Are you an individual or making a submission on behalf of an organisation?

Organisation

Organisation name

Connected Self

Is your organisation....?

- A provider currently funded under one or more of the 5 programs in scope for this consultation

What type of service or support do you mostly provide?

- Prevention or early intervention services
- Intensive family supports

What state or territory does your organisation deliver services and supports in?

- South Australia

Where does your organisation deliver most of their services and supports?

Major city

1. Does the new vision reflect what we all want for children and families?

The new vision captures several important elements of what we collectively want for children and families. However, it omits a core pillar: the role of community. There is strong emphasis on responding to community need in the investment priority areas, yet community connection is not reflected in the proposed streams. This creates a gap between intent and operational delivery. Strong families are vital, but resilient children are shaped not only by their immediate caregivers—they are shaped by the networks, relationships and environments around them.

A substantial body of research shows that children develop resilience when they have at least one consistent, healthy, loving relationship with a stable adult, and this protective relationship is often found outside the family—through teachers, coaches, extended kin, youth workers, Elders, and community members (National Scientific Council on the Developing Child (2015). Community connection also protects against isolation, strengthens cultural identity, and provides relational buffers when families are under strain.

Recent lived-experience evidence reinforces this. The ALIVE National Centre's

Dataset of Mental Health Priorities—one of the most contemporary collections of lived-experience perspectives from young people, families and kinship groups—shows a strong preference among young people for community-led, group-based supports to complement individual interventions (ALIVE, n.d.). Young people consistently articulate that belonging, peer connection, cultural identity and community participation are central to their wellbeing and resilience. Our own local observations reflect these findings - the skills children and young people learn in individual targeted support they then must practice in real world where group dynamics exist - individual support and group support function in harmony.

By focusing solely on "families" without embedding the broader community ecosystem, the vision risks unintentionally narrowing support systems and overlooking the protective role of schools, communities, ACCOs, neighbourhood networks, and trusted adults who often hold children through the hardest periods of adversity.

A truly strong vision must reflect families within community, not families in isolation.

Reference: ALIVE. (n.d.). The ALIVE National Centre Dataset of Mental Health Research Priorities (2022-current) by people with lived-experience of mental ill-health and carer, family and kinship group members.
https://alivenetwork.com.au/mental-health-priorities-database/

National Scientific Council on the Developing Child (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper No. 13. Retrieved from www.developingchild.harvard.edu.

2. Are the two main outcomes what we should be working towards for children and families? Why/Why not? - Outcome 1: Parents and caregivers are empowered to raise healthy, resilient children - Outcome 2: Children are supported to grow into healthy, resilient adults.

The proposed outcomes are clear, measurable and easy to interpret. However, like the vision, they lack an explicit focus on community. Community connection could either be articulated as a third standalone outcome, or embedded as a key indicator within the existing outcomes. For example, one critical pathway through which the DSS outcome 'children are supported to grow into healthy, resilient adults' can be achieved, is through safe, culturally grounded, community-based relationships and environments—not only through families or services.

Without an explicit community component, the current outcomes risk overlooking a critical protective factor that young people themselves identify as essential (ALIVE, n.d.). Integrating community into the outcomes framework would better reflect how resilience is actually built—in families, yes, but also in connection with the communities around them.

ALIVE. (n.d.). The ALIVE National Centre Dataset of Mental Health Research Priorities (2022-current) by people with lived-experience of mental ill-health and carer, family and kinship group members. https://alivenetwork.com.au/mental-health-priorities-database/

3. Will a single national program provide more flexibility for your organisation?

Connected Self has delivered trauma-informed, relationship-based programs to South Australian children and families since 2007, working across more than 50 schools and supporting over 1,000 students, including Aboriginal young people, Culturally and Linguistically Diverse (CALD) communities and students with disabilities. As a long-standing member of the Department for Education's preferred provider panel, we bring deep relational practice, fast adaptation, and program fidelity, positively impacting thousands of students through hundreds of dedicated sessions and tailored interventions. This includes our extensive work through Pre-School Boost and other state-funded initiatives delivered in collaboration with the Department for Child Protection (DCP), the SA Housing Trust (SAHT), and a range of schools, community services, and early years settings. Our experience across multiple government portfolios means we can integrate supports, reduce duplication, and respond quickly to emerging needs.

The program we provide which was previously through the Communities for Children (CfC) funding stream, Adventure to Thrive, is a clear case study of the challenges identified in the DSS discussion paper. We have consistently been able to pinpoint where children and families need deeper, targeted support for the greatest impact— yet have been constrained by funding structures that prevent multiple, integrated services from being delivered under one model. This is precisely the type of high-impact, community-embedded work that has been limited by rigid systems.

We therefore strongly welcome the proposed shift toward relational, flexible commissioning. This direction has the potential to maximise impact, safeguard program quality, and support whole-of-system accountability.

4. Does the service or activity you deliver fit within one of the three funding streams? Do these streams reflect what children and families in your community need now – and what they might need in the future?

Yes – Since 2022, we have partnered with AnglicareSA to deliver Adventure to Thrive, through the Communities for Children (CfC) funding stream. Independent

qualitative and quantitative evaluation shows consistent, measurable gains in children's emotional regulation, resilience, group cohesion, confidence, and overall wellbeing. The program has generated a peer-reviewed scientific publication, with more expected to be published shortly in collaboration with Flinders University, Swinburne University and University of Tasmania. It has also delivered observable gains in school behaviour, engagement, and attention, captured by teacher observations. As one student shared, "I now know how to handle problems in my life."

This program will fit perfectly under the stream for Prevention and Intervention. Adventure to Thrive is also already a living example of relational commissioning in practice. Connected Self and Anglicare have worked in genuine partnership for many years, each contributing strengths that create outcomes neither could achieve alone:

• Anglicare provides invaluable infrastructure and oversight— routinely fund and manage programs adjacent to—but outside of—Connected Self's ecosystem, which enables them to identify emerging gaps, monitor what is and isn't working across sectors (i.e. real-time insight into community trends and system-wide pressures).

• Connected Self provides the specialist expertise — trauma-responsive program design, polyvagal-informed delivery, co-design with children, and long-standing relationships with local schools and partners.

One direct outcome of this partnership was the creation of an intensive, tailored pilot program for children experiencing school refusal or "school can't" as they transition to high school. The need for this support was identified through Connected Self's long-standing relationships with local schools and families and reinforced by complementary insights from Anglicare—enabling both organisations to respond quickly and collaboratively.

Together, this partnership demonstrates the very model the DSS reforms are seeking to expand.

The three proposed funding streams broadly align with what children and families in our community need both now and into the future. Prevention, early intervention, and targeted support remain essential pillars. However, several refinements are needed to ensure the streams are fully responsive to the lived realities and emerging needs of families across Australia.

1. Community must be recognised as a core protective factor

Children do not grow up in families alone; they grow up in networks of community connection. Lived-experience research such as the ALIVE National Centre Dataset shows that young people consistently request community-led, group-based and relational supports alongside individual interventions. Without acknowledging

community connection as a key mechanism of resilience, the streams risk overlooking a major driver of wellbeing. Our own local work has reflected these wider trends showing that the skills children learn in individual targeted support they then must practice in group dynamics to adapt them to the real world. Individual work and group work occur in harmony.

2. Future demands: Children's needs are becoming more complex, not less

The streams need clarity around how providers working with high-complexity cohorts will be resourced appropriately. The DSS proposes using SEIFA, Census data, the Australian Early Development Census (AEDC), and Child Protection data to recognise levels of need within communities, rather than allocating funding based solely on population size. We strongly support this direction. These datasets are well suited to identifying structural and community-level disadvantage, helping ensure resources are distributed fair/equitably rather than equally.

However, these data sources primarily measure population characteristics, not individual complexity. Their most appropriate use is for equity weighting, not for determining complexity loadings (i.e individual-level complexity). Within any community (high or low SEIFA), the complexity of individual children varies widely. Without a mechanism to recognise individual or cohort-level complexity, a funding model risks overlooking children with the highest relational, emotional and psychological needs—particularly those experiencing multiple, intersecting adversities. This is why complexity loadings are essential: they prevent providers from being penalised for doing intensive, relational, trauma-responsive work with high-complexity cohorts. Instead, higher-complexity children and families require longer engagement, more stabilisation, and a greater number of touchpoints before sustainable outcomes can be achieved.

We suggest the need to introduce a dual funding structure combining equity weightings and complexity loadings. To ensure resources flow fairly and proportionally to both community-level need and individual-level complexity

In summary, the streams are directionally correct, but their long-term effectiveness depends on strengthening community involvement and resourcing complexity appropriately.

5. Are there other changes we could make to the program to help your organisation or community overcome current challenges?

Preventing Forced Consortia:

Mandating or preferentially rewarding consortia bids risks producing administrative partnerships rather than functional integration. Evidence from prior national reforms shows that when consortia are required, providers often form paper collaborations (ANROWS, 2016; Productivity Commission, 2013)that create expensive:

• bureaucratic governance overhead,
• slower decision-making,
• reduced agility,
• blunted local responsiveness, and
• resource diversion from frontline service delivery.

Moving Away from Forced Consortia Strengthens DSS Outcomes: Research across child protection, health systems, and community services consistently shows that relational integration—shared practice, warm handovers, transparent communication, and joint problem-solving—is far more effective for families than structural integration e.g., formal consortia boards or mandatory MOUs (ANROWS, 2016; AIFS Community Engagement Paper, 2016; Muir et al., 2010; Productivity Commission, 2013; Nielsen-Hewett et al., 2023, Orygen, 2022). Forced consortia also disproportionately burden small and culturally specific organisations, whose resources are consumed by governance requirements instead of service delivery (SNAICC & Deloitte, 2024).

Agile, place-based services require autonomy. When providers are locked into consortium structures, they lose the ability to adapt quickly to school and community needs, tailor delivery to cultural contexts, and flex resources toward emerging risks or opportunities (Productivity Commission, 2013; State of Victoria, Department of Health & Human Services, 2016). This flexibility is core to the proposed commissioning model.

Suggested approach: Support integration through demonstrated practice rather than forced consortia. The department could:

a. Measure collaboration in practice—not in procurement paperwork.

Providers should demonstrate genuine ecosystem engagement through:
• evidence of co-delivery, not membership in a consortium
• ecosystem mapping: clear understanding of assets, gaps, and referral pathways
• verified warm handovers reported in contract reviews (e.g., quantify and report genuine collaborative behaviours such as proportion of children receiving supported referrals, frequency of joint meetings or case coordination, evidence of communication with allied providers)
• testimonials or letters from local partners
• examples of co-design, joint planning, and shared problem-solving

b. Use Capability-Based Scoring for Integration

DSS can assess organisations on their:
• history of collaboration
• depth of local partnerships
• culture of shared learning

• demonstrated capacity to work effectively within local ecosystems

c. Avoid Mandatory or Preferential Consortia Requirements
This prevents:
• unnecessary governance costs
• administrative complexity
• loss of agility in high-need communities
• barriers that disproportionately affect small and culturally specific organisations

d. Encourage Relational Integration Mechanisms
Instead of structural consortia, DSS can
• support communities of practice
• promote shared learning sessions
• encourage joint training
• fund collaborative projects through voluntary partnerships

This approach ensures true sector-wide learning, preserves autonomy, and keeps resources focused on frontline outcomes rather than administrative structures.

6. Do you agree that the four priorities listed on Page 4 are right areas for investment to improve outcomes for children and families?

Yes, the four priorities represent the right direction for improving outcomes for children and families, and they reflect many of the system-level challenges that frontline providers see daily. They are aligned with what research, lived experience, and community feedback all point to: the need for prevention, community connection, and intensive support for families facing adversity.
However, the success of these priorities will depend on how they are implemented. Several critical gaps must be addressed (see next section)

7. Are there any other priorities or issues you think the department should be focusing on?

The priority areas are broadly on the right track, but each requires further consideration to avoid foreseeable pitfalls in implementation. Specifically:
1. Priority Area 1 (invest early) – Complexity and equity must be addressed together
Funding reform must incorporate complexity loadings in addition to equity weightings, ensuring providers supporting children with intersecting needs are not

disadvantaged – see response to question ‘Responding to community need Beyond locational disadvantage, what other factors should the department consider to make sure funding reflects the needs of communities?’

2. Priority Area 2 (Connected/co-located) – Avoiding forced consortia

The system must ensure integration is driven by demonstrated collaborative practice, not by mandatory consortia arrangements, which have historically created administrative partnerships rather than functional ones. See response to question ‘Are there other changes we could make to the program to help your organisation or community overcome current challenges?’.

3. Priority Area 3 – Strengthening community alignment

There is strong emphasis on responding to community need in the investment priority areas, yet community connection is not reflected in the proposed streams. This creates a gap between intent and operational delivery. Suggested Approach: explicitly define the role of community. Also see response to question ‘Does the new vision reflect what we all want for children and families?’.

4. Priority Area 4 – Supporting smaller providers

Smaller and culturally specific organisations need dedicated support, stable contracting conditions, and genuine access to funding streams, otherwise the reform risks reinforcing the dominance of large providers. See response to question ‘How could the grant process be designed to support and increase the number of ACCOs delivering services to children and families?’.

8. Do the proposed focus areas – like supporting families at risk of child protection involvement and young parents match the needs or priorities of your service?

Yes, the proposed focus areas align closely with the needs and priorities we see across our service. Many of the children we support are experiencing early indicators of adversity, dysregulation, developmental vulnerability, or family stress—factors that often precede child protection involvement.

Similarly, parents are a cohort we engage with through school-based and community pathways. This includes providing accessible “postcard” information brochures with QR codes that link to simple activities parents can continue at home with their children. We see significant need for relational, strengths-based support for many parents across all of our services, who often face compounding challenges including housing instability, financial stress, limited social support, and intergenerational trauma.

Our program model—particularly Adventure to Thrive—already addresses these focus areas by:

- providing early emotional regulation and relational safety skills for children;
- providing information about appropriate services before issues escalate;
- identifying children who may require additional targeted support;

• working collaboratively with partners such as Anglicare to recognise students at risk; and
• engaging parents, caregivers and schools in relational, trauma-informed approaches.

These focus areas not only reflect the current needs we are seeing—they are exactly where we have expertise and where we see our greatest impact.

9. Are there other groups in your community, or different approaches, that you think the department should consider to better support family wellbeing?

Yes. Based on our work across schools, families and communities, there are several additional groups and approaches the Department should consider to strengthen family wellbeing and prevent escalation into crisis systems.

1. Families experiencing "hidden" complexity (not engaged with statutory services)

Many families experiencing trauma, violence, disability, or chronic adversity may not present to child protection services or other professional forms of care. Without proactive relational engagement, they remain invisible to systems. Community services can act as a buffer to protect families during times of stress, however there are no streams to enable community building in this new approach. Community based models that build connection and identify early signs of stress and connect families to support before risk escalates.

2. Children with intersectional or compounding needs

Children who experience multiple adversities—such as trauma exposure, disability, neurodiversity, poverty, or family instability—require supports that are flexible, relational, and multidisciplinary. Incorporating complexity loadings within funding models enables providers to allocate the time and intensity needed for deep relational work. This acknowledges that meaningful progress for higher-complexity cohorts often takes longer, and that supporting a smaller number of children more intensively can produce stronger, more sustainable outcomes over time.

10. What are other effective ways, beyond co-location, that you've seen work well to connect and coordinate services for families?

The coordination of services for families has been highly effective through our Adventure to Thrive program, which already operates as a living example of relational commissioning in practice. Connected Self and Anglicare have worked in a genuine, long-standing partnership where each organisation contributes distinct but complementary strengths that neither could achieve alone:

• Anglicare provides invaluable infrastructure and oversight— routinely fund and manage programs adjacent to—but outside of—Connected Self's ecosystem,

which enables them to identify emerging gaps, monitor what is and isn't working across sectors (i.e. real-time insight into community trends and system-wide pressures).

• Connected Self provides the specialist expertise — trauma-responsive program design, polyvagal-informed delivery, co-design with children, young people and caregivers and long-standing relationships with local schools and partners.

Through this model, Anglicare can provide steering, whilst we provide opportunities to school groups to learn and practice emotional regulation in a dynamic group environment. This relational model enables a seamless coordination pathway.

Within program delivery, we are able to identify individual children who may benefit from additional or specialised support. Through relational case discussions with Anglicare, we can jointly determine the most appropriate targeted responses—combining Connected Self's practice insight with Anglicare's broader system knowledge to link families with adjacent supports that would otherwise sit outside our line of sight.

The primary limitation to date has been the inability to fund these tailored intensive supports, despite clear evidence of need. The new national program has the potential to finally create a pathway for these children, enabling relational decision-making to translate into funded action.

This experience demonstrates that effective coordination does not require co-location. It requires:

• a trusted relational partnership (not forced consortia)
• complementary organisational roles,
• shared visibility of children's needs, and
• flexible pathways for warm handovers and collaborative decision-making.

This is the type of integration that relational commissioning seeks to achieve—and Adventure to Thrive already shows that it works. In direct opposition to this is forced consortia.

Our Adventure to Arrive (AtA) model for children experiencing "school Can't" / School refusal further illustrates how strong outcomes emerge when partnerships form around shared goals and shared purpose, rather than contractual obligation.

AtA brings together three schools—two primary feeders and a high school—to support young people during the critical transition into Year 7. These schools are not co-located, yet they collaborate closely because they hold a common priority: ensuring vulnerable students experience a safe, connected, and confident transition.

Through these shared goals, partners naturally engage in:

• dynamic information sharing,
• joint planning and problem-solving, and
• coordinated support for individual students and families.

This relational model contrasts with the limitations of co-location or mandated consortia, where collaboration depends on structures rather than trust. Co-location alone does not guarantee shared practice; nor do formal consortia, which often impose governance layers that slow decision-making and reduce agility.

What makes AtA successful is not proximity or structure—it is that partners are aligned in values, motivated by a common purpose, and committed to working collaboratively for the young people they share. This allows for nimble, responsive support that meets students where they are, across multiple settings and relationships.

Together, these examples show that relational commissioning fosters real integration grounded in trust and shared goals, not compliance or paperwork.

11. What would you highlight in a grant application to demonstrate a service is connected to the community it serves? What should applicants be assessed on?

Authentic community-led design must be ongoing. Lived experience should be embedded at every stage—design, delivery, evaluation and governance. There needs to be a mechanism for tracking this post application stage. Evidence shows that one-off consultations lead to shallow 'tokenistic' engagement which perpetuate harm (Pratt, 2020). A review of the health sector demonstrated that without continuous community voice, services drift away from need, become less effective, and generate higher downstream costs through disengagement, crisis escalation or program misalignment Cortis & Blaxland, 2022).

Suggested approach:

Embed mechanisms for continuous community voice throughout the contract lifecycle—not just at application. DSS could require:

• Annual community feedback loops to capture lived experience insights from families, children, schools and local partners.

• Co-design/community input reviews during contract renewal to demonstrate how community voices shaped service adaptations over time.

• Real-time feedback systems, such as short digital prompts, advisory panels, or community check-ins, enabling providers to adjust quickly as needs evolve.

12. Beyond locational disadvantage, what other factors should the department consider to make sure funding reflects the needs of communities?

The DSS proposes using SEIFA, Census data, the Australian Early Development Census (AEDC), and Child Protection data to recognise levels of need within communities, rather than allocating funding based solely on population size. We strongly support this direction. These datasets are well suited to identifying structural and community-level disadvantage, helping ensure resources are

distributed fair/equitably rather than equally.
However, these data sources primarily measure population characteristics, not individual complexity. Their most appropriate use is for equity weighting, not for determining complexity loadings (i.e individual-level complexity). Within any community (high or low SEIFA), the complexity of individual children varies widely. Without a mechanism to recognise individual or cohort-level complexity, a funding model risks overlooking children with the highest relational, emotional and psychological needs—particularly those experiencing multiple, intersecting adversities. This is why complexity loadings are essential: they prevent providers from being penalised for doing intensive, relational, trauma-responsive work with high-complexity cohorts.
Limitations of proposed datasets:
• SEIFA measures area-level socioeconomic disadvantage. It cannot detect whether individual children in a high-SEIFA area have high trauma, disability, family violence exposure. It 'smooths data' across whole suburbs, hiding pockets of extreme hardship. It is ideal for equity weighting.
• Census data / ACDC is useful for context, but not appropriate for complexity loadings on their own. They both indicate risk of long-term disadvantage, but it is historical (may lag by 3–5 years), the data is aggregated and not connected to individual trauma or family functioning.
• Child protection data is highly relevant to complexity loading but only if the DSS gains access to local-level data as state-level data would be too coarse. However, it cannot be used soley to attribute complexity as it misses rating complexity for those not involved with child protection agencies who may be equally if not more vulnerable.
Suggestion: Introduce a dual funding structure combining equity weightings and complexity loadings. To ensure resources flow fairly and proportionally to both community-level need and individual-level complexity, DSS could consider:
a. Tiered funding options which combine equity and complexity
Implement a flexible structure that integrates both community-level equity and individual-level complexity:
• Universal tier (equity-weighted) – Provide baseline relational and wellbeing support determined by equity weightings (e.g., SEIFA), ensuring providers working in structurally disadvantaged or high-risk ecosystems receive proportionate resourcing.
• Complexity tiers (add-on intensive supports) – Enable providers to access complexity loadings when they can demonstrate a disproportionately high-need cohort or individual caseload (e.g., referral surges, ACEs profiles, intersectionality, crisis presentations, disability, safety risks, or sustained dysregulation). Complexity tiers serve as the operational mechanism for allocating additional resources.

13. What's the best way for organisations to show in grant applications, that their service is genuinely meeting the needs of the community?

The best way for organisations to demonstrate that their service genuinely meets community needs is through evidence that goes beyond statements of intent and shows verifiable, relational, community-driven practice. High-quality applications should include a combination of:

1. Demonstrated community voice and co-design
• summaries of community consultations, co-design workshops, or engagement sessions
• lived-experience input, including quotes or themes
• evidence that community feedback directly shaped service design or adaptation
• case studies of those who took part in their service
2. Data that reflects real, local need
• school or community referral patterns
• complexity indicators (ACEs trends, trauma exposure, dysregulation presentations)
• waitlists, outreach demand, or patterns of crisis presentations
3. Evidence of integration within the local ecosystem
• warm handovers
• joint planning notes
• letters of support from schools, Aboriginal Community Controlled Organisations (ACCOs), youth services or community leaders
4. Clear outcome evidence – quantitative and qualitative
• validated tools (e.g., wellbeing measures, regulation indicators)
• pre/post program shifts
• case studies showing growth over time
• testimonials from families, schools or young people
5. Adaptation and learning over time
• respond to emerging community trends
• adjust program content /service delivery based on feedback
• refine processes through reflective practice
• use data to improve delivery
6. Governance and cultural safety embedded in practice
• partnerships with ACCOs or other cultural /lived experience groups
• cultural governance structures
• training in trauma-informed and polyvagal-informed practice
• workforce stability metrics

14. How could the grant process be designed to support and increase the number of ACCOs delivering services to children and families?

Smaller and/or culturally specific organisations are critical to relational commissioning because they hold deep community trust, cultural knowledge, and long-term relationships. However, research shows they are often disadvantaged in competitive funding processes. For example, the Secretariat of National Aboriginal and Islander Child Care & Deloitte (2024) found that large providers routinely dominate tenders due to scale advantages, while smaller and ACCO organisations face disproportionate administrative burden and lose funding despite delivering culturally safer services.

Large national providers often dominate competitive funding. Without explicit mechanisms to protect and grow these organisations, the unified framework may unintentionally consolidate funding within large NGOs—reducing cultural safety, community trust, and local responsiveness. This ultimately increases long-term system costs, as families disengage from services that lack cultural alignment.

Suggested approach:

Ensure the unified framework intentionally protects, resources, and strengthens small and culturally specific providers. The department could:

a. Longer Contract Terms

Provide multi-year (3-5 year) contracts to stabilise workforce, governance and leadership structures—reducing turnover and improving continuity of relationships.

b. Subcontracting and Partnership-Based Delivery

Enable flexible arrangements where large NGOs can subcontract to or partner with smaller providers, ensuring:

- community-specific expertise is embedded
- cultural safety is upheld
- funding flows into grassroots organisations
- smaller organisations retain autonomy while benefiting from NGO infrastructure

c. Reduced Administrative Burden for Small Providers

Streamline reporting and provide tiered compliance expectations that reflect organisational size and risk, freeing up capacity for frontline delivery.

d. Equity Weightings Within Funding Models

Apply loadings that recognise the additional cultural, geographic, linguistic and relational labour borne by small and ACCO providers.

15. What else should be built into the program design to help improve outcomes for Aboriginal and Torres Strait Islander children and families?

The following analysis is drawn directly from a resource published by the Secretariat of National Aboriginal and Islander Child Care – the National Voice for Aboriginal

and Torres Strait Islander children (SNAICC , 2012).

Research shows that barriers to participation in early childhood services extend well beyond the availability of services in a given area. As Flaxman and Muir emphasise, “Increasing the number, scope and capacity of services did not necessarily mean Indigenous families accessed and engaged with these services.” Instead, a wide range of complex and interrelated factors contribute to lower engagement, including:

• Venues that are too small, inadequately resourced, or not appropriately set up for young children.
• Difficulty accessing services due to isolation, distance, or limited transport options — an issue that also affects families living in outer suburban areas.
• Limited transport availability, which also restricts the involvement of Elders and community members.
• Prohibitive fees, even when services are heavily subsidised.
• Unmet cultural, relational, or support needs of families.
• Complex cultural relationships within communities, including family or community conflict.
• Fears of racism, judgement, or that engagement with early childhood settings may undermine Aboriginal culture.
• Negative associations with government services and institutions, including concerns that children may be removed.
• Inflexible entry requirements, such as access only via referral.
• Workforce challenges, including difficulties recruiting and retaining Aboriginal and Torres Strait Islander staff, limited language fluency among staff, and a lack of systematic cultural competency training.

The SNAICC publication articulates key principles, recommended practices, and expected outcomes, along with practical guidance on how to implement them. We recommend reviewing the full document for further detail and direction.

We suggest reading this document for guidance as well as the other guidance documents on their website.

SNAICC – National Voice for our Children. (2012). Improved outcomes for Aboriginal and Torres Strait Islander children and families in early childhood education and care services: Learning from good practice. Retrieved December 4, 2025, from https://www.snaicc.org.au/resources/improved-outcomes-in-ecec/

16. What types of data would help your organisation better understand its impact and continuously improve its services?

Previously funding was streamlined through local partners such as Anglicare, who held a broad ecosystem view and provided essential feedback on gaps, strengths,

and emerging needs. By removing the 'gatekeeper', there is a risk that individual providers will be blind to trends outside of, but still relevant to, their own ecosystem. Without common data platforms, providers lack the ability to benchmark performance, improve quality, or understand where community needs are shifting—leading to duplication, inefficiencies, and higher long-term costs.

Suggested Approach:

To support whole-of-system improvement, DSS should consider:

a. Repositioning the historical 'gatekeepers' (e.g., Anglicare) into a new systems-integration role.

Rather than removing these organisations entirely, they could be supported to act as integration facilitators—helping to connect providers, maintain historical community knowledge, and support practical, problem-oriented collaboration across the local ecosystem. This would economically preserve critical system intelligence, historical lived-experience, and strengthen cross-provider coordination.

b. Establishing simple, accessible data infrastructure to support shared learning and continuous improvement, such as:

De-identified regional trend dashboards (e.g., quarterly newsletters or online portals) showing demand trends, complexity, demographics and referral patterns. The purpose of this is not to compare providers but rather to identify emerging gaps, monitor what is and isn't working across sectors (i.e. insight into community trends and system-wide pressures).

17. What kinds of data or information would be most valuable for you to share, to show how your service is positively impacting children and families?

The most valuable data for us to share is a combination of quantitative outcomes, qualitative case insights, and culturally grounded measures that together show both individual change and community-level impact. Specifically:

1. Pre–post outcome data using validated, culturally appropriate tools

We collect pre–post data indicating domains of resilience (wellbeing, sense of belonging, outlook and emotional regulation abilities) using a validated tool that is culturally appropriate for Australian students. This includes cultural appropriateness for use with Aboriginal and Torres Strait Islander children—developed alongside community, endorsed by cultural advisors, and optionally available in First Nations languages.

This allows us to:

- measure changes in emotional regulation, resilience, belonging and wellbeing
- compare cohort outcomes with national baseline data
- track shifts over time and across population groups
- provide strong quantitative evidence that our service delivers meaningful change.

2. Rich case studies illustrating growth over time

Alongside quantitative data, we use structured case-study templates that show:

• the individuals starting point
• changes in emotional regulation, behaviour and engagement
• contextual factors influencing progress
• the relational and community supports involved
• how targeted interventions contributed to outcomes

These case studies humanise the data and demonstrate the nuance of relational practice.

3. Community and school feedback

Feedback from schools and families demonstrate:

• the service is relevant
• culturally safe
• responsive to local need
• integrated within the community ecosystem

Additionally, we have records of the number of schools who've requested we return to deliver the program to new cohorts demonstrating the success in the wellbeing coordinators viewpoint.

4. Indicators of system-level impact

We can also provide:

• referral patterns
• engagement with complementary services
• early identification trends (e.g., dysregulation, developmental vulnerability - These indicators show how our service contributes to prevention, reduces escalation, and supports broader system coordination.

19. What kinds of templates or guidance would help you prepare strong case studies that show the impact of your service?

We already use field-tested templates developed over several years through multidisciplinary design and partnership with community stakeholders. These tools enable us to track growth over time, coordinate referrals, and capture both qualitative and quantitative outcomes in a clear, meaningful way.

20. What does a relational contracting approach mean to you in practice? What criteria would you like to see included in a relational contract?

Relational commissioning only delivers if trust, autonomy and practice adaptivity remain central. If oversight becomes overly bureaucratic, it replicates traditional transactional models and undermines relational intent (PMC, 2022).

Suggested approach:

• Shift focus from outputs to outcomes: Anchor accountability in a small set of shared outcomes (e.g., belonging, regulation, wellbeing, engagement) using a small set of shared measures (qualitative + quantitative)
• Maintain and strengthen shared learning cycles—such as quarterly reflective practice sessions and provider forums—already operating effectively under Communities for Children. These structures should be retained within the new approach to ensure continuous learning, shared insight, and relational practice across providers.
• Jointly agree on adaptation parameters, clarifying which changes require approval and which are within provider discretion
• Support shared risk and joint problem-solving among providers and DSS
• Require adaptation logs and reflective practice rather than punitive sanctions
• Quality of relationships with families and partners - Relational quality is the strongest predictor of outcomes in trauma-informed and early intervention systems. It also correlates with retention, trust, and safety. This can be assed via evidence of warm handovers, joint planning notes, collaboration across ecosystem

Additionally, a relational model only works if funding can flex in real time. When providers demonstrate strong outcomes and increasing demand, rigid budgets force families onto waitlists, reduce impact, and create higher long-term costs (e.g., escalation to crisis services, disengagement from school). For example, the research report "Counting the Cost of Late Intervention" shows that delayed support for at-risk children in Australia costs around AUD $15.2 billion annually (The Kids Research Institute Australia, 2020). Allowing transparent, evidence-driven funding adjustments is far more cost-effective than recommissioning, retendering, or repeatedly onboarding new providers. It preserves program continuity, protects quality, and directs resources where they will prevent harm and reduce downstream system costs.
Suggestion: Build a flexible, cost-effective allocation model that allows funding to scale based on evidence rather than competitive re-tendering. This could operate through:
a) Predetermined tiered Funding Add-Ons
Triggered through relational evidence (not retendering) to allow for funding:
• additional cohorts
• Supplementary intensive support for high-need students/families
• Short-term targeted work as needs arise

b) Evidence-Based "Growth Requests":
Providers can apply mid-contract for added funding based on:
• increased referrals or waitlists

• higher trauma or complexity loads
• demonstrated program effectiveness
• local ecosystem changes (e.g., school closures, new developments, crises)
• the need to innovate or adapt service delivery in response to presenting needs—including refining existing approaches, trialling new modalities, or introducing specialised supports when the community signals a gap

c) Contingency or Innovation Pools

A small portion of national funding could be held for:
• rapid responses to emerging community issues
• proven programs needing additional support to meet demand

This prevents delays and avoids full recommissioning cycles.

d) Annual or Bi-Annual Capacity Reviews

A formal review point where providers submit:
• outcome trends
• demand data
• complexity profiles
• community feedback - If the evidence shows increased need, funding can be scaled proportionally.

References: The Kids Research Institute Australia. (2020). Counting the cost of late intervention. https://www.thekids.org.au/our-research/impact/2020/collaboration/counting-the-cost-of-late-intervention/?utm_source=chatgpt.com

21. What's the best way for the department to decide which organisations should be offered a relational contract?

Relational commissioning only produces improved outcomes if contracts go to organisations with demonstrated relational capability, trauma-informed practice and community trust (Royal Commission, 2017; NSW Audit Office, 2022, Klassman et al., 2024).

Suggested approach: To ensure relational commissioning delivers the outcomes intended in the DSS reforms, organisations selected for relational contracts should meet evidence-based criteria, such as:
• Evidence of community-led or co-designed practice - Authentic co-design is associated with stronger outcomes, higher cultural safety, and greater local relevance (AIFS, 2016; Nielsen-Hewett et al., 2023).
• Demonstrated relational, trauma-informed practice using verifiable indicators such as joint cases, reflective practice logs, community testimonials, as evidence shows relational quality is the strongest predictor of safety, engagement, and

outcomes. (Royal Commission, 2017; NSW Audit Office, 2022).
• Multi-year partnerships with communities
Longstanding relationships increase trust, engagement, and cultural safety—key predictors of outcomes in place-based and outreach evaluations (Department of the Prime Minister and Cabinet, 2022)
• A track record of flexible, high-quality delivery
Evaluations of complex-needs services show that flexibility, responsiveness, and cultural adaptation consistently improve engagement and outcomes (Klassman et al., 2024).
• Strong evaluation capability (e.g. use of validated tools, mixed methods, public reports, links to research) High-performing organisations demonstrate use of validated tools, mixed-methods evaluation, transparent reporting, and partnerships with research bodies—shown to correlate with stronger service quality and accountability (Productivity Commission, 2013; Department of Health and Aged Care, 2023)
• Multidisciplinary workforce - Effective relational and trauma-informed systems rely on multidisciplinary teams capable of addressing psychological, social, cultural, and environmental determinants (Russ et al.,, 2022; Orygen, 2022).
• Organisational stability and governance to maintain relational continuity Stable governance and leadership significantly improve safety, service consistency, and long-term outcomes (NSW Audit Office Child Protection System Review, 2022; Royal Commission, 2017).
• Demonstrated risk management and safe practice systems for complex needs - Systems inquiries show that providers working with vulnerable families must demonstrate strong risk frameworks to prevent harm and ensure continuity of safe relationships (Royal Commission, 2017; DHHS, 2016).
• Partnerships with Aboriginal Community Controlled Organisations (ACCOs) and/or Evidence of cultural governance or First Nations advisory structures when working with First Nations Populations - Cultural governance and ACCO partnerships are essential for safety and effectiveness, as consistently highlighted in early years, child welfare, and ACCO funding reviews (SNAICC & Deloitte, 2024)

References:
Australian Institute of Family Studies. (2016). Community engagement: A key strategy for improving outcomes for Australian families (CFCA Paper No. 39). https://aifs.gov.au/cfca/sites/default/files/cfca39-community-engagement.pdf
Audit Office of New South Wales. (2022). Oversight of the child protection system. https://www.audit.nsw.gov.au/our-work/reports/oversight-of-the-child-protection-system
Department of Health and Aged Care. (2023). Evaluation of outreach programs.

https://www.health.gov.au/sites/default/files/2023-10/evaluation-of-outreach-programs-report.pdf
Department of Health & Human Services. (2016). Roadmap for reform: Strong families, safe children. Victorian Government. https://www2.health.vic.gov.au/Api/downloadmedia/%7BC3FDE64A-1C05-45C5-841F-7A4B5B8821DA%7D
Department of the Prime Minister and Cabinet. (2022). Practical place-based initiatives: Better practice guide. https://www.pmc.gov.au/sites/default/files/foi-logs/foi-2022-196-practical-place-based-initiatives-better-practice-guide.pdf
Klassman, K., Malvaso, C., Delfabbro, P., Moulds, L., & Young, J. (2024). A rapid evidence assessment of barriers and strategies in service engagement when working with young people with complex needs. Children and Youth Services Review, 156, 1–14. https://doi.org/10.1016/j.childyouth.2023.107292
Neilsen-Hewett, C., de Rosnay, M., Singleton, J., & Stouse-Lee, K. (2023). Supporting service integration through early childhood education: Challenges and opportunities in regional contexts. Frontiers in Education, 8, 1220658. doi: 10.3389/feduc.2023.1220658
Orygen. (2022). Youth mental health models of care: Sector advice paper. Orygen, The National Centre of Excellence in Youth Mental Health. https://www.orygen.org.au/Orygen-Institute/Youth-Mental-Health-Models-Of-Care
Productivity Commission. (2013). Reform of the Australian service sector. Australian Government Productivity Commission. https://www.pc.gov.au/research/completed/service-sector-reform/service-sector-reform.pdf
Russ, E., Morley, L., Driver, M., Lonne, B., Harries, M., & Higgins, D. (2022). Trends and needs in the Australian child welfare workforce: An exploratory study. Institute of Child Protection Studies, Australian Catholic University. https://doi.org/10.24268/acu.8x396
Royal Commission into Institutional Responses to Child Sexual Abuse. (2017). Final report. Australian Government. https://www.childabuseroyalcommission.gov.au/final-report
SNAICC – National Voice for Our Children, & Deloitte. (2024). Funding models for Aboriginal community-controlled early years services. https://www.snaicc.org.au/wp-content/uploads/2024/05/240507-ACCO-Funding-Report.pdf

22. Is your organisation interested in a relational contracting approach? Why/why not?

Yes, our organisation is strongly interested in a relational contracting approach. In many ways, we are already operating within a relational commissioning model. Our

core service design, partnerships, and delivery approach are built around the principles that underpin relational contracting: long-term trust, shared decision-making, adaptive practice, and genuine collaboration with community.

Through our multi-year partnership with AnglicareSA on Adventure to Thrive, we have demonstrated that relational commissioning is not only feasible but highly effective. Our model blends:

• Connected Self's specialist expertise in trauma-informed, polyvagal-informed, and relational practice;

• Anglicare's system-level oversight, infrastructure, and broader visibility across services; and

• Community and school partnerships that allow for responsive, place-based adaptation.

This partnership is already delivering what relational contracts seek to achieve: integrated practice, shared accountability, flexible adaptation, and improved outcomes for children.

A relational contracting approach suits our organisation because:

• It aligns with our core structure, which is built on deep relationships with schools, families, and communities.

• It reflects how we already operate—identifying emerging needs early, working collaboratively across providers, and continuously adapting practice.

• It enables the flexibility required to support children with complex, intersecting needs—something traditional contracts have constrained.

• It leverages our strengths as a small, agile organisation, while benefiting from the governance and system visibility of larger partners.

• It is consistent with our evidence base, which shows relational engagement is the strongest predictor of positive outcomes for children experiencing adversity.

In short:

We are not only interested in relational contracting; we are an existing proof point that this model works. A relational contract would allow us to scale what we already do well and deepen the outcome pathways that current funding restrictions have limited.

23. Is there anything else you think the department should understand or consider about this proposed approach?

Frontline relational models involve emotionally intensive work, complex needs, and high demands on staff. Without support, burnout increases, staff turnover rises, and service quality declines.

DSS mentions a focus on preventing burn out. However, relational and intensive models require emotionally demanding work.

Suggested approach:

• Fund reflective practice and supervision, recognising the emotional intensity of relational work
• Provide complexity loadings for cohorts requiring high relational investment
• Offer trauma-informed and relational practice training as ongoing professional development
• Award longer contracts to stabilise workforce and enable sustained relationships
• Co-design workforce plans with providers to ensure alignment with reality on the ground

Additionally, the department should consider how best to balance fidelity to evidence-based models with the need for local adaptation. Evidence-based models are most effective when their core components are preserved but delivery is adapted to culture, context, and local need. Evidence-based practice must evolve in real contexts.

Suggested approach:

Support “flexible fidelity” by enabling providers to:

• retain the core evidence-informed components of programs (e.g., theory of change, relational mechanisms)
• adapt delivery to cultural, linguistic, community and local school contexts
• document adaptations using mixed-method evaluation (qualitative feedback, practice logs, case studies, outcome shifts)
• share learnings across providers through communities of practice