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SUBMISSION

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FRSA Response to Department of Social Services Discussion Paper 2020: Families and Children Services

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INTRODUCTION

ABOUT FRSA

As the national peak body for family and relationship services, Family and Relationship Services Australia (FRSA) has a critical leadership role in representing our extensive network of Member Organisations to support their interests and the children, families and communities they serve across Australia. FRSA plays a significant national role in building and analysing the knowledge and evidence base relating to child and family wellbeing, safety and resilience. We undertake research and work with government and non-government stakeholders to inform policy and shape systemic change. FRSA's vision is that the wellbeing of all children, families and communities in Australia is supported and protected.

FRSA has 165 members. This includes 135 providers of programs under the Families and Children Activity (FaC) and the Family Mental Health Support Services (FMHSS) program.

FRSA RESPONSE TO THE DISCUSSION PAPER

Our response to the Department of Social Services (DSS) Discussion Paper is informed by:

- The experience and wisdom of our members, many of which have been providing services to Australian children and families for over 60 years.
- Consultation sessions with FRSA providers of FaC programs (January-February 2021)
- FRSA members' written commentary and feedback on the Discussion Paper
- Prior written submissions to a range of inquiries and review processes about family and relationship services.

The DSS Discussion Paper refers to proposed reforms to the FaC Activity. The stated objective of the reforms is to 'improve and measure outcomes for Australian families and children'. While the discussion paper does not canvass high level structural reforms, it does call for a stronger focus on outcomes and suggests a number of improvements aimed at ensuring funded services remain capable, accessible, collaborative, accountable and adaptable to external impacts.

FRSA's first observation is that the shift in thinking from outputs measurement to outcomes measurement commenced some time ago. A key point in the evolution to a stronger focus on outcomes was 2014, when DSS approved a project logic for FaC that incorporated a high-level aim, service activities, inputs, outputs, service quality outcomes and immediate, intermediate and long-term outcomes for individuals, families and communities. The introduction of DEX and SCORE standardised an approach to outcomes reporting by identifying common data fields and data items across a number of outcome domains. As DEX and SCORE were rolled out, DSS provided guidelines and training for outcomes measurement. Over those early years FRSA also provided support to members on understanding and accessing evidence and sharing information and expertise about outcomes measurement tools. While the sector has now embraced DEX, SCORE and the Partnership Approach, a full picture of outcomes attributable to FaC Activity is not yet available.

The Discussion Paper presents an opportunity for the FaC sector to embrace the next stage of developing that picture. FRSA is pleased to see DSS's acknowledgement that output data alone is insufficient; to that we would add that quantitative data on its own, even if it is measuring outcomes, is also insufficient. The development of a new Outcomes Framework is an opportunity to ensure that the aims, objectives and outcomes attributable to the FaC Activity, and the indicators associated with these, are clearly identified, articulated, measurable and applicable to clients. We are pleased to have this opportunity to contribute the insights of FRSA members to that process.

Our second high-level observation is that it is critical that development of a FaC Outcomes Framework be in alignment with related social service objectives and outcomes frameworks – notably DSS's own high-level aims and outcomes,[1] and the next iterations of the National Framework for Protecting Australia's Children and the National Plan for Reducing Violence against Women and their Children.

Finally, FRSA recommends that all improvements and changes proposed under the four other reform objectives canvassed in the discussion paper are considered *systemically*, i.e. acknowledging and intersecting with the broad range of other government and community activity focused on the wellbeing and safety of children, young people and families.

FRSA will respond to the discussion paper in three parts (answering discussion paper questions as they relate to each part):

- **Part 1:** feedback on the proposed **outcomes** and their relevance to the four key aims of the FaC program and the aims and objectives of broader government and non-government aspirations for child and family wellbeing.
- **Part 2:** through the lens of client outcomes, comment on the four recommended **improvements** (certainty and accountability; targeting and accessibility; collaboration and coordination; and capability and innovation).
- **Part 3:** feedback on the impact on service delivery and client outcomes of **recent events**, notably the coronavirus pandemic and natural disasters (bushfires and flood), implications for future service delivery/prioritisation/outcomes.

[1] We note that in July 2020, DSS consulted with the broader community services sector on strengthening outcomes driven performance management for the delivery of DSS-funded programs. We have been advised that the findings of the departmental-wide strengthening outcomes work align with the direction of the FaC Activity consultation, but no further information has yet been provided.

SUMMARY OF RECOMMENDATIONS

That DSS:

1. Group the proposed outcomes according to outcome domains:

- **Safety**
- **Social and emotional wellbeing**
- **Learning and development**
- **Resilience**
- **Relationships**
- **Community connections and participation**

2. Reword the individual outcomes so that they are more clearly *outcomes* (not strategies or indicators) and better align with outcomes already incorporated into DEX, SCORE, and service provider's program descriptions, and with high level aims of the National Framework for Protecting Australia's Children.[2]

3. Revise the page 13 diagram to reflect the outcome domains applying to all four cohorts (children and young people, adults, families, communities), and rephrase the individual outcomes to better align with those used in DEX and SCORE (see suggested rewording in Attachment 1; and possible diagram alternatives at Attachments 2 and 3).

4. Provide comprehensive training, including online workshops, and ongoing support for services using, or about to enter into, the DEX Partnership Approach. Support to include training on the use of validated outcomes measurement tools and their translation into SCORE.

5. Expand the range of reliable and validated outcome measurement tools for translation into SCORE.

6. Improve DEX's report generation capacity, so that services using the Partnership Approach have access to community reports e.g. to enable data-informed conversations between CfC FPs and CPs about the collective impact of their services and to address local needs and barriers to access.

7. Take account of and learn from services' other assessments of outcomes, whether they be anecdotal, evaluation-based or measured with tools incompatible with DEX.

8: After the FaC Outcomes Framework has been developed: Develop a Program Logic template that can be adopted by services that do not yet have a program logic *or* modified so that it can be readily adapted to existing program logics.

9: Allow a realistic transition time for services to adopt or adapt the new Program Logic template and provide resources and training opportunities to assist that transition.

[2] Based on the current Framework
https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf

10. Confirm ongoing funding to CaPS and BBF post June 2023, to align with the new CfC FP grant period (i.e. to June 2026) *regardless of the nature of the 'integration' of CaPS and BBF with CfC FP.*

11. Ensure that the ACOSS principles for monitoring, evaluation and performance improvement[3] are reflected in the final outcomes framework.

12. Facilitate workshops for the purpose of developing the full outcomes framework once the high-level outcomes have been finalised.

13. Maintain direct funding agreements with small organisations and continue to support diversity of services across the FaC spectrum.

14. Clarify its rationale and intentions for proposing an integration of BBF and CaPS with CfC FP, including clarification of the benefit to client outcomes.

15. Provide clarity about what integration of CaPS and BBF with CfC FP would look like.

16. Detail the funding mechanism for the proposal to integrate CaPS and BBF with CfC FP, noting FRSA's position that any integration does not result in funding reductions for direct service delivery for either BBF/CaPS or the CfC FP's management and coordination role.

17. Facilitate a workshop on enabling systemic collaboration across key government and non-government stakeholders relevant to the FaC sector, with a view to strengthening linkages across universal services and referral pathways.

18: Resource the establishment of Communities for Practice, focusing on issues of key concern to providers including innovation, and resource FRSA to coordinate and run the forums.

19. Acknowledge the importance of enabling services to offer a mix of face-to-face and online service modes and provide assurance of ongoing resources and support to ensure that mix remains both viable and flexible into the future.

[3] https://www.acoss.org.au/wp-content/uploads/2018/10/ACOSS-Briefing-note_Commissioning-and-Getting-Better-Outcomes.pdf, pp 6-7.

PART ONE: OUTCOMES

The diagram on page 13 of the Discussion Paper suggests that the four FaC program aims are essentially high-level outcomes, and the 'outcomes' within each circle are associated outcomes. The four aims refer to an overall vision for each cohort (children and young people, families, adults, communities) and the smaller-font outcomes, although not yet fully fleshed out, point to that vision. However, not all outcomes are actually 'outcomes': they are a mix of outcomes, indicators and strategies. For example, 'linked to appropriate services' does not necessarily result in children and young people thriving, but 'linking' is a strategy for achieving an outcome, such as 'mental and emotional wellbeing', and 'being linked' is an indicator that the journey toward wellbeing has commenced.

The 'contextual factors' are also problematic. For example, 'physical health' is both an indicator of wellbeing, and an outcome of strategies to improve mental, physical and material wellbeing. We would see contextual factors as including external influences such as the physical environment, socio-economic conditions, cultural background and emerging crises (e.g. the pandemic).

Aligning aims, outcomes and indicators
While at a high level the intention of the aims and 'outcomes' resonates closely to the intention of FaC and its sub-programs, more work needs to be done to better represent the intersection of outcomes as they apply across all (cohort focused) aims. For FRSA, a missing piece is 'indicators.' It is the indicator which will point to the way a particular outcome will be measured for a particular cohort. Indicators must be measurable and evidence-informed. For example:

In this example the same high level 'outcome' applies to all cohorts, but the indicators of whether that outcome is being achieved will be different for each cohort.

Aim: Children and young people thrive

Outcome: Improved child wellbeing/agency

Indicator: Increase in developmental milestones met

Aim: Families flourish

Outcome: Improved family wellbeing/functioning

Indicator: Reduction in family conflict

Aim: Adults are more resilient (empowered)

Outcome: Improved adult wellbeing/functioning

Indicator: Reduction in mental illness symptoms

Aim: Communities are cohesive

Outcome: Improved community wellbeing/connectedness

Indicator: Increase in number of clients connected to support networks

Discussion paper question 2: Are the proposed key outcomes for families and children the right ones?

Bearing the comments above in mind, FRSA suggests that while the high-level outcomes (aims) appear to be the right ones, the next level outcomes should be refined.

Aims

Feedback from FRSA members suggested a general consensus that the aims (high-level outcomes) resonate with the breadth of their work with families and children. However, we suggest that the aims be written more consistently: children and young people thrive, families flourish, adults are empowered, communities are cohesive.

Note: we suggest removing the word 'relationships' from the families aim because, as a FRSA member pointed out, we want to see families flourish as a whole, including the relationships that may comprise a family. We have suggested below that 'relationships' form one of six outcomes domains that are applicable to all cohorts (children and young people, adults, families and communities).

We further note that discussion with FRSA members suggested that the word 'empowered' was not helpful, as 'power' and therefore 'empowerment' are understood differently in different cultures. An obvious example is the disparity within the child protection system, in which Aboriginal children are removed from their families far more often than non-Aboriginal children. How are parents being 'empowered' in this situation? Are structures that might support 'empowerment' available? Making 'empowerment' an aim might suggest that an individual is responsible for their own outcomes – regardless of the availability of a support system and whether access to that system is equitable. A better word for the aim relating to adults might be 'resilient', but at this point we have focused our discussion on 'empowered', as included in the original aim.

Outcomes

FRSA members also suggested there is room for improvement in the detail, presentation and language used to describe the lower-level outcomes; and also referred to the need to reflect the relationship of FaC outcomes to the broader (government and non-government) system of support for children, young people and families.

Detail: some concepts are currently missing from, or understated in, the diagram on page 13. This includes safety, connection to culture, financial resilience, mental health, family diversity and complexity (e.g. cultural, intergenerational), disability, service quality outcomes and transition stages. In addition, the diagram does not make clear that outcomes do not necessarily apply to all programs, and many outcomes apply to more than one cohort (children, families, etc).

We also note that the diagram on page 13 does not incorporate service quality outcomes, although these are also important for both assessing performance and improving (as noted in DSS' 2014 FaC program logic, which included increased use of

evidence-informed outcomes, increased service integration and collaboration, better targeted early intervention and improved access for vulnerable/disadvantaged individuals and families as service quality outcomes).[4]

Language: the language used to describe the outcomes is quite varied. As mentioned above, they are not all measurable 'outcomes' (e.g. children. have a say' is a strategy toward achieving self-agency). In addition, while there are obvious connections between the outcomes suggested in the discussion paper and DEX, SCORE and program outcomes, the actual language used is often quite different, with some outcome domains missed out completely (e.g. resilience). It was also felt that many of the outcomes are subjective and build in assumptions and pre-conceptions about families, thereby not capturing the breadth of family life (e.g. in relation to gender or culture) and the various roles that different family members, particularly older members (e.g. grandparents), might play in parenting and family functioning.

Presentation: FRSA members did discuss whether the diagram should place the child at the centre, and although for many services that is indeed the priority, for others it is not quite as direct. Many suggested that the diagram did not satisfactorily convey the relevance of outcomes to all cohorts, e.g. 'self-efficacy and confidence' should not be limited to the 'adults' cohort, or the relationships between cohorts. There was also considerable discussion about whether it was possible to reflect, either diagrammatically or in the text, the life course of an individual or family and the various transition points that occur during the duration of that life course (i.e. not only developmental transitions during the first 1000 days, or learning transitions through pre-school, school and post-school learning pathways, but also transitions through the various phases of family formation and separation, and transitions in and out of different living circumstances and support requirements, etc).

The broader system: FRSA members agreed that the high-level aims and outcomes need to complement the high-level aims and objectives of the National Framework for Protecting Australia's Children. In the absence of a shared vision and direction for the next iteration of the Framework, we have sought to reflect the essence of the current Framework, in particular its recognition that wellbeing and safety are essentially systemic issues involving all levels of government, the social services sector, other sectors such as health and education, and the broader community. By the same token, FaC outcomes should ideally resonate with the National Plan to Reduce Violence Against Women and their Children, high-level aims and objectives of other DSS Activities and with the related Activities of other Commonwealth departments and state/territory governments.

FRSA considered this feedback and reflected on how closely the proposed new outcomes reflect existing FaC guidelines, DEX/SCORE outcomes and individual program outcomes as reflected in AWPs. There are clearly common themes, not all of which have been captured in the diagram on page 13. We suggest that the outcomes be grouped according to these common themes or domains, recognising

[4] https://www.dss.gov.au/sites/default/files/documents/07_2014/families_and_children_programme_logic_0.pdf

that while the domains apply to all cohorts, the way outcomes are expressed for each cohort may differ.

FRSA member feedback has been summarised in the matrix at **Attachment 1**. The matrix identifies possible outcome domains and aligns each with the relevant DSS proposed outcomes, FRSA member feedback and DEX-SCORE outcomes. The matrix also includes suggested rewording of DSS outcomes based on that material and identifies contextual factors which may apply to each and every outcome domain and cohort.

Recommendation 1:

That DSS group the proposed outcomes according to outcome domains:

- **Safety**
- **Social and emotional wellbeing**
- **Learning and development**
- **Resilience**
- **Relationships**
- **Community connections and participation**

Recommendation 2:

That DSS reword the individual outcomes so that they are more clearly *outcomes* (not strategies or indicators) and better align with outcomes already incorporated into DEX, SCORE, and service providers' program descriptions, and with high level aims of the National Framework for Protecting Australia's Children.[5]

FRSA also recommends revising the diagram so that the applicability of outcome domains to each cohort is clearer, and so that the outcomes identified are the most appropriate for underpinning an eventual outcomes framework – i.e. they can be aligned with evidence-informed indicators and measures. In other words, revise the diagram so that it connects the four cohorts with all domains, and specifies cohort-specific outcomes within each domain. The current diagram is not dynamic – it does not yet convey the intersection of outcomes and their relevance to all cohorts.

We have taken the liberty of redrawing the diagram along these lines. We offer two alternatives for DSS' consideration, as follows:

Attachment 2 is similar to DSS's 'overlapping circles model' but suggests the communities cohort also be depicted as an overlapping circle, with the outer circle containing contextual factors that apply to all four cohorts. The outcomes included in each cohort circle are therefore identified according to the six domains suggested above – safety, social and emotional wellbeing, learning and development, resilience, relationships and community connections/participation, and one example outcome per domain has been given for each cohort. That left us with a 'busy'

[5] In the absence of the next iteration, refer to the current Framework https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf

diagram that still lacks a full sense of the relationship between outcome domains and high-level cohort aims.

Attachment 3 also depicts the relationship between the four cohorts and the relevance of each outcome domain to each cohort:

- **Cohorts:** This diagram takes the 'ecological model' approach – a wheel with the child in the centre, and with concentric circles to represent the other three cohorts (adults, families and communities) in relation to that centre. The outcome domains are depicted more clearly as segments of the wheel, with each segment applying to all cohorts.
- **Outcomes:** ***Sample*** outcomes are offered for each cohort within each domain. Sometimes the outcomes for each cohort are quite similar, but the language may be slightly different to reflect that *particular* cohort.[6]
- **Contextual factors:** We have taken a broader view of contextual factors (again, based on member feedback and DEX information) and provided examples of contextual factors which could apply to **any or all** cohorts and **any or all** outcome domains (the diagram, being two-dimensional, does not adequately convey the dynamic interplay of contextual factors with all outcome domains and cohorts).

The outcomes model at Attachment 3 is our preferred alternative because it represents the above points more clearly and less repetitively than does the Discussion Paper's page 13 diagram.

Attachment 4 considers further outcomes options focusing on the 'children and young people thrive' aim. Once again, these outcomes are examples of FRSA members' program outcomes (as summarised in Attachment 1).

Acknowledgements: The diagram at Attachment 3 draws on Bronfenbrenner's Ecological Systems Theory,[7] which views child development as a complex system of relationships including immediate family, extended family, peers and significant others, community and government agencies, cultural attitudes and ideologies and environmental changes that occur over the life course. While many (wellbeing) outcomes frameworks also draw on ecological systems theory, FRSA particularly acknowledges ARACY's Common Approach for Identifying and Responding to Indicators of Need (formerly Common Approach to Assessment, Referral and Support - CAARS), which identifies outcome domains pertinent to the prevention of child abuse and neglect.[8]

[6] One example per domain per cohort is provided for illustrative purposes. There are many other possibilities – see the table at Attachment 1 for key outcomes as identified in DEX and SCORE, and in specific programs.

[7] While there are many relevant articles on the Ecological Systems Theory, a core source is Bronfenbrenner, U *Ecological Systems Theory,* 1992. Jessica Kingsley Publishers

[8] https://www.aracy.org.au/documents/item/127

Recommendation 3:

That DSS revise the page 13 diagram to reflect the outcome domains applying to all four cohorts (children and young people, adults, families, communities), and rephrase the individual outcomes to better align with those used in DEX and SCORE (see suggested rewording in Attachment 1; and possible diagram alternatives at Attachments 2 and 3).

Using evidence to inform outcomes and how they are to be achieved

FRSA members already draw on a wealth of evidence[9] to inform the way they work with children, adults, families and communities. That evidence is included in program logics and helps to shape the ways services think about their overall aims and outcomes, and the changeable nature of the journey toward achieving those aims and outcomes.

While DSS' discussion paper states that service providers will be asked to demonstrate (i.e. provide evidence) that their program activities will contribute to intended outcomes, the paper overlooks an important prerequisite to that request. The outcomes themselves, and the indicators and measures used to determine whether they have been achieved, will also need to be evidence-informed. There is no point in identifying an outcome if it cannot be measured, and if that measure has not been demonstrated to indicate whether or not the outcome has been achieved. For example, for the outcome '(children) feel safe and supported at home', evidence has shown that measuring the amount of time children spend with their parent/s will provide *one* indication the outcome is being met. This particular measure, or indicator, is one of many economic, social and environmental measures comprising a comparative and time-series body of evidence utilised by the OECD.[10] It is important that all outcomes identified in the proposed outcomes framework, and the indicators and measures which point to whether or not that outcome has been achieved, are evidence-informed. Evidence also needs to be culturally relevant.

The outcomes framework should allow for immediate, intermediate and long-term outcomes to be reported at all cohort levels – children and young people, adults, family and community.

Discussion paper question 3: How can we include strengths-based outcomes that focus on family or child safety?

FRSA members already focus on strengths-based activity, e.g. giving children agency through child inclusive practice, or increasing parental capacity based on parents' existing knowledge and skills. Any outcomes included in the eventual FaC outcomes framework must not be based on an assumption that an individual or family starts with no assets or skills, but that each person and family already has a base upon which to build. We therefore recommend that the eventual outcomes framework uses

[9] That 'evidence' might be evidence-based or evidence-informed. In this paper we have tended to use the term evidence-informed unless referring to a specific program that has been accredited as 'evidenced -based' through a rigorous analysis.

[10] For example, OECD evidence-informed outcome measures inform ARACY's *Report Card 2018: The Wellbeing of young Australians*

strengths-based language and focuses on outcomes measures that point to an increase/improvement in protective factors as well as reduction in risk.

Successful child, family or community safety outcomes will be the result of strength-based strategies and activities that incorporate child- and person-safe principles and strategies and ensure that children's (and adults') voices are heard. Context is also important, for example cultural connections or access to material basics such as stable housing.

Discussion paper question 4: What tools or training would support you to effectively measure and report outcomes through the data exchange Partnership Approach?

If reports generated through the Partnership Approach are to be meaningful, the first requirement is that proposed outcomes in the new outcomes framework truly reflect the overall vision and intent of FaC and mirror the outcome domains and outcomes identified in SCORE. At present, the diagram on page 13 does not accurately mirror SCORE – the obvious example being personal and family safety (only child safety at home is mentioned). If DSS approves a new outcomes framework and it does not align with outcomes identified in SCORE, outcomes reporting will have limited value (unless SCORE is updated). It is for this purpose of 'meaningful alignment' that FRSA selected the outcome domains in the Attachment 1 table. All suggested domains relate to existing Partnership Approach data fields and to the principal outcomes identified by our members; it will be up to DSS to ensure the new outcomes framework also aligns precisely and consistently with those data fields.

There are many problems with DEX and SCORE, not least because working with families' complex needs usually requires longer than the six-month reporting period. FRSA members commented that:

- DEX and SCORE are not necessarily clinically useful.
- Available measurement tools do not necessarily match what is in SCORE and therefore cannot be fed into SCORE.
- The Partnership Approach is a blunt instrument and subjective, with the quality of the data dependent on who is entering it.
- DEX calls for quantitative data with little if any scope for qualitative data to be reflected.
- There is an insufficient range of outcomes measurement tools in the translation matrix (as FRSA members' support for expanding the range of reliable and validate outcome measurement tools has been reflected in Recommendation 5 below).
- The translation matrix does not pick-up changes in progress and therefore distorts outcomes.

Telling a complete story

DEX and SCORE alone are not sufficient for telling a complete story about outcomes. While the AWPs are another vehicle for providing data, it is critical that DSS enables service providers to be able to tell that complete story, using other outcomes measurement tools, evaluations, and anecdotal and contextual information. However, such a 'hybrid' approach must not be onerous or add another

administrative burden. At the same time, it is too simplistic to attribute individual changes over time to one particular service provided – outcomes are likely to be attributable to a range of interventions and contextual factors.

Other limitations of DEX and the Partnership Approach were noted by FRSA members:

- DEX is not tailored to different service types, e.g. for anonymous services cohort level data may be more appropriate than client-level data.
- Data collection can be a barrier to engaging with families, especially when it is perceived that the level of engagement about data is greater than the actual service intensity. This can make obtaining a complete set of pre- and post- information difficult. Clients may also be reticent to provide information sought by DSS in the extended data set, for a variety of reasons, e.g. language barriers, historical trauma, or pressure from a family member (Note: FRSA members suggested that some potentially controversial questions may not be needed at all – e.g. if it is already known that a client receives a Centrelink payment, their income has already been assessed and there is no need to ask about income again).
- There can also be barriers to the logistics of collecting data, e.g. collecting data in remote communities is a problematic exercise, partly because it takes considerable time for service providers to build relationships of trust.
- Data may also be limited if information from children cannot be included in authentic way.
- At present SCORE outcomes need to be recorded for at least 50% of clients and 10% of clients require a satisfaction SCORE. If these percentages were to increase, it *could* create a disincentive for services to reach out to particularly vulnerable client groups. DSS would need to safeguard against that.

Providing adequate information, support and training

The Partnership Approach has potential for more consistently collecting and reporting on outcomes data, but more work needs to be done to ensure that consistency, and also to ensure definitions and expectations are clear and meaningful. In particular, DSS should consider providing additional resources for training staff who use the Partnership Approach – understanding the data items and data fields, ensuring consistency of data entry, learning how to read reports and analyse trends, and dealing with barriers to data collection. Staff need to be educated about the importance of data and how to convey that importance to clients while still assuring them of confidentiality. Communicating the value of the data collected and how DSS will use that data is an important precondition to securing staff engagement in data collection.

Training on DEX is needed at the national and state/territory level. Training could be undertaken by a neutral organisation (on behalf of, and funded by, DSS), to ensure consistent delivery. Support to service providers should be ongoing – a helpline is insufficient. Funding Arrangement Managers (FAMS) would also benefit from training on how better to support service providers with DEX issues, as FAMS are potentially a useful link between providers and DSS, helping to understand and convey the full story of quantitative (DEX-entered) data *and* qualitative and contextual information.

However, not all FAM/provider relationships would enable that, partly due to high turnover of FAMS in some regions.

FRSA members suggested that DEX provide an easy-to-access repository of information about evidence-informed common measurement tools and their focus/purpose and cultural relevance (to complement the Industry List).

Data is only useful if it can be interpreted and shared. At present service providers have limited capability to draw down the reports they know can be generated through the Partnership Approach because many do not have the technical expertise. Even those organisations which have been using the Partnership Approach for several years are unable to see the community reports that DEX generates, and DSS can access. FRSA members called for better feedback from DSS on data they have entered into DEX, and more assistance from DSS, through training, mentoring and workshops, to get reports out of DEX.

Benchmarking

FRSA supports outcomes measurement and program evaluation for the purpose of improving services' capacity to meet client needs (whether those needs are met directly by the service or in conjunction with other services) but does not support the use of SCORE for benchmarking services against one another. As elaborated in our response to the Productivity Commission's 2016 *Preliminary Findings Report into introducing competition, contestability and user-choice in the family and relationship services sector,*[11] collaboration among service providers is the key to holistic support and workable support pathways. Because many services may contribute to client outcomes, it is not always possible to attribute a particular outcome to a specific intervention. Benchmarking does not take sufficient account of the collective impact of the many interventions that serve to meet the multiple and nuanced needs of clients, nor does it take account of the complex and varied contexts in which clients live and services operate.

Recommendations:

4. That DSS provide comprehensive training, including online workshops, and ongoing support for services using, or about to enter into, the DEX Partnership Approach. Support to include training on the use of validated outcomes measurement tools and their translation into SCORE.

5. That DSS expand the range of reliable and validated outcome measurement tools for translation into SCORE.

6. That DSS improve DEX's report generation capacity, so that services using the Partnership Approach have access to community reports e.g. to enable data-informed conversations between CfC FPs and CPs about the collective impact of their services and to address local needs and barriers to access.

7. That DSS take account of and learn from services' other assessments of outcomes, whether they be anecdotal, evaluation-based or measured with tools incompatible with DEX.

[11] https://frsa.org.au/wp-content/uploads/2019/02/DRAFT-FRSA-response-to-Productivity-Commissions-Preliminary-Findings-report-into-introducing-competition-contestability-and-user-choice-FINAL.pdf

Discussion paper question 5: Do (FRSA members) already have a program logic or theory of change outlined for (their) FaC program? If not, what has been a barrier to development? What capacity building support would assist service providers to develop program logics and theories of change?

Many FRSA members already use program logics and theories of change. They are useful because they capture the purpose of the program, identify individual and community needs, describe outcomes in relation to the service being provided and describe the context in which the service exists, including intersection with other service provision and community support. The program logic will help determine what outcomes are directly (and indirectly) attributable to the program activity. Program logics help staff to understand the full client journey.

If the proposed outcomes framework uses the high-level outcomes identified on page 13 of the discussion paper as a basis, it is unlikely that existing program logics will need to change in any substantial way. However, mapping outcomes into individual program logics is not an exact science, and there needs to be scope for aligning outcomes across the program logics of different programs which are also working to improve the lives of a local client population.

Program logics and theories of change should be updated regularly so that they remain living documents. Language may also need to be updated, for example heteronormative language may underplay the need for greater attention to diversity in relationships and family structures. Barriers to the application of program logics include the difficulty of tracking data across a range of collaborating service providers, making it hard to attribute outcomes to specific FaC interventions.

FRSA members supported the idea of a (high level) program logic template (developed by DSS) as long as it could be used as both a basis for building a new, program-specific program logic where that does not already exist, *and* as a checklist for existing program logics, to ensure they complement or can be adapted to align with the template in an overarching sense while retaining flexibility for the existing, bespoke program logic. As a tool for service providers who do not yet have a program logic in place, the template should be accompanied by (DSS-provided) resources to build capacity for adapting the template and implementing it in accordance with the specific program and context. Such resources could include online guides and workshops. This support will be integral to the success of program logic implementation in those organisations not currently using program logics. Members who already use program logics and theories of change emphasised how valuable but also how resource and time-intensive the process of developing a program logic is.

Recommendation 8:

That, after the FaC Outcomes Framework has been developed, DSS develop a Program Logic template that can be adopted by services that do not yet have a program logic *or* modified so that it can be readily adapted to existing program logics.

Recommendation 9:
That DSS allow a realistic transition time for services to adopt or adapt the new Program Logic template; and that DSS provide resources and training opportunities to assist that transition.

PART TWO: FAC ACTIVITY IMPROVEMENTS

2.1 CERTAINTY AND ACCOUNTABILITY

FRSA welcomes the implementation of five-year grant arrangements for Communities for Children Facilitating Partners (CfC FP), Family and Relationship Services (FaRS) and Family Mental Health Support Services (FMHSS). While we also welcome the current two-year extension of Children and Parenting Services (CaPS) and Budget Based Funded (BBF) services as an interim measure, we note that the proposal to roll these into CfC FP by the end of those two years does not include specific reference to a concomitant funding intention, i.e. that funding for these programs then also aligns with the new CfC FP grant period. At this point, there is no guarantee that integration of CaPS and BBF into the CfC FP model will be feasible; however some guarantee of their ongoing funding to June 2026, regardless of the 'integration' outcome, is desirable.

Recommendation 10:

That DSS confirm ongoing funding to CaPS and BBF post June 2023, to align with the new CfC FP grant period (i.e. to June 2026) *regardless of the 'integration' or otherwise of CaPS and BBF with CfC FP*.

The other funding guarantee that has not yet been given is that of regular indexation to cover increases in the real costs of service delivery. Baseline funding for FaC funded services has remained the same over multiple years. Since 2012-13, when indexation has been applied to FaC programs, indexation rates have been on average approximately 1.5 percent, and applied to the original grant funding value, rather than on a cumulative, annual basis .[12] However, costs related to service planning and implementation, maintaining and skilling an effective workforce, engaging with existing and potential partners and stakeholders, updating technology and infrastructure and fulfilling all compliance obligations continue to increase.[13]

Review points

Mid-point reviews should be considered not only as an opportunity to track the success of the program to date (through AWPs, outcomes measurement, evaluations and anecdotal feedback), but also as an opportunity for reflection and learning about what worked, what did not and why, and what could be changed. The review point then becomes a critical tool for innovation and continuous improvement. The review point should *not* be a barrier to learning and innovation – if outcomes are not being achieved as expected, it is important not to jump to conclusions about the service's capabilities or performance. As 2020 demonstrated, external influences on clients' needs and engagement with services, and on achievability of short and long-term outcomes, can be outside of a service provider's control.

[12] CIE (20 March 2020), *Final Report: Expiry of the Social and Community Services Pay Equity Special Account – Implications for Family and Relationship Services*, p.37.
[13] CIE (20 March 2020), *Final Report: Expiry of the Social and Community Services Pay Equity Special Account – Implications for Family and Relationship Services*, p. 10.

FRSA member feedback indicated that program review should not rely on DEX data alone, particularly if barriers to utilising DEX and the Partnership Approach are unresolved. The review should also refer to the findings of other outcomes measurement tools, qualitative data, evaluations, and anecdotal information (e.g. through case studies) and contextual information including the investment of time and resources to build relationships of trust and support the client through what can be a complex and sensitive support journey. Reviewing a program against agreed KPIs will only be effective if the story behind the data can be told.

FRSA members also pointed to the need for consistent and strong relationships with FAMS (these have been variable) and suggested that the single customer experience 'Net Promotor Score' be considered as a common measure of client satisfaction across programs unless clearly inappropriate.

Discussion paper question 6: As longer-term agreements are implemented, how can the department work with you to better develop criteria to measure and demonstrate performance? How can the data exchange better support this?

See also our response to question 4.

Criteria for measuring and demonstrating performance will depend on the final selection of outcomes, including outcome domains applicable across all FaC activity and program outcomes for each FaC sub-activity. After these high-level outcomes have been confirmed, the Department can build the outcomes framework that will then underpin subsequent outcomes and performance measurement. The Department can work with the sector by:

- Facilitating consultations to involve the sector in codesign of the elements of the outcomes framework
- Sharing its own (departmental) program logic and theory of change for FaC activity (perhaps building on the program logic developed in 2014)
- Providing a repository of evidence for using particular measures
- Ensuring the data fields used in DEX/SCORE complement the final agreed outcomes and measures.

An outcomes framework will require the following elements:

- Vision
- Outcome domains
- High-level outcomes within each domain
- High-level strategies for achieving outcomes, noting contextual factors which will influence outcomes and targets
- Indicators
- Targets
- Data collection tools
- Analytical tools
- Conditions/resources for a culture of learning and continuous improvement

We also refer DSS to the principles and practice developed by ACOSS in 2018[14] for the purpose of assessing need, designing services, and purchasing services (under the commissioning model) and for getting better outcomes. The principles for monitoring, evaluation and performance improvement include proportionality, clarity, respect, timeliness, innovation and cost.

Recommendation 11:

That DSS ensure that the ACOSS principles for monitoring, evaluation and performance improvement[15] are reflected in the final outcomes framework.

FRSA members have appreciated the consultation process to date. It would be helpful for all FaC services to have the opportunity to participate in the next stage of outcomes framework development.

Recommendation 12:

That DSS facilitate workshops for the purpose of developing the full outcomes framework once the high-level outcomes have been finalised.

Discussion paper question 7: What does success look like for (FRSA) services, and how do they assess the overall success of services?

FRSA members measure the success of their work with children, families and communities in a number of ways. Measuring client outcomes will give a picture of how the service has impacted on client wellbeing, learning, social participation, etc, but will not provide the full story. As mentioned earlier, outcomes are not always attributable to one single intervention. Indeed, it is the collective impact of a number of interventions and players that is likely to demonstrate whether interventions can be considered successful. 'Success' can mean more than 'outcomes have been met' and may or may not be reported in the DEX context. Success might mean:

- Relationships of trust have been built between the service provider and individuals or families, even before they officially become 'clients' (as defined in DEX)
- Partnerships are forged with other service providers or community facilities (e.g. schools) with a shared vision for supporting clients or the local community more broadly
- Clients are supported to connect with other services, as part of a holistic response to their needs which may or may not include support from the FaC service that initially enabled 'soft entry' to a support pathway
- Services have adapted to working differently because they have placed clients at the centre of their own support pathway.

[14] https://www.acoss.org.au/wp-content/uploads/2018/10/ACOSS-Briefing-note_Commissioning-and-Getting-Better-Outcomes.pdf
[15] https://www.acoss.org.au/wp-content/uploads/2018/10/ACOSS-Briefing-note_Commissioning-and-Getting-Better-Outcomes.pdf, pp 6-7.

FRSA members aim to reflect these dimensions of success and their holistic response to people seeking support in their AWPs.

Success, including a range of outputs, outcomes and service improvements, might be assessed in a number of ways, not all translatable to DEX or SCORE, e.g. through:

- Validated outcomes measurement tools
- Evaluations
- Action research
- Case studies
- Anecdotal feedback
- Client satisfaction services
- Feedback from community partners and stakeholders, and the wider community.

2.2 TARGETING AND ACCESSIBILITY

During the DSS-initiated consultation sessions, in which many FRSA members participated, it was helpful to learn from DSS that the question of ensuring vulnerable people have access to FaC services was less about active targeting (away from 'universal' access) and more about removing barriers to access. In other words, FaC services remain universally available to Australian children, young people and families, but effort is made to ensure no one group misses out because of particular vulnerability, e.g. cultural barriers, sensitivities related to sexuality, trauma, lack of resources (e.g. transport for physical access; technology for online access) and other complexities.

Members reported that they often adopt a tiered or triaged approach to service access to help ensure the service remains welcoming to all while enabling a prioritised response according to need without stigmatising any individual or group.

FRSA members suggested that ensuring services are accessible to vulnerable people requires good knowledge of the local population's demographic characteristics, socio-economic situation and community needs. FRSA members already consult closely with their local communities in the planning, design and implementation of services, and would also welcome better access to population data that can be interrogated at a local level – ABS, AEDI, DSS aggregated info from DEX, Public Health Networks (PHN), and suggested a central repository for this.

Removing barriers to service access also requires the establishment and maintaining of strong community partnerships and networks, e.g. working with local schools and community facilities to identify vulnerable cohorts and barriers to access and taking time to build relationships of trust that enable safe and respectful transition through the relevant support pathways.

We heard from members that service development could theoretically benefit from co-design to better respond to high-needs groups within communities. However, co-design with high-needs groups can also be problematic. Singling out particular groups as vulnerable or high-need can be stigmatising, creating immediate barriers to

engagement. In addition, co-design requires a considerable investment of time and expertise. This is particularly so for high-needs groups where additional sensitivities and safety issues may need to be managed. In the main, providers are not sufficiently resourced in existing funding models to undertake this level of co-design.

As noted earlier, DSS data collection requirements can also present a barrier to engaging high-needs groups who, for a range of reasons, may be unwilling or unable to share their information.

Discussion paper question 8: Do (FRSA members) currently service cohorts experiencing vulnerability, including those at risk of engaging with the child protection system? If not, how does service delivery need to adapt to provide support to these cohorts?

All FRSA members consulted work closely with vulnerable children and young people, adults, families and communities. This includes children and adults at risk of engaging with the child protection system and related systems – police and criminal (including juvenile) justice, Family Court, mental health, acute and public health facilities, emergency services, and Alcohol and Other Drugs services.

The FaC Guidelines state that the aim of FaC activity is to "support families, improve children's wellbeing and increase participation of vulnerable people in community life to enhance family and community functioning"; and note that FaC is "predominantly focussed on early intervention, prevention, and support, including assistance for relationship breakdown."[16]

FRSA members expressed concern that the discussion paper reflects a stronger push toward the 'pointy end', i.e. tertiary interventions, moving *away* from prevention and early intervention. This is of concern as the success of FaC lies in its emphasis on prevention and early intervention through universal (primary) services available to anyone, *before* already complex issues spiral into crises requiring targeted (secondary) or statutory (tertiary) intervention. Evidence shows that prevention and early intervention are not only more effective in relation to long-term outcomes, but also more cost effective in relation to the long-term impacts intervening too late.[17] The universality of prevention and early intervention services means they tend to be stigma-free, i.e. people are more likely to get help early if they are not labelled as needing help at a level different to that of the general population, and more likely to optimise opportunities for building relationships of trust so that support can be provided early enough to prevent high risk behaviour such as abuse and neglect (and thereby obviate the need for more complex, intensive and potentially costly interventions).

Service delivery across FaC Activity has already adapted and is responsive to the support needs of vulnerable clients at risk of engaging with the child protection and other statutory systems. A key to that responsiveness is an understanding of *collective* impact and the importance of meaningful community connections and partnerships

[16] https://www.dss.gov.au/sites/default/files/documents/12_2017/program_guidelines_overview_-_families_and_children.pdf
[17] https://frsa.org.au/wp-content/uploads/2016/05/FRSA-Research-Report-Printable.pdf

that identify and support hard-to-reach individuals and families. Rather than ask how service delivery needs to adapt, DSS should be asking how the Department itself, and other government agencies, can better collaborate and allocate resources to ensure joined up, holistic and culturally and locally appropriate support for vulnerable and at-risk clients (see 2.3 below).

Systemic approach to targeting and accessibility

Consideration of the best ways to ensure vulnerable groups access services and receive timely support needs to be *systemic* in recognition that the safety and wellbeing of children and families is the responsibility of all levels of government and of the wider community. Ideally, child, family and community support services would be structured in a public health model, with an emphasis on universal services focused on prevention and early intervention. As stated in the first National Framework for Protecting Australia's Children (2009-2021), "the best way to protect children is to prevent child abuse and neglect from occurring in the first place. To do this, we need to build capacity and strength in our families and communities, across the nation." The Framework called for a unified approach where governments, communities, businesses, services and families would work together in the recognition that the protection of children is not simply a matter for the statutory child protection systems. The vision was to turn the current system for protecting children on its head, to reduce the heavy demands on the statutory system and place greater emphasis on prevention and early intervention using a public health approach.

The services funded under FaC play a key role in the attempt to place more emphasis on universal services that focus on prevention and early intervention. This role needs to be reflected in the next iteration of the National Framework, which will have a focus on protecting children before crises escalate, during periods of crisis and after abuse and neglect have occurred – with the overall aim of reducing the risk of abuse and neglect for all children and responding quickly and effectively to all levels of need. At the very least, FaC activity milestones should align with, or complement, those of the next National Framework, noting that the supporting outcomes identified in the current Framework cover safety and wellbeing support, early intervention, risk identification and management, support where abuse has occurred, prevention of child sexual abuse and exploitation and a special focus on Indigenous children.

Issues of targeting and accessibility also need to be considered collaboratively, with all levels of government and all relevant community partners, stakeholders and sectors. Confidence in 'the system' depends largely on a well communicated vision, shared commitment to prioritisation of effort, alignment of timeframes, visible and easily negotiated service pathways from soft entry to statutory interventions, seamless sharing of data, mutual consideration of 'intelligence' (contextual information, shared research, service wisdom, expert knowledge and evidence of 'what works') and strong relationships of trust.

2.3 COLLABORATION AND COORDINATION

The discussion paper's section on collaboration and coordination raises more questions than it answers. While the paper includes some recommendations for integrating specific services, it gives no clear rationale for integration or a sense of what integration will look like, and whether/how the process of planning and implementing integration will be resourced. If no additional funds are forthcoming, how will the costs of both integration and ongoing management of the new structure/s be borne? Will services to clients need to be reduced? What will happen to those bespoke services offered through CaPS and BBF that meet the needs of clients who cannot be catered for in any mainstream service (e.g. because in addition to their child/family needs, they have specialised AOD needs which other child and family services cannot support)? Without CaPS, these families would fall through the cracks. Will integration widen those cracks? How would a move from one provider to another be negotiated e.g. for Kids in Focus?

DSS's expectation that services collaborate has for many years sat in tension with the expectation that services will participate in competitive tendering. If collaboration and coordination are to be encouraged, they also need to be resourced.

FRSA members reported that part of the complexity is that in these difficult times of pandemics and bushfires/floods the service intensity increases massively for everyone. This increases all services' need-to-know and need to pass on information for timely and effective coordination and collaboration. FRSA members pointed to the ongoing need for better coordination across health, education and social services and at Commonwealth, state/territory and local government levels. While regional forums may go some way to forging better communication and expertise sharing, the onus for maintaining networks should not be placed on individual service providers. Instead, governments need to be actively working better together. It is not clear whether or how the new National Cabinet model will take on the responsibilities for children and families of the former Council of Australian Governments (COAG), but at the very least, the next iteration of the National Framework for Protecting Australia's Children should include a nationally endorsed mechanism for ensuring multi-jurisdictional collaboration on child and family matters.

FRSA supports the concept of communities of practice and FaC peer networks for the purpose of sharing knowledge and practice wisdom, and to connect small and large organisations. While different to the Australian Institute of Family Studies' (AIFS) Child Family Community Australia (CFCA) role, FRSA already plays a significant role in terms of enabling opportunities for learning and sharing of expertise and practice wisdom across its membership (for example, webinars and online platforms for problem solving as organisations learned to adapt to working in accordance with pandemic-related restrictions). While that role could be expanded to encompass the broader FaC sector, there would need to be greater clarity about the vision for the information-sharing or collaboration/coordination being sought, with a systems approach to developing and resourcing collaborative mechanisms and centralised repositories of information so that these complement support already provided by AIFS.

Recommendation 13:

That DSS maintain direct funding agreements with small organisations and continue to support diversity of services across the FaC spectrum.

Discussion paper question 9: Do FRSA members who are CaPS or BBF service providers currently link with a CfC FP or other regional planning mechanism to understand what other services are provided in the community and what the community identifies as their needs? How does this work in practice? Would these CaPS and BBF services value the increased support of being attached to a local FP?

FRSA members have provided feedback that it has been particularly difficult to respond to this question and section of the discussion paper because there is insufficient clarity about what/where the CaPS and BBF services are, and/or where the CfC FP services are and what they are intended/designed to do. Without a comprehensive 'map' of existing services in relation to CfC sites and some understanding of client needs in the regions concerned, consideration of 'integration' can at best be theoretical.

Critically, DSS's rationale for suggesting the integration is unclear – how would implementation of this proposal improve client outcomes? Or does the proposal intend to achieve other outcomes, e.g. reducing the number of services with which DSS has a contractual relationship? If the former, what improved outcomes does DSS envisage? If the latter, FRSA is concerned that DSS may be overlooking the significant impacts and unintended consequences that may result:

- Smaller and niche or bespoke services play a critical role in the overall system of support for children and families – especially the most vulnerable people whose needs are not readily met by mainstream services. The Productivity Commission's comprehensive inquiry into the not-for-profit sector concluded that "Smaller community-based bodies can play an especially important role in generating community connections and strengthening civil society…(and) mergers and growth can detract from valued processes, particularly in smaller organisations."[18]
- Forcing smaller, unique services into an ill-fitting relationship with a larger provider risks disempowering the smaller service and eroding its capacity to connect meaningfully with its local community.
- At the same time, there is no assurance that the administrative and workforce development burden placed on the larger organisation will not outweigh the benefits to clients and communities (which DSS has not yet stated).
- Depending on local contexts and demographic complexities, rolling a BBF or CaPS service into a CfC FP may have a negative impact on the CfC FP's vision for its community (to which community partners – CPs – have subscribed) or subsume the BBF or CAPS services objectives for their high-needs client groups.

Importance of diversity in the nature and size of FaC services

[18] https://www.pc.gov.au/inquiries/completed/not-for-profit/report/not-for-profit-report.pdf - pages xxix and 21.

- FRSA's membership covers a range of organisations which vary in terms of breadth of service delivery, geographical reach and specialisation. Some organisations are large and multi-faceted; others are small and focused on specific client groups, service types, locations or expertise. The diversity and intersection of service types and approaches is critical for a healthy service system because it increases the sector's ability to both reflect and respond to the diversity of client needs and experiences.
- FRSA has serious concerns about DSS' apparent intent to move toward a model of funding that would either remove small organisations from the mix or make their funding conditional on being part of a consortium. Small, specialised services can play an important role in service pathways, but their potential contribution (often unique) to a consortium may be overlooked or discounted by the consortium lead agency. Many smaller services are the *only* FaC service in their region providing that particular specialisation (e.g. culturally sensitive SFVS; CaPS service with an AOD focus). Indeed, because of their close and often long-standing connections with the local community, small organisations are far better equipped to build and maintain relationships of trust with the most vulnerable people who feel excluded from mainstream life and can help to connect them with other services to ensure support is holistic. Essentially, small services have a key role in *removing* access barriers faced by vulnerable groups (see also response to question 8 above).

In its submission to the Productivity Commission's Inquiry into Human Services,[19] FRSA identified a number of negative consequences arising from the competitive tendering process and government's increasing preference for tenders submitted by large (national and state-wide) consortia rather than small organisations. These negative consequences could also apply if integration is undertaken too hastily – in particular, the larger body may not recognise the smaller service's unique role in the support pathway (e.g. relating to a specific specialisation or type and level of expertise, cross-cultural experience or deep and long-held connections to the local community).

Before any further consideration is given to integration it is critical that DSS understand the overall service *system* in a region, and how that system and all of its parts works in the best interests of the clients. If changes to services in a region are not considered systemically, there is no guarantee clients will be supported holistically along a cooperative support pathway.

Children and Parenting Services

Bearing all of the above in mind, FRSA members considered that integration may not be impossible and could result in a positive exchange of knowledge and skills. Indeed, some synergies between CfC FPs and relatively nearby CaPS already exist and could be built on. However, it would take considerable time and resources for the CfC FP to gain a comprehensive understanding of the CaPS community (which, in accordance with FaC guidelines, will be in a different geographic, and probably socio-economic, region) and to build/invest in relationships with new community partners and

[19] https://frsa.org.au/wp-content/uploads/2019/02/DRAFT-FRSA-response-to-Productivity-Commissions-Preliminary-Findings-report-into-introducing-competition-contestability-and-user-choice-FINAL.pdf

stakeholders. FRSA members asked several questions about the proposed integration of CaPS with CfC FPs:

- Where will resourcing for that investment come from? It should *not* be taken from CaPS, which is already minimally funded with a high proportion of funds directed to clients, or from the CfC FP. If DSS is introducing (but not funding) yet another layer of management, this will not only increase the CfC CP's administrative burden but also reduce the amount of funding that can be directly applied to clients.
- What happens if an organisation is already a CfC FP *and* deliverer of FaCS? The FP cannot be the CP too?

Budget Based Funded Services

FRSA members have limited knowledge about BBF services. There is very little information available in the public domain, and, as mentioned above, any consideration of potential integration with CfC CP would at this stage be only theoretical.

CfC FPs would need to know much more about BBF service providers and their locations, the nature and extent of services offered, and the extent of community and client needs in the geographic regions concerned before assessing the appropriateness of integration.

Recommendations:

14. That DSS clarify its rationale and intentions for proposing an integration of BBF and CaPS with CfC FP, including clarification of the benefit to client outcomes.

15. That DSS provide clarity about what integration of CaPS and BBF with CfC FP would look like.

16. That DSS detail the funding mechanism for the proposal to integrate CaPS and BBF with CfC FP, noting FRSA's position that any integration does not result in funding reductions for direct service delivery for either BBF/CaPS or the CfC FP facilitating partner's management and coordination role.

Moving FMHSS into the Family and Children Activity

Again, a clear rationale for this proposal was not outlined in the discussion paper. However, the proposal is more straightforward, and members could see potential benefits.

FRSA members emphasised that it is critical that moving FMHSS into FaC does not diminish its focus on mental health; rather, the move should optimise opportunities for coordination with other FaC services to provide holistic child and family support. FMHSS is the only DSS program that uses a family-based approach to children's mental health, and it combines a number of services that are different to the range of services currently included in FaC. The focus on child mental health means working with families in a different way, often through a safe third party such as a school. FMHSS combines education and case management; it is not counselling based. Before any integration with the FaC Activity occurs, it will be important to better understand whether there are any synergies between FMHSS and other FaC programs, and how FMHSS and other FaC services might best complement each other – in a systemic way which places client outcomes first.

Currently, FMHSS has an important and unique role *alongside* other FaC programs, and other Commonwealth/State/Territory programs – it tends to pick up complex cases that drop off the radar of other programs which may not have capacity to provide mental health support within a family therapy model. FMHSS's uniqueness means that the service is constantly striking a balance between early intervention and more targeted mental health support for children and families.

Incorporation of SFVS into FaRS

Although the integration of Specialised Family Violence Services (SFVS) into FaRS was not specifically canvassed in the discussion paper, FRSA members used the consultation process as an opportunity to express their concerns about the on-the-ground implications of that integration. Firstly, SFVS are already insufficiently funded to do what is expected, and engagement with clients in this service is far more complicated and intense than DSS seems to recognise. If SFVS are integrated into FaRS, that intensity and need for specialised resources must not be overlooked. There was a general feeling that one program (FaRS) cannot achieve all outcomes including specialised family violence outcomes, for all clients, without some level of diversification within it – it cannot be a one-size-fits-all approach.

Discussion paper question 10: Are there other ways to improve collaboration and coordination across services and systems?

While the discussion paper does talk about collaboration and coordination across services and systems and refers to current initiatives such as the NT Children and Families Tripartite Forum, the reforms suggested are more along the line of improvements than systemic reform. However, if coordination and collaboration are to be effective on the ground, systems thinking is essential.

An obvious benefit of thinking systemically relates to information sharing. We see the need for a better mechanism for mapping and sharing information about services available in a region or state. Services can currently access some information and local data through LGAs, PHNs, interagency networks, etc, but partnerships at the local level are partly forged on a 'who you know' basis, and of course depend on the kind of partnerships or relationships required. For example, FMHSS requires expertise across case management, counselling, community engagement, school engagement and early intervention mental health; while a CaPS program working with people affected by AOD will require partnerships with hospitals, family drug treatment programs, outreach and case management.

While networking forums do exist, often key players are missing because they have limited availability due to the intensive nature of their work (notably child protection and housing), or it has been difficult to establish a culture of collaboration (e.g. with NDIS providers, which may see themselves in a different category even though they may be working with the same families). One service's collaboration priorities may be quite different to those of another service, and without overarching strategic priorities for that community or region, it is difficult to ensure collaboration occurs systemically

rather than reactively and dependent on individuals and the relationships between them.

A key to effective systemic collaboration and coordination across the families and children sector is the capacity to engage with all relevant government and non-government stakeholders in a structured way. In its 2010 Linkages and Collaboration Report,[20] FRSA identified a number of enablers and barriers to collaboration across national and state/territory jurisdictions, drawing on the work of Winkworth and White.[21] Enablers and barriers were identified in four categories:

- Predisposing factors such as history of cooperation (or distrust); willingness to innovate/take risks (unwillingness to change)
- The authorising environment such as legislation and policy that endorses collaboration (or limits it); agreement on the evidence for collaboration (or disagreement)
- Perception of public value as seen through a common vision and agreed outcomes (or fundamental differences); shared planning and other governance mechanisms (or non-existent or token mechanisms).
- Capacity to implement including through relational and interactional processes and 'system bridgers' (or relational tensions and lack of systemic connections); compatible agency boundaries (or different geographical boundaries).

Systems thinking is essential for a public health model that emphasises the roles of universal services and strengthens connections among support pathways. As noted in FRSA's 2018 Research Report *Strengthening prevention and early intervention services for families into the future*, "many health and social problems have common foundations in experiences across the family life course. Hence, harnessing the family and relationship sector's existing capacity within a public health approach to increase the delivery of prevention and early intervention services makes sense as a strategy for coordinating with other professionals and organisations addressing Australia's priority health and social problems." [22]

Such coordination needs to occur across the range of universal, targeted and statutory services that aim to support child and family safety and wellbeing and reduce the risk of abuse, neglect and other crises. Importantly, coordination and collaboration cannot occur unless all parts of the system share a common vision, commit to a supportive culture (embracing respect, trust and shared responsibility) and draw from common governance arrangements and legislative support.[23]

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[20] https://frsa.org.au/wp-content/uploads/2019/02/312-FRSA-Linkages-Collaboration-Report-vWeb-2.pdf

[21] Winkworth, G., & White, M., (2010) May Do, Should Do, Can Do: Collaboration Between Commonwealth and State Service Systems for Vulnerable Children. Communities, Children and Families Australia

[22] https://frsa.org.au/wp-content/uploads/2018/01/FRSA-Research-Report-Printable.pdf

[23] These key elements of collaboration are detailed in https://www.aracy.org.au/publications-resources/command/download_file/id/107/filename/Inverting_the_pyramid_-_Enhancing_systems_for_protecting_children.pdf

As noted above, at present in Australia, the national government vehicle for steering collaboration across all jurisdictions does *not* include children and families as a priority issue. The National Federation Reform Council (with National Cabinet in centre), which replaced the former Council of Australian Governments in 2020, has prioritised job creation, mental health, emergency management, Indigenous Affairs, Veterans and women's safety, but there is no obvious mechanism for guiding systemic support for children and families or overseeing the development of the next National Framework for Protecting Australia's Children.

Recommendation 17:

That DSS facilitate a workshop on enabling systemic collaboration across key government and non-government stakeholders relevant to the FaC sector, with a view to strengthening linkages across universal services and referral pathways.

2.4 CAPABILITY AND INNOVATION

The discussion paper seems to focus on capability for evidence, outcomes measurement, reporting and evaluation, and also for better targeting of services to families who are very vulnerable/have complex needs, but does not detail capability and innovation for service delivery *per se*.

It is important not to stifle innovation by imposing 'evidence-based' programs (EBP) and EBP ratios without negotiating their relevance on a case-by-case basis. Just because a program has been accredited as 'evidence-based' does not mean it is suitable to be purchased 'off the shelf' and applied to a local context without any adaptation. FRSA's position is that while program activity can and indeed should be informed by a range of evidence, working with complex families and individuals by its very nature requires openness to innovation and flexibility, including trying things differently even when the 'evidence' suggests a different path. To that end, funding needs to include a level of flexibility to allow for responses to emerging situations and needs (the pandemic being a case in point).

Barriers to innovation include:

- Short-term funding periods and resource limitations – it is hoped these will improve once five-year contracts are in place, BUT without an increase in funding, organisations will continue to go backwards in real terms.
- Changes in (government) policy, not only within FaC but in relation to other DSS Activities and those of other departments and jurisdictions which have responsibilities for children, young people, families and communities.
- A paucity of systems thinking (see also 2.3 above). A cross-governments and departments systems approach is an important enabler for providers to build capability and foster innovation for collective impact. In its 2018 Inquiry into Human Services,[24] the Productivity Commission suggested that the best possible outcomes are not being achieved in family and community services because of service gaps, duplication, poor coordination, prescriptive contracts and short-term funding. Alongside the longer-term contracts already

[24] Family and community services: Chapter 8 - Inquiry report - Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services (pc.gov.au)

announced, we would encourage a more systemic approach to planning and coordination of services including an analysis of the needs of the service user population and identification of the outcomes government-funded programs are seeking to achieve. Thinking systemically about collaboration, including collaborative approaches to innovation, must be part of that.

- Little capacity for sharing information and innovation. All individual services are required to adapt to changing circumstances and external influences such as the pandemic; capacity for innovation would be greatly enhanced if mechanisms for sharing wisdom, expertise and problem-solving were developed from a systems perspective.

Discussion paper question 11: The capability building support offered under FaC activity programs has gone through several iterations. What works well? What do you think should change?

FRSA members indicated that the AIFS Expert Panel and Industry List are, in the main, considered positive initiatives for which Departmental support needs to continue to ensure that service design and adaptability is evidence-informed, and outcomes can be meaningfully measured. However, there were some concerns:

- The high cost and length of time involved in attaining accreditation is a significant (and insurmountable) barrier for many services.
- The Industry List range of programs is too narrow, for example it would be helpful to add more child-focused and relationship- focused programs.
- The AIFS accreditation process has a narrow view of what comprises 'evidence-based' – this can be unhelpful and counterproductive, e.g. in relation to the intent and philosophy of CfC FP.
- At least one FRSA member reflected that, given the relationship of panel members to the rest of the sector, it was important that possible conflicts of interest be identified before a service engages with the panel.

Feedback from FRSA members on more support needed:

- As noted earlier, capability could be supported by the provision of bigger-picture data, for example high level population data that points to wellbeing measures for all children and families in that region. If services have a better picture of wellbeing-related needs, they will be better able to tailor their programs to meet those needs.
- With reference to our response to question 5, if a program logic template is to be provided it will need to be accompanied by additional support for implementation and adaptation at the local level, with ongoing support to utilise and improve program logics and thereby improve service delivery and respond in real time to the challenges associated with achieving client outcomes. See recommendation 9.
- DSS assistance to analyse and assess data and provide a better understanding of reports that can be generated from DEX and SCORE.
- Resourcing to assist services in the AIFS accreditation process.

Discussion paper question 12: How can the department best work with (FRSA members) to support innovation in services while maintaining a commitment to existing service delivery?

The ability to innovate requires flexibility and capacity to adapt. The Department can support that flexibility by firstly affirming services' capacity to adapt to changing needs and circumstances – indeed, that is the very nature of their work with vulnerable individuals and families in complex situations, as demonstrated throughout 2020 (see part 3 below). Secondly, the Department can support innovation by allowing services licence to try things differently, to learn by doing and to use feedback on what is not working well to inform a process of continuous improvement. One obvious way to provide that support would be for the Department to view the Program Logics not as a point-in-time accountability measure, but as a tool that enables reflection, modification, adaptation and improvement, and points to ways of supporting innovation and further encouraging flexibility.

As discussed earlier, members have indicated they would benefit from more regular assistance to generate, read and understand reports they can get out of DEX and SCORE. Not all providers (particularly smaller providers) are aware of, or have the capacity to, access the range of reports offered in DEX. There are of course, specific concerns for CfC FPs and more support from DSS may be needed to facilitate shared reporting between CPs and FPs. Members also noted that more feedback from DSS on other reports submitted, such as AWPs, CfC Community Plans and Stocktake reports would contribute to continuous improvement including innovative changes to service delivery.

Other workforce support

DSS can support both existing service delivery and services' capacity to adapt and innovate by ensuring that funding and training support for the FaC workforce keep pace with both rising costs and the increasingly complex environment in which services are provided. FRSA members also suggested that funding agreements include a discrete, flexibly applicable allocation for innovation, and that DSS supported forums aimed at sharing and encouraging innovation would be useful.

Recommendation 18:

That DSS resource the establishment of Communities for Practice, focusing on issues of key concern to providers including innovation, and resource FRSA to coordinate and run the forums.

PART THREE: IMPACT OF RECENT EVENTS

The family and relationship services sector has, by its very nature, always been responsive to external influences including natural disasters, economic downturns and social change. Service provision has had to be both adaptable and resilient so that children, young people, families and the communities in which they live can themselves remain or become adaptable and resilient. Some situations have been ongoing, such as extended drought in communities already experiencing some level of social or economic disadvantage. Other situations may take place for a shorter period but have equally long-lasting and devastating effects, such as bushfires and floods. The impact of the pandemic in 2020 and 2021 is in another category altogether, with the whole nation, social and economic engagement, individuals, families and communities affected.

Discussion paper question 1: How have (FRSA members) adapted service delivery in response to recent crises such as bushfires, drought, floods and the Coronavirus pandemic? When has it worked and when hasn't it worked? How will this affect how you deliver services in the future? Have your service adaptations included better integration with other initiatives?

As soon as the pandemic was declared, FRSA members adapted quickly to ensure that transitions to new ways of working with clients were undertaken smoothly. While some client engagement still had to be provided face-to-face, much interaction with clients, community partners and stakeholders had to shift to telephone and online engagement.

Overall, moving to technology-assisted modes of engagement, assessment, case management and follow-up occurred smoothly with a high level of take-up by clients. Barriers to online engagement included limited or no access to appropriate technology (including access to computing and phone devices, internet access and data capacity; or competition within the household to use available technology e.g. for school and work as well as family support), concerns about e-Safety and the difficulty of dealing sensitively with clients for whom face-to-face engagement would be safer and more appropriate, especially for building and maintaining trust. Online engagement in group contexts was variable – it worked very well in some situations and was not suitable in others.

The impact of online engagement on actual outcomes was also variable. In many cases, service support could be fast-tracked and short-term outcomes achieved quickly, but in other cases, difficulties with access to or reliability (or appropriateness) of technology meant that outcomes were far more difficult to achieve. Many services found creative ways to connect with clients who did not have internet access, e.g. by providing mobile phones for regular telephone contact and support. Other barriers to services' ability to achieve outcomes included reported increases in the use of alcohol and other drugs, mental health issues and family violence, reduced child safety and clients experiencing financial issues.[25]

[25] FRSA (forthcoming), *Survey: Impacts of the COVID-19 Pandemic on Service Demand.*

The home environment became a critical contextual factor for determining the effectiveness of online engagement – the same home could provide a safe, stress-free environment for confidential engagement during non-lockdown periods *and* a highly stressed, noisy environment during lockdown when both schooling and work took place at home. Positive impacts of using online modes of support included substantial increases in attendance and completion rates because parents were less stressed, could participate after hours and had control over their participation. However, from a trainer/practitioner perspective, online platforms were limited in terms of assessing how clients were feeling and how well they were engaging.

Some services were not adaptable to online platforms and for some clients, face-to-face contact became even more important during periods of social restriction and lockdown. Where appropriate and permitted, home-visits were increased to educate and support parents who were struggling and needed more personal, face-to-face support. For other clients, online technology allowed them to engage with services that were supporting their children, where previously access to the parent/s had been much more difficult.

The focus of support also needed to change in many instances. In addition to the clients' original issues or concerns were added anxiety, the need for information and practical support such as food and IT (including devices, internet access and download capacity), and helping parents to home-school their children.

Operating in crisis mode gave service providers licence to do things differently when in the past change may have been resisted. The need to do things differently was an opportunity for more immediate cooperation with other programs to ensure clients could be linked with all necessary supports. In addition, the shift to telepractice and online support has opened opportunities for some services to offer support outside of nine-to-five business hours. At present this could be offered by only those workforces with enterprise bargaining conditions allowing work to be conducted outside of standard business hours.

Impacts on service demand

Service demand trends were impacted by the pandemic. Service demand data is not currently captured by DSS (data entered into DEX captures met demand but not unmet demand). In late 2020, FRSA conducted exploratory research via a qualitative survey to FRSA members to gauge changes/anticipated changes to service demand across the suite of Families and Children (FaC) Activity services.

High-level findings show that while there had been fluctuations in demand since March 2020 – attributed to service delivery constraints arising from lockdown restrictions[26] – an increase in service demand was experienced across a number of family and relationship services (on top of fluctuations), particularly family and relationship counselling and Specialised Family Violence Services. Where decreases in demand were reported, this generally resulted in a backlog/anticipated backlog as social restrictions eased.

[26] For example, due to court closures service demand for the Parenting Orders Program temporarily decreased and then providers began to experience backlogs as the courts re-opened.

Looking ahead, survey participants anticipated an increase in demand over 2021 as the impacts of the pandemic, such as job losses, continued to unfold and the JobSeeker Coronavirus Supplement is further wound back.[27]

Recent discussions with Victorian-based members, who have experienced far greater lockdown restrictions than the rest of Australia, highlight the issue of backlogs and the interplay with contractual commitments. Across an approximate 6-month period, and despite modifying service delivery to support families in a changed context, a number of families could not be seen, and service delivery targets could not be met. School and court closures, pressures on staff working from home, limited safe face-to-face spaces to see clients, inability to recruit – all impacted on service delivery. Those providers are now facing a backlog of clients alongside a potential increase in clients and need time to reforecast plans and seek approvals, in a timely manner, for carrying over underspends to meet this looming demand.

Looking ahead

While the initial response was quick and responsive, providing opportunities for new ways of engaging and working with clients, many questions remain. It is important to take time to reflect, and to undertake a full risk analysis and assessment of how satisfactorily outcomes have been achieved from the point of view of clients and practitioners. Such an assessment might include:

- The longer-term impact of the pandemic on client outcomes, service capacity to meet changing needs and impact on the workforce. It is possible that less complex issues were readily supported through online platforms, but more complex cases may take more time and face-to-face contact, and investment of other resources.
- Changes to working practices, including the provision of flexible and after-hours service, will have industrial relations implications that are yet to be teased out.
- Consideration of changes to geographic boundaries.
- The long-term repercussions (on clients and staff) of providing services through periods of crisis may take some time to become clear.
- The potential for adapting or expanding telepractice and online service interventions in the future and perhaps in different ways, e.g. extended reach across currently fixed geographic regions, expansion of after-hours service availability and increased scope for more cross-agency collaboration and learning opportunities. But there are also challenges e.g. geographic expansion of telepractice service may make it difficult to enable to enable consistency – e.g. connecting with the same practitioner. Issues of safety and suitability of telepractice must be addressed.[28]

Recommendation 19:

That DSS acknowledge the importance of enabling services to offer a mix of face-to-face and online service modes and provide assurance of ongoing resources and support to ensure that mix remains both viable and flexible into the future.

[27] FRSA (forthcoming), *Survey: Impacts of the COVID-19 Pandemic on Service Demand.*

[28] To this end, FRSA has embarked on a project with the Australian Institute of Family Studies that looks at telepractice for family and relationships services in terms of safety, suitability, enablers and risks.

Attachment 1: Rewording of the high-level outcomes

Overall vision: Children and young people thrive, families flourish, adults are resilient (empowered), communities are cohesive.

Outcome domain (all cohorts)	**Outcomes in DSS diagram**	**Members' comments/subsequent feedback**	**Consistency with DEX Partnership approach?** (includes SCORE outcomes, extended demographics, client goals, circumstances and satisfaction. Some domains overlap.	**Outcomes (all cohorts) – reflecting discussion paper, member feedback and DEX Partnership approach**	**Context/related service contexts/ special focus** *Applies to all cohorts and all outcome domains*
Safety	C&YP - 'feel safe and supported at home)	Make more prominent; safety in other contexts too – school, community Separate safety from support	Yes – personal and family safety	Feel safe and supported (at home, at school, in community) Individuals have someone they can trust Access to trusted support networks Family violence is reduced Child-safe communities	Family context – nature, composition, culture, intact, separated, blended, gender, parents (single, couple, young, older, gender), intergenerational, grandparents and other family members Gender, sexuality, identity Transition through life stages
Social and emotional wellbeing	C&YP – 'optimal mental and emotional wellbeing Adults – 'good mental and emotional wellbeing'	Link to mental health, substance abuse. Importance of parent-child attachment	Yes – mental health, wellbeing and self-care Feel listened to and understood	Improved mental health (reduced mental illness) Stronger relationships Improved understanding (and regulating) of emotions Improved social connections Increased self esteem Decrease in self harm	

				Reduced exposure to neglect/abuse Stronger self-efficacy Have a voice/feel listened to Increased understanding of own/child's/other's mental health issues and needs Decrease in anti-social behaviour Health and mental health literacy	Trauma Physical and mental health incl. co-morbidity; AOD Cultural context – identity, tradition, language, nature of families, expectations, culturally appropriate support; access to other supports CALD contexts e.g. recent arrivals or long-term First Nations contexts Location – geography; socio-economic area; rural, remote, regional metro
Learning/development	C&YP – 'better connected to school'; 'optimal learning/cognitive development Adults – 'increased parenting knowledge' Families - 'good communication skills'; 'good conflict management skills'; 'positive parenting practices'	Increasing knowledge and skills more strategies than outcomes. Being connected to school does not equate to a positive learning outcome. How to reflect transition points?	Yes - Age-appropriate development Knowledge, skills and education (for personal and family goals) Changed skills Changed knowledge and access to information	Developmental milestones are reached Ready for school/school and work transitions Improved language and literacy skills Improved knowledge and skills for personal growth (e.g. resilience, parenting) Increase in positive parenting practices School attendance and engagement / access to learning pathways Greater parent involvement in children's learning Greater enjoyment of learning	

Resilience	Adults – 'sense of self-efficacy and confidence' NB aim refers to 'empowered' individuals – does not reflect power imbalances e.g. in Aboriginal communities	Missing: financial resilience	Yes – financial resilience; empowerment, choice and control to make own decisions Also: changed impact of immediate crisis Engagement with relevant support services Better able to deal with issues	Improved self-efficacy and confidence Improved physical health (also relates to wellbeing) Increased knowledge and coping strategies to manage health, wellbeing, relationships, life skills Increased control over own environment/ decision-making Improved financial literacy and money management	Housing – affordability and quality, security of tenure Environment – built environment, open spaces Material basics including financial security, food security, technology, transport Community assets – schooling, health, retail, civic, economic (incl. employment opportunities), recreational, spiritual
Relationships	Family – 'positive caregiver-child relationship'; 'couple relationship satisfaction'; 'cooperative parenting' Communities – 'understand issues facing C&YP and families'; and 'C&YP have a say'	Relationship 'outcomes' don't reflect the complexity/diversity of families e.g. intergenerational, cultural, gender. How to reflect transition points?	Yes – family functioning	Strong **attachment** between child and primary care giver Increased **parental capacity** (and knowledge of developmental stages) Stronger family relationships (children, siblings, parents, grandparents, other kin, care givers, partners, elders, other) Improved communication, conflict management and problem-solving skills	

				Improved family functioning (regardless of 'family' situation) Increased trust in support resources (caregivers, other adults) Reduced family conflict Workable (separated) parenting arrangements	External influences including natural disasters, economic downturns, government policy (e.g. on JobSeeker) Existing referral pathways Links to/support from crisis services – police, emergency, child protection
Community connections and participation	C&YP – 'positive social relationships'; 'linked to appropriate services'; 'strong connection to community' Adults: 'strong connections to social supports and communities'; 'linked to appropriate services'; 'participation is enhanced' Communities - 'social ties and community cohesion' NB 'employment' listed as contextual	'Links to appropriate services' doesn't equate to actual outcomes – what's improved for the individual/family? Barriers to connection include language barriers, cultural concepts of family, inability to access systems, lack of income support. At community level, insert reference to child-friendly/safe communities Difficulty of enabling connections with NDIS providers.	Yes – community participation and networks; employment; engagement with relevant support services Also: Community infrastructure and networks Community knowledge, skills, attitudes and behaviours Social cohesion	Sense of belonging and connection Feel supported in community settings Increased participation in community life and events Feel more able to get support in time of crisis Increased engagement in education and work Successfully connected with wrap-around support Improved community wellbeing/connectedness Child-safe communities Socially inclusive communities	

Housing; and Material wellbeing and basic necessities	Not listed as outcomes, but as contextual factors	Material basics are often prerequisite outcomes for other outcomes to be achieved, e.g. access to IT; adequate and safe shelter; food security; access to bi-lingual information	**Yes** – listed in 'circumstances' group	See next column	See contextual factors above
Physical health	Not listed as an outcome, but as a contextual factor	Physical health outcomes are relevant – e.g. CaPS or FaRS services with AOD focus	**Yes** – listed in 'circumstances' group	See next column	See contextual factors above

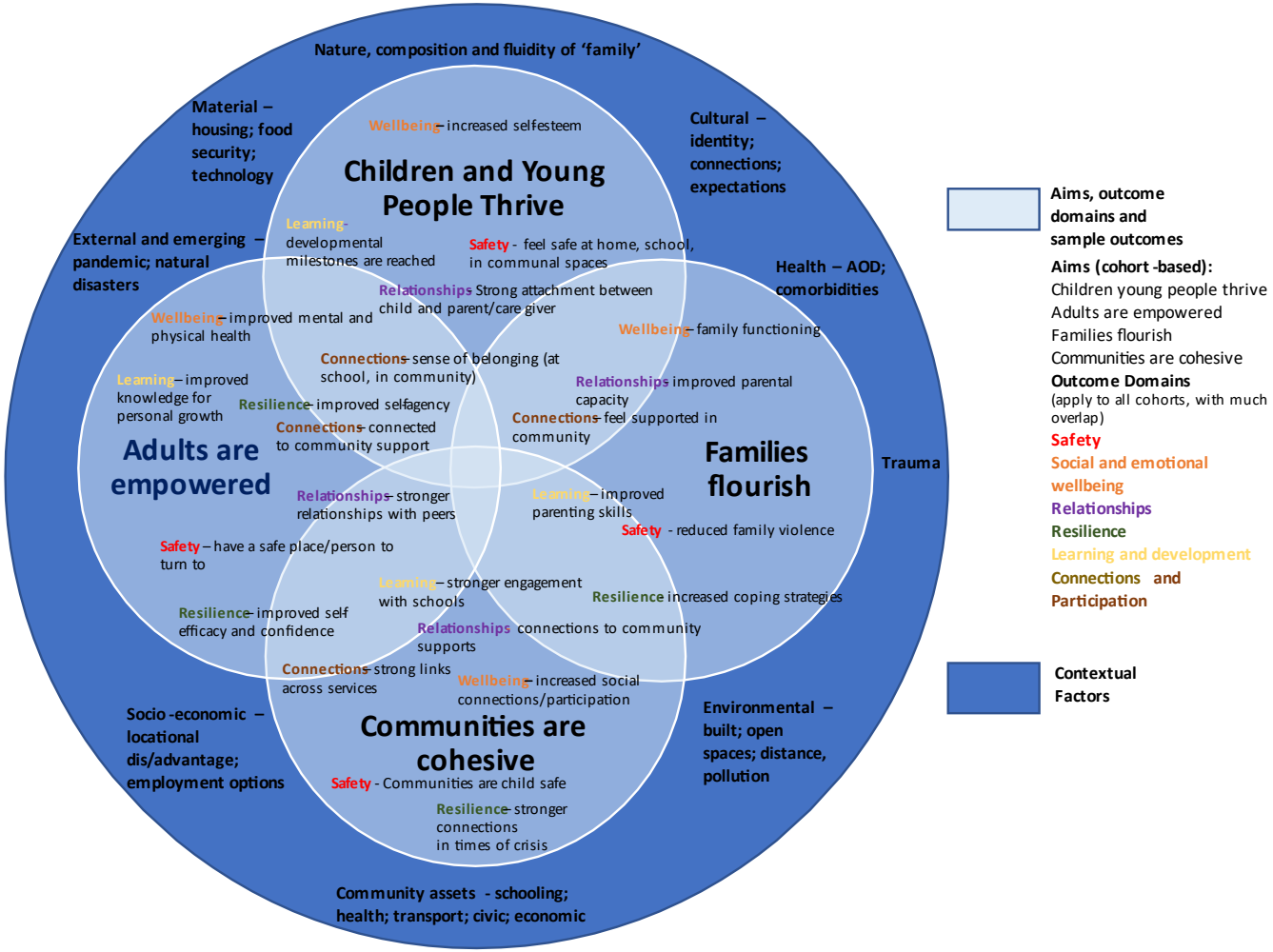
Focus of the above is client/population outcomes.

Attachment 2: Revised DSS diagram – see further explanation on page 10

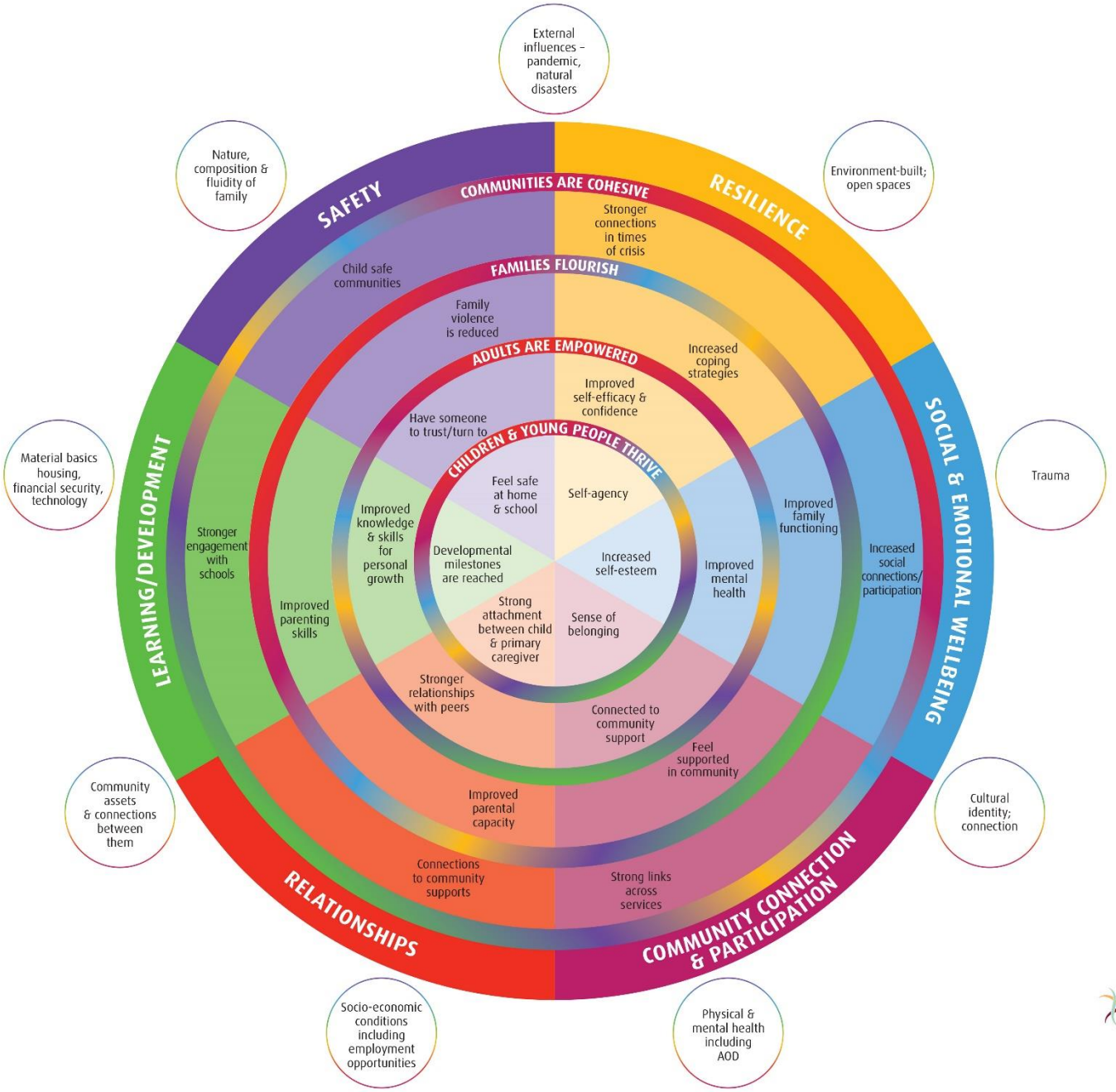
Families and Children Activity – suggested revision of high -level outcomes diagram (page 13 of DSS Discussion Paper), to better convey the intersection/overlap of outcomes and contexts, and to reflect input of FRSA members and other FaC providers participating in DSS consultations.

Note:

1. The suggested outcomes are indicative only; the list is by no means complete.
2. The same outcome may apply to all cohorts, whether or not it overlaps with other cohorts in the diagram.



Attachment 3: Alternative diagram – see explanatory text on pages 10-11



Attachment 4: Additional outcomes for 'children and young people thrive'