 'getting' parents – finding them, informing them of services, and helping them get to the services
- The second is 'keeping' them – providing programs that meet their needs and an environment that they feel comfortable in

The key to meeting both these challenges is **engagement** – that is, building a relationship with the parents that involves them in meaningful partnerships with professionals. What do we know about how successfully the challenge of engaging vulnerable families is being met by Australian services?

Supporting vulnerable Australian families

Studies that have looked the use made of early childhood services by vulnerable families in Australian settings include Carbone, Fraser, Ramburuth & Nelms (2004) and Winkworth, Layton, McArthur, Thomson & Wilson (2009).

In a Brotherhood of St. Lawrence study of strategies to promote more inclusive antenatal and universal early childhood services, Carbone et al. (2004) concluded that, despite the limited data available, the available data suggest the majority of children and parents make good use of existing services. However, it was also clear that service use varied along a continuum from very high to very low, and that there was a small but significant minority of families that underused some or all of these services. Carbone et al comment that, given the optional nature of these services, it is understandable that not everyone will choose to use them. While some degree of 'underuse' would therefore be expected across

the population, the actual pattern is not uniform: certain (disadvantaged) neighbourhoods have very high rates of underuse, and certain families have very high rates of underuse.

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

In most cases, it appears 'keeping' the parents on service is the problem, rather than 'getting' them there in the first place, particularly within Maternal and Child Health services, kindergarten and primary schools. Most parents make contact with services, but some might then cease attendance, attend infrequently, or not become fully involved in the services' activities. This failure to retain families on service is a major issue to be addressed.

In a small-scale study conducted by the Institute of Child Protection Studies, Winkworth, Layton, McArthur, Thomson & Wilson (2009) surveyed financially disadvantaged parents of young children in northern Canberra who were not well connected to formal services. They found that around two thirds of the parents raising children under five and in receipt of Parenting Payment Single from Centrelink reported high parental efficacy, were well connected to formal and informal supports and knew where to get parenting information when they needed it. They are well informed and make good use of the extensive range of parenting resources available in Inner North Canberra. However, another significant group of parents (around a third) regarded themselves as not at all well connected to either informal or formal supports, and had a strong sense that single parents such as themselves were negatively judged by their own families, their communities, and the services which are funded to assist them.

Barriers to accessing services

What are the barriers to vulnerable families accessing early childhood and family support services? A number of barriers have been identified (Carbone, Fraser, Ramburuth & Nelms, 2004). These fall into two broad groups:

- Service level (structural) barriers can include lack of publicity about services, cost of services, limited availability (for example child care places), inaccessible locations, lack of public transport, limited hours of operation, inflexible appointment systems, limited access to specialist supports for children with additional needs, poor coordination between services, lack of attention to multiculturalism, and insensitive or judgmental attitudes and behaviours of staff or of other parents.

- Barriers specific to children, parents and their situation can include limited income, lack of social support, lack of private transport, unstable housing or homelessness, low literacy levels, large family size, personal preferences and individual beliefs about the necessity and value of services, lack of trust in services, fear of child protection services, physical or mental health issues or disability and day-to-day stress.

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

Improving access to services

How can we improve the take-up of services by vulnerable families? Based upon analyses of the effective features of community-based intervention services (eg. CCCH, 2007), a set of best characteristics for working with vulnerable families of various types is described below. There is a general consensus that best practices in engaging vulnerable families include the following features:

- ***Strength-based approaches.*** Strength-based approaches have emerged as the one of the key best practice principles in supporting families with a range of vulnerabilities (Caspé & Lopez, 2006; McCashen, 2004, 2005; Maton, Schellenbach, Leadbeater & Solarz, 2004; Petr, 2004; Saleebey, 2006; Scott & O'Neill, 1996; Solarz, Leadbeater, Sandler, Maton, Schellenbach & Dodgen, 2004; and Walsh, 1998, 2003). These approaches are based on recognising and building on family strengths and competencies rather than focusing mainly or exclusively on their deficits or problems.
- ***Solution-focused approaches.*** The use of solution-focused strategies in work with vulnerable families has been championed by Berg (1994), Lee (2003), and Turnell & Edwards (1999). The family-based service approach developed by Berg (1994) focuses on the family as the target of intervention, rather than the child or the parents separately, on the basis that the best way

to provide services to the child is through strengthening and empowering the family as unit:

- ***Family-centred practice.*** Family-centred practice (also known as family-centred care) is an approach to working with families that respects their values and choices and which provides the supports necessary to strengthen family functioning. The key features of this approach are treating families with dignity and respect, sharing information so families can make informed decisions, providing families with choices regarding their involvement in and provision of services, and parent/professional collaborations and partnerships (Dunst, 2002; Dunst, Trivette & Hamby, 2007; Moore & Larkin, 2006; Petr, 2004; Trivette & Dunst, 2005, and Turnbull, Turnbull, Erwin & Soodak, 2006).
- ***Culturally-responsive approaches.*** Respect for diversity and difference and the use of culturally responsive practices are widely recognised as essential features of effective services for young children and their families (Barrera, Corso & Macpherson, 2004; Carbone, Fraser, Ramburuth & Nelms, 2004; Gonzalez-Mena, 2004; Hanson & Zercher, 2001; Kalyanpur & Harry, 1999; Petr, 2004; Siraj-Blatchford & Clarke, 2000).
- ***Relationship-based practice.*** All of the above strategies depend upon the success to which mainstream and specialist early childhood practitioners establish positive relationships with parents. Because of this, effective services and service systems need to be relationship-based, that is, they should be based on a recognition of the importance of building positive relationships with families as well as between professionals, and an awareness of how these relationships flow through to other relationships, including that between parents and children (Moore, 2007).
- ***Accessible and family-friendly environments.*** The importance of early childhood services being both accessible and family-friendly is well recognised (Katz, La Placa & Hunter, 2007; Moore, 2001; Weeks, 2004). A review of the barriers to families accessing mainstream services by Katz, LaPlaca & Hunter, (2007) found there were both physical and practical barriers. These included lack of knowledge of local services and how they could help, problems in physically accessing services (because of lack of safe and affordable transport), and services whose geographical location precludes easy access by some families (some disadvantaged areas do not have local services).

Specific strategies for engaging vulnerable and high-risk families have been addressed in a number of studies, including Barlow, Kirkpatrick, Stewart-Brown & Davis (2005), Carbone, Fraser, Ramburuth & Nelms (2004), Ghate & Hazel, (2002), Hogue, Johnson-Leckrone & Liddle (1999), and Katz, La Placa & Hunter (2007).

On the basis of the Brotherhood of St. Laurence study referred to earlier, Carbone, Fraser, Ramburuth & Nelms (2004) suggest that inclusive services need to:

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

Among the most critical factors is workers' ability to:

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

Carbone et al. suggest that parents want empathetic, empowering help and are wary of criticism, interference or surveillance. They also want prompt, practical and relevant information, supports and services, preferably from the one person or the one location. Truly inclusive services are flexible and have the capacity to match assistance to each child or family's needs and offer choice to their clientele. A 'one-size-fits-all' approach is not always useful. *Universal* services do not need to be *uniform* services. Further, given the importance of social connections and the distrust some parents have of professionals, services should preferably include a blend of 'professional' and 'informal' assistance, involving volunteers, peer providers and parent groups (general and population-specific). Parents typically welcome the opportunity to meet with other parents, particularly those in similar circumstances. The physical environment of the service can also play a role in facilitating or inhibiting these connections.

In summarising, Carbone et al. propose that, to be more inclusive, services will need to implement strategies which:

- minimise the 'practical' (structural) access barriers and support parents to overcome their knowledge, financial, transport and time difficulties to maintain attendance
- build positive and affirming relationships with parents, which counteract distrust and stigma, and assist parents to connect with others
- ensure their programs are culturally sensitive and provide a perceived 'value for effort', both short term and long term, for the child and their parents

- establish strong reciprocal links with other services, particularly those targeted to vulnerable families.

Similar lessons emerged from a large scale study of parents' experiences of parenting in objectively defined 'poor parenting environments' in the UK (Ghate & Hazel, (2002). When parents were asked how they wanted family support services delivered, three main themes emerged:

- ***Services that allowed parents to feel in control.*** Parents wanted services that allowed them to feel in control. They defined 'good' support as 'help that nevertheless allowed them to feel 'in control' of decisions and what happened to them and their families'. There is clearly a delicate balance to be struck between 'help' that genuinely supports (or as some would term it, 'empowers') and help that in fact undermines, disempowers and de-skills.
- ***Practical, useful services to meet parents' self-defined needs.*** Parents set great store by the practical value of services, but often only insofar as they met their own self-defined needs. The implication is that it is important that family support services pay more attention to parents' perception of the support they provide in terms of the manner in which the support is delivered and parents' feelings about how useful and appropriate the service is.
- ***Timely service.*** Another key principle is that what parents want from support is help when *they* feel they need it, not weeks, months or even years later.

Based on a review of the barriers to vulnerable families accessing mainstream services, Katz, LaPlaca & Hunter (2007) identify a number of strategies which can be used by parenting and family support services to engage with parents:

- ***Personal relationships between providers and service users.*** The relationship between front-line providers and service users has consistently been identified as a major factor influencing the engagement of parents in mainstream services.
- ***Practical issues and patterns of delivery.*** A number of practical issues have been shown to be important in understanding how best to engage 'hard to reach' parents in a range of different services. One issue is how services respond to parents whose problems are not deemed sufficiently serious and who 'fall below the threshold of provision'. Parents whose request for help is turned down can become disillusioned with services and are less likely to ask for help in the future. This makes it more likely that they will allow problems to escalate.
- ***Service culture.*** The overall culture of services and ways they perceive their users can erect barriers to participation. Many parents are put off because of the unequal power relations between parents and services. Services may also be unresponsive to the needs and views of users.

- **Consultation, information and targeting.** Consultation with service users and their involvement in planning services have been seen as an effective means of reducing barriers to engagement and advancing social inclusion. Information and advice to parents need to be tailored not only in content but also in the mode of delivery, so that parents from different groups can have equal access.
- **Community development approaches.** Parents can be included in services at a number of levels other than as service users, eg. decision-making within service delivery, involvement in case planning, and involvement in service evaluation, monitoring service planning, and strategic planning. Community development approaches have enormous potential for increase engagement of parents.

In this section, we have looked at the first of the two challenges involved in meeting the needs of disadvantaged children, that of engaging the families of these children so that they make full use of the services available to them and their children. We have seen that there is a minority of families who do not make sustained use of early childhood services, and have identified some of the barriers that cause this. We have also reviewed the strategies that are known to improve access to and use of services. These strategies for engaging families are based on building personal relationships, providing services that address families' immediate needs as they see them, and designing services in partnership with parents so that they have a greater sense of personal control.

With these strategies for engaging families in mind, we turn to the second challenge to be faced in meeting the needs of vulnerable children, one that involves early childhood services much more directly: this is the challenge of providing fully inclusive services that are capable of meeting the needs of children with a wide range of interests, abilities and backgrounds.

4. INCLUSIVE PROGRAMMING IN EARLY CHILDHOOD SERVICES

Current approaches to inclusive programming

Within the early childhood sector, approaches to inclusion vary according to underlying assumptions about the nature and purposes of early childhood services:

- When early childhood services are seen as providing care and education for children within the 'normal' range, then catering for children outside that range (ie. children with additional or special needs) becomes a matter of adding resources specifically to meet their needs.
- When early childhood services are seen as providing care and education programs for *all* children, regardless of their abilities, backgrounds and needs,

then the aim of the program is to provide flexible and universally applicable programs that are designed 'from the ground up' to be inclusive.

In practice, services fall somewhere on a continuum between these two models, with the majority focused on adding resources to meet the needs of children outside the 'normal' range. However, given the shift in ideas about inclusion, the weaknesses of this model are becoming increasingly evident, and a new alternative service paradigm is emerging.

One of the problems with the 'additive' model is the flawed assumption that there is a core group of learners that is mostly homogeneous, outside of which other learners fall (Hitchcock, Meyer, Rose & Jackson, 2002; Rose, Meyer, Strangman & Rappolt, 2002). Moreover, the efforts that then have to be made to accommodate children with diverse learning needs are costly, time-consuming, and only modestly effective. These drawbacks stem from the mistaken view that students with diverse learning needs are 'the problem' when in fact barriers in the curriculum itself are the root of the difficulty (Rose & Wasson, 2008). As discussed above, all learners are unique, and there is as much variation within 'normal' groups as within other different groupings.

Another problem with this model relates to its dependence upon a separate set of specialist services (eg. early childhood intervention services) catering for children with additional needs. As Moore (2008b) has argued, there is a growing realisation that the strategy of differentiating early childhood intervention services as a separate system to mainstream services is making it harder to achieve the outcomes we now consider to be desirable.

One of the main problems is that early childhood intervention services can be difficult to get into and equally difficult to get out of. Getting into the early childhood intervention system can be problematic because of the eligibility requirements – some children have to wait until they get 'worse' relative to normally developing children before they meet the specified eligibility criteria, while for others there can be a protracted period in limbo while they search for a diagnosis that will make them eligible. Once in the system, it can be difficult to be accepted back into the mainstream service system: there is still a residual assumption among mainstream service providers that only specialists can meet the needs of children with developmental disabilities, and this assumption acts as a barrier to services becoming truly inclusive. (Moore, 2008b)

As a result, the current system has difficulty providing children and parents with opportunities to participate in typical community programs and activities, although this is now recognised as one of the central principles of effective early childhood intervention (Bailey, McWilliam, Buysse & Wesley, 1998; Guralnick, 2008; Moore, 2008b).

Children learn best when provided with multiple opportunities to practice developmentally appropriate and functional skills in real life settings. The key to promoting the acquisition of such skills by children with developmental disabilities lies in what happens to children in the times and settings when the specialist early childhood intervention staff are *not* there, i.e. in their family, community and early childhood service settings. (Moore, 2008b)

The peak bodies in the early childhood field are strongly supportive of inclusive practices and in statements on inclusion, minimal distinction is made between 'abled' and 'disabled', reflecting the focus on providing flexible and universally applicable programs. For instance, Early Childhood Australia's Position Statement on inclusion (ECA, 2005) is as follows:

- All children have the right to access and participate in early childhood programs and services.
- Diversity is valued and acknowledged in all early childhood programs and services.
- Early childhood professionals work as partners with families, and in collaboration with other agencies, in providing a program that responds to the individual strengths and needs of all children and respects families priorities and concerns.
- Staff promote the empowerment of families/caregivers as decision-makers about their children's development and wellbeing.
- The early childhood program is inclusive of all children's abilities and interests, seeking to enhance children's development and wellbeing.
- All staff take equal responsibility for the care and learning of all children.
- Staff access specialised advice and appropriate training in developing and implementing inclusive programs, building on existing strengths and accessing additional resources where required.
- Additional staff support a whole-team approach to meeting the needs of all children.
- The environment maximises children's participation, minimises risk and provides a safe physical and emotional environment.
- Planning for successful transition to other programs and services occurs with the child's family and other agencies to support the child's wellbeing and continuity in learning and development.

Emerging approaches to inclusive programming

Any discussion of best practices in early childhood services needs to take account of the changing ideas and assumptions about the nature and purposes of early childhood services. As argued above, much current service provision is

based upon an 'additive' model of inclusion, in which the core services are directed at children within the 'normal' range, and special provision is made for those outside that range. Within this model, best practice involves delivering high quality early childhood education and care programs for children who are learning and developing 'normally', and then making high quality adaptations or special provisions for children with additional needs.

However, there is an alternative set of ideas and assumptions about the nature and purposes of early childhood services that is emerging. This sees early childhood education and care programs as providing care and education programs for *all* children, regardless of their abilities, backgrounds and needs. Within this inclusive curriculum model, the aim is to identify the learning and developmental needs of *all* children, and make appropriate provision to meet them. In this model, *all* children are understood to have special (ie. individual) needs, although meeting those needs will take dramatically different forms and involve greater effort in some instances.

In the light of this discussion, the best practices discussed below focus on the emerging service paradigm of a fully inclusive curriculum. Three themes are explored:

- Strengthening universal early childhood services
- Building a tiered system of universal, secondary and tertiary services
- Using progressive or hierarchical intervening processes

Strengthening universal early childhood services

As noted above, the successful inclusion of children with vulnerabilities or additional needs depends upon the provision of a high-quality mainstream early childhood education and care programs.

What do we know about high quality early childhood education and care programs? There is a large body of literature on what constitutes best practice in such programs (eg. Centre for Community Child Health, 2006a; Epstein, 2007; Gonzalez-Mena, 2007; Gonzalez-Mena & Eyer, 2007; MacNaughton, 2003) as well as a number of well-regarded curriculum frameworks, such as the NSW Curriculum Framework for Children's Services – *The Practice of Relationships* (NSW Department of Community Services, 2005), and *Te Whāriki: The New Zealand Early Childhood Curriculum* (Ministry of Education, 1996; May & Carr, 2000).

A recent synthesis of the ***key interpersonal features of effective early childhood services*** (Moore, 2008d) identified the following features:

- Responsive and caring adult-child relationships are critical for effective service delivery

- Parents and families are recognized as having the primary role in rearing children and are actively engaged by early childhood services
- An individualised and developmentally appropriate approach is used
- Early childhood staff build upon children's interests, previous learning experiences and strengths
- Staff observe and monitor children's performance to ensure the provision of challenging yet achievable experiences
- Staff model appropriate language, values and practices
- A play-based approach is used
- Children are active and engaged
- Staff are also active and engaged and use intentional teaching strategies
- Adults and children engage in a process of cognitive 'co-construction'
- There is a balance of child-initiated and teacher-directed approaches
- The social setting is organised in ways that support learning
- There is a balance between a cognitive / academic focus and a social / emotional focus
- Respect for diversity, equity and inclusion are prerequisites for optimal development and learning
- The physical setting is organised in ways that promote learning
- Daily routines are used to strengthen bonds and support learning

Besides the interpersonal features just listed, there are several **structural features of effective early childhood services**. There is a strong association between the ability of staff to create a sound early learning environment and the key structural features of group size (number of children in a class), staff-child ratio, and caregiver qualifications (years of education, child-related training, and years of experience)(CCCH, 2006; Cleveland, Corter, Pelletier, Colley, Bertrand & Jamieson, 2006; Early Childhood Learning Knowledge Centre, 2006). Smaller group sizes and favourable staff-child ratios allow each child to receive individual attention and foster strong relationships with caregivers (Early Childhood Learning Knowledge Centre, 2006; Graves, 2006; Melhuish, 2003; Work and Family Policy Roundtable, 2006). (It should be noted that these structural features are important not because they lead directly to high quality programs, but because they provide the conditions under which high quality programming can occur - that is, they make it more likely that the interactions between adults and children in the program will be characterised by the key interpersonal features listed above.)

While these features of best practice are well understood, they are not necessarily uniformly applied in practice. For effective inclusion to become a

reality, it is essential that the overall quality of early childhood education and care programs be raised – which means efforts to improve both the interpersonal and structural features of high quality programs identified above.

Moreover, as the implications of the social changes outlined earlier work their way through to the early childhood sector, there is a growing emphasis on the importance of programs being fully inclusive and able to cater for all children. For instance, the *Infant / Toddler Learning and Development: Program Guidelines* developed by WestEd for the California Department of Education (2006) describe program policies and day-to-day practices that will improve program services to *all* infants and toddlers. (The document specifically notes that, whenever infants, toddlers, or children are mentioned, the intention is to refer to all children.) Ways of strengthening the capacity of universal early childhood education services to meet the needs of *all* young children and families are now being developed. One of these is to base programs on the principles of **universal design**. (The account that follows is taken from Moore, 2008b). In its original form, universal design is an approach to the design of all products and environments to be as usable as possible by as many people as possible regardless of age, ability, or situation. Originally developed by designers, architects and engineers at the Centre for Universal Design at North Carolina State University (<http://www.design.ncsu.edu/cud/>) to provide guidance in the design of environments and products, it has since been applied to educational and other settings (Blagojevic, Twomey & Labas, 2002; Hitchcock, Meyer, Rose & Jackson, 2002; Reidman, 2002; Rose, Meyer, Strangman & Rappolt, 2002).

The Council for Exceptional Children (1999) outlines what this involves:

In terms of learning, universal design means the design of instructional materials and activities that make the learning goals achievable by individuals with wide differences in their abilities to see, hear, speak, move, read, write, understand English, attend, organize, engage, and remember. Universal design for learning is achieved by means of flexible curricular materials and activities that provide alternatives for students with differing abilities. A universally-designed curriculum offers multiple means of representation to give learners various ways of acquiring information and knowledge, multiple means of action and expression to provide learners alternatives for demonstrating what they know, and multiple means of engagement to tap into learners' interests, challenge them appropriately, and motivate them to learn. These alternatives are built into the instructional design and operating systems of educational materials – they are not added on after-the-fact.

Guidelines for applying universal design for learning principles in educational settings have been developed (Rose & Wasson, 2008). In their introduction to these guidelines, Rose and Wasson make the following points:

The usual process for making existing curricula more accessible is adaptation of curricula—and especially instructional materials and methods—so that they are more accessible to students. Often, teachers themselves are forced to make heroic attempts to adapt curricular elements that were not designed to meet the learning needs of diverse students. The term "universal design" is often mistakenly applied to such after-the-fact adaptations.

However, Universal Design for Learning refers to a process by which a curriculum (i.e., goals, methods, materials, and assessments) is intentionally and systematically designed from the beginning to address individual differences. With curricula that are universally designed, much of the difficulties of subsequent "retrofitting" and adaptation can be reduced or eliminated – and a better learning environment for all students can be implemented.

The universal design for learning approach is guided by three key principles (Conn-Powers, Cross, Traub & Hutter-Pishgahi, 2006; Lieber, Horn, Palmer & Fleming, 2008; Rose & Wasson, 2008):

- *Multiple means of representation.* This principle ensures that instruction, questions, expectations, and learning opportunities are provided in various formats and at different levels of complexity, addressing a range of ability levels and needs.
- *Multiple means of engagement.* This principle ensures various opportunities are presented for arousing children's attention, curiosity, and motivation, addressing a wide range of interests, preferences, and personal learning styles. Engagement is then maintained by providing various levels of scaffolding, repetition, and appropriate challenges to ensure successful learning.
- *Multiple means of expression.* This principle ensures children have a variety of formats for responding; demonstrating what they know; and for expressing ideas, feelings, and preferences. In addition, children have options in their use of materials, addressing individual strengths, preferences, and abilities.

Conn-Powers, Cross, Traub & Hutter-Pishgahi (2006) suggest that the goal should be to design early education programs that meet the needs of all learners within a common setting rather than relying solely upon specialised programs and settings. Early childhood services should plan learning environments and activities that cater for a diverse population – that is, universally designed settings in which *all* children and their families can participate and learn. The implications of this concept of universal design for early childhood services are beginning to be explored (Darragh, 2007; Lieber, Horn, Palmer & Fleming, 2008), and both guidelines (Conn-Powers, Cross, Traub & Hutter-Pishgahi, 2006) and curriculum statements (Lieber, Horn, Palmer & Fleming, 2008) are being developed.

While these features of best practice are well understood, they are not necessarily uniformly applied in practice. For effective inclusion to become a reality, it is essential that the overall quality of early childhood education and care programs be raised – which means efforts to improve both the interpersonal and structural features of high quality programs identified above.

Building a tiered system of universal, secondary and tertiary services

Designing services that support universal inclusion requires a better coordinated and more easily accessible system of services for young children and their families. A recent review of the evidence regarding the service system (CCCH, 2006; Moore, 2008c) detailed forms of action including a shift from treatment and targeted services to a universal prevention approach incorporating the development of an integrated tiered system of universal, targeted and specialist services.

The service system needs to shift from targeted and treatment approaches to a universal prevention approach to service provision (CCCH, 2006; Moore, 2008c; Drielsma, 2005; O'Donnell, Scott & Stanley, 2008; Perry, Kaufmann & Knitzer, 2007). In the existing system, targeted and treatment services are mostly located separately from universal services; there are referral 'bottlenecks' that result in delays in help being provided; and the communication between services tends to be one way. Services have difficulties meeting the needs of all children and families effectively because they are too dependent upon scarce specialist services. Inevitably, there are delays in children with additional needs receiving the specialist support they need, and many children end up getting little or no help at all.

The answer is not simply to increase funding for targeted and treatment services (such as early childhood intervention services) in their current forms. First, given the range of services that would need additional funding (which includes health, mental health, disability, special education, family support, parenting, and child protection services), the cost would be prohibitive. Second, the evidence would suggest that the targeted approach is not the most efficient and effective way of meeting the needs of all children and families, or even those of the most vulnerable children and families for whom they are intended (CCCH, 2006). As discussed above children fare best when provided with real life opportunities to practice developmentally appropriate and functional skills.

There is a significant amount of literature available that argues for a universal service approach to a range of community services including child protection, preschool and disability services. For instance, Sanders, Cann & Markie-Dadds (2003) argue that, to reduce the prevalence of child maltreatment, we need to adopt a population-level approach, creating community-wide support structures to support positive parenting. Blair & Stanley (2002) argue that the evidence

regarding effective prevention strategies for disabilities or other conditions suggests that 'simple, low-cost, universal measures implemented early in the pathway may be more effective, but less visible, means of prevention than relatively expensive medical interventions selectively implemented late in the causal path' (p. 184). On the basis of the cumulative research evidence, Robson, Silburn & the Aboriginal Suicide Prevention Steering Committee, Western Australia (2002) suggest that interventions are most effective when they are 'preventive, comprehensive and integrated across communities and across the life-span' (p. 5).

The argument for the adoption of a universal prevention approach to service delivery has been most clearly stated by Richardson & Prior (2005):

'Targeted policies and services to meet the special needs of children with chronic problems, or who face difficult circumstances, will always be required. However, such services will continue to consume an ever increasing proportion of public expenditure on social and other human services unless there is a substantial repositioning of policy from its current focus on remedial and treatment services towards increased investment in universal prevention for all children – particularly in the early years. Without such investment, we are likely to see a continuation of the present trends of increasing inequality and localised concentration of an adverse outcomes for children and youth, including vulnerability to emotional and behavioural problems, substance use and abuse, alienation from school, and disengagement from or rejection of civic and social values and hopes for the future.' (p. 318)

In supporting young children and their families, we need to use the available resources in ways that are both effective (that achieve the outcomes we are seeking) and efficient (that do so with least amount of effort and cost). Among other things, this involves knowing what combination and balance of universal, targeted and treatment services is needed (Centre for Community Child Health, 2006b). The current system of services is having difficulty coping with the overall demand, with many specialist services having waiting lists. As a result, there are many children not receiving the additional help they need (Sawyer, Arney, Baghurst, Clark, Graetz, Kosky, Nurcombe, Patton, Prior, Raphael, Rey, Whaites & Zubrick, 2000; Sayal, 2006). It is often those with the greatest need that are least likely to be able to access available services (Fonagy, 2001; Offord, 1987; Watson, White, Taplin & Huntsman, 2005).

To overcome the difficulties discussed, the existing service system of universal, targeted and treatment services needs to be reconfigured as an integrated and tiered system of secondary and tertiary services, built upon a strong base of universal and primary services (CCCH, 2006; Gallagher, Clifford & Maxwell, 2004). (The following account of tiered systems is taken from Moore, 2008b). Secondary and tertiary services are similar to targeted and treatment services in that they provide direct services to children and families with problems and

conditions that are either mild or moderate (secondary services) or chronic, complex and severe (tertiary services). The three service tiers not only serve children and families with different levels of need, but also perform different functions. In the context of mental health services, Kaufman & Hepburn (2007) describe these different functions in the following terms:

- *Promotion and universal services and supports.* Health promotion activities such as educational campaigns and advertising activities are directed at all children and their families and include approaches aimed at improving parenting knowledge and skills, child development, and social-emotional health. The majority of children and families will require only these forms of universal intervention.
- *Prevention and indicated services and supports.* Preventive measures are aimed at specific populations who are considered to be at risk because of biological or environmental factors. Preventive services are available before there are diagnosable symptoms. These interventions can be integrated into environments that serve children and families at risk. About 10 to 15% of the population might need these services.
- *Intervention and targeted services and supports.* Intervention services and supports for children who have a significant delay or disability in psychosocial development essential to help them achieve their full potential and improve the quality of their relationships. Only 5 to 10% of the population will need these additional indicated mental health services.

Kaufmann and Hepburn note that there is a need for both services and supports. *Services*, or formal intervention strategies, tend to be provided by licensed personnel, to be more clinical in focus, be evidence-based, and be evaluated for efficacy. *Supports* can be less formal; may be provided by families, volunteers, paraprofessionals or unlicensed personnel; and maybe more informational, educational, or supportive in nature, with particular sensitivity to the cultural and linguistic backgrounds of the families.

There have been numerous descriptions of tiered service systems, usually involving three or four levels (eg. Gascoigne, 2006; O'Donnell, Scott & Stanley, 2008; Zeanah, Nagle, Stafford, Rice & Farrer, 2004). Although there are some variations between these models, they share common features:

- All are based on the notion of a strong universal service level with a focus on promoting positive health and development
- All seek to address the needs of the majority of children within this universal service level
- All involve an expanded role for specialist services

The integrated tiered system differs in approach from the current system in a number of important ways:

- It has the capacity to respond to emerging problems and conditions, rather than waiting until problems become so entrenched and severe that they are finally eligible for service;
- It focuses on targeting problems as they emerge through the secondary and tertiary layers, rather than people as risk categories, thus avoiding unnecessary stigmatising;
- It aims to drive expertise down to universal and secondary services, facilitating collaboration and strengthening their capacity to deliver prevention and early intervention strategies; and
- It would have outreach bases co-located with universal services to facilitate collaboration and consultant support.

Feinstein, Duckworth & Sabates (2008) call this combination of strong universal services and tiered secondary and tertiary services ***progressive universalism***. This approach aims to provide support and intervention on a needs basis within a system that recognises the entitlement of all children and families to such support. An important objective is to identify those with greatest need at the earliest possible opportunity and to provide appropriate support. In practice, the development of universal prevention-focused services entails joined up services with highly trained staff members reaching out to the community to engage with young children and their families. These services need to be able to identify and address issues with family functioning and/or child development. The development of Victorian and Australian government policy and funding with respect to integrated hub-based services is consistent with a universal prevention-focused approach.

Using progressive or hierarchical intervening processes

The first strategy described earlier looked at ways of strengthening universal programs, but there was little detail given of how children's individual learning needs might be addressed. The second strategy outlined an expanded role for specialist services in supporting mainstream early childhood service practitioners, but little detail of how the specialists might perform this role was given. The present section describes strategies that simultaneously provide ways of individualising programs to meet children's particular developmental and learning needs, and involve specialist practitioners in supporting mainstream services.

These strategies take the form of ***progressive or hierarchical intervening processes***, whereby the individual needs of children are met through a series of progressively more structured interventions. (The description of these strategies is based on Moore, 2008b).

There are three progressive intervening processes described. These are drawn principally from work with children who have developmental disabilities or delays,

but the principles are readily applicable to other groups with particular vulnerabilities or learning needs. The three strategies are as follows:

- A 'building blocks' model to promote the inclusion of young children with disabilities in early childhood programs (Sandall & Schwartz, 2002, 2008)
- A 'teaching pyramid' model to promote social emotional development and prevent the development of challenging behaviour (Fox, Dunlap, Hemmeter, Joseph & Strain, 2003; Hemmeter, Ostrosky & Fox, 2006) and similarly the 'hierarchical intervention' systems for promoting positive peer relationships in young children with disabilities (Brown, Odom & Conroy, 2001)
- The 'response to intervention' strategies developed for school-age children (Barnett, Elliott, Wolsing, Bunger, Haski, McKissick & Vander Meer, 2006; Bender & Shores, 2007; Fuchs & Fuchs, 2005; Fuchs, Mock, Morgan & Young, 2003; Jimerson, Burns & VanDerHeyden, 2007) and their early childhood counterpart, the 'recognition and response' model (Coleman, Buysse & Neitzel, 2006; FPG Child Development Institute, 2008).

The common features of the progressive intervening strategies are that they:

- are based on the provision of strong universal services with a prevention and promotion focus
- seek to meet as many of the needs of as many children as possible within mainstream settings
- seek to respond to emerging problems, and to have well-developed surveillance and monitoring procedures, and
- use a systematic approach to providing interventions of increasing intensity

The **building blocks** model (Sandall & Schwartz, 2002, 2008), has four key components. The foundation – a high-quality early childhood program – is important for all children. The remaining three components may be appropriate for some children for some of their learning objectives. The intensity and specificity of each successive component increases. The four building blocks are:

- *High-quality early childhood programs.* A high-quality program is a necessary but not sufficient condition for meeting the unique needs of children with disabilities or other additional needs.
- *Curriculum modifications and adaptations.* Changes may be needed to activities, routines and learning areas in order to include children with disabilities and other additional needs in the classroom and to enhance their participation.
- *Embedded learning opportunities.* Children's learning of particular skills can be enhanced by embedding or integrating planned opportunities to use these skills within the usual classroom activities and routines.

- *Explicit child-focused instructional strategies.* Some children will need more explicit instruction in order to learn particular skills.

The ***teaching pyramid*** approach (Fox, Dunlap, Hemmeter, Joseph & Strain, 2003; Hemmeter, Ostrosky & Fox, 2006) has been developed specifically to promote social emotional development, provide support to children's appropriate behaviour, and prevent challenging behaviour. It involves four levels of support and interventions (noted in ascending order):

- *Positive relationships with children, families, and colleagues.* The foundation of an effective early education program must be positive, supportive relationships between teachers and every child, as well as with families and other professionals.
- *Classroom preventive practices.* The classroom environment (including adult child interactions and the structure of activities) affects children's behaviour. Changes in the environment can support the development and use of appropriate behaviour in the children. This involves a combination of giving children positive attention for their prosocial behaviour, teaching them about routines and expectations, and making changes to the physical environment, schedule, and materials. These preventive practices will encourage children's engagement in daily activities, and prevent or decrease the likelihood of challenging behaviour.
- *Social and emotional teaching strategies.* Some children need explicit instruction to ensure that they develop competence in emotional literacy, impulse control, interpersonal problem-solving, and friendship skills.
- *Intensive individualised interventions.* A few children are likely to continue to display challenging behaviour and will need planned intensive individualised interventions in the form of Positive Behaviour Support (Carr, Dunlap, Horner, Koegel, Turnbull, Sailor, Anderson, Albin, Koegel & Fox, 2002; Crimmins, Farrell, Smith & Bailey, 2007; and Koegel, Koegel & Dunlap, 1996).

When the three lower levels of the pyramid are in place, only about 4% of the children in a classroom or program will require more intensive support. The key implication here is that most solutions to challenging behaviours are likely to be found by examining adult behaviour and overall learning environment practice, not by singling out individual children for specialised intervention.

Another hierarchical intervention approach has been developed by Brown, Odom & Conroy (2001) to help interventionists in deciding how to promote the peer interactions of young children with peer-related social competence difficulties in natural environments. Like the two previous hierarchical approaches, this model makes developmentally appropriate and inclusive early childhood programs the foundation for improved peer interactions.

The third example of hierarchical intervening approaches is the ***response to intervention*** (or response to instruction) set of strategies developed for identifying and meeting the learning and behavioural needs of children in schools (Bender & Shores, 2007; Fuchs & Fuchs, 2005; Fuchs, Mock, Morgan & Young, 2003; Jimerson, Burns & VanDerHeyden, 2007; National Association of State Directors of Special Education, 2005). Several variations of this approach have been described, but all are based on an assumption that all children can be taught effectively if the following conditions are met:

- Child progress is monitored to inform the teaching strategies used
- Intervene early when children have difficulty learning
- Use research-based, scientifically validated interventions/instruction, to the extent available.
- Use a multi-tiered approach to providing interventions of increasing intensity according to the individual child's needs
- Use a problem-solving approach to identify and evaluate instructional strategies
- Use an integrated data collection and assessment system to monitor student progress and guide decisions at every level.

In the early childhood context, this approach is called the ***recognition and response*** model (Coleman, Buysse & Neitzel, 2006; FPG Child Development Institute, 2008). This is designed to help parents and teachers respond as early as possible to learning difficulties in young children who may be at risk for learning disabilities, beginning at age 3 or 4, before they experience school failure and are deemed eligible for specialist services. It is based on the premise that parents and teachers can learn to recognise critical early warning signs that a young child may not be learning in an expected manner and to respond in ways that positively affect a child's early school success. In this approach, there is limited reliance on formal diagnosis and labelling. Instead, the emphasis is on a systematic approach to responding to early learning difficulties that includes assessing the overall quality of early learning experiences for all children and making program modifications, tailoring instructional strategies, and providing appropriate supports for individual children who struggle to learn (Coleman, Buysse & Neitzel, 2006).

5. DISCUSSION

In this paper, we have seen that meeting the needs of disadvantaged children involves meeting two challenges: learning how to engage the families of these children so that they make full use of the services available to them and their children, and learning how to provide fully inclusive services that are capable of meeting the needs of children with a wide range of interests, abilities and backgrounds. These two challenges are inextricably linked to one another: if the

parents are not committed to bringing their children to early childhood services on a regular basis, then no amount of inclusive programming will be of any use; and if early childhood services do not provide programs that the parents see as inclusive of them and their children, they will not make use of the service.

So whose responsibility is it to meet these two challenges? The second is clearly the primary responsibility of early childhood services, albeit with the support of other mainstream and specialist services. However, responsibility for the first challenge – that of engaging vulnerable families – is less clear. Early childhood services generally do not see it as part of their primary role to build supportive relationships with vulnerable families, and do not have the resources to provide the outreach services and home visits that such relationship-building often requires. Early childhood services are therefore dependent upon parents being willing and able to bring their children regularly, as well as being able to support their children's learning and development. But as we saw earlier, there has been a shift in thinking about 'hard to reach' families: instead of such families being seen as solely responsible for making use of services, the services themselves are seen as having a complementary responsibility to reach out to the families, seeking to build relationships with them and to provide services at times, in places and in formats that will maximize parental involvement and child attendance.

This task of reaching out to and engaging vulnerable families is really one that should be undertaken by the service system as a whole rather than by early childhood services on their own. Early childhood services need to build partnerships with other early childhood and family support services, seeking to create an integrated system capable of providing outreach support to engage vulnerable families and flexible service options to maximize their involvement.

6. CONCLUSIONS

In response to profound social changes, there are ongoing changes occurring in societal ideas and values regarding difference and diversity. These present a challenge to our traditional forms of service provision for young children.

An alternative service paradigm is emerging based upon strengthening the capacity of universal services to meet the needs of all children, ie. to be fully inclusive. To make services fully inclusive, we also need to consider ways in which we reach out to and engage the most vulnerable children and their families. While this will involve some expansion of the role of early childhood services, it is a task that should involve a range of early childhood and family support services working in partnership.

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