Introduction

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 and additional or targeted services are needed and how these should be deployed.

One of the key ways in which human services vary is according to their aims or target groups. Three forms of services that are usually distinguished are universal, targeted and treatment services, and defined as follows:

- *Universal services* are available to the whole of the population and are designed to promote positive functioning and thereby decrease the likelihood of specific disorders developing.

- *Targeted services* are available to selected groups or individuals who are known to be at risk of developing a particular health or developmental problem, and are designed to reduce the incidence of the problem developing.

- *Treatment services* are available to individuals or families who have an established condition or problem and are designed to minimise the negative impact of the condition or problem.

This paper seeks to rethink these forms of service and the relationship between them. It proposes an alternative relationship, a tiered system of universal, secondary and tertiary services that are more closely integrated than the existing universal, targeted and treatment services, and that are designed to strengthen the capacity of the universal services to be truly inclusive and to cater more effectively for the diverse needs of all children and families.

Why is this issue important?

There are a number of reasons why we need to rethink the way that we provide services to young children and their families.

The first concerns the impact of recent social and demographic changes. Over the last two or three decades, families and family circumstances have changed to such an extent that the service system that worked well when society was more homogeneous and the demands on families were fewer is no longer adequate (Richardson, 2005; Richardson and Prior, 2005a; Stanley, Prior and Richardson, 2005; Zubrick, Silburn and Prior, 2005). One indication that all is not well is that we are seeing worsening or unacceptably poor health and well-being outcomes among young people (Keating and Hertzman, 1999; Rutter, 2002; Sawyer, 2004; Stanley, Prior and Richardson, 2005). These poor outcomes all have associated costs that are a significant drain on public resources and undermine national productivity and prosperity (Kids First Foundation, 2003; Heckman, 2006).

A second cause of concern is the growth in the numbers of those who are socially excluded: despite overall growth in prosperity, the gap between the rich and the poor has widened, with the result that there are children and families who do not or cannot easily access the services they need (Hertzman, 2002a; Richardson, 2005; Wilkinson, 2005). This has negative consequences for their long-term health, achievements and well-being (Hertzman, 2002a; Shonkoff and Phillips, 2000). 'Social gradient' effects are evident in the distribution of these poor outcomes: the more socioeconomically disadvantaged families are, the more likely it is that they and their children will be experiencing problems (Brooks-Gunn, Duncan and Britto, 1999; Keating and Hertzman, 1999; Marmot, 2004; Offord, 2001). These gradient effects are evident at birth (in the form of low birth weight and other birth complications) and apply to all aspects of children's development. The gradients do not seem to be reduced by schooling (which may even reinforce disparities rather than reduce them), and they continue through the adolescent years. The gradients exist along the entire income distribution, with those in deep poverty faring worst but poor outcomes still being evident among those in the highest income brackets (Brooks-Gunn, Duncan and Britto, 1999).

Third, the service system is also having difficulty coping with the overall demand. Many specialist services have waiting lists, and these create referral bottlenecks. As a result, there are many children not receiving the additional help they need. This suggests that specialist services are underfunded. However, given the range of specialist services in this position (health, mental health, disability, special education, family support, parenting, child protection etc.), the cost of trying to eliminate waiting lists by increasing funding to all specialist services *in their current forms* would be prohibitive (Fonagy, 2001; Sawyer, Arney, Baghurst, Clark, Graetz, Kosky, Nurcombe, Patton, Prior, Raphael, Rey, Whaites and Zubrick, 2000). Instead, specialist services need to review how best to utilise their expertise so as to meet the needs of the greatest number of people and reduce the need for the most intensive forms of specialist help. (It should be noted that this is not an argument for *not* increasing funding for specialist services: it is a question of whether additional funding should be used to increase the capacity of existing forms of specialist

service, or should be used to diversify the forms of support that specialist services provide so as to deploy their expertise more effectively.)

What does the research tell us?

Evidence of problems with the current service system

The service system is having difficulty providing support to all families who are eligible, and waiting lists are increasingly common, particularly for specialist services of various kinds (Fonagy, 2001). For instance, in the mental health field, it has been estimated that as many as 75% of children and families experiencing difficulties do not receive the help they require (Cox, 1993; Flisher, Kramer, Grosser, Algeria, Bird, Bourdon, Goodman, Greenwald, Horwitz, Moore, Narrow and Hoven, 1997; Sawyer et al, 2000; Sayal, 2006).

How this occurs has been explored by Sayal (2006) who identified four stages of help-seeking and shows how each of these can act as filters to prevent children being referred for specialist help. The four stages are:

– *Parental perception of problems.* Following parental awareness of child symptoms, parental perception of problems is the key initial step in the help-seeking process.

– *Use of primary care services.* Although children with mental health problems or disorders are regular attenders within primary care and most parents acknowledge that it is appropriate to discuss concerns about psychosocial issues in this setting, few children are presented with mental health symptoms even if their parents have such concerns.

– *Recognition within primary care.* Subsequently, less than half of children with disorders are recognised in primary care.

– *Referral to or use of specialist health services.* Amongst recognised children, about half are referred to specialist services.

Overall, up to one-third of children with disorders receive services for mental health problems. Sayal concludes that, as there are inequities in patterns of service use, a greater emphasis on developing resources at population and primary care levels is required. Barriers involving parental perceptions and expression of concerns within consultations should be minimised at these levels.

Another problem with the current service system is that many forms of service are treatment-oriented (Prilleltensky and Nelson, 2000). This means they are can only help those who meet specified criteria (health, educational, disability, welfare) indicating that they have a level of need that justifies a specialist form of intervention. Services are therefore unable to respond to the *emerging* needs and problems of children and families, and thus miss opportunities to reduce the numbers needing intensive help (Tolan and Dodge, 2006). Moreover, by the time they are eligible for specialist help, the problems experienced by these families are likely to have become so well-established and serious that they are resistant to change and very costly to remediate in terms both of time and resources (Fonagy, 2001). Responding early to

problems as they emerge is more efficient and cost-effective than waiting until they meet particular eligibility criteria.

There is also evidence that it is often those with the greatest need that are least likely to be able to access available services (Fonagy, 1996; 2001; Offord, 1987; Watson, White, Taplin and Huntsman, 2005). On the basis of a review of the evidence for the efficacy of different forms of early intervention, Watson, White, Taplin and Huntsman (2005) conclude that there is often a low take-up of opportunities to participate in programs, as well as a high attrition rate among program participants and staff providing the services. This is particularly apparent amongst the most vulnerable families for whom the programs are often intended.

Even universal services have difficulties engaging and retaining all families. To do this effectively, universal services need to be inclusive, that is, willing and able to cater for the needs of all children and families. Australian studies (Carbone, Fraser, Ramburuth and Nelms, 2004; Walker, 2004) suggest that universal early childhood services are not as accessible or inclusive as they need to be. For instance, in a study of usage of antenatal and universal early childhood services in Victoria, Carbone, Fraser, Ramburuth and Nelms (2004) found that the majority of children and parents make good use of these services, but there was a small but significant minority of families that underuse some or all of these services. This was most apparent in disadvantaged neighbourhoods and in vulnerable families. Often it appeared that retaining the families on service was more of a problem than access: most parents make contact with services, but some might then cease attendance, attend infrequently, or not become fully involved in the services' activities. Both these studies found that there were many barriers to access: some reflect family circumstances, some relate to resources, while others reflect systemic problems.

What this shows is that the existing system does not do a good job of catering for the needs of the most vulnerable families. Yet these families are often the ones who, because of the poor outcomes they and their children eventually present, will need intensive support and intervention later on, taking up a disproportionate amount of professional time and resources. Universal, targeted and specialist services all have problems reaching and retaining these vulnerable families.

Evidence of efficacy of different service models

There is evidence of that each of the three forms of service discussed here – universal, targeted and treatment – can be effective (Homel, 2005; Loxley, Toumbourou, Stockwell, Haines, Scott, Godfrey, Waters, Patton, Fordham, Gray, Marshall, Ryder, Saggers, Sanci and Williams, 2004). It is also clear that each approach has its strengths and weaknesses (Barnet, Brown and Shore, 2004; Fonagy, 2001; Gilham, 2003; Homel, 2005; Offord, Kraemer, Kazdin, Jensen, Harrington and Gardner, 1999).

Treatment services. The great virtue of treatment programs is that they have the capacity to tackle the most difficult and chronic conditions and, some of the time at least, make a difference. There is evidence that treatment programs for a wide range of problems (including health, mental health, drug abuse, crime, family interventions,

disability) can be effective (eg. Farrington, 2002; Fonagy, Target, Cottrell, Phillips and Kurtz, 2002; Guralnick, 1997, 1998; Loxley et al., 2004).

However, these interventions are not without their problems. The most commonly cited problem is that, by the time they become eligible for treatment services, people's problems are often so severely entrenched that they are difficult to shift (Fonagy, 2001). This reduces the efficiency of such services. For instance, even those mental health interventions with the best evidence base (pharmacotherapy, psychotherapy) are far less than 100% effective, possibly because they are used so late in the evolution of the disorder (Fonagy, 2001). Moreover, even highly effective mental health treatment services rarely make a serious impact on the population prevalence of the disorder (Fonagy, 2001).

Another problem is the cost. Treatment needs to be intensive and tailored for individual families to be at all effective, which makes such services costly in terms of time, effort and money. A related issue is the difficulty in providing adequate coverage of populations and ensure that everyone has easy access to these services.

Another problem with treatment services is that they stigmatise the families they aim to help, which tends to make them ambivalent or even hostile to the service. This leads to many needy families dropping out of service, or never approaching them in the first place. Thus, these interventions may inadvertently increase inequalities rather than decreasing them, because it is the most socially excluded who are least likely to benefit from the intervention (Fonagy, 2001).

Targeted services. Targeted services have the capacity to provide intervention before symptoms or disorders are well-established, which is particularly important in conditions where results of treatment are disappointing or treatment services over-stretched. There is strong evidence that targeted programs can be effective in improving the lives of children and families (Karoly, Greenwood, Everingham, Houbé, Kilburn, Rydell, Sanders and Chiesa, 1998; Karoly, Kilburn and Cannon, 2005; Shonkoff and Phillips, 2000; Williams, Toumbourou, McDonald, Jones and Moore, 2005).

As with treatment services, the targeted approach has some disadvantages. If the selection of targeted individuals or areas can be done accurately, targeted approaches can be an efficient way of preventing later problems. However, there are often difficulties with screening, as screening procedures fail to identify many of the individuals who ultimately develop the problem (Gilham, 2003). Even when risks are relatively easy to identify, the developmental pathways to subsequent poor health and developmental outcomes are complex and poorly understood (Cowen, 2000; Blair and Stanley, 2002), and therefore it can be unclear what form the targeted service should take in order to be effective. Prevention programs are only effective if they are able to influence key risk and protective factors that have a causal relationship with the problems being addressed, that is, that they have a strong conceptual framework built on a solid empirical base which describes the relationship between risk and protective factors, and relevant problems (Giesen, Searle and Sawyer, 2007).

There is another problem with a risk-based approach to targeting: not all those who are identified as being at risk will develop problems. By their very nature, risk factors only indicate an increased likelihood of problems emerging, and many or most of those in a risk group will not develop problems. Thus, risk factors lack sufficient specificity and sensitivity to be useful in predicting poor outcomes; there are no risk factors that always lead to poor outcomes, ie. that have 100% specificity and 100% sensitivity. Hence, although targeted programs are potentially efficient if the targeting is accurate, if it is not, then those children who are misidentified will be unnecessarily labeled or stigmatized, while some who are in need of help will not be detected (Offord, 2001). The use of risk assessment procedures is particularly problematic in sensitive areas such as child protection (Goddard, Saunders, Stanley and Tucci, 1999). This is partly because risk assessment involves a professional judgment of what might happen in the future rather than a parental report of what has happened or is happening now.

Targeted programs have lower costs than treatment services, and should produce higher returns per dollar invested than universal programs (Karoly and Bigelow, 2005). However, they are more expensive than universal programs because of the administrative costs of determining eligibility and addressing changes in eligibility over time. Like treatment services, targeted services can stigmatise the families they aim to help, which leads to many needy families dropping out of service, or never approaching them in the first place.

Another key issue is that, although the concentration of those who would benefit from particular interventions may be highest in targeted populations, the absolute number of individuals who develop a disorder may actually be higher in low-risk groups who do not receive the intervention (Offord, 2001; Offord, Kraemer, Kazdin, Jensen, and Harrington, 1998). This reduces the efficiency of the targeted approach. Evidence of this in the Australian context comes from a study of child social exclusion resulting from poverty in Booroondara, one of Melbourne's wealthiest municipalities (Stanley, Mestan and Ng, 2007). This estimated that 12 % of children in Booroondara (representing about 4500 children under the age of 15) were living in poverty. Although 12% of children living in poverty is much lower than the regions in Melbourne where disadvantage is concentrated (at rates above 25%), the number of children involved may outweigh the sum of people living in poverty in regions where disadvantage is concentrated. Moreover, because Boroondara is largely an affluent area, it does not have some of the supportive infrastructure of other areas where poverty is concentrated. Paradoxically, such families are more at risk in wealthy municipalities because of their isolation and the lack of appropriate support services.

This example highlights a problem with 'place-based' targeting initiatives. Such initiatives provide resources for specific communities and works with them to address particular local issues, such as crime, amenities, neighbourhood appearance, or social cohesion. This approach is popular with governments (eg. the Neighbourhood Renewal initiative adopted by the Victorian Government to address aspects of social exclusion). However, these place-based initiatives will not help those disadvantaged people living in other areas, nor can they deal with the problems of scattered poverty in areas of higher relative wealth. Scattered poverty can be more difficult to address because the disadvantage is more covert.

Universal services. Because of the difficulties associated with targeted and treatment approaches, universal services have a number of features to recommend them. Since the interventions are offered to all children and populations, there is no labelling or stigmatisation involved, and therefore they are likely to be more effective at identifying and reaching all targeted children. Moreover, universal programs are particularly beneficial for the most disadvantaged children (Barnett, Brown and Shore, 2004; Karoly, Kilburn and Cannon, 2005; Melhuish, 2003). Although successful universal interventions typically have very small effects for the average participant, such effects can add up to large benefits for society (Offord, Kraemer, Kazdin, Jensen, and Harrington, 1998).

There is evidence that universal programs can be effective. In a review of mental health interventions, Greenberg, Domitrovich and Bumbarger (1999) found that such programs produced positive outcomes in either specific symptoms of psychopathology or commonly accepted risk factors associated with psychopathology. Further evidence comes from a Canadian study (Peters, Petrunka and Arnold, 2003) that evaluated a community-based, universal project designed to prevent emotional and behavioral problems and promote general development in young children. The project also sought to improve family and neighbourhood characteristics, to link effectively with existing services, and to involve local residents in project development and implementation. Long-term follow up showed that the program led to significant improvements in children's and parents' social-emotional functioning and physical health, parenting behaviours, and neighbourhood and school characteristics. An Australian study, the Gatehouse Project, has shown that a school-wide prevention strategy designed to promote social inclusion and commitment to education was effective in reducing student health risk behaviours and improving their emotional well-being (Patton, Bond, Carlin, Thomas, Butler, Glover, Catalano and Bowes, 2006). The study provides support for prevention strategies in schools that move beyond health education to promoting positive social environments.

There is also evidence that high-quality preschool programs lead to significant improvements in children's early language, literacy and mathematical development, regardless of ethnic background or economic circumstances (Barnett, Lamy and Jung, 2005; Committee on Economic Development, 2006; Gormley, Gayer, Phillips and Dawson, 2005; Henry, Henderson, Ponder, Gordon, Mashburn and Rickman, 2003; Schulman and Barnett, 2005; Waldfogel, 2006). On the basis of this evidence, there has been a groundswell of opinion in the US in favour of providing universal preschool programs (Barnett, Brown and Shore, 2004; Committee on Economic Development, 2006; Karoly and Bigelow, 2005; Schulman and Barnett, 2005).

In addition, there is the evidence that interventions during the early years can be cost effective (Heckman, 2000, 2006; Heckman and Masterov, 2004; Karoly, Greenwood, Everingham, Houbé, Kilburn, Rydell, Sanders and Chiesa, 1998; Karoly, Kilburn and Cannon, 2005; Lynch, 2004; Rolnick and Grunewald, 2003). Universal preschool programs in particular have been shown to be cost effective (Bellfield, 2004; Calman and Tarr-Whelan, 2005; Committee on Economic Development, 2006; Lynch, 2004; Karoly and Bigelow, 2004).

Implementing an effective universal approach can be challenging. One problem is the difficulty of ensuring the high quality of service needed for such services to be effective (Barnett, Brown and Shore, 2004; Melhuish, 2003). Expanding universal options takes time, and patience is required to build capacity while maintaining or improving quality (Barnett, Brown and Shore, 2004). Another challenge is matching services to needs: universal programs that do not match the needs of families or are not delivered in ways that are easily accessible are not likely to be effective (Scott, O'Connor and Futh, 2006).

Then there is the challenge is ensuring that universal services are truly inclusive and able to meet the needs of all children and families, including those with additional needs. Providing universal services does not mean providing uniform services (Carbone, Fraser, Ramburuth and Nelms, 2004; Committee on Economic Development, 2006). Some children and families who are at risk or have additional needs will require additional services (such as more intensive instruction, parent education, home visits, or access to health care services) (Barnett, Brown and Shore, 2004). This means that strengthening universal services must be coupled with the development of an efficient tiered system of targeted and treatment services.

What are the implications of this research for policy and programs?

Four major themes emerge from this evidence:

- the need to shift from treatment and targeted services to a universal prevention approach
- the need to develop an integrated tiered system of universal, targeted and specialist services
- the need to shift from a risk-based approach to targeting children and families in need to a response-based approach
- the need to develop better ways of engaging and retaining the most vulnerable families

The first major theme emerging from this evidence is that there needs to be a shift from treatment and targeted services to universal prevention approaches (Albee and Gullota, 1997; Coie, Watt, West, Hawkins, Arsanow, Markman, Ramey, Shure and Long, 1993; Cowen, 2000; Fonagy, 2001; Homel, 2005; Prilleltensky, Peirson and Nelson, 2001; Richardson and Prior, 2005; Sanders, Cann and Markie-Dadds, 2003; Schorr, 1991; Winkworth, 2003). As noted by Robson, Silburn and the Aboriginal Suicide Prevention Steering Committee, Western Australia (2002), a number of adverse outcomes – including family violence, alcohol and substance abuse, juvenile and adult crime, sexual abuse of children and women, mental health problems and suicide – are known to develop along similar causal pathways. The fact that these diverse problems arise from exposure to a common set of risk factors 'clearly indicates the need for significant new investment in broadly based primary prevention' (p. 5). On the other hand, there is evidence that adopting several positive health behaviours has a cumulative effect in reducing mortality (Khaw, Wareham, Bingham, Welch, Luben and Day, 2008).

There have been calls for a universal service approach across a wide range of services, including preschool services (Barnet, Brown and Shore, 2004), child protection services (Barlow and Stewart-Brown, 2003; Sanders, Cann and Markie-Dadds, 2003; Winkworth, 2002), mental health services (Park, 2003), health services (Tolan and Dodge, 2005), and disability services (Blair and Stanley, 2002). For instance, Sanders, Cann and 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 and 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). Similarly, on the basis of the cumulative research evidence, Robson, Silburn and 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 and 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)

The second major theme is the need to develop an integrated, tiered system of universal, secondary and specialist services. The evidence suggests that existing service systems may be too dependent upon scarce specialist expertise. For instance, it has been argued that, in the current mental health service system, there tends to be an over-reliance on out-of-home and out-of-community treatment options and an overemphasis on traditional psychotherapeutic interventions (Huang, Stroul, Friedman, Mrazek, Friesen, Pires and Mayberg, 2005). To counteract this tendency, we should be seeking to incorporate interventions for more vulnerable children and families into existing early childhood and family support services (Knitzer and Kreader, 2004).

To do this, the capacity of universal services to cater for the needs of a broad range of children and families will have to be strengthened. This will involve several strategies, including training of primary care workers (Sayal, 2006), increased support from specialist services (NHS Health Advisory Service, 1995), and the use of inclusive practices and strategies (such as the natural learning opportunities

approach used with young children who have developmental disabilities)(Dunst, Hamby, Trivette, Raab and Bruder, 2000; Hanft and Pilkington, 2000; Noonan and McCormick, 2005). However, the main strategy needed is to create a more integrated system of universal, targeted and treatment services, and to deploy the expertise of specialists more broadly.

As the evidence has shown, clinical, targeted, and universal programs all have advantages and disadvantages - one type of program alone will never be sufficient to meet all the needs of all young children and families. What is needed is a tiered approach to service delivery (NHS Health Advisory Service, 1995; Statham, 1997) incorporating all three approaches and built upon a strong base of universal services. To help distinguish this new tiered approach from the existing system, it is proposed that the three levels of service be designated *universal*, *secondary* and *tertiary*. All three would have a prevention focus (Simeonsson, 1991; Statham, 1997): universal services directed to whole populations aim to strengthen capacity and reduce the incidence of developmental and other problems; secondary services directed to individuals or groups with emerging problems aim to reduce the numbers who develop significant problems; and tertiary services directed to those who have identified problems aim to reduce the sequelae or complications of the condition.

As shown in Figure 1, 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. Figure 2 shows how, in an integrated system, secondary and tertiary services would have outreach bases co-located with universal services, would provide consultant support for children who have emerging problems, and would work collaboratively with universal service providers.

The third major theme involves the need to shift from a risk-based approach to targeting children and families in need to a response-based approach. Because risk-based targeting can be inefficient, missing some of those in need and including many who do not need intervention, it should not be the sole basis on which targeting is conducted, but should be combined with (or replaced by) a response-based approach. This involves providing support in response to emerging child and family problems rather than attempting to predict ahead of time which children and families might need help.

These two approaches differ in the nature of the relationship between professionals and parents: a risk-based approach involves judgments made by professionals about family needs whereas a response-based approach involves a partnership between parents and professional in which the professionals seek to identify and respond to parental concerns. A partnership approach is to be preferred both for philosophical and practical reasons (American Academy of Pediatrics, 2003; Glascoe and Dworkin, 1995; Squires, 1996). Monitoring and surveillance tools based upon parental identification of children's problems have been developed, such as the Parents' Evaluation of Developmental Status (PEDS) (Glascoe, 1997, 1998). These have been demonstrated to be as efficient and cost effective as professionally administered tools (Glascoe, Foster and Wolraich, 1997; Squires, 1996; Wright and Oberklaid, 2004).

The fourth major theme is the need to develop ways of engaging and retaining contact with the most marginalised and vulnerable children and families. The service system needs to become more equitable and inclusive (Carbone, Fraser, Ramburuth and Nelms, 2004; Hertzman, 2002b, Offord, 2001).

What can we do?

- ***Seek to ensure that the general community is supportive of all families*** (Long and Hoghughi, 2004; Offord, 2001; Stanley, Prior and Richardson, 2005). The key element of a comprehensive strategy to deliver services for children is the presence of what Offord (2001) calls a civic community. Among other things, this means a community where all children have the right of full participation in community life, and where everyone accepts responsibility for what happens to children.

- ***Shift from targeted and treatment approaches to a universal prevention approach*** (Coie, Watt, West, Hawkins, Arsanow, Markman, Ramey, Shure and Long, 1993; Cowen, 2000; Fonagy, 2001; Prilleltensky, Peirson and Nelson, 2001). This would serve to increase both the effectiveness and efficiency of investments in early childhood services (Barnett, Brown and Shore, 2004; Hertzman, 2002b; Waldfogel, 2004, 2006; Watson, White, Taplin and Huntsman, 2005). Building the capacity of universal services without compromising the quality of secondary and tertiary services will take time and patience (Barnett, Brown and Shore, 2004). It will also require that specialist professionals receive training in consultation (Buysse and Wesley, 2004) and coaching skills (Hanft, Rush and Shelden, 2004) to ensure that they are able to share their expertise with universal services providers effectively.

- ***Promote greater integration of universal and specialist support services*** (Fonagy, 2001; Hertzman, 2002b; Knitzer, 2000; Knitzer and Lefkowitz, 2006; Sawyer et al, 2000). As Fonagy (2001) states, 'It is now generally recognized that the promotion of early intervention will not take place without extensive integrations at various levels of the social care system.' This would include providing greater support for and access to short-term intervention in primary care settings (Tolan and Dodge, 2005).

- ***Ensure that there is an efficient and effective tiered system of universal, secondary and tertiary services capable of meeting the needs of all children and families*** (NHS Health Advisory Service, 1995; Offord, 2001). Strategies to achieve this include specialist services providing support to universal services in the form of training and consultation; secondary and tertiary services establishing outreach services in universal service settings; and developing more effective and efficient screening and referral pathways for children and families who need more specialised help.

- ***Promote more effective ways of identifying emerging child and family problems.*** Train staff in the use of tools such as Parents' Evaluation of Developmental Status (PEDS) (Glascoe, 1997, 1998) and develop matching tools to identify parenting and family concerns.

- ***Explore ways of varying eligibility requirements to allow specialist services to respond to emerging child and family needs***, and not wait until problems become so entrenched and severe that they are finally eligible for service (Tolan and Dodge, 2005). This could involve a version of the response-to-intervention model being used in the special education field in the US (Fuchs and Fuchs, 2005; National Association of State Directors of Special Education, 2005) and now being trialed in early childhood settings (Coleman, Buysse and Neitzel, 2006).

- ***Increase the range of universal services available to all children,*** including high quality preschool programs (Barnett, Brown and Shore, 2004; Richardson and Prior, 2005b; Schulman and Barnett, 2005).

- ***Explore ways of making universal services more inclusive.*** This could involve ensuring that such services are affordable, well publicised, and geographically accessible; providing outreach and support with transport; providing a family-friendly and culturally inclusive physical environment; employing skilled and responsive staff working from a family-centred, culturally sensitive perspective; promoting social connectedness through informal supports; and establishing strong reciprocal links with other relevant services (both universal and specialist)(Carbone, Fraser, Ramburuth and Nelms, 2004).

- ***Make special efforts to reach the marginalised groups who make poor use of services, universal or otherwise*** (Carbone, Fraser, Ramburuth and Nelms, 2004). Ways of making universal services more acceptable to vulnerable families have been identified by Carbone, Fraser, Ramburuth and Nelms (2004), Ghate and Hazel (2002), Hogue, Johnson-Leckrone and Liddle (1999), and Weeks (2004). For instance, Carbone et al suggest that, since it is highly unlikely a service will have *no* vulnerable children and parents among its potential clients, *every* service needs to make the service attractive to families, rather than waiting to change once they arrive. Among the most critical factors is workers' ability to establish positive, non-judgmental relationships with all children and parents, and to proactively engage and sensitively follow-up vulnerable children and parents who are at risk of 'dropping out'. Weeks (2004) stresses the importance of the physical environment in service delivery, and identifies ways of creating services that are comfortable, safe, friendly and attractive for people who are facing family difficulties in attending.

This Working Paper is an expanded and updated version of the following CCCH Policy Brief published in 2006:

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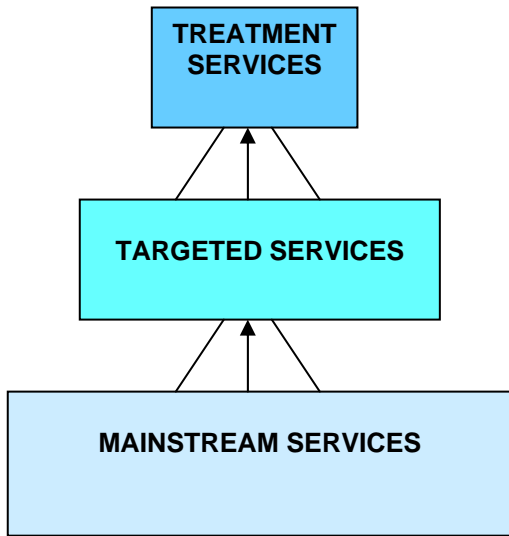Parkville, Victoria, Australia 3052

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Figure 1

TRADITIONAL SYSTEM

- Specialist services are usually located separately from mainstream services

- Children have to meet certain criteria to be eligible for specialist services.

- There are more children needing support than the specialist services are able to accept, resulting in referral bottlenecks and some children not receiving help at all.

- Information tends to flow one way only – from the mainstream services to the specialist – and collaboration between specialist and mainstream services is limited

Figure 2

INTEGRATED SYSTEM
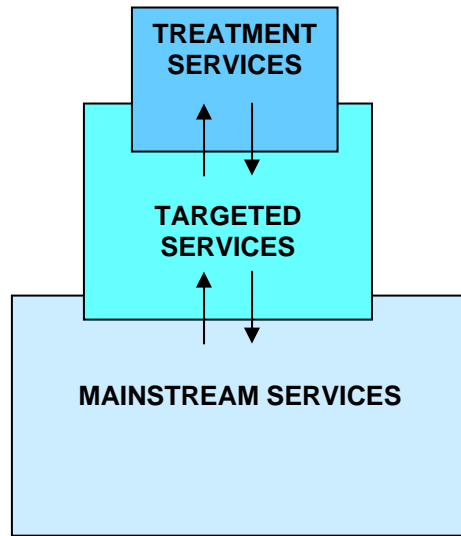
- Specialist services have outreach bases co-located with mainstream and other specialist services

- Specialist services provide at least some support in family and early childhood settings

- Specialist services work directly with some 'eligible' children, and provide consultant support for all others

- Specialist services also provide consultant support to mainstream services on a broad range of child and family issues

- Information flows both ways between mainstream and specialist services – they collaborate as equal partners