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

Organisation

Organisation name

KidsXpress

Is your organisation....?

- None of the above

Please specify

Not-for-profit service provider delivering trauma-informed mental health, wellbeing and education supports for children, their carers and educators.

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

The original vision - “All children and young people are supported by strong families who have the skills and confidence to nurture them” — sounds positive, but it risks unintended messaging. Phrases like “strong families” and “skills and confidence” can make families who are struggling feel blamed, rather than recognising the pressures and barriers they face. It also frames support as something families must “learn,” rather than something that happens through trust, connection, and broader systems support.

A more inclusive phrasing, like “All children and young people are supported by families, carers and communities who are equipped and trusted to nurture their safety, wellbeing and growth,” keeps the aspiration while recognising that nurturing children is a shared responsibility — one that depends as much on relationships and support systems as on individual parental capability.

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.

Changing the wording from “empowered” to “supported” makes the outcomes more inclusive and trauma-informed. Saying parents and caregivers are “supported” focuses on guidance, resources, and relational help, rather than implying they currently lack ability or confidence.

Similarly, framing children as “supported” to grow into healthy, resilient adults emphasises assistance and partnership over individual responsibility.

The language better reflects real-world practice, where positive outcomes are built through relationships and systems working alongside families, not by assigning blame or authority.

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

Yes — a single national program has the potential to provide more flexibility, particularly if it reduces siloed funding rules, reporting duplication and artificial program boundaries. The five existing programs have created a fragmented system that makes real-world delivery challenging for families and providers.

However, flexibility will only be realised if the new program operates as a genuine continuum rather than three fixed boxes. Families’ needs change over time and intensity must rise or fall accordingly. Providers need the freedom to respond across prevention, early intervention and intensive family support without re-categorising children or forcing new referrals. If organisations are locked into one stream, the system will recreate silos under a new label and reduce responsiveness.

A flexible, relational national model — grounded in trust, outcomes, streamlined commissioning and reporting, and locally responsive delivery — would enable providers to spend more time supporting families and less time managing bureaucracy.

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?

KidsXpress does not fit neatly within a single stream. Our service model spans the continuum, because in practice children and families move between prevention, early intervention, and intensive support depending on what is happening in their lives. Needs are dynamic, not static, and intensity must be able to rise or fall without breaking the service relationship.

We welcome the intention to provide a clearer continuum of support, but the current distinction between Stream 2 (Early Intervention) and Stream 3 (Intensive Family Support) risks creating an artificial divide between two parts of the same spectrum. Intensive family support is often early intervention when delivered early

enough to prevent escalation, statutory involvement, or placement breakdown. Treating it as separate from prevention confuses timing with intensity and may force families to deteriorate before qualifying for help — the opposite of what a prevention-focused system is trying to achieve.

We are also concerned about advice given in the town hall consultation sessions that providers will only be able to apply for one stream and remain in that stream when funding is released. This creates silos under a new label and shifts the burden onto children to be "stream-eligible" rather than allowing providers to scale support responsively. A more functional design would allow trusted providers to operate across streams, with accountability based on outcomes and distance travelled, not fixed program categories. This would preserve continuity of care, reduce handovers, and enable genuinely flexible responses as community needs evolve over time.

In short, the streams can be useful as a funding framework only if they operate as a flexible continuum and enable multi-stream delivery, so that the right support can be provided at the right time and intensity without re-referring families or fragmenting care.

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

Yes. The strongest version of a national families and children program will be flexible, relational and locally responsive — not rigidly divided into streams, outputs or compliance-heavy rules. The reform intent is exactly right; the main risk is recreating siloed logic under a new structure. We recommend the following changes to ensure the program achieves its aims and overcomes the challenges the sector has repeatedly raised.

1. Treat the three streams as a continuum, not fixed boxes
In real-world delivery, prevention, early intervention and intensive family support are not separate stages — they are different intensities of the same relational work. Intensive support is often early intervention when delivered early enough to prevent crisis escalation. If Stream 3 is positioned as "post-crisis", families may need to deteriorate before qualifying, which contradicts prevention goals.
Recommendation: keep streams as a 'funding framework only' but design eligibility and delivery as a flexible continuum.

2. Allow providers to move across streams (not just clients)
Advice from the town hall that organisations may apply for only one stream will re-

silo services. Families' needs change over time, and the most effective services are those that can scale intensity up or down while maintaining continuity of care.
Recommendation: enable multi-stream commissioning for capable providers, with outcomes-based accountability rather than fixed program categories.

3. Measure "distance travelled", not only benchmarks
Outcomes reporting should capture meaningful gains over time, not just whether a child meets a final threshold. Many children impacted by trauma or chronic adversity may not reach population norms within short timeframes, yet can still make clinically significant progress. A distance-travelled lens avoids perverse incentives to prioritise only "easy wins" and better reflects therapeutic reality.
Recommendation: embed distance-travelled measures alongside benchmarks in the national outcomes framework.

4. Streamline outcomes reporting and support mixed-method evidence
A national program should reduce duplication by using a single outcomes framework that values both quantitative and qualitative evidence. Validated tools should sit alongside lived-experience measures, parent and educator feedback, and child voice.
Recommendation: adopt a mixed-methods reporting model and a single outcomes dashboard to reduce red tape.

5. Embed the child's voice as legitimate evidence
Children's perspectives provide unique insight into safety, progress and what genuinely helps. Ethical, age-appropriate methods (opt-in, de-identified themes from drawings, reflections, or child-reported measures) strengthen accountability and keep services effective.
Recommendation: explicitly include child voice as part of outcomes evidence and co-design expectations.

6. Strengthen integration beyond co-location
Co-location helps, but integration depends on relationships, shared planning, and joint practice. Effective models involve multi-agency collaboration, shared care pathways and professional learning across education, health and community sectors.
Recommendation: fund and reward genuine collaborative delivery and shared outcomes, not parallel services.

7. Enable safe, consent-based cross-system data sharing
Families should not need to retell their story at every service point. Without shared

visibility of risk, history and supports already in place, services duplicate or miss critical steps. We recognise sensitivities, but practical data-sharing pathways with clear consent, privacy safeguards and purpose limits are essential, particularly between education and health systems.
Recommendation: build consent-based information-sharing protocols into program design to support continuity of care.

8. Recognise schools and early learning settings as critical early identifiers
Schools (including early learning centres) are often the first place distress becomes visible. Vulnerability is not confined to low-SES areas — high-advantage communities can have hidden distress shaped by pressure, emotional neglect, stigma, or reputation concerns. Schools can identify this early, even where families are reluctant to engage in external support.
Recommendation: weight community need using psychosocial indicators and explicitly recognise schools as early-identification and early-intervention settings across all socioeconomic contexts.

9. Address social and cultural stigma that blocks help-seeking
Some communities openly seek support; others avoid disclosure due to stigma, fear of labelling, concerns about future education, career or insurance implications, or school reputation management. Program design must account for stigma-driven under-reporting as a real access barrier.
Recommendation: include stigma-reduction and normalisation strategies in universal and targeted program elements.

10. Invest in universal trauma-informed training and fix the pre-service training gap
Educators and early childhood workers are central to early intervention, yet trauma-informed practice is not a standard component of teacher or educator degrees. Graduates enter schools without the tools to recognise or respond to childhood trauma and mental health needs. Universal training also ensures children benefit even if they decline direct therapy.
Recommendation: embed trauma-informed capability in both pre-service qualifications and funded professional learning, using whole-school/whole-setting approaches.

11. Fund multiyear delivery, not short cycles
Meaningful cultural and practice change — especially trauma-informed change in schools and communities — takes time. Short grants undermine workforce stability, trust and outcomes.
Recommendation: prioritise multi-year agreements (minimum 3–5 years) aligned

to realistic change timelines.

12. Recognise expressive and creative modalities as evidence-based early intervention
Children often cannot verbalise distress. Evidence-based expressive therapies (art, music, movement, drama, play) provide developmentally appropriate, non-verbal pathways to regulation, trauma processing and resilience. These modalities are effective across early childhood and primary years and align well with community-based and culturally grounded approaches.
Recommendation: explicitly recognise expressive and creative therapies within the national evidence framework.

13. Maintain proportionate accountability so red tape truly falls
If reporting intensity remains high or overly standardised, the reform intent will not be realised.
Recommendation: shift from compliance-heavy reporting to relational contracting and learning-focused reviews that prioritise outcomes, integration and distance travelled.

In summary: the program will work best when it trusts providers, funds a flexible continuum, supports integration and safe data sharing, measures progress fairly, and builds the workforce capability required for genuine prevention and early intervention. These changes would materially reduce red tape while improving outcomes for children and families now and into the future.

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 on page 4 are the right areas for investment and reflect longstanding sector feedback.

Invest early to improve family wellbeing and reduce later interventions (e.g., child protection): Strongly agree. Early, relationship-based support prevents escalation and is far more cost-effective than crisis responses. The focus areas you've identified (families at risk of child protection involvement, early support for children aged 0–5, and young parents under 25) are appropriate as high-impact entry points. At the same time, we welcome the paper's explicit statement that support must continue through childhood and adolescence, because developmental transitions and trauma impacts don't stop at age five.

Prioritise connected, co-located and integrated services: Strongly agree. Co-

ordination across education, health and community systems is essential for families to experience support as seamless, not fragmented. The emphasis on local partnerships, shared delivery and genuine integration is pragmatic and consistent with what works in practice.

Ensure services are informed by and respond to community needs: Agree, with the caveat that "need" should be interpreted broadly. The listed indicators (SEIFA, AEDC, Census/NEET, child protection engagement) are useful starting points, but must be complemented by psychosocial complexity, access barriers, stigma and hidden vulnerability, including within high-advantage communities.

Improve outcomes for First Nations children and families by increasing ACCO delivery: Strongly agree. ACCOs are best placed to lead culturally grounded supports. The commitment to prioritising ACCO-led delivery in communities with significant First Nations populations is critical and should be supported by long-term funding and capacity resourcing.

Overall, these priorities provide a solid and evidence-aligned foundation for the national program.

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

KidsXpress would prioritise investment in school-based hubs as universal early-intervention platforms, supported by co-located trauma-informed therapy, workforce training, flexible service delivery, and meaningful evaluation. Schools and early learning settings are already where children spend most of their time, where distress first becomes visible, and where families are most routinely engaged. Treating them as hubs enables prevention and early intervention to happen early, in familiar environments, without stigma, and with far stronger continuity of care.

This aligns closely with the discussion paper's priorities: investing early to improve family wellbeing, prioritising connected and co-located services, and ensuring services respond to community need. Our model shows how children can access support early in trusted settings, how services can collaborate effectively around the child, and how educators can be trained to deliver safe, trauma-informed responses. Funding that supports flexibility across prevention, early intervention, and intensive family support ensures services respond to real family needs rather than rigid program categories.

Other priorities
Beyond the listed priorities, the Department should prioritise intensive, individualised family support for families with complex needs. Tailored, relational coaching can prevent escalation and build parental capacity. Investment in flexible funding, relational contracting, and trauma-informed workforce development would allow providers to respond to changing circumstances rather than rigid program rules. In short, targeted intensive supports complement early intervention and prevention, strengthening family resilience and keeping children safe.

Improving family wellbeing – proposed focus areas
Labelling young parents or families as "at risk of child protection involvement" risks placing blame on them rather than recognising systemic failures or policy shortcomings. Many families face poverty, trauma, or structural disadvantage — factors beyond their control. KidsXpress experience shows that support works best when it is relational, early, and non-judgmental, helping families build capacity without stigma or fear of surveillance.

Connected, co-located and integrated services
Connecting and coordinating services for families works best when it's relational, not just about location. Beyond co-location, KidsXpress experience shows that shared care planning, multi-agency case management, joint professional development, and integrated data systems all strengthen collaboration. Families need trusted adults who understand their context and can respond flexibly. Involving families in decision-making and offering outreach where needed ensures services meet real needs, reduce duplication, and build lasting resilience.

Responding to community need
Locational disadvantage alone does not capture the real needs of communities. Funding should also reflect psychosocial complexity, cultural and linguistic diversity, access barriers, stigma, and hidden vulnerability across all socioeconomic groups. Resources must target the children and families who need them most, not just the places they live.

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, broadly. The proposed focus areas align with the needs we see in practice, particularly the emphasis on prevention and early intervention for families under stress and those at risk of escalation into statutory systems. Supporting parents early, reducing stigma, and strengthening the relational environments around

children are all consistent with what improves child and family wellbeing.

However, these focus areas should not be interpreted too narrowly or as fixed "target groups." In real-world delivery, risk and need are dynamic. Families may not present as "at risk of child protection involvement" until stress has compounded, and young parents often sit within wider family systems where support needs to be multigenerational and relational rather than category-based.

We also welcome the paper's explicit statement that support must continue through childhood and adolescence. While early years investment is vital, the transitions and challenges that shape family wellbeing do not stop at age five. Primary school years remain a key window for early identification and intervention, as distress and developmental concerns often first become visible through schooling and peer environments.

Overall, we support the focus areas, provided implementation remains flexible, trauma-informed, and responsive to families' changing circumstances across the full childhood continuum.

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

Yes. In addition to the proposed focus areas, the Department should explicitly consider both additional groups and delivery approaches that reflect how vulnerability and help-seeking actually operate in communities.

Other groups to prioritise:

Children and families experiencing hidden vulnerability in high-advantage communities, where stigma, reputational concerns, or fear of labelling suppress help-seeking. Need is not confined to disadvantaged postcodes.

Families showing early signs of stress, trauma exposure or developmental concern identified through schools and early learning settings, even where formal risk datasets are not triggered.

Caregivers and educators who form the child's daily protective environment (parents, teachers, school counsellors, early childhood educators). Building their trauma-informed capacity is one of the fastest ways to improve child wellbeing at scale.

Families facing intersectional barriers (CALD communities, disability, housing insecurity, intergenerational trauma) where layered stress increases risk but may not map neatly to a single category.

Approaches to strengthen family wellbeing

Embed support in universal, trusted settings — especially schools and early learning centres as early-intervention hubs. These settings enable prevention to occur early, reduce stigma, and improve engagement for families who may distrust external services.

Enable child self-referral pathways within universal settings. In school-embedded services we regularly see children self-refer who would not be flagged through teacher or counsellor referral alone — including quieter students or those masking distress. Self-referral increases early access, reduces stigma, and strengthens equity by ensuring support reaches children who might otherwise be missed.

Whole-of-family and whole-of-setting responses, not child-only interventions. Children's outcomes improve most when direct therapy is paired with caregiver coaching and trauma-informed training for educators and child-facing professionals.

Evidence-based expressive and creative therapies for young children. Many children cannot verbalise distress; creative modalities (art, music, movement, storytelling) offer developmentally appropriate pathways to regulation, trauma processing and resilience.

Measure "distance travelled" as well as benchmarks, so progress is recognised appropriately for children starting from high adversity.

Multiyear funding, particularly for embedded school/early learning hubs, because trauma-informed cultural change takes sustained partnership over 3–5 years.

Safe, consent-based cross-system data sharing, so education, health and community services can coordinate care and families don't have to retell their story repeatedly.

International and Australian evidence consistently shows that school-based mental health and wellbeing programs improve engagement, continuity of care and positive long-term outcomes. When therapy for children and support for caregivers

are embedded within the school environment (rather than delivered only through external outreach), retention is higher and families — including Aboriginal and CALD parents — report greater trust and accessibility. School-embedded models also free teachers to focus on teaching rather than managing wellbeing crises.

KidsXpress outcomes reflect these benefits: 95% of children report the program was helpful, 97% of parents observed benefit, and 89% of teachers noted improved classroom engagement and emotional regulation. The University of Sydney's Matilda Centre is currently conducting an external evaluation of our embedded school-based mental health model in eight partner schools; findings will inform an updated cost-benefit analysis. Comparable international models such as Place2Be (UK) report benefits of around £8 for every £1 invested, suggesting strong potential returns for embedded, trauma-informed school hubs. Our earlier Deloitte Access Economics ROI of 1:2.75 (2015) reflected only a standalone group therapy program and likely underestimates the return of the expanded embedded model now in place.

These additions would allow the program to better meet family wellbeing needs across diverse communities, including those not captured by geography or narrow target-group definitions.

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

Beyond co-location, the most effective integration we see is relational and system-based, not structural alone. Practical mechanisms that work include:

Shared care planning and case coordination: regular joint meetings (with consent) between schools/early learning, health providers, community services and family supports, so there is one plan around the child rather than parallel plans.

Clear referral pathways with warm handovers: families engage better when referrals are active and relational (introduced to the next service), not passive "go here and call this number".

Cross-sector professional practice communities: joint training and supervision between educators, clinicians and community workers builds a common language (trauma-informed, child-centred, culturally safe) and reduces duplication.

Agreed roles plus a lead professional: integration improves when one service is clearly accountable for holding the relationship with the family, while others

provide wraparound support.

Shared outcomes frameworks: services coordinate better when they are funded and assessed against common outcomes, including distance travelled, rather than separate program KPIs.

Safe, consent-based information sharing: continuity of care depends on education, health and community services being able to share relevant information with clear consent, privacy safeguards and purpose limits. Without this, families must retell their story and services repeat assessments.

Child and family voice in coordination: integration works best when families understand who is doing what, why, and feel they can shape the plan.

In practice, these mechanisms allow services to function as a connected continuum even where physical co-location is not possible. For example, in school-embedded models we see strong integration when therapists, educators, parents, school counsellors and external agencies share planning, training and (with consent) information — enabling consistent support over time rather than fragmented episodes of care.

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?

A strong grant application should show genuine community connection in ways that are observable and assessable, not just asserted. Key indicators include:

Evidence of co-design and community governance: applicants should demonstrate how local families, carers, children/young people, schools/early learning services, and community leaders have shaped service design, and how they will continue to influence delivery (e.g., advisory groups, feedback loops).

Demonstrated local partnerships with defined roles: not a list of logos, but clear descriptions of who does what, how referrals work both ways, and how plans/outcomes are shared.

Cultural safety and ACCO partnership where relevant: in First Nations communities, applications should reflect ACCO leadership or genuine partnership by invitation, with cultural safety embedded in practice and reporting.

Use of local need data plus lived experience: applicants should connect

SEIFA/AEDC/child protection and other data to what they are hearing locally, showing they understand both structural need and hidden or stigmatised need.

Accessibility and trust pathways: applications should show how families access support in low-stigma ways (including outreach, embedded settings, child self-referral where appropriate, and language/cultural supports).

Workforce capability specific to the community: evidence of trauma-informed, culturally responsive practice, and local workforce development rather than fly-in/fly-out delivery.

Mixed-methods outcomes and continuous improvement: applicants should name validated tools and qualitative methods, and explain how data is used to improve services (including distance travelled). Ethical inclusion of child voice — for example, de-identified themes from opt-in feedback, drawings or child-reported measures — strengthens credibility.

Integration maturity: assess whether the service can operate across systems (education, health, community), including safe information-sharing protocols and shared care planning.

In practice, these indicators look like long-term, trust-based delivery that is co-designed with the settings families already rely on. For example, in our School Partnership Program we embed therapists within schools for multi-year partnerships, coordinate shared care planning with parents, teachers and school counsellors, and accept both school referrals and child self-referrals — the latter often reaching quieter or masked children who would otherwise be missed. We measure outcomes using validated tools (CORS for children, ARTIC for adults) alongside parent/teacher feedback and child voice, and track distance travelled over time, not only end-point benchmarks.

We also demonstrate integration across education, health and community settings. Through our partnership with the Medicare Mental Health Centre in Canterbury (co-delivered with One Door), we provide therapy and parent support onsite while linking children and families into our partner schools across the Canterbury LGA (e.g., Hampden Park, Riverwood, Peakhurst, Narwee) for ongoing school-embedded follow-up care. Referrals move both ways to maintain continuity. Our trauma-informed consultants support and train teachers in those schools, while parent clinicians provide coordinated caregiver support through both the MMHC and the child's school setting.

Overall, DSS should assess applicants on depth of local relationship and integration — whether the service is trusted, embedded, co-designed, culturally safe, outcomes-driven, and able to coordinate wraparound support that reflects real community need.

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

Locational disadvantage alone is not a reliable indicator of vulnerability. Funding decisions should also account for psychosocial complexity, cultural and linguistic diversity, access barriers, social stigma, and local service capacity.

Vulnerability often exists in pockets within otherwise advantaged areas. In many lower-income communities, need is visible and support is welcomed. In contrast, more affluent areas can experience invisible vulnerability — families under pressure to appear successful, cultural norms that discourage open discussion of mental health, and schools concerned about reputation. In these environments, children may mask distress or develop maladaptive coping strategies while families avoid external help. Some parents worry that formal diagnoses or mental health plans could jeopardise their child's future education, career, or insurance prospects. Others over-schedule children or outsource caregiving, leaving emotional needs unmet.

Because of this, schools and early learning settings should be recognised as critical early identifiers of need across all socioeconomic groups, including where disadvantage is not geographically obvious. However, this role depends on adequate workforce capability, sustained partnerships, and flexible funding that can respond to emerging or hidden need.

Recommendations

Weight funding according to both geographic indicators and psychosocial need (including family stress, trauma exposure, disability, housing instability, and cumulative risk).

Recognise schools and early learning settings as key early identifiers of children's emotional and developmental needs, regardless of socioeconomic status.

Address cultural and social stigma that prevents help-seeking in some communities; program design should normalise mental health support and reduce

perceived risks associated with disclosure or diagnosis.

Support universal trauma-informed capability in education and early childhood settings so educators can recognise distress and respond safely even when families are reluctant to engage.

Close the pre-service training gap: trauma-informed child development and mental health literacy are not standard components of many education or early childhood degrees, leaving graduates ill-equipped to respond to trauma and mental health challenges.

Enable flexible use of funds so services can respond quickly to changing community circumstances or emerging patterns of need.

Require evidence of local co-design with families, schools and community organisations to ensure cultural fit and genuine responsiveness.

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

To demonstrate that a service is genuinely meeting community need (without increasing red tape), grant applications should balance quantitative outcomes, qualitative evidence, and community voice — including children's perspectives where appropriate. Strong applications show that programs are both evidence-informed and locally responsive in practice, not just in principle. This can be demonstrated by:

Evidence of meaningful outcomes, not just activity counts: report validated outcome measures (e.g., child wellbeing, family functioning, engagement) and "distance travelled" over time, rather than only service volumes or attendance.

Clear proof of local scoping and co-design before delivery: show how the provider assessed need with the community or setting first (e.g., structured listening, workforce capability review, referral mapping, family/child input), then tailored the model accordingly. For example, KidsXpress typically undertakes a sustained scoping and readiness phase with schools and communities (usually 6-months) before embedding therapy, followed by joint co-design of delivery priorities.

Community partnership with defined roles: describe who the service works with locally and how — including warm referral pathways, shared care planning, and collaboration that prevents duplication.

Ethical inclusion of child voice: include children's perspectives in age-appropriate, opt-in and de-identified ways (e.g., themes from children's drawings, feedback forms, or child-reported measures), paired with parent and teacher reports to show how children experience progress and safety.

Short case vignettes that illustrate responsiveness: brief aggregated examples that demonstrate tailoring to real family circumstances, used to complement (not replace) data.

Continuous improvement loops: explain how outcome data and lived experience are reviewed and used to refine delivery in real time.

Integration maturity: show how the service coordinates across education, health and community systems so families experience a seamless pathway rather than fragmented episodes of care.

Overall, the emphasis should be on outcomes over outputs, relationships over reporting, and learning over compliance. Applications that evidence impact through both numbers and narrative give government a clearer line of sight into what works — while keeping administration proportionate.

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

KidsXpress acknowledges that Aboriginal Community-Controlled Organisations (ACCOs) are best placed to lead culturally grounded services for Aboriginal and Torres Strait Islander children and families. The grant process should be designed to increase ACCO delivery by removing structural barriers and resourcing ACCO leadership, including:

ACCO-priority funding and dedicated funding pools in communities with significant First Nations populations, with assessment processes led or co-led by Aboriginal and Torres Strait Islander representatives.

Long-term, flexible contracts that reflect the time required for community-led change and trust-building, rather than short cycles that force renegotiation and administrative churn.

Capacity-building and workforce supports embedded in the grant (e.g., funding for clinical supervision, evaluation capability, workforce development and

infrastructure), not treated as optional add-ons.

Simplified application and reporting pathways for ACCOs, including tailored DSS support, culturally appropriate documentation, and proportional reporting requirements.

Fair partnership rules with mainstream organisations, where ACCOs can lead by invitation and retain decision-making authority, and where subcontracting arrangements are transparent, adequately funded, and do not shift risk onto ACCOs.

Place-based commissioning that values local governance, allowing ACCOs to define priorities and service models in line with community-identified need.

While KidsXpress is not an ACCO, we regularly work with Aboriginal Education Officers, local Elders and ACCO partners where invited, and we support grant settings that elevate ACCO leadership and autonomy as the default in First Nations communities.

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

Program design should recognise that healing for Aboriginal and Torres Strait Islander children is grounded in connection — to culture, Country, community, family and story. To improve outcomes, the national program should include:

ACCO-led design as the norm in communities with high First Nations populations, including community-determined priorities, governance and local workforce development.

Cultural safety embedded in funding requirements, with clear expectations for cultural protocols, local consultation, and culturally safe practice environments.

Strength-based, trauma-informed approaches that acknowledge the impacts of intergenerational trauma and systemic disadvantage while centring resilience, identity and belonging.

Evidence-based expressive and creative modalities as recognised interventions for children. Creative therapies (art, music, movement, play, storytelling) provide developmentally appropriate, non-verbal ways for children to express distress, build regulation and strengthen relationships, and align closely with cultural

traditions of storying, song, dance and collective meaning-making.

Family and community-wide supports, not child-only interventions — including caregiver support, kinship-inclusive practice, and workforce training for educators and child-facing professionals.

Flexible delivery shaped locally, recognising that one model will not suit all Nations or communities; services must adapt to local languages, histories, and cultural strengths.

Outcomes frameworks that include distance travelled and cultural wellbeing, not only mainstream clinical benchmarks, so progress is captured in culturally meaningful ways.

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

A mix of quantitative and qualitative data is essential to understand impact and drive continuous improvement. For KidsXpress, and for similar child-and-family services, the most helpful data includes:

Child wellbeing and functioning measures collected at multiple points (intake, mid-point, exit, follow-up), covering social/emotional wellbeing, regulation, behaviour, relationships and engagement. Validated child-reported tools are critical (e.g., KidsXpress uses CORS).

Distance travelled / progress over time, not only end-point benchmarks. Many children affected by trauma or chronic adversity may not reach population norms within a short intervention window, yet still make clinically meaningful gains. Tracking movement and incremental change provides a fairer, trauma-informed picture of effectiveness and avoids incentives to focus only on less complex cases.

Adult/caregiver and educator capability measures, because children's outcomes are shaped by the adults around them. Tools that capture shifts in trauma-informed knowledge, confidence and practice are valuable (e.g., KidsXpress uses ARTIC alongside coaching feedback).

Engagement and retention indicators, including patterns of attendance, drop-off points, and self-referral or help-seeking behaviour from children and families.

Qualitative child and family voice, captured ethically and age-appropriately (de-

identified themes from drawings, feedback statements, yarns, or opt-in forms), which helps interpret why change did or didn't occur.

Partner/system-level data, showing how services integrate across education, health and community settings, reduce duplication, and support continuity of care.

Longer-term follow-up where feasible, to understand durability of gains beyond immediate program contact.

This combination enables genuine learning about what works for whom, in what conditions, and how services can adapt in real time to community need.

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 information to share with DSS is data that demonstrates meaningful change, equity of impact, and practical benefit to families, without creating excessive reporting burden. This includes:

Validated outcomes data for children, reported as change over time (distance travelled) as well as final status, to show progress for complex cases — not only those who reach a benchmark.

Caregiver and educator outcomes, showing increased capacity to support children's wellbeing and safety, including trauma-informed practice shifts where relevant.

Participation, engagement and continuity indicators, such as retention, completion, re-engagement, self-referral pathways, and reduced need for escalations or re-referrals.

Mixed-methods evidence, pairing quantitative change with brief, de-identified stories or thematic summaries that illustrate what the change meant in a child's life, and how families experienced safety and trust.

Evidence of cultural safety and local responsiveness, including community co-design processes and child/family voice incorporated in ethical, age-appropriate ways.

Integration outcomes, demonstrating how coordination with schools, health and

community partners strengthens wraparound support and reduces fragmentation.

Where available, economic or social value indicators (even if periodic rather than annual), to show longer-term benefit to children, families and systems.

Sharing a small set of high-value measures consistently — focused on outcomes, distance travelled, and lived experience — gives government a clearer picture of impact than large compliance datasets, while supporting genuine improvement.

18. If your organisation currently reports in the Data Exchange (DEX), what SCORE Circumstances domain is most relevant to the service you deliver?

Mental health, wellbeing and self-care (primary Circumstances domain). Our work also contributes to age-appropriate development, family functioning, personal/family safety, and education/engagement, but mental health and wellbeing is the core domain.

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

KidsXpress supports minimal, light-touch guidance rather than rigid templates. Case study requirements should standardise only the core elements needed for consistency and comparability, while giving providers freedom to reflect local context and diverse service models.

A useful approach would be:

A short national case study template (optional but recommended) that captures a small set of consistent fields:

*presenting needs/context
*service approach and intensity over time
*key outcomes and distance travelled (progress, not only end-point status)
*child, caregiver and educator perspectives (where relevant)
*cultural safety considerations
*lessons learned / what changed in service delivery as a result.

Clear guidance on ethics and privacy, including child-safe, age-appropriate ways to include child voice (de-identified themes, opt-in feedback, drawings or child-reported measures).

Examples of strong case studies across different settings (schools, community, health; prevention through to intensive support) so providers can see what “good” looks like without being forced into one narrative style.

Guidance on linking narrative to data, showing how to pair qualitative stories with validated outcomes measures, rather than relying on anecdotes alone.

Overall, the aim should be to reduce red tape while improving usefulness: a simple consistent spine, with space for providers to tell the real story of change in their community.

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

A relational contracting approach puts trust and partnership at the centre of how services are funded and delivered. Instead of government buying outputs, it builds genuine collaboration with providers who know their communities best. This means long-term relationships, shared goals, and the professional freedom to respond to families’ real needs — not a checklist of KPIs. Human relationships are the infrastructure of good care. When services and government work as equal partners, focused on learning and impact rather than compliance, children and families benefit from support that is stable, flexible, and grounded in respect.

In practice, effective relational contracts should include:

* Shared outcomes and learning goals that are mutually agreed, measurable, and reviewed regularly.

* Flexibility to adjust intensity and approach as families’ needs change, without constant contract variations.

* Proportionate, outcomes-based reporting focused on impact and distance travelled, rather than volume compliance.

* Structured partnership routines (e.g., joint planning, learning reviews, transparent communication loops).

* Multi-year timeframes that allow workforce stability and real cultural/system change.

* Clear mutual responsibilities — providers commit to evidence, ethics and

transparency; government commits to timely decisions, stable settings and not shifting requirements midstream.

* Support for integration across education, health and community systems, including safe information-sharing protocols.

Relational contracting has the potential to reduce red tape while strengthening service quality — but only if the contract design actively builds trust, clarity and learning, rather than re-labelling compliance.

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

Relational contracts should be offered to organisations that can demonstrate both trustworthiness and learning maturity. The department could assess this through a small set of practical indicators:

Track record of outcomes and transparency: consistent use of validated measures, evidence of distance travelled for complex cases, and a willingness to share both strengths and limitations.

Depth of local partnership: services embedded in communities with demonstrated co-design, shared care planning and integration with local systems.

Workforce and clinical governance capability: strong supervision structures, cultural safety practice, and stable staffing.

Continuous improvement in action: proof that data and lived experience directly inform service refinement, not just reporting.

Ability to work across a continuum of need: providers who already operate flexibly across prevention, early intervention and more intensive support are well suited to relational funding.

Readiness for mutual accountability: organisations that engage constructively with government, contribute sector insight, and can participate in collaborative learning rather than transactional compliance.

A staged approach could help: pilot relational contracts with a diverse mix of

providers and settings, evaluate what works, then scale based on demonstrated partnership and outcomes performance.

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

Yes. KidsXpress is strongly interested in a relational contracting approach because it aligns with how effective child and family support works in the real world.

Our model relies on long-term, trust-based partnerships with schools, communities and health services, where children's needs shift over time and intensity must be adjusted without unnecessary bureaucracy. A relational contract would enable us to maintain continuity with families, respond flexibly across levels of need, and focus on meaningful outcomes — including distance travelled — rather than narrow outputs.

We also value the shared-learning intent of relational contracting. With established outcomes tools, continuous feedback loops, and an external evaluation underway (University of Sydney's Matilda Centre), we are well positioned to participate transparently in partnership-based contracting that prioritises impact and improvement.

Relational contracting will only succeed if it genuinely reduces administrative burden and embeds mutual trust. If designed that way, we believe it will materially improve outcomes for children and families while strengthening service sustainability.

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

This proposed approach will only deliver on "less red tape and more flexibility" if implementation avoids hardening into new silos. Four things matter most:

Don't reproduce stream silos in rollout. The suggestion that providers be contracted into a single stream risks re-creating the fragmentation this reform is trying to fix. Implementation should enable trusted providers to operate across streams so intensity can rise and fall without changing the service relationship.

Pilot the new mechanics before scale-up. Trial the cross-stream continuum model, distance-travelled outcomes reporting, and safe data-sharing arrangements between education, health and community services in a small set of sites first. Use

these pilots to refine guidance and reporting so they stay proportionate and genuinely outcomes-focused.

Balance depth with breadth in commissioning — and fund the continuum, not just volume. Streamlining shouldn't default to fewer, larger national contracts awarded on reach alone, because that can unintentionally defund specialist, community-embedded services delivering deep trauma-informed work. KidsXpress illustrates why. We deliver depth through free expressive therapy to around 300–400 children per year, with support continuing for as long as clinically needed — often weekly for up to a year. We moved away from a rigid 10-week group model because it did not reflect real therapeutic journeys. Children step up or down in intensity and modality (1:1, dyad, or group) depending on readiness and distance travelled. At the same time, we deliver significant breadth through our School Partnership Program's whole-of-school training and trauma-informed practice support, reaching over 2,500 children annually indirectly across eight partner schools, alongside teachers and caregivers. This is place-based reach rather than national scale, but it creates universal protective impact while allowing intensive support for those who need it most. A national program should allow and value this flexible continuum delivery even where direct beneficiary counts are lower, because impact per child is greater and escalation is prevented.

Use digital supports as a complement, not a substitute. Online programs and resources can extend reach, but they are often inherently monolingual, less relational, and can exclude families who are not IT-savvy, have low literacy, limited access to devices/data, disability-related barriers, or low trust in digital services. Commissioning should therefore protect a mixed ecosystem where high-reach digital options sit alongside high-depth, face-to-face, relationship-based services for children and families who need more intensive support.

Getting these details right in rollout will determine whether the reform genuinely reduces bureaucracy for families and providers, or simply re-labels it.