UnitingCare

Submission: Department of Social Services Discussion Paper: A new approach to programs for families and children

December 2025

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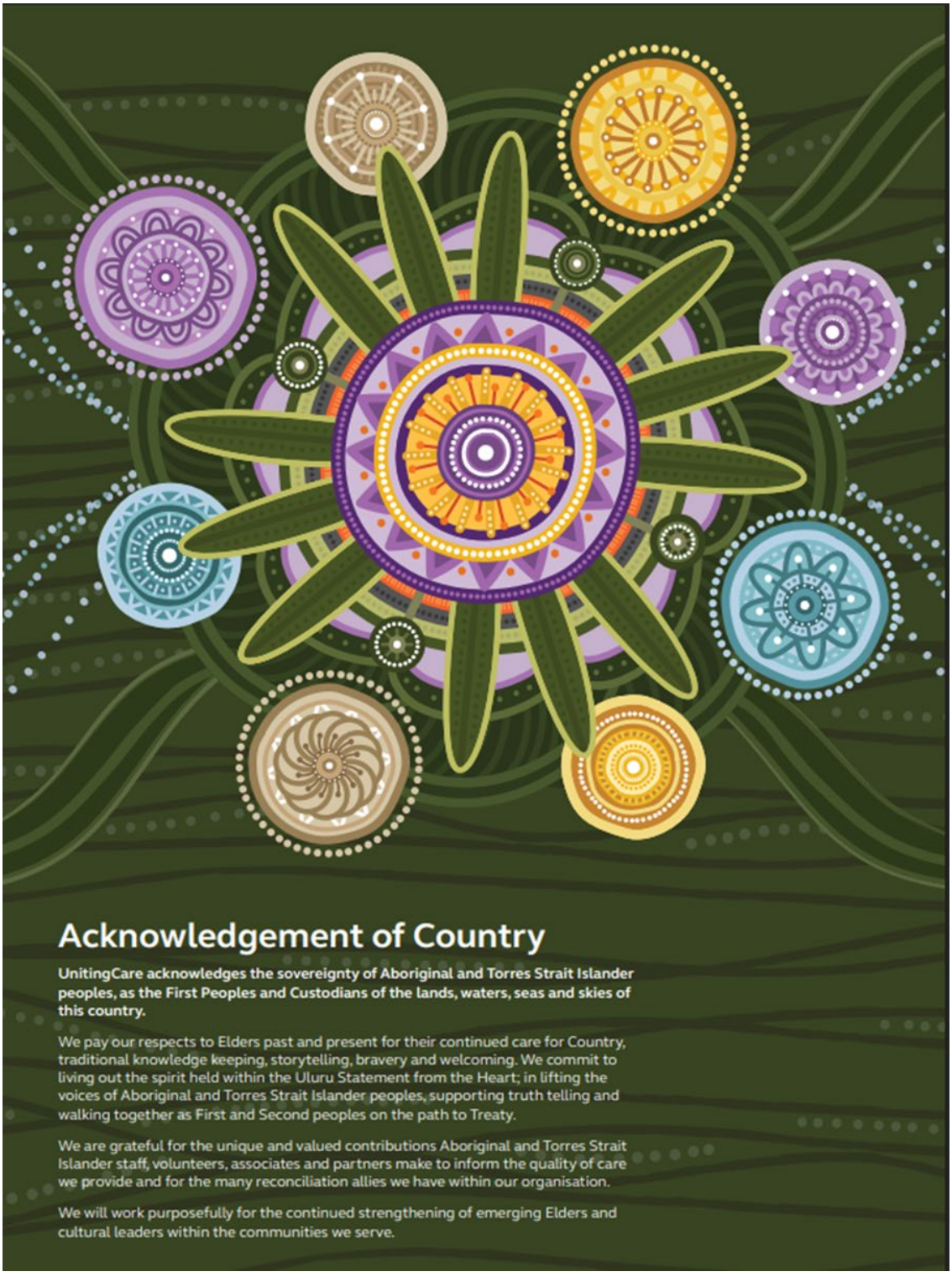

Acknowledgement of Country

UnitingCare acknowledges the sovereignty of Aboriginal and Torres Strait Islander peoples, as the First Peoples and Custodians of the lands, waters, seas and skies of this country.

We pay our respects to Elders past and present for their continued care for Country, traditional knowledge keeping, storytelling, bravery and welcoming. We commit to living out the spirit held within the Uluru Statement from the Heart; in lifting the voices of Aboriginal and Torres Strait Islander peoples, supporting truth telling and walking together as First and Second peoples on the path to Treaty.

We are grateful for the unique and valued contributions Aboriginal and Torres Strait Islander staff, volunteers, associates and partners make to inform the quality of care we provide and for the many reconciliation allies we have within our organisation.

We will work purposefully for the continued strengthening of emerging Elders and cultural leaders within the communities we serve.

Introduction

UnitingCare Queensland has been supporting at-risk families and communities across Queensland for over 40 years. With operations in more than 460 locations—including hospitals, aged care facilities, and family support hubs—we employ 16,848 staff and 6,500 volunteers. Annually, we assist over 430,000 individuals across urban, rural, and remote areas. Our services promote well-being, mental health, financial resilience, and social inclusion for vulnerable groups, including women, children, and Aboriginal and Torres Strait Islander communities.

UnitingCare Queensland Family and Disability operates various programs across Queensland, including Targeted Family Support, Rural and Remote Supports, Parenting and Family Support Programs, Family Intervention Service, StandBy, Queensland Men Stopping Violence Program and Men Choosing Change, Lifeline Telephone Counselling and 13YARN, Financial Resilience and Wellbeing Services, Gambling Help, Out of Home Care Services and the Early Childhood Approach. The success of these well-established community programs demonstrates our strong community partnerships and service integration.

UnitingCare Queensland has been providing a range of services under the Family and Community Program and its predecessors for many years. This includes Northern Gold Coast Communities for Children; Children and Parenting Support (CaPS) services in Maroochydore and Redcliffe; Children and Parenting Support (CaPS) services in Mossman/Daintree; Children and Parenting Support (CaPS) rural and remote services including the Rural Area Families Service (RAFS) in Charleville, Mount Isa and Longreach, and Remote Family Care Service – Statewide; Minds Alive, a Family Mental Health Support Services (FMHSS) in Mackay and Maroochydore; Specialised Family Violence Service in Hervey Bay, which includes outreach to Maryborough and Family and Relationship Services in Bundaberg, Hervey Bay, Maryborough, Kingaroy, Gympie and the Sunshine Coast (Maroochydore).

UnitingCare Queensland: Demonstrated Capability in Community Engagement

UnitingCare Queensland excels in engaging local communities through a suite of proven strategies:

- **Building Trust**: Staff actively participate in community outreach and local events, fostering rapport and trust with families.
- **Strategic Partnerships**: Collaboration with local organisations, schools, and community leaders extends our reach and strengthens support networks for families who may be hesitant to engage.
- **Flexible Service Delivery**: Services are offered in multiple formats—including home visits, online support, and group sessions—ensuring accessibility and responsiveness to family needs.
- **Empowerment and Co-Design**: Families are involved in decision-making and service planning, promoting ownership and increasing engagement.
- **Cultural Competence**: Our workforce is trained in culturally sensitive approaches, enabling tailored support for Queensland's diverse communities.

These approaches reflect UnitingCare Queensland's capability to deliver inclusive, adaptable, and effective support for families across the state

UnitingCare Queensland has a demonstrated commitment to working with Aboriginal and Torres Strait Islander communities, families and individuals. Our commitment is evidenced in UnitingCare's current 2024-2027 stretch Reconciliation Action Plan (RAP) which includes a pledge to be culturally responsible and committed to social justice for Aboriginal and Torres Strait Islander Peoples.

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Vision and outcomes

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

UnitingCare Queensland believes that the new vision does reflect what we all want for children and families and it reinforces what the 5 current DSS funded programs are currently working towards. The new vision reflects an early intervention pathway to support children and families prior to points of crisis that may lead to long term impacts of trauma.

There are some areas of support and target groups that are not directly mentioned in the strategy document but are currently supported by the programs listed in scope for the change. For example many of our services provide activities and services for the whole of a community, including community capacity building activities. We are confident on reflection that this national strategy would include services to those similar to our current client groups, however we want to expand on this.

People currently provided services that may be outside the scope:

- Individuals who are not part of a traditional family, ie not a parent, carer or child. This is particularly relevant to those living in rural and remote communities that have limited services available outside those programs currently offered through DSS funding. A strong example of how our Rural and Remote teams go beyond supporting just families is through the community events facilitated or supported by our RaFS program. While CaPS/RaFS programs primarily target families, these events bring together people from diverse backgrounds and create opportunities to share information and connect individuals and communities with the supports they need. Social connection is also a huge part of community wellbeing and these broader community events and activities really promote that.
- Grandparents who are not the primary carers, however provide invaluable support to a family unit.
- Adolescents as it is unclear about the breadth of focus on their well-being if they are not young parents. The strategy is focused on teenage parents and could risk missing the broader support for teenagers, for adolescents that don't have children, for young people becoming adults and then potentially parents.
- Couples without children who require support with relationships through the stages including formation, strengthening or separation.

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.

UnitingCare Queensland supports the outcomes and the government's commitment to working towards this. These outcomes are reflected in the current DSS funded programs provided by UnitingCare so we feel that we are in a good position to support the government with achieving this.

UnitingCare Queensland are currently embedded in many local communities across Queensland providing vital services for families, and the scale and breadth of UnitingCare ensures we are able to provide streamlined referrals. Additionally, we are engaged in local networks and work in collaboration with other services in our community.

Outcome 1 highlights a focus on early intervention for parents through knowledge and support, reducing social and emotional distress, enhancing well-being and self-esteem and capacity to strengthen family bonds improves long term outcomes for children.

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Outcome 2 highlights a focus on children's lived experiences through inclusion in direct service delivery, will enhance resiliency through social and emotional skills (managing and expressing feelings), interacting with others (inclusion), and cognitive skills (problem solving).

However, we feel there needs to be further clarity regarding 'healthy'. Family support programs can assist with social and emotional skills (managing and expressing feelings); interacting with others (inclusion), and cognitive skills (problem solving) and we assume this is what is meant when the outcomes refer to healthy above. However, this may not be how the word is read by those who access the services. Healthy could be interpreted as focusing more on the physical health of a child. If this opinion is widely accepted, we wonder how families with children with chronic illnesses and living with disabilities might feel, whether they might feel that the new programs exclude them. We would suggest that "capable, competent and secure" might capture the goals of the strategy better?

Even though the outcomes above state parents and carers, we believe that government would consider how important the role of the wider family and community are in supporting families with these outcomes. Perhaps this is an important point that can be reinforced when sharing these outcomes?

While there seems to be a focus on 0-5 years, there is also mention in the discussion paper of the importance of continued intervention beyond these years. Could the outcomes also be expanded to highlight the importance of age appropriate support across the development spectrum?

Another area of focus in the outcomes could emphasise the need for culturally safe, flexible and place-based service delivery, as the guidelines do mention the focus on place-based activities. Our work with diverse communities across Queensland has reinforced the complexity in the community and the need for families to have a strategy that adequately addresses this.

Program Structure

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

UnitingCare Queensland believes in theory that a single national program will provide more flexibility for our organisation, however we are looking forward to more guidance on how the government will implement this. Potentially a single national program could be as complex to roll out as the current focus on 5 individual funding areas, given the division into 3 different streams, should they not be well defined from the beginning.

A single national program may provide more flexibility, if the model is amenable to place based services and community need, and is adaptable to avoid replication of other locally government funded services. The scope of outcomes would vary in geographical locations when taking into consideration connected, co-located and integrated services.

It is also unclear how a single national program will change the current reporting process to streamline this, for example, will there be one report per organisational contract or it continue to be a requirement to submit a separate report per program or stream? We are also looking forward to the guidance on a single national strategy and how this will impact funding processes, deal with surpluses and the allocation the funds across the programs, for example how does the government envision the division of funds across multiple programs within the one organisation, as one lot of funding to be allocated by the organisation or a defined amount per service?

A question to consider when developing a single national strategy is how easy it is for an organisation to adapt their delivery based on community needs. Flexibility must be maintained in order to meet a community's specific needs and the streams focus should allow flexibility to address a broad range of family structures, age groups

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and community needs now and into the future. The focus on place-based services will help address the unique issues in regional areas, if it is matched with the flexibility to target the services focus on these issues. This has been a particularly beneficial feature of programs such as those funded under the Communities for Children funding program.

Additionally, intensive family support could replicate state-based funding if not careful i.e. Intensive Family Support which is part of the secondary service system and Family Interventions Services which provide tertiary services, however this might be an area that the ACCOs could focus on?

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, including those currently funded by DSS as follows -

- Northern Gold Coast Communities for Children – would fit in Stream 2 Prevention and Early Intervention and has the potential to offer programs in Stream 3 Intensive Family Support as well.
- Children and Parenting Support (CaPS) – we have several current CaPS programs that would fit Stream 2 Prevention and Early Intervention.
- Family and Relationship Services (FaRS) – our current services provided under this funding would fit Stream 2 Prevention and Early Intervention.
- Family Mental Health Support Services (FMHSS) – services provided currently under this funding stream would translate to Stream 2 Prevention and Early Intervention.
- Specialised Family Violence Services (SFVS) – these services fit within the Stream 3 Intensive Family Support.

Additionally, UnitingCare provides several Intensive Family Support programs, funding by the State Government, so have experience in providing targeted support to families within our communities.

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

UnitingCare Queensland would appreciate the flexibility within the funding to continue to be able to adapt to changing community needs and a focus that allows services to be innovative in their responses to these needs. A benefit of previous funding programs has been the provision of funding to hold real time community consultations and to adjust programs and services based on what is discovered through these processes. This experience has shown that a focus on qualitative evaluation, i.e. narrative evaluation, is a benefit and if this national strategy could provide a focus and funding for this, it would help our organisation support our communities by providing us with the stories of what has worked.

The focus of the strategy on providing long term contracts is helpful, as it can take time to make an impact in a community. It is also beneficial for us to know beforehand when a service is not being refunded, to allow time to exit the community and focus on sustainability planning.

We do appreciate the government's commitment to streamline reporting requirements to allow organisations to focus on service provision and not admin. We also appreciate the references to services being place-based as this provides the flexibility to respond to the individual community needs and support integrated service delivery.

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We are hopeful that the real target cohort will be broadened beyond parents, carers and children as the government is aware of the need for whole of community support and the benefits that provides to the diversity of our communities.

We would like to see an investment in workforce knowledge and skill development in recognition of the complexity of client circumstances supported by services and that services are faced with unprecedented social challenges such as housing, domestic and family violence systems abuse, neurodiversity, and impacts of social media and artificial intelligence. The circumstances and challenges for families, is evolving faster than university degree curriculum.

UnitingCare Queensland has found that our workers are required to develop skills beyond therapeutics and knowledge beyond early intervention therapeutic support, which require significant investment in workforce training and development. Additionally, UnitingCare Queensland sees the need for investment in workforce well-being and the recognition and contribution to support for systems of care for workers to avoid workforce fatigue, burnout and psychological injury – noting workforce themselves may be impacted by the same circumstances and challenges as clients in need.

Additionally, there is a need for investment in inclusion and accessibility to best practice service delivery. There are benefits and limitations to both face-to-face service delivery and remote service delivery. The cost of maintaining physical locations is expensive and especially so in locations that support accessibility e.g. locations in urban areas close to public transport. The costs of reliable cyber security in an ever-evolving landscape also requires investment.

Prioritising investment

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

UnitingCare Queensland supports the focus of the four priorities listed in the discussion paper, however we are seeing families experiencing a range of complex needs (i.e. Domestic Violence and Child Safety, cost of living and housing pressures). It is our hope that this program will allow for organisations to design programs to address these wider needs as well.

Some of our programs have traditionally found it difficult to engage with young parents within an early intervention space. To prioritise this group, it is apparent that organisations need to create flexible programs for this and to be able to pilot ideas. The funding provided and outcomes expected, need to reflect this reality.

We acknowledge that there was a limit in what could be described in the discussion paper, and it appears there is a gap in focus on support for our minority groups and CALD families. We anticipate that this will be rectified in the tender application as we know that these groups need support. There is a focus on First Nation families, which is vital, however other groups also require tailored support such as the CALD communities and our LGBTQIA+ families, which may include adolescents who are not young parents yet but do have support needs.

Again, UnitingCare Queensland recognise that within the framework, services may need to be able to make adjustments to their programs in order to ensure inclusive, flexible and responsive services that address the diverse needs of families in all communities.

Are there any other priorities or issues you think the department should be focussing on?

During the last few years, many of our programs have seen an increased need for support around financial wellbeing. One of our current services has expressed the importance of implementing place based financial

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support and Emergency Relief strategies specific to their community. Northern Gold Coast Communities for Children are seeing an increasing number of people seeking support, and in particular first-time clients who are trying to navigate the system for help. These families are not only requiring financial support, they are also needing help to address the shame they may experience by accessing support for the first time, as the services are increasingly seeing non-intergenerational welfare dependant families reaching out for help.

Another issue faced by several of our communities relates to those experienced by transient populations, and this includes rental shortages and housing instability, and lack of extended families support resulting in social isolation and the issues this creates. Both Emergency Relief programs and soft entry programs have been a benefit to these families.

School preparedness continues to be an area of concern and need, as local research with schools has discovered concerning reports of high levels of children not prepared for school. Programs that have a child development focus assist with this, helping families to support the children's developmental goals.

It should be noted that vulnerable communities may be over-serviced communities. Statistics regarding vulnerability do not always paint a full picture of need. One of our services, located in a rural community, noted that many of the families they work with don't fill out the census and are living semi off grid, so they may not identify as vulnerable in the ABS data, even though they are. Additionally remote, rural and transient communities often lack the basic services they need, even if they are not traditionally seen as a vulnerable population. As noted in the discussion paper, another factor the government may consider is whether similar services already exist in the area, so it is UnitingCare Queensland's hope that service mapping will occur in conjunction with the review of the data mentioned in the discussion paper, when decisions on where the funding investments are made.

As mentioned above, the groups who may be vulnerable who seem not to be mentioned within the discussion paper include CALD families, grandparents who are not carers and couples with no children. These groups are currently being provided services through the 5 existing DSS programs and we hope that the strategy has the flexibility to continue to support these groups should there be an unmet need in a particular community. Additionally we see a need to support siblings, extended families, older children and adolescents, and address the integration of issues faced by families, for example, family support needs, DFV and housing.

Another group that some of our services are starting to see accessing services are older women who are retiring into poverty and poor health. An example of a FARS client is D aged 58, self-referred to FARS, seeking support for mood disorder, neurodiversity and social support. D immigrated from Israel to America, then America to Australia, and lived with adverse childhood experiences leading to long term estrangement from all family members, however also worried for their safety in ongoing warfare between Israel and Gaza. D had never married and had no dependants. D had developed coping strategies of alcohol overuse, excessive shopping, and hoarding. Due to significant anxiety D was unable to work. D had recently experienced domestic violence and subsequently withdrew from community. D was unable to attend treating medical professionals due to crippling fear and was at risk of homelessness through loss of accommodation, as she would not allow property managers to conduct routine rental inspections. D wanted to manage her anxiety, reduce conflict with others, and attempt to reconnect with family. A combination of CBT, DBT and mindfulness was used to support D to navigate trauma triggers and manage anxiety. Developing communication skills and conflict management skills assisted D to begin communicating more confidently in the community. D reconnected with two family members, purchased a home, took regular exercise, attended treating professionals, and began volunteering in the community. D developed and maintained friendships in her local community. D and counsellor agreed goals to attain and maintain quality of life has been reached and D exited the service.

Another trend for services is the increase in people experiencing loneliness and the vital support that services can provide, as this loneliness can lead to suicide particularly impacting older men. R aged 81, self-referred to

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FARS. R has a history of child sexual abuse (victim), and a past history of alcohol and gambling addiction. These addictions had serious life-consequences and negatively impacted on R's family relationships. R had no contact with past partners or adult children, or grandchildren. R's current immediate family relationships had also become strained. R was experiencing a deep sense of loneliness. R's mood fluctuated from depression, experienced as sadness and withdrawal, to anxiety characterised by obsessions and hyper-activity. R was spiritual and the intervention of interpersonal and cognitive therapies were overlayed with mindfulness and connection to R's spirituality. Motivational interviewing and behavioural activation were used to re-engage R with self-care, medical follow up (for aging health), exercise and sleep. Interpersonal therapy was used to process grief and loss, while mindfulness cognitive behavioural therapy was used to challenge unhelpful thinking, perspective taking, reframing and to build communication skills. R reconnected with immediate and extended family members, established and maintained ongoing social connections in the community, followed health guidance and was maintaining part-time employment. Overall, R's relationships were healthier, and he felt a strong connection to his youngest adult daughter and recently separated wife. R shared he is managing his mood, and his health has also improved. R is maintaining his quality of life. R and counsellor agreed goals had been reached, and R exited the service with motivation to maintain his quality of life and support to access when needed.

Consideration also needs to be given to those clients who are identified as neurodiverse or are living with a disability. People facing mental health, learning challenges, and disabilities experience socio-economic disadvantage which has impacts on health and well-being. Whilst some significant mental health disorders and disabilities do not meet NDIS or disability support payment criteria, the associated challenges have a significant impact on individual, family and community well-being. Programs such as FARS have filled the gap where targeted services have been unable to support general needs.

Improving family wellbeing

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, these priorities do match what UnitingCare Queensland is experiencing, however we also support a wider range of vulnerable people including families at risk of DFV, transient populations, those facing cost of living crisis and trying to maintain housing, and young people living in residential care. Our programs currently funded by DSS have allowed us to support these vulnerable groups.

Again, we would like to highlight the need for the strategy to remain flexible to address the family context, varying age groups of family members, the wider community needs and geographic needs or this may create a significant gap that is not being addressed. UnitingCare staff have expressed their concern that we will feel the impact of retracted services for children once they are aged over 5 years should the funding for this age group be cut back.

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

As mentioned above it is not always the areas of high disadvantage that are the only ones needing more services, sometimes areas of lower disadvantage but with limited services need investment to avoid future issues arising. We encourage the government to consider investing in areas of moderate disadvantage with limited services, not just high disadvantage areas where services are already present.

Outreach is an important component of some programs to meet cultural needs, lack of transport, and mobility concerns. Sometimes funding is targeted to capture an area one day a week from a surrounding city, however the outreach is not always of the same quality as there can be nowhere to meet. This is just an example of how

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a lack of community infrastructure in a community can be an issue that needs addressing. This is where the funding to provide flexible service models, such as digital and hybrid models, helps with access by regional and remote clients.

As outlined above we also support the funding of services for older women and older men, including supports for grandparents, and supports for neurodiverse clients and people living with disabilities who may not qualify for an NDIS plan.

Connected, co-located, and integrated services

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

We appreciate the idea of co-location in that it can help support integrated cross sector partnerships, with agencies from mental health, housing, DFV and financial support services working together. However, co-location is not the only solution to offering integrated support. We have outlined other effective ways below that we have had experience with or feel would support the role out of the strategy.

- Being members of Neighbourhood Networks, Local Area Alliances and Communities of Practice.
- Facilitating Service Expos, co-facilitating programs with other services and undertaking projects together with other services using pilot funding. An example of this was Gr8Start, a partnership on the Gold Coast that was funded by Medicare Local. A small amount of funding was given, which allowed organisations to work together on pilot projects which built the capacity of the group to continue to work together on other projects.
- UnitingCare Queensland itself has models of co-location where state and federally funded projects work in the same location and refer. However, it needs to be different types of services co-located, to avoid the over-servicing of families in one area at the expense of the needs of another, i.e. not all services providing generalist family support.
- Key worker models where one worker is the primary contact for the family, working with the family and other services to meet their needs. This can include integrated case planning, to avoid clients telling their story multiple times, and instead multiple service providers sit around the table with the client and they can talk to everyone. The process is led by one organisation but all the services make decisions together to avoid the over servicing or under service of those in need. UnitingCare used this model for a 'Service Navigator' in Gladstone post the fires and floods in the region. This worker was the link between multiple services and assisted community members impacted by linking them into what they needed. They were essentially the conduit between services and stayed involved through the client's entire journey to be a one point contact. This model is also used a lot in NDIS and disability services (https://treehouse.org.au/wp-content/uploads/2025/04/Key-Worker-Flyer-Model.pdf).
- MOUs between services with clearly defined agreements on roles, shared responsibilities and coordinated service delivery. This can also streamline referrals between local organisations.
- Services undertaking outreach, bringing services to the community through accessing schools, homes and community hubs, to enhance access.
- Outreach models for First Nations and Culturally and Linguistically Diverse Families led by ACCOs or cultural leaders, underpinned by established working partnerships. This requires clear guidance in governance, accountability and reporting. Outcomes could initially be progress and reconciliation based on decolonisation of main-stream services and refined outcomes for data exchange reporting are required for First Nations and culturally led groups.
- A shared referral system or platform amongst providers supported by Government funding, i.e Police

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– Infoexchange.

- A national social campaign and community education about healthy families, with a national contact point that connects families to their local service providers. It can provide education for the community about the benefits of engaging.

One issue raised in consideration of co-location was in relation to infrastructure. Consideration needs to be given to who will fund the infrastructure to co-locate, would this be something the government will fund?

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?

UnitingCare Queensland would suggest the following areas would be beneficial to assess an application:

- Community Research and Needs Analysis undertaken by the service and the findings shared in the application. Services also showing that they have been a part of community consultations.
- Involvement in local networks and evidence of the co-facilitation of programs. Services show they are connected to the community it serves, participates in networking and is involved in Local Level Alliance meetings and community events.
- Evidence of success or depth and breadth of local partnerships, evidence of culturally safe and inclusive practices and responsive to client and community needs. Connection to State Health and Education Services, and local businesses.
- Able to show evidence of community voice and co-design activities, including codesign workshops and feedback loops to and from the community. A governance model could have a community working group, maybe once a quarter for input and feedback.
- Track record of outcomes and sustained engagement with the community and evidence of a flexible approach that improves accessibility and integration.
- Dedicated supports for diverse client needs including First Nations, Culturally Diverse, those living with a disability, and the LGBTQI+ community.
- Demonstrated use of outreach models.
- Able to show they are engaging with Elders.
- Evidence of using Social Media for a broader reach, for example to engage with adolescents.

Responding to community need

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

Funding allocation needs to be focused on a holistic evidence-based view of the specific community needs. All areas will differ, and consideration should be given to both social and demographic factors to ensure equitable and effective investment in family wellbeing.

UnitingCare Queensland believes that the other factors outlined below should be considered by the government:

- DFV statistics and Child Protection data,
- Number of services already available in the community (service mapping) and evidence of lack of services in area.
- Issues faced by working poor due to the rising cost of living.

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- Housing stress caused by increasing rental costs and housing shortages.
- Statistics regarding mental health, people living with disabilities, cultural diversity and older people needing support.
- Complexity of presenting issues in a community and evidence of first-time families accessing services.
- Families living in rural and remote areas. The gap is widening between urban and rural/remote communities and it can be a challenge for services trying to employ someone to work there.

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

The following are a list of ways an organisation can show that their service is meeting the needs of their community:

- Community Research and needs analysis undertaken. Service Mapping data provided, showing how they are filling gaps not provided by other services. Evidence showing how the service has adapted to community needs.
- Evidence of actively collecting feedback from service users and stakeholders and using that feedback to make changes to the program.
- High attendance of programs. Evidence of word of mouth reach and strong community awareness
- Involving the community voice, shared decision-making structures, use of Advisory Groups, co-design programs and participation in community consultation.
- Data and outcomes from services provided, client stories and direct client feedback.
- Able to show engagement with families, the community and cultural groups.
- Evidence of working with networks and other community organisations, stakeholders, and community leaders. Partnerships and collaborative programs.
- Services and programs that show cultural and place based relevance.
- Services demonstrate they are responsible and innovative.
- Sustainability and evidence that services are embedded in the community and the organisation is capable of providing support over time.
- Have provided remote service delivery and are investing in sophisticated telehealth options.
- Processes in place to provide outreach on a rotational basis (where it is difficult to recruit professionals in the rural/remote regions) through the development of stable rotational outreach models.

Improving outcomes for Aboriginal and Torres Strait Islander children and families

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

- Investment to allow the development of culturally safe service models and governance structures. Thought given to investing in capacity building support activities to provide pre-application guidance, financial management advice, HR management advice, quality and safety management advice and

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how to report, if appropriate. This could be provided to new organisations perhaps through mentoring and partnering with other local organisations with experience with the department.

- Outcome tools that are aligned with First Nations culture, with a focus on reconciliation and empowering self-determination. A focus on outcomes related to reconciliation, well-being outcomes, rather than just outputs.
- The validation and inclusion of case collaboration and case review (working together) as progress and an outcome in of itself, as well as a focus on culturally meaningful outcomes for First Nations Peoples as defined with First Nations Peoples.

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

- Governance by ACCO or co-governance model, or at a minimum co-design workshop.
- Service expected to seek guidance from Elders and implement feedback loops.
- Investigating the use of Yarning Circles as a case work method. Yarning Circles is something that First Nations people use. It might be a suitable model to be used in conjunction with more traditional case work modalities and perhaps incorporating Yarning Circles with families that services are working with can help remove power imbalances as well.
- Co-design of programs, delivered in culturally safe ways, sufficient resourced to support sustainable place based holistic service delivery – e.g. one stop shop or case coordinator.
- Seek examples of TORs for establishing and maintaining working relationships with mainstream services to support the establishment and growth of ACCOs.

Measuring outcomes

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

- Qualitative data and the funding to support evaluation in this area. When Communities for Children was first established, funding was included to contract another organisation, such as a University, to support research efforts.
- Collection and analysis of the data types (needs, client outcomes, demographics, attendance and participation rates, and engagement patterns to monitor reach and access) to demonstrate effectiveness of the program and remain relevant.
- Collection of direct client feedback and experience.
- Data regarding the collaboration activities undertaken with other agencies, including the evaluation of the success of the partnerships.
- Cultural relevant measures and indicators that are meaningful to First Nations communities, for example around their connection to their cultural and community wellbeing as outcomes. Services need to measure that they are being culturally responsive.
- The ability to use other tools. UnitingCare Queensland currently uses Outcome Star in many of our programs. This provides a holistic view and staff have found that SCORE doesn't give a richness of data and is averaged across families. Outcome Star also supports the outcomes, the needs are identified and can be worked towards with the client. It can be used to engage them in goal setting.
- Benchmarking data across the sector as it enables services to compare performance, identify gaps

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and good practice, and drive continuous improvement in outcomes for clients.

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?

- To be most effective, a balance of qualitative and quantitative data is needed. UnitingCare Queensland has noticed there has been a recent switch in focus to quantitative at the expense of the client stories.
- Robust, measuring impact, supporting evidence-based decision making and continuous improvement, highlighting the community and cultural relevance.

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

- Communities for Children – Family Functioning, Age-appropriate Development, Mental Health, Wellbeing and Self-Care, and Community Participation and Networks.
- CAPS – Family Functioning, Age-appropriate Development, Mental Health, Wellbeing and Community Participation and Networks.
- FaRS and SFVS – Family Functioning, Age-appropriate Development and Community Engagement.

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

- Narrative and storytelling evaluation guidance. The Narrative and Story-telling methods may assist with seeking feedback from First Nations participants too.
- Standard templates and clear guidance would help service providers to consistently capture and present meaningful and ethical evidence-based stories of impact. Templates that include background, presenting issues, pre-measure, intervention (#weeks engaged, what evidence-base was used, stakeholders engaged, goals), outcomes, and the sustainable change.
- Guidance on collecting data in a culturally safe way.
- Guidance on collecting evidence and best practice examples.

Working together

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

Our understanding of this approach is a focus on shared governance, a trust-based partnership and the ability of the services to adapt to the changing needs in their community. The Department partners with Service Providers to work on shared outcomes, not solely relying on compliance and prescriptive plans. This approach would focus on flexibility and mutual accountability, hopefully allowing services to be adaptable and innovative while there is transparency and accountability both ways. It would hopefully help us deliver the best possible outcomes for our clients.

It is a good approach however it would require oversight, and the careful recording of changes and tracking of agreements. It would require that the adaptability and flexibility based on changing community, be

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documented in a living document (agreement) so that the adaptation/flexibility is discerned from 'straying'. Relational contracts rely on good communication and a common understanding.

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

The best way is to assess the providers' demonstrated capability in collaborative practice, quality and safeguarding performance, cultural competence and consistent delivery of strong client outcomes over time.

Is your organisation interested in a relational contracting approach? Why/why not?
Our organisation would be interested in relational contracting, as we see strong potential for deeper collaboration, improved client outcomes, and more stable service delivery; however we would need further information on the expectations, resourcing implications, performance framework and governance arrangements before confirming our full commitment.

Other

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

As a final point, UnitingCare wanted to share some experiences and feedback from our programs that currently receive DSS funding, to show the impact of the programs already established.

FARS has been integral in supporting individuals, children and families, whose needs seem too diverse, too complex, or ill-defined, that do not fit within the criteria of targeted services, and has validated all people and supported in relationship, to self, others, families.

CAPPS
Single Mum, son (7) and daughter (13), have been receiving support for around a year now. Son and daughter have experienced trauma from previous DV relationship and the son has ADHD. The young boy has found it difficult to regulate his emotions and sustain a school day, without escalating behaviour, and hence Mum is regularly called to collect him.

Over the past year, we have been working on creating a calmer household with more effective communication strategies within the family unit. We have also been concentrating on improving Mum's parenting style, aiming to transition from 'permissive', to 'authoritative' and assisting Mum to regulate herself, hence being able to co-regulate with her son. We have also been assisting Mum to navigate the hormonal and emotional changes in relation to her daughter, who has also been struggling with friendships at school and adapting to the differing parenting approaches from Dad's house to Mum's.

Through psychoeducation and emotion focussed therapy, the family system has evolved into a calmer and more functional environment. Mum has learnt how to set boundaries, whilst still meeting the children's emotional needs and big behaviours have minimised at home. The son is now sustaining whole school days, and the daughter is understanding her friends better, through increased emotional intelligence. The family are now spending more time having fun together and can communicate their emotions more effectively.

What working with Miss D has meant to me…
Miss D helps little kids and especially kids having trouble at home. She also helped me with lack of confidence and build my communication skills. Miss D helped me to speak up for myself and say things that were hard to say. Miss D is cool because she basically makes you do like a selfcare bingo for yourself. This means she

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helps you tick ways you're looking after yourself. When you're better at things you've been working on, she tells you you've improved. Miss D helps kids with anxiety, anger and when they have worries of stress. I know this from having worked with Miss D, that in the future I am going to be successful and take the right path. Thank you for improving my skills and being caring, kind, nice and loving.

Communities for Children
Mother of 3 children, has attended the Early Years Hubs for the past two years with her youngest daughter. When she began, she had just left a relationship with DFV. She had no support and no support services in place. The facilitator was able to build trust and rapport with Mum and slowly she began to share her situation.

During the past two years CfC has been able to support Mum through the Early Years Hubs, with counselling sessions, the Food Box program and with emergency support vouchers when the family was going through a very difficult financial period due to a forced move because of rental cost increases. Since beginning with CfC Mum's confidence has grown and she has made new friends. Mum now goes out of her way to welcome new families to the CfC Early Years Hubs and she is very grateful for all the assistance her family has received.

Mum of 5 children, started 13 years ago at the CfC Early Years Hubs and has just returned after having her 5th child. Suffering with postnatal depression after the birth of her fifth child she reached out to Early Years Hubs again and was thrilled to see the same facilitator she had connected to many years ago. Mum needed community connection and support. Mum is now bringing her son and grandson to the hubs regularly and reconnecting with new mums and children the same age. As a previous recipient of the food box program several years ago Mum recently raised money through her netball club and was able to donate vouchers towards the CfC Christmas Hamper program.

When Amina (name changed for privacy), a Syrian mother of two young daughters, arrived on the Northern Gold Coast, she carried with her the layered weight of migration, single parenting, and deep emotional wounds. Her marriage and life in the UK had ended and she was now raising her 4- and 8-year-old daughters with the support of her own mother.

Amina initially sought Emotion Coaching to address an emotional eating issue, but it soon became clear that her struggles were rooted in unprocessed trauma. As trust grew, she began exploring the emotional residue of growing up in a home where her father was violent toward her mother. Later, she herself had experienced domestic violence in her own marriage, a pattern she was determined to break—for herself and for her daughters.

Over the past six months, Amina has attended weekly Emotion Coaching sessions with unwavering consistency. She's also taken part in a weekly group art therapy program, which has offered her a creative, communal outlet for processing difficult emotions. Throughout this time, she's shown exceptional commitment to her healing, doing emotional homework between sessions, reflecting deeply, journaling and building and practising hands-on strategies to support her wellbeing.