



How outreach facilitates family engagement with universal early childhood health and education services in Tasmania, Australia: An ethnographic study

Kim Jose^{a,*}, Catherine L. Taylor^{b,g}, Alison Venn^a, Rachael Jones^c, David Preen^d, Paula Wyndow^b, M'Lynda Stubbs^e, Emily Hansen^f

^a Menzies Institute for Medical Research, University of Tasmania, Medical Science Precinct, Private Bag 23, Hobart, TAS 7000, Australia

^b Telethon Kids Institute, 15 Hospital Avenue, Nedlands, WA 6009, Australia

^c School of Social Sciences, University of Tasmania, Private Bag 1340, Launceston, TAS 7250, Australia

^d School of Population and Global Health, The University of Western Australia, M431, Part, WA 6009, Australia

^e Chigwell Child and Family Centre, Department of Education, 4 Bethune St, Chigwell, TAS 7001, Australia

^f School of Social Sciences, University of Tasmania, Private Bag 22, Hobart, TAS 7001, Australia

^g The University of Western Australia, Crawley, WA, Australia

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ABSTRACT

Tasmanian early childhood services (ECS) are attempting to improve their engagement with vulnerable families and increase the uptake of universal health and education services in this population. This paper presents qualitative findings from the [name] Study, focusing on the scope and role of outreach in supporting family engagement in the Tasmanian ECS. Using an ethnographic study design, over 100 naturalistic observations were recorded in health and education ECS settings in Tasmanian communities between April 2017 and February 2018. In addition, 42 ECS providers and 32 parents/guardians with pre-school aged children participated in semi-structured interviews. Interview transcripts and observation field notes were analysed thematically, focusing on family engagement and the role of outreach across three key universal ECS. Outreach was undertaken by all services involved in this study, but varied in practice and scope. Outreach was not directed at specific population groups, but was instigated in response to an identified need with more vulnerable families to address issues of inequity in service access. Policies and strategic frameworks within services provided little or no guidance about outreach beyond procedures for conducting home visits. Attending specialised services alongside parents, a strategy adopted by one service, was particularly effective for facilitating connection to services for vulnerable families. The capacity of services to offer outreach was constrained by structured service systems, individual providers' skills and capability, resource limitations and lack of clarity with respect to policies and procedures. Outreach activities are occurring within the universal ECS system in Tasmania, facilitating engagement with vulnerable Tasmanian families and children. Flexible service systems, building the skills and capacities of service providers and clearer policies and procedures would enable services to more fully embed outreach practices within existing ECS.

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1. Introduction

Childhood is a critical time period for addressing social and health inequities across the life course (Heckman, 2011; Marmot Review, 2010). Increasing recognition of the importance of the early years for enhancing children's long-term health, cognitive and social outcomes has resulted in growing investment in health and education services designed to support young children and their families. Family engagement is vital if these systems and programs are to achieve the aim of promoting children's cognitive,

* Corresponding author.

E-mail addresses: kim.jose@utas.edu.au (K. Jose),

Cate.Taylor@telethonkids.org.au (C.L. Taylor), alison.venn@utas.edu.au

(A. Venn), Rachael.jose@utas.edu.au (R. Jones), david.preen@uwa.edu.au (D. Preen),

Paula.Wyndow@telethonkids.org.au (P. Wyndow),

mlynda.stubbs@education.tas.gov.au (M. Stubbs), emily.hansen@utas.edu.au

(E. Hansen).

physical and social and emotional development as highlighted by the Council of Australian Governments National Early Childhood Development Strategy (Council of Australian Governments, 2009) and the U.S. Departments of Health and Human Services and Education (U.S. Department of Health and Human Services and U.S. Department of Education, 2016).

In recent decades advances in neuroscience, biology, genetics and epigenetics have increased our understanding about brain development in the early years (Black et al., 2017; Shonkoff et al., 2012). These new insights have reinforced the importance of nurturing care, supportive environments and enriching experiences in the critical time windows in early childhood that affect human capability formation across the life course (Black et al., 2017; Caspi et al., 2016; Shonkoff et al., 2012). Early interventions have shown benefits for children's health, cognitive and non-cognitive outcomes (Britto et al., 2017; Duncan & Magnuson, 2013; Peacock-Chambers, Ivy, & Bair-Merritt, 2017). Supportive environments and experiences in the first years of life have the potential to influence adult health and the health and developmental outcomes of future generations (Moore, Arefadib, Deery, Keyes, & West, 2017; Shonkoff et al., 2012). Early childhood interventions may have particular benefits for children growing up in more adverse circumstances (Heckman, 2011; Shonkoff et al., 2012). Recent research has drawn attention to the multi-dimensionality of early life disadvantage (Caspi et al., 2016; Goldfeld et al., 2018; Taylor, Zubrick, & Christensen, 2019). Children exposed to multiple adversities are likely to have higher service needs, yet the inverse care law applies, and these children are less likely to receive services (Cortis, Katz, & Patulny, 2009; McArthur, Thomson, Winkworth, & Butler, 2010).

This paper will present findings about the role of outreach in facilitating family engagement with universal early childhood health and education services using data from the Australian based [name] Study. For services and programs to meet the needs of children experiencing adversity they must first engage with families. Principles of effective family engagement are centred around equity, inclusiveness, cultural appropriateness and positive goal-oriented relationships. The establishment of trusting relationships between families and professionals are central features in family engagement practice along with embedding engagement strategies within systems and programs (Southwest Educational Development Laboratory (SEDL), 2013; U.S. Department of Health and Human Services and U.S. Department of Education, 2016; U.S. Department of Health and Human Services Administration for Children and Families, Office of Head Start, & National Center on Parent Family and Community Engagement, 2018). Family engagement frameworks have been developed to assist ECS and schools track progress and build capacity for family engagement (Southwest Educational Development Laboratory (SEDL), 2013; U.S. Department of Health and Human Services Administration for Children and Families, 2018). Family engagement has been found to influence children's school readiness, influencing socio-emotional and academic competencies (Emerson, Fear, J., Fox, & Sanders, 2012; Powell, Son, File, & San Juan, 2010; Sheridan, Knoche, Kupzyk, Edwards, & Marvin, 2011) and assist in the transition to kindergarten (Smythe-Leistico et al., 2012).

1.1. Universal health and education platforms

The Australian universal health and education systems are important platforms for delivering early childhood interventions across the whole population. In 2009 the Coalition of Australian Governments (COAG) endorsed the Australian National Early Childhood Development Strategy – Investing in the Early Years. Support for vulnerable families was identified as one of its six reform priorities; 'Improving outreach and engagement with vulnerable families in supporting child development in the home and in participating in ser-

vices at all levels, especially universal health, early childhood education and care, and family support' (Council of Australian Governments, 2009, p. 28). Thus, engaging families in these services is critical if they are to achieve their goals and reduce current social and health inequities.

The Australian National Framework for Universal Child and Family Health Services lists engagement with parents and guardians as one of eight key objectives, but does not define the term (Commonwealth of Australia, 2011). The Australian Department of Education refers to parent engagement in learning as, 'parent involvement in schooling as well as a broader range of activities, including parent support for children's learning at home, at school and in community contexts—recognising the cultural and social diversity of families and communities' (Family-School & Community Partnerships Bureau, 2008, p. 1). The Australian Government has prioritised research that leads to family engagement in the early years' service system which has been described in the USA as, 'the systematic inclusion of families in activities and programs that promote children's development, learning, and wellness, including in the planning, development, and evaluation of such activities, programs, and systems' (U.S. Department of Health and Human Services and U.S. Department of Education, 2016, p. 1). Effective family engagement requires services and systems to work in partnership with families (Council of Australian Governments, 2009; U.S. Department of Health and Human Services and U.S. Department of Education, 2016).

Not all eligible families in Australia with young children access the early childhood health and education services designed to support them. For example, use of the community based child health services in the Australian states of Tasmania and Victoria declines from over 90% at the first check to less than 60% for the 3 year old check (Tasmanian Government, 2009; Victorian Auditor-General, 2011). The representation of children from indigenous and culturally and linguistically diverse families, children living with a disability and children living in areas identified as most disadvantaged enrolled in a preschool program in the years prior to commencing full-time schooling was less than their representation in the community (Productivity Commission and Canberra, 2018). Additional population groups underrepresented in the ECS system include homeless families, fathers, families experiencing mental illness and socioeconomically disadvantaged families (Cortis et al., 2009; McArthur et al., 2010). A range of factors influence engagement with the ECS system. These include individual (e.g. beliefs, psychosocial factors, perception of need), service (e.g. promotion, access, staffing skills and capacity) and system (e.g., scheduling, targeting) factors (Cortis et al., 2009; McArthur et al., 2010; Slee, 2006). Some families experience a range of complex and inter-related needs that all contribute to lower engagement with the ECS system (Doherty, Hall, & Kinder, 2003).

To break the cycle of disadvantage the Tasmanian Government's overarching early years strategy for children (pregnancy to eight years) 2018–2021 is aimed at ensuring that Tasmanian children are thriving in strong, connected communities with three key focus areas; quality, equity and partnerships (Department of Education, 2017). To achieve this, services need to be responsive to the needs of local communities and to work in ways that encourage community engagement with the services and programs that are available to them.

1.2. Defining outreach

Outreach is recommended as a key strategy for increasing engagement with families with children younger than five years of age who are not currently accessing the services and supports available to them (Boag-Munroe & Evangelou, 2012; Cortis et al., 2009; Council of Australian Governments, 2009; Marmot Review,

2010). However, there is no clear definition of what constitutes 'outreach'. It is generally accepted however, that outreach involves the provision of a service outside the usual location of that service (Wakerman et al., 2008). Traditionally, outreach has been conducted with more marginalised or 'hard-to-reach' members of the community such as homeless people, youth, drug users, sex workers or people experiencing mental illness and is a common approach in social work (Andersson, 2013; Mackenzie et al., 2011). However, outreach has also been incorporated into universal services that are designed to meet the needs of the entire population (Commonwealth of Australia, 2011; Cortis et al., 2009) and may be used to provide more specialised health services to people living in remote areas (Wakerman et al., 2008). In social work, outreach is considered a process that focuses first on building relationships (i.e., engagement), then linking people with (or providing) the services and support they need, and finally by the provision of ongoing support (Andersson, 2013). For the purpose of this study we adopt this definition.

National Australian frameworks from health and education guide and inform the delivery of health and education services in the early years (Australian Department of Education & Training, 2009; Commonwealth of Australia, 2011), while responsibility for funding and delivering services largely lies with State Governments. Hence, while services in Australia are informed by the same set of guiding principles, delivery of service models may vary between local jurisdictions. This study was conducted in the island state of Tasmania, Australia (population approximately 515,000 people). Tasmanian children live in some of the most disadvantaged communities in Australia (Australian Bureau of Statistics, 2016b) and have poorer education (Lamb, Jackson, Walstab, & Huo, 2015) and health outcomes in adult life (Australian Bureau of Statistics, 2016a).

1.3. The Tassie Kids project

The Tassie Kids project was established in partnership with the Tasmanian Departments of Health and Human Services, Education and Premier and Cabinet to investigate the uptake and reach of ECS and to explore how ECS are engaging with Tasmanian families. The Tasmanian Government has established a comprehensive free universal early childhood health and education service system. These services include the Child Health and Parenting Service (CHaPS), Launching into Learning (LiL), Child and Family Centres (CFCs) and are available to Tasmanian families with children aged 0–5 years of age (Table 1) (Jenkins, Haynes, & McInerney, 2009). Despite services being free policy makers and practitioners from ECS expressed concern about the low uptake of services, particularly among more vulnerable families (Tasmanian Department of Education, 2018).

1.4. The services

CHaPS is a community-based service offering free child health and developmental checks for all Tasmanian children aged 0–5 years. The service has operated in Tasmania for over 100 years and along with developmental checks for children, provides parenting support and advice. The service aims to identify health and developmental concerns in children and facilitate access to early intervention services where necessary. If parents have concerns they can contact the service to organise an additional visit, attend an open clinic, where available, or visit their General Practitioner (GP). Child health nurses work from a variety of settings including stand-alone clinics, community health centres, CFCs and schools.

Launching into Learning (LiL) is a free program designed to strengthen the relationship between families and children and

their local primary school. The program commenced in 2007 and supports the transition to school, which in Tasmania commences with kindergarten (kinder) when children are aged 4 years as at 1st January. In Tasmania the first compulsory year of schooling is Prep (at age 5 years for most children). LiL is delivered by early childhood teachers with parents, teachers and children participating together in play-based activities that support children's physical, social, emotional and cognitive development and promote child/parent relationships. Activities offered include age-appropriate play-based activities, excursions in the local community and attendance at activities such as "learn to swim." In some schools LiL may be offered to specific age groups, pre-kinder (3 years) or babies.

In 2009, Child and Family Centres (CFCs) were adopted as a whole of government initiative to provide a single-entry point to ECS in Tasmanian communities identified as having higher needs. Twelve Centres now operate across Tasmania. CFCs offer a range of services including CHaPS, LiL, specialist early intervention services (e.g., speech therapy), parenting programs, counselling, children's activities and other services tailored to the specific needs of the community (Taylor, Jose, van de Lageweg, & Christensen, 2017). Services and supports in the Centres are provided by government, non-government organisations and by the community. All Centres are staffed by a Centre Leader, Community Inclusion Worker and Educational Officer (teacher). Additional staff include a combination of Centre Assistants, Aboriginal Early Years Support Workers or allied health workers as determined by the needs of the community.

This ethnographic study investigated family engagement in the Universal ECS in Tasmania. Outreach was identified as a strategy for facilitating engagement, but no data existed on how outreach was being implemented in the ECS nor its impact. This ethnographic study sought to elucidate the role of outreach in ECS, revealing the strategies used, extent and impact of outreach on families' engagement with the universal ECS.

2. Material and methods

2.1. Study design

An ethnographic study design was selected as it provides in-depth insights into people's views and actions with respect to their situation or location, through the collection of detailed observations and interviews (Reeves, Kuper, & Hodges, 2008). Ethical approval was received from the Human Research Ethics Committee (Tasmania) (H0016195).

2.2. Sites and services

This ethnographic study was conducted in two primary sites in Tasmania with data supplemented from two additional sites. Primary site selection was informed by data on births, socioeconomic disadvantage, service use, outcomes from the Australian Early Development Census (AEDC) (Commonwealth of Australia, 2016), presence or absence of a Child and Family Centre, logistical considerations for researchers and input from government partners from the early childhood health and education sectors. The primary sites included one rural community with a CFC (pseudonym, Distant Hills) and one suburban area without a CFC (pseudonym, River Town) as there was interest in understanding the impact of CFCs on families' engagement with ECS in different residential areas.

Distant Hills, a rural region with a population of just over 10,000 people (Australian Bureau of Statistics, 2016b), has one main township with a population of over 5000 people surrounded by a number of smaller towns. A CFC is situated near the town centre. CHaPS

Table 1
Summary of Tasmanian Universal Early Childhood Services.

Service	Anacronym	Government Department Responsible	Service characteristics
Child Health and Parenting Service	CHaPS	Department of Health and Human Services	<p>Eligibility: Children aged 0–5 years</p> <p>Community based: various settings</p> <p>Delivered by Child Health Nurses</p> <p>Screening health and developmental checks for children:</p> <ul style="list-style-type: none"> • 2, 4 & 8 weeks • 6 & 12 months • 2 & 4 years <p>Appointment based system</p> <p>One open 'drop in' session per week</p> <p>Additional targeted services available</p> <p>Eligibility: Children from 0 to 4 years</p> <p>School based</p> <p>Delivered by early childhood teachers</p> <p>Support child development, parent/child relationships and facilitate the transition to school</p>
Launching into Learning	LiL	Department of Education	<p>Play-based activities, excursions</p> <p>Parents/carers present with children</p> <p>Structured 2-h sessions</p> <p>Available during school Terms</p> <p>Number of sessions determined by each school. For schools in this study the number of sessions ranged from seven per week to once per week.</p> <p>Eligibility: Children from 0 to 5 years</p>
Child and Family Centres	CFC or Centre	Department of Education	<p>Twelve sites in Tasmania. All Centres staffed by Centre leader, Community Inclusion Worker, Early childhood teacher. Other staff vary across Centres in response to community need.</p> <p>Health, education and community services offered at the Centre.</p> <p>Operate 5 days per week</p> <p>Open year round</p> <p>Parents and children can 'drop in' at any time</p>

nurses who serviced all families in the area were based at the CFC. There were five primary schools located throughout Distant Hills, two in the main township and three situated in surrounding towns. River Town, a small (population 1000) outer suburb situated on the edge of a major urban centre has an existing community centre offering a range of services and one primary school offering LiL. The closest CHaPS clinic and another primary school were situated in the adjoining suburb, 4 km away. In Australia, the Index of Relative Socioeconomic Disadvantage (IRSD) identifies and ranks areas from 1 to 10, in terms of their relative socio-economic disadvantage using information on the economic and social conditions of people and households (Australian Bureau of Statistics, 2016b); 1 = high disadvantage and 10 = low disadvantage. Distant Hills and River Town have IRSD ratings of 1, placing them amongst the most disadvantaged communities in Australia (Australian Bureau of Statistics, 2016b).

The additional sites were two CFCs located in different regions of the state, one a town of over 18,000 people and the other a small town of just over 2000 people which serviced the surrounding rural area. These towns were also ranked amongst the lowest two deciles of disadvantage using the IRSD (Australian Bureau of Statistics, 2016b).

2.3. Data collection

Data were collected from extensive fieldwork and observations of service provider activities and in-person interviews with service provider staff and parents. These were conducted by two researchers (KJ and RJ) from April 2017 and February 2018. During this time-period KJ conducted observations, formal and informal interviews at the Distant Hills CFC on 44 days, Distant Hills LiL programs on 9 days and at the additional CFC sites on 9 days. Researcher RJ conducted observations, formal and informal interviews at River Town LiL programs on 22 days and CHaPS clinics on 12 days. All participants consented to interviews and participant observation.

2.4. Participant observation

Researcher KJ was embedded within the CFC at Distant Hills. After spending one week full-time at the centre the researcher attended the CFC on average once per week during the data collection period (April 2017–February 2018). During this time the researcher participated in a range of activities and programs for parents and children, attended CFC team meetings, and spoke informally with service providers and families. Researcher KJ also spent one week at each of the two additional CFCs. All CFC users were aware of the researcher's presence in the centre and their purpose. In addition to time spent at the CFCs, researcher KJ attended all the LiL programs offered by the five primary schools in Distant Hills. Four of these programs were visited twice and one of them once. Researcher KJ joined in activities that were programmed during the sessions and chatted informally with parents and staff. The identity of the researcher and their purpose was made known to everyone present.

Researcher RJ was embedded within River Town and spent time in a range of different sites in River Town and surrounding suburbs that provided early childhood services and supports to families who lived in River Town. These included the local community centre, CHaPS clinic and two local primary schools. During this time researcher RJ spoke informally with families and service providers and participated in activities and programs available for children and parents such as new parent groups, community outreach events and excursions. She also attended 12 LiL sessions delivered from both the primary schools, speaking informally with teachers and families who used the service. In addition, RJ attended local early childhood network meetings for services providing programs to families in River Town. These included government and non-government services service. At all locations service providers and families were aware of the researcher's identity and purpose. In addition, researcher RJ spent three days in the CFC in Distant Hills and researcher KJ attended three CHaPS clinics with researcher RJ.

Field notes were written up by each researcher after all sessions. The decision was made to an unstructured observation technique without a structured observation schedule. This is suitable for an ethnographic study that requires flexibility and responsiveness. This approach was influenced by [Wolfiger \(2002\)](#) description of the salience hierarchy where the observer records what seems important at the time. All researchers agreed that they would record date, time and place of observation, details about who was present and what was happening at the site for each session. Researchers recorded the following when it seemed relevant. Conversations between participants including specific words and phrases, descriptions of practices, non-verbal behaviours and communication, interaction between participants, emotions and characteristics of the physical space. Researchers also recorded questions about people or behaviours for future investigation and their personal responses to the events observed. When applicable they gathered artefacts such as handouts, brochures or took photographs of posters, spaces (but not of participants). These were collated with the fieldnotes. Researchers shared their field notes with each other throughout the study and this supported reflexive adaptation of future fieldnotes by individual researchers. Researchers did not attend any private consultations between service providers and families. The extensive period of observation facilitated the development of trust with participants and allowed for a greater understanding of how ECSs operate and engage with families. Current policies, strategic plans and frameworks for each of the services, where available were collected and analysed during fieldwork.

2.5. Interviews

2.5.1. Service providers

Semi-structured interviews were conducted with service providers from CHaPS, LiL and CFCs situated in Distant Hills and River Town as well as additional sites. Interview schedules with service providers were developed following discussion among researchers and project partners, some of whom were service providers. A review of the literature was also used to inform interview topics and questions. Interviews focused on the role of the service, the role of the interviewee within the service, engagement with families including outreach, collaboration with other early childhood services and barriers and facilitators to collaboration, including the impact of co-location on service collaboration (see supplementary material). Interviews were conducted on site at the CFCs, schools or clinics and lasted on average 47 min. Service managers gave approval for service providers to participate in this study and all participants provided informed written consent to participate.

2.5.2. Parents

Purposeful sampling was used to ensure that a variety of perspectives on the topic under study was represented ([Hansen, 2006](#)). In this study we were interested in the viewpoints and experiences of a wide range of parents/guardians including, first-time parents as well as parents with multiple children, fathers', variation in service use, parents/guardians whose children were about to transition to school and parents of varying ages. Extensive fieldwork facilitated the recruitment of 32 parents into this study; 15 from Distant Hills, 16 from River Town and 1 from an additional site. One parent was recruited into the study while attending an activity in River Town but was not formally interviewed as they did not live in the River Town community.

In Distant Hills researcher KJ approached parents or guardians during attendance at an ECS activity, such as the CFC or LiL session. This approach occurred after participating informally with parents/guardians and children in programs offered on site.

Recruitment was also assisted by LiL teachers and CFC staff who discussed the study with families or assisted with identifying families for inclusion. Participants were given a choice of interview location. All interviews took place on site at the CFC or the local schools.

In River Town researcher RJ initially spent time at the community centre attending programs for families with young children. Two participants were recruited from the centre, with one interview occurring at the participant's home and the other at the centre. RJ also spent time at LiL sessions held at the local primary school, talking informally with parents and teachers. At this site school staff approached families about being involved in the study following discussions with the researcher about the aims of the study and range of families required for the study (e.g. parents with one child, parents with more than one child, single and partnered parents). The school then scheduled interview times with researcher RJ. All these interviews took place on site at the school.

Interviews with families focused on parenting experiences, use and experience of ECS and avenues for accessing parenting support when needed (see supplementary material). Parent interviews averaged 32 min.

2.6. Data analysis

Interview audio-recordings were fully transcribed by a professional transcription service and any relevant interview field notes were attached to the de-identified transcripts before being imported into the qualitative data analysis software program NVivo 11 (QSR International 2012). Data were then analysed thematically using an iterative process that utilised coding and the constant comparison technique ([Grbich, 1998](#)). Transcripts underwent an initial preliminary analysis soon after the interview was conducted so the researchers could take insights from that interview into any subsequent interviews. Subsequently the researcher who conducted the interview would read and re-read within and across transcripts and code them focusing on families' engagement with ECS, the role of outreach and how outreach was conducted across the three different services. Policies, strategic plans and frameworks for each of the services were also reviewed for references to outreach or practices that could be considered outreach.

Initial codes were developed from the data (a type of open coding) and included many in vivo codes. Following a process of compare and contrast the codes were then sorted, refined and regrouped into higher order conceptual categories. Coding decisions, key concepts ideas and reflections were identified and recorded in the project log and memos ([Cresswell, 2007](#)). For the purpose of investigator triangulation and to encourage reflexivity the first author met the other members of the ethnographic research team to review project memos, compare coding and refine the analysis ([Finlay, 2002](#)). Any disagreements were resolved via discussion. The first author then regrouped the codes and initial themes into the larger thematic categories presented in this article. These were reviewed by the group and finalised. Analytic narrative vignettes were also developed to illustrate key elements in outreach work ([Hansen, 2006](#)).

3. Results

The following results include a summary of study participants and an overview of outreach in the three services before presenting the key themes of: (a) addressing inequity and responding to the needs of families; (b) outreach strategies, purpose and benefits; (c) parents experience of outreach; and d) the principles that underpinned outreach. Differences between services are high-

Table 2
Participant characteristics.

Parents, N	32
Gender	
Female (%)	87.5
Age (average, range)	33 (18–56)
Parent age first child (years)	
First child < 20	9
First child > 35	4
First child 20–35	19
Number Children First Interview	
One child	6
Two/three children	19
More than three children	7
Average number children	2.7
Age of pre-school aged children at first interview (years)	
<1	3
1–3	28
4–5 (transition to school)	10
Number of services used (self-report)	
Multiple	21
CHaPS only	3
LiL only	8
LiL and CHaPS	8
Family Structure First Interview	
Single parents	10
Partner	22
Education	
Year 10 or less	17
Year 11/12	10
Certificate	3
Batchelor	1
Service providers, N	42
Gender	
Female (%)	100
Age, years Average, range	49 (31–74)
Educational attainment	
Certificate	7
Batchelor	35
Early Childhood Sector	
Health	13
Education	29
Timing working early childhood sector Average, range years	13.4 (0.3–54)

lighted where these exist. All names used in the presentation of the results are pseudonyms.

3.1. Study participants

Forty-two service providers and 32 parents were recruited into this study with 73 interviews and 100 observation sessions conducted across the two primary sites and two additional sites.

Service provider participants included early childhood service providers from each of the three services and included child health nurses, nurse managers (CHaPS), allied health providers (CHaPS, CFCs), early childhood teachers (CFC, LiL), CFC Leaders, Community Inclusion Workers, CFC Assistants and Aboriginal Early Years Support Workers (CFCs). All service providers were female and the time spent working in the early childhood service sector ranged from <1 to >50 years (Table 2).

The majority of parent participants were female (87.5%) and living with a partner (69%). Family structure ranged from those with only one child (19%) to those with more than three children (22%) with a median of two children. All parents had one child currently aged less than five years. Parents reported used ECS services with varying frequency and regularity. All parents had access to CHaPS and LiL services, but only those living in Distant Hills or the additional sites had access to CFCs (Table 2).

Based on observations and interviews all services were conducting outreach, but strategies varied across the three services as will be discussed below. The timing of outreach activities with respect to the age of the child also varied across the three services. CHaPS nurses conducted most of their outreach activities in the first 4–6 months following birth, supporting new parents around specific concerns such as infant feeding, sleep and maternal mental health. LiL teachers offered outreach activities to older children as they approached the age where they would start formal schooling (i.e. kindergarten, 3–4 years). CFC staff offered outreach to families with children of all ages.

Outreach was more embedded within the scope of practice of CFC staff than LiL or CHaPS with observations indicating that 30–50% of the work undertaken in CFCs could be categorised as outreach. In contrast, CHaPS and LiL service providers offered outreach to families in extraordinary circumstances, when service providers were concerned about the child or family, and when resources allowed. None of the services routinely collected data on 'outreach' activities although CFCs recorded details about transporting parents and some details of parent contact. Routine CHaPS data collection would indicate if appointments were conducted at home or in clinics. Parent participants who received additional support from services were generally not aware that they were the recipients of 'outreach'.

3.2. Addressing inequity and responding to the needs of families

Outreach was considered essential for addressing concerns about inequity of service access and use, "For us it means, doing whatever it is to enable every family to have the same opportunities (CFC)."

There was broad agreement between providers from all services that some families were 'vulnerable' and living in more complex social circumstances than others. Outreach was frequently undertaken with vulnerable families. Families were identified as more vulnerable when they were connected with the child safety system, experiencing domestic violence, mental health issues or drug and alcohol problems, were new arrivals in Australia or had specific child health concerns (i.e. premature birth). Parental mental health issues, including severe social anxiety, were identified by many providers as contributing to the need for outreach activities

For me, the biggest client base for people that need outreach from my perspective are the ones who do suffer anxiety disorders. They find coming into a centre – they might be able to come once a week, and it takes them the rest of the week to recover. (CFC)

Outreach services were undertaken across all services in response to identified needs and was not focused on specific population groups.

CFCs had a broader focus on working with the family, identifying their needs and working with them to support the health and wellbeing of young children. A considerable proportion of outreach work undertaken in CFCs focused on engaging with vulnerable families who may not be accessing ECS

It would be the families that we hear and know of that wouldn't otherwise come without having had a prior relationship with someone where they feel supported to come or that we have to build that relationship before they are feeling ready or able to access anything for their children. (CFC)

For all services, a decrease in attendance at an activity by a child or family would instigate outreach strategies to determine if the child and family needed assistance.

Table 3
Outreach activities and purpose (engagement, connecting, ongoing support) for each of the universal services, verbatim quotes.

Outreach activities	Service	Purpose	Example
Home visits	CHaPS LiL CFC	Engagement Connecting or providing the service themselves Ongoing support	<i>So, I'll go and do home visits and take – educational games and toys, and that's really just an excuse to keep that connection, we talk about what's good about these games, why the kids are playing them. (CFC)</i> <i>I was already doing the universal home visit and things were quite intense at that time . . . and I was like, "Oh, well, I'll pop round next week if you'd like me to." It's never you have to. It's an invitation. (CHaPS)</i> <i>I go out, usually to [Town], and visit some families. We probably would have more at risk families living up there. . . I always go in with a big box of puzzles and games and sorting things and things to draw with and books. (LiL)</i>
Phone calls	CHaPS LiL CFC	Engagement Connecting Ongoing support	<i>So we start with a phone call and offer a visit with a toy bag, and then we can do that for as long as that parent's comfortable doing that . . . a year or two before saying, "All right then, I might as well come and see what that playgroup is all about." So that's the value of that. (CFC)</i> <i>I can do phone consultations if need be with someone if they're further away. (CHaPS)</i> <i>Initially a lot of it is phone calls. So if they've been coming along this year, at the beginning of next year making that contact with them. (LiL)</i>
Attending appointments/services with families	CFC LiL	Connecting Ongoing support	<i>Some of the outreach stuff that I do is go out to playgroup and things like that [LiL] where people are accessing another service or where I can help them connect to another service. . . you're actually taking people and connecting them to something else. (CFC)</i> <i>We've had situations here at school where teachers have gone along to doctors' appointments with the parents . . . because they just haven't got the capacity to sit with a doctor and deliver the information that the doctor needs to hear, to then help their child. (LiL)</i>
Facebook	CFC LiL	Engagement	<i>Facebook is a really good tool for engagement, but again it tends to be accessed by the families who are sort of ticking along better than some of the other families. (CFC)</i>
Transport	CFC	Engagement Connecting Ongoing support	<i>Sometimes people will tell me things in the car that they might not say when they're here, they're just chatting about things. (CFC)</i> <i>Then we're going to be able to transport them which is another amazing facilitator of outreach for us. It's hugely important. (CFC)</i>
Connecting with community	CFC LiL	Connecting Support	<i>Like I said with one of those families they wanted to be involved in the community more, the Aboriginal community more. (CFC)</i> <i>We took the children to the dentist. The parents didn't know that it was a free service. . . it was a big event for some of the children. (LiL)</i>
Other e.g. Texting/SMS	CFC CHaPS	Engagement Connecting Ongoing support	<i>A lot of text messages because they won't answer the phone. . . if I don't get a response . . . [after one week] I will give them a buzz and I will get [staff] to come in the car and we will just go and check on them. (CFC)</i> <i>I feel like a stalker a lot of the time. . . I do chase them. I've learnt that. Like I'll chase them. . . If I'm really concerned about them I might send them four or five texts. (CHaPS)</i>

3.3. Outreach strategies, purpose and benefits

Outreach strategies varied according to the needs of families and service capacity and could be categorised as focusing on: (1) engagement, (2) connecting families with services and (3) provision of ongoing support. The specific strategies used included home visits, phone calls, attending services with families, Facebook and other social media, transport and connecting with the community. The strategies, who offered them, their category along with examples are provided in Table 3 and described in more detail below.

3.3.1. Home visits

CHaPS receives notification of all births in Tasmania and an initial visit is offered to parents, typically within the home, within the first two weeks.

Most of the time when we first engage with a family, it will be through the home visit that we do. . . If they don't pick up, we send a text message and if you've done a few attempts to contact, then we assume that they are choosing not to engage; so obviously it's not a compulsory service, so we let them go without annoying them too much. (CHaPS)

Additional home visits were offered to families they perceived to be more vulnerable or where they had identified concerns; for example, a new parent with limited social support and baby not settling. Nurses frequently make home visits alone, but nurses located at CFCs reported undertaking home visits with Centre staff on occasions. LiL teachers were less likely to make home visits. However, three (23%) of the more experienced teachers did visit people's homes. The frequency of home visiting varied between the CFCs with, staff in one CFC not conducting home visits while staff in other

CFCs conducted home visits weekly. Some CFC staff had regular 'door-stop' interactions with families

I can remember there's a couple of families, they'd been three years doing [activity] every week, catching up at the doorstep, sometimes coming in, relationship building. . . Three and half years later, they're coming in here for a small group. (CFC)

3.3.2. Phone calls

Phone calls with parents was a critical outreach strategy for all services. In addition to using phone calls for providing information about services and programs CHaPS nurses used phone calls to follow-up with families after clinic or home consultations and CFC staff used phone calls to engage with families identified as needing additional support. They were often undertaken by more experienced staff with details about contact frequency and any follow-up tracked.

So, with [Mother], we've done [child program] – she's come to the Centre, she's had a worker, but then I rang just on Friday and the worker hasn't been in contact for nine weeks, so now I will follow that up and our action now is just to keep in touch randomly, not intensively, and keep her on Message Media so that when new programs come we can [contact] her. (CFC)

3.3.3. Attending services with families

Attending other services with families to provide support, advocacy, social integration, transport or other support deemed necessary by parents was commonly undertaken by CFC staff. This included attending appointments with medical specialists, child safety meetings, other service providers and attending LiL sessions with families.

Table 4
Impact of outreach activities.

Outreach activity	Experience and outcome	
	Parent and/or child	Service provider
Home visit	[CHaPS nurse] got assigned to these guys (twins). . . a nurse was able to – had to come out to my house and thankfully for her, she was able to come out weekly and just give me advice and check on them as well as – sometimes she'd have to go a little bit out of her way to give me that extra help with them. . . she did the usual things that nurses have to do, like weigh them and check their feeding and make sure that they're ok. But a couple of times, she'd just sit there with me and listen to me. (Mother, twins)	I had another little one . . . They didn't attend the clinic for this little one's eight-week check and I went and did a home visit after the two missed appointments at 11 weeks and I unwrapped the baby and the baby was physically starving and just had – yeah – in very poor shape but mum had been breast feeding quite successfully up until four weeks. (CHaPS) Most of them I do are the ones that don't have transport and they just can't come. So if I didn't go out and sit down with the children – so the families with kinder age children, I'll go out. We'll do some counting activities and I'll say, "Right. This week we're concentrating on counting to five." (LiL) Just to make the people who are not attending any early years programs, to get them into the centre. I've worked with one family for twelve months in the home, home visits every week, and then finally get them into here, and then to the school. It's a really big process . . . (CFC)
Phone calls	Well that was really good because it was like they (CHaPS) contacted me and that's really good. If it was left up to me I'd probably procrastinate or not have time to look up, who do I have to get in touch with? . . . it was really good that they rang me, text me as well, came out to my house then made the next appointment to be in here so that was good. . . it made it so much easier. (Mother, one child)	How are we going to engage them? And we'll give them a phone call, another phone call, another phone call, and then we'll start to text them as well when things are on and just hope that the regular contact might – and you know, some we can't engage and that's OK. (CFC)
Attending service with family	If I have a problem with anything . . . they almost go out of their way to try to solve it, either talk to a teacher or work it around how we feel. . . They think outside the square and they've got everything sorted . . . And they sorted it out for [child] about okay what time, they watch him. (Mother, two children)	So next week she'll be taking them to pre-kinder and hopefully that will be enough to get them connected. But it's really challenging and it's not just let's try once and see how it goes, it's being for that family I think we've tried about 10 times. (CFC)
Transport	Transport's always the issue living out here without a car . . . (Father, one child) Transport, they've (CFC) helped me out with heaps. (Father, five children)	It might be picking them up to take them to [service] for their [session] and then taking them straight home, they might not even come in here, which we do for one family. So it's connecting on their terms at the time that they . . . need it most. (CFC)
Facebook	I check out the [CFC] Facebook page, and see what's going on down here, we don't always make it down here, but sometimes we do, we try to. (Mother, one child)	I know there's something sitting in our inbox (Facebook) . . . I need to follow that up. So "hello I've just seen your post regarding First Aid, I would like to register to attend". So now I need to follow that up. (CFC)
Community activities	[At the CFC] we talked about things around the community. I didn't even know anything about the community health. And I found out a lot about that, which is fantastic, I didn't even know existed. Didn't even know there was a [service] up here, an actual – which is good. (Mother, two children)	And a parent in the pre-kinder – she goes to some of the LiL programs, and also comes to pre-kinder, said 'I'm going along to the library in town'. And what a wonderful thing. (LiL)

That's why we do go to support them, they have a friendly face that they know. . . because we know when they start going to LiL or kinder if there's not a strong friendly face with them, they're just not going to go. So, we'll go and stick by them like glue for the first few times, . . . so that they start to build relationships with other people in the kinder, and then hopefully be able to withdraw support until they can do it on their own. (CFC)

In contrast, LiL teachers indicated that they occasionally attended appointments with families and CHaPS nurses referred families to services but did not attend with them.

3.3.4. Transport

Many of the families had no access to private transport and public transport in all sites was limited. Every CFC had a car and Centre staff were able to transport parents and children from their homes to the CFC or use the car to transport parents and children to appointments.

3.3.5. Facebook and other forms of communication

Social media, such as Facebook was used by CFCs and LiL to communicate with parents about what activities were on, advertise new programs and communicate about changes to scheduling. Some CFCs used Facebook to communicate with parents about the connection between children's play-based activities at the CFC and developmental outcomes. Hence, reinforcing learning and making direct connections between activities

offered at the CFC, parent/child interaction and children's development.

CFCs adopted the broadest range of outreach strategies, including social media (e.g., Facebook), transport, meeting parents in community settings, text messaging and linking families to other community services and support. Some of these strategies focused on facilitating engagement and providing ongoing support while others linked families with the services and supports available to them and their children. CFCs and LiL services were not provided with notification of births in their area and at the time of this study there was no formal mechanism for sharing information between ECSs from health and education. Consequently, providers from CFCs and LiL adopted a range of strategies focused on engaging with families.

3.4. Parents' experience of outreach

Parents were generally unaware that they were receiving 'outreach' services, although some parents were aware they were receiving or had received support from a service that was beyond usual care. Parents valued the extra support and reported the positive impact of services providing them with additional support at times of greater need (Table 4). These included: listening to them, making the appointments for them, providing transport, knowing what was going on in the community through social media and finding out about other services they could access.

Families valued all forms of outreach activities, but the capacity of CFC staff to connect families to other services by attending sessions or appointments with them appeared a particularly valuable strategy for some parents.

3.5. Key principles underpinning effective outreach

While outreach was conducted in response to an identified need, it was observed that these activities were purposeful with clear goals and objectives related to engaging, connecting families with services or provision of support. The planned nature of these activities was evidenced by the formation of a cross-site outreach group by one CFC with representatives from the four local schools, non-government and specialist. This group met once per term and aimed to ensure all families were connected with the services they needed, prevent duplication of support provided and link families to their local school in the year prior to children commencing kindergarten.

Some strategies focussed on providing information about programs and activities while others aimed to enhance engagement and build relationships with families. Other outreach strategies were directed towards delivering or connecting families to services. Outreach activities focusing on engagement and building relationships typically required a commitment of time and the capacity to work in partnership with families, allowing families to set the pace for interaction. Principles that informed outreach approaches included being consistent, reliable, flexible, responsive, and persistent. These key elements of outreach and principles built trust with families and are illustrated, respectively, in each of the four vignettes for each of the services (Box 1).

Factors that constrained services' capacity to provide outreach included inflexible schedules, staffing levels, resourcing, staff capability and skills, lack of clarity around policies and procedures, personal safety concerns and time restraints. Structured service delivery models and staff capacity were the most commonly discussed reasons limiting outreach. These constraints operated across all services, but were more evident for CHaPS and LiL services due to their structured, appointment or program-based service delivery models; "We went and did a home visit yesterday to another [Mum] and I didn't have the capacity to do another home visit next week because my calendar's full (CHaPS)."

CHaPS nurses discussed being booked out for the next month, impacting on their capacity to respond to the needs of families as they arose.

Some service providers identified a lack of specialised skills in this area as limiting their capacity to respond and support families and children in this way; "I don't feel specially qualified to understand how to make relationships with all people, I'd really like a little bit more knowledge about how I can do that (LiL)."

Developing the skills and capacity of staff with respect to outreach was also identified as a challenge for services.

I realise this week that we had one of the service providers come to say that one of the families was really put off. . . 'cause you've invaded my space and I didn't ask you to. Which made me start to think well you assume that people understand about outreach but I realise now that they don't. . . we're now going to have to start to look at all the staff and talk about what outreach means. (CFC)

3.6. Review of policy, strategic planning or framework documents

Not all service policies and procedures were accessed for review and not all services had current strategic plans or frameworks. After reviewing what was publicly available, out of the current or most recent policies or strategic frameworks and plans for the three ser-

vices only two references to outreach were uncovered and both of these were in CHaPS documents. None of the documents defined outreach or provided any guidance about the provision of outreach nor possible strategies. The Department of Education procedures guide for conducting home visits noted that home visits may be conducted to build relationships, breakdown barriers and support learning (Tasmanian Department of Education, 2012). However, the guide focused on the process of conducting home visits from a staff safety perspective. An initial home visit was embedded in CHaPS routine service delivery model, but additional visits were considered outreach. The review of policy and procedure documents found no explicit restrictions on outreach.

4. Discussion

This study found that, while variable in practice, all ECSs in Tasmania were offering outreach activities as part of their universal service system and that outreach strategies were facilitating engagement with more vulnerable families. In line with the universal service model, service providers did not target specific groups within their local communities. The focus was on increasing engagement with all families presenting as vulnerable or for whom access and engagement with their service was limited or had decreased. Importantly, despite outreach being offered by all services, and comprising a significant proportion (30–50%) of CFC activity, a documentation review revealed that there was no guidance about the role of outreach in the practice frameworks for any of the three services resulting in a lack of clarity for service providers about the role of outreach within their practice.

Mackenzie et al. (2011) outlined a continuum of complexity that might lead to non-engagement in preventive health services. This engagement continuum ranged from lack of knowledge of a service to multi-faceted and interrelated psychosocial and structural challenges. Extending this typology by incorporating the perspectives of members of the Traveller Community, Lhussier, Carr, and Forster (2015) identified three levels of engagement; behavioural, cognitive and emotional. These led to the outreach outcomes of participation, behaviour change and building social capital. Building trusting relationships was identified as critical for facilitating behaviour change and social capital outcomes. In contrast, participation or 'behavioural engagement' in less complex preventive activities such as vaccination or screening was less dependent on significant levels of engagement with the provider. Boag-Munroe and Evangelou (2012) recommend that services respond to complexity by taking responsibility for reaching out to families in innovative ways, adopting flexible approaches while remaining consistent and ensuring the sustainability of services.

The ECS in this study were adopting a range of outreach activities (i.e., phone calls, SMS, social media, transport, home visits and attending programs or appointments with families) to facilitate cognitive and emotional engagement for the purpose of influencing behaviour and facilitating social change. None of the strategies were identified as preferable over another. Outreach strategies were adopted that met the needs of families and reflected the purpose and capacity of services. Some of the outreach strategies identified in this study; phone calls, messaging on mobile phones or direct contact have been shown to improve childhood vaccination rates (Harvey, Reissland, & Mason, 2015; Jacobson Vann, Coyne-Beasley, Asafu-Adjei, & Szilagyi, 2018). Directed discussion during health visits or education screening has been found to increase registration for child health insurance in the USA (Gordon & Dupuie, 2001; Jenkins, 2018). However, services in this study considered behavioural engagement the first step in the engagement process rather than the primary outcome of outreach activities. As Andersson (2013) outlined, outreach was considered a process that

Box 1: Outreach vignettes for the ECS.*Vignette 1 – CFC*

A young mother called Amy and her preschool aged daughter often played in the park next door to a CFC. CFC worker Rose would see them walking past and began chatting with Amy. Over several months she continued to chat over the fence between the park and the CFC or in the street until Amy and her daughter began attending the CFC. After some time, Amy told Rose that she was experiencing family violence at home. Rose offered to provide help if it was wanted and several visits later Amy asked Rose for her help. She was referred to the community social worker, Child Protection services were notified and a Safe Families support worker allocated (family violence response). Rose provided transport for Amy while she was attending meetings with various services. One morning when a researcher was present Rose was taking Amy and her daughter to an appointment with the Safe Families worker. Rose was intending to care for the little girl while Amy met with the worker.

Vignette 2 – CFC

Louise and her youngest child both found public settings challenging and experienced anxiety in new situations. Louise was particularly worried about taking her daughter to pre-kindergarten sessions and hated to think about her starting kindergarten the following year. CFC staff recognised that *'the pre-kinder model wasn't going to work for her in front of the other families'*. CFC staff negotiated access to the kinder space for Louise and her daughter outside regular pre-kinder sessions, enabling Louise to attend alone with her daughter, the key worker from the CFC and the kindergarten teacher. The CFC staff member gradually withdrew from the sessions as Louise and her daughter became more comfortable. Louise knew this was not the standard approach for preparing children for kindergarten and was grateful that the CFC and school had worked to find a solution that worked for her and her daughter. Louise recalled *'It has worked, I would say we're lucky we've got such a great team that are open-minded and do come up with ideas like this, . . . that's clever.'* CFC staff described to a researcher how they had *'set a goal, as a team – this is what we're aiming to do by this point. How are we going to do it?'* and worked towards that.

Vignette 3 – CHaPS

When Amanda, the child health nurse, started in her current role she learnt about a family who lived remotely and who had been difficult for the services to engage. When Amanda arrived, the family had three other children and new baby and it was hoped that a new CHaPS nurse might be able to engage more easily with the mother than the previous nurse. Amanda made a home visit for the new baby and felt that she and the mother were getting on well. Subsequently Amanda *'did a couple of home visits, so she didn't have to come to us'*. She realised that the family was struggling to access food so Amanda asked her manager if she could take out food from the CFC Food Bank *"so she can see what's available"* if you come into the CFC and work with the staff there. This was approved and Amanda took food with her on next home visit. Amanda recalled that she *'worked with [the mother] for quite a bit and we ended up, she would come in here. The youngest child had all his checks, and more.'* The family became linked with the CFC and the older children began attending the dentist and accessing the learning support services they required.

Vignette 4 – LiL

Sharon who lived locally with six children had limited mobility and speech. Angela, the LiL teacher already knew of the family as she was supporting one of Sharon's older children who was attending kindergarten. Angela was aware that there were younger children at home hoped that Sharon could be encouraged to attend LiL sessions. She initiated contact by sending notes home outlining the LiL program. She sometimes also telephoned or visited Sharon in her capacity as support teacher *"I didn't stay long, and we just chatted outside . . . it was a very long, slow process"*. Angela *'found that being there, talking personally was so much easier'* than other forms of communication due to Sharon's speech issues. Eventually Angela discussed bringing the younger, preschool aged child to LiL. Sharon was unable to drive so Angela organised transport for Sharon and her child on the school bus. Eventually other local families offered Sharon transport home. Sharon is now attending LiL regularly and her son recently received a certificate in assembly for coming every week. Angela reflected that *'you have to be a little bit deliberate about those things, that was the way to do it'*.

extended beyond contact making to connecting people with the services and supports they need and providing ongoing support.

To our knowledge there is no literature demonstrating the effectiveness of outreach in the early years education sector. However, a recent review of supported playgroups (i.e., groups designed to support families with young children who are disadvantaged or marginalised in order to enrich children's early learning and developmental opportunities) found that mobile playgroups were provided to families living in remote locations in Australia (Williams, Berthelsen, Viviani, & Nicholson, 2018). Notably, the term 'outreach' was not used to describe this model of mobile supported playgroups possibly indicating that outreach is a concept more commonly used within the health and social sectors.

Sustained engagement and connection to early childhood services for some families in this study required more extensive outreach approaches such as, home visiting, transport and attending services with families. Home visiting programs for parents with particular support needs have been found to improve parenting quality and child development (National Health & Medical Research Council, 2017). Improving access to health care for homeless people was most effective when there was an orientation to health clinics not just referral and the provision of information about services and processes (Jego, Abcaya, Stefan, Calvet-Montredon, & Gentile, 2018; Toole, Johnson, Aiello, Kane, & Pape, 2016). These intensive outreach approaches are often incorporated into

targeted programs and services. In this study, the capacity to incorporate these approaches into the Universal service system was impacted by systems level factors as well as staff skills and capability.

The lack of literature from education sector on outreach in the universal service system may explain why there is little guidance around outreach in education practice frameworks. The new model of place-based ECS delivery offered through CFCs has enabled outreach to become a significant part of their practice, but policies and frameworks are yet to reflect this new role. The incorporation of an initial home visit into the standard service schedule for CHaPS made it difficult to differentiate between usual care and outreach in this service. But the additional home visits offered to families identified as requiring additional support were evidence of CHaPS nurses providing enhanced support through outreach.

The development of outreach guidelines or an outreach framework would make the outreach work currently undertaken across the ECS more visible and assist in identifying the resources and skills required to undertake this work. Outreach guidelines need not be prescriptive but could emphasise the different elements and purposes of outreach and include the key principles that were identified in this study (i.e. flexible, responsive, persistent). Staff training, and resources are also critical if outreach work is to be incorporated into service delivery models. Case studies reflecting best practice and different strategies could be incorporated. Making

outreach work more visible would assist with determining when to adopt outreach and with whom, making it easier to capture the impact of outreach on families and children. Capturing more accurate outreach data would also provide evidence of the financial and human resources required to perform outreach which could then be used to advocate for additional funds to address unmet need.

This study has some limitations. Researchers did not each have the same degree of access across all services and sites. Not all service policies and procedures were accessed for review and not all services had current strategic plans or frameworks. However, the policies, frameworks and procedures accessed were reflected in observations and service providers discussions about outreach. Researchers may have missed outreach activities undertaken during private consultations or away from key sites or not captured the range of activities undertaken in each site and service as they were not always present. It is possible that researcher's may have misinterpreted the purpose of some activities observed as they were not always able to discuss these with those involved. Researchers were not always aware of issues within the broader community nor system initiatives being experienced across the services that may have impacted on activities in the services.

5. Conclusions

To our knowledge this study is the first to investigate outreach activities being offered throughout the universal ECSs in an Australian setting. Outreach was occurring across all ECS to facilitate engagement with more vulnerable families and connect them with services and supports, but this work was not reflected in current service policy or practice frameworks. The implicit role of outreach in ECS means that it is difficult to capture its impacts and ensure it is adequately resourced and supported. The development of outreach guidelines would assist in clarifying the role of outreach in ECS services, making this critical work more visible and recognising its value in facilitating engagement with more vulnerable families.

Author contribution

KJ contributed to study design, data collection, data analysis and interpretation and writing of this manuscript. CT contributed to study design, data interpretation and writing. RJ contributed to data collection, analysis and writing. AV contributed to study design, data interpretation and writing. DP contributed to study design, data interpretation and writing. MS contributed to recruitment and data interpretation and writing. PW contributed to interpretation, writing and editing. EH contributed to study design, data analysis, data interpretation and writing. All authors read and approved the final manuscript.

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Conflict of interest

None.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <https://doi.org/10.1016/j.ecresq.2020.05.006>.

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