Evaluation of the Medicare Mental Health Kids Hubs Initiative | Final Report

Department of Health, Disability and Ageing

2 April 2026

nous

Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of Country throughout Australia. We pay our respect to Elders past and present, who maintain their culture, Country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

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Glossary

Term	Definition
Aboriginal Community-Controlled Organisation (ACCO)	Aboriginal and/or Torres Strait Islander Community-Controlled Organisation delivers services, including land and resource management that builds the strength and empowerment of Aboriginal and Torres Strait Islander communities and people and is: • incorporated under relevant legislation and not-for-profit • controlled and operated by Aboriginal and/or Torres Strait Islander people • connected to the community, or communities, in which they deliver the services • governed by a majority Aboriginal and/or Torres Strait Islander governing body.
Age ranges	'Children' includes those 0-12 years old. Specific terminology for the different age ranges within 0-12 includes:[1] Infancy: neonate and up to one year of age Toddler: 1-5 years of age Childhood: 3-11 years old Early childhood: 3-8 years old Middle childhood: 9-11 years old
Australian Government	The Commonwealth of Australia is a federation of six states and two self-governing territories. The national government is the Australian Government. The constitution gives certain powers to the federal government, some powers are shared with the states and territories, while other powers remain with the states and territories.
Bilateral Schedule on Mental Health and Suicide Prevention (the bilateral schedule/s)	A bilateral schedule is a written agreement between two parties that outlines the specific actions they will take to collaborate on a common goal. The Bilateral Schedule(s) on Mental Health and Suicide Prevention outlays the respective commitment between the Australian Government and each state and territory to improve mental and wellbeing outcomes and reduce suicide for all Australians.
Culturally and Linguistically Diverse (CALD)	A term primarily used to describe populations with diverse ethnic, language, or religious backgrounds. It refers to people born outside of

[1] National Library of Medicine. (2023). Human Growth and Development.

Term	Definition
	Australia, non-Anglo-Celtic backgrounds, or those speaking languages other than English at home.
Care coordination	Children and families will often access multiple service providers at the same time. Regular and comprehensive communication between providers is required to coordinate their care. Care coordination is where a team of care providers and the child and family work together to develop and undertake comprehensive care planning that considers the child in the context of their health and wellbeing. Also referred to as collaborative care.
Co-design	Co-design is a practice that involves bringing families, health workers, and service managers together to design, evaluate, and improve services. It involves those who use (or represent those who use) services and service providers identifying problems within services and working collaboratively to find solutions. Co-design should involve people who will be impacted by the proposed service, either directly or indirectly. It is guided by five principles: equal partnership, designing together, openness, respect, and empathy.
Complex support needs	Where a child/family have multiple health, developmental, economic, educational, cultural, and/or social needs and challenges that require access and support from multiple services within the community.
Early intervention	The current system is not designed to provide early interventions and fails to address the factors that increase vulnerability and risk. Waitlists and strict eligibility criteria often mean that supports address critical situations rather than preventing the initial development of a child's difficulties. In this context, early intervention can refer to both 'early' in the disease/ill-health progression and 'early' in life stages (i.e. in infancy and childhood). It is common for these to occur at the same time, which reinforces the importance of supporting children aged 0-12 with mild to moderate emerging complexity.
Expression of Interest (EOI)	A formal application process to demonstrate interest, suitability and availability. Some state and territory policy leads invited service providers to complete an expression of interest to deliver the Kids Hub in that area.
Family	The term family is used flexibly and inclusively to reflect the diverse caregiving arrangements in children's lives. It may include parents, carers and kin, as well as grandparents, non-biological family members, and other trusted adults who play a primary caregiving or support role. This includes extended and culturally specific kinship

Term	Definition
	systems, recognising that family structures vary across communities and contexts.
FTE	Full-Time Equivalent, a unit of measurement representing the total hours worked by employees.
GP	General Practitioner.
Implementation	To implement the Kids Hubs means to actively set them up. This involves key steps such as designing the local service model, acquiring a premises, training staff, and starting service delivery.
Integrated care	The provision of seamless and effective service characterised by a high degree of communication, coordination, and collaboration in partnership with the child and family and across health and other care providers such as education, early childhood, and family services. It involves the sharing of information and development and management of a comprehensive care plan to address the physical, emotional, social, and spiritual needs of a child and family.
LGBTIQ+	Lesbian, gay, bisexual, trans/transgender, intersex, queer and other sexuality, gender, and bodily diverse.
Lived-experience	People with lived-experience identify either as someone who is living with (or has lived with) mental health challenges or psychological distress, or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental health challenges or psychological distress. People with lived-experience are sometimes referred to as 'consumers' or 'carers', acknowledging that the experiences of consumers and carers are different. See related 'peer support'.
Local service model	The National Service Model is designed to be tailored to local contexts in each jurisdiction. Through a co-design process, state and territory policy leads designed local service models. As outlined in the National Service Model, the mix of services which the Kids Hubs provide in-house may vary from location to location and will depend on arrangements negotiated with Local Health Networks (LHNs) and other local services.
Kids Hub leads	The team leaders at the Kids Hubs that provide operational oversight and governance. The Kids Hub leads are employed by the service provider and work closely with the state and territory policy leads to oversee the Kids Hubs.
Mental health and wellbeing challenges	Mental health and wellbeing challenges reduce the cognitive, social, and emotional functioning of an individual, but are not experienced to the extent that meets the criteria for a mental illness diagnosis. Such

Term	Definition
	challenges could be a result of a range of environmental, social, and individual life stressors, such as the loss of a loved one or housing and financial instability, and therefore, can resolve over time when the individual's circumstances change or improve. However, mental health and wellbeing challenges can develop into mental illnesses if they persist or increase in severity. They can also further develop without timely access to appropriate mental health services and supports.
Mental health and wellbeing supports	Mental health and wellbeing supports refer to any form of assistance or guidance that is designed to preserve and promote mental wellbeing and/or prevent or treat mental health issues. There are three levels of the healthcare system in Australia:[2] Primary care: Health services where consumers access care, treatment, and support without the need for a referral or without needing to meet certain eligibility criteria. Primary care settings include general practices, community health services, and some allied health services. Primary care can be offered by a wide range of professionals including GPs, allied health professionals such as social workers, mental health nurses, psychologists, maternal child and health services, and pharmacists. It is often the entry point to the healthcare system. Secondary care: Health services that require a referral from a primary care provider (usually a GP). A common example is a referral from a GP to a private psychologist under the Better Access Scheme. Another common form of secondary care is where a GP refers a consumer to a psychiatrist for a mental health assessment and treatment. Secondary care may be provided in a hospital clinic or the community. Tertiary Care: Highly specialised healthcare usually over an extended period that involves advanced and complex procedures and treatments performed by medical specialists mostly as a hospital in-patient or in specialist community-based clinics. Requires referral from a primary or secondary health professional unless in an emergency. In these levels of the healthcare system, there are many other types and modes of supports. This includes mental health community support services (MHCSS), mental health and psychosocial support (MHPSS), social services, children and family services, disability services, and other allied health services.
Mental illness	A mental illness is a diagnosable condition that is generally defined as a mental, behavioural, or emotional disorder. As a result, it impacts how a person thinks, feels, behaves, and interacts with others. The

[2] Australian Government, Department of Health, Disability and Ageing. Medicare Mental Health Kids National Service Model.

Term	Definition
	diagnosis of a mental illness is generally made using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-11), which are widely recognised and adopted classification systems for mental health disorders. Mental illness varies in severity and can cause impairment based on the level of distress caused by the intensity of symptoms and level of interference in daily, social and occupational functioning. A serious mental illness is distinguished by severe impairment that significantly interferes with the daily functioning or major life activities of an individual. Any mental illness can be classified as or develop into a serious mental illness, but common diagnoses include schizophrenia, bipolar disorder, or major depressive disorder.
Multidisciplinary team	A multidisciplinary team is a group of experts and professionals from different disciplines who work together to provide comprehensive care for children and families. The specific profiles of these teams are determined locally by the Kids Hubs, but include child and youth psychiatrists, paediatricians, psychologists, Aboriginal and Torres Strait Islander health workers or liaison officers, mental health nurses, occupational therapists, speech pathologists, physiotherapists, and social workers.
National Service Model	The Medicare Mental Health Kids National Service Model.
Operating context	The environment and conditions in which the Kids Hubs exist and the enablers and constraints that determine how services can be delivered. This includes operational factors such as workforce availability, funding mechanisms, and governance arrangements.
Peer support	Peer support is when people give or receive support based on shared experiences of mental health concerns. Peer support provides mental health benefits through empathy, acceptance, and skill-sharing that comes from dealing with similar lived-experiences. See related 'lived-experience'.
Policy context	The state and territory government decisions, commitments, strategies, plans, reforms, and investments in each jurisdiction that shape the local model of care design and service delivery.
Service delivery context	The on-the-ground reality of how services are currently provided, including what services exist, how they connect, and how accessible they are. The broader system and existing service landscape influences the establishment and delivery of the Kids Hubs. Understanding the service context is crucial for integration, as the Kids Hubs look to

Term	Definition
	establish partnerships with existing service providers and bolster referral pathways.
Service provider	The term 'service provider' refers to the organisation responsible for the establishment and operations of the Medicare Mental Health Kids Hub. This can include government and nongovernment organisations. The Initiative aims to address key gaps in the health system by coordinating a network of skilled service providers across the Kids Hubs and related services, including a community of practice and shared learnings.
State and territory policy leads	The representatives from each state and territory that govern the Medicare Mental Health Kids Initiative in their jurisdiction.
Supported transition	Kids Hubs are designed to consider the different services/systems involved at the different phases of the child's development and ensure that transitions are smooth, supported, and informed. This is supported by warm referrals (see below).
Warm referral	To provide a warm referral means actively communicating with the other service to which the child and family are being referred to, to provide essential information about their needs before transferring their care. Support is then maintained for the child and family until they are received by the other service. Providing warm referrals to services reduces the burden on families to navigate the complex service system on their own. Also known as 'warm transfer', 'warm handover' or 'facilitated referrals'.

Executive Summary

Background to the Initiative

The Australian Government has committed $84.85 million, and state and territory governments a further $82.6 million, over four years to partner in establishing a national network of Medicare Mental Health Kids Hubs for children aged 0–12 years, their families, carers, and kin. The Kids Hubs aim to provide more timely and equitable access to holistic and integrated mental health and wellbeing services for children and families with a focus on prevention and early intervention. The Kids Hubs are designed to operate as a secondary level child mental health and wellbeing service, targeting mild to moderate needs for children. The Medicare Mental Health Kids National Service Model (the Model) was developed to support consistency in the establishment, implementation, monitoring and evaluation of the Kids Hubs, as well as providing clear expectations regarding functions and quality of care.

The Kids Hubs deliver on Action 2.1c of the National Children's Mental Health and Wellbeing Strategy (the Strategy) and are governed through the National Mental Health and Suicide Prevention Agreement (the National Agreement). The bilateral agreements outline clear roles, responsibilities, and shared funding arrangements between the Australian Government and state and territory governments for the implementation and operation of the Kids Hubs. Collectively, the agreements provide for the establishment of 17 Kids Hubs nationally by June 2026.

Purpose of the Evaluation

The Australian Government Department of Health, Disability and Ageing (the Department) has engaged Nous Group (Nous) to evaluate the implementation of the national network of Kids Hubs between November 2023 and April 2026. The aim of the Evaluation is to assess the appropriateness, implementation, effectiveness, and future opportunities of the Kids Hubs nationally. One of the key objectives of the Evaluation is to develop robust evidence on what works for whom and how, to support continuous improvement of the Kids Hubs and inform policy and funding decisions.

The Evaluation utilised a mixed methods design and a developmental approach to support continuous improvement as implementation progressed. The developmental approach recognised that jurisdictions and the Kids Hubs are at different stages of implementation so the Evaluation could facilitate information sharing and learnings. The Evaluation answers five Key Evaluation Questions (KEQs) using information across three data sources: literature, qualitative, and quantitative data.

The KEQs for the Evaluation are:

1. **Appropriateness:** To what extent are the Kids Hubs focusing on the right things, to respond to the context and community needs?
2. **Implementation**: What is being implemented – to whom, where, and how, and what is different across the different contexts?

3. **Effectiveness**: What is changing as a result of the Kids Hubs, for whom, and how?
4. **Cost-effectiveness**: To what extent are Kids Hubs using resources well and how cost-effective are the Kids Hubs compared to similar models?
5. **Future opportunities**: What improvements would enable the model to meet its objectives?

Summary of findings

Appropriateness

The Medicare Mental Health Kids Hubs Initiative responds directly to long-term gaps in Australia's child mental health system. The system has historically prioritised crisis and acute care, with most funding for interventions directed toward older children and severe presentations. This has left limited accessible support for children aged 0–12 with emerging, or mild to moderate needs; particularly where distress is driven by developmental, family, or social factors rather than diagnosable mental illness. As a result, many children and families experience long wait times, fragmented pathways, or no support until difficulties escalate.

The Kids Hubs Model responds to the National Children's Mental Health and Wellbeing Strategy and align with other national policy priorities. The Model shifts the focus away from diagnosis-driven, reactive care toward early intervention, prevention, and whole-of-family support. The Model recognises that children's mental health and wellbeing is shaped by their family, context, and social determinants. Providing free, multidisciplinary support without requiring a diagnosis or referral removes key access and financial barriers and enables earlier engagement with families who are often poorly served by existing systems.

Local co-design has further strengthened appropriateness by ensuring each Kids Hub responds to community needs, service gaps, and local system conditions. Services have been designed to be culturally safe, welcoming, and integrated with existing health, education, and family services, rather than duplicating these. This flexibility has allowed Kids Hubs to complement local service landscapes while maintaining alignment with the national Model. Overall, the Initiative is well positioned to address unmet need, improve early access, and support better mental health and wellbeing outcomes for children and families in a constrained and fragmented system.

Implementation

Implementation of the Kids Hubs has been guided by clear national direction and enabled by flexibility for local tailoring. Early implementation benefited from collaborative relationships between the Australian Government and jurisdictions, which supported effective problem-solving, alignment to the Model, and shared ownership of the Initiative. Jurisdictions used flexible commissioning approaches to select service providers with existing presence and system connections, enabling the Kids Hubs to integrate with existing service landscapes and respond to varied workforce and community contexts.

Co-design was central to implementation in all jurisdictions and when done well, supported integration of the Model into local contexts. Early and inclusive co-design with children, families, communities, and system stakeholders shaped intake pathways, service navigation, workforce

composition, partnerships, and physical environments. Where co-design was sustained and involved both community and system partners, implementation was smoother, roles were clearer, and local ownership was stronger. Co-design also supported culturally safe and welcoming service environments and helped ensure the Model complemented, rather than duplicated, existing services.

While nearly all Kids Hubs are now operational (14 out of 17), implementation pace and maturity have varied. Workforce availability was the most persistent constraint, alongside challenges securing suitable premises and navigating funding and administrative processes. In response, some Kids Hubs provided services from existing or satellite sites. The Kids Hubs also adopted workforce strategies including part-time and shared roles, use of telehealth and specialist consultation, and a strong focus on training and capability uplift. Investment in multidisciplinary and interdisciplinary ways of working has supported service continuity and helped build workforce capability and confidence in an emerging model of care.

Partnerships are critical implementation enablers across all sites. Kids Hubs established extensive relationships with health, education, child and family services, and community organisations to strengthen referral pathways, manage demand, and support integrated care. Partnerships with Aboriginal Community Controlled Organisations (ACCOs) were particularly important for reaching Aboriginal and Torres Strait Islander families and providing culturally safe care. The depth of these partnerships varied, but where relationships were Aboriginal-led, trust-based, and embedded in governance or service delivery, Kids Hubs achieved stronger engagement and integration. The national Community of Practice also supported early alignment of the Model and shared learning, though its influence was less consistent as implementation progressed.

Characteristics of the children and families

Most children accessing Kids Hubs are in early primary school, aged 5-8 the most common age group. Boys (57%) represent a slightly higher proportion of service users than girls (43%). No gender diverse children accessed the Kids Hubs.

Service uptake among priority populations varies substantially across Kids Hubs. Overall, 17% of families accessing Kids Hubs identify as Aboriginal and Torres Strait Islander, 9% are from culturally and linguistically diverse (CALD) backgrounds, and 9.7% of children have a disability or chronic illness. Differences in uptake are likely influenced by variation in service models, particularly the extent to which individual Kids Hubs target specific priority populations.

Psychosocial vulnerability is a common characteristic of the families who have accessed the Kids Hubs. 27.3% of families experience co-occurring psychosocial vulnerabilities, including family violence, parental mental health, housing instability and financial stress. Almost half of families require support from multiple services, highlighting the complexity of need and the importance of integrated, multidisciplinary responses.

Referrals to Kids Hubs come from a range of sources, most commonly community health services, schools and self-referrals. Referral sources to Kids Hubs vary widely across locations, reflecting locally designed pathways and relationships. Where walk-ins are available they account for a substantial proportion of referrals, indicating strong community awareness and accessibility,

while schools and other community services are also common referral pathways. In many sites, reliance on one or 2 key referral sources reflects intentional targeting of pathways during establishment to manage demand.

Effectiveness

There is strong evidence that the Kids Hubs are delivering early outcomes consistent with the Model's intent. The Initiative has improved access to timely, flexible, and family-centred support, particularly for children and families who experience long wait times, barriers to access including eligibility, and fragmented pathways. By removing cost, referral and diagnostic requirements, the Kids Hubs have lowered barriers to entry and enabled earlier engagement. Holistic, multidisciplinary assessment processes are effectively identifying emerging developmental, behavioural, psychosocial, and mental health needs that would otherwise likely remain unmet until they escalate. Early identification is critical to the Model achieving its intent.

Children and families report very high satisfaction with their experience of the Kids Hubs. This is due to the Kids Hubs providing tailored, non-judgemental supports, safe and welcoming environments, and trusted relationships with staff. Children enjoy attending, and parents report increased confidence, capability, and understanding of their child's needs and how to support them. Multidisciplinary, and in some sites interdisciplinary ways of working enable collaborative care planning, shared problem-solving, and on-the-job capability uplift across the workforce. These approaches strengthen service quality and staff confidence, but their effectiveness is uneven and constrained in some locations by workforce shortages, fragmented systems, limited time for care coordination, and varying levels of clinical and operational leadership.

Strong partnerships are central to the effectiveness of the Kids Hubs. The Kids Hubs are enhancing local service systems by building referral pathways, supporting schools and community services to identify early need, and coordinating care across health, education, and social services. Cultural competence is emerging across the Kids Hub network, with stronger engagement and outcomes where Aboriginal and Torres Strait Islander leadership, genuine community partnerships, and trust-based approaches are embedded. The Kids Hubs are also supporting transitions to other services through warm handovers and navigation, helping families move more confidently through the system. However, the consistency and impact of supported transitions vary and are often limited by capacity constraints and access barriers in the broader service system.

Cost-effectiveness

Early evidence indicates that the Kids Hubs are cost-effective and broadly comparable to similar child and family hub models in Australia. While a full cost-effectiveness or cost-benefit analysis is not yet feasible due to data limitations and the early stage of implementation, available financial data suggests that resources are being directed to core service functions that are supporting early positive outcomes. Most funding has been used to support frontline service delivery, particularly multidisciplinary staff, alongside capital and infrastructure costs required to establish safe, accessible hubs. This spending profile is consistent with the Model's intent to prioritise early intervention, accessibility, and integrated care.

The Initiative is a shared funding model between the Australian Government and states and territories, which has supported joint accountability and integrations. Co-funding arrangements have supported shared ownership of implementation and enabled jurisdictions to align Kids Hubs with existing service systems and reform priorities. Importantly, the funding model provides flexibility in how funds are allocated locally while maintaining consistency to achieve the intent of the national Model. This has allowed jurisdictions to tailor staffing profiles, invest in partnerships, and adjust service delivery approaches in response to local workforce availability, geographic contexts, and community needs. In some cases, jurisdictions have chosen to distribute funding across multiple sites to extend reach, and some have leveraged existing infrastructure to reduce capital costs.

Some state and territories experienced variability in funding distribution, administrative complexity, and challenges. Short funding horizons or rigid financial rules limited carry-forward or capital planning and in some cases, these administrative challenges contributed to implementation delays.

There is early evidence the Kids Hubs will likely deliver longer term economic value by supporting children and families earlier and enhancing system integration and sustainability. By supporting earlier identification of need, improving care coordination, and reducing fragmentation across services, the Kids Hubs are positioned to shift children and families away from more intensive and costly crisis-driven responses. Evidence from comparable hub models indicates positive economic returns over time, largely through avoided downstream costs and improved child and family outcomes. A future economic evaluation will require more mature outcome data, longer-term follow-up, and consistent national measures of costs and benefits to fully assess value for money. However, early signals suggest the Kids Hubs are a strong investment within a prevention- and early-intervention-focused system.

Lessons learnt and future opportunities

The Evaluation has identified several lessons to guide continuous improvement of the Model and alignment with current policy priorities. These include:

- Joint commitment and strong leadership enable effective implementation.
- Integration depends on governance, partnerships and deliberate effort to build relationships.
- A minimum multidisciplinary capability is essential to achieve the Model's intent.
- Outreach and soft entry points improve access for under-represented cohorts.
- Whole-of-family and relational approaches drive sustainable outcomes for children.

There is also an opportunity to deepen Aboriginal-led governance and partnerships, embed culturally responsive practice more consistently, and strengthen alignment with current and emerging policy such as Thriving Kids. As the Initiative matures, a clearer articulation of the Kids Hubs' role within the broader child and family service system will be critical to managing demand, avoiding duplication, and maximising long-term impact.

Recommendations

The Evaluation found that Kids Hubs are improving access to support, strengthening referral pathways, identifying needs earlier and supporting families who would otherwise face delayed or fragmented services, with early positive impacts reported for children and families. The recommendations respond to the evaluation findings and lessons learnt to support the effectiveness, sustainability and longer-term impact of the Kids Hubs.

Overall

	Recommendation	Timing
1	Continue the implementation of Kids Hubs nationally to strengthen early intervention and system integration.	Ongoing

Australian Government

	Recommendation	Timing
2	Maintain an active stewardship role to maintain the focus and intent of the National Service Model.	Ongoing
3	Re-establish the national Community of Practice as a forum for regular sharing of learnings across states/territories and service providers.	< 6 months
4	Update the National Service Model to clearly define the core components required for effective Kids Hub implementation and sustainability, while preserving flexibility for local tailoring.	< 6 months
5	Continue and refine national data collection to monitor Kids Hub performance, maturity and alignment with the intent of the Model.	6-12 months

State and territory governments

	Recommendation	Timing
6	Enable and fund ACCOs to deliver Kids Hubs as lead providers or formal co-providers.	6-12 months
7	Provide additional funding for Kids Hubs in remote areas, starting with Central Australia and WA.	> 12 months
8	Consider how the Kids Hubs model sits alongside Thriving Kids, including how Kids Hubs enablers can support the implementation and success of Thriving Kids.	6-12 months

Service providers

	Recommendation	Timing
9	Establish more partnerships with organisations and services supporting CALD communities and gender diverse children/LGBTQI+ families to increase engagement with unmet priority population groups.	< 6 months

A note about terminology

- The term **Australian Government** is used to collectively refer to the Australian Government, including the Department of Health, Disability and Ageing (the government department responsible for the Medicare Mental Health Kids Hubs).
- The services evaluated in this report are referred to as **Medicare Mental Health Kids Hubs Initiative (the Initiative)**. This reflects the current naming and re-branding from the original Head to Health Kids Initiative, as part of broader mental health reforms and the national shift to align services with the Medicare brand.
- **The National Service Model** (the Model) outlines the overarching design, principles and core requirements for the Medicare Mental Health Kids Hubs Initiative, at a national level. **A Kids Hub** is an individual, locally tailored service under the Medicare Mental Health Kids Hubs Initiative with a local service model. A Kids Hub may operate across several locations, as opposed to a single 'hub' location. Some Kids Hubs operate under local name variations, for example as 'Kids Services' or 'Child and Wellbeing Locals'.
- The term **family** is used flexibly and inclusively to reflect the diverse caregiving arrangements in children's lives. It may include parents, carers and kin, as well as grandparents, non-biological family members, and other trusted adults who play a primary caregiving or support role. This includes extended and culturally specific kinship systems, recognising that family structures vary across communities and contexts.

1 Background to the initiative

The mental health and wellbeing of children is critical to healthy child development and impacts their life outcomes. The Australian Government is providing $84.85 million over four years from 2022-2023 to work in partnership with states and territories to create a national network of 17 Medicare Mental Health (formally Head to Health) Kids Hubs for children aged 0-12 years, their families, carers and kin. The Kids Hubs aim to:

1. Provide free and comprehensive secondary level multidisciplinary support and early intervention which supports children, their families and carers, with mild to moderate emerging complexity.
2. Improve early intervention outcomes for children's mental health and wellbeing.
3. Complement and enhance existing services provided to children, their families, and carers.

The development and implementation of the Kids Hubs is outlined in bilateral agreements with states and territories under the National Mental Health and Suicide Prevention Agreement.[3]

In 2025, the Head to Health Kids Initiative (the Initiative) was rebranded as the Medicare Mental Health Kids Hubs (Kids Hubs) as part of broader mental health reforms and the national shift to align services with the Medicare brand.

The Kids Hubs aim to provide more timely and equitable access to holistic and integrated mental health and wellbeing services for children and families, with a focus on prevention and early intervention. The Kids Hubs are intended to operate as a secondary level child mental health and wellbeing service, targeting mild to moderate emerging complexity.

The Kids Hubs deliver on Action 2.1c of the **National Children's Mental Health and Wellbeing Strategy** (the Strategy) to "Establish a model of integrated child and family care networked across Australia that provides holistic assessment and treatment for children 0-12 years old and their families."[4]

The Medicare Mental Health Kids National Service Model (the Model)[5] builds on the findings of the Strategy, **Mental Health: Productivity Commission: Inquiry Report (2020)** and **the Royal Commission into Victoria's Mental Health System Final Report (2021).** It draws on a range of national frameworks, policies, and plans that guide efforts to improve achievement of optimal health and wellbeing outcomes for children and their families. This is explored in Section 0.

[3] The National Mental Health and Suicide Prevention Agreement sets-out the shared intention of the Australian, state, and territory governments to work in partnership to improve the mental health of all Australians, reduce the rate of suicide toward zero, and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system.
[4] National Mental Health Commission. (2021). The National Mental Health and Wellbeing Strategy.
[5] Department of Health, Disability and Ageing Care. (2025). Medicare Mental Health Kids National Service Model.

2 About the national evaluation

2.1 Purpose of the Evaluation

The Department of Health, Disability and Ageing (the Department) has engaged Nous Group (Nous) to evaluate (the Evaluation) the implementation of the national network of Kids Hubs between November 2023 and April 2026. Evidence from the Evaluation will inform:

- An understanding of the extent to which the Kids Hubs meet the intended outcomes and aim of the Strategy and the Model (at this stage of implementation, the Evaluation will only measure early indicators of progress towards the outcomes and some immediate outcomes).
- An evidence-base that outlines what works for whom and how, to support the continuous improvement of the Initiative.
- An understanding of the extent to which the Department's approach to the funding and governance of the Kids Hubs in partnership with the states, territories, and Primary Health Networks (PHNs) is fit for purpose in supporting integrated mental health service delivery.
- Future decision-making about the Kids Hub's model of care and the funding model, and other related policy including Thriving Kids.

2.2 Governance

Nous engaged with the Department, the Evaluation Advisory Group, and the National Community of Practice across the Evaluation period through scheduled meetings to design the approach to the collection and sharing of data and contextualise findings.

Evaluation Advisory Group

The Evaluation Advisory Group (EAG) is responsible for providing oversight, guidance, and advice for the Evaluation. The EAG is chaired by Matthew Short (former Assistant Secretary – Child, Youth and Priority Populations Branch) and Dr Sophie Davison (Australian Government's Chief Psychiatrist) and includes a mix of sector experts, representatives from jurisdictions and service providers of the Kids Hubs, lived-experience representatives, Aboriginal and/or Torres Strait Islander representation, and other representatives from the Department. The EAG met nine times over the course of the Evaluation to provide advice on aspects of evaluation design, methodology, and the interpretation of findings.

National Community of Practice

The National Community of Practice (CoP) has representatives from each state and territory as well as service providers. Service providers attend meetings at the discretion of state and territory project leads based on the agenda. The CoP is largely comprised of policy and clinical stakeholders. The CoP has met several times since its establishment and was formally engaged three times during the Evaluation. They have supported the Evaluation by:

- informing the development of the Evaluation Framework

- supporting local data collection activities, driving consumer recruitment activities, and coordinating key elements of the Evaluation, as appropriate
- providing feedback on emerging insights and validating Evaluation outcomes.

Aboriginal and Torres Strait Islander governance arrangements

Aboriginal and Torres Strait Islander governance is outlined below in Section 2.2.1.

2.2.1 Aboriginal and Torres Strait Islander governance

Nous and the Department recognise the importance and value of having a community-controlled process for engaging with Aboriginal and/or Torres Strait Islander people. This is valuable for the Initiative in the long-term and required for ethical approval to be granted to engage with Aboriginal and/or Torres Strait Islander people throughout the Evaluation. In the Evaluation this included ensuring:

- **Culturally safe engagement**: enabled Aboriginal and/or Torres Strait Islander participants to feel safe, valued, and free from racism and discrimination during any form of engagement. It ensures Indigenous cultures and belief systems are acknowledged and celebrated, and that they contextualise and inform research findings.
- **Indigenous data sovereignty (IDS)**: describes how the rights of Aboriginal and/or Torres Strait Islander peoples, their experiences, values, and understanding are developed and reflected in any data and information gathered about them and their communities.[6]
- **Indigenous data governance (IDG)**: covers Aboriginal and/or Torres Strait Islander rights to govern, retain, control over, and manage the collection, usage, and application of data for their purposes; and to use it in ways that aligns with their self-determined priorities, aspirations, and practices.[7] Data sharing and reciprocity is a key outcome of Indigenous data governance.

IDS and IDG are important when considering the disaggregation of quantitative data by Aboriginal and/or Torres Strait Islander status. If the data cannot be disaggregated for the Evaluation, Nous will not compare the data in the consumer data reporting or triangulate the quantitative data with findings from consultations and will instead report findings as a national cohort.

When partnering with Aboriginal and/or Torres Strait Islander communities, an ethical approach is one in which local communities are engaged in research design and lead research that responds to an identified community need. It was important the Evaluation had an Aboriginal and Torres Strait Islander community-controlled process for engaging with Aboriginal and/or Torres Strait Islander people. This ensured findings and recommendations reflect Indigenous stories; and experiences accurately and empower Indigenous people and their communities. Moreover, under the Australian Code for the Responsible Conduct of Research, Aboriginal and/or Torres Strait Islander peoples have the right to be involved in research that affects them.[8]

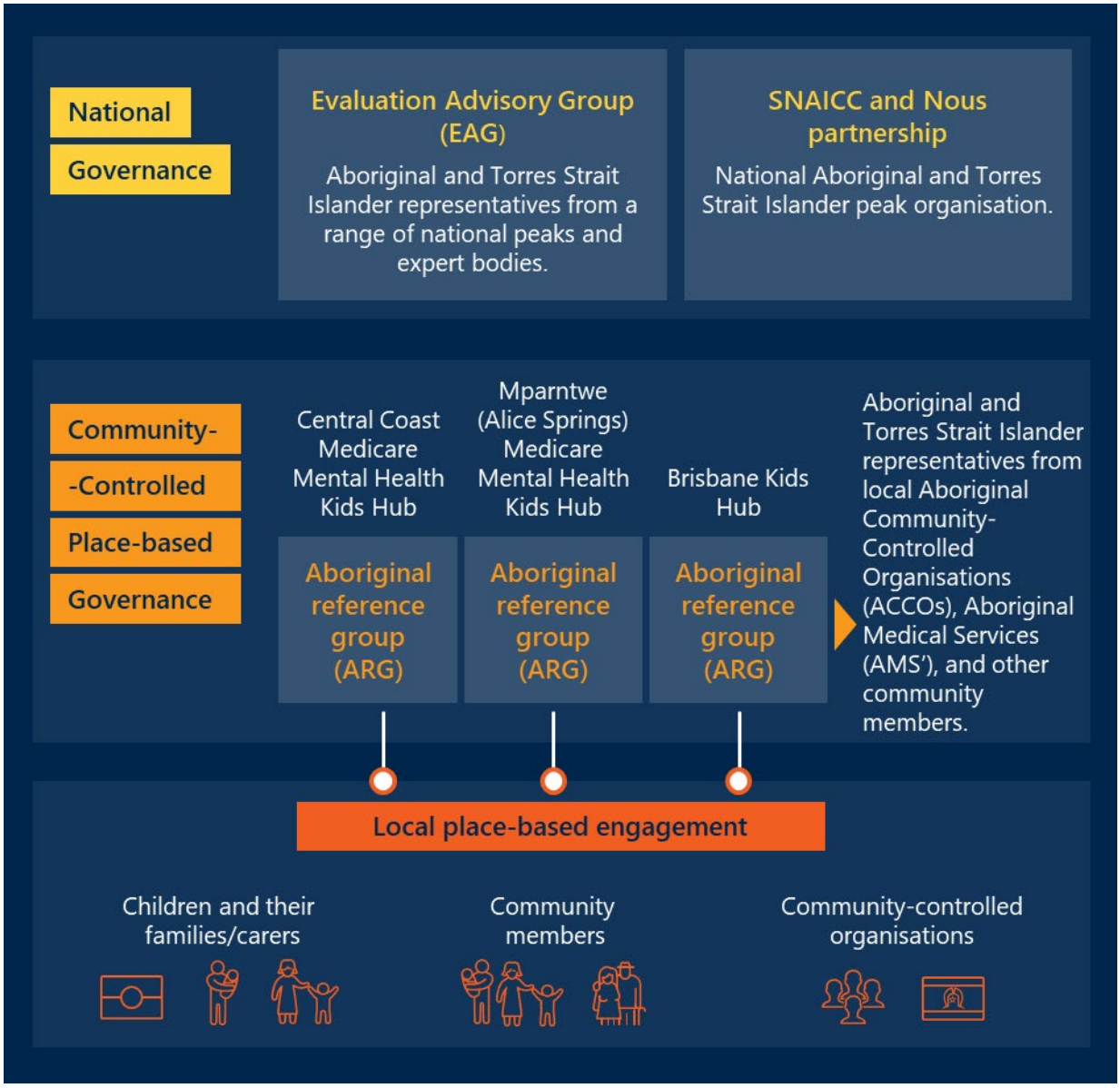
[6] Lowitja Institute Indigenous Data Sovereignty and Governance. Research Pathways: Information Sheet Series. https://www.lowitja.org.au/wp-content/uploads/2023/11/328550_data-governance-and-sovereignty-1.pdf
[7] Ibid.
[8] AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research. (2022). https://aiatsis.gov.au/sites/default/files/2022-02/aiatsis-code-ethics-jan22.pdf

Given this, Nous recognised that a partnership with an Aboriginal and/or Torres Strait Islander peak body alone is likely not sufficient to understand the local contexts and needs in each state and territory. In our experience, dominant feedback does not always reflect the broad representation. As such, Nous designed an approach to governance that balances genuine partnership and community-controlled decision-making, while minimising the burden on Aboriginal and/or Torres Strait Islander people.

2.2.2 Aboriginal and Torres Strait Islander evaluation governance structures

The Evaluation has three Aboriginal and Torres Strait Islander governance structures (listed below and shown in Figure 1) that balance genuine partnership and community-controlled decision-making, while minimising the burden on Aboriginal and/or Torres Strait Islander people.

Figure 1 | Aboriginal and Torres Strait Islander governance arrangements



[Detailed image description:

This diagram outlines the governance structure for Aboriginal and Torres Strait Islander mental health initiatives, focusing on national governance, community-controlled place-based governance, and local engagement.

National Governance:

- **Evaluation Advisory Group (EAG)**: Includes Aboriginal and Torres Strait Islander representatives from various national peak and expert bodies.
- **SNAICC and Nous Partnership**: Represents the national Aboriginal and Torres Strait Islander peak organisation working with Nous.

Community-Controlled Place-Based Governance:

- Aboriginal Reference Groups (ARGs):
  - Central Coast Medicare Mental Health Kids Hub.
  - Mparntwe (Alice Springs) Medicare Mental Health Kids Hub.
  - Brisbane Kids Hub.
- **Representation**: Aboriginal and Torres Strait Islander representatives from:
  - Local Aboriginal Community-Controlled Organisations (ACCOs).
  - Aboriginal Medical Services (AMS).
  - Other community members.

Local Place-Based Engagement:

- A connection is shown between the Aboriginal Reference Groups and local place-based engagement.
- **Engagement Focus**:
  - Children and their families/carers.
  - Community members.
  - Community-controlled organisations.

End of detailed image description]

1. Strong Aboriginal and Torres Strait Islander representation in national governance structures

The EAG was responsible for providing oversight, guidance, and advice for the Evaluation. Representation from national Aboriginal and Torres Strait Islander organisations and peaks helped to ensure cultural safety across all aspects of engagement and data collection, analysis, and development of recommendations in the Evaluation. National representation also enables the disaggregation of data and supports nuanced insights and recommendations for Aboriginal and/or Torres Strait Islander people.

2. A place-based engagement approach supported by community-controlled governance (local Aboriginal Reference Groups)

Community-controlled governance arrangements were critical to ensure culturally safe engagement, and Aboriginal and/or Torres Strait Islander data sovereignty and governance for the Evaluation. Nous established community-controlled governance (local Aboriginal Reference

Groups) at three Kids Hubs (Central Coast Medicare Mental Health Kids Hub, Mparntwe (Alice Springs) Medicare Mental Health Kids Hub, and Brisbane Kids Hub) to ensure the Evaluation delivered quality findings and was conducted in a culturally appropriate way. It is important that the findings from place-based engagements are shared with Aboriginal and/or Torres Strait Islander communities to support improvements in services for their people.

The purpose of the local Aboriginal Reference Groups was to ensure the Evaluation delivers quality findings and the consultations and engagements were conducted in a culturally appropriate and safe way. The role of these groups was to:

- Identify Aboriginal and/or Torres Strait Islander stakeholders to participate in place-based engagements, including children, their families, and carers who have engaged in the Kids Hubs, Aboriginal Community-Controlled Organisations (ACCOs) and Aboriginal Medical Services (AMSs) who refer into the Kids Hubs, and other local community members and partners.
- Provide oversight and advice to Nous on the development of engagement materials to ensure they are culturally safe and appropriate for Aboriginal and/or Torres Strait Islander children, families, carers, and communities.
- Support Nous to develop, interpret, and contextualise the findings from place-based engagements in relation to the experiences of Aboriginal and/or Torres Strait Islander children, families, carers, and communities.
- Review the community reports developed from the engagements and support the development of recommendations for the Evaluation report (this document) that may impact Aboriginal and/or Torres Strait Islander people.

3. A partnership between Nous and SNAICC[9]

SNAICC provided national guidance to ensure the Evaluation appropriately considers the context and needs of Aboriginal and/or Torres Strait Islander people, building on the insights from the place-based engagements and local Aboriginal Reference Groups. As part of the partnership, SNAICC:

- Provided guidance and oversight on the approach to engaging with Aboriginal and/or Torres Strait Islander people, families, and communities to ensure alignment with the **National Agreement on Closing the Gap** Priority Reforms at all stages of the Evaluation.
- Reviewed engagement findings and interpretations to ensure they appropriately represent the needs and views of Aboriginal and/or Torres Strait Islander people, families, and communities.
- Ensured the context and needs of Aboriginal and/or Torres Strait Islander children and families were considered in all stages of the Evaluation planning and delivery. This included considering and applying findings and recommendations from key strategies, reviews, and plans (e.g. the National Agreement on Closing the Gap, Family is Culture, National Aboriginal and Torres Strait Islander Early Childhood Strategy, the Early Childhood Care and Development Sector Strengthening Plan etc.).

[9] SNAICC: Secretariat of National Aboriginal and Islander Child Care. The national peak body for Aboriginal and Torres Strait Islander child and family services.

- Alongside Nous, attended and participated in the Evaluation Advisory Group meetings, specifically speaking to matters that impact Aboriginal and/or Torres Strait Islander children and families.

2.3 Program logic and theory of change

Nous has followed a robust evaluation framework that was developed through extensive research and consultation in 2023 and 2024. The methodology for the Evaluation was developed and agreed with input from the Department, state and territory policy leads, representatives from Kids Hub service providers, and expert advisors between November 2023 and August 2024. This included engagement with the CoP and the EAG.

The review is underpinned by a program logic, shown in Appendix A. The program logic outlines what was expected to happen, and how, through the mechanisms of change. The program logic describes the causal pathways by showing how specific inputs (e.g., funding) and activities (e.g. Kids Hub core activities) lead to outputs (e.g. services and supports for children and families), and outcomes (e.g. more timely access to support, and improvement in mental health and wellbeing). This was particularly important in the Evaluation given the changes are often gradual, indirect, and influenced by multiple factors at different levels of the system.

A theory of change is fundamental to evaluating the Model, particularly given it is a new approach to supporting children's mental health and wellbeing supported by a strong evidence-base. The Model represents a significant shift in how services are delivered, introducing new models of care, and ways of working that require time to establish and mature in each of the local contexts. Developing an evidence-base about effectiveness and demonstrating impact takes time to measure and evaluate effectively.

Theory of change

Children's mental health and wellbeing is conceptualised as a continuum from 'well' to 'struggling' to 'unwell'.[10] This approach highlights opportunities for universal and targeted early supports to prevent escalation and long-term harm. Children and families often do not access mental health and wellbeing support early enough because the service system is predominantly oriented around risk and crisis and focuses on diagnosis and other eligibility criteria to access support. There is strong evidence that early intervention is the most effective and cost-effective approach to improving child mental health and wellbeing, as it strengthens protective factors, prevents escalation of risk and complexity, and avoids the need for more intensive and costly responses over time.[11]

Evidence further indicates that children's mental health outcomes are strongly influenced by family functioning, caregiver wellbeing, and the home environment.[12] Interventions that adopt a whole-of-family approach are more likely to achieve sustained improvements in child wellbeing, strengthen family capacity, and promote long-term resilience.[13] In contrast, approaches that focus narrowly on the child without addressing family context have limited impact and are less likely to produce enduring outcomes.

The Model is designed to prioritise early intervention without a need for a diagnosis. The Kids Hubs provide children and their families access to safe, free, multidisciplinary mental health and wellbeing services. The Model uses a family-focussed and culturally appropriate approach to holistic assessment, timely identification of needs, treatment, and care coordination. This enables children and families to receive earlier interventions, tailored to their needs, from services that are more integrated and easier to access.

By intervening earlier and addressing family contexts alongside child needs, the Model aims to improve child and family mental health and wellbeing outcomes and reduce the likelihood that mental health challenges and family distress will escalate.[14] In addition, the Kids Hubs are intended to reduce service duplication and silos, improve coordination across services, and reduce demand on other services over time.[15]

In complex systems, where multiple variables influence outcomes and change occurs gradually, it is unlikely changes in long-term outcomes can be demonstrated. The relationship between intervention and outcome is rarely linear or immediate, particularly when working with children's developmental trajectories. The Evaluation therefore adopts a theory of change framework, to identify and track early indicators of system change, while building an evidence-base to measure progress towards longer-term impact.

While the Evaluation timeframe may not capture full outcome changes, a theory of change approach enables us to observe and document important changes in service delivery, changes in

[10] Department of Health, Disability and Ageing. (2025). Medicare Mental Health Kids Hubs National Service Model
[11] National Mental Health Commission. (2021). The National Mental Health and Wellbeing Strategy.
[12] National Mental Health Commission. (2021). The National Mental Health and Wellbeing Strategy.
[13] National Mental Health Commission. (2021). The National Mental Health and Wellbeing Strategy.
[14] Department of Health, Disability and Ageing. (2025). Medicare Mental Health Kids Hubs National Service Model
[15] Department of Health, Disability and Ageing. (2025). Medicare Mental Health Kids Hubs National Service Model

the behaviours and experiences of children and families, and progress towards system integration. By understanding these early changes, we can make informed assessments about the progress towards expected improvements in children's mental health outcomes. This approach aligns with best practice in system level health and social policy evaluations, recognising that system transformation requires both immediate evidence of implementation progress and longer-term demonstration of impact.

2.4 Key evaluation questions

The Evaluation is guided by five key evaluation questions (KEQs) which are listed below. Appendix A outlines the KEQs and the associated research questions.

1. **Appropriateness:** To what extent are the Kids Hubs focusing on the right things, to respond to the context and community needs?
2. **Implementation**: What is being implemented – to whom, where, and how, and what is different across the different contexts?
3. **Effectiveness**: What is changing as a result of the Kids Hubs, for whom, and how?
4. **Cost-effectiveness**: To what extent are Kids Hubs using resources well and how cost-effective are the Kids Hubs compared to similar models?
5. **Future opportunities**: What improvements would enable the model to meet its objectives?

2.5 Data collection

The Evaluation design and approach used mixed methods and a developmental approach to support continuous improvement throughout the Evaluation. The developmental approach recognises that the jurisdictions and Kids Hubs are at different stages of implementation and as such, there are opportunities for the Evaluation to facilitate information sharing and learnings.

The Evaluation assessed the five KEQs by collecting information across three streams: literature review, qualitative data, and quantitative data. Information across all three streams was analysed through a variety of mixed methodologies and insights were triangulated and mapped to answer the KEQs and more detailed research questions. The data collection activities are listed in Table 1.

Table 1 | Data collection activities, by stream

Literature review	Quantitative data	Qualitative data
• Review of literature, evidence, and the national policy, strategic, and funding context.	• Staffing financial and implementation template. • Consumer data reporting. • Child survey. • Family survey. • Kids Hub staff survey.	• Interviews with the Department. • Interviews with state and territory policy leads. • Interviews with Kids Hub leads.

Literature review	Quantitative data	Qualitative data
	• Partner and referrers survey.	• Focus groups with Kids Hub staff. • Interviews with children. • Interviews with families and carers. • Focus groups with partners and referrers.

2.6 Ethical oversight

The Evaluation received approval from the Bellberry Human Research Ethics Committee (HREC) (reference number 2024-04-540) and Children's Health Queensland (CHQ) HREC (reference number HREC/24/QCHQ/11237) to conduct in-depth primary research (interviews and surveys) with children who have accessed mental health, wellbeing services, and support through the Kids Hubs and their families, carers and kin, as well as interviews with Kids Hub staff who deliver these services. This included several site-specific assessments in line with each service provider's research governance policies and requirements.

The Evaluation also received additional approval from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) HREC for the Aboriginal and/or Torres Strait Islander specific components of the research (reference number REC-0320).

The Evaluation was determined by Bellberry HREC, CHQ HREC, and AIATSIS HREC to meet the requirements of the:

- National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2023)
- Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Code of Ethics for Aboriginal and Torres Strait Islander Research (2020).

2.7 Limitations of the Evaluation

The Evaluation addressed several common limitations, including inconsistent national data and variation in how Kids Hub teams defined, captured, and reported consumer information. To mitigate these issues, Nous co-designed the data collection approach with states and territories through the CoP, supporting national consistency while leveraging data already collected by services. The Nous Evaluation team also worked closely with individual states, territories, and service providers to understand practical barriers to data collection and identify workable solutions to improve data quality and completeness.

The Evaluation notes some limitations, outlined below.

- **Delays in Kids Hub implementation postponed data collection.** This resulted in limited survey and consumer data for some Kids Hubs at the time of reporting. Implementation delays also

meant Kids Hubs in South Australia and the Australian Capital Territory were not included in the Evaluation. The Nepean Blue Mountains LHD (NSW) Kids Hub was always out of scope, as it is not scheduled to become operational until after 30 June 2026.

- **The Evaluation did not directly engage children under five years of age, nor survey children under eight.** This exclusion was agreed as part of the ethics approval process, resulting in 67.5 per cent of the service cohort (children aged eight years and younger) not being interviewed directly, and 23.2 per cent (children aged five years and younger) not being surveyed. While it is recognised that evaluations of services for children and families can be designed to safely and ethically include the perspectives of infants and young children, this was not pursued due to the Evaluation timeframes and practical constraints. As a result, the voices of younger children are under-represented in the findings. The Evaluation acknowledges that children under five are a critical cohort for the service and that their perspectives are important to inform future research and evaluation in this area.
- **Data limitations impacted the strength of Evaluation findings**. Key limitations include:
  - **Limited survey response rate.** Low responses to the surveys of children (n=36), parents/carers (n=174), staff (n=83), and referral partners (n=55). While there was a lower-than-expected number of survey responses, data on children, family, and staff experiences were supplemented by site visit consultations at Kids Hubs where Nous engaged with a total of 18 children, 48 parents or carers, 136 staff and team leaders, and held 10 workshops with referral partners.
  - **No follow-up data.** The original Evaluation design included a follow-up survey administered six months after the initial child and family survey to assess changes over time. However, delays in implementation meant this follow-up could not be distributed, preventing longitudinal analysis of outcomes. As a result, the Evaluation relies on cross-sectional data only. The initial child and family survey captures families' experiences of the Kids Hub on the day of attendance and does not provide insight into longer-term impacts.
  - **Proxies for data collection don't provide the full picture.** To balance feasibility with data coverage, the Evaluation relied on proxy indicators for several consumer data items, drawing on existing state/territory-collected data. While this approach enabled inclusion of consumer-level insights that would otherwise be unavailable, it required interpretive analysis and provides only a partial view of consumer experience, particularly in a system that is difficult to navigate and for families who face persistent barriers to accessing support. Consumer data assumptions and analysis proxies are found in Appendix B.
  - **Different consumer data collection windows.** Variations in implementation timelines and the timing of ethics approvals meant that consumer data collection commenced at different points across the Kids Hubs, resulting in uneven data coverage and limiting comparability between local models of care.

3 KEQ 1 – Appropriateness

This section answers the following Key Evaluation Question:

KEQ 1 Appropriateness: To what extent are the Kids Hubs focusing on the right things, to respond to the context and community needs?

This section outlines the background and context underpinning the design of the Initiative. It explores the needs the Initiative is intended to address, the outcomes it seeks to achieve, and if the Kids Hubs are focused on the right priorities to respond to community need.

The section also examines alignment with the broader policy, operating, and service delivery context in which the Initiative is being implemented.

Summary of findings

- Challenges with children's mental health and wellbeing is often understood through diagnostic categories and does not recognise broad social, emotional, and developmental drivers of distress that often emerge early in life.
- Children's wellbeing concerns are closely intertwined with family and psychosocial factors, including parental mental health issues, housing instability, alcohol and other drug issues, financial stress, experiences of violence, abuse, or neglect, and neurodevelopmental needs.
- Australia's mental health system is heavily weighted toward crisis and acute care, with around three-quarters of mental funding directed towards acute and severe presentations.
- There is limited focus on early intervention and prevention (both early in life and early in need) despite strong evidence that half of all mental health conditions emerge before age 14, and that early support can alter life-course trajectories.
- The Initiative directly addresses this gap by providing early, multidisciplinary, child- and family-centred support for children aged 0–12, without requiring a formal diagnosis.
- The Initiative is strongly aligned with the Strategy, particularly its shift away from 'wait-to-fail' approaches toward integrated, whole-of-child, and family-inclusive models of care.
- The Model operationalises the Strategy through six core functions, including accessible referral pathways, holistic assessment, evidence-based therapies, care coordination, supported transitions, and a multidisciplinary workforce.
- Local co-design has strengthened the relevance and accessibility of the Model, ensuring services are responsive to community needs, culturally safe, and well-integrated with existing local service systems.

3.1 The Initiative addresses gaps in early intervention by improving access to multidisciplinary, child- and family-centred supports beyond diagnosis-led models of care

KEQ 1.1 | What need does the Initiative aim to meet, and what changes does it seek to achieve?

3.1.1 Challenges with children's mental health and wellbeing is often understood through diagnostic categories and does not recognise broad social, emotional, and developmental drivers

Australia is experiencing a significant child and adolescent mental health crisis. However, the way children's mental health and wellbeing is understood, and responded to, remains narrowly framed. Policy and service systems continue to understand challenges with children's mental health primarily through diagnostic categories and clinical thresholds, rather than recognising the broader social, emotional, and developmental drivers of distress that often emerge early in life.

Population-level data shows that many Australian children experience social and emotional challenges, including mental health and behavioural disorders. While these statistics provide one perspective, there is inherent difficulty in measuring children's mental health and development. Many children experience distress that does not meet diagnostic thresholds or presents through other pathways such as developmental concerns, behavioural difficulties, or challenges identified in education settings.

Concerns about a child's wellbeing are often closely intertwined with broader family and psychosocial circumstances, including parental mental health wellbeing, housing instability, alcohol and other drug issues, financial stress, experiences of violence, abuse, or neglect, and neurodevelopmental needs. When systems focus primarily on diagnosis, these complex and overlapping presentations are poorly accommodated, leaving many children without timely or appropriate support.

Social and emotional challenges experienced by Australian children[16]

In 2022, the leading causes of disease burden amongst children aged between 5-14 years were:

- Anxiety
- Depressive disorders
- Conduct disorders

The most common disorders experienced amongst children were:

- Attention Deficit Hyperactivity Disorder (ADHD), affecting 8.2% of children
- Anxiety, affecting 6.9% of children.

Suicide is the second leading cause of child death in Australia (aged 5-17 years) in 2022, having previously been the leading cause of death in children since 2013. These figures are higher for young adults, with suicides accounting for around a third of deaths among people aged 15-24 years.

10.5% (around 1 in 10) Victorian children had emotional, developmental, or behavioural problems for which they needed treatment or counselling as reported by their parents. This proportion has increased from:

- 7.1% in 2013
- 9.35 in 2019

3.1.2 Australia's mental health system prioritises crisis intervention for older children over early intervention

Children's mental health presentations are becoming increasingly complex, influenced by factors such as social media, family stress, and the long-term impacts of the COVID-19 pandemic.[17] The mental health system is struggling to meet this demand and complexity, with persistent workforce shortages and long wait times.[18]

Within this constrained environment, the system prioritises crisis intervention for older children and adolescents – approximately 75 per cent of mental health funding is directed towards acute and severe presentations.[19] This creates a significant service gap for children aged between 0-12 with mild to moderate needs, despite evidence that 50 per cent of mental health conditions emerge

[16] Australian Institute of Health and Welfare. (2022). Australian Burden of Disease Study 2022; Australian Institute of Health and Welfare. (2023). Children with mental illness; Australian Bureau of Statistics. (2022). Australia's leading cause of death; Productivity Commission. (2020). Mental Health – Productivity Commission Inquiry Report. No.95, Volume 1.
[17] Botha, F., Morris, R.W., Butterworth, P., & Glozier, N. (2023). Working Paper Series: The Kids are not alright: differential trends in mental ill-health in Australia. The University of Melbourne. Melbourne, Australia.
[18] Department of Health, Disability and Ageing. (2024). National Mental Health Workforce Strategy 2022-2032. Australian Government.
[19] Productivity Commission. (2023). Report on Government Services 2023: Part E, Health. Australian Government.

before age 14.[20] The limited focus on early intervention and prevention, both early in life and early in need, represents a critical systemic failure.

3.1.3 The Initiative aims to provide early, multidisciplinary intervention for children aged between 0-12 that considers their broader family and social context

The Initiative seeks to address service gaps by strengthening access to early, developmentally appropriate, mental health and wellbeing support for children - without reliance on clinical diagnosis. This includes providing support focused on early intervention for children aged 0-12, taking a whole-of-family approach, and responding to emerging needs before they escalate.

[20] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer, M., Ainley, J., & Zubrick, S. R. (2015). The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Disability and Ageing, Canberra.

3.2 The Model explicitly addresses needs identified in the Children's Strategy, emphasising early intervention and family-centred care

KEQ 1.4 | To what extent does the design of the Model meet the needs identified in the National Children's Mental Health and Wellbeing Strategy and through local co-design processes?

3.2.1 The Strategy provides a nationally agreed approach to support early intervention for the wellbeing of children and families

The Strategy was developed by the National Mental Health Commission and is the first time the Australian Government has developed a strategy that considers mental health and wellbeing outcomes for children from birth to 12 years of age, their families, and communities. It presents compelling evidence that mental health trajectories are established early in life and that timely, appropriate support during these formative years can have lasting benefits.

The Strategy advocates for a fundamental shift in service delivery, moving away from the traditional 'wait-to-fail' approach towards an integrated, whole-of-child model that considers family context, developmental stages, and community connections.[21] It identifies eight fundamental principles to guide governments, commissioning bodies, and service providers.

The foundational principles of the National Children's Mental Health and Wellbeing Strategy are to be child centred, strengths-based, equitable and accessible to children and families, and prevention-focused. The Strategy also expects a universal system that uses evidence-informed best practice and continuous quality evaluation, supports early intervention, and is needs based rather than diagnosis driven.

Central to the Strategy is the establishment of Kids Hubs as a new service type to address critical gaps in early intervention. The Kids Hubs are intended to provide multidisciplinary, integrated, and family-inclusive care representing a deliberate departure from siloed and crisis-driven models of service delivery.

3.2.2 The Model outlines key elements and core functions of the Kids Hubs

The Model was developed by the Australian Government, in consultation with an Expert Reference Group, to support consistency in the establishment, implementation, monitoring, and evaluation of the Kids Hubs as well as providing clear expectations regarding functions and quality of care. The Model outlines six core functions that all Kids Hubs are expected to provide. These are shown in Table 2.

[21] National Mental Health Commission. (2021). National Children's Mental Health and Wellbeing Strategy.

Table 2 | The six core functions of the Kids Hubs

Core function	Description[22]
Access and referral	Kids Hubs are multidisciplinary child mental health and wellbeing services that accept referrals from a wide range of community touchpoints; prioritising vulnerable children and families, including those less likely to access universal services. They emphasise outreach, strong integration with local services, and clear referral pathways across child, youth, and adult systems to support whole-of-family wellbeing. Kids Hubs work collaboratively with health, education, and community services, can engage families without referrals, provide triage and support, and contribute to capacity building and secondary consultation, supported by national assessment and referral tools.
Initial assessment	Following referral, a qualified professional will assess the child and family's needs, considering the child's emotional wellbeing, development, behaviour, mental health, and family wellbeing. Assessment outcomes will guide appropriate interventions, either within Kids Hubs or via supported referrals to other services. Validated, age-appropriate assessment tools will be used to ensure consistency, support evaluation, and enable learning across the Kids Hubs network.
Treatments and therapies	Kids Hubs will deliver evidence-based, trauma-informed assessments, treatments, and supports through strengths-based, family-centred care plans. Services will be culturally safe and inclusive for Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), and LGBTIQ+ families, with appropriate language and interpreting supports. Care will address nuanced family dynamics, social and cultural needs, and social determinants, using multidisciplinary and specialised interventions, with telehealth available to improve access and reach.
Care coordination	Kids Hubs will coordinate care for children and families who are often involved with multiple services, ensuring regular communication and integrated support. For those with complex needs, the Kids Hubs will provide care planning, coordination, and assistance navigating other services. Care will be child-centred and family-focused, with collaborative decision-making and strong information sharing across mental health, health, education, disability, and community services to support the whole family system.
Supported transition	Kids Hubs will support smooth, well-coordinated transitions by working across relevant systems and establishing formal local partnerships and information-sharing agreements. They will collaborate closely with schools, maternal and child health, child development, mental health, and

[22] Descriptions are summarised from the National Service Model.

Core function	Description[22]
	headspace services to ensure age-appropriate, supported transitions, including as children move to services beyond the age of 12.
Workforce	Kids Hubs will be staffed by multidisciplinary teams tailored to community needs, supported by strong clinical governance, supervision, and professional development. To address workforce shortages, innovative models such as shared roles, telehealth access to specialists, training rotations, and expanded workforce scopes will be used. Kids Hubs will also support workforce development through student placements, postgraduate training, communities of practice, and a strong focus on cultural competency to deliver inclusive, culturally safe care.

3.2.3 The Model, and subsequent local adaptation of the Model through co-design, has aligned to the needs identified in the Strategy

The Model outlines the delivery of safe, free, multidisciplinary mental health and wellbeing services without the need for diagnosis. Its emphasis on family-focused, culturally appropriate practice, holistic assessment, early identification of needs, and coordinated care pathways align closely with the Strategy's whole-of-child principles and focus on early intervention.

Local adaptation of the Model through co-design further strengthened this alignment. Co-design processes ensured that services are responsive to local contexts, integrated within existing service systems, and were accessible to children and families with diverse needs. For more detail on co-design activities undertaken, see Section 4.2. This local tailoring supports the Strategy's emphasis on community connection and ensures that the Model not only reflects national policy intent but is grounded in the lived-experience and priorities of children, families, and service providers.

3.3 The Initiative is broadly aligned to national priorities and other jurisdictional strategies

KEQ 1.3 | To what extent does the Initiative align to, and complement, other national and state strategies, policies, and programs/services?

3.3.1 There are many government strategies, plans, and initiatives focused on improving child mental health, wellbeing, and development across Australia

Addressing child mental health and wellbeing is both critically important and challenging. This is reflected in the number of national and state strategies, policies, plans, frameworks, and initiatives[23] that emphasise the complexity of the challenge and the need for greater investment and system reform. There are many government strategies and plans that focus on improving child mental health, wellbeing, and development across Australia.

Children and families receive mental health and wellbeing support from conception through to adolescence, delivered through a wide range of services, systems, and levels of government. These supports span antenatal and maternal health care, early childhood and childcare services, primary and community care, education, health and mental health services, as well as social and family support provided by non-government organisations across local, state, and national systems.

Because children and families interact with multiple parts of a complex service system over time, they are shaped by a wide range of national and state strategies and plans that guide service planning and commissioning and determine what services are available. The list below, drawn from the Literature and Policy Review, presents a non-exhaustive overview of the key strategies and plans shaping the mental health and wellbeing service landscape for children and families.

Key national strategies and plans include:

- National Aboriginal and Torres Strait Islander Health Plan 2021–2031
- The National Framework for Universal Child and Family Health Services
- The Fifth National Mental Health and Suicide Prevention Plan
- Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031
- Vision 2030
- Productivity Commission's Inquiry into Mental Health
- National Mental Health Workforce Strategy 2022–2032
- The National Plan to End Violence against Women and Children 2022–2032
- National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030

[23] For simplicity these are referred to as 'strategies and plans'.

- The National Mental Health and Wellbeing Pandemic Response Plan
- The COVID-19 National Health Plan
- Australian Child Maltreatment Study (ACMS)
- The Royal Commission into Victoria's Mental Health System.

Table 3 below also outlines the relevant state and territory policy context shaping the mental health and wellbeing service landscape for children and families.

Table 3 | State and territory policy context

State or Territory	Policy context
Australian Capital Territory	• ACT Mental Health and Suicide Prevention Plan 2019–2024 • ACT Mental Health Workforce Strategy
New South Wales	• First 2000 Days Framework • Strategic Framework for Suicide Prevention 2022–2027 • Aboriginal Mental Health and Wellbeing Strategy 2020–2025
Northern Territory	• 10-Year General Strategy for Children and Young People 2023–2033 • Mental Health Strategic Plan 2019–2025
Queensland	• Early Years Plan • Mental Health and Wellbeing Strategy 2024–2029 • Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037 • Every life: The Queensland Suicide Prevention Plan 2019–2029
South Australia	• Wellbeing for Learning and Life • Mental Health Services Plan 2020–2025
Tasmania	• Child and Youth Wellbeing Strategy – It takes a Tasmanian Village • Change for Children Strategy and Action Plan • Rethink 2020
Victoria	• Healthy kids, healthy future • Roadmap for Reform: Strong Families, Safe Children
Western Australia	• Child and Adolescent Health Service Strategic Plan 2023–2025 • At Risk Youth Strategy 2022–2027 • Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018–2025

3.3.2 The Initiative aligns closely with key government strategies and plans listed above, including consistent focus on child mental health and wellbeing, social determinants, and early intervention

The Strategy is the first national framework with a dedicated focus on children's mental health and wellbeing, and the first of its kind in the world.[24] The Initiative is a priority action from the Strategy which provides the strategic direction and framework for investment in the mental health and wellbeing of children and families.

However, the Initiative also aligns with and complements other existing national and state strategies and plans. Table 4 below outlines how the Kids Hubs align to the focus areas of relevant national and state/territory strategies and plans.[25]

Table 4 | Alignment of Kids Hubs to focus areas of national and state/territory strategies and plans

Focus area	Insights:	The Kids Hubs:
The mental health and development needs of children and young people	• At a national level, key strategies and frameworks highlight the physical health, mental health, wellbeing, and developmental needs of children and young people. • State and territory strategies and plans vary in focus, but all emphasise supporting children (and young people) and families in the early years.	• Have multidisciplinary teams which bring together a range of professionals to support children holistically. • Involve families and carers which promotes a holistic approach to supporting the child's overall development. • Are strengths-based, building on the positive attributes of the child and family, which supports the holistic mental health and development needs of children. • Do not require a clinical diagnosis for service eligibility, allowing them to support a broader range of developmental and behavioural challenges.
Population level mental health and wellbeing	• Within all these broader strategies and plans there are objectives and actions that focus on better supporting the mental health and wellbeing of children and families.	• Target children and help build a foundation for lifelong mental health, impacting overall population well-being. • Provide data and information at their level to inform at state and territory level (where appropriate) and a national level, which provides valuable insights for

[24] Department of Health, Disability and Ageing. (2021). Media Release: Australia launches world's first children's mental health and wellbeing strategy.

[25] A review of these strategies and plans is listed and described in more detail in Appendix A of the Literature and Policy Review.

Focus area	Insights:	The Kids Hubs:
	• Within these strategies and plans, (particularly in more recent strategies and plans), there is a strong focus on suicide prevention. • Most of these strategies identify the importance of a specialist and culturally competent workforce and that there are challenges in attracting, developing, and retaining this workforce.	shaping broader future mental health policies. • Focus on early intervention and prevention which may reduce the demand on acute mental health services, contributing to a more sustainable health system. • Increase the capacity and skills of the mental health workforce to work in a holistic and child-focused way which contributes to a more robust and capable support system for the population.
Social determinants of mental health and wellbeing	• There are national and state/territory strategies that focus on the social and non-medical factors that influence mental health and wellbeing. There are several other relevant strategies that indirectly address children's mental health and wellbeing. • Many of these strategies have a focus on social justice, preventing child abuse and neglect, and focus on addressing broader socioeconomic issues that can impact on children's wellbeing.	• Receive and provide referrals to other social support services, connecting families to resources that address broader social and economic challenges. • Are community-based and are often co-located with other local services that target the social determinants of health and mental health for children and families. • Involve parents and caregivers in care plans, thereby strengthening family dynamics, which are crucial social determinants of a child's mental health.
Early intervention and prevention	• These strategies and plans emphasise the national need for greater early intervention and prevention, and the need for greater person-centred and holistic models of care.	• Specifically target the mental health needs of children aged 0-12 with mild to moderate emerging complexity. • Prioritise early intervention by providing immediate support to children and families at risk. • Focus on the child's overall functioning, rather than just clinical symptoms, supporting a holistic approach to early intervention.

3.4 The policy, operating, and service delivery context has shaped local adaption of the Model, as well as implementation progress

KEQ 1. 2 | What is important to understand about the policy, operating, and service delivery context for implementation?

3.4.1 The policy, operating, and service delivery context varies significantly across jurisdictions

As outlined in Section 0, the national policy context is focused on improving child mental health and wellbeing, recognising the complexity of the challenge and the need for greater investment and system reform.

In terms of **operating context,**[26] jurisdictions varied substantially in workforce availability, funding arrangements, and governance structures. For example, while there are workforce constraints nationally, the availability of specific clinical and non-clinical roles varies substantially across jurisdictions affecting local service design and staffing models. Fiscal conditions also vary, with some jurisdictions operating under tight budget constraints that limit flexibility to expand or adapt services, while others have made significant mental health investments as part of broader reform agendas. These differences are compounded by diverse governance arrangements, ranging from highly centralised health systems to more devolved, regionally driven models, which influence decision-making speed, accountability, and implementation processes.

The **service delivery context** represents the most pronounced area of variation. Some jurisdictions have relatively strong community-based mental health services but limited child-specific programs, while others have well-developed hospital-based services with fewer community options for early intervention. The degree of integration between mental health, primary care, education, and family services also varies considerably across jurisdictions, shaping how easily children and families can navigate pathways between services. These differences directly affect how Kids Hubs are positioned in local systems and the extent to which they fill genuine gaps versus complement existing services.

3.4.2 Flexibility of the Model has enabled each Kids Hub to align with the local policy, operating, and service delivery context

Given the difference in policy, operating, and service delivery context across jurisdictions, successful implementation and operation of the Kids Hubs requires thoughtful adaptation to local conditions rather than a rigid and standardised national approach. While the key elements of the Model remain consistent, each Kids Hub has the flexibility to integrate with existing service systems, respond to local needs, and address jurisdiction-specific service gaps. This adaptable

[26] The operating context refers to the enablers and constraints that determine how services can be delivered.

approach means Kids Hubs can complement rather than duplicate existing services, fostering better system integration and more cohesive support for families.

The Initiative supports genuine system transformation by enabling locally appropriate implementation while maintaining core principles (moving beyond simply adding another service), to fundamentally improving how children and families access and experience mental health and wellbeing support.

3.4.3 Several contextual factors have influenced the implementation of Kids Hubs across jurisdictions, acting as both enablers and barriers

In the **policy context**, strong political backing has created momentum and helped to prioritise implementation activities. In jurisdictions where there was existing reform momentum, established mechanisms and processes helped to expedite the establishment of Kids Hubs. Across all states and territories, the strong alignment between the Initiative and the priorities of government has accelerated implementation. However, in some jurisdictions, competing reform priorities slowed progress as the Kids Hubs compete for attention, resources, and strategic focus within broader mental health system changes.

The **operating context** significantly impacted implementation timelines through practical enablers and constraints. For example, some jurisdictions benefited from established governance structures that enabled faster decision-making and streamlined procurement processes for service establishment. Most states and territories faced substantial barriers recruiting staff for the Kids Hubs, including workforce shortages and recruitment challenges, particularly for specialised clinical roles (see Section 4.5). Finding and securing appropriate locations and premises that meet Kids Hub requirements also caused significant delays, as well as complex procurement processes (see Section 4.3).

The **service delivery context** similarly shaped the pace of progress. Where strong sector relationships, service partnerships, and clear referral pathways exist, Kids Hubs have integrated more quickly into the existing system and built operational partnerships. However, fragmented pathways and coordination challenges in some states and territories has meant it takes additional time to build the foundations for effective service delivery. This includes establishing new partnerships, developing shared protocols, and creating clear pathways between services.

These influences are further shaped by the respective policy teams in each jurisdiction, whose personal experience, expertise, and understanding of child mental health and wellbeing inform the local design and conceptualisation of the model, as well as the implementation approach.

4 KEQ 2 – Implementation

This section answers the following Key Evaluation Question:

KEQ 2 Implementation: What is being implemented – to whom, where, and how, and what is different across the different contexts?

This section outlines findings on the national implementation of Kids Hubs, describing where Kids Hubs are located, when they opened, how they were implemented, and how approaches varied across different contexts.

SUMMARY OF FINDINGS

Implementation

- Under the National Mental Health and Suicide Prevention Agreement, the bilateral agreements provide for the establishment of 17 Kids Hubs by June 2026 and outlined responsibilities, funding arrangements, and delivery expectations.
- Strong, collaborative relationships between the Australian Government and jurisdictions supported effective implementation and early problem solving.
- The ability for jurisdictions to flexibly select service providers supported better integration of Kids Hubs within existing local systems and workforce conditions.

Co-design

- All jurisdictions undertook co-design processes with child, family, community, and system stakeholders. This played a central role in shaping how the Kids Hubs operate in practice, including intake, navigation, partnerships, and physical environments.
- Early, inclusive, and sustained co-design with both community and system stakeholders contributed to smoother implementation and stronger shared ownership of the local model of care.
- Service providers used their understanding of the local community and service context to adapt the Model, tailor core functions, and support integration. Key similarities and differences have emerged in how Kids Hubs have been delivered across different contexts.

Enablers and barriers

- Implementation progress has varied across jurisdictions: 14 Kids Hubs are operational, and three sites are at earlier stages of establishment.[27]
- Enablers of effective implementation included reform momentum and policy alignment, integrated governance structures, and strong existing sector relationships.

[27] As of March 2026.

SUMMARY OF FINDINGS

- Common barriers to successful implementation included challenges with workforce availability and recruitment, issues securing suitable physical locations, and funding/administration constraints.

Clinical governance

- Clinical governance arrangements were shaped by how, and where, services were embedded in local service systems and drew on existing governance structures.
- Where Kids Hubs are delivered by a single service provider, clinical governance arrangements typically align with the provider's existing frameworks. In consortium or partnership models; clinical governance responsibilities are shared across organisations.

Workforce

- Service providers consistently reported recruitment challenges due to broader workforce shortages and difficulty identifying candidates with the skills and attributes required by the Model.
- Kids Hubs have addressed workforce shortages through intentional recruitment, flexible staffing, and capability uplift. Training has played a critical role in building internal capability and enabling staff to work confidently in an emerging model of care.

Partnerships

- All Kids Hubs have invested in partnerships to strengthen referral pathways, minimise duplication of services, connect with priority cohorts, and deliver culturally appropriate care.
- Reported partnerships span family services and child protection services (28%), government and community services (25%), education and early childhood services (18%), Aboriginal and Torres Strait Islander services (16%), and health and mental health services (15%).
- Kids Hubs have also partnered with ACCOs to provide culturally safe care to Aboriginal and Torres Strait Islander families – the depth, maturity, and form of these partnerships differ across sites.
- In several jurisdictions, Kids Hubs have established deep partnerships with ACCOs as part of consortium models or as dedicated service in-reach partners. These partnerships were strengthened where Kids Hubs invested time, leadership, and workforce capability into respecting Aboriginal and Torres Strait Islander ways of knowing, being, and doing, rather than relying solely on formal agreements.

Community of Practice (CoP)

- State and territory policy leads described the CoP as valuable and supportive during the establishment phase of the Kids Hubs and helped jurisdictions develop a shared understanding of the Model, service expectations, and evaluation requirements. The CoP also provided opportunities to discuss and share learnings on common implementation challenges including; workforce constraints, data requirements, and commissioning approaches.

SUMMARY OF FINDINGS

- However, multiple jurisdictions reported that the frequency of the CoP has been inconsistent and that later sessions tended to focus on Australian Government priorities, such as evaluation frameworks and re-branding, rather than being a two-way forum for operational learning.

4.1 Implementation maintained a clear national direction, while giving jurisdictions flexibility to tailor local delivery

KEQ 2.1 | What activities have been undertaken to co-design and implement the Kids Hubs, and to what extent does this vary across Kids Hubs and states and territories?

4.1.1 The bilateral agreements established clear responsibilities, funding arrangements, and delivery expectations for the Kids Hubs

Under the National Mental Health and Suicide Prevention Agreement, the bilateral agreements outlined clear roles, responsibilities, and shared funding arrangements for the implementation and operation of the Kids Hubs. The agreements also specified the number of Kids Hubs to be established in each jurisdiction, along with target years for their establishment and operation. Collectively, the agreements provide for the establishment of 17 Kids Hubs nationally by June 2026 (shown in Table 5).

Table 5 | Locations of the Kids Hubs and opening dates

State	Kids Hub	Opening date	Additional detail
Australian Capital Territory	Tuggeranong	TBC	Kids Hub is not yet operational
New South Wales	Orange Medicare Mental Health Kids Hub	08/2025	
New South Wales	Penrith	TBC	Kids Hub is not yet operational
New South Wales	Central Coast Medicare Mental Health Kids Hub	02/2025	
New South Wales	Illawarra Medicare Mental Health Kids Hub	03/2025	
Northern Territory	Mparntwe (Alice Springs) Medicare Mental Health Kids Hub	03/2025	

State	Kids Hub	Opening date	Additional detail
Queensland	Brisbane Kids Hub	01/2023	
Queensland	Gold Coast Kids Hub	10/2023	
South Australia	Southern Adelaide Medicare Mental Health Kids Hub	TBC	Kids Hub is not yet operational
South Australia	Northern Adelaide	TBC	Kids Hub is not yet operational
Tasmania	Burnie Medicare Mental Health Kids Hub	05/2025	
Tasmania	East Tamar Medicare Mental Health Kids Hub	07/2025	
Tasmania	Jordan River Medicare Mental Health Kids Hub	03/2025	
Victoria	Loddon Children's Health and Wellbeing Hub	07/2023	
Victoria	Brimbank Melton Children's Health & Wellbeing Local	11/2022	
Victoria	Children's Health and Wellbeing Local (Southern Metropolitan Melbourne)	10/2023	
Western Australia	Midland Medicare Mental Health Kids Hub	01/2025	

While the specific arrangements vary across jurisdictions, the agreements set out at a high level, the respective responsibilities of the Australian Government and each state/territory. These core responsibilities are outlined in Table 6.

Table 6 | Responsibilities outlined in the bilateral agreements

Australian Government	Joint	State/Territory
• Provide national support for implementation and operation of Kids Hubs.	• Co-design a service model. • Co-fund on a 50:50 basis[28] the establishment and ongoing operation of Kids Hubs (further detail on the funding model and its	• Establish and operate the Kids Hubs in accordance with the Model and branding.

[28] Except for Victoria where the Kids Hubs are funded on a 60:40 basis (state:federal) and South Australia where the Kids Hub is fully funded by the Australian Government.

Australian Government	Joint	State/Territory
	effectiveness is provided in Section 7). • Agree the minimum data specifications and reporting process to monitor service activity.	

4.1.2 Strong inter-governmental relationships supported effective implementation and roll-out

State and territory policy leads consistently described the relationship between the Australian Government and states/territories as collaborative and effective, characterised by open communication and mutual support. Stakeholders attributed this to several factors, including a small and consistent Australian Government team, which enabled continuity in relationships and a deep understanding of jurisdictional contexts.

> "The relationship with the Commonwealth has been strong, with good communication and openness to additional needs."
>
> - State policy lead

Consultations with Australian Government policy leads highlighted that regular bilateral meetings provided structured opportunities to discuss progress and challenges, supported by informal communication between meetings to facilitate timely problem-solving. Additionally, they reported that the CoP was a valuable forum to support alignment and problem-solving during early implementation. For more detail on the CoP, see Section 4.8.

4.1.3 Allowing jurisdictions to select providers flexibly was central to achieving the Kids Hub's intent

State and territory policy leads emphasised the importance of being able to identify service providers[29] capable of delivering the Kids Hubs model in ways that aligned with local policy settings, operating environments, and service delivery context. This flexibility allowed jurisdictions to commission providers that supported integration of the model within existing service systems and addressed workforce conditions.

As a result, Kids Hubs are delivered by a diverse mix of public and non-government service providers nationally including:

[29] The term 'service provider' refers to the organisation responsible for the establishment and operations of the Kids Hub.

- **Public services** (government service providers): Public Health Service in Victoria, Local Health Districts (LHDs) in NSW, Child and Youth Mental Health Services (CYMHS) in Tasmania, and Hospital and Health Services (HHS) in Queensland.
- **Non-government organisations** (non-government service providers): a consortium of five partners in Western Australia, an ACCO in the Northern Territory, and a Community Health Organisation in Victoria.

Jurisdictions adopted varied approaches to select Kids Hub service providers. While some identified potential providers early in the establishment phase, most undertook Expression of Interest (EOI) processes aligned to their interpretation of the Model. Although selection criteria differed across jurisdictions, EOIs commonly required providers to demonstrate their capacity to:

- design locally tailored service models
- build and sustain strong partnership capability
- deliver comparable services based on prior experience
- respond to known workforce shortages.

Many jurisdictions also undertook demand modelling and service mapping to identify priority locations and narrow the pool of potential providers before commencing the EOI process.

4.1.4 Co-design shaped how the Kids Hubs would work across intake, navigation, partnerships, and physical location

Each jurisdiction undertook a co-design process to adapt the Model to local contexts. States and territories and service providers invested significant time and resources in this process, recognising that co-design was critical to not only shaping the model of care, but to enabling effective implementation.

Co-design informed how services would operate in practice, including intake and navigation processes, workforce composition, partnerships, and physical design. Service providers (with support from their respective policy teams) used structured methods such as workshops, interviews, and surveys to gather input from children, families, community members, and system stakeholders (See Table 7). Many service providers published co-design findings to demonstrate how community input shaped decisions, supporting transparency and early buy-in from key stakeholders.

Table 7 | Co-design activities and stakeholder groups

	Engagement with children, families, and communities	System stakeholder and partner engagement
Common consultation methods	Community co-design centred children and families early in the design process. Designated implementation teams held or attended events, facilitated drop-in sessions to meet	Service providers connected with existing organisations in the local service system, such as schools, health services, local councils, ACCOs, and

	Engagement with children, families, and communities	System stakeholder and partner engagement
	community members, and listened to what families needed. Common consultation included: • parent/carer discussions in public areas e.g. libraries, schools • targeted engagement in small or remote towns • engagement with lived-experience representatives • community events.	local non-government organisations (NGOs). Consultation focused on the scope of other local services and how the Kids Hubs could complement and bolster, not duplicate, what already exists. Common consultation included: • workshops and interviews • drop-in sessions • online survey • establishment of advisory/working groups with partner organisations • attendance at local events.
Sample insights from consultations	What was important to them: • feeling safe, welcomed, and not judged • holistic support that recognises the interdependence between child wellbeing and family wellbeing • culturally safe and inclusive services • easy access, navigation, and continuity • practical supports that meet their everyday needs.	What was important to them: • a clear, shared purpose • integration and coordination across services • trust, credibility, and engagement with the community • workforce capability and sustainability, and the value of navigators, peer workers, bilingual staff, and Aboriginal and Torres Strait Islander roles.

Co-design also surfaced important insights about local service systems. For sites where engagement was broad and sustained, the process highlighted:

- which service gaps mattered most to families
- where existing services were strong and should be complemented rather than duplicated
- the readiness of partners to collaborate and share responsibility.

Co-design also reinforced the importance of strength-based, non-stigmatising approaches, shaping language, service tone, and how families are welcomed into the Kids Hub.

4.1.5 Where co-design was early, inclusive, and sustained - implementation was smoother

Where co-design was initiated early and involved both community and system stakeholders, it created the conditions for smoother implementation. Early engagement enabled partners to jointly

shape core service processes before services commenced, reducing the need to retrofit arrangements once Kids Hubs were operational. These sites were better able to:

- align referral pathways and clarify roles across the local service system
- design intake and assessment processes that reflected how families actually seek help
- establish shared ownership of the model of care across providers.

By contrast, sites required to co-design and deliver services concurrently, often due to compressed timeframes, reported challenges establishing partnerships and embedding the model of care while services were already live, increasing re-work and coordination effort.

While all Kids Hubs undertook co-design, approaches varied in duration, timing, and stakeholder involvement. Longer timeframes (often 12 months or more) were typically associated with broader or statewide consultation and engagement with underserved communities. In some jurisdictions, such as Victoria, co-design is ongoing, allowing services to test and refine elements of their model of care as implementation progresses. Jurisdictions with more mature Kids Hubs reflected that effective co-design, particularly where multiple providers were involved, required sustained investment over an extended period.

Sites that placed greater emphasis on engaging children, families, and people with lived-experience reported stronger alignment between service design and community need. Where engagement focused primarily on system stakeholders, service models of care typically reflected existing structures rather than lived-experience.

In several jurisdictions, the effectiveness of co-design was constrained by key decisions made prior to stakeholder engagement. Where foundational elements (such as location, service scope or target cohorts) were pre-determined, partners described the process as consultative rather than genuinely co-designed. This reduced stakeholders' ability to influence core aspects of the model of care and weakened shared ownership.

Fragmented or late engagement of partners also created duplication and coordination challenges during implementation, occasionally contributing to operational tensions once services were established.

4.2 Providers adapted the Model to respond to local needs and contexts to support service integration

KEQ 2.10 | How have the Kids Hubs been tailored to different contexts? What is similar/different and why?

4.2.1 The types of service providers vary across states and territories

Jurisdictions were able to select service providers in order to align with local policy settings, operating environments, and service delivery context. As a result, the types of service providers differ between state and territories. Table 8 providers an overview of service providers, and further detail about each Kids Hub is available in Appendix C.

Table 8 | Overview of Kids Hub service provider types

State/territory	Kids Hub	Service provider	Service provider type
NSW	Central Coast Medicare Mental Health Kids Hub	Central Coast Local Health District (CCLHD)	Government
NSW	Illawarra Medicare Mental Health Kids Hub	Illawarra Shoalhaven Local Health District (ISLHD)	Government
NSW	Orange Medicare Mental Health Kids Hub	Western NSW Local Health District (WNSWLHD)	Government
NT	Mparntwe (Alice Springs) Medicare Mental Health Kids Hub	Central Australian Aboriginal Congress (CAAC)	ACCO
QLD	Brisbane Kids Hub	Children's Health Queensland Hospital and Health Service (CHQ HHS)	Government
QLD	Gold Coast Kids Hub	Gold Coast Hospital and Health Service (HHS)	Government
TAS	Jordan River Medicare Mental Health Kids Hub	Tasmania Child and Youth Mental Health Service (CYMHS)	Government

State/territory	Kids Hub	Service provider	Service provider type
TAS	Burnie Medicare Mental Health Kids Hub	Tasmania Child and Youth Mental Health Service (CYMHS)	Government
TAS	East Tamar Medicare Mental Health Kids Hub	Tasmania Child and Youth Mental Health Service (CYMHS)	Government
WA	Midland Medicare Mental Health Kids Hub	Parkerville Children and Youth Care	Consortium
VIC	Brimbank Melton Children's Health & Wellbeing Local	IPC Health	NGO
VIC	Children's Health and Wellbeing Local (Southern Metropolitan Melbourne)	Monash Health	Government
VIC	Loddon Children's Health and Wellbeing Local	Bendigo Community Health Services (CHS)	NGO

4.2.2 A clear understanding of the local community and service context was essential to adapt the Model and support integration

There is wide variation in the contexts in which Kids Hubs operate, including metropolitan and regional settings, policy environments, population demographics, workforce availability, and the range of services available locally. Understanding these factors was critical to adapting and delivering Kids Hub services that met family needs, built on what existed, addressed gaps, and supported greater system integration.

Policy teams and service providers invested time in understanding local context through:

- demand modelling to identify where needs were most concentrated
- service mapping to develop an objective view of existing services and gaps
- co-design and consultation with families, service providers, and other system stakeholders to understand how Kids Hubs should operate in practice.

4.2.3 Service providers used their understanding of local needs to tailor core functions outlined in the Model

The Model outlines six core functions (as detailed in Section 3.2) to be delivered by the Kids Hubs to ensure equity, consistency, and quality. Importantly, the Model allows flexibility in how they are adapted and delivered in each location.

All Kids Hubs have fulfilled this intent of the Model, drawing on their understanding of local needs to tailor the delivery of the core functions. The Evaluation has identified features of the Model that are consistent nationally, alongside key areas of variation. These variations demonstrate how Kids Hubs have adapted the Model to respond to differences in population need, service systems, workforce availability, and operating environments, while maintaining alignment with the Model's core intent.

Table 9 on the following page, summarises the similarities and differences in how the core functions are delivered across the Kids Hubs and highlights the influence of local context. The impact and effectiveness of different tailoring is explored later in the report, in Section 6. A detailed profile for each Kids Hub is found in Appendix C.

Table 9 | Similarities and differences across core functions of the Model

Core function	Similarities	Differences
Access and referral	• All Kids Hubs have taken a **broad approach to referrals**, with multiple access pathways for families. • **All Kids Hubs have prioritised accessibility by establishing services in central, easily accessible locations**, including dedicated facilities, satellite offices, or locations embedded within existing infrastructure such as Family Centres or schools.	• **Co-location with other services** varies depending on where the Kids Hub sits within the broader system (e.g. mental health vs child and family services). Some Kids Hubs are not co-located due to limitations in available physical space. • **Not all Kids Hubs are currently accepting walk-in referrals**, reflecting decisions about targeted referral pathways and broader demand management, particularly in areas of high need. • **Focus on priority populations** varies from those identified in the Model depending on local demographics and needs, e.g. sites in Victoria have a strong focus on CALD families due to local population demographics.
Initial assessment	• **All Kids Hubs undertake holistic, whole-of-family assessments** to understand child and family needs together.	• **Assessment tools vary across sites**, including use of the IAR (as outlined in the Model), ASQ-3, and locally customised tools – this is influenced by tools commonly used by

Core function	Similarities	Differences
	• **All Kids Hubs apply a 'no wrong door' approach**, supporting warm referrals to other services where the Kids Hub is not the most appropriate option and/or providing feedback to referrers.	partners and where the Kids Hub is situated in the system. • **The person(s) responsible for conducting assessments varies,** and includes single-discipline clinicians, care navigators, or multidisciplinary teams for more complex presentations. The involvement of peer workers in initial assessment also varies, reflecting workforce availability and local service design.
Treatments and therapies	• **All Kids Hubs deliver brief interventions** aligned with early intervention and stepped-care principles. • **All Kids Hubs emphasise family-based interventions** and parenting education and support. • **All Kids Hubs deliver supports flexibly** depending on family preferences including meeting families in the Kids Hub, at school, at home, in a park, or via telehealth.	• **The mix of multidisciplinary capability varies** depending on identified local need and challenges with workforce recruitment. • **Approaches to diagnosis vary,** with some Kids Hubs providing diagnostic assessments in their service. This is influenced by local interpretation of the Model, availability of specialist disciplines, and the setup of the required clinical governance arrangements. • **The availability of group-based interventions varies:** some Kids Hubs have not set up group programs due to capacity constraints.
Care coordination	• **All Kids Hubs use regular multidisciplinary team meetings** or case conferencing to support collaborative care planning.	• **Care coordination is led by different roles across sites**, including dedicated care coordinators, care navigators, case workers, or family support workers; versus clinician-led coordination.
Supported transition	• **All Kids Hubs support transition** through warm handovers and clearly documented summaries of care.	• **The scope of partnerships to support transitions vary across sites**: this depends on where the Kids Hub sits in the system, which partners were engaged during co-design, and any pre-existing relationships of Kids Hub staff.

Core function	Similarities	Differences
Workforce	• **All Kids Hubs have invested in workforce development**, including mandatory training, trauma-informed and family-centred practice, and ongoing supervision.	• **Workforce composition varies across sites**, including the balance between clinical, non-clinical, and administrative roles – see below for more detail.

Workforce composition varies significantly across sites. This is largely due to differences in workforce availability, what expertise was identified through co-design, and the needs of priority populations. Table 10 outlines common staff roles under three categories and Table 11 provides an overview of role distribution across the Kids Hubs by jurisdiction.

Table 10 | Common Kids Hub roles and classification

Clinical roles	Non-clinical roles	Management and administration
• Psychiatrist • Psychologist • Paediatrician • Nurse • Nurse practitioner • Occupational therapist • Speech pathologist • Dietician • Social worker • Music therapist	• Care coordinator • Service navigator • Wellbeing coordinator • Lived experience worker • Peer worker • Family engagement officer • Community engagement officer • Aboriginal health worker • Aboriginal liaison officer • Aboriginal family support worker	• Hub manager • Team leader • Administration • Data support • Research or evaluation officer

Table 11 | Distribution of clinical, non-clinical, and management/admin roles across the Kids Hubs by state, FTE

State	Kids Hub	Clinical	Non-clinical	Management and administration
NSW	Central Coast Medicare Mental Health Kids Hub	9.2	4.0	2.6
NSW	Illawarra Medicare Mental Health Kids Hub	8.3	0.0	6.0
NSW	Orange Medicare Mental Health Kids Hub	5.4	4.0	3.6

State	Kids Hub	Clinical	Non-clinical	Management and administration
NT	Mparntwe (Alice Springs) Medicare Mental Health Kids Hub	1.7	9.6	2.0

State	Kids Hub	Clinical	Non-clinical	Management and administration
QLD	Brisbane Kids Hub	10.5	6.0	4.6
QLD	Gold Coast Kids Hub	5.4	5.0	2.3

State	Kids Hub	Clinical	Non-clinical	Management and administration
TAS	East Tamar Medicare Mental Health Kids Hub	2.8	0.0	1.0
TAS	Burnie Medicare Medical Health Kids Hub	1.8	0.0	0.6
TAS	Jordan River Medicare Mental Health Kids Hub	4.0	0.0	0.6

State	Kids Hub	Clinical	Non-clinical	Management and administration
VIC	Loddon Children's Health and Wellbeing Hub	8.4	6.6	2.8
VIC	Brimbank Melton Children's Health & Wellbeing Local	9.4	8.9	4.2
VIC	Children's Health and Wellbeing Local (Southern Metropolitan Melbourne)	15.2	6.9	2.0

State	Kids Hub	Clinical	Non-clinical	Management and administration
WA	Midland Medicare Mental Health Kids Hub	4.8	8.3	1.7

4.3 Implementation progress has varied across jurisdictions due to a range of enablers and barriers

KEQ 2.3 | What are the barriers and enablers to effective implementation and how have they been addressed in different contexts?

At the time of writing, 14 Kids Hubs are operational, and three sites are at earlier stages of establishment. Table 12 overleaf shows the detailed implementation timing for all Kids Hubs at the time of this Evaluation. In some jurisdictions, implementation of the Kids Hubs has progressed slower than planned due to various factors. This Evaluation has addressed enablers of effective implementation, and common barriers in this section.

4.3.1 Enablers of effective implementation:

- **State/territory-wide reform momentum and policy alignment.** Implementation was facilitated where the Initiative aligned closely with existing jurisdictional reforms and strategic priorities, particularly in child, family, and mental health. This alignment created early legitimacy for the Model and enabled jurisdictions to integrate the Kids Hubs into established planning, funding, and governance arrangements rather than establishing standalone services.
- **Established and integrated governance structures.** Jurisdictions with established governance arrangements (such as cross-agency steering committees) were able to progress implementation more efficiently. These structures supported faster decision-making and streamlined procurement processes for service establishment.
- **Strong existing sector relationships and partnerships.** Pre-existing relationships between the Kids Hub staff and other services accelerated system integration by supporting co-design, establishing referral pathways, and facilitating access to children and families.

4.3.2 Common barriers to successful implementation:

- **Workforce availability and recruitment challenges.** Workforce constraints were the most consistently reported barrier across Kids Hubs. Challenges included shortages of suitably qualified clinicians, difficulty recruiting to regional and remote locations, competition with other services, and the impact of short-term funding arrangements on workforce stability. Section 4.5 outlines ways the Kids Hubs have addressed workforce shortages.
- **Securing suitable physical locations.** Identifying and securing appropriate physical locations for the Kids Hubs proved challenging in many jurisdictions. Constraints included limited availability of suitable buildings, delays associated with leasing or refurbishing premises, compliance and fit-out requirements, and competing demand for community infrastructure. In several cases, these challenges delayed service commencement. Kids Hubs addressed this barrier by establishing temporary sites, co-locating with other services, and prioritising outreach services.

- **Funding and administration constraints.** In several jurisdictions, rigid annual funding rules limited the ability to roll over unspent funds and, in some cases, led to the loss of allocated funding. This was compounded by the absence of dedicated capital budgets and early capital planning, which delayed site establishment in several locations. It was difficult for Kids Hubs to directly address these challenges as they related to structural processes and established funding rules. Refer to Section 7.2 for more detail about the appropriateness and effectiveness of the funding model.

Table 12 | Implementation timing for all operational Kids Hubs

State	Kids Hub	Co-design period	Date of first service delivery
NSW	Central Coast Medicare Mental Health Kids Hub	January 2024 – April 2024	April 2025
NSW	Illawarra Medicare Mental Health Kids Hub	March 2024 – July 2024	December 2024
NSW	Orange Medicare Mental Health Kids Hub	October 2024 – November 2024	July 2025
NT	Mparntwe (Alice Springs) Medicare Mental Health Kids Hub	February 2024 – December 2024	March 2025
QLD	Brisbane Kids Hub	May 2023 and January 2024	March 2024 and January 2025
QLD	Gold Coast Kids Hub	December 2022 – July 2023	December 2023
TAS	Jordan River Medicare Mental Health Kids Hub	June 2023 – November 2024	March 2025
TAS	Burnie Medicare Mental Health Kids Hub	June 2023 – November 2024	May 2025
TAS	East Tamar Medicare Mental Health Kids Hub	June 2023 – November 2024	July 2025
WA	Midland Medicare Mental Health Kids Hub	January 2023 – December 2023	January 2025
VIC	Brimbank Melton Children's Health & Wellbeing Local	December 2022 – ongoing	November 2022

State	Kids Hub	Co-design period	Date of first service delivery
VIC	Children's Health and Wellbeing Local (Southern Metropolitan Melbourne)	February 2023 – ongoing	May 2023
VIC	Loddon Children's Health and Wellbeing Local	March 2023 – February 2024	July 2023
SA	Southern Adelaide Medicare Mental Health Kids Hub	April 2024 – ongoing	November 2025

4.3.3 Due to delays in implementation, Kids Hubs in South Australia and the ACT were not included in data collection and therefore not evaluated in this report.

South Australia

The South Australian Kids Hubs are in early implementation, with services operating in Marion and a limited outreach site in Aldinga. Planning is underway for a site in Adelaide's north. The Kids Hubs are fully funded by the Australian Government and delivered by Sonder in consortium with Kornar Winmil Yunti (KWY) Aboriginal Corporation, Kudos, and the Multicultural Communities Council of South Australia (MCCSA), using a staged approach to staffing and service rollout.

Current service delivery focuses on individual referrals and walk-ins, primarily for children with moderate mental health and neurodevelopmental needs, with psychology, social work, and allied health supports progressively becoming operational for more complex social needs. Implementation has been constrained by short establishment timeframes, refurbishment and space limitations at Marion, early-stage data availability, and the complexity of coordinating a multi-partner consortium while eligibility criteria, intake processes, and the model of care are still being finalised.

The ACT

The ACT Kids Hub is in the final stages of establishment and is progressing towards commencement of service delivery. The lease for the site has been signed and builder procurement completed, with design and fit-out underway. The service delivery grant process has progressed, with negotiations with the preferred respondent underway. Service delivery is expected to commence later this year.

Implementation has faced significant challenges, including workforce shortages, funding pressures that led Canberra Health Services to withdraw, and prolonged delays in site selection due to planning constraints and limited suitable facilities. Additional complexity has arisen from stakeholder confusion with overlapping initiatives and uncertainty caused by short funding horizons, which has affected provider engagement.

4.4 Clinical governance arrangements were shaped by how and where services were embedded in local service systems

KEQ 2.5 | What clinical governance has been established in each local context?

The Model outlines the need for clinical governance to "…ensure staff are appropriately credentialled, trained and supported to deliver high-quality care, with clear protocols for reviewing care and responding to critical incidents and complaints." Across jurisdictions, service providers established clinical governance arrangements based on their local delivery contexts, drawing on existing organisational and system-level governance structures.

Where Kids Hubs are delivered by a single service provider, clinical governance arrangements typically align with the provider's existing frameworks. For example, in Tasmania, clinical and operational day-to-day governance is managed through established Community CYMHS reporting structures in each region. Similarly, the Mparntwe (Alice Springs) Medicare Mental Health Kids Hub leverages Central Australian Aboriginal Congress' (CAAC's) existing clinical governance systems, including risk management, workforce supervision, and quality assurance processes.

In consortium or partnership models, clinical governance responsibilities are shared across organisations. Partner agencies retain responsibility for credentials, supervision, and professional standards for their own staff, while collective governance is provided through steering committees, advisory groups, and formal partnership or service agreements. Integrating clinical governance across multiple organisations has proven challenging in some sites; particularly where roles, the ownership of clinical risk, and accountability for children and families were not clearly defined from the outset. See Section 6.4 for detail on the impact of these arrangements.

Despite variation in delivery models, several common clinical governance arrangements were evident across sites:

- **Governance bodies:** Many sites established governance bodies such as local leadership groups or quality and safety committees to provide focused oversight of implementation and operations. These groups typically include senior clinical leaders and managers and are responsible for monitoring service quality, reviewing incidents and complaints, overseeing risk, and supporting continuous improvement.
- **Operational practices:** Clinical governance is embedded in day-to-day operations through practices such as daily team debriefs, structured case discussions, and ongoing workforce training. Investment in training and supervision was widely viewed as essential to supporting safe practice, particularly given workforce shortages and the emerging nature of the Model. See Section 4.5 for more detail on training.
- **Centralised clinical oversight:** Most Kids Hubs have also established a centralised clinical oversight mechanism responsible for reviewing new referrals, case conferencing, and managing escalation of clinical risk. These groups typically included senior clinicians such as psychiatrists, paediatricians, and service managers; and function as a key safeguard for children and families presenting with complex needs.

4.5 Kids Hubs have addressed workforce shortages through intentional recruitment, flexible staffing, and capability uplift

KEQ 2.6 | To what extent are the Kids Hubs using innovative approaches to address workforce shortages?

4.5.1 Service providers consistently reported recruitment challenges due to broader workforce shortages and difficulty identifying candidates with the skills and attributes required by the Model

Recruitment of multidisciplinary staff was consistently raised as a challenge across Kids Hubs. While a small number of more established Kids Hubs reported success in building relatively stable teams over time, the majority have experienced ongoing difficulty recruiting to key roles, with vacancies frequently remaining unfilled for extended periods.

Challenges were most pronounced for specialist and culturally specific positions, including paediatricians, psychiatrists, psychologists, Aboriginal and Torres Strait Islander health workers, multicultural support workers, and senior social workers. Some regions had shortages in allied health roles including speech pathologists and occupational therapists, often due to limited training opportunities and therefore a smaller pipeline of these roles. These difficulties reflect broader health system workforce shortages and a limited supply of suitably qualified practitioners.

Recruitment was particularly challenging in regional and smaller jurisdictions, where the workforce pool is limited and successful recruitment risked creating shortages in other local services. In response, jurisdictions reported working closely with partners to manage system-wide impacts.

Recruitment timelines were further extended by the requirement to identify candidates who met both professional expectations and the capability profile required by the Model. Kids Hub leads reported challenges recruiting clinicians with the necessary soft skills and willingness to adapt to the Model's new way of working. Clinicians transitioning from hospital-based settings were often perceived to require greater adjustment to the Model, whereas those with primary health care experience adapted more readily.

4.5.2 Most states and territories have Aboriginal and Torres Strait Islander identified roles

All Kids Hubs acknowledge the need for identified Aboriginal and Torres Strait Islander positions as part of the model of care. Kids Hubs staff identified three key roles that identified Aboriginal and Torres Strait Islander positions play:

- Providing support to Aboriginal and Torres Strait Islander children and families, alone or in partnership with non-Aboriginal and Torres Strait Islander multidisciplinary team members.
- Establishing partnerships with ACCOs and liaising as the key contact.

- Supporting Aboriginal and Torres Strait Islander families to navigate supports at the Kids Hubs and external services.

The various identified Aboriginal and Torres Strait Islander positions across each state and territory who undertake these roles are shown in Table 13.

Table 13 | Identified Aboriginal and Torres Strait Islander positions across operational Kids Hubs

State or territory	Aboriginal and/or Torres Strait Islander position
New South Wales	• Aboriginal Health Worker and Aboriginal Care Navigator positions in Central Coast Medicare Mental Health Kids Hub. • Challenges recruiting to funded position in Illawarra Medicare Mental Health Kids Hub. • Aboriginal Care Navigator in Orange Medicare Mental Health Kids Hub.
Northern Territory	• Four Aboriginal Family Support Workers who work with non-Aboriginal care navigators and/or clinicians in bi-cultural pairs.
Queensland	• Aboriginal and Torres Strait Islander Senior Health Worker at Brisbane Kids Hub. • Non-Aboriginal clinician in-reach for Aboriginal and Torres Strait Islander families at IUIH. • Challenges recruiting to funded position at Gold Coast Kids Hub.
Tasmania	• No Aboriginal identified roles.
Victoria	• Multiple funded roles delivered via partnership with ACCOs at Loddon Children's Health and Wellbeing Local (one not filled as of Nov 2025). • Aboriginal Family Support Worker at Children's Health and Wellbeing Local (Southern Metropolitan Melbourne). • Challenges recruiting to funded position in Brimbank Melton Children's Health & Wellbeing Local.
Western Australia	• Aboriginal Care Navigators funded through ACCO consortia partner who work with non-Aboriginal care navigators and/or clinicians in bi-cultural pairs.

The various identified Aboriginal and Torres Strait Islander roles are designed to strengthen cultural safety, improve access, and support engagement with Aboriginal and Torres Strait Islander children and families. For example:

- The Central Coast Medicare Mental Health Kids Hub's Aboriginal Health Worker has established strong relationships with families, teachers, and referring partners through their part-time role at the Kids Hub and their work as an Aboriginal Liaison Officer at a local school. This is further

strengthened by the Kids Hub's culture, where relational connections foster a strong willingness to work collaboratively and appropriately.

- The bi-cultural staff pairing at the Mparntwe (Alice Springs) Medicare Mental Health Kids Hub is allowing both members to build a strong relationship with the children and better understand their needs. Staff are enjoying the opportunity to be flexible and creative in designing personalised supports for children and families.

4.5.3 Kids Hubs are implementing innovative approaches to mitigate workforce shortages

The flexibility of the Initiative has enabled Kids Hubs to focus on the unique needs in their local context rather than filling prescriptive clinical and non-clinical roles. This allows service providers to innovate and adapt their workforce structure and recruitment approach to the local situation. Approaches implemented by Kids Hubs to address workforce and recruitment challenges are listed in Table 14 below.

Table 14 | Innovative approaches to address workforce shortages

Theme	Approach	Description
Recruitment strategies	**Targeted, role-specific recruitment**	Kids Hubs have shifted away from broad recruitment toward more focused, role-specific strategies. This includes refining job design, clarifying role expectations, and expanding recruitment channels such as community-based talent pools and professional networks.
Recruitment strategies	**Regrading and redefining roles**	Some Kids Hubs have adjusted role classifications and awards (including grading positions at higher levels or redefining professional awards), to attract more experienced candidates and broaden the potential applicant pool.
Flexible workforces	**Flexible employment arrangements**	Most Kids Hubs have recruited to part-time roles, offered flexible working arrangements, and tailored the model of care to align with locally available skills, rather than insisting on full-time or highly specialised roles.
Flexible workforces	**Advanced clinical capability 'on-call'**	Where specialist roles were difficult to recruit, some Kids Hubs accessed advanced clinical expertise on a

Theme	Approach	Description
		consultation or on-call basis, rather than embedding these roles in day-to-day service delivery.
Flexible workforces	**Staff sharing across sites**	Some Kids Hubs are sharing clinical and management staff across multiple sites to maintain service coverage and allow scarce expertise to be deployed flexibly.
Workforce development	**Training and capability uplift**	Rather than relying solely on recruitment, Kids Hubs have invested in training and upskilling existing staff to build capability internally.
Workforce development	**Pipeline development through education partnerships**	A small number of Kids Hubs identified longer-term workforce pipeline strategies, including partnerships with universities to support student placements and future recruitment.
Service adaptation	**Redesigning models to reduce reliance on scarce specialists**	Some Kids Hubs intentionally designed models of care that do not rely heavily on hard-to-recruit specialist roles, instead emphasising multidisciplinary collaboration and generalist capability.

4.5.4 Investment in training has been essential to equip staff with the required skills to meet the complex needs of children and families

Given the newness of the Model and ongoing workforce shortages, capability gaps could not be addressed through recruitment alone. Training therefore has played a critical role in building internal capability and enabling staff to work confidently within an emerging model of care. Several Kids Hubs located in the same jurisdiction also arranged joint training sessions. Service Managers in NSW reported that this was helpful to build the capability of their respective teams. Broadly, Kids Hubs have invested in six types of formal training outlined in Table 15.

Table 15 | Types of training delivered to Kids Hub staff

Type of formal training	Examples or programs or courses provided in Kids Hubs
Foundations of child and family mental health and wellbeing	• Plain Language Training with Enliven • Black Box • TAR3
Parenting and family-based intervention training	• Positive Parenting Program (Triple P) • Circle of Security • Parents Under Pressure • Cool Kids • Confident Carers Cooperative Kids • Tuning into Kids/Tuning into Dads • Child Parent Psychotherapy • Managing school refusal – Parent Hope training
Cultural responsiveness and Aboriginal and Torres Strait Islander specific training	• Aboriginal and Torres Strait Islander Youth Mental Health First Aid • Tracy Westerman Suicide Prevention in Aboriginal Communities • "See Me See You" cultural responsiveness • Healing Through Culture
Discipline specific	• Lego®-based therapeutic group training • Narrative Therapy • ASQ-TRAK developmental assessment training • Autism assessment and treatment training • ADOS fidelity training
Trauma, risk, and safety training	• Therapeutic Crisis Intervention (TCI) • Protective behaviours and sexualised behaviours • Managing Disclosures • Suicide Prevention and Management – Black Dog Institute • Accidental Counsellor • Family, Sexual, and Domestic Violence training
Safety and compliance training	• Child Safe Organisation training • OHS/WHS requirements • Incident Reporting

4.6 All Kids Hubs have invested in partnerships, recognising their importance in supporting integration in the local context

KEQ 2.7 | What partnerships have been established to support implementation?

The Model's flexible approach to collaboration enables Kids Hubs to establish fit-for-purpose partnerships, with partners taking on roles that respond to local needs and complement existing services. All Kids Hubs have strategically formed partnerships to:

- support the development of their local model of care
- strengthen referral pathways in and out of the Kids Hubs
- minimise duplication in service delivery in the local area
- deliver culturally appropriate care
- connect with priority cohorts.

A list of the partnerships that Kids Hubs have formed are shown in Table 16 below, grouped into five types.

Table 16 | Example types of partnerships

Type	Examples
Health and mental health services	• Allied Health Services • Child and Adolescent Mental Health Services (CAMHS) • Child and Youth Mental Health Services (CYMHS) • Child development services • Developmental and disability support services • General practitioners • Health hubs • Maternal and child health services • Medicare Mental Health phone line • Other community health services • Primary Health Networks • Psychology centres • Regional health services
Aboriginal and Torres Strait Islander services	• Aboriginal Community Controlled Health Organisations (ACCHOs) • Aboriginal Community Controlled Organisations (ACCOs) • Aboriginal Medical Service (AMS) • Aboriginal women's health and welfare organisations

Type	Examples
Family services and child protection services	• Community child protection service • Family services • Integrated family services and networks • Parent and carer programs • Programs for complex-high risk families • Services to support children in residential care
Education and early childhood services	• Child and family learning centres • Community kindergartens and daycare • Early childhood development intervention services • Local learning and employment networks • Local schools
Government and community services	• Justice and legal-related services • Refugee and settlement service programs • State and territory government agencies

Across all partnerships established by the Kids Hubs, the majority are with family services and child protection services, and government and community services. Table 17 outlines the distribution of partner types across all the Kids Hubs.

Table 17 | Distribution of partner types

Service type	Distribution
Family services and child protection services	28%
Government and Community services	25%
Education and early childhood services	18%
Aboriginal and Torres Strait Islander services	16%
Health and mental health services	15%

The flexibility of the Model allows Kids Hubs to establish partnerships that suit their local context, with partners taking on different roles and responsibilities based on community needs and existing service arrangements. Across all Kids Hubs, partnerships take several forms and play different roles in line with need.

The roles and intent of partnerships can be broadly grouped into five categories which are listed in Table 18 below. It should be noted that these categories are not mutually exclusive as partnerships may have multiple purposes depending on its nature and intent.

Table 18 | Purposes of partnerships

Purpose	Example	Outcome
Co-location	• The Brimbank Melton Children's Health & Wellbeing Local is co-located with other services at IPC Health community health centre. • The Central Coast Medicare Mental Health Kids Hub is co-located with CAMHS.	• Situates the Kids Hub multidisciplinary teams with similar organisations to promote community engagement and streamline referral pathways. • Supports sustainable integration with existing established services.
Service in-reach	• Clinicians from the Brisbane Kids Hub visits Mununjali (ACCO).	• Embeds Kids Hub clinicians directly into community settings, providing resources to deepen local capacity and embed Kids Hub supports within place-based ecosystems.
Consortia	• Midland Medicare Mental Health Kids Hub is delivered through consortia of five different partners.	• Leverages existing infrastructure to deliver services.
Referral partners	• Schools, ACCOs, NGOs, early intervention services, community health organisations.	• Ensures the Kids Hub can engage appropriate children and families through smooth referral pathways. Also, secondary consultations and outgoing referrals when a family's needs are outside scope.
Multi-agency working groups/steering committees	• The WA interagency working group is comprised of WA Mental Health Commission, WA Primary Health Alliance, Australian Government, Department of Education, Department of Communities, lived-experience representatives, and Aboriginal cultural representatives.	• Provides input and guidance such as during co-design of the model of care and procurement processes to commission a service provider.

4.7 Kids Hubs have partnered with ACCOs to provide culturally safe care to Aboriginal and Torres Strait Islander families

KEQ 2.8 | To what extent are the Kids Hubs investing in partnerships with Aboriginal Community Controlled Organisations and communities?

Aboriginal and Torres Strait Islander stakeholders reflected that building trust to promote engagement takes time, particularly given historical and ongoing service and system experiences. Kids Hubs have sought to address this by leveraging ACCOs whose trust, relationships, and accountability to community are already embedded. Across jurisdictions, there is clear and growing investment in partnerships with ACCOs and Aboriginal community organisations, but the depth, maturity, and form of these partnerships vary. Broadly, there are three levels of engagement with ACCOs across the Kids Hubs:

- **Strong and embedded partnerships.** In several jurisdictions (NT, QLD, NSW, and WA), Kids Hubs have established deep, relational partnerships with ACCOs or Aboriginal organisations. In these models, ACCOs are engaged as service providers, consortia partners, or dedicated in-reach partners and identified Aboriginal and Torres Strait Islander roles are funded as part of the model of care. Across these jurisdictions, partnerships were strengthened where Kids Hubs invested time, leadership, and workforce capability into respecting Aboriginal and Torres Strait Islander ways of knowing, being, and doing, rather than relying solely on formal agreements.

Aboriginal and Torres Strait Islander insight

In Yarrabilba (a Brisbane Kids Hub location), there is an embedded relationship with Mununjali Housing Co Ltd, and Aboriginal and Torres Strait Islander organisation and key referrer to the Kids Hub. A Mununjali representative reported that the partnership is high-trust and relational, with Kids Hub practitioners "…comfortable in the Mununjali space…" and co-creating cross-cultural care. It is seen as critical for ensuring Aboriginal and Torres Strait Islander families are fast-tracked to support and don't fall through service gaps.

- **Moderate, more service-to-service partnerships.** In some jurisdictions (Victoria as an example), Kids Hubs demonstrate a moderate level of investment in partnerships with Aboriginal and Torres Strait Islander organisations. These Kids Hubs commonly partner with Aboriginal and Torres Strait Islander health or child wellbeing programs and employ Aboriginal and Torres Strait Islander family support workers, but do not commission ACCOs as service providers.
- **Early or indirect investment.** In a smaller number of Kids Hubs (Tasmania as an example), investment in ACCO partnerships remains early or indirect. In these contexts, Aboriginal and Torres Strait Islander children and families are identified as a priority cohort, but there are no explicit partnerships with ACCOs.

4.8 The Community of Practice supported alignment and problem-solving during early implementation, with variable use across jurisdictions as implementation progressed

KEQ 2.9 | To what extent is the Community of Practice working as a network to support learning and continuous improvement?

State and territory policy leads described the CoP as valuable and supportive during establishment phase of Kids Hubs. They noted the role of the Australian Government Medicare Mental Health Kids policy team in facilitating collaborative problem-solving and alignment between the Australian Government and the states and territories.

During early implementation, the CoP supported jurisdictions to develop a shared understanding of the Model, service expectations, and the Evaluation requirements. Stakeholders reported that this shared forum assisted with sense-making in the context of establishing a new national initiative and provided opportunities to discuss common implementation challenges, including workforce constraints, data requirements, and commissioning approaches.

The CoP also enabled some cross-jurisdiction learning on practical implementation issues. Jurisdictions reported learning from the more established Kids Hubs about training and supervision models, interdisciplinary staffing arrangements, co-location and outreach approaches, and partnerships with schools and non-government organisations. These exchanges supported local adaptation of the model in some contexts.

However, stakeholders reported variation in how consistently the CoP was used to support implementation across jurisdictions. Differences in the frequency, focus, and structure of sessions meant that the extent to which shared learning informed local decision-making varied, with some jurisdictions drawing more directly on CoP discussions than others as implementation progressed. These strengths and limitations of the CoP are summarised in Table 19.

Table 19 | Strengths and limitations of the CoP

Strengths	Limitations
• **A strong foundation for cross-Kids Hub knowledge exchange.** States and territories highlighted that the CoP offers an "…excellent platform for cross-fertilisation of ideas between states and territories…", strengthened further by including local Kids Hub leads where appropriate. This has helped jurisdictions build a shared understanding of the Model, service expectations, and the Evaluation requirements early in implementation.	• **Variable frequency and limited scope of sessions.** Multiple jurisdictions reported that the CoP's frequency has been inconsistent and that sessions have tended to focus on Australian Government priorities, such as evaluation frameworks and re-branding, rather than being a two-way forum for operational learning. • **Lack of structure for shared learnings and best practice across regions.** While the CoP has facilitated high-level learning, its

Strengths	Limitations

• **Supports alignment, sense-making, and shared problem-solving.** Stakeholders noted that the CoP has:
  • Created shared understanding of the National Model of Care and the Evaluation requirements.
  • Supported sense-making across jurisdictions in response to common implementation challenges.
  • Helped teams learn from each other's approaches to workforce shortages, data requirements, and commissioning arrangements.
• **Facilitates learning about workforce and implementation issues.** The CoP has contributed to:
  • Sharing strategies for managing limited workforce supply.
  • Learning from more mature Kids Hubs about training, supervision models, and interdisciplinary staffing.
  • Understanding implementation enablers such as co-location, outreach models, and partnerships with schools and NGOs.
	practical influence is uneven. Some jurisdictions have leveraged the CoP to refine their model of care or governance approaches, while others expressed limited ability to convert shared insights into local implementation. This reduces the CoP's immediate relevance in some contexts, despite strong foundational learning support.
	• **Opportunity cost of unstructured or highly technical sessions.** Several jurisdictions highlighted the administrative and evaluative burden on states and territories (e.g., reporting duplication, differing state/territory and national evaluation frameworks). Some jurisdictions suggested that CoP sessions could more directly support problem-solving around these pain points rather than amplifying them.

5 Profiles of children and families accessing the Hubs

This section presents the common characteristics and needs of the children, their families, and carers accessing the Kids Hubs and how this compares to service uptake in similar child and family hub models.

SUMMARY OF FINDINGS

- Children aged between 5-8 make up the most common age group (44.3 per cent). This age group made up the majority in all Kids Hubs (except two), but some had a relatively high percentage of the 0-4 age group. This is due to close working relationships (through co-location and partnerships) with early years settings and maternal and child health services.
- Just over half of the children accessing the Kids Hubs are male (57 per cent).
- Seventeen per cent of the families who access the Kids Hubs identify as Aboriginal and/or Torres Strait Islander. The Mparntwe (Alice Springs) Medicare Mental Health Kids Hub is delivered through an ACCO and therefore 99.8 per cent of families seen identified as Aboriginal and/or Torres Strait Islander. Central Coast Medicare Mental Health Kids Hub had a relatively high percentage for a non-ACCO delivered Kids Hub (28.4 per cent of families). This is reportedly driven by well-connected Aboriginal-identified roles (1 FTE) and two strong partnerships with ACCHOs.
- Nine per cent of the families who access the Kids Hubs identify as CALD.
- Sixty-six per cent of families have at least one psychosocial vulnerability and 27.3 per cent of families have co-occurring (two or more) psychosocial vulnerabilities. This includes housing instability, financial stress, experience of violence, abuse and neglect, engagement with alcohol and other drug, and experience of poor mental health.
- Community health services (33.9 per cent) and self-referral (19.1 per cent) are the most common sources of referral.

5.1 Characteristics and needs of the children and families

KEQ 2.2 | What are the characteristics and needs of children, their families and carers accessing the Kids Hubs?

5.1.1 Over 44 per cent of children accessing the Kids Hubs are within the 5–8 age bracket

Table 20 presents the age distribution across three age ranges for each Kids Hub. The 5–8 age group accounts for the highest number of presentations in all Kids Hubs except Orange Medicare Mental Health Kids Hub. Nationally, the 0–4 age group has the fewest presentations; however, in four Kids Hubs this group comprises more than one quarter of total presentations.

Table 20 | Age distribution by Kids Hub[30]

Kids Hub	0-4 years	5-8 years	9-12 years
Central Coast Medicare Mental Health Kids Hub	4.7%	53.1%	**42.4%**
Illawarra Medicare Mental Health Kids Hub	21%	54.3%	24.6%
Orange Medicare Mental Health Kids Hub	7.1%	42.9%	**50%**
Mparntwe (Alice Springs) Medicare Mental Health Kids Hub	13.6%	50.9%	35.5%
Brisbane Kids Hub	22.4%	49.4%	27.7%
Gold Coast Kids Hub	9.1%	51.5%	39.5%
Jordan River Medicare Mental Health Kids Hub	**36%**	38%	24%
Burnie Medicare Mental Health Kids Hub	**28.1%**	37.5%	34.4%
East Tamar Medicare Mental Health Kids Hub	**30%**	40%	30%
Midland Medicare Mental Health Kids Hub	18.1%	45.8%	36.1%
Brimbank Melton Children's Health & Wellbeing Local	22.5%	45.9%	28.1%
Children's Health and Wellbeing Local (Southern Metropolitan Melbourne)	14%	47.7%	37.3%
Loddon Children's Health and Wellbeing Local	**36.4%**	32.9%	27.7%

The Literature and Policy Review found anxiety, depressive disorders, and behavioural concerns are among the leading issues in children aged 5–14 in Australia.[31] Early signs often emerge during school years but may go undiagnosed or untreated for long periods. The 5-8 age range is the developmental window where concerns become visible as children start school but diagnostic thresholds, service eligibility and access, and a lack of navigation support for parents often delays support.

Kids Hub team leaders and staff noted that many children they see were infants or born during the COVID-19 pandemic. During Australia's lockdowns, many early childhood developmental services closed or faced long waitlists, meaning families often missed timely developmental milestone checks. Staff reflected that as a result, developmental delays and concerns frequently went

[30] It should be noted that four Kids Hubs do not present a full 100 per cent split. One Kids Hub had incomplete data and three included data for children aged over 13 years of age which was subsequently excluded.
[31] Head to Health Kids Initiative Literature and Policy Review, 2024.

unnoticed until children started school. Children who were school-aged during the COVID-19 pandemic are now presenting in the 9–12 age range with much more complex needs.

The Literature and Policy Review found that child mental health and wellbeing declined during and after the COVID-19 pandemic, with the pandemic identified (alongside broader societal changes) as a major driver of poorer outcomes.[32] Central Coast Medicare Mental Health Kids Hub and Orange Medicare Mental Health Kids Hub are evidence of this, with a high proportion of the children presenting in the 9-12 age range.

Children aged 0–4 are currently the most underserved cohort in Kids Hubs. This mirrors broader system-wide patterns, where children under five have historically received less than one per cent of services.[33] Many Kids Hubs noted an intention to prioritise this age group as their implementation progresses and their service models mature, enabling them to support a higher volume of families. However, in four Kids Hubs, this age group accounts for more than a quarter of all participants. This is noted in bold text in Table 20.

Age distributions vary significantly across jurisdictions, reflecting both the service environment surrounding each Kids Hub and the local system's ability to attend to certain age cohorts. Policy leads noted that the system has increasingly shifted focus toward older, higher-risk children, and many Kids Hubs are able to concentrate resources on this cohort for the first time. In some locations, this shift is more pronounced due to the severity and complexity of presenting needs.

Kids Hubs which are co-located or work very closely with Child and Adolescent Mental Health Services (CAMHS) (such as Central Coast Medicare Mental Health Kids Hub), see disproportionately high numbers of older children whose developmental needs have escalated, leaving little capacity to work with infants. Conversely, Kids Hubs in Tasmania support a relatively high proportion of children aged 0–4. While the Tasmanian Kids Hubs are operationally delivered by CYMHS (formerly named CAMHS), staff report access to this younger cohort is supported by their integration and delivery within child and family learning centres, which are designed for this age group. Established reputations and sector relationships mean families with young children are already familiar or engaging with child and family learning centres and therefore more likely to attend than Kids Hubs without a specific infant focus. This is also true for Kid Hubs with established referral pathways from maternal and child health services.

5.1.2 Families are presenting with complex needs and face barriers to accessing services

Families and children accessing the Kids Hubs often present with a mix of emotional, behavioural, developmental, and social challenges. This is usually compounded by financial hardship, social isolation, complex family dynamics, and inconsistent access to other services. Children themselves may present with behavioural challenges, developmental or learning concerns, emotional distress, or difficulties functioning at home or school; and often need integrated support across family, school, and community environments.

[32] Head to Health Kids Initiative Literature and Policy Review, 2024.
[33] Head to Health Kids Initiative Literature and Policy Review, 2024.

Staff reported that parents and carers frequently need help understanding their child's needs, building confidence in parenting strategies, and overcoming previous negative service experiences. These families often require practical support, parenting guidance, and coordinated navigation through fragmented systems, particularly when services are overstretched or when children do not clearly meet thresholds for other programs.

The consumer data indicates many families reported experiencing multiple stressors, including financial stress, unstable housing, mental health concerns in the family, experience with family and domestic violence, and a family history of drug and alcohol concerns. Table 21 presents the total proportions of families who reported experiencing the following psychosocial factors.

Table 21 | Psychosocial factor by Kids Hub, as a percentage of total families in data collection period

Psychological factor	Percentage of total families
Engagement with developmental and/or behavioural sciences	47.5%
Financial stress	20.7%
Experience of violence, abuse, neglect and/or engagement with family violence services	19.4%
Experience of poor mental health and/or behavioural services	15.4%
Engagement with alcohol and other drug services	5.4%
Housing instability	5.2%

These findings largely reflect the patient data already collected by services, which often acts as a proxy for psychosocial needs and vulnerabilities rather than a complete picture of need. Staff and families consistently reported that most families are experiencing multiple overlapping challenges, including mental health concerns, family and domestic violence, financial stress, and broader family distress. These pressures are frequently compounded by significant worries about their children.

> "I feel guilty that as a parent I didn't pick up on what (child) needed. I was struggling, we just had so much going on"
>
> - Parent/carer

Staff across all Kids Hubs reported that families are more complex than initially expected, with families experiencing multiple, compounding challenges that increase stress and support needs. Families and staff reported that these multiple, compounding challenges in families often reduce their capacity to engage with services.

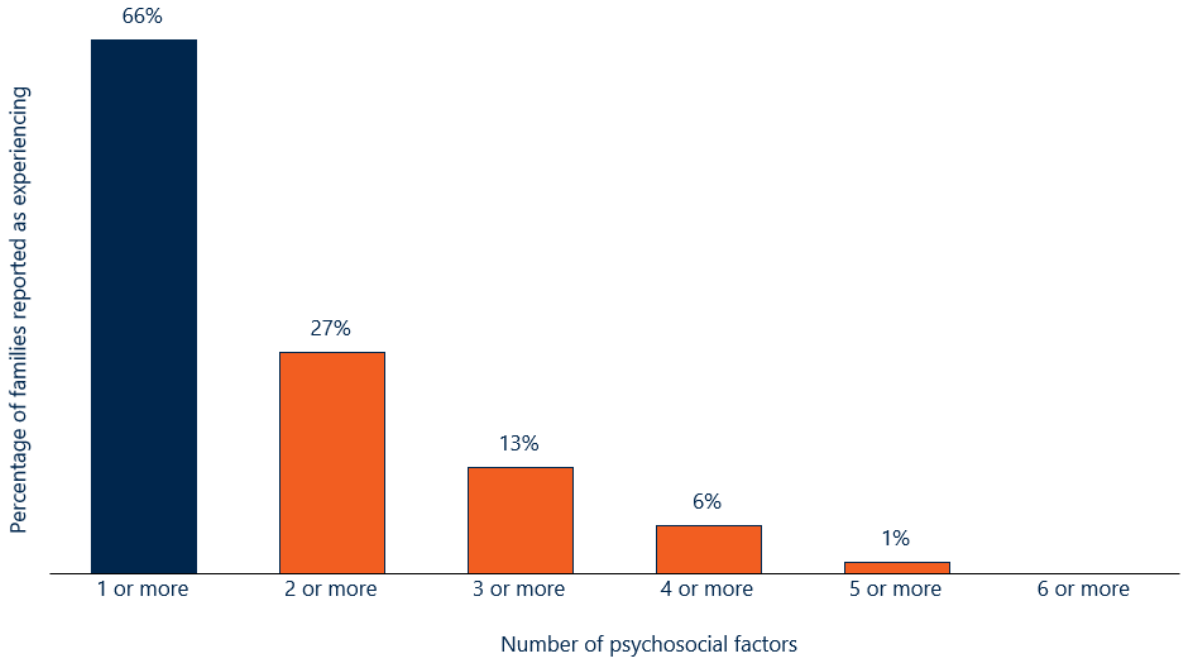
One staff member noted, "…no two families are the same." Each family requires a carefully considered, multidisciplinary individualised response.

Figure 2 shows the percentage of families that experience multiple psychosocial factors as reported through the consumer data. The most common combinations of co-occurring psychosocial factors are:

- Financial stress and experience of violence, abuse, or neglect (11.4 per cent of families reported).
- Financial stress and engagement with developmental and/or behavioural services (10.1 per cent of families reported).
- Engagement with developmental and/or behavioural services and experience of poor mental health and/or engagement with mental health services (10.1 per cent of families reported).
- Financial stress and experience of poor mental health and/or engagement with mental health services (9.6 per cent of families reported).

> "Everything escalated so quick because I was frustrated"
>
> - Parent/carer

Figure 2 | The percentage of families who reported experiencing multiple psychosocial factors



[Detailed image description:

This bar chart illustrates the proportion of families affected by varying numbers of psychosocial factors.

Key Details:

- Y-Axis: Percentage of families reported as experiencing psychosocial factors, ranging from 0% to 70%.
- X-Axis: Number of psychosocial factors experienced, ranging from '1 or more' to '6 or more.'

Data Points:

- 1 or more factors: 66% of families reported experiencing at least one psychosocial factor.
- 2 or more factors: 27% of families reported experiencing two or more factors.
- 3 or more factors: 13% of families reported experiencing three or more factors.
- 4 or more factors: 6% of families reported experiencing four or more factors.
- 5 or more factors: 1% of families reported experiencing five or more factors.
- 6 or more factors: No families reported experiencing six or more factors.

Visual Representation:

- The bar for '1 or more' is the tallest, coloured in dark blue, indicating the highest percentage (66%).
- Subsequent bars, coloured in orange, decrease in height as the number of psychosocial factors increases, reflecting lower percentages.

End of detailed image description]

5.2 Service uptake

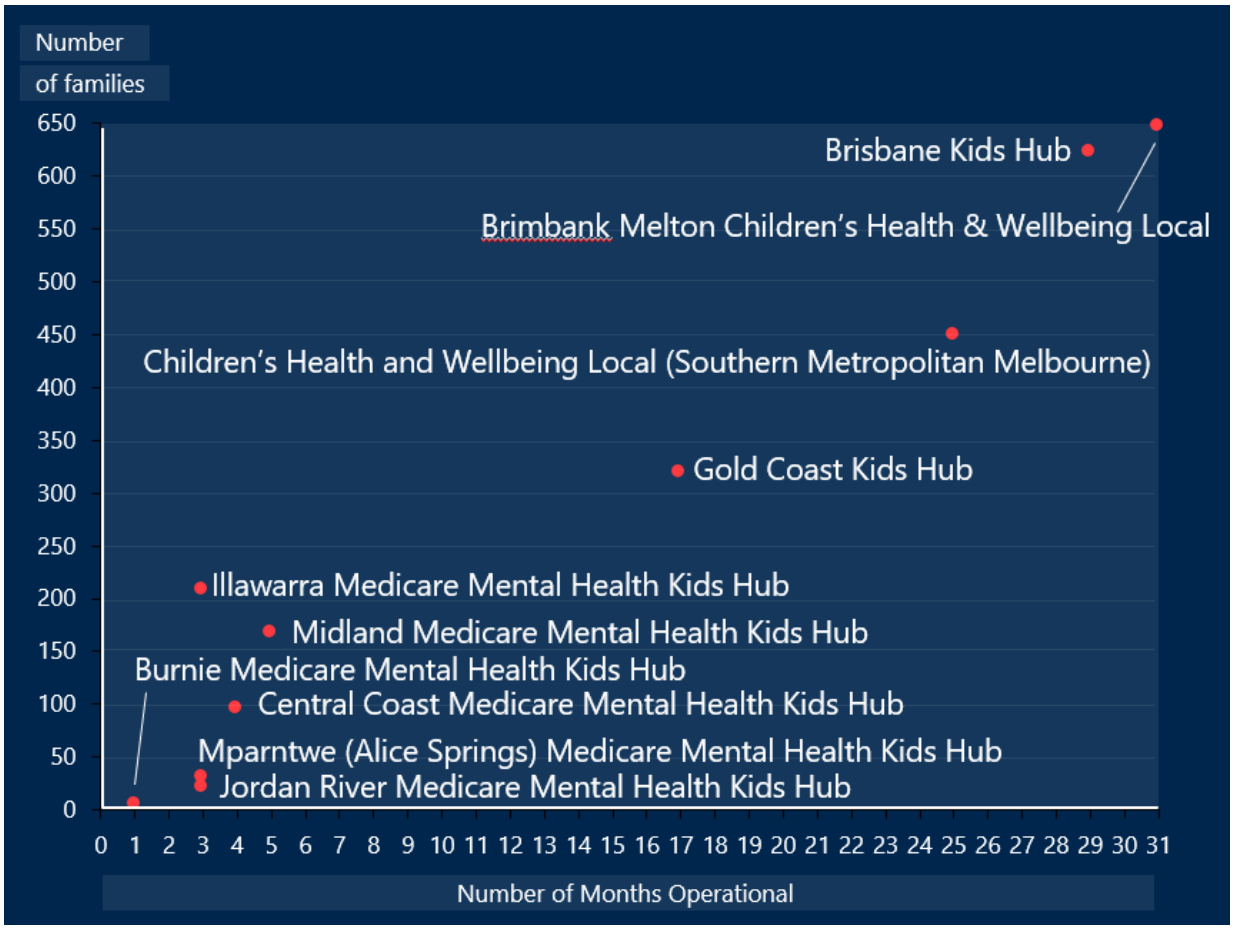
KEQ 2.4 | What is the uptake by cohort and location and how do participation rates compare to other services?

5.2.1 In the data collection period, the Kids Hubs supported 3,574 children and their families

Figure 3 shows the number of families who visited a Kids Hub for support from when the Kids Hub became operational up to 30 June 2025. These figures were reported to the Australian Department of Health, Disability and Ageing by each state and territory, not sourced from the quantitative primary data collection for the Evaluation.

Loddon Children's Health and Wellbeing Local has been operational since July 2023 but did not provide data for Figure 3. East Tamar Medicare Mental Health Kids Hub and Orange Medicare Mental Health Kids Hub were not operational in FY2025 and therefore did not provide data for Figure 3.

Figure 3 | Number of families who received support from the Kids Hubs up until 30 June 2025



[Detailed image description:

This graph illustrates the number of families supported by various Kids Hubs across Australia, plotted against the number of months each Kids Hub has been operational.

Axes:

- X-axis: Number of months operational (ranging from 0 to 31 months).
- Y-axis: Number of families supported (ranging from 0 to 650 families).

Key Observations:

1. Brisbane Kids Hub:
- Supported the highest number of families (approximately 600).
- Operational for around 31 months.

2. Brimbank Melton Children's Health & Wellbeing Local:
- Supported approximately 550 families.
- Operational for 31 months.

3. Children's Health and Wellbeing Local (Southern Metropolitan Melbourne):
- Supported around 450 families.
- Operational for 31 months.

4. Gold Coast Kids Hub:
- Supported approximately 300 families.
- Operational for 31 months.

5. Other Medicare Mental Health Kids Hubs:
- Includes Illawarra, Midland, Burnie, Central Coast, Mparntwe (Alice Springs), and Jordan River.
- Supported fewer families (ranging from 50 to 200).
- Operational for varying durations, with most under 10 months.

End of detailed image description]

5.2.2 Uptake by cohort varies significantly between Kids Hubs, likely attributed to distinct service models' targeting of certain priority populations

The Literature Review identifies Aboriginal and Torres Strait Islander children, children with disability, children who identify as CALD, and children with refugee or asylum seeker status as priority cohorts experiencing higher prevalence of mental health challenges and poorer access to services. The Model explicitly recognises that these children are at higher risk of mental health and wellbeing challenges and are systematically underserved by existing services. The data collected through the Evaluation indicates uptake in each of these priority cohorts.

Table 22 indicates the demographic factors in each Kids Hub. There is very high variation across Kids Hubs in the proportion of Aboriginal and/or Torres Strait Islander children likely due to different engagement with ACCO partnerships and perceived cultural competency by families (see Section 6.7 for more information).

Kids Hubs in Victoria have the highest representation of CALD communities. These communities are recognised as priority populations, with Kids Hubs establishing targeted partnerships to support their engagement (see Section 4.6 for more information).

Table 22 | Demographic breakdown by Kids Hub, as a percentage of total families in data collection period

Kids Hubs	Aboriginal and/or Torres Strait Islander	Culturally and linguistically diverse	Disability or chronic illness of the child	Refugee or asylum seeker status
Central Coast Medicare Mental Health Kids Hub	**28.40%**	1.90%	36.50%	0.90%
Illawarra Medicare Mental Health Kids Hub	**29.70%**	1.40%	39.10%	0%
Orange Medicare Mental Health Kids Hub	23.20%	1.80%	37.50%	0%
Mparntwe (Alice Springs) Medicare Mental Health Kids Hub	**99.10%**	0%	29.10%	0%
Brisbane Kids Hub	11.60%	0.80%	12.60%	0.30%
Gold Coast Kids Hub	11.30%	6.60%	3.10%	0.90%
Jordan River Medicare Mental Health Kids Hub	32%	0%	44%	0%
Burnie Medicare Mental Health Kids Hub	25%	0%	81.20%	0%
East Tamar Medicare Mental Health Kids Hub	15%	5%	20%	0%
Midland Medicare Mental Health Kids Hub	11.60%	5.40%	4%	0.40%
Brimbank Melton Children's Health & Wellbeing Local	5.20%	**24.50%**	0%	**3.50%**

Kids Hubs	Aboriginal and/or Torres Strait Islander	Culturally and linguistically diverse	Disability or chronic illness of the child	Refugee or asylum seeker status
Children's Health and Wellbeing Local (Southern Metropolitan Melbourne)	16.80%	19.30%	0.30%	**5.80%**
Loddon Children's Health and Wellbeing Local	14%	7.40%	3.20%	0.20%

Uptake by cohort varies significantly between Kids Hubs, likely attributed to distinct service models' targeting of certain priority populations. Table 23 presents some examples of this.

Table 23 | Where Kids Hubs have targeted priority populations and seen higher service uptake by these groups

Kids Hub	% of target priority populations	Detail
Mparntwe (Alice Springs) Medicare Mental Health Kids Hub Northern Territory	99.1% are Aboriginal and Torres Strait Islander Families	This Kids Hub is community governed and led with a strong reputation in the NT. This gives Aboriginal and Torres Strait Islander families confidence that programs reflect their cultural values, lived-experiences, and priorities. Kids Hubs are intentionally designed for Aboriginal and Torres Strait Islander children and families, with program models grounded in local knowledge, community expectations, and culturally responsive practice approaches.
Central Coast Medicare Mental Health Kids Hub New South Wales	28.45% are Aboriginal and Torres Strait Islander Families	Team leaders, staff, and Aboriginal Reference Group members reported that well-connected Aboriginal-identified roles (1 FTE) and two strong ACCHOs have enables collaborative ways of working at the Kids Hub.
Brimbank Melton Children's Health & Wellbeing Local South Australia	25.5% are CALD families and 3.5% are refugee families	This Kids Hub identifies CALD communities and recently arrived refugee or asylum-seeker families as priority cohorts, noting factors such as low health literacy, interpreter requirements, and cultural beliefs that may act as barriers to care. The Kids Hub has a formal partnership with Foundation House (a refugee and asylum-seeker support organisation),

Kids Hub	% of target priority populations	Detail
		strengthening referral pathways and support for refugee families with complex settlement or trauma-related needs. These targeted efforts operate in a community where almost 50 per cent of residents were born overseas and more than 55 per cent speak a language other than English at home, meaning the catchment inherently includes a higher proportion of CALD families.

Community health services and self-referral are the most common sources of referral.

Table 24 presents the distribution of accepted referrals to the Kids Hubs by source. Community health services account for over one-third of all referrals (33.9 per cent, illustrated by the orange bar), reflecting the strong integration of the Kids Hubs in existing local health service systems. Self-referrals, largely through walk-ins, make up just under one-fifth of referrals (19.1 per cent). Given that fewer than half of Kids Hubs currently accept walk-ins, this proportion is notable and suggests strong community awareness and accessibility where walk-ins are available. Other key referral pathways include schools (11.8 per cent) and unspecified 'other' services (14.1 per cent), demonstrating that the Kids Hubs draw on a diverse network of community-based referral points. Table 25 overleaf shows this data disaggregated by Kids Hub.

The proportion of referrals coming from different sources is highly inconsistent across locations due to locally shaped referral pathways, relationships, and system gaps. Many Kids Hubs have only one or two key referral sources, indicating where Kids Hubs have targeted referral pathways while they manage demand during implementation.

Table 24 | Proportion and number of referrals from each source, total

Referral source	Number and % of total referrals
Community health service	1146 (34%)
Self-referral	647 (19%)
Other	477 (14%)
School	399 (12%)
Family member	208 (6%)
Emergency or crisis service	198 (6%)
Paediatrician	88 (3%)
General Practitioner	74 (2%)
Psychiatrist/Psychologist	72 (2%)

Referral source	Number and % of total referrals
Aboriginal Medical Service	69 (2%)
Justice system	2 (0%)

Table 25 | Proportion of overall referrals received from each source, by Kids Hub

State	Kids Hub Location	Aboriginal Medical Service	Emergency or crisis service	Family member	General Practitioner	Other	Paediatrician	School	Self-referral	Community health service	Psychiatrist / Psychologist	Justice system
NSW	Central Coast Medicare Mental Health Kids Hub	2.4	0.5	1.4	0	5.2	0.9	31.8	36.5	21.3	0	0
NSW	Illawarra Medicare Mental Health Kids Hub	0	0	10.9	0.7	16.7	47.1	8	0	15.9	0.7	0
NSW	Orange Medicare Mental Health Kids Hub	0	1.8	5.4	7	5.4	8.9	3.6	0	67.9	0	0
NT	Mparntwe (Alice Springs) Medicare Mental Health Kids Hub	25.5	1	10	1	5.5	3	51.8	2.7	0	0	0
QLD	Brisbane Kids Hub	0	10.4	0.9	3.3	38.9	0	13.3	5.7	26.5	0.9	0
QLD	Gold Coast Kids Hub	0	0	0	1.6	76.2	0	0	0	21	1.3	0

State	Kids Hub Location	Aboriginal Medical Service	Emergency or crisis service	Family member	General Practitioner	Other	Paediatrician	School	Self-referral	Community health service	Psychiatrist / Psychologist	Justice system
TAS	Jordan River Medicare Mental Health Kids Hub	0	0	0	2	36	14	48	0	0	0	0
TAS	Burnie Medicare Mental Health Kids Hub	0	0	0	0	34.4	9.4	43.8	0	12.4	0	0
TAS	East Tamar Medicare Mental Health Kids Hub	0	0	5.1	2.6	25.6	0	59	0	7.7	0	0
WA	Midland Medicare Mental Health Kids Hub	1.4	0	56	1.4	20.6	1.1	14.8	1.1	2.9	0.4	0.4
VIC	Brimbank Melton Children's Health & Wellbeing Local	0	20.3	0.6	0.4	1.3	0	1.1	1.1	74.4	0.6	0.2
VIC	Children's Health and Wellbeing Local (Southern	2.3	2.3	0.8	2	0.5	0	30.3	0.3	56.7	4.8	0

State	Kids Hub Location	Aboriginal Medical Service	Emergency or crisis service	Family member	General Practitioner	Other	Paediatrician	School	Self-referral	Community health service	Psychiatrist / Psychologist	Justice system
	Metropolitan Melbourne)											
VIC	Loddon Children's Health and Wellbeing Local	2.1	6.4	1	3.7	0.5	0	0.7	50.7	30.9	3.8	0

Kids Hubs achieve greater uptake than comparable early-years and family services

Table 26 provides a brief overview of comparable early-years and family services: Early Years Places, Centre of Research Excellence (CRE) Child and Family Hubs, and Healthy Homes and Neighbourhoods (HHAN). More information on each comparable model is found in Appendix D.

Table 26 | Comparable early-years and family services

Early years and family service	Detail
Early Years Places	Integrated early childhood and family support hubs providing 'one-stop' access to multiple services under one roof. Early Years Places offer parenting programs, early learning activities (playgroups, early childhood education), child health clinics, nutrition and antenatal support, and family support services (like counselling, referrals for housing, or employment assistance).
Centre of Research Excellence (CRE) Child and Family Hubs	Child and Family Hubs co-locate paediatric healthcare (such as child and maternal health services) with family support, early childhood services, and social care on-site. The model's goals are early identification of family adversity (e.g. family violence, mental health issues, housing, or financial stress) and providing wrap-around support to prevent problems from escalating.
Healthy Homes and Neighbourhoods (HHAN)	HHAN does not prescribe an age range as it offers 'whole-of-family' wrap-around support led by a multidisciplinary team. HHAN is not a single site, but rather a networked service model that assigns each enrolled family a care coordinator (clinical nurse consultants, social workers, etc.) who works with the family over an extended period (often 12+ months).

Kids Hubs reach more families than similar child- and family-focused services operating at comparable intensity. Their uptake reflects their role as early-intervention, multidisciplinary hubs designed for younger children and families experiencing adversity. Key comparisons in service uptake between the Kids Hubs and comparable models include:

- Kids Hubs serve a broader age range than comparable early-years services, positioning them uniquely between early childhood and youth mental health systems. Unlike CRE Child and Family Hubs or Early Years Centres (0–8 years), Kids Hubs target children aged 0–12, filling a gap during the transition to adolescence. This wider cohort enables greater uptake by families who previously did not fit neatly into either early-years or youth mental health services and supports the transition into adolescence.

- Kids Hubs have strong uptake among Aboriginal and Torres Strait Islander families, exceeding comparable services. Early Kids Hubs data show approximately 17 per cent of families identify as Aboriginal and/or Torres Strait Islander; higher than Early Years Centres (approximately nine per cent). This suggests Kids Hubs' partnerships with ACCOs, and culturally safe staffing models are converting into meaningful service engagement.
- Kids Hubs reach 'hard-to-engage' families at similar or higher rates than existing early-years services. Kids Hubs focus on families facing adversity including disability, developmental concerns, and complex social circumstances. This aligns with CRE Child and Family Hubs, HHAN, and Early Years Centres; but Kids Hubs appear to be reaching a comparable or larger volume of these families while also offering on-site coordination and easier walk-in access.

6 KEQ 3 – Effectiveness

This section answers the following Key Evaluation Question:

KEQ 3 Effectiveness: What is changing as a result of the Kids Hubs, for whom, and how?

This section presents the Evaluation findings about the effectiveness of the Kids Hubs Model (Key Evaluation Question 3).

The Model has been designed for flexible implementation and delivery to adapt to local service contexts and family needs (as outlined in Section 4 Implementation). This section presents the evidence for how well the Kids Hubs are achieving the intent of the Model; both at a national and local level, and where impacts vary due to differences in implementation.

Each sub-section presents insights and evidence to answer the Evaluation's research questions under KEQ 3. Sub-sections are organised to first present questions that assess the effectiveness of underlying functions and mechanisms of the Model, before presenting findings against questions about the impacts. Finally, this section summarises how mechanisms and impacts are contributing to improvements in child and family mental health and wellbeing.

Findings in each sub-section are mapped to the relevant elements of the Kids Hubs Program Logic. Table 27 contains a summarised version of the Program Logic with elements relevant to this section.

Summary of findings

Impacts for children, families, and other stakeholders

- There is strong evidence the Kids Hubs are making progress on all elements of the Program Logic that drive improvements in child and family mental health and wellbeing.
  - The Model lowers access barriers to connect families with timely, flexible supports while managing demand. Ninety-five per cent of families reported it was easy and fast to access the Kids Hubs and 92 per cent reported their access to services had improved since going to the Kids Hubs.
  - The Model enables Kids Hubs to identify needs and challenges that can lead to poor mental health and wellbeing. Eighty-three per cent of staff agreed that the Kids Hubs processes were effective at achieving this, and profiles of families accessing the Kids Hubs (see Section 5) indicate these needs are being identified and supported.
  - Eighty-six per cent of children enjoy coming to the Kids Hubs 'a lot' and 97 per cent of parents were happy with their experience. Families report strong satisfaction is driven by tailored care and sense of safety.

Summary of findings

- Culturally competent care is emerging (93 per cent of families agreed they received care that respected their culture), with stronger outcomes where genuine community partnerships and cultural capability are established.

- Kids Hub staff and external stakeholders are generally satisfied with the Model and how it is working in practice. However, some report poor understanding of the role of the Kids Hubs, inefficient processes, and inconsistent leadership.
- A small number of unintended outcomes have emerged, including the positive outcome of families forming social connections with each other (such as friendships and support networks), and negative outcome of increased difficulty positioning Kids Hubs as a welcoming child and family service following Medicare Mental Health re-brand.

Mechanisms and activities at the Kids Hubs

- Kids Hubs fill early-intervention gaps for underserved families while strengthening access through integrated partnerships and referral pathways.
- Most Kids Hubs are collaborating well with partner organisations, but operational challenges and fragmented communication limit the effectiveness of this. More than 60 per cent of referral partners did not agree that Kids Hub systems and processes support integrated care between them.
- Multidisciplinary ways of working facilitate collaborative care delivery and planning, with 73 per cent of staff agreeing their team collaborates effectively. Ineffective systems and processes hinder information sharing between staff. Only 47 per cent agreed that current data and IT systems effectively support integrated care.
- The Kids Hubs generally support improvements in workforce capability and capacity through training, multidisciplinary ways of working, and partnerships. Capacity constraints and weak clinical governance hinder this in some Kids Hubs.
- Kids Hubs are connecting families to new services and 'holding' them through warm handovers, but effectiveness is inconsistent between Kids Hubs and between families. Only half of referral partners agree that referral pathways adequately support transitions out of the Kids Hubs.

Table 27 | Summarised Program Logic with elements relevant to KEQ 3 Effectiveness

Mechanisms of change	Outputs	Outcomes	Benefits

• **Broad access and referral approach:** By adopting a broad access and referral approach (not based on a diagnosis or ability to pay), vulnerable children do not experience delays and will get the help they need.
• **Integration and coordination:** By integrating and coordinating with other parts of the system, the Kids Hubs provide timely access and assessments of needs. Children and families are more likely to receive effective early support that is holistic, considers all factors, and addresses root causes.
• **Individualised and culturally appropriate care:** By providing individualised and culturally appropriate care via multidisciplinary teams and local partnerships, children and families are more likely to engage in the service (particularly those who are more vulnerable, typically hard to
	• **Children and families**
	  • Free and easily accessible hub service for children and families.
	  • Improved referral pathways for children and families.
	  • Free services for children and families.
	  • Culturally safe, and flexible care to meet the needs of children and families.
	  • Early identification of issues/needs known to lead to poorer mental health, leading to referral to appropriate services.
	• **Sector**
	  • Staff are appropriately skilled and qualified.
	  • Staff work collaboratively as a team and in partnership with local services and organisations.
		Immediate – during/post service
		• **Children and families**
		  • More timely access to support services.
		  • Reduced stigma associated with seeking help.
		  • Positive experience of seeking help for mental health concerns.
		  • Improved mental health and wellbeing.
		  • Improved mental health literacy.
		  • Improved opportunities for connection.
		• **Sector**
		  • Kids Hubs teams and system stakeholders are satisfied with the Model and how it is working.
		  • Increased clinical supervision, professional development, and training opportunities for multidisciplinary teams.
		<u>Medium-term</u>
		• **Children and families**
		  • Increased help seeking behaviour and reduced stigma.
		  • Increased planned engagement with appropriate and holistic services.
			• **Children and families**
			  • Universal access to safe, multidisciplinary, and low-cost care.
			  • Increased mental health resilience.
			  • Improved mental, behavioural, and developmental outcomes.
			  • More engaged with early childhood education and school.
			• **System**
			  • Integration/effective collaboration of services related to the mental health, safety, and wellbeing of children.

Mechanisms of change	Outputs	Outcomes	Benefits

reach, or have had negative service-system experiences).
• **Collaborative care coordination and planning:** Through collaborative care coordination and planning, the Kids Hubs support children and families to navigate multiple service providers or transition to new services. By doing this, children and families will be more likely to continue with care for longer periods.
• **Workforce opportunities:** The Kids Hubs provide additional workforce opportunities through multidisciplinary care teams, supportive opportunities for professional growth, and student placements.
	• The model reflects innovative, place-based approaches to care.	• Improvement in broader biopsychosocial drivers of poor mental health and wellbeing.
		• **Sector**
		  • Improved multidisciplinary collaborative care within the Kids Hub and with external services.
		  • Staff have increased job satisfaction.
		  • Clear protocols for the sharing of information and care coordination.
		The Kids Hubs Model of Care improves and contributes to evidence-based practice.	

6.1 Kids Hubs enhance local service systems by addressing early-intervention gaps for underserved children and families, through integrated partnerships and referral pathways

KEQ 3.3 | To what extent are the Kids Hubs complementing and enhancing the existing services in each location?

This section answers Key Evaluation Question 3.3. Findings are presented against the following mechanisms and outcomes in the program logic:

- Co-design processes deliver place-based Kids Hub service delivery models that meet local need and complement existing services.
- Establishment of partnerships and relationships between Kids Hubs and local services including Aboriginal Community Controlled Organisations and communities.
- Improved knowledge and capacity of the existing workforce to identify and respond to early signs of child mental health and wellbeing challenges.

This sub-section outlines how effectively the Kids Hubs are complementing existing services and enhancing connectivity of the broader system.

6.1.1 The Kids Hubs complement existing services and address service gaps by providing earlier intervention to an underserved cohort

Kids Hubs fill a critical gap between universal and specialist services by supporting children with mild to moderate mental health needs, neurodevelopmental challenges, and family vulnerabilities (as outlined in Section 3.1). Staff and team leaders in several jurisdictions noted that there is no comparable early-intervention mental health service for children aged 0-12. Staff noted that the Model is designed to sit between child and maternal health services and CAMHS/CYMHS, bridging the gap between universal health and development assessments, and targeted support for severe and/or acute mental health and wellbeing issues. Families described waiting up to two years for single-discipline supports (e.g. paediatricians, diagnostic, and allied health services), with fragmented and unclear referral pathways compounding these delays.

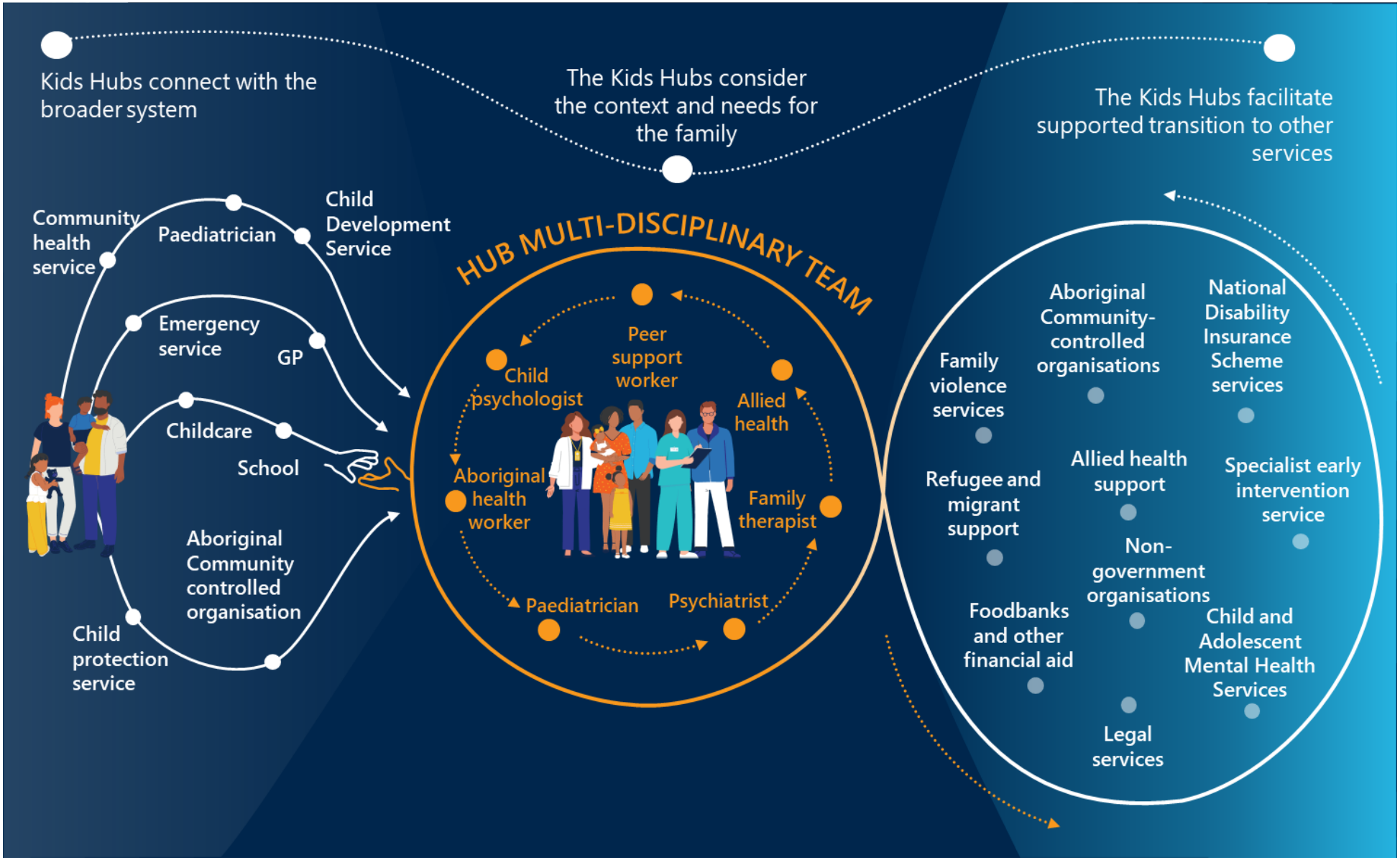
> "A service targeting this age group has never existed – the only existing mental health service for this age group has been CYMHS for moderate–severe needs."
>
> - Team leader

As a secondary-level, community-based service, Kids Hubs address these system gaps by offering flexible, multidisciplinary early-intervention supports and navigation that can be accessed without a diagnosis, general practitioner (GP) referral, or out-of-pocket costs. This provides a practical and accessible service for families who may otherwise fall through the gaps.

The Kids Hubs are a free service that does not require a Medicare card or diagnosis, which removes financial and structural barriers and enables genuine early access for families who benefit most. Staff noted that families facing psychosocial challenges, language barriers, or low health literacy are often not engaged with a GP and are therefore unlikely to be reached by GP-only referral pathways. Even Kids Hubs that do not accept walk-ins maximise access by partnering with other community touchpoints, such as schools and community health and development services. More information on how the Kids Hubs improve access to supports for families is in Section 6.5.

Figure 4 illustrates how the Kids Hubs support pathways between universal and community supports and more targeted services through established referral pathways and supported outreach.

Figure 4 | Where the Kids Hubs are situated between community and tertiary or specialist supports



[Detailed image description:

This diagram illustrates the role of Kids Hubs as secondary-level services that connect families to community and specialist supports. It is divided into three sections: community services, the multidisciplinary team at the core of the Kids Hubs, and tertiary or specialist supports.

Community Services

On the left, community services are depicted as entry points for families. These include:

- community health services
- paediatricians
- emergency services
- general practitioners (GPs)
- childcare
- schools
- aboriginal community-controlled organisations
- child protection services
- child development services.

Families and carers access these services, which then connect them to the Kids Hubs for additional support.

Hub Multidisciplinary Team

At the centre of the diagram is the multidisciplinary team within the Kids Hubs. This team coordinates care based on the family's context and needs. It includes:

- peer support workers
- allied health professionals
- family therapists
- psychiatrists
- paediatricians
- aboriginal health workers
- child psychologists.

The team works collaboratively to provide holistic support for behavioural, developmental, and psychosocial challenges.

Tertiary or Specialist Supports

On the right, tertiary and specialist supports are shown as services that the Kids Hubs facilitate transitions to. These include:

- Aboriginal community-controlled organisations
- National Disability Insurance Scheme (NDIS) services

- specialist early intervention services
- Child and Adolescent Mental Health Services
- allied health support
- non-government organisations
- family violence services
- refugee and migrant support
- foodbanks and financial aid
- legal services.

Key Functions of the Kids Hubs

- **Connection to the broader system:** The Kids Hubs identify children, families, and carers who would benefit from holistic support through partnerships with community services.
- **Coordination of care:** The multidisciplinary team addresses the family's needs through integrated care.
- **Facilitating transitions:** The Kids Hubs support families in accessing specialist services based on local availability and capacity.

This diagram highlights the Kids Hubs' role in bridging the gap between universal services and targeted support for acute mental health challenges and social wellbeing concerns.

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6.1.2 Kids Hubs are creating seamless referral pathways, and increasing access to support for families, through partnerships and other arrangements

Nationally, the Kids Hubs are complementing existing services by building new partnership structures, co-location arrangements, and coordinated referral pathways. An overview of the partnerships established in each jurisdiction is found in Section 4.6.

All Kids Hubs have created extensive partnership and consortium arrangements that connect the Kids Hubs with local services and agencies. Beyond governance agreements, most Kids Hubs are using partnerships for referral pathways, co-location, in-reach/outreach, and supported transition through warm handovers – all of which enhances the way existing services work together around families.

The Evaluation found that Kids Hub team leaders worked closely with partner organisations through the co-design and early implementation to ensure alignment and to avoid duplication. Partnerships and other arrangements are established for multiple purposes (Table 18), which support the integration of the Kids Hub with the existing service system (Table 28).

Table 28 | How different partnership arrangements enable integration

Arrangement purpose	Impacts on service integration and identification of children and families
Co-location	Co-location supports system integration by placing services and practitioners in the same physical environment which strengthens collaboration, information-sharing, and coordinated care. It reduces access barriers by embedding services alongside those already used by families, helping identify children earlier through shared referral pathways and warm handovers (e.g., Kids Hubs co-located with existing child, family, and disability services)
Service in-reach	Service in-reach places Kids Hub clinicians directly in community settings, supporting integration and building local capability. By working alongside schools and services, clinicians help partners better identify families who need support, embedding early intervention within existing system structures.
Consortia	Consortia arrangements support system integration by bringing together organisations with aligned values, complementary expertise, and established relationships - enabling shared planning, multidisciplinary responses, and warm referral pathways.
Referral partners	Referral partnerships enable 'no wrong door' access, warm handovers, and shared care approaches using collaborative pathways that reduce fragmentation within the system and ensure families are connected to the most appropriate supports. Strong relationships with schools, health services, NGOs, and ACCOs improve visibility of vulnerable families and streamline referrals so children are not lost between services.
Multi-agency working groups/steering committees	Involving representatives from multiple agencies in co-design helps ensure stronger system-wide buy-in and results in a model that aligns more closely with how the current system operates and what already exists. This collaborative approach also helps ensure that new initiatives are appropriately aligned with existing structures, services, and ways of working - reducing duplication and supporting smoother implementation.

Staff and partners across different jurisdictions described how Kids Hubs are bridging gaps between services, supported by clearer communication channels, quicker feedback loops, and stronger cross-sector relationships. For example:

- In Loddon Children's Health and Wellbeing Local, team leaders reported holistic cross-agency collaboration around individual families (across Victorian Child Protection Service, Maternal and Child Health, and schools) creating more seamless service journeys.
- In the Brisbane Kids Hub, the Kids Hub teams said they often act as mediators between schools, parents, and referral partners; helping resolve strained communication and ensuring families understand next steps.
- At Brimbank Melton Children's Health & Wellbeing Local, the Kids Hub leaders highlighted how weekly team meetings, joint appointments, and case-conferencing with partner organisations reduce siloing and create more integrated pathways; improving the consistency of how families move through the system.

Referral partners generally perceive the Kids Hubs as responsive, collaborative, and able to engage families who other services struggle to reach; with two-thirds of referral partners surveyed agreeing the Kids Hubs' care-coordination efforts help families navigate multiple providers.

The extent to which partnerships are enabling effective collaboration between the Kids Hubs and other primary, secondary, and specialist care services is discussed in Section 6.2 below.

6.1.3 Some Kids Hubs are seeing families with increasing complexity, at times with a child with needs beyond their intended mild-to-moderate scope, driven by broader system capacity constraints

Some staff described operating beyond the Kids Hub's intended mild-to-moderate scope, primarily due to system capacity pressures and the level of unmet demand for this cohort. Most Kids Hubs reported engaging with families with very high psychosocial complexity and, in some cases, children with long-escalating moderate-to-severe developmental concerns that do not fall under early intervention.

In the Midland Medicare Mental Health Kids Hub, capacity constraints in CAMHS, Child Development Services, and paediatric services (combined with low access barriers and at times an unclear understanding of the Kids Hub's role by referral partners, see Section 6.5) have resulted in higher-acuity presentations to the Kids Hubs. Due to very open access pathways to the Kids Hub and an absence of appropriate alternative services, the Kids Hub has stretched to absorb caseloads and prevent families falling through system gaps.

> "All our work is relational and based on trust, so if we're in these spaces but can't deliver, we just contribute to the access barriers."
>
> - Staff member

6.2 Most Kids Hubs collaborate well with partner organisations and other services, but operational and communication challenges limit effectiveness

KEQ 3.4 | How effective is collaboration between the Kids Hub and other primary, secondary, and specialist care services?

This section answers Key Enquiry Question 3.4. Findings are presented against the following mechanisms and outcomes in the program logic:

- Co-design processes deliver place-based Kids Hub service delivery models that meet local need and complement existing services.
- Establishment of partnerships and relationships between hubs and local services including Aboriginal Community Controlled Organisations and communities.
- Improved multidisciplinary collaborative care within the Kids Hub's multidisciplinary teams and with external services.
- Improved availability, sustainability, and effectiveness of the mental health workforce and services.

This sub-section outlines the effectiveness of partnerships at enabling collaboration and care coordination between services. An overview of what types of partnerships (including types of partnerships and their purpose) have been established across jurisdictions and how is outlined in Section 4.6).

6.2.1 The Kids Hubs have established effective mechanisms for collaboration with partner organisations to enable service integration and referral pathways

The Evaluation has found that where Kids Hubs invest in collaborative ways of working with partners, they build efficient referral pathways, smooth stepped-care transitions, and coordinated responses for families. Collaboration between the Kids Hubs and other services improves the timeliness, appropriateness, and coordination of referrals, reduces duplication, and enables more seamless transitions between services.

Kids Hubs have established several mechanisms to promote collaboration with partners, including:

- **Co-design of the local service model with partners:** Across jurisdictions, local models were co-designed with key partners to define the Kids Hub's role in the local service system, clarify who the Kids Hub is for, and determine how it would sit alongside existing services. An overview of co-design processes is outlined in Section 4.1. Partners helped determine local service offerings, inform referral pathways and access points, and identify priority cohorts and gaps in the current system, so that each Kids Hub complemented rather than duplicated other services.

  This process strengthened collaboration by clarifying roles, reducing duplication, establishing shared referral processes, and creating ongoing mechanisms for joint problem-solving. How

well the Kids Hubs complement and enhance existing service landscapes is outlined in Section 6.1.

- **Joint referral coordination:** Many Kids Hubs are working closely with referral partners to coordinate referrals and funnel families to them. Collaborative referral processes consistently lead to clearer decision-making about appropriateness, smoother referral pathways, and stronger working relationships between the Kids Hubs and partner organisations.

  These mechanisms reduce duplication, ensure families are directed to the right service earlier, and support shared understanding of roles and capabilities. In some Kids Hubs (such as those in Tasmania) several partner agencies come together with the Kids Hub to discuss referrals and ensure families are directed to the right service. Team leaders describe this as "…highly valued…" for ensuring referrals are appropriate and the service will be able to respond.

- **Stepped care through close collaboration with acute services:** Some Kids Hubs are collaborating closely with CYMHS/CAMHS and other acute services as a service provider; through co-location, or through governance. Staff at these Kids Hubs describe how collaboration enables smooth triage, clear stepped-care pathways, warm handovers, and efficient referrals between the Kids Hub (mild-moderate needs) and CYMHS/CAMHS (severe, acute needs). Where Kids Hubs sit within CYMHS governance structures, this alignment has enabled streamlined referral processes, quicker escalation when required, and regular cross-team discussions to coordinate care.

- **Warm handovers to new services:** Kids Hubs are working closely with referral partners to support warm handovers to new services (see Section 6.8). This involves staff directly contacting the receiving service, passing on essential information, and remaining the key contact until the family is safely 'picked up' by the receiving service. The Kids Hubs have sometimes remained in the care team after handover for an interim period to ensure service engagement.

  These practices create more direct communication between staff, improve shared understanding of family needs, and build trust and responsiveness across services. Consultations with partners and families indicate that handovers work well where strong relationships and processes exist, with staff noting families arrive more confident and engaged. Partners value the responsiveness and joint problem-solving enabled through this practice, which is emerging as an effective mechanism for strengthening coordination and reducing drop-off.

- **Building partner capability and shared understanding of roles, eligibility, and referral pathways**: Kids Hubs are working closely with partner organisations to strengthen shared understanding of the types of families who will most benefit from the Kids Hubs, and how referral pathways should operate. Kids Hub staff described collaborating with partners through secondary consultation, informal pre-intake discussions, and joint review of referrals to ensure referrals are appropriate and well-supported. Kids Hubs are also actively building partner capability by defining their service offering alongside other services and encouraging referrers to identify alternative supports where appropriate. Some Kids Hubs work closely with teachers to strengthen their ability to recognise emerging concerns, trial classroom strategies, and manage lower-level issues in the classroom. Staff noted that this support can reduce the need

for formal referral, or, where referral is still required, ensure it is more targeted and collaborative.

These approaches are mechanisms that strengthen collaboration, helping partner organisations become more capable and self-sufficient while maintaining strong collaborative relationships for ongoing support. More information on building partner capability is in Section 6.2.

- **Integrating service delivery with partners through co-location and on-site delivery:** Some Kids Hubs are co-locating in community health services, child and family learning centres and school sites, and operating from temporary or satellite partner locations while permanent spaces are secured. Co-location, satellite delivery, and on-site supports create the conditions for stronger collaboration by enabling instant interaction, shared decision-making, and early identification of needs.

  These mechanisms translate into more accurate and timely referrals, smoother handovers, and more integrated support planning. Staff reflected that being physically alongside partners enables constant informal collaboration such as through quick discussions, warm handovers, and ad-hoc multidisciplinary input.

> "Fragmented pathways and coordination challenges in some states and territories have meant it takes additional time to build the foundations for effective service delivery, including establishing new partnerships, developing shared protocols, and creating clear pathways between services."
>
> - Interim Report

6.2.2 Collaborative co-design with partners has enabled stronger working relationships and more effective referral processes

Partnerships established through early and genuine consultation and co-design operate more effectively from the outset, with buy-in and smoother integration between services. Co-design informed referral pathways by mapping what services already exist and where the gaps were. The result is more coordinated transitions and warm handover processes both when families completed a period of support with the Kids Hub, and when the Kids Hub was not the most appropriate option at the outset. These clearer pathways reduced the likelihood of families being turned away without support or falling through service gaps. For more information on how partners were involved in co-design, see Section 4.1.

6.2.3 Operational challenges and fragmented communication limit the effectiveness of collaboration

Most stakeholders valued partnerships and recognised their importance to the Model, however inconsistent partner involvement in co-design has caused operational issues once the Kids Hubs began accepting referrals. Kids Hubs and partner organisations report ongoing operational challenges that impact service delivery. Key challenges include:

- **Different organisational systems and processes** between Kids Hubs and referral partners creates significant operational challenges, contributing to siloed practice, duplication of effort, and fragmented care. Separate client management systems undermine continuity of care and risk management, while data and information technology systems are widely seen as ineffective for supporting integrated working. This is reflected nationally, with **fewer than 40 per cent** of referral partners surveyed agreeing that current systems support integrated care (38 per cent, n=53). Staff and referral partners described a reliance on incompatible eMRs, templates, and governance arrangements, alongside clunky and unfit-for-purpose referral forms, all of which impede seamless information sharing and coordination.
- **Unclear and iterative eligibility requirements** can lead to inconsistent acceptance of referrals and poor feedback loops. Referral partners reported confusion about service scope, especially during early implementation as the Model is being refined.
- **Low workforce capacity** limits relationship-building and sustainment. Part-time workforces, high turnover, and a reliance on personal relationships hinder sustained engagement with partners.

Consultations and surveys with staff and referral partners indicate that nationally, partnerships are working well. Satisfaction is explored further in Section 6.10.

6.2.4 Some referral partners reported poor understanding of the role of the Kids Hubs

Consultations revealed a wide variation in how referral partners understood the purpose and focus of the Kids Hubs, with some expecting diagnosis (in Kids Hubs that do not offer it), some expecting behavioural management, and others expecting high-intensity therapeutic intervention. This was particularly the case in Kids Hubs experiencing recruitment challenges – the absence of a full multidisciplinary team and key clinical roles means that some referral partners did not understand how a Kids Hub is distinct from other existing services.

Many referral partners reported confusion about what constitutes an appropriate referral. Kids Hub staff reflected that it seems some referral partners see the Kids Hubs as an 'easy' referral solution (especially when waitlists to other services are long) without properly understanding the service or scope of support available. This creates challenges in receiving suitable referrals and providing support to target cohorts. At one Kids Hub, referrers stated that early advertising didn't match how the Model eventually evolved. This resulted in inappropriate referrals, parents arriving without understanding the Kids Hub's purpose, and schools sending children when neither the school nor parents had clarity on the issues. In another Kids Hub, miscommunication about catchment boundaries led to confusion about who could be referred and what the Kids Hub would provide.

Referral partners and staff reported that communication can be disjointed or inconsistent. Most referral partners surveyed (**73 per cent**, n=55) **agree** that there are effective and efficient communication channels and information sharing mechanisms to support care coordination with the Kids Hub, with eight per cent disagreeing or strongly disagreeing with this statement. Consultations echoed this variability; despite overall satisfaction, many expressed the desire for more regular operational updates from the Kids Hubs, including changes to waitlist length, eligibility criteria, and availability of multidisciplinary supports.

Referral partners also value ongoing updates about referred families and their progress to support the continuity and coordination of care. Some referral partners shared their frustration at needing to repeatedly follow-up with the Kids Hub for outcomes of referrals, or referrals being denied without explanation.

6.2.5 Strong partnerships with ACCOs work best when they are flexible, involve Aboriginal and Torres Strait Islander leadership, and are built on trust and genuine relationships rather than formal or transactional approaches

There is established evidence that effective engagement with Aboriginal and Torres Strait Islander populations depends on building trust and relationships in communities. In efforts to reach and connect with these communities, some Kids Hubs have focused more on building partnerships with ACCOs and other community organisations, as outlined in Section 4.6.

ACCOs help Kids Hubs reach communities because they are already embedded in local networks, using long-standing relationships, cultural programs, and grassroots outreach to build the trust and rapport that families recognise and respond to. Kids Hubs with ACCO partnerships experience higher uptake from Aboriginal and Torres Strait Islander communities. Four in five engaged Aboriginal families are accessing Kids Hubs with ACCO partners.

However, effectiveness of partnerships with ACCOs varies across sites. Some Kids Hubs described lower levels of engagement and collaboration with these partners, including a low number of referrals to the Kids Hub. Consultations with staff and ACCO partners at these sites revealed the Kids Hub had invested less time in relationship building and community in-reach. Partnerships are strengthened when Kids Hub staff work at the ACCO's pace and create the time, space, and autonomy needed for relationships and meaningful activities to develop organically.

One Kids Hub partnered with an ACCHO for service delivery, including funding in-reach positions and planned permanent cultural roles, but did not invest in the relationship-building needed to make the partnership work. As a result, the partnership became 'dysfunctional', with unclear expectations, poor communication, and minimal engagement.

Further enablers of effective ACCO partnerships include:

- Flexible, needs-driven partnerships: The Model's flexibility allows partnerships to form around priority community needs, with services co-delivered in locations that work for families and ACCOs.
- Cultural leadership at the centre: Having an Aboriginal and Torres Strait Islander-identified role at a Kids Hub (including the right Aboriginal and Torres Strait Islander leader with cultural authority, confidence, and capability) drives trust, shapes the partnership, and fosters staff engagement.
- Culturally competent care and recognition of the expertise of community: ACCOs are more likely to encourage Aboriginal and Torres Strait Islander families to engage with the Kids Hub when they are confident that care is culturally appropriate competent, and the expertise and role of the ACCO and the community is recognised and respected. See Section 6.7 for further detail on cultural competency of the Kids Hubs.
- Trust-based, community-grounded approach: Prioritising time, trust, and genuine connection over medical-model or resource-driven approaches ensures partnerships are grounded in community confidence and existing trusted relationships.
- Shared understanding and complementary roles: Developing a clear, shared understanding of ACCO roles, value, and capacity ensures the Kids Hub complements rather than burdens ACCOs, helping address capability gaps and strengthen capacity through genuine partnership.

6.3 Multidisciplinary ways of working facilitate collaborative care delivery and planning, but ineffective systems and processes hinder information sharing between staff

KEQ 3.5 | To what extent do the Kids Hubs facilitate information sharing and collaborative care planning within the Kids Hubs?

This section answers Key Evaluation Question 3.5. Findings are presented against the following mechanisms and outcomes in the program logic:

- Multidisciplinary team members have respect and trust for each other and a clear understanding of each discipline's roles, skills, and scope practice in supporting children and families.
- Improved multidisciplinary collaborative care within the Kids Hub's multidisciplinary teams and with external services.
- Improved knowledge and capacity of the existing workforce to identify and respond to early signs of child mental health and wellbeing challenges.
- Improved availability, sustainability, and effectiveness of the mental health workforce and services.

This sub-section outlines how effectively the Kids Hubs are collaborating within multidisciplinary teams.

6.3.1 Multidisciplinary and interdisciplinary approaches operate along a continuum across the Kids Hubs, enabling holistic support, shared information, and collaborative care planning

Both the Strategy and the Model recognise that children's mental health and wellbeing is shaped by interconnected factors and rarely exists in isolation. The Model acknowledges that many children and families have complex support needs that cannot be met by a single service or discipline, reinforcing the need for collaborative and multidisciplinary approaches.

The Evaluation found that collaboration in multidisciplinary teams is strong overall. **Seventy-three per cent** (n=83) **of Kids Hub staff agreed** their team collaborates effectively to support the complex needs of children and families, and 65 per cent reported it has been easy to collaborate with colleagues when delivering support. Staff consultations reinforced this, with many describing multidisciplinary teamwork as **one of the most rewarding aspects of the Model**, and central to planning and delivering holistic and coordinated care.

Staff frequently describe the multidisciplinary team structure as one of the most effective and rewarding aspects of the Model. The characteristics of effective multidisciplinary collaboration are described as:

- shared goals
- open communication
- flexibility in adapting approaches.

Multidisciplinary team members have respect and trust for each other and a clear understanding of each discipline's roles, skills and scope practice in supporting children and families.

- A short-term outcome listed in the Program Logic (see Appendix A)

Kids Hubs with robust multidisciplinary teams are those with minimal workforce gaps and an ideal ratio of clinical and non-clinical support staff. At these Kids Hubs, staff report delivering integrated, flexible, and holistic care, where practitioners from different disciplines work together to respond to complex, co-occurring child and family needs.

Because the Model is designed to be flexible and Kids Hubs are at different stages of maturity, multidisciplinary ways of working look different across jurisdictions. Some Kids Hubs are still in early stages of implementation, with workforce composition and team processes continuing to evolve. More mature Kids Hubs have expanded their staffing profiles and report stronger collaborative practices, clearer roles, and more consistent delivery of multidisciplinary support. Examples of differences in multidisciplinary team approaches across the Kids Hubs are included in Table 29.

Table 29 | Examples of multidisciplinary team approaches

Jurisdiction	Approach	Insights
Queensland	The Brisbane Kids Hub previously implemented paired practice approaches. Staff from complementary backgrounds (such as lived-experience workers and clinicians) partnered to engage families and deliver support.	Staff reported that this pairing helped teams build rapport with families quickly and reduce barriers to engagement. This approach was later discontinued, and staff noted that family engagement now takes longer, with fewer opportunities to establish trust early.
Victoria and New South Wales	Two Kids Hubs (one in Victoria and one in New South Wales) hold multidisciplinary case review and intake meetings to ensure all disciplines contribute to decision-making. This structure ensures families receive holistic support and allows the team to refine practices collectively.	In Illawarra Medicare Mental Health Kids Hub, while this approach built shared understanding and supported consistent clinical reasoning, staff reported it was resource-intensive and not sustainable long-term. The team has since refined the process to balance inclusiveness with operational efficiency.

Jurisdiction	Approach	Insights
Northern Territory	In Northern Territory, the Kids Hub model supports multidisciplinary collaboration. They do this through bi-cultural working arrangements. Aboriginal support workers and clinical staff work together to support families, ensuring cultural safety and continuity. The approach deepens cultural insight, strengthens engagement, and supports trust-building with Aboriginal families.	Staff reflected this approach reflects local context and community need but requires substantial training and coordination; particularly given workforce shortages and recruitment challenges in Central Australia.

Consultation with team leaders and staff suggest that while most Kids Hubs operate in a multidisciplinary manner, several reported moving toward an interdisciplinary model. Interdisciplinary team functioning involves multidisciplinary team staff blending expertise and sharing responsibility for joint goals. Roles overlap, collaboration begins early (often at intake), and team members learn from each other to deliver integrated care.

An interdisciplinary approach is characterised by shared care planning, overlapping roles, and joint engagement with families. In practice, this includes:

- **Joint intake or triage:** Two or more disciplines conducting the initial assessment together, forming shared hypotheses early.
- **Shared care planning:** Family goals developed collaboratively in a single meeting rather than discipline-specific plans stitched together later.
- **Co-delivered sessions:** For example, a psychologist and occupational therapist running sessions together, or paediatrician attending part of a team meeting to support clinical reasoning across the group.
- **Flexible role boundaries:** Staff stepping beyond traditional scopes (e.g., social worker supporting emotional regulation work guided by psychologist; occupational therapist supporting functional routines guided by paediatric advice).
- **Warm handovers within the team:** Rather than referrals, practitioners jointly meet with families to transition between supports.
- **Team-based problem-solving:** Regular case conferencing where the team works on a single case together.

These approaches appear to strengthen continuity of care, streamline communication, and support more holistic responses to complexity.

Reported benefits of interdisciplinary ways of working include:

- **More integrated experience for families:** Families see fewer people, avoid repetition and double handling, and receive coordinated support without siloed handoffs.
- **Earlier identification of needs:** Shared clinical reasoning captures interacting co-occurring earlier.
- **Greater responsiveness:** Overlapping roles mean care continues even with workforce shortages.
- **Supports upskilling across the team:** Disciplines learn from each other in real time.

6.3.2 Multidisciplinary teams reported that communication pathways, IT systems, and resourcing constraints hinder information sharing

Kids Hub staff also highlighted conditions that make collaboration and information sharing challenging. Some reported limited time for integrated multidisciplinary teamwork, unclear or evolving processes, and communication gaps driven by high demand and stretched resourcing. These experiences are reflected in the quantitative results (Table 30): 53 per cent of staff agreed their Kids Hub has clear systems, protocols and communication pathways, however 63 per cent did not agree that current data and IT systems effectively support integrated care. This indicates that structural enablers for collaboration are not yet consistently in place across Kids Hubs.

Table 30 | Kids Hub staff survey results | Perceived collaboration (n=83)

Survey Question	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
I feel that it has been easy to collaborate effectively with other staff to provide supports to children and families	10%	11%	14%	40%	26%
The Hub has clear systems, protocols and communication pathways between Hub staff	8%	19%	19%	45%	8%
The data and information technology systems are effective at supporting integrated care	9%	27%	27%	30%	7%
The team collaborates effectively to support children and families	4%	10%	14%	40%	33%

Resourcing constraints limit care coordination in some Kids Hubs; limiting information sharing and collaborative care planning and weakening support for children and families. Despite being a core function of the Model, care coordination (including dedicated care coordinator roles) is sometimes deprioritised relative to service delivery. Where Kids Hubs operate with minimal staffing and high client volumes, staff report that they "…do what they can…" informally but are not adequately resourced to provide proactive follow-up, goal monitoring, or multi-agency coordination at the level intended in the Model.

This is contributing to inconsistent experiences for families and limiting the Kid Hub's capacity to support complex care needs across the system. Staff at the Children's Health and Wellbeing Local (Southern Metropolitan Melbourne) emphasised the importance of care coordination and transition planning but acknowledged ongoing demand pressures and the need to balance risk and capacity. Broadly, care coordination effectiveness is inhibited by two key factors:

- **Capacity constraints reduce the care coordination role to intake and handover rather than active coordination.** High caseloads and limited workforce mean designated care coordination roles cannot consistently deliver structured or ongoing coordination, despite the role being seen as highly valuable.
- **Demand for coordination and system navigation exceeds available capacity, especially during transitions.** Referrers emphasise the importance of care coordinators in managing transitions but rising clinical referrals and system navigation pressures are stretching services beyond what current capacity allows.

6.3.3 Mature multidisciplinary teams need stronger coordination structures

Staff at Kids Hubs with complete multidisciplinary teams (those with no reported workforce gaps, or gaps of only one key role or discipline) experience more challenges collaborating effectively than those with incomplete multidisciplinary teams (those with workforce gaps across two or more key roles or disciplines). Table 31 provides a comparison between more mature and less mature Kids Hubs (in terms of the completeness of their multidisciplinary team). The more complete teams had less systems and processes to support communication, and less opportunity to collaborate.

This indicates that perceived collaboration can reduce in Kids Hubs with fuller multidisciplinary teams, not necessarily because teams work less collaboratively, but because coordinating more disciplines, roles, and part-time arrangements is inherently more complex. As multidisciplinary teams grow, this highlights the need for clearer roles, stronger structures, and protected collaboration time to maintain the high levels of teamwork the Model depends on.

Table 31 | Kids Hub staff survey results | Perceived collaboration at Kids Hubs with complete multidisciplinary teams versus incomplete multidisciplinary teams (n=83); Total % of Kids Hub staff that agreed or strongly agreed to survey question

Survey question	Kids Hubs with mature multidisciplinary teams (n=36)	Kids Hubs with developing multidisciplinary teams (n=47)
I feel that it has been easy to collaborate effectively with other staff to provide supports to children and families	54%	74%
The team collaborates effectively to support children and families	63%	80%
The Kids Hub has clear systems, protocols, and communication pathways between Kids Hub staff	30%	70%
The data and information technology systems are effective at supporting integrated care	13%	56%

6.4 The Kids Hubs improve workforce capability through training, multidisciplinary ways of working, and partnerships but are hindered by capacity constraints and weak clinical governance

KEQ 3.5 | This section answers the research question:

To what extent do the Kids Hubs support improvements in workforce capability and capacity (e.g. clinical supervision, professional development, and training opportunities for multidisciplinary teams)?

Findings are presented against the following mechanisms and outcomes in the program logic:

- Multidisciplinary team members have respect and trust for each other and a clear understanding of each discipline's roles, skills, and scope of practice in supporting children and families.
- Kids Hubs establish agreed clinical governance structures as well as systems and protocols for communication, care coordination, and integration.
- Increased clinical supervision, professional development and training opportunities for multidisciplinary teams.

This sub-section assesses how well the Kids Hubs are improving workforce capability and capacity, including within, and outside of the Kids Hubs.

6.4.1 Despite investment, uneven and often misaligned training undermines consistent capability uplift

Some Kids Hubs are investing in training that directly builds the skills their staff need, but others rely on centrally prescribed training that does not always fit local practice. Staff consistently say they value the professional development offered through the Kids Hubs, especially where it strengthens early identification skills, multidisciplinary work, and shared practice. Strong team culture, clear leadership, and a focus on wellbeing help make these opportunities meaningful.

At the same time, many staff emphasise that their training needs to keep pace with the specific needs of the children and families they support. They note that centrally designed training can feel too generic and may not align with the realities of the target cohort or the multidisciplinary model. In some cases, staff want more say in the design or choice of training, particularly in places where the Kids Hub's work focuses heavily on certain supports, such as parenting programs.

6.4.2 Multidisciplinary team structures inherently support workforce capacity through expertise sharing

The Kids Hubs create opportunities for clinicians and staff to learn from one another through co-located service delivery, case discussions, cross-disciplinary input, and shared problem solving. The Model's multidisciplinary structure functions as an informal and ongoing professional development mechanism. This is operationalised in different ways across the Kids Hubs. For example:

- In the Queensland Kids Hubs, weekly clinical meetings, case presentations, and co-located service delivery allow clinicians to access advice from psychiatrists, paediatricians, occupational therapists, speech pathologists and peers, enhancing skills through exposure and modelling.
- The Midland Medicare Mental Health Kids Hub staff emphasised that the consortium model enables different specialists to "…learn from each other…", leveraging expertise including occupational therapy, peer work, family support, and clinical streams.

More on how multidisciplinary teams collaborate and share expertise is discussed in Section 0.

6.4.3 Interdisciplinary teamwork drives capability uplift across the workforce

Interdisciplinary ways of working help lift capability because they create constant opportunities for staff to learn from each other and respond more effectively to families' needs. When teams work together, collaborate early, and share overlapping roles; they naturally exchange knowledge, problem-solve together, and build their skills organically. This informal, continuous learning strengthens the whole workforce, not just individual roles. Evidence shows that interdisciplinary practice is steadily strengthening workforce knowledge and capacity over time. In line with the Program Logic, this sustained capability uplift supports a more available, sustainable, and effective mental health workforce for children and families.

As staff repeatedly work with families experiencing complex and co-occurring challenges, they become more confident in recognising emotional regulation difficulties, trauma-related behaviours, attachment issues, and the social factors that influence mental health. Kids Hub staff also report strong growth in their skills: **75 per cent surveyed (n=83)** say the Kids Hub has improved their ability to identify and respond to early signs of child mental health and wellbeing challenges, and **84 per cent (n=83)** feel their employment at the Kids Hub has supported their professional development.

The Kids Hub's holistic model further builds capability by allowing staff to notice early signs that may not emerge in traditional clinic-based settings. By seeing families in their broader context and working as a coordinated team, staff can detect challenges earlier and respond more effectively.

6.4.4 Kids Hubs' contribution to capability uplift varies according to workforce capacity, partnership strength, and local system conditions

All Kids Hubs build partner capability to some extent by working closely to explain the Kids Hubs role and how to identify families who might benefit. Kids Hubs especially focus on building the capability of schools and early childhood services, reflecting the central role that education settings play in referring children and supporting them before, during, and after engagement with the Kids Hubs.

Kids Hub staff work closely with teachers to share tailored strategies, explain a child's needs, and ensure schools can adjust supports in real time. Many also deliver broader capability uplift, helping education staff better understand how to support children with mild to moderate mental health and neurodevelopmental needs, identify when a child requires additional support, and respond to behavioural and functional challenges in the classroom. Some Kids Hubs extend this role to the broader system, providing contextual information to psychologists and psychiatrists about family functioning and trauma histories to guide specialist care.

A key mechanism for this capability building is the routine participation of Kids Hub staff in case coordination meetings, multi-agency intake meetings, and governance or interagency groups. These structures create shared understanding across sectors, embed joint decision-making, and help universal services like schools translate Kids Hub expertise into their everyday practice. They also normalise cross-sector communication, making it easier for teachers, maternal and child health nurses, social workers, and other referral partners to seek advice early, even without a formal referral.

While this is consistent nationally, the degree to which Kids Hubs engage in broader system capacity building varies. Kids Hubs with stronger relationships across sectors, clearer referral pathways, co-location, or formal partnerships (e.g. Tasmania's joint training with Department for Education, Children and Young People and Child Health and Parenting Service), and a well-resourced workforce tend to deliver more structured and proactive capability uplift. Others take a more informal approach, responding to advice requests as they arise (e.g. Loddon Children's Health and Wellbeing Local). These differences appear linked to local system maturity, workforce stability, and the extent to which partner organisations see the Kids Hub as a trusted and knowledgeable source of early years mental health expertise.

However, in Kids Hubs facing workforce shortages and high demand, capability building is harder to prioritise. When Kids Hubs are overwhelmed with referrals, they divert effort to holding families and meeting immediate needs, rather than system-level or partner-focused work. Many staff noted the tension between responding to demand and investing time in training, outreach, or partner development activities.

Referral partners also reported having little capacity, reducing their ability to participate in, or benefit from, capability-building efforts. As a result, cross-service capability-building reportedly becomes de-prioritised, not because it is seen as unimportant, but because Kids Hubs focus on seeing families first. Thirty-six per cent of referral partners report improved ability to identify and respond to early signs of child mental health and wellbeing needs through their work with the Kids Hub. Results from referral partner survey regarding capability uplift are outlined in Table 32.

Table 32 | Referral partner survey (n=53) | Perceived capability uplift

Survey Question	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
My involvement with the Hub has provided effective supports and opportunities for professional growth and development	4%	20%	39%	22%	15%
The Hub has increased my capacity to work effectively within the cultural context of each child and family	6%	19%	36%	28%	11%
Working with the Hub has improved my ability to identify and respond to early signs of child mental health and wellbeing challenges	8%	23%	34%	26%	9%

6.4.5 Fragmented governance and non-integrated systems weaken clinical oversight, coordination, and staff support

As discussed in Section 4.4, clinical governance in the Kids Hubs is either under the remit of clinical leads and implementation teams or managed through partnerships and consortia.

Clinical governance in Kids Hubs works best when the Kids Hub use integrated systems and clear internal leadership, but it weakens when governance is shared across partners without shared processes, data, and clinical expertise. Consultations showed wide variation in clarity, oversight, and team cohesion. In several jurisdictions, staff described fragmented governance (separate systems across delivery partners, unclear accountability pathways, and no shared clinical data systems). This fragmentation made it harder to coordinate care, maintain oversight, consistently monitor risk, and shaped day-to-day experience. Staff reported inconsistent supervision, limited access to higher-level clinical expertise, and reliance on informal communication to manage complex cases.

Survey results mirror these differences: while **65 per cent of staff (n=83)** agreed their Kids Hub had clear and effective clinical governance, agreement dropped to **51 per cent** in partnership-governed Kids Hubs (n=55) and rose to **93 per cent** in Kids Hubs with internal governance (n=28). Staff consistently linked internally led models to stronger multidisciplinary coordination, clearer escalation pathways, and more predictable supervision, while partnership-governed models more often created uncertainty, duplication, and uneven access to clinical guidance and professional development.

The absence of integrated systems is a key driver of poor clinical governance as it reduces visibility across services, increases duplication, and forces teams to rely on relationship-based, manual workarounds rather than dependable system processes. This issue is present in both referral

partnerships and co-provider arrangements. Team leaders in co-provided Kids Hubs (such as through partnerships or consortia) reported that aligning governance protocols across providers is difficult and requires a shift away from siloed clinical ways of working; with one reflecting their need for support from the state policy leads to help manage the tension of bringing multiple clinical organisations together to deliver holistic, consumer-led care.

Referral partners in Tasmania described unclear governance structures, inefficient meetings, and referral pathways built on retrofitted processes and informal relationships. Referrers often did not know if a referral was accepted or declined, or why, because there was no feedback mechanism, reinforcing uncertainty (see Section 6.2 for more information).

Where partners operate with different systems and expectations, collaboration becomes harder in practice. At one Kids Hub, staff reported clinicians working at the Kids Hub across multiple organisations had separate emails, notes, and governance processes, which made coordinated case discussions effectively impossible and left staff "…feeling like they work a different job." At another Kids Hub, referral partners described having to consciously reduce duplication and streamline communication through direct calls, informal follow-ups, and repeated information-sharing to stop families getting "…lost…" (see Section 6.2 for more information).

Without shared systems, Kids Hubs and partners may unknowingly work with the same family, blurring accountability and oversight. For example, staff and referral partners in Tasmania pointed to duplication across child and family learning centres, the Child Health and Parenting Service, and CYMHS, as well as confusion about eligibility and age ranges, which reduced referrer confidence and contributed to families disengaging. Staff also noted that relying on relationships rather than structured information systems makes consistent case review, risk monitoring, and quality assurance hard to sustain.

Gaps in clinical expertise compound these governance weaknesses. In one jurisdiction with no paediatrician or psychiatrist, staff felt unsupported in assessment and decision-making and asked for more clinical guidance. They suggested recruiting a part-time medical role (e.g., a paediatrician one day per fortnight) to strengthen clinical oversight and reduce pressure on allied health and support staff.

6.5 The Model lowers access barriers to connect families with timely, flexible supports while managing demand

KEQ 3.7 | This section answers the research question:

To what extent is the Model improving access to supports?

Findings are presented against the following mechanisms and outcomes in the program logic:

- Broader access and referral: By adopting a broad access and referral approach (not based on a diagnosis or ability to pay), vulnerable children do not experience delays and will get the help they need.
- Free and easily accessible hub service for children and families (particularly underserved groups).
- More timely access to support services (particularly for underserved groups).
- Universal access to safe, multidisciplinary, and low-cost care. Broader access and referral: By adopting a broad access and referral approach (not based on a diagnosis or ability to pay), vulnerable children do not experience delays and will get the help they need.

This sub-section explores how effectively the Kids Hubs are improving access to supports for children and families, including by:

- removing barriers to enter the service
- managing demand to ensure timely access, and providing interim supports where appropriate
- engaging flexibly with families to ensure they remain engaged in services
- building parent capability to improve ongoing and future access to supports.

6.5.1 The Model removes barriers and makes it easier for children and families to access supports

Many families accessing the Kids Hubs have not engaged in mental health or other services beyond primary care due to their challenges navigating and accessing these supports. Sixty-seven per cent of families surveyed reported not being able to access the right supports for their child before going to the Kids Hub. Long waitlists, confusing pathways, low health literacy, and past negative service experiences previously prevented many families from accessing supports. The intent of the Model is to reduce structural and practical barriers that prevent children and families from accessing timely and earlier support. It does this by providing a no-cost, welcoming service that removes financial barriers and offers family-centred support in accessible community settings.

The Model ensures broad access by providing an alternative to diagnosis-driven eligibility requirements for children that present with a range of emotional, behavioural, or developmental concerns and do not meet diagnostic and eligibility thresholds but still require early support. Kids Hubs operationalise this through holistic assessment, multidisciplinary intervention, and service navigation to help families access other services.

Consultations and survey data indicate that this is being achieved across the Kids Hubs. Ninety-five per cent of families surveyed agreed or strongly agreed that it was easy and fast to access the Kids Hub. Families and staff report Kids Hubs provide "…a practical and accessible entry point…" after experiencing year-long waits for paediatricians and allied health services in the existing system. Referral patterns support this; community health referrals (33.9 per cent) and self-referrals (19.1 per cent) indicate open, low-barrier access routes.

Many of these families also indicated that their access to services had improved from previous experiences since going to the Kids Hub (92 per cent agreed or strongly agreed). In consultations, parents and carers also described the Kids Hub as easier to access than other services. Some said they felt prioritised for the first time due to the Kids Hub's willingness to meet them where they're at by taking the family's circumstances into consideration and tailoring supports to suit their family's unique needs and preferences.

Family profiles of children and families accessing the Kids Hubs (see Section 5) provide further evidence that the Kids Hubs are enabling easy access for underserved groups, particularly those presenting with compounding psychosocial risk indicators (66 per cent of families present with at least one psychosocial vulnerability and 27.3 per cent experience compounding vulnerabilities (e.g., family and domestic violence exposure, housing instability, financial stress)).

6.5.2 All Kids Hubs are managing demand to ensure timely access for the families who will most benefit from the Model

All operational Kids Hubs report high demand and sustained pressure on capacity as referrals continue to grow. Staff highlighted the importance of managing demand in early stages of implementation while they establish and stabilise service operations. They described a significant risk of opening the "…floodgates of referrals…" too early.

> "The current demand for services is already through the roof and we're not fully open yet"
>
> - State and Territory Policy Lead

Most team leaders and staff consulted believe demand is being managed well so far, with 73 per cent of staff surveyed agreeing that the Kids Hub improves the timeliness of support for children and families.

All Kids Hubs are taking steps to actively manage demand while they move towards stable operations during early implementation, including:

- **Working closely with partners to build capacity and understanding of what constitutes an appropriate referral:** Several Kids Hubs described the importance of having strong partnerships with referral organisations to ensure shared understanding of eligibility criteria and appropriate referrals. While some Kids Hubs have effectively built strong communication and shared understanding with referral partners, others have invested less time in building these partnerships and are experiencing challenges. Staff at these Kids Hubs reported ongoing challenges with referral quality, noting that they continue to receive inappropriate referrals, and

referral partners described uncertainty about who the service is for and have frustration at sending referrals that are declined without clear feedback. See Section 6.2.

- **Closely managing referral pathways**: Most Kids Hubs are deliberately and closely managing referral pathways and referral pools to prevent service overload and ensure families who most need support can access it. Managing referral pathways includes providing referral-only support (i.e. not accepting walk-ins), targeted and partnership-based referrals, controlled expansion of referral sources, and intentionally limited advertising, especially of diagnostic capabilities. Most Kids Hubs are not yet accepting walk-ins. Evidence shows that opening to walk-ins too early can rapidly overwhelm capacity. One Kids Hub began accepting walk-ins immediately. This caused an immediate surge in families seeking support, leading to a three-month waitlist for psychology support within three months of being operational. Managing referral pools includes investigating waitlists of other services on the family's behalf to refer families onwards instead (where available).
- **Using catchment areas to define eligibility**: Most Kids Hubs only accept referrals from families in a targeted catchment area. Catchment areas are seen as essential in defining eligibility and managing demand, but team leaders and staff reported challenges, including inconsistent or confusing catchment criteria (e.g. where a child lives in the catchment but is ineligible because their school falls outside of the catchment).

6.5.3 When demand for services is too high, Kids Hubs provide interim support to prevent family disengagement with services

Kids Hub staff and team leaders emphasised the importance of offering some level of interim support to families who are ineligible for the Kids Hub or are placed on a waiting list (at the Kids Hub or elsewhere). This ensures families are not left without support or guidance. Even limited interim support is seen as critical to maintaining engagement with services and reducing the risk of families falling through service gaps.

Kids Hubs are doing this through:

- **Regular communication with families waiting for services:** Kids Hub staff reported that regularly checking in with families while they wait for services helps maintain engagement and ensures emerging needs are monitored while families wait for support. They explained that ongoing contact reassures families and encourages them to re-engage once services become available. Families reported that these check-ins made them feel cared for and supported.
- **Group programs:** Several Kids Hubs are using group programs to provide support for families while they wait for individual sessions. Team leaders explained that group delivery enables them to reach more families at once, sustain engagement, and provide practical strategies that help stabilise family situations in the interim. Parents reflect the group programs enable peer support and community building. Kids Hubs in Tasmania primarily rely on group programs as interventions to manage high demand and workforce constraints (see Section 4.5 mitigate workforce shortages). The Midland Medicare Mental Health Kids Hub offers a range of group play sessions to maintain contact and provide meaningful support until individual appointments become available.

- **Assisting with service navigation:** Kids Hub staff support families to access other services that are better equipped to meet their needs, including when the Kids Hub lacks capacity, when families are ineligible, or when specialised supports (e.g. family and domestic violence or housing services) are more appropriate. One and a half per cent of families received only Supported Transition or Information and Education (not Intake and Assessment, Treatments and Therapies, or Care Coordination). Staff described this navigation role as essential to ensuring families are directed to the right services rather than left without support.

6.5.4 The flexibility of the Model enables staff to meet families where they are, increasing accessibility and engagement

Across all Kids Hubs, staff are using flexible, supportive, and family-centred engagement approaches to better reach target families and address barriers described in Section 6.5. Families report that these flexible approaches increase accessibility and make them feel supported by staff. Flexible engagement approaches across the Kids Hubs include:

- **Working with families when it's right for them:** Kids Hubs provide responsive support by tailoring services and engagement to families' circumstances and readiness. Staff described "…holding families…" through periods of instability and re-connecting when circumstances allow. In practice this involves regular communication (via telephone, email, and text message) to check-in, gather information on the family's context, and offer information or navigation to other sources of support. The 'hold periods' include allowing pauses in engagement without penalisation, maintaining light-touch contact, and keeping the door open for re-entry at a more appropriate time. Families reported that this flexibility reduces fear of judgment and maintains trust to support sustained engagement.

> "I needed a break to deal with family stuff, and they (the Kids Hub) kept in touch until we were ready. It was so helpful"
>
> - Parent

- **Engaging with families flexibly to suit their individual circumstances:** This includes meeting children and families in schools and other community settings, providing transport to and from the Kids Hub (e.g., taxi vouchers), or offering phone/telehealth sessions. Most Kids Hubs also offer appointments at times that work for the families (including outside of business hours). This is not reflected across all Kids Hubs, with some families reporting the narrow operating hours were too restrictive and didn't accommodate school or employment responsibilities.

> "As the key contact for the family, I run joint sessions with the other clinicians to provide soft introductions. I've gained the family's trust so it's already there when they meet other clinicians"
>
> - Kids Hub multidisciplinary team member

- **Providing a single point of contact**: Kids Hubs provide families with a single point of contact to support service navigation. These designated roles are designed to build trust and relationships

with families. Staff report that having a single point of contact strengthens care coordination, wraparound care, and helps maintain service continuity in family-centred practice.

- **Proactively communicating with families in a way that maintains connection but acknowledges their sometimes-challenging context**: Kids Hubs demonstrate a proactive approach to support, with continuous check-ins and clear communication throughout the referral process. Most staff consulted maintain strong ongoing communication with families, including during waiting periods between referral and their first appointment.

> "They'd call and ask how we were if we missed an appointment. I really felt cared about for a change."
>
> - Parent/carer

One example of how flexible engagements can impact accessibility of services for families can be captured in this case study on Leah and her daughter Tian (11).

Leah is a single parent who works irregular nursing shifts and experiences intermittent mental health challenges. Her 11-year-old daughter Tian had been increasingly showing signs of anxiety and distress, and Leah spent years trying to get support. After being on a waitlist for a paediatrician for 18-months, Leah missed their appointment due to a last-minute shift change and was informed in an automated email that she needed to call and reschedule. Leah described feeling invisible and lost as a result.

When Tian's school referred her to the Kids Hub, Leah missed the first appointment again as she was experiencing a period of distress with her own mental health. The Kids Hub intake officer called Leah at the appointment time and then again two days later. Leah answered and was able to reschedule their appointment for the coming weeks.

The Kids Hub arranged school-based sessions for Tian and brief phone check-ins during Leah's breaks, booked sessions outside standard hours when possible, and never penalised last-minute changes. Their care coordinator also sent her a text messages for appointment reminders, at Leah's request.

The flexibility and persistence reduced Leah's stress, restored her confidence in seeking help, and enabled consistent support for Tian.

6.5.5 Kids Hubs are navigating the tension between flexible engagements and number of families supported, particularly where there are more severe capacity constraints

Staff reflect that engaging flexibly with families is resource and time intensive because it requires extra staffing and travel time to meet families at specific times and locations. This creates a tension between accommodating one family's circumstances at the expense of another's. An example provided by staff was when 30-minutes of travel to visit one family replaces a 30-minute appointment with another.

The Kids Hubs are approaching this in different ways. Most have emphasised a quality-over-quantity approach, highlighting that delivering a comprehensive and effective engagement for one family is preferable to providing multiple incomplete engagements.

As outlined above, the Tasmanian Kids Hubs' local service model prioritises group programs over tailored support where there is high demand and low capacity. While they maintain some aspects of flexible engagement (e.g. meeting children at school and providing taxi vouchers to parents), the local service model impacts their ability to provide flexible engagement for families.

6.5.6 Parent capability uplift improves ongoing help-seeking behaviour and confidence accessing future supports

Kids Hubs also have a strong parent capability uplift focus, to help parents and carers understand their child better and know how they can support them. This looks different for each household, depending on their circumstances, needs, and preferences. For most parents, this includes targeted parenting supports and service navigation.

> "My understanding of how to support my kids has been developed so much from being at the Kids Hubs and dealing with my own challenges."
>
> - Parent

Capability uplift supports provided to families include:

- Practical tools for use at home (e.g., strategies for emotional regulation, communication, routines).
- Information and education to build understanding of children's mental health and development.
- Specialist evidence-based parenting programs (e.g., Tuning in to Kids, Parents Under Pressure, Triple P – Positive Parenting Program).
- Linkages to broader services such as FDV support, financial aid, food, and clothing bank
- Family-focused goal setting aligned with household priorities.
- Tailored parenting support and 1:1 coaching.

Parental support helps parents and carers gain the confidence and skills needed to support their child to access services on an ongoing basis. **Ninety-six per cent** of families surveyed (n=174) reported they had learnt something useful at the Kids Hub to help them support their child. Parents describe supports as non-judgmental and tailored to their evolving situation. They report **increased confidence**, improved communication, and a **better understanding** of their child's needs and how to access supports.

6.6 The Model facilitates both identification and intervention for needs and challenges that can lead to poor mental health and wellbeing

KEQ 3.6 | This section answers the research question:

To what extent does the model facilitate identification of issues/needs known to lead to poor mental health and wellbeing (neurodevelopmental, behavioural, developmental, mental, social)?

Findings are presented against the following mechanisms and outcomes in the program logic:

- Earlier identification and response to unmet mental health and wellbeing challenges.

Neurodevelopmental and behavioural issues can signal emerging mental health needs in children, highlighting the importance of early intervention before risk and complexity escalate

As outlined in the Literature and Policy review, children's earliest signs of mental health and wellbeing challenges often present as developmental and behavioural concerns, not as diagnosable mental health symptoms that may present in adolescents and adults. These early signs can be difficult to identify and 'treat' as there are many contributing factors that can change rapidly with development. Child mental health and wellbeing is also heavily dependent on the family context, less so than in adolescence and adulthood. These dynamics, coupled with adverse childhood experiences and social determinants, are direct drivers of distress. When these early biopsychosocial, neurodevelopmental, and/or behavioural issues are not identified and supported, risk and distress can escalate for both children and families.

The Model is explicitly designed to identify and respond to these early, non-diagnosed presentations and to support families before distress escalates. The Model allows access based on emotional, behavioural, and developmental need rather than formal diagnosis, focusing on whole-family support and parenting capacity, integrating multidisciplinary assessment with care coordination and strong links to universal and community services. This positions the Kids Hubs to fill a system gap by identifying needs and providing support before issues escalate.

6.6.1 Outreach through partnerships creates soft entry points that reveal issues not visible in clinical settings

The Kids Hubs' approach to outreach supports identification of issues known to lead to poor child mental health and wellbeing. These include:

- **Social determinants of health and mental health**

  The Model's outreach to priority populations (established through co-designed partnerships) enables early and routine identification of key social determinants linked to poor mental health and wellbeing. Kids Hub team leaders reported that working with trusted partners in community settings helps identify relevant demographic and psychosocial information, such as Aboriginal or CALD identity needs, housing instability, family violence history, and parental stress. By working with partners through outreach and referral pathways, Kids Hubs can identify and reach priority cohorts with an identified need.

- **Early behavioural and developmental concerns**

  Schools are a critical partner of the Kids Hubs, as they provide an effective mechanism for early identification and engagement with children and families. As discussed in the Literature and Policy Review, children in primary school may show difficulties with behaviour, attention, emotional regulation, learning, or social interaction - which can signal emerging mental health or developmental concerns. As such, schools are identified as critical settings for early identification. The Productivity Commission emphasises that schools should act as 'effective gateways' to help and support children and families.[34]

  Referral pathways with schools enable the identification of issues such as school refusal, anxiety, behavioural dysregulation, and psychosocial factors, as well as continuity of support after transition (Section 6.8) and capability uplift of the education sector (Section 6.4). All Kids Hubs accept referrals from local primary schools, with a total of 399 referrals nationally to date. Embedded outreach to schools and place-based service delivery at schools allow clinicians to observe functioning across multiple settings, uncovering needs not visible in clinic-based environments.

6.6.2 Holistic assessments effectively support early intervention by identifying issues known to lead to poor mental health and wellbeing, allowing Kids Hubs to focus on deescalation of risk

Kids Hubs are using holistic assessments to identify risks before families reach a clinical threshold and/or crisis. Staff described that many children present with needs that sit 'below the threshold' of specialist services but still carry significant implications for wellbeing, and that the Kids Hub's way of working is designed to identify these early warning signs.

Holistic intake processes enable practitioners to consider the whole child (developmental, behavioural, social, and family factors) rather than relying on narrow clinical triage, with staff noting that local referral forms and screening tools used by the Kids Hub reveal vulnerabilities earlier than pathways relying solely on GP screening. Intake and assessment consider the broader family context and include the parents in early discussions and goal setting. Staff across the Kids Hubs emphasised that the family is 'part of the whole solution' and work closely with the family to consider the child's entire context. This is described as "…crucial…" in identifying issues and planning appropriately.

> "Kid's behaviour is often the result of family stress… there's often a lot of other stuff happening in the background"
>
> - Multidisciplinary staff member

[34] Productivity Commission 2020, Mental Health, Report no. 95, Canberra

This early identification matters: half of all adult mental health challenges emerge before age 14,[35] reinforcing the importance of intervening when the first signs appear rather than waiting for a diagnosis threshold to be met.

Evidence from the Evaluation indicates this approach is working:

- **Eighty-three per cent** (n=83) of Hub staff agreed that initial assessments effectively identify emerging needs, and staff described multidisciplinary collaboration as enabling them to "…pick people's brains across disciplines…" to spot risks that might otherwise go unseen.
- Families consistently said this was the first time a service looked at 'what's really going on' across the whole family rather than isolating the child.

6.6.3 Iterative, multidisciplinary intake and assessment, and care planning processes identify developmental and psychosocial complexities

All Kids Hubs use intake and assessment processes to collect information to understand the child and the family's needs and circumstances. Intake and assessments are coordinated through multidisciplinary processes that focus on understanding the child and family's holistic needs and where to prioritise support, rather than functioning as a single discipline triage step, like in typical clinical services.

Unlike conventional models, assessment does not end at intake, instead it is ongoing and evolves with new information. Families may be re-discussed in allocation meetings if new information suggests they could benefit from other supports at the Kids Hub or elsewhere. This continuous reassessment is critical for detecting layered risks such as school-based concerns, parental mental health challenges, or current family/domestic violence.

Intake conversations and assessment tools intentionally explore family dynamics and stressors to identify needs and tailor supports precisely. Staff emphasised that assessments are framed as collaborative conversations, not something 'done to' families, which helps build trust and shared understanding. This approach is flexible in practice: assessments might involve parents (one or two) alone, the child alone, or the whole family (sometimes including siblings) to develop a comprehensive understanding of the factors contributing to the child's presentation. Families reflected the positive impact this had on them: 96 per cent reported the Kids Hub focused on the issues that were important to them, and 96 per cent felt listened to throughout assessment.

During intake, staff collect developmental and psychosocial histories, conduct biopsychosocial assessments, and hold structured multidisciplinary team case reviews to collect information. Examples of this in practice include:

- Brimbank Melton Children's Health & Wellbeing Local, uses a comprehensive Initial Family Meeting, developmental histories, validated screeners (DBC, DP-4), and multidisciplinary team conferences to identify developmental and behavioural issues at intake.

[35] The National Children's Mental Health and Wellbeing Strategy.

- Kids Hubs in New South Wales manage weekly referral management, case allocation, and multidisciplinary team case reviews to identify developmental and other support needs via structured processes.

> "We can pick [other peoples'] brains and have corridor conversations… different lenses help prioritise the right care"
>
> - Multidisciplinary staff member

- Care planning discussions in the Queensland Kids Hubs explicitly incorporate environmental and psychosocial factors, aiding identification of social risk factors.

Staff in a small number of Kids Hubs reported that the intake and assessment processes in their local service model are not adequately multidisciplinary. In these cases, mental health clinicians were often excluded from intake meetings, care planning, and limited integration with the multidisciplinary team. As a result, mental health clinicians in these Kids Hubs reported only receiving referrals once children are already identified for mental health support without consultation. These staff reported concerns that the lack of integration and multidisciplinary team support inhibits the Kids Hubs ability to identify broader developmental or behavioural needs.

6.6.4 The Model is highly effective at uncovering complex and layered psychosocial needs and risk factors after intake

There is established evidence about the relationship between adverse childhood experiences, social determinants, neurodevelopmental vulnerabilities, and how when unsupported, can dramatically increase risk of mental health diagnosis and suicidality. Across all Kids Hubs, consultations consistently demonstrated that the Model enables staff to identify co-occurring and intersectional psychosocial, developmental, relational, cultural, and environmental factors that shape children's presentations.

Children and their families frequently present to the Kids Hubs with multiple and often complex needs across neurodevelopment, trauma, and the social determinants of health. The characteristics, presentations, and needs of families are presented in-depth in Section 5. The most common presentations reported in consultations were nationally consistent and are shown in Table 33.

Table 33 | Common characteristics of children and families reported in consultations nationally

Child	Family
• 17% are Aboriginal and/or Torres Strait Islander • 9% of children are culturally and linguistically diverse • 43% of children are 5-8 years old • Trauma • Neurodevelopmental concerns • School disengagement • Communication difficulties • Attention challenges	• Parental mental illness • Family and domestic violence • Financial hardship • Child protection involvement • Housing instability

Team leaders reflected that intake, and assessment processes don't always capture all the required data to inform a family's profile, needs, and priorities - and that capturing this information takes time. The flexibility of the Model creates this time to build trust and relational safety, allowing information to emerge gradually as families become more comfortable. Parents and staff repeatedly emphasise that trust-building, warmth, and flexible pacing are central to uncovering layered issues and needs. This relational depth is what allows disclosure of sensitive and distressing information (such as family violence, parental trauma, burnout, neurodivergence in parents, housing insecurity, and other psychosocial issues) that would not surface in a standard triage appointment.

> "Sometimes the first session is just rapport building… you pick out the pieces over time. If people don't have rapport and built-up trust and safety, there's no opportunity to engage clinically"
>
> - Multidisciplinary staff member

> "Over time you pull back the layers of trust and then you get to the heart of what the family needs"
>
> - Multidisciplinary staff member

6.6.5 The Kids Hubs balance demands of both diagnostic and holistic care in a diagnosis-driven health system

There is variation nationally if the Kids Hubs provide diagnostic services. If they do, it is often a response to how the Model was translated in the jurisdiction, demand identified in co-design, and existing diagnosis capability and capacity in the local service context. Approximately half of the operational Kids Hubs (seven out of 14) do not offer a diagnostic capability. This is for a range of

reasons including availability of clinicians who can conduct diagnostic assessments, a way for the Kids Hubs to manage caseloads, keeping care holistic, and family focused in line with the intent of the Model.

The Kids Hubs that do have diagnostic capability see their role in the local service system as a diagnostic service to meet high demand and act as a gateway to additional services. Table 34 below outlines how family diagnostic experiences vary between Kids Hubs with or without diagnostic functions.

Table 34 | Family experience visiting a Kids Hub with or without diagnostic function

	Kids Hub WITH diagnostic function	Kids Hub WITHOUT diagnostic function
Advantages	• Faster access to assessment and clarity. • Enables access to NDIS, school supports, and medication pathways. • Gives families shared language and understanding of their child.	• Keeps the Model centred on early, functional, family-focused support. • Avoids early or unnecessary diagnosis. • Encourages exploration of environmental, relational, and trauma-related drivers.
Disadvantages	• Can drive high demand and overwhelm the Kids Hub. • Risks shifting focus away from early, holistic intervention.	• Families still face long waits for external diagnosis. • Some families feel diagnosis is key to understanding and navigating supports.

The current child mental health and wellbeing service system in Australia is largely structured around clinical diagnosis, with access to many services and funding streams contingent on a child meeting formal diagnostic criterion. As the Literature and Policy Review noted, services often prioritise assessment and diagnosis as the gateway to support, which can delay access for children experiencing early or emerging difficulties that do not yet meet diagnostic thresholds.

This diagnosis-led orientation tends to focus system effort on downstream, more severe presentations, reinforcing a bias towards acute and clinical responses rather than early intervention and prevention. Pursuing a diagnosis may result in children and families experiencing siloed pathways and limited access to holistic supports that address social determinants of mental health and whole-of-family needs.

The diagnosis-centric structure of the system creates an expectation for families and other system stakeholders (such as schools and other healthcare providers) that a diagnosis is valuable and needed. Policy leads, team leaders, and staff widely recognise that diagnosis carries considerable practical and emotional value for families, particularly in accessing supports through the NDIS and schools.

6.6.6 The value of a diagnosis depends on its use and role in the broader context of the child and family

The emerging evidence is highlighting that the value of a diagnosis is different for each family and clinicians in the broader system. The extent to which a diagnosis improves the experience, and mental health and wellbeing of the child and family depends on what the diagnosis is being used for, and how this is considered in the child and family context.

When a diagnosis is embedded in the Model and enables access to supports previously restricted by existing system structures, it can help achieve the Model's intent by reducing mental health distress within the family. Parents, carers, and staff highlighted that a diagnosis unlocks targeted supports, provides a shared language to understand and describe the child's behaviour and needs, and offers children a sense of understanding and empowerment.

> "[Child] is now medicated for her ADHD; she has less meltdowns at home and the school is finally onboard."
>
> - Parent/carer

> "[Child] has embraced that her brain comes from a different place."
>
> - Parent/carer

A strong focus on diagnosis can create risks in some family circumstances, as a diagnosis may only represent one part of a much broader picture, particularly when age, developmental stage, and other underlying issues are likely to be contributing factors. An early emphasis on diagnostic labelling can direct children into specific service pathways that may not comprehensively address the underlying causes of their challenges. Some staff reflected that early or unnecessary diagnosis can send families down a particular single-discipline pathway that doesn't necessarily match their most critical needs or capture all factors at play; especially when behaviours reflect environmental stress, trauma, family dynamics, or school experiences rather than neurodevelopmental conditions.

> "I don't care about the label; I care about the support."
>
> - Parent/carer

> "My wife and I were nervous they'd push him to get diagnosed because we didn't want him on medication, but they didn't"
>
> - Parent/carer

Table 35 shows two case studies and how individual circumstances and priorities drive the value and role of a diagnosis.

Table 35 | How the value of a diagnosis is shaped by circumstances and priorities

	Diagnosis Pathway	Non-diagnostic pathway
Context	Liam (6) received a diagnosis that gave his parents the tools and language to support him, and access to specialised support.	Maya (9) was supported by the Kids Hub to address trauma-driven behaviours, avoiding unnecessary diagnostic pathways.
Circumstances and behaviours	Liam is six and struggles daily with transitions, noise, and unexpected change. At school he is described as disruptive. At home he has intense meltdowns after holding it together all day. His parents feel blamed and exhausted, having tried behaviour charts and parenting strategies with little success. Liam's teacher suggest to his parents that they should visit the Kids Hub where they are supported to look beyond behaviour and understand Liam's sensory and communication needs.	Maya is nine and presents with impulsivity, emotional outbursts, and difficulty concentrating at school. Her teacher raises concerns about ADHD and recommends assessment. At home, Maya is anxious, tearful, and increasingly resistant to attending school.
Response from the Kids Hub and the outcome	Through a coordinated diagnostic pathway, Liam receives an autism diagnosis. This gives the family shared language, helps school adjust expectations, and opens access to targeted supports through the NDIS. Alongside diagnosis, the Kids Hub supports practical strategies that reduce stress and build confidence in Liam at home and school.	While her presentation aligns with common ADHD characteristics, the Kids Hub takes a holistic approach to understand what is driving her behaviour. Through careful conversations and contextual assessment, it becomes clear Maya is experiencing ongoing bullying and feels unsafe. Her behaviour reflects trauma responses—hypervigilance, fight-or-flight reactions, and emotional overload. When the bullying is addressed and Maya is supported with regulation and coping tools, her behaviour and engagement improve significantly, without the need for diagnosis.

The value of the Kids Hub is the ability to support the family to consider a diagnosis alongside other parts of the holistic assessment to prioritise the best support or intervention, whether that be a diagnosis alongside multidisciplinary intervention, or just multidisciplinary intervention. Team leaders broadly reflected that diagnosis alone is insufficient for effective mental health and wellbeing support in children, as psychosocial, relational, and contextual factors are known to drive distress at a young age.

In practice, Kids Hubs with diagnostic capability operate within a broader assessment framework, where diagnostic considerations are weighed alongside psychosocial, relational, and contextual factors to guide decisions about appropriate supports.

6.6.7 Diagnosis is most effective when considered alongside a multidisciplinary assessment and intervention

There is emerging evidence from the Kids Hubs about the 'diagnostic dilemma' whereby mental health concerns in children have multiple complex factors, and presentations can be attributed to how these factors interact. A 'diagnostic dilemma' occurs when a clinician cannot make a clear diagnosis because multiple factors are interacting and driving a child's presentation. Kids Hubs address this by providing multidisciplinary assessment and intervention, allowing multidisciplinary teams to understand the whole picture and plan next steps together. Without this approach, children may be sent down a single pathway that does not fit their needs. This can lead to escalating behaviours or needs because the underlying issues were not properly identified or addressed.

Regardless of if a Kids Hub has diagnostic capability, they can play an important role in preventing the need for this by providing holistic assessments and multidisciplinary intervention while diagnoses are being considered. In some cases, it might be deemed that a diagnosis is not needed because the root causes of the issues were identified and addressed through multidisciplinary assessment. Ultimately, a diagnosis is more likely to be effective when all factors have been closely considered, addressed, or excluded.

Clinical partners (e.g., paediatricians) reported seeing the Model as highly valuable in addressing diagnostic dilemmas by providing holistic, multidisciplinary assessment, and care coordination that is not available elsewhere. The Model is viewed as complementing diagnostic services, reducing pressure on paediatricians, and enabling more accurate and context-informed diagnostic decision-making. Referral partners consistently described the Kids Hubs as uniquely capable of gathering comprehensive information about the whole child and family, which strengthens the quality and appropriateness of diagnostic decisions.

6.6.8 Integrated service systems enable Kids Hubs to support families, without requiring diagnoses to access support

Emerging evidence from the Evaluation suggests that diagnostic assessment does not need to sit within a Kids Hub; provided it is well integrated with other parts of the service system that can prioritise diagnosis when needed. Through holistic support, coordinated care, and strong collaboration, families can be effectively supported without the Kids Hub delivering diagnostic assessments directly. Clear referral pathways and close working relationships enable Kids Hubs to

complement existing diagnostic services and ensure families receive the right support across disciplines.

Integrated pathways allow Kids Hubs to support or 'hold' families while diagnostic processes occur elsewhere, or while the family is on a waitlist for a diagnosis. All non-diagnostic Kids Hubs reported providing targeted interventions (e.g. occupational therapy, speech pathology, counselling), as well as case coordination, wraparound support, school liaison, and parenting support while they are awaiting diagnosis. This holistic support helps diagnostic assessments to be more focused and effective.

Without a diagnostic function, Kids Hubs are positioned as the lead service holding the family, addressing parenting and family needs, and preparing families to engage with paediatric and psychiatric services when access becomes available. Parents reported that Kids Hubs helped them navigate diagnostic systems, prepare for appointments, and advocate for themselves and their children. Some Kids Hubs also complete pre-work (such as functional assessments, family history, and cognitive or sensory profiles) to inform diagnostic assessments and support faster access to appropriate services. Partners, including paediatricians, report that these activities support a more effective and efficient diagnostic assessment, and the right support to be provided to the whole family.

6.7 Culturally competent care is emerging, with stronger outcomes where genuine community partnerships and cultural capability are established

KEQ 3.9 | This section answers the research question:

To what extent is the Model providing culturally competent care for diverse population groups?

Findings are presented against the following mechanisms and outcomes in the program logic:

- By providing individualised and culturally appropriate care via multidisciplinary teams and local partnerships; children, their families and carers are more likely to engage in the service (particularly those who are more vulnerable, typically hard to reach, or have had negative service-system experiences - such as children in Out Of Home Care and Aboriginal and Torres Strait Islander families).
- Culturally safe, and flexible care to meet the needs of children and families.

This sub-section outlines what culturally competent care looks like across the Kids Hubs, how effectively it is happening, and what is enabling this.

6.7.1 Cultural competency is central to the Model and critical for delivering supports that are culturally safe and responsive to the needs of diverse populations

The Model positions cultural safety and equity as core to its intent. Research identified in the Literature and Policy Review demonstrates that Aboriginal and Torres Strait Islander children and children from CALD communities experience disproportionate risk of poor mental health outcomes - and face persistent barriers to accessing timely, appropriate care. The Model emphasises place-based and co-designed service delivery that is culturally safe, family-centred, and strengths-based.

The Literature and Policy Review reinforces that culturally safe care is not limited to cultural awareness, but requires Kids Hubs to actively address power imbalances, racism, historical trauma, and social determinants of health while supporting children within their family, community, and cultural contexts. Research highlights that trust, continuity of relationships, culturally responsive assessment and intervention, language support, and genuine shared decision-making with families and communities are critical enablers of engagement and effectiveness for both Aboriginal and Torres Strait Islander and CALD families.

Applying a social and emotional wellbeing lens is central to cultural competency for Aboriginal and Torres Strait Islander children and families.

For Aboriginal and Torres Strait Islander families, cultural safety and belonging are critical determinants of social and emotional wellbeing and essential practice standards. The National Aboriginal and Torres Strait Islander Early Childhood Strategy reinforces that Aboriginal and Torres Strait Islander children thrive when they are strong in culture, connected to family and Country, and supported by culturally safe environments.

Embedding these principles within the Model ensures services actively affirm identity and belonging, address intergenerational trauma, and reflect Aboriginal and Torres Strait Islander knowledge systems and ways of knowing, being and doing, including self-determination.

6.7.2 Kids Hubs are showing strong intent and emerging practice to create culturally safe environments

Families surveyed and interviewed generally report the Kids Hubs deliver care that respects their culture. Ninety-three per cent of all families surveyed who identified as either Aboriginal and Torres Strait Islander or CALD agreed, or strongly agreed, that their child received care that respected their culture. Families interviewed similarly expressed a strong sense of cultural safety, respect, and connection.

Kids Hubs are making genuine efforts to embed cultural safety across all key functions of the Kids Hub. Families and staff, including Aboriginal and Torres Strait Islander and other workers, shared key Kids Hub practices used to support culturally safe care, including:

- **Building cultural competency of all Kids Hub staff** through dedicated cultural competency training (see Section 0) and shared learning from cultural workers to uplift cultural competency of other multidisciplinary team members. At Kids Hubs in Western Australian and the Northern Territory, Aboriginal and non-Aboriginal Kids Hub staff deliver shared sessions through bi-cultural pairings to facilitate collaborative uplift of cultural competency. This allows staff members to build a strong relationship with the family and better understand their needs.
- **Embedding genuine respect for Aboriginal ways of knowing, being, and doing** to establish strong trust and relationships. Several staff and community members stated that building trust through community is a key strength of the Kids Hubs, built on genuine respect for Aboriginal ways of knowing, being, and doing.
- **Recruiting Aboriginal, Torres Strait Islander, and cultural peer workers in core roles**, including Aboriginal Care Navigators, Aboriginal Health Workers, and multicultural support workers (see Section 4.5). Kids Hub team leaders and staff described the effectiveness of blending cultural and clinical skills to drive cultural safety for families and strengthen relationships with partner organisations. This enables stronger cultural competency of care and connection to community. One Kids Hub's Aboriginal Health Worker established strong relationships with families, teachers, and referring partners through a part time role at the Kids Hub and as an Aboriginal

Liaison Officer at a local school. Aboriginal families who received support at a Kids Hub with a dedicated Aboriginal identified position reported 90 per cent agreement that their child received care that respected their culture, compared to 80 per cent for those visiting a Kids Hub without one.

- **Co-designing physical spaces that feel welcoming, culturally safe, and comfortable** for children and families. Kids Hub locations that were able to refurbish or renovate their space were able to create culturally informed spaces that make families feel comfortable. This includes art installations by local Aboriginal artists and naming clinic rooms using the local Aboriginal language(s). Some Kids Hubs have been able to incorporate their natural environment into the space. For example, the Midland Medicare Mental Health Kids Hub operates from a purpose-built facility designed in consultation with local Aboriginal Elders and includes a gated sensory playground that showcases surrounding bushlands.
- **Taking a holistic, family-centred, and strengths-based approach** to identify and respond to diverse needs. Staff are navigating complex family and kinship systems with cultural understanding, often working with children, parents, and carers together. Parents report that this builds their confidence, and staff deliver services in a way that makes them feel respected and not judged. Family-centred goals are set with clear purpose and measurable milestones, and staff work alongside families with curiosity, authenticity, and commitment. This enables culturally safe care to be appropriate and timely from the beginning. Using clear, culturally responsive, and non-clinical language improves understanding, encourages help-seeking, and strengthens parent and carer confidence.

6.7.3 Perceived cultural competency was slightly lower for Aboriginal and Torres Strait Islander families compared to CALD families, due to inadequate time to build strong relationships

Trust and relationship-building are essential to create cultural safety. This enables early engagement and prevention, facilitate collaboration and continuity of care, and support strengths-based practice.[36] Survey results indicate slightly lower perceived cultural competency for Aboriginal and Torres Strait Islander families. **Over 86 per cent** of Aboriginal and Torres Strait Islander families agreed that their child received care that respected their culture. This was **100 per cent** for CALD families and 96.7 per cent for families from neither group (see Table 36).

The slightly lower rating of perceived cultural competency among this cohort may be due to the early stage of implementation. Some staff and ACCO partners reflected that at this stage of implementation, connections with community may not have had adequate time to build genuine trust and respect.

Even when most families report positive experiences, discrepancies in perceived cultural competency reflect the reality that achieving strong, enduring cultural safety for Aboriginal and Torres Strait Islander families requires more time to build relationships and more specialised, place-based, and relational approaches than for other cohorts.

[36] SNAICC (2020). Stronger ACCOs, Stronger Families Final Report. https://www.snaicc.org.au/wp-content/uploads/2023/05/SNAICC-Stronger-ACCOs-Stronger-Families-report-2022.pdf.

Table 36 | Family survey results | Perceived cultural competency of care for families accessing the Kids Hubs, disaggregated by Aboriginal and Torres Strait Islander (n=11), CALD (n=23), and neither (n=134)

Population group	Strongly Disagree	Disagree	Agree	Strongly Agree
Aboriginal and or Torres Strait Islander	9%	5%	36%	50%
CALD	NA	NA	32%	68%
Neither	3%	NA	26%	70%

6.7.4 Some Kids Hubs are finding it more difficult to build cultural competency with Aboriginal and Torres Strait Islander communities

While feedback from Aboriginal and Torres Strait Islander families about the cultural competency of care received is generally positive, this is not consistent for all families. Some Aboriginal and Torres Strait Islander families surveyed (13.6 percent) disagreed with the above question about if their child received care that respected their culture. Challenges noted by Kids Hub staff include:

- **Workforce capacity and capability constraints**. As discussed in Section 4.5, Kids Hubs are experiencing ongoing workforce capacity and capability pressures, particularly in recruiting and retaining specialist cultural staff. These challenges limit the ability to effectively engage and support priority populations, particularly Aboriginal and Torres Strait Islander families. Kids Hubs have identified the need for targeted recruitment strategies to build a culturally representative workforce.
- **Fragmented cultural support across the service journey**. Support for families is not consistently coordinated across the service pathway. Intake processes do not always identify Aboriginal and Torres Strait Islander status or clearly offer Aboriginal Health Worker support, resulting in missed opportunities for culturally appropriate engagement from the outset. Aboriginal staff are also not always routinely involved throughout the full family journey, limiting continuity of care and culturally informed responses as needs change.
- **Integration of partnerships.** The strength and integration of partnerships vary across Kids Hubs. As discussed in Section 0, some report ongoing difficulties establishing or sustaining relationships with ACCOs, including challenges linked to unfilled Aboriginal-identified roles and partnership models that are transactional or top-down. Limited time and space for shared understanding can weaken collaboration. Governance and service integration gaps between Kids Hubs and partner organisations further restrict information sharing, continuity of care, and the ability to provide coordinated and holistic responses for families. Short-term funding cycles also make it difficult to invest in long-term, trust-based partnerships.
- **Broader community and system context.** High population mobility, historical displacement, rapid population growth, and limited non-clinical supports affect community connection and equitable access to the health system. These factors affect community connection and equitable access to services. Ongoing mistrust of government services, driven by historical trauma and stigma, continues to reduce engagement.

6.7.5 ACCO-led delivery is a strong enabler of culturally safe care, particularly in the Mparntwe (Alice Springs) Medicare Mental Health Kids Hub

Partnerships with ACCOs and other community-based organisations are being used to leverage existing trust and expertise in the community and provide culturally safe care to CALD and Aboriginal and Torres Strait Islander families (see Section 4.6). Partnerships with ACCOs often involve in-reach to the ACCO by a Kids Hub clinician, meaning families can receive support on Country.

Most Aboriginal and Torres Strait Islander families accessing Kids Hubs do so through hubs with established ACCO partnerships. These families reported 90 per cent agreement that their child received care that respected their culture, compared to 75 per cent for those visiting a Hub without an ACCO partnership.

Effectiveness of these relationships depends on the partnership moving at the ACCO's pace. For example, the Brisbane Kids Hub has developed a strong partnership with Mununjali Housing and Development Company (Mununjali) by working at their pace, investing time and trust, and allowing the relationship to grow organically.

Case Study: Mparntwe (Alice Springs) Medicare Mental Health Kids Hub

The Mparntwe (Alice Springs) Medicare Mental Health Kids Hub is delivered through an ACCO, the Central Australian Aboriginal Congress (CAAC). Being part of CAAC allows access to additional multidisciplinary supports, including by leveraging Child & Youth Assessment and Therapeutic Service paediatrician and Children's Development team. Kids Hub staff indicate that positioning the Kids Hub under the CAAC model has been valuable in implementing and delivering the Model in a culturally competent way that is locally-tailored to the area's needs and context.

The reach and reputation of the CAAC enabled the Kids Hub to gain community trust rapidly and continues to enable the Kids Hub to deliver outreach services and build connections with local partners.

The Kids Hub is using a social and emotional wellbeing framework to tailor supports for the community and make an impact for Aboriginal children's broader holistic wellbeing. This includes supporting practical needs and helping children develop emotional literacy, build self-regulation skills, establish structure and routine, and providing a safe space to voice their thoughts and feelings. Staff are also supporting children's connection to culture through cultural activities.

The Kids Hub is enabling cultural competency by meeting families where they are, using flexible engagement and outreach. Families appreciate that the Kids Hub come to them – home and school visits reduce disruptions and make engagement easier.

6.8 Kids Hubs are connecting families to new services and 'holding' them through warm handovers

KEQ 3.8 | This section answers the research question:

To what extent are the Kids Hubs facilitating appropriate transitions to new services for children, their families and carers? What has been the uptake and engagement of those services?

Findings are presented against the following mechanisms and outcomes in the program logic:

- Through collaborative care coordination and planning, the Kids Hubs will support children, their families and carers to navigate multiple service providers or transition to new services. By doing this, children, their families and carers will be more likely to continue with care for longer periods.
- Improved referral pathways to other services for children and families.
- Improved opportunities for connection.

This sub-section outlines how effectively Kids Hubs are supporting children and families to transition to other services, including:

- at intake and assessment, when other services are decided to be more appropriate
- through warm handovers as families transition out of the Kids Hub to other services.

6.8.1 Before and during intake and assessment, Kids Hub staff consider if other services may be more appropriate, and connect families to these supports

The Model states that Kids Hubs must be integrated into the broader system and ensure transitions are smooth, supported, and informed, rather than hold families long-term. Staff described the Kids Hubs as a "…connector in the web of services…" that helps families move between supports rather than fall out of the system.

Staff across Kids Hubs described the importance of identifying when a family's needs would be best met at other services and supporting them to access them. This includes when needs fall outside service scope or eligibility criteria, where specialist supports are required, or where the Kids Hub does not have capacity to offer the support needed. Staff describe this navigation as essential to preventing families being 'left without support' and ensuring they receive the most appropriate care.

For some families the Kids Hub's primary role is connecting them to more appropriate services without providing direct support and therapies. National consumer data shows that around two per cent of families received 'Supported Transition or Information and Education' only.

Scenarios where Kids Hubs might 're-direct' families to other services at intake:

- **When the Kids Hub does not have the required workforce or service capability**, such as when a psychologist, speech pathologist, or other specialist role is not available. In these cases, staff refer families to external providers and 'hold' them through the waiting period until support is picked up elsewhere. In Tasmania, challenges recruiting medical roles (like a paediatrician) have led to a strong service navigation focus, where the Kids Hub supports families to access these services elsewhere.
- **When children present with higher-acuity mental health needs**, Kids Hubs redirect families to other tertiary services through stepped-care pathways. Close collaboration with CYMHS/CAMHS (see Section 4.6) enables smoother triage, faster escalation, clearer role delineation, and more efficient referrals. Staff reported that this alignment supports timely warm handovers for children whose needs exceed the Kids Hub scope.
- **When specialist supports are needed,** including for practical supports like housing, safety-focused organisations like external family and domestic violence services, or women's legal services.
- **When functional, developmental, or disability-related needs exceed the Kids Hub's scope**, staff may support children to access NDIS or other disability services.

Some Kids Hubs with strong partnerships or individual relationships with connecting services shared they can connect directly with the connecting service and prioritise referrals depending on need.

> Through collaborative care coordination and planning, the Hubs will support children, their families and carers to navigate multiple service providers or transition to new services. By doing this, children, their families and carers will be more likely to continue with care for longer periods.
>
> - Program Logic mechanism of change

6.8.2 Kids Hubs support warm handovers by working closely with referral partners and 'holding families' while they transition, though effectiveness of transitions is inconsistent between Kids Hubs

Warm referrals for families as they transition out of the Kids Hubs are built into the design of the Model. They are based on evidence that early trust and relationship-building are indicators of higher uptake and engagement of new services. Staff shared that warm handovers are much more than simply handing over a referral. They involve contacting the receiving service directly, sharing essential information, and remaining involved until the family is 'safely picked up' by the new provider. In the national consumer data period, 21 per cent of families received a supported transition to other services, including warm handovers.

When warm handovers are done effectively, they reduce stress and improve engagement with follow-on services. Families, Kids Hub staff, and referral partners shared the value and impact of warm handovers for families transitioning to new services. Families that were interviewed said supported transitions reduce stress and made it easier to stay connected to care.

Referral partners reported that where these processes and relationships are strong, children and families arrive at new services more confident and engaged, and uptake of referred services is stronger. They shared that the Kids Hub's responsiveness and joint problem-solving efforts help ensure families are appropriately supported, reducing risk of disengagement.

Effectiveness of handovers to new services varies between Kids Hubs and between families. **Seventy-five per cent** of Hub staff (n=83) and **67 per cent** of referral partners (n=55) surveyed agreed that the Kids Hub's collaborative care coordination efforts are effective in helping children and families navigate multiple service providers. However, only **half** of Kids Hub staff (n=83), and **half** of referral partners (n=55) surveyed agreed that referral pathways adequately support transitions out of the Kids Hub.

These results indicate two things:

1. The reported effectiveness of supported transitions is relatively low across the Kids Hubs (as reported by staff and referral partners), and this is largely due to capacity constraints in the broader system.
6. The relative alignment of responses between referral partners and Kids Hub staff indicates the level of effectiveness is consistent across the transition process, from the originating service through to receiving services.

Interviews with families also indicated varying effectiveness of supported transitions. Families shared that they value clear communication during exit planning, though some reported unclear pathways, abrupt endings, or limited onward planning. One family said their last appointment felt quite abrupt, and they were invited to re-join the Kids Hub's six-month waitlist, without a referral letter to other services. Another said they were not referred anywhere after finishing. Both families shared desire for a more supported departure from the Kids Hub.

Across sites, transition planning is generally embedded in care, but the time at which exit planning commences varies by Kids Hub. Staff at one Kids Hub shared that planning for transitions out of the Kids Hub begins during initial assessment and is embedded across the family's care journey at the Kids Hub. Another Kids Hub was in early stages of implementation at the time of consultation and had not yet established a clear protocol for exit pathways. When asked about exit processes they shared that there was no embedded process for planning transitions, and families were 'held' for an undefined amount of time.

6.8.3 System capacity and structural constraints limit the appropriateness and timeliness of some transitions, even when Kids Hubs do their part well

System-level constraints limit the appropriateness and timeliness of some transitions out of the Kids Hubs, even when Kids Hubs carry out their role effectively. Staff shared those downstream services (including CYMHS/CAMHS, allied health, diagnostic services, and the NDIS) often operate with long waitlists or strict eligibility requirements, creating delays and uncertainty for families even after a supported transition is made.

Families in several Kids Hubs also reported experiences of 'handover into a gap', where they were referred to services that ultimately could not take them or had long waitlists, indicating that the

broader system is not always able to absorb referrals. These structural constraints mean that even when transition decisions are appropriate and aligned to need, the effectiveness of transitions also depends on what's happening at the referral location.

6.8.4 There are early signs that supported transitions improve family engagement with onward services, but evidence of uptake is limited

Kids Hub staff and referral partners both reported that uptake of new services is higher when families transition slowly, with warm handovers and trust-building in place. Early evidence (as outlined above) indicates that these conditions are present across most Kids Hubs, with many referral partners observing that families arrive more confident and engaged at new services due to supported transitions out of the Kids Hub. However, the varied quality and consistency of supported transitions across Kids Hubs indicates room for improvement to maximise uptake at other services.

6.9 Children, families, and carers are very satisfied with their experience at the Kids Hubs, driven by tailored care and sense of safety

KEQ 3.1 | This section answers the research question:

To what extent are children, their families and carers satisfied with the care they receive and their experience of the service?

Findings are presented against the following mechanisms and outcomes in the program logic:

- Positive experience of accessing the Kids Hub.
- Improved mental health literacy.

This sub-section summarises child and parent satisfaction, as reported in the child and family surveys and interview consultations. It also outlines why family satisfaction is an early outcome indicator, drivers of satisfaction for both groups, and any factors that are negatively impacting satisfaction.

6.9.1 Child and parent satisfaction is a key impact of the Model and early indicator of future outcomes

Negative previous experiences and low trust of other clinical or government services can inhibit family engagement with care, and this is often compounded by other demographic and psychosocial factors. The Model is designed to reach and support these families through holistic support, centred around the family's goals, through flexible engagement approaches to meet families where they are.

By delivering services at a location and pace that families feel comfortable with, the Kids Hubs can maximise satisfaction and engagement. This comfort is driven by enjoyment and a sense of safety. When children enjoy visiting a Kids Hub and spending time with the staff, and parents feel listened to and their wishes respected, families are more likely to stay, return, and seek help in the future.

6.9.2 Children enjoy coming to the Kids Hubs and like the play-based supports and have trusted relationships with staff

Evidence shows that children enjoy attending the Kids Hubs - 86 per cent of children surveyed (n=36) liked visiting the Kids Hub 'a lot'. In consultations, children described the Kids Hubs as fun, welcoming, and comfortable, and often wanted to stay longer or to return. According to one parent at Central Coast Medicare Mental Health Kids Hub, their child was "…so sad to finish with the Kids Hub they cried at the end." Children taking part stated their enjoyment in attending their Kids Hub, believing it to be a "really good place because [the Kids Hub] made school feel easier" and would "recommend the Kids Hub to [their] friends". Various children also commented that they "loved it [at the Kids Hub]' as they felt they were "able to just talk and start and feel comfortable" with themselves and one another.

Relationships with staff are a major driver of satisfaction. Across Kids Hubs, staff are investing time in relationship building with children and families, including through playful engagement and spending time understanding what matters to them. Evidence shows children value one-to-one attention and consistent, trusted relationships, with one child noting, "I liked seeing [Hub staff member] and I want to work at H2H Kids QLD when I grow up." Staff-created warmth and predictability were strong enablers of engagement, and carers observed that children "…really want to come here." These relational elements reinforce children's confidence and support positive experiences across home, school, and social settings.

Children responded well to **play-based supports**, which are a core engagement mechanism across Kids Hubs. One child stated, "I like to play the games.", and parents reinforced this "…my son really enjoyed the play and chat sessions." Children who attended the Children's Health and Wellbeing Local (Southern Metropolitan Melbourne) said they enjoyed playing games with nurses, and children at the Illawarra Medicare Mental Health Kids Hub also spoke about play-based activities as a key part of their experience. This aligns with broader evidence from the Literature and Policy Review that flexible, child-centred play builds comfort and trust.[37]

> "The Kids Hubs took their time to make sure (child) was comfortable. I didn't realise how important that was until (child) said how much they loved coming here."
>
> - Parent/carer

Child survey results reinforced findings from consultations that children had positive experiences at the Kids Hubs (see Table 37).

Table 37 | Child survey results (n=36) | Satisfaction

Survey Question	Not at all	Not much	A little	A lot
Did people listen to you at the Kids Service?	NA	3%	23%	74%
Did the Kids Service help you?	NA	3%	22%	75%
Did you feel safe at the Kids Service?	NA	3%	19%	78%
Did you like coming to the Kids Service?	NA	NA	14%	86%
Do you feel people at the Kids Service understood what was important to you?	NA	NA	22%	78%
Was it easy to visit the Kids Service?	NA	NA	50%	50%

[37] Literature Review.

6.9.3 Tailored supports, involvement in decision-making, and creation of safe spaces are driving strong satisfaction and positive experiences for parents and carers

In survey results and consultations across the Kids Hubs, families consistently reported feeling supported, respected, and emotionally safe when engaging with the Kids Hub, with many saying it was 'the first time' they had felt this way when accessing a service. Trust-based relationships with staff built through deep listening, consistent care, and meaningful connection over time drove this sense of safety. Families were also highly satisfied with the tailored, holistic, and flexible supports their child and family received. Family survey results show very consistent and strong agreement about their satisfaction and experience across several key areas (see Table 38).

> "I had little faith in the Kids Hub, I thought it would be just another roadblock, but I was pleasantly surprised."
>
> - Parent/carer

> "I finally feel listened to and supported, it's been a 'hallelujah moment'."
>
> - Parent/carer

Table 38 | Family survey results (n=174) | Satisfaction

Survey Question	Strongly Disagree	Disagree	Agree	Strongly Agree
I have learnt something useful that could help to improve my child's and family's overall wellbeing	4%	1%	33%	62%
I was involved as much as I wanted in making decisions about my family's participation in the session	4%	1%	23%	73%
I'm happy with my experience at the Hub	3%	NA	23%	74%
It was easy and fast to access the Hub	4%	1%	30%	64%
My child received care that respected their culture	3%	1%	29%	67%
My child's needs were met	4%	1%	30%	66%
People listened to what I had to say and what I was concerned about	3%	NA	17%	79%
The Hub focused on the issues that were important to me	4%	NA	27%	69%

Survey Question	Strongly Disagree	Disagree	Agree	Strongly Agree
I have learnt something useful that could help to improve my child's and family's overall wellbeing	4%	1%	33%	62%

Across consultations, several themes emerged that are driving parent satisfaction across sites. These include the following:

- **Holistic and tailored supports** were a major driver of satisfaction across sites, with families consistently reporting that they valued personalised, flexible, and practical care. Evidence shows strong appreciation for one-on-one support, flexible scheduling ("Staff are super supportive and flexible with times."), and multidisciplinary input that met both child and family needs. Parents described support as "…above and beyond…", "…very holistic and tailored…", and "…meeting all our family's needs…", with some noting it had helped create calmer home environments. Ninety-six per cent (n=174) of parents surveyed agreed or strongly agreed that their child's needs were met at the Kids Hub.
- **Welcoming, non-clinical environments, and judgement-free spaces** were frequently mentioned by parents as highlights of the service. They shared that this helped them feel safe, which was especially important for families experiencing unsafe situations outside the Kids Hub. Parents said they "…love the environment, it's not clinical and there are friendly staff…" and "…every time [the Kids Hub staff member] talks it makes [them] feel respected and safe to ask questions." Some Kids Hubs struggled to create warm physical spaces due to challenges locating a dedicated physical site and are working in temporary spaces. Some parents at these Kids Hubs noted this during consultations.
- **Genuine involvement in decision-making** made parents feel heard. They explained that the Kids Hub listened to their views and focused on the issues that mattered most to them from the very first intake and assessment conversations. Family survey results (n=174) show that 97 per cent of parents felt listened to, 96 per cent agreed the Kids Hub focused on what was important to them, and 96 per cent felt involved as much as they wanted in decisions about their family's participation. Evidence from consultations reinforces this, with parents describing assessments as collaborative and shaped around their concerns. For many parents, this was the first time a service had asked what they needed rather than telling them what to do.
- **Support 'carrying the load'** of managing and advocating for their child's needs and the practical effort of navigating multiple services was a key impact for many parents. Evidence shows that proactive communication and coordinated engagement with schools and other providers helped families feel supported rather than solely responsible for pushing for help, reflected in comments like "I don't feel like I'm alone in this" and "It all makes a difference when every day is so stressful." Families said this support made it easier to deal with their child's needs day-to-day while also reducing the stress of advocating across a fragmented system.

- **Increased mental health literacy, confidence, and understanding of their child**, which has led to improved help-seeking behaviour for many parents. Evidence shows the Kids Hubs help parents feel less judged, better understand what drives their child's behaviour, and use targeted strategies at home, with 96 per cent (n=174) agreeing they learnt something useful to improve their child and family's wellbeing. For some, this meant tools to support emotional regulation or school routines; for others, it was about rebuilding their own confidence – "…GP just told me to build my confidence. The Kids Hub showed me how." Parents also reported a clearer sense of where to go for help and said they felt more able to advocate for their child with schools and other services, which is translating into earlier, more active engagement with supports.

6.9.4 Some parents were not satisfied with physical spaces, processes, and service offering at the Kids Hubs

Some parents raised fewer positive experiences. The most common challenges for parents included clunky forms, systems, and administrative processes that made engagement harder than it needed to be. A few noted that physical spaces felt too clinical, particularly where Kids Hubs operated from temporary sites rather than purpose-designed environments. Others were unclear about eligibility or what the service offered, leading to confusion at intake and exit. Some parents also expressed disappointment when only group sessions were offered in situations where they felt one-on-one support would have better met their child's needs.

6.10 Kids Hub staff and external stakeholders are generally satisfied with the Model and how it is working in practice

KEQ 3.2 | This section answers the research question:

To what extent are system stakeholders (multidisciplinary teams and external stakeholders) satisfied with the Model and how it is working?

Findings are presented against the following mechanisms and outcomes in the program logic:

- Multidisciplinary team members have respect and trust for each other and a clear understanding of each discipline's roles, skills, and scope practice in supporting children and families.
- Staff have increased job satisfaction and job retention.

This sub-section outlines system stakeholder satisfaction with the Model, including:

- staff satisfaction and confidence in the Model
- how staff confidence in the Model improves Kids Hub team culture and job satisfaction
- the impact of leadership at all levels on satisfaction
- referral partner satisfaction with the Kids Hubs and support provided.

6.10.1 Kids Hub staff expressed satisfaction and confidence in the Model, emphasising the importance of its flexibility

Evidence from the Evaluation site visits and consultations shows that staff across all Kids Hubs are motivated, invested in the Kids Hubs, and confident in the Model.

Across staff interviews, the flexibility of the Model was one of the most consistently identified strengths of the service. Staff emphasised the importance of initial flexibility to design tailored local service models that meet local needs, but also ongoing service flexibility to adapt care for individual families. This enhances motivation of staff and outcomes for families because it gives staff room to be creative and collaborative in the care they deliver, rather than defaulting to discipline-specific clinically prescribed approaches.

It also enables them to focus on the individual needs of families in the moment and tailor care in a way that suits them and will drive genuine impact. Eight-two per cent of Kids Hub staff agree that the supports offered at the Kids Hub cater to the functional needs of children and families who visit. Staff at Kids Hubs with a high uptake of Aboriginal and Torres Strait Islander families noted flexibility to adapt supports to family and community contexts is essential for culturally safe practice.

Table 39 visualises staff satisfaction across various components of the Model. While responses generally indicate high satisfaction, satisfaction with outreach (63 per cent agree or strongly agree) and intake procedures (67 per cent agree or strongly agree) are lower. This affirms evidence of potential pressure points at the system interface, where the Model relies most heavily on effective

integration with existing services, referral pathways, and shared understanding across stakeholders (see Section 6.1).

Table 39 | Kids Hub staff survey (n=83) | Satisfaction with the Model

Survey Question	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
The Hub improves the timeliness of support for children and families effectively	2%	5%	19%	45%	29%
The Hub team are effective at providing useful direct treatments, therapies and supports to children and families	1%	4%	13%	49%	33%
The Hub's approach to outreach is effective and captures the target cohorts	4%	6%	28%	42%	20%
The Hub's collaborative care coordination efforts are effective in supporting children and families to navigate multiple service providers	2%	6%	16%	52%	23%
The Hub's initial assessments effectively facilitate early identification of issues and needs known to lead to poor mental health and wellbeing (neurodevelopmental, behavioural, developmental, mental health, social)	1%	7%	13%	58%	20%
The access and intake procedures are easy to navigate	4%	13%	16%	49%	18%
The treatments, therapies and supports offered at the Hub cater to the functional needs of children and families who visit	1%	4%	13%	53%	29%

Staff are also observing positive impacts on child and family wellbeing, school functioning, and emotional regulation, which strengthens their confidence and motivation to deliver the Model. Many described feeling privileged to support families, noting, "…being able to help them through the hardest times is such a privilege." Staff highlighted that the Model's early-intervention,

relationship-based approach enables meaningful support for children with mild-moderate needs, and parenting focus supports more "…sustainable change…" for families.

> "One of the most rewarding parts of our job is that we can actually make a difference and that kids really want to come here."
>
> - Multidisciplinary staff member

6.10.2 Shared purpose and confidence in the Model drive strong Kids Hub team culture and job satisfaction

Across jurisdictions, shared purpose is translating to strong team culture and high job satisfaction, with 78 per cent of Kids Hub staff agreeing they enjoy coming to work, and only 25 per cent likely to look for a new job within the next year. An overview of Kids Hub staff job satisfaction, as reported in the staff survey, is presented in Table 40 below.

Table 40 | Hub staff survey results | Job satisfaction (n=83)

Survey question	% responses agree or strongly agree
I enjoy coming to work at the Kids Hub	78%
My team members respect me and value the role I play in the multidisciplinary team	85%
I trust my team members	83%
I feel burned out because of my work	15%
I am likely to look for a new job within the next year	25%
The team collaborates effectively to support children and families	73%
The scope and boundaries of my role are clear and well defined	70%

Staff described how strong team culture drives multidisciplinary team functioning, service quality, and ultimately outcomes for families. Teams with strong culture described open, trusting, and psychologically safe environments, illustrated by staff saying there is "…no fear to sit down and discuss when something isn't working." **Eighty-three per cent** of staff agree that they trust their team members, and **85 per cent** agree that their team members respect them and value the role they play in the multidisciplinary team.

According to Kids Hub leads, consistent workforce mindset is critical. Staff reflected that working in strong, motivated teams supports professional growth and effective multidisciplinary decision-making. These teams also handle complexity better; staff noted that collaborative problem-solving and shared learning helped them manage complex or challenging family

presentations. In several Kids Hubs, this culture is contributing to low turnover and stable staffing, which staff attributed directly to a positive environment and supportive leadership.

> "How much we've learnt from one another is amazing"
>
> - Multidisciplinary staff member

Teams noted that this philosophy needs to be considered during recruitment, which can create challenges in sourcing candidates who are both clinically capable and aligned to the Model's relational, holistic approach.

> "There's a lot more heart than ego in this team and it comes through every person."
>
> - Multidisciplinary staff member

6.10.3 Strong leadership drives satisfaction and begins at the executive and policy level, with Kids Hubs reporting mixed levels of support from leadership to enable the Kids Hub to be effective

Effective leadership acts as the 'glue' of the Model by providing clear purpose, consistent expectations, and key performance indicators that help teams stay aligned, even under workforce pressure. Leadership at several levels is impacting staff satisfaction:

- **Kids Hub leadership and governance:** Kids Hub leadership and governance strongly influence staff satisfaction, confidence, and ability to deliver the Model as intended. Where this is present, staff report feeling supported to manage complexity - reflected in high agreement that they receive sufficient support when challenging situations arise (88 per cent agree).

  However, leadership and governance are not consistent across Kids Hubs. In some locations, staff described stretched leadership capacity, unclear governance and processes, and inconsistent decision-making, reducing confidence and day-to-day satisfaction. In other cases, clinicians working alongside the Kids Hubs were not fully integrated into multidisciplinary teams, limiting access to shared clinical information and weakening coordinated care. Staff reported that inconsistent messaging from leadership about the Model made it harder to deliver its intent.

- **Executive leadership:** Across several jurisdictions, Kids Hub leaders expressed challenges engaging and receiving support from executive leadership at the state/territory and policy level. Effective executive-level leadership is a critical enabler of the Model because it sets the clarity, stability, and consultation foundations that Kids Hub leaders need to implement the Model as intended. It also enables ongoing decisions to adapt to the Kids Hubs' needs as they evolve.

  Evidence collected across the Evaluation site visits showed that in jurisdictions where this leadership is inconsistent or unclear, frontline teams feel the impact immediately. In one jurisdiction Kids Hub leaders reported having "…nowhere to throw ideas up…", feedback not being listened to, and being pushed to open before they had time to build their team or design core processes. In another jurisdiction, Kids Hub leaders described decisions being made "…above their heads…", with limited consultation and promised community co-design not

eventuating. In both examples, the quality of executive leadership and lack of consultation impacted Kids Hub leaders' ability to make informed decisions, establish safe practice, and deliver the Model to meet local needs.

6.10.4 Staff satisfaction is limited in some Kids Hubs by inadequate resourcing and fragmented systems

Across consultations, staff revealed conditions which impact their satisfaction and ability to implement the Model**.**

Inadequate resourcing and support are a widespread constraint across the Kids Hubs. Only 61 per cent of staff agreed that they have all the resources they need to do their job well. Staff described how incomplete staffing profiles and reliance on part-time roles limit the functioning of multidisciplinary teams and increase pressure on existing staff. This slows intake and assessment processes and reduces service capacity and availability of specialist expertise.

In Kids Hubs with incomplete resourcing, such as in Tasmania, Kids Hub staff shared that unmanageable workloads affect their satisfaction and ability to implement the Model. Team leaders in the Northern Territory also noted that operating without a fully staffed workforce makes it difficult to determine if the Model is working as intended or how it should be refined, as delivery is shaped by capacity constraints rather than design.

Fragmented system processes and information technology further constrain staff satisfaction and limit the ability to deliver the Model as intended. As outlined in Section 0, staff reported that inconsistent systems, limited interoperability, and poor access to shared information increase administrative burden and disrupt multidisciplinary ways of working. These challenges make it harder to coordinate care, share clinical information, and track family journeys across services, undermining the efficiency of intake, assessment, and ongoing support.

6.10.5 Referrers often report a lack of clarity about the Model, leading to confusion and dissatisfaction

Referrers broadly view the Kids Hubs as filling an important gap in the service system and providing a valuable early-intervention option for children and families. However, referrer satisfaction with the Model is often constrained by limited understanding of how it operates in practice and what the Kids Hubs can offer families. Across multiple sites, referrers reported a lack of clarity about acceptance criteria, inconsistent decisions about which families are taken on, and a lack of clear information about what the Kids Hubs offer, leading to hesitation to refer and reduced confidence in the service.

Clearer communication and feedback are critical to strengthening partners' satisfaction with the Model and likelihood of referring into the service. Referrer perspectives on the effectiveness of partnerships and collaboration with Kids Hubs are discussed further in Section 6.2.

6.11 There is strong evidence the Kids Hubs are achieving all elements of the Program Logic that drive improvements in child and family mental health and wellbeing

KEQ 3.10 | This section answers the research question:

To what extent are the Kids Hubs supporting improvements in the mental health and wellbeing of children, their families and carers?

Findings are presented against the following mechanisms and outcomes in the program logic:

- Improved mental health and wellbeing, behavioural, and developmental outcomes as demonstrated through other elements of the Program Logic.

This sub-section outlines evidence of progress toward improved mental health and wellbeing for children and families. This includes a visual synthesis of evidence against the program logic that early indicators of improved mental health and wellbeing are being achieved, as well as a summary of observed improvements identified in the Evaluation consultations.

6.11.1 Children's mental health comprises more than clinical symptoms or diagnoses

The Strategy outlines that children's mental health and wellbeing encompass' their safety, emotional regulation, developmental needs, relationships, and the broader social and environmental conditions. Isolating 'mental health' from these factors or focusing narrowly on clinical diagnosis does not consider how children experience distress and recovery. For Aboriginal and Torres Strait Islander children, social and emotional wellbeing is shaped by every part of a person's life, relationships, and connection to Country.

> "Good mental wellbeing means that children are able to feel safe, happy, heard, and supported, and have meaningful, loving connections with family, friends, and community."
>
> - The National Children's Mental Health and Wellbeing Strategy

The Model focuses on identifying emerging needs early and providing multidisciplinary, family-centred support before issues escalate. Over time, the cumulative impact of early interventions is expected to contribute to improved mental health trajectories. Because the Kids Hubs are still in the early stages of implementation, it is not appropriate or possible to attribute clinical mental health outcomes directly to the Kids Hubs at this stage. Instead, mental health and wellbeing outcomes can be assessed through evidence of early indicators.

Research in the Literature and Policy Review highlighted three core insights about early indicators of improved child mental health and wellbeing:

- **The best outcomes come from intervening early, before needs escalate or crystalise**. Early identification and timely response allow children to develop emotional regulation, coping, and problem-solving skills at the stage when their brains are most adaptable.

- **Family capability is an essential mechanism for child improvement**. Children's outcomes consistently improve when parents and carers feel more confident, better informed, and equipped to support their child's development and emotional needs.
- **Environmental and relational conditions such as safety, stability, routine, connection, and reduced stress act as powerful protective factors**, often outweighing individual risk factors.

6.11.2 Kids Hubs are achieving the necessary drivers to support improved mental health and wellbeing outcomes for children and parents

There is strong evidence that the Kids Hubs are achieving early indicators of improved child and parent mental health and wellbeing. Staff and parents report that families often face complex challenges that have compounded over time.

> "The children's mental health needs are mild-to-moderate, the families are more complex than we expected."
>
> - Kids Hub staff member

Many children observed are presenting with concurrent developmental and behavioural concerns that intersect and can cause distress for families.

- 65.9% of families have at least one psychosocial vulnerability.
- 27.3% of families have co-occurring psychosocial vulnerabilities.

Table 41 is a synthesis of evidence from the Evaluation, indicating the Kids Hubs are improving child and family mental health and wellbeing. It summarises evidence against the relevant mechanisms, outputs and outcomes of the Kids Hubs Program Logic (see Appendix A).

Table 41 | Mechanisms of change that improve child and parent mental health and wellbeing

Mechanisms of change	Outputs for children and families	Outcomes for children and families	Benefits
Broad access and referral approach • The Model removes barriers and makes it easier for children and families to access supports. **Supported transitions** • The Kids Hubs provide warm handovers to new services. **Holistic assessment of needs** • Kids Hubs are using iterative, multidisciplinary intake and assessment, and care planning processes to identify developmental and psychosocial complexities. **Individualised and culturally appropriate care** • Kids Hubs are showing strong intent and emerging practice to create culturally safe environments. **Workforce opportunities**	• **95%** of families agreed it was fast and easy to access the Kids Hub. • Families and staff report Kids Hubs provide "…a practical and accessible entry point." • Staff described the Kids Hubs as a "…connector in the web of services…" that helps families move between supports rather than fall out of the system. • Referral partners reported stronger engagement with families who received a supported transition from the Kids Hub. • Holistic assessments reveal developmental, behavioural, and biopsychosocial indicators of mental health challenges.	• **73%** of staff surveyed agree that the Kids Hubs improve the timeliness of support for children and families. • **92%** of parents reported their access to supports had improved since visiting the Kids Hub. • **86%** of children enjoy coming to the Kids Hub 'a lot'. • **97%** of parents were happy with their experience at the Kids Hubs. • Parents described their homes becoming calmer and more predictable through Kids Hubs' support, with strengthened communication and reduced stress. • Parents and children reported connecting with peers at the Kids Hubs.	• Improved mental health and social and emotional wellbeing outcomes for children and parents • Improved quality of life and avoided cost of future more intensive supports.

Mechanisms of change	Outputs for children and families	Outcomes for children and families	Benefits
• All Kids Hubs are including families in care including; goal-setting, parenting supports, and providing strategies and tools.	• **83%** of staff agree that initial assessments effectively identify emerging needs. • **93%** of families agreed they received care that respected their culture • Families feel supported and 'held' by staff. • Families reported that they are involved in goal setting and receive supports to better understand their child. • **96%** of families learnt something useful at the Kids Hub to help them support their child.	• Families report increased confidence and understanding of how and where to seek help.	

6.11.3 Parents and staff are observing early improvements in children's behaviour, functioning, and emotional wellbeing after engaging with the Kids Hub

Consultations with children, families, and staff indicated that the Kids Hubs are supporting improvements in children's behaviour, emotional regulation, school functioning, and social participation. These are consistent with early-stage changes expected from an early-intervention model and indicate that the conditions for longer-term mental health and wellbeing improvements are beginning to emerge.

Behaviour and emotional regulation

Evidence from consultations across multiple Kids Hubs indicates observable improvements in children's behaviour, emotional regulation, school functioning, and ability to manage daily situations. Parents reported that their "[child's] behaviour has improved a lot", seeing fewer emotional meltdowns, improved self-regulation, and more predictable daily routines. Children also stated being able to understand and voice their emotions for the first time, with parents sharing that their child "could understand why [they] felt certain emotions" and "voices [these] emotions which [they] have never down before". Staff similarly observed calmer behaviour, improved routines, and reduced distress.

School functioning and learning engagement

Across consultations with children, schools, and staff, Kids Hubs are reported to support improved engagement and functioning at school. Children shared that it felt easier to focus and participate at school since attending the Kids Hub. Teachers also noticed changes in the classroom, including reduced dysregulation and improved classroom readiness. Some children experienced academic gains, including one who moved from "…two years behind to surpassing peers…" according to their parent.

Social participation and confidence

Kids Hubs provided safe, child-friendly environments that helped children build confidence and engage socially. Children described "…starting to enjoy being with people…" and "…feeling heard...". Play-based and sensory-friendly settings appeared to contribute towards reduced anxiety and supported engagement, especially for neurodivergent children. One parent reported their child had pride and reduced stigma around their ADHD diagnosis, whilst one child who was selectively mute found themselves to be able to speak after six weeks of Kids Hub sessions.

6.12 While the Model has achieved its intended objectives overall, a small number of unintended outcomes have emerged for some cohorts

KEQ 3.12 | What (if any) are the unintended outcomes or consequences of implementing the Model?

While there have been several lessons learnt about how the Model has been implemented, most observed outcomes of the Kids Hubs align closely with the intent and expectations of the Model. This section outlines two unintended outcomes of the Model which were observed through this Evaluation.

6.12.1 Positive outcome: group-based supports created unexpected social connections between families

Some families reported forming new friendships at the Kids Hubs. Parents described making social connections and learning from other parents during group parenting sessions, as well as connecting in informal spaces and waiting rooms. For some families, this led to organising 'play dates' with their children. Some children also built social confidence and made friends in group play activities. For example, Midland Medicare Mental Health Kids Hub's play-based sessions gave children and families a relaxed space to connect with peers.

These experiences indicate that group supports and activities at Kids Hubs can create moments of social connection for families, improving parents' networks, and children's social participation.

6.12.2 Negative outcome: the transition to 'Medicare Mental Health' branding has created some challenges positioning the Kids Hub as 'more than just a mental health service', leading to confusion for families and frustration from Kids Hub staff

Early consultations with policy and Kids Hub leaders highlighted that the Kids Hub placement within the broader system (for example, sitting within an existing mental health service) shapes how families and other stakeholders perceive the Kids Hub's role and service offering. They emphasised the importance and challenge of ensuring families understand it is more than just a child mental health program, and rather a holistic, wraparound child and family hub – this drives the destigmatisation of services, particularly for families accessing supports for the first time.

Staff across several Kids Hubs reported that the 'Medicare Mental Health' re-brand exacerbated challenges positioning the Kids Hubs as more than a mental health service. It created confusion for families around eligibility and what the Kids Hubs offered. Some families saw it as 'just another mental health service', and others without a Medicare card were unsure if they could still attend.

Additionally, one Kids Hubs had previously invested time, resources, and effort into co-designed and child-friendly local branding and physical design elements. The re-brand required these

materials to be replaced. Staff described this as an additional burden during implementation, noting that it diverted attention and resourcing from core activities. Some also described the new branding as more clinical and less welcoming, which affects how families perceive the service.

7 KEQ 4 – Cost Effectiveness

This section answers the following Key Evaluation Question:

KEQ 3 Cost-effectiveness: To what extent are Kids Hubs using resources well and how cost-effective are the Kids Hubs compared to similar models?

The previous section described the overall effectiveness of the Kids Hubs. This section presents insights on cost-effectiveness, including if the Kids Hubs are using resources well, and how cost-effective the Kids Hubs are compared to similar models.

This section also presents considerations for a future economic evaluation and what data and information will be required to support this.

SUMMARY OF FINDINGS

Funding allocation

- Funding for the Initiative is set out in the bilateral agreements and outlines co-funding commitments – the Australian and state/territory governments co-funded over $167 million to implement the Initiative over FY2021-2026.
- There is some variation between Australian Government and state/territory contributions – Victoria provided additional funding from the Royal Commission into Mental Health (~$10 million) and in South Australia, the Initiative is fully funded by the Australian Government (no state contributions).
- Funding was primarily used for service delivery staff salaries (45 per cent of total FY2024-2025 costs), and capital and rent expenses (26 per cent of total FY2024-2025 costs). For staff salaries, the highest proportion of costs were for Therapeutic and allied health services (27 per cent) and Clinical and medical professionals (26 per cent).
- Capital investment in facilities was often a major cost driver, though this varies by jurisdiction – purpose-built or customised facilities attract higher capital and rental costs, whereas sites that leveraged existing infrastructure faced significantly lower capital and rental costs.
- While most of the funding is specified through the bilateral agreements, some Kids Hubs drew on additional supports and resources to deliver services, such as additional state government funding, philanthropic grants ,and existing state-funded services.

Funding model

- There are no strict requirements in the bilateral agreements for how funding should be allocated – this flexibility has been critical to support implementation of the Kids Hubs into the local context.
- Policy teams reported that this flexibility allowed Kids Hubs to respond to local needs by adjusting staffing profiles and adapting delivery approaches.

SUMMARY OF FINDINGS

- This flexibility enabled some jurisdictions to allocate funding across multiple geographic sites to expand access and reach. However service managers and staff have expressed challenges with sharing resources across multiple sites, and the sense that decisions were politically driven and not adequately considerate of resourcing and staffing constraints.
- Inconsistent funding rollout arrangements across jurisdictions have created administrative and operational challenges, including challenges with rolling over unspent funds, poor administration of capital funds, complex joint commissioning arrangements, and a lack of clarity on bundled bilateral payments.

Cost-effectiveness

- The cost of establishing and operating Kids Hubs are comparable to other child and family hub models.
- The Kids Hubs improve system effectiveness through earlier identification of needs, more timely interventions, and better coordination across the system. The Kids Hubs seek to shift child and family trajectories, through family-focused and earlier interventions that reduce the need for multiple and costly mental health interventions, particularly at the crisis end of the system.
- A full cost-effectiveness or cost-benefit analysis is not currently possible due to data limitations, but Kids Hubs are expected to generate economic value through avoided system costs and improved quality of life for children and families.
- Other similar child and family hub models have quantified value for money through social and economic benefits, with an average cost-benefit ratio of 1:2.6.
- A future economic evaluation of the Kids Hubs requires analysis of establishment and operational costs, compared to economic benefits through reduced or avoided costs, and long-term quality of life outcomes.

7.1 The Australian and state/territory governments co-funded over $167 million to implement the Initiative

KEQ 4.1 | What funding was allocated to support the implementation of Medicare Mental Health Kids Hubs initiative?

7.1.1 Funding for the Initiative is set out in the bilateral agreements and outlines co-funding commitments from FY2021-2026

In the National Mental Health and Suicide Prevention Agreement, bilateral agreements between the Australian Government and each state/territory jurisdiction operationalise the implementation of the Kids Hubs. These agreements include a clear commitment from parties to co-fund the implementation and ongoing operation of Kids Hubs on an equal 50:50 basis. The original bilateral schedules outline funding commitments through to 30 June 2026, and recent renegotiations extend annual funding to June 2027.

Between 2021 and 2026, the total funding committed amounts to $167,386,197. This includes:

- Australian Government contribution of $84,858,000
- State/territory contributions of $82,528,197.

There is some variation between Australian Government and state/territory contributions – Victoria provided additional funding from the Royal Commission into Mental Health (~$10 million) and in South Australia, the Initiative is fully funded by the Australian Government (no state contributions). A breakdown of funding contributions per Australian Government and each state or territory is in Table 42, and detailed amounts are in Appendix E.

Table 42 | Federal and state/territory funding contributions ($m), FY2021-2022 to FY2025-2026

Year	Federal funding	State/territory funding
2021-22	0	2.9
2022-23	14.0	14.6
2023-24	21.3	17.8
2024-25	23.2	22.3
2025-26	26.2	25.0

7.1.2 Funding was primarily used for service delivery staff salaries, and capital and rent expenses

In FY2024-2025, most costs across all Kids Hubs are attributed to service delivery staff (45 per cent of total costs) and capital and rent costs (26 per cent of total costs). This reflects the resource-intensity of delivering Kids Hub services, and their phased implementation, whereby several sites incurred upfront establishment costs in FY2024-2025 such as recruitment and setting up a physical location. Capital investment in facilities was often a major cost driver, though this varies by jurisdiction:

- **Purpose-built or customised facilities** attract higher capital and rental costs. For example, due to limited availability of suitable NSW Government-owned buildings, Kids Hubs in New South Wales have leased commercial premises and undertaken custom fit-outs, including a gym, outdoor spaces, and fit-for-purpose rooms.
- **Sites that leverage existing infrastructure** face significantly lower capital and rental costs. For instance, Kids Hubs in Tasmania used existing child and family learning centres and primary school facilities to deliver services, and the Kids Hub in the Northern Territory was allocated vacant office space at the existing Central Australian Aboriginal Congress site.

Table 43 outlines the reported costs of delivering Kids Hubs across eight cost categories in FY2024-2025.

Table 43 | Reported costs of delivering the Kids Hubs services nationally in FY2024-2025

Cost indicator[38]	Value ($AUD)	Proportion of total cost
Practitioner, clinician, and other service delivery staff salaries	$16,282,000	45%
Capital and rent costs	$9,419,000	26%
Management and administration staff salaries	$3,900,000	11%
Other office overheads	$3,246,000	9%
Service delivery activities	$1,514,000	4%
IT costs	$512,000	1%

[38] Note that individual responses to staffing, financial, and implementation templates did not all use the cost categories provided due to differences in their respective financial reporting practices. Where there are similar line items, we have categorised costs against the relevant cost categories. Any line items that differ significantly from the cost categories have been categorised as 'other costs'. Costs are aggregated nationally and presented by cost category to provide an overarching view of the costs associated with the implementation of the Model. Costs are rounded to the nearest $1,000 and are presented based on data for the 2024-2025 financial year as this was the only expenditure data captured consistently in the staffing, financial, and implementation templates; noting that implementation of individual Kids Hubs occurred at different times and across different financial years.

Cost indicator[38]	Value ($AUD)	Proportion of total cost
Professional development and training	$453,000	1%
Other costs	$1,033,000	3%
Total	**$36,360,000**[39]	**100%**

Practitioner, clinician, and other service delivery staff made up 45 per cent of the annual cost of delivering the Kids Hubs nationally. In this group, therapeutic and allied health staff, and clinical and medical professionals accounted for more than half of total staffing costs. Table 44 below shows proportions of salary expenditure across key role groups.

Table 44 | Proportion of total salary expenditure across all Kids Hubs in FY2024-2025

Salary expenditure	% proportion
Therapeutic and allied health services (e.g. social workers, speech pathologists, dieticians)	27%
Clinical and medical professionals (e.g. paediatricians, psychologists, psychiatrists)	26%
Community and cultural engagement	17%
Leadership and management	16%
Support and coordination services	8%
Admin & operational support	6%

Clinical and medical professionals (such as psychologists, paediatricians, and psychiatrists) had the highest salary costs per FTE (Table 45). These professionals often work on a part-time basis, providing support to other staff and support efficient distribution of specialist resources.

[39] There are some discrepancies between funding amounts reported in bilateral schedules and reported costs of delivering Kids Hubs services as some locations did not provide cost estimates.

Table 45 | Salary expenditure by FTE on each role classification in FY2024-2025

Role classification	Total annual salary expenditure	Total FTE[40]	Salary per FTE
Therapeutic and allied health services	$6,310,377	47.7	$132,249
Clinical and medical professionals	$6,082,150	34.5	$176,269
Community and cultural engagement	$3,860,591	35.7	$108,019
Leadership and management	$3,654,372	21.9	$166,866
Support and coordination services	$1,924,575	18	$106,921
Administrative and operational support	$1,337,592	13.8	$96,787
Total	$23,169,656	171.645	$134,986

KEQ 4.3 | What other support or resources were required to deliver the Kids Hub services in each state and territory, and nationally?

7.1.3 While most of the funding is specified through the bilateral agreements, some Kids Hubs drew on additional supports and resources to deliver services

Under the bilateral agreements, jurisdictions negotiated federal funding to support the delivery and operation of Kids Hubs. In some cases, sites have supplemented this funding with additional resources from other sources, including:

- **State government funding:** The Kids Hubs in Victoria receive additional support through funding associated with the Royal Commission into Victoria's Mental Health System. The Royal Commission identified the need for a renewed focus on early intervention and age-appropriate care to better address developmental and mental health challenges in younger children.

[40] The total FTE figures exclude reported FTE for Loddon Children's Health and Wellbeing Local as salary data was not provided by this site.

- **Philanthropic funding:** Midland Medicare Mental Health Kids Hub has received targeted funding through the Paul Ramsay Foundation's Strengthening Family-Centred Collaborations grant to expand family and domestic violence support in its Kids Hub.
- **Existing state-funded services:** The Illawarra Medicare Mental Health Kids Hub has incorporated an existing state-funded service (Illawarra Shoalhaven Diagnostic and Assessment Service), to support delivery and provide diagnostic capability in its Kids Hub.

It is difficult to determine the extent to which these additional resources were required to deliver Kids Hub services. Further analysis is needed to assess if the Kids Hubs are delivering value for money under the existing bilateral funding agreements.

7.2 Flexibility of the funding model supported local implementation of the Kids Hubs, but also created challenges

KEQ 4.2 | To what extent was the funding model appropriate and effective at supporting the aims of the Medicare Mental Health Kids initiative?

7.2.1 Funding flexibility has been critical to support implementation of the Kids Hubs into the local context, building on what exists and addressing gaps

The bilateral agreements established a 50:50 co-funding arrangement between the Australian Government and each jurisdiction for establishment and ongoing operation of the Kids Hubs. Beyond this, there are no strict requirements for how the funding should be allocated. This is a unique approach in comparison to other national programs and initiatives that are often more prescriptive.

State and territory policy leads reported that the funding flexibility has been critical in the implementation of the Kids Hubs and achieving the intent of the Model. They shared that it enables Kids Hubs to respond to local needs by adjusting staffing profiles and invest in services to complement the existing landscape (not duplicate) or adapt delivery approaches. Some Kids Hubs have redistributed funding across financial years to manage implementation timing and establishment costs, which has been particularly valuable for sites that have faced challenges in workforce recruitment or facility procurement.

> "The flexibility of funding has been generally good, allowing for adjustments in staffing and moving money around as needed without a complex process."
>
> - State and territory policy lead

7.2.2 This flexibility enabled some jurisdictions to allocate funding across multiple geographic sites to expand access and reach

As per the Model, flexibilities are allowed to address any local or jurisdictional requirements, including determining the expected geographical service area. In some jurisdictions, policy teams decided to allocate funding across multiple Kids Hub sites to expand reach of the service. For example:

- For the Brisbane Kids Hub, two sites were established in different locations using one funding source. Senior management and clinical staff work across both locations.
- In Tasmania, a similar decision was made to distribute funding across three different sites due to regional needs, recruitment challenges, and political reasons. Management staff is shared across the multiple sites.

- In South Australia, funding for one Kids Hub is being used to set up two sites – this decision is tied to an election promise.

While the flexible funding extended the reach of Kids Hubs, service managers and staff have expressed challenges with sharing resources across multiple sites, and the sense that decisions were politically driven and not adequately considerate of resourcing and staffing constraints.

7.2.3 Inconsistent funding rollout arrangements across jurisdictions have created administrative and operational challenges

Across several jurisdictions, differences in funding rollout and financial management arrangements have increased administrative burden, reduced efficiency, and contributed to implementation delays. This includes:

- **Challenges with rolling over unspent funds:** In most jurisdictions, implementation activities have often taken longer than anticipated, resulting in slower than planned expenditure. Some Kids Hubs noted that their state/territory government policies have made it difficult to rollover unspent funds from one year to the next, which in some cases has led to the loss of allocated funding. One Kids Hub Service Manager noted that "…the service has faced difficulties due to funding being ring-fenced to certain years, leading to a loss of funds when they weren't spent in time."
- **Poor administration of capital funds:** There was no dedicated capital budget and limited capital expenditure planning, despite the Initiative involving an infrastructure component. Kids Hub leads shared that early property investigation and dedicated capital budgets could have accelerated the establishment of Kids Hubs, and in circumstances where this was not considered early, timelines have been substantially extended.
- **Bundled bilateral payments and limited clarity:** New South Wales and Queensland reported that accessing funding through the bilateral agreement was challenging, particularly with all bilateral funding packaged up into one payment. They reported a lack of clarity about rollovers, carry forwards and whether funding could be moved between initiatives.

7.2.4 Delays shortened the operational funding period, placing further constraints on planning and implementation

Newly funded service models typically require substantial time to establish before they can operate at scale. For the Kids Hubs, this included commissioning and appointing service providers, developing local models of care through co-design, identifying and securing appropriate locations, and recruiting a multidisciplinary workforce. In practice, these activities took longer than initially anticipated across many jurisdictions. Delays were commonly associated with finalising models of care, agreeing on locations, negotiating service provider contracts, and securing suitable premises.

Although the Initiative was funded over a four-year period, a significant proportion of this time was absorbed by establishment activities outlined above, leaving a shorter effective operational funding window. The compressed operational timeframe created additional implementation challenges,

including limited ability to offer longer-term employment contracts, difficulties securing long-term leases, and constraints on appointing service providers under short-term funding arrangements.

Some jurisdictions sought to mitigate this risk by committing funding beyond the term of their bilateral agreements, for example by underwriting longer-term leases or extending employment arrangements. While these approaches improved short-term stability and supported continuity of service delivery, they also created financial exposure for jurisdictions if the Initiative does not receive continued federal funding beyond the current period.

7.2.5 Ongoing funding for the Initiative has not been decided, and will be informed by this Evaluation and the broader policy and funding context

This Evaluation provides evidence on the appropriateness of the funding model, the effectiveness of implementation arrangements, and early indications of service performance and outcomes. It also offers early insights into value for money, including how funding has been used to support establishment, workforce development, and service delivery across jurisdictions. These findings are expected to inform future funding decisions including the scale, structure, and the ongoing role of the states/territories and the Australian Government in supporting Kids Hubs.

Consideration of future funding will also need to consider the broader policy and reform environment, including related child and family mental health initiatives and system reforms such as Thriving Kids, to ensure alignment, avoid duplication, and support sustainable integrated service delivery.

7.3 Similar child and family hub models provide insight into how to measure cost-effectiveness

KEQ 4.4 | How do the costs of the Kids Hubs compare to other child and family hub models?

7.3.1 The Kids Hub model's capital and operating costs are comparable to other child and family hub models

Similar child and family hub models were identified to support cost comparisons with the Kids Hubs – Early Childhood Hubs (ECH) and the Integrated Child and Family Hub (Wyndham Vale). These models deliver similar hub-based services and support comparable cohorts. Further detail on the services provided and populations supported is included in Appendix E.2.

Overall, operating costs across these child and family hub models are broadly comparable to the Kids Hubs, with staffing consistently representing the largest cost driver. Infrastructure costs for the hub models vary, with some leverage existing infrastructure and others requiring purpose-built facilities. Several Kids Hubs operate within existing services or have adapted existing facilities, reducing the need for purpose-built infrastructure. In addition, service in-reach models and flexibility in where staff meet families reduce reliance on large physical sites.

Kids Hubs also achieve a low unit cost due to the larger number of families supported at each location. Families are supported with brief interventions and/or group programs, which enable the Kids Hubs to reach more families within available resources. Table 46 compares costs across key categories.

Table 46 | Breakdown of operational costs for the Kids Hubs and similar models

Subcategory	Kids Hubs	Hybrid Early Childhood Hub (ECH)[41]	Integrated Child and Family Hub (Wyndham Vale)[42]
Glue[43]	$390,000	$560,000	$274,423
Services	$494,000	$620,000	$2,217,756
Infrastructure	$258,000	$220,000	$42,650
Other	$81,000	$100,000	$51,122
Total operating cost	**$1,223,000**	**$1,490,000**	**2,585,951**

[41] Social Ventures Australia (2025). Indicative costing for an Early Childhood Hub which serves 100 families and has a 60 place Early Childhood Education and Care – hybrid service model. *From vision to viability: Funding requirements for effective Early Childhood Hubs.* Retrieved from https://www.socialventures.org.au/wp-content/uploads/2025/10/Funding-requirements-for-effective-Early-Childhood-Hubs-1.pdf

[42] Ameer Lambrias, Suzy Honisett, Kim Dalziel (2024). Costing the Child and Family Hub. Retrieved from: cre-camh-beyond-blue-final-report-2024-v2-3.pdf

[43] Glue encompasses the underlying leadership, administration and other elements required to operationalise and effectively manage hubs.

Breakdown of capital costs for the Kids Hubs and similar models

Subcategory	Kids Hubs	Hybrid Early Childhood Hub (ECH)[44]	Integrated Child and Family Hub (Wyndham Vale)[45]
Infrastructure	$742,000 - $2,350,000[46]	$2,130,000	$30,000
Total capital cost	**$742,000 - $2,350,000**	**$2,130,000**	**$30,000**

Total (operational and capital) costs for the Kids Hubs and similar models

	Kids Hubs	Hybrid Early Childhood Hub (ECH)[47]	Integrated Child and Family Hub (Wyndham Vale)[48]
Total cost	**$1,965,000 - $3,573,000**	**$3,620,000**	**$2,615,951**

Breakdown of children/families supported per year for the Kids Hubs and similar models

Subcategory	Kids Hubs	Hybrid Early Childhood Hub (ECH)[49]	Integrated Child and Family Hub (Wyndham Vale)[50]
No. of children/ families supported (per year)	228[51]	100[52]	Unavailable
Unit cost	$8,601-$15,640	$36,200	Unavailable

[44] Social Ventures Australia (2025). Indicative costing for an Early Childhood Hub which serves 100 families and has a 60 place Early Childhood Education and Care – hybrid service model. *From vision to viability: Funding requirements for effective Early Childhood Hubs.* Retrieved from https://www.socialventures.org.au/wp-content/uploads/2025/10/Funding-requirements-for-effective-Early-Childhood-Hubs-1.pdf

[45] Ameer Lambrias, Suzy Honisett, Kim Dalziel (2024). Costing the Child and Family Hub. Retrieved from: cre-camh-beyond-blue-final-report-2024-v2-3.pdf

[46] Given the varying nature of how and when Kids Hubs infrastructure is established across states and territories, reported costs for this cost category has been presented as a range.

[47] Social Ventures Australia (2025). Indicative costing for an Early Childhood Hub which serves 100 families and has a 60 place Early Childhood Education and Care – hybrid service model. *From vision to viability: Funding requirements for effective Early Childhood Hubs.* Retrieved from https://www.socialventures.org.au/wp-content/uploads/2025/10/Funding-requirements-for-effective-Early-Childhood-Hubs-1.pdf

[48] Ameer Lambrias, Suzy Honisett, Kim Dalziel (2024). Costing the Child and Family Hub. Retrieved from: cre-camh-beyond-blue-final-report-2024-v2-3.pdf

[49] Social Ventures Australia (2025). Indicative costing for an Early Childhood Hub which serves 100 families and has a 60 place Early Childhood Education and Care – hybrid service model. *From vision to viability: Funding requirements for effective Early Childhood Hubs.* Retrieved from https://www.socialventures.org.au/wp-content/uploads/2025/10/Funding-requirements-for-effective-Early-Childhood-Hubs-1.pdf

[50] Ameer Lambrias, Suzy Honisett, Kim Dalziel (2024). Costing the Child and Family Hub. Retrieved from: cre-camh-beyond-blue-final-report-2024-v2-3.pdf

[51] Annual estimate is based on the total number of families supported in FY2024-25, proportioned across Kids Hub locations.

[52] Cost estimates are based on a model that serves 100 families with a 60 place Early Childhood Education and Care.

Each child and family hub model is unique and incurs different costs for various reasons, including the size of the hub, the number of places or families served, or if the hub itself is a new build or co-located within an existing service. Key differences of other Hub models are noted below in Table 47.

Table 47 | Considerations for hub model cost comparisons

Early Childhood Hub (ECH)	Integrated Child and Family Hub (Wyndham Vale)
• While both Kids Hubs and ECHs deliver similar core services (e.g. allied health, parenting programs and service coordination), the ECH also includes early childhood education and care and Maternal and Child Health. • Glue costs include wages for one ECH Coordinator, two Community Engagement Officers, and one administration role. • Services costs include wages for part time Educator, part time Social Worker to run playgroups and engage with families informally, four Social Workers providing family support services, and one Allied Health Professional. • Infrastructure costs are higher for a once-off infrastructure build cost, including a consultation room, community room, informal space, and play environment. In some instances, co-location or use of existing infrastructure may be available, however ECH providers consistently highlighted the integral role purpose-built facilities play in ECHs integrated service delivery and limitations on repurposing existing buildings.	• Infrastructure establishment costs are lower that other services as the Wyndham Vale Hub operates within an existing community health service operated by IPC Health. Some establishment costs were required for minor renovations, furniture, toys and equipment. • Services costs are higher due to core staff wages – there are 18 practitioners working within the Hub, including paediatricians, GPs, nurses, speech pathologist, dietician, financial counsellor, lawyers, social workers and a mental health clinician.

To provide a consistent overview of costs for different child and family hub models, cost data and estimates have been classified into cost categories taken from Social Ventures Australia's Early Childhood Hubs funding requirements report. Appendix E details what each of these cost categories are, and which costs of each model are grouped into each cost category.

7.4 Evidence suggests investment in Kids Hubs is contributing to outcomes for children and families, like other hub models

KEQ 4.5 | How cost-effective is the Kids Hub model compared to other child and family hub models?

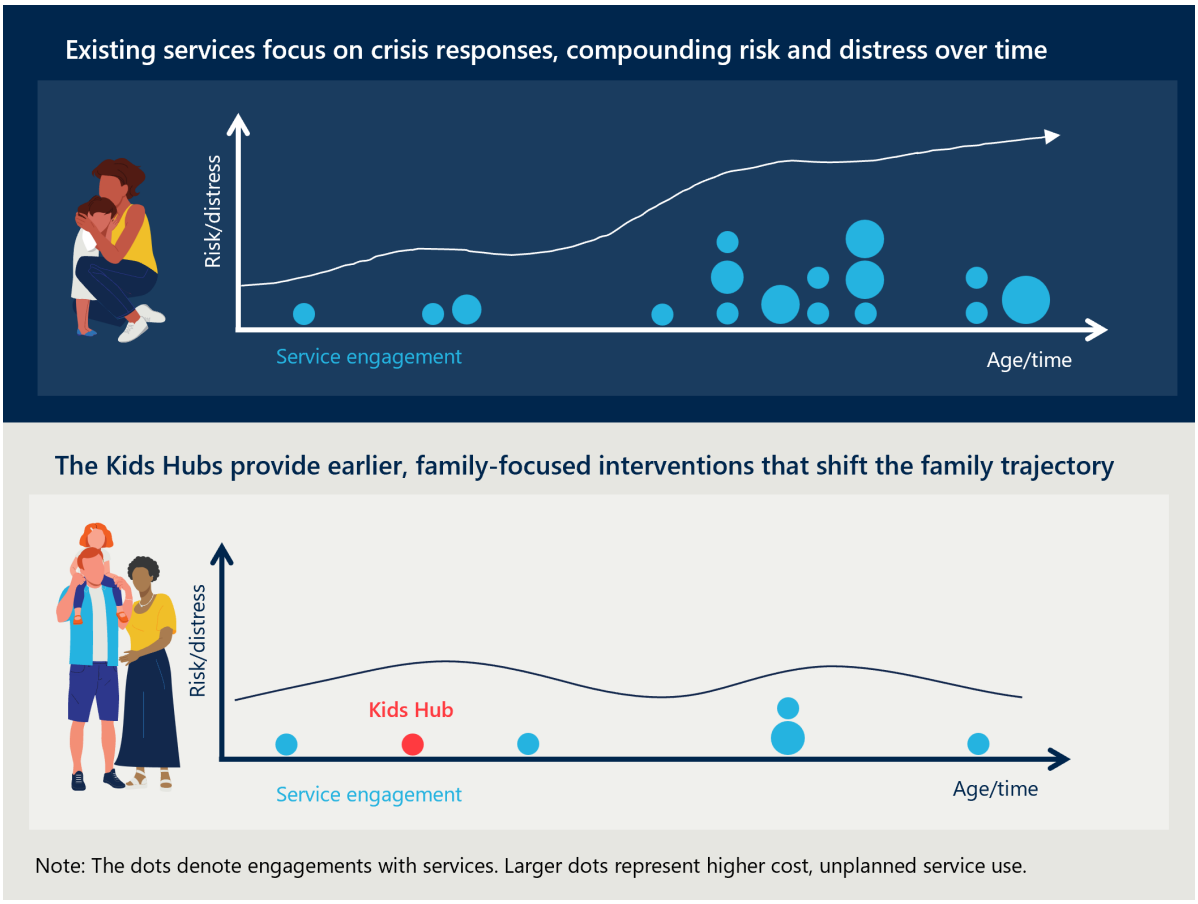
7.4.1 The Kids Hubs improve system effectiveness through earlier identification of needs, more timely interventions, and better coordination across the system

As outlined in the Theory of Change, the Model is designed to shift the system response upstream, away from late, crisis-driven intervention and toward earlier, coordinated support for children and families. The Kids Hubs aim to achieve this through:

- Identifying needs earlier, particularly those that are known indicators of poorer mental health and wellbeing outcomes.
- Providing timely, multidisciplinary assessment and intervention to prevent the escalation of mental health and wellbeing challenges and family distress.
- Improving coordination and integration across the service system to reduce fragmentation, duplication, and inefficiencies.

Existing children's mental health services lack a developmental or prevention-focused lens, with services largely weighted towards acute care for diagnosed conditions and crisis intervention. The current experience of families usually involves repeated service engagement (often at times not suited to family needs), with increasing risk and distress over time. The Kids Hubs seek to shift this trajectory, through family-focused and earlier interventions that reduce the need for multiple and costly mental health interventions, particularly at the crisis end of the system. Figure 5 compares the family experiences in each scenario.

Figure 5 | Comparison of family trajectories with and without Kids Hub intervention



Note: The dots denote engagements with services. Larger dots represent higher cost, unplanned service use.

[Detailed image description.

This image compares family trajectories in terms of risk and distress over time with two different approaches: existing services verses Kids Hub interventions. It uses two graphs to illustrate the differences.

Existing Services

Graph Description:

The graph shows a rising trajectory of risk and distress over time. Service engagements are represented by dots along the timeline. Larger dots indicate higher-cost, unplanned service use. The frequency and size of the dots increase as time progresses, indicating that existing services focus on crisis responses, which compound risk and distress over time.

Illustration:

A distressed family is depicted in the top left corner, reinforcing the emotional toll of delayed interventions.

Kids Hub Interventions

Graph Description:

The graph shows a flatter trajectory of risk and distress, with a noticeable reduction compared to the existing services graph. Early intervention by the Kids Hub is marked on the graph, showing a

proactive approach that stabilises the family trajectory. Service engagements are represented by fewer and smaller dots, indicating reduced reliance on high-cost, unplanned services.

Illustration:

A family is shown in the bottom left corner, appearing supported and less distressed, symbolising the positive impact of early, family-focused interventions.

End of detailed image description.]

7.4.2 Early results show the Kids Hubs are expected to generate economic value through avoided system costs and improved quality of life for children and families

There is well established evidence that shows early intervention and family-focused approaches are more effective and more cost effective than late, crisis-driven responses.[53] Over the long-term, the Model seeks to avoid or delay high-cost service use and improve quality of life outcomes. This Evaluation has identified early indicators of cost-effectiveness outlined in Table 48.

Table 48 | Early indicators of cost-effectiveness of the Kids Hubs

Early indicator	Rationale	Indicative economic value
More timely access to supports	Timeliness of support for children and families is a proximate indicator that early intervention is occurring. Evidence from Kids Hub staff, families, and referral partners indicates that children and families are accessing assessment and support more quickly than would typically occur through standard pathways. The Kids Hubs are also proactively identifying and providing access to priority cohorts, including families who have previously not engaged with supports. In the absence of early support, needs that are initially 'mild' or 'moderate' often progress to higher acuity, making families eligible for more intensive and costly services. Faster access to support through the Kids Hubs therefore represents an early signal that the Model is interrupting this	Timely access to early support helps prevent the escalation of need and reduces the likelihood that families move from low-acuity to higher-acuity services. Earlier intervention can therefore enable cost avoidance, including reduced reliance on Medicare-funded services such as paediatricians, psychologists, and psychiatrists.

[53] Productivity Commission. (2020). Mental Health – Productivity Commission Inquiry Report. 95(1).

Early indicator	Rationale	Indicative economic value
	trajectory and reducing costly system usage.	
Access to the 'right service at the right time'	The Kids Hubs are improving access to services that are appropriate to need, rather than repeated or ineffective service contacts. Multidisciplinary assessment in the Kids Hubs, combined with strong local partnerships, supports more informed decision-making about where families should receive support either in the Kids Hub or through external services. This helps to: • reduce duplication across services • limits inappropriate service use • decreases the likelihood that families cycle through multiple services without resolution.	Accessing the 'right service at the right time' is substantially less costly than engaging with multiple services or entering crisis pathways later. Avoiding inappropriate or duplicated service use can create economic value through: • more efficient use of system resources • reduced administrative and assessment burden across services • time savings and increased workforce participation for parents/carers.
Improved wellbeing and quality-of-life	The Evaluation also identified early evidence of improvements in child and family wellbeing outcomes that align with recognised quality-of-life domains. The Model is not designed to demonstrate short-term changes in mental health through clinical assessment tools, but rather to address the factors that lead to poorer mental health outcomes over time. Families reported: • increased understanding of their child's needs • greater confidence to engage with services • improved social participation • improvements in psychosocial functioning.	These outcomes align with domains that underpin the quality-adjusted life year (QALY) framework, such as WHOQoL-BREF (physical health, psychological health, social relationships, environment) and MHQoL-7D (self-image, independence, mood, relationships, daily activities, physical health and hope). Improvements in wellbeing are a key pathway through which early intervention delivers long-term system sustainability. The value of these improvements can be converted into a dollar value using the value of a statistical life year (VSLY), consistent with guidance from the Department of the Prime Minister and Cabinet.

A cost-consequence analysis suggests that investment in the Kids Hubs is contributing to outcomes for children and families. Table 49 presents cost and Table 50 shows outcome indicators with relevant data collected as part of the Evaluation.

Cost-consequence analysis

Given the complexities of this Evaluation (including the availability of data and information), a cost consequence analysis is the most appropriate method of understanding what the costs are to deliver the Medicare Mental Health Kids Initiative, and emerging evidence against a range of outcomes.

A cost consequence analysis presents costs and outcomes of an intervention in a disaggregated format, allowing decision-makers to see all consequences side-by-side without combining them into a single metric. Cost consequence analyses have been important decision-making tools in healthcare settings, the methodology is well suited to the implementation structure of the Kids Hubs, and to account for the limitations outlined above.

With the information available as part of this Evaluation, a cost consequence analysis provides insight into if the funding model was delivered effectively without detailed analysis of outcomes. To conduct the cost consequence analysis, cost data and information provided by individual states and territories through staffing, financial, and implementation templates completed in November 2025 has been collected and used.

Table 49 | Cost-consequence analysis of the Kids Hubs[54]

Cost Indicator	Value ($AUD)
Practitioner, clinician, and other service delivery staff salaries	$16,282,000
Capital and rent costs	$9,419,000
Management and administration staff salaries	$3,900,000
Other office overheads	$3,246,000
Service delivery activities	$1,514,000
IT costs	$512,000
Professional development and training	$453,000
Other costs	$1,033,000
Total cost	**$36,360,000**

Table 50 | Outcome-consequence analysis of the Kids Hubs

Outcome Indicator	Early Evidence from this Evaluation
Timeliness of support	• Characteristics and needs of families supported, including demographics, psychosocial factors, and presenting symptoms. • Ninety-five per cent of families surveyed reported it was easy and fast to access the Kids Hub. • Avoided costs of accessing other services, e.g., acute services, diagnostic services.
Access to the 'right service at the right time'	• Eighty-three per cent of staff agree or strongly agree that initial assessments effectively identify emerging needs. • Seventy-five per cent of Kids Hub staff and 67% of referral partners surveyed agreed that the Kids Hub's collaborative care coordination efforts are effective in helping children and families navigate multiple service providers
Improved wellbeing and quality-of-life	Children reported improvements in: • emotional regulation, behaviour, and ability to manage daily situations • school functioning and learning engagement • social participation and confidence. Parents and carers reported improvements in: • understanding their child's needs (96% of parents learned something useful to support their child and family) • confidence responding to behavioural and emotional challenges • ability to navigate services.

At this stage of implementation, it is not possible to determine the full cost effectiveness of the Model as available data does not support a comprehensive cost-benefit or cost-effectiveness analysis. There is also additional complexity to assessing value for money of the Kids Hubs, including:

- **The Kids Hubs are all unique:** each Kids Hub offers unique services and supports to children and families, and as such, each have their own unique costs and outcomes.
- **There are a broad range of potential benefits:** the benefits of the Kids Hubs extend beyond immediate mental health improvements and there are many long-term direct benefits and avoided costs.
- **The benefits are difficult to quantify in monetary terms:** translating social benefits into monetary terms is complex and may not fully capture the true value of the benefits.
- **It is difficult to attribute cause and effect:** determining the direct impact of Kids Hubs on specific outcomes can be challenging due to the influence of external factors and the difficulty in isolating the effects of the Kids Hub from other interventions or environmental factors.

Instead, the Evaluation focuses on if there is early evidence that the Model is progressing toward its intended economic outcomes, consistent with its theory of change, and the evidence-base for early intervention and family-focused models of care.

7.4.3 Other similar child and family hub models have quantified value for money through social and economic benefits, with an average cost-benefit ratio of 1:2.6

There is a growing body of literature and evidence on the cost-effectiveness of child and family hub models of care. Several Australian and international hubs have assessed value for money, with analyses indicating substantial social and economic benefits. Table 51 below provides an overview of example value for money assessments.

Table 51 | Examples of value for money analysis of child and family hub models

Model	Scope of services	Value for money
National Community Hubs Program (NCHP), 2023 Evaluation *Australia*	The NCHP model is a place-based and person-centric method of connecting newly arrived families with their community, schools, and existing health, education, and settlement services. Each community hub enables and facilitates access to services that build social connections and social capital in newly arrived communities. Community hubs are physically co-located with primary schools and provide a safe and welcoming environment to access services and supports. Like the Kids Hubs, the flexibility, responsiveness, and integrated nature of the community hubs model represent a relatively unique and efficient approach to meeting emerging community needs.	**Cost-benefit ratio: 1:3.5** **In 2023, the NCHP provided $65.7 million in social benefits to Australia. This equates to a social return of $3.5 for every $1 invested in the program.**[55] Social impacts included: • Improvements in quality of life for participants, including social connections, access to services, and improved confidence and skills. • Value of employment gained by participants through job support provided by the hubs. • Value of improved development outcomes for children through access to playgroup, childhood nurses, and other development supports. • Value of volunteering opportunities to people throughout the community.
National Community Hubs Program	As above.	**Cost-benefit ratio: 1:2.2** **An earlier evaluation of the NCHP in 2019 found that for every $1 invested**

[55] 2023 SROI evaluation of the NCHP

Model	Scope of services	Value for money
(NCHP), 2019 Evaluation *Australia*		**in the program, there were $2.2 in social benefits realised in Australia.**[56] Social impacts included: • improved quality of life for participants • increased productivity in the economy by employees and volunteers • early education benefits relating to early detection and access to supports for learning delays.
Early Years Places, Queensland *Australia*	Early Years Places are community-based hubs across Queensland that support families with children aged from 0- 8. Like the Kids Hubs, families can access multiple services in one location or receive a referral to specialist services. Supports and services often include: • playgroups and early learning activities • early childhood education and care (e.g. kindergarten) • child and maternal health services • parenting programs and family support • information, referrals, and connections to other services in the community.	**Due to data limitations, a comprehensive Cost Benefit Analysis has not been undertaken yet.** However, like the Kids Hubs, there is emerging data on outcomes, including[57]: • improved child development • improved family wellbeing (parenting, mental, social, and financial wellbeing) • improved child safety • improved social connection.
Sure Start (now known as Best Start) *United Kingdom*	The Sure Start program is an early intervention initiative that aims to improve the health and wellbeing of children (0-5) and their families in disadvantaged areas.	**Cost-benefit ratio: 1:2.05** **For every £1 the government spent on Sure Start centres, there were societal benefits of £2.05.**[58] Analysis identified impacts of Sure Start on education, health, absences, special

[56] National Community Hubs Program SROI Evaluation Report FINAL
[57] Early Years Impact Measurement Framework | The Benevolent Society
[58] Carniero, P. et al. (2025) *The short- and medium-term effects of Sure Start on children's outcomes,* The Institute for Fiscal Studies. Retrieved from https://ifs.org.uk/publications/short-and-medium-term-effects-sure-start-childrens-outcomes

Model	Scope of services	Value for money
	Since its launch in 1999, the program has evolved significantly, growing from small initiatives into over 2,000 community-based centres. However, many of these centres were scaled back following budget reductions during the 2010s. In its early years, and like Kids Hubs, Sure Start did not operate under a fixed service model. Local programs worked in partnership with their communities to design services that responded to local needs, allowing support to be tailored to the specific challenges faced by families in each area. Over time, centres were required to provide a more formalised set of core supports, including childcare, information and advice for parents, outreach and family support services, child and family health services, and links to government services offering training and employment advice.	educational needs, youth offending, and children's social care. Cost savings to the government from: • increased tax revenue • reduced hospitalisations and use of health services • reduced spending on support for special education needs • reduced spending on children's social care • change to spending on youth justice. Individual benefits included: • increased long-run earnings • savings on health care costs • increased victimhood from youth crime. Due to the preventative nature of many services, the true benefits of the program may only start to emerge many years after children were eligible for participation.
Isle of Wight Intensive Family Support Service (Early Help) *United Kingdom*	Isle of Wight Family Centres are commissioned to deliver Intensive Family Support to families with identified needs in three or more areas, including education, early years development, physical and mental health, substance use, family relationships, child safety, crime prevention, family/domestic abuse, housing, and financial stability. Like the Kids Hubs, the service focuses on whole-of-family	**Cost-benefit ratio: 1:2.6** **For every £1 invested in the service, the benefit to the state is around £2.60.**[59] Analysis found that effective family support services can achieve meaningful improvements in families' outcomes and reduced demand for more extreme interventions. Family outcomes included: • improved mental health and wellbeing

[59] Smith, N. (2021). *It takes a village: The case for family support in every community,* Barnardo's. Retrieved from https://www.barnardos.org.uk/research/it-takes-village-case-family-support-every-community

Model	Scope of services	Value for money
	support. Eligible families must complete a whole-family assessment and are allocated a family support worker for up to nine months. The worker collaborates with the family and the team around the family to develop a whole-family plan, reviewed every three months. Support focuses on strengthening family functioning, improving outcomes, and keeping children safe at home.	• reduced/safer consumption of controlled substances • not exposed to family/domestic abuse/violence • enter and sustain employment, education, or training. Based on the average reduction in risk across each family outcome, the analysis estimated the avoided fiscal, economic, and social costs to the state that would have occurred without intervention.

7.5 A future economic evaluation requires analysis of establishment and operational costs, and long-term outcomes

KEQ 4.6 | What data and information is required to conduct a cost-benefit analysis of the Medicare Mental Health Kids Hub model for a future economic evaluation?

7.5.1 Assessing value for money for the Kids Hubs requires a focus on reduced or avoided costs, and long-term quality of life outcomes

Consistent with the Program Logic, many of the intended benefits of the Model are realised over time and at a system level. These include:

- universal access to safe, multidisciplinary, and low-cost care
- improved mental health and wellbeing, behavioural, and development outcomes
- a service system increasingly oriented towards early intervention and prevention
- improved availability, sustainability, and effectiveness of the mental health workforce
- reduced waitlists and pressure on the health system, including fewer unplanned emergency department presentations
- improved integration and collaboration of governments and service providers to support the mental health and wellbeing of children.

The value of the Model is therefore best understood through long-term, longitudinal follow-up that reflects its focus on early intervention and family-centred care. Providing timely access to the 'right services' is critical; early and appropriate support for children can materially shift life trajectories. Small and incremental changes can accumulate to produce meaningful outcomes.

The Model's strength also lies in its flexibility and whole-of-family approach, rather than single-person or episodic interventions. As identified in the Literature and Policy Review previously, effective intervention often requires a collaborative approach that builds the capacity of the family. Family-centred support and capacity building are expected to create more sustainable change when compared to individual interventions.

7.5.2 A cost-benefit analysis should include longitudinal data to observe the change in child and family trajectories over time

A future cost-benefit analysis should therefore need to draw on three core categories of data as shown in Table 52.

Table 52 | Core categories for future cost-benefit analysis

Data analysis approach	Sample data items
Longitudinal outcomes data for children and families to observe changes in trajectories over time, including stabilisation or improvement in child and family wellbeing. Quality-of-life measures are widely recognised as robust tools for capturing social, emotional, and mental health benefits that are difficult to monetise but central to understanding the Model's impact.	• Quality-of-life measures for children and families across recognised QoL domains, e.g. WHOqoL-BREF, MHQoL-7D. • Average time spent at a Kids Hub. • Change in quality of life due to participation at the Kids Hub.
Service-use data to quantify avoided utilisation and costs of other services and the extent to which early intervention prevents escalation to more intensive and costly supports. There are two possible approaches: • Logic model: Use a logic model and agreed indicators and draw on existing evidence to infer downstream impacts (e.g. reduced escalation). • Linked data analysis: More robust analysis of linked data to directly measure outcomes for individuals across systems (often more time-consuming and resource intense).	• Time between identification and initial assessment by the Kids Hub. • Number of referrals to other services. • Number of services accessed that were referred by the Kids Hub. • Partner-reported feedback on how well the Kids Hub supported effective service transitions.
Comprehensive program cost data, including both establishment and recurrent operating costs. Evidence indicates that the Model requires significant upfront investment in co-design, workforce recruitment and training, and establishment and integration activities. Over time, fixed and establishment costs are absorbed across a larger number of families, workforces stabilise, and cumulative benefits increase as families experience sustained improvements following engagement with the Kids Hubs.	• Staffing costs. • Service delivery costs. • Professional development and training costs. • IT costs. • Capital and rent costs. • Office overhead costs.

Data analysis approach	Sample data items
This reinforces the importance of adopting a sufficiently long-time horizon in any cost–benefit assessment, rather than focusing on the early years of implementation when costs are highest and benefits are only beginning to emerge.	

Importantly, agreeing on a common set of indicators enables meaningful national reporting and comparison, even where jurisdictions operationalise or measure these indicators in slightly different ways. In designing measures, it is also important to work within existing data realities. Australian Government reporting predominantly relies on aggregated data rather than unit-record datasets, and therefore measures should be practical, feasible, and aligned with data already collected wherever possible.

8 KEQ 5 – Future Opportunities

This section answers the following Key Evaluation Question:

KEQ 5 Future opportunities: What improvements would enable the model to meet its objectives?

8.1 Lessons learnt

KEQ 5.1 | What have we learnt through implementation of the Model to guide continuous improvement?

This Evaluation recognises that states, territories, and all the Kids Hubs are at different stages of implementation and as such, there are opportunities to facilitate information sharing and learning. Implementation of the Model to date has provided several insights to guide continuous improvement, including for new and maturing Kids Hubs. The following sections outline key lessons learnt, including:

- What have we learnt about the system context? (Section 8.1.1).
- What have we learnt about children and families that benefit most from this Model? (Section 8.1.2).
- What have we learnt about key enablers of implementation of the Model? (Section 8.1.3).

8.1.1 The Model highlights the challenges children and families face in accessing support, and the lack of whole of family approaches in existing systems

Implementation of the Kids Hubs has demonstrated that the Model aligns strongly with the evidence-base and current policy direction toward prevention, early intervention, and equity of access. Findings from this Evaluation highlight the need for system-level alignment to better support early intervention approaches. Sustained improvement will require clearer pathways into and between supports, funding arrangements that enable prevention-focused responses, and greater support for holistic interventions.

Eligibility thresholds continue to shape access, despite policy intent to prioritise early intervention

Implementation has demonstrated that, in practice, access to child-focused services remains largely governed by diagnosis and eligibility thresholds rather than assessed need. In many jurisdictions, children can only access services once they have a formal diagnosis or are deemed sufficiently high risk, regardless of earlier identified need. As a result, younger children are rarely prioritised unless concerns have escalated to meet these thresholds.

Kids Hubs are therefore operating within systems that continue to manage demand through exclusion rather than early response. Children with emerging, co-occurring, or moderate needs frequently fall between universal and specialist services, leaving families with limited options until challenges escalate. Many families reported challenges accessing appropriate supports and encountering significant waitlists for other services. This Evaluation highlights the tension between policy commitments to prevention and early intervention, and the practical realities of how access is currently determined.

There are many opportunities to identify children's needs, but very few pathways into support

Across Australia, children's needs are routinely identified through maternal and child health services, early childhood education and care settings, primary care, and developmental screening initiatives. Implementation of the Kids Hubs has highlighted that while there are many opportunities for early identification of needs, there is a lack of accessible pathways to translate this into timely support.

Kids Hubs have consistently received referrals for children whose needs were recognised well before engagement, but for whom no suitable service response was available at the time. This reinforces the insight that existing systems contain multiple points of identification, but few mechanisms to respond early and effectively. The Evaluation found that 67 per cent of families surveyed reported they were unable to access the right supports for their child prior to attending a Kids Hub, contributing to delayed intervention and increased risk of escalation.

Relational, whole-of-family practice is effective but not well supported by existing service structures

Implementation of the Model has demonstrated the importance of relational, whole-of-family approaches in responding to children's mental health and wellbeing needs. Kids Hubs have shown that many presenting concerns are closely linked to parenting stress, parental mental health and wellbeing, family relationships, and broader social pressures. The Evaluation found that children accessing Kids Hubs commonly experience multiple, overlapping psychosocial factors, with 66 per cent of families reporting at least one psychosocial vulnerability.

Working with children and families together has supported engagement, trust, and more effective responses to complexity. Families reported high satisfaction with the Model, and staff also observed early improvements in child functioning, emotional regulation, and school engagement.

At the same time, implementation has highlighted the extent to which the broader service systems remain siloed. Many services are structured around either the child or the parent, with limited coordination across supports. Kids Hubs are required to actively bridge these divides through multidisciplinary assessment, care

coordination, and supported transitions; demonstrating both the value of family-centred practice and the structural barriers that limit its broader adoption.

Kids Hubs are addressing an underserved need within current Australian and state and territory government investments

Prevention and early intervention for children and young people is a key priority for the Australian Government, reflected in a range of initiatives including the expansion of headspace and headspace Plus, Youth Specialist Care Centres, Perinatal Mental Health Centres, parenting and school-based programs (such as Triple P, Be You, and Raise Mentoring), and digital supports and helplines. Within this broader agenda, Kids Hubs represent an important and targeted component, focused specifically on delivering accessible, early intervention support for younger children and their families.

This Evaluation has reinforced that the Model occupies a distinct and currently underserved position in the service landscape. Across Australia, Kids Hubs are not the only initiative delivering early intervention, family-centred care, multidisciplinary support, and access without a formal diagnosis; however, they represent one of the most comprehensive efforts to combine these features within a single, nationally coordinated model. The Kids Hubs provide integrated mental health and wellbeing support for children aged 0–12 and their families, with no requirement for diagnosis or referral and a strong emphasis on prevention and early intervention. While comparable elements exist within state and territory initiatives, these vary in design and access pathways and are not delivered through a consistent national service model. Implementation has demonstrated the value of this position, while also highlighting the need for changes to support early intervention more consistently across the broader service system.

8.1.2 The characteristics of children and families accessing the Model largely align with its intended target cohorts, though there are gaps for some priority populations

The Evaluation has provided important insights into the types of children and families who benefit most from the Model (among those who have been able to access it to date). Overall, these cohorts are consistent with the Model's intent and the Strategy, and include:

- **Families with co-occurring and compounding psychosocial needs:** This Evaluation indicates that the Model is particularly well suited to children and families experiencing multiple, intersecting psychosocial needs rather than a single, discrete issue. The Evaluation found that children and families accessing Kids Hubs commonly experience high levels of complexity, with many families experiencing psychosocial vulnerabilities, including parental mental health and wellbeing concerns, housing instability, family violence, and financial stress.

  These families appear to benefit most from the Model's multidisciplinary approach, care coordination, and flexibility to work across child and family domains simultaneously. Implementation suggests that these needs are difficult to address through single-discipline or issue-specific services, and that the Model's integrated, family-centred design enables more effective responses to complexity than is typically possible within existing services.

- **Families engaged with the service system but unable to access timely or appropriate support:** Implementation has shown that many families accessing Kids Hubs were already engaged with the service system but were unable to progress due to long waitlists, ineligibility for specialist services, or cost barriers. For these families, Kids Hubs have functioned as an alternative entry point, providing multidisciplinary support without requiring a formal diagnosis. This allows families who are actively seeking help to access coordinated support while they wait for, or are unable to access, traditional single-discipline services.
- **Families with recognised needs but limited capacity to seek or navigate support:** Implementation has also highlighted the value of the Model for families whose children's needs have been identified through schools, early childhood services, or screening programs - but where parents or carers lack the capacity, time, or confidence to pursue support. These families are often managing multiple pressures and may deprioritise mild to moderate concerns until difficulties escalate.

  The Model's low barrier to access, proactive engagement, and care coordination reduce the burden on families to navigate a complex service system or advocate strongly for support. Implementation suggests that this enables earlier engagement with families who might otherwise disengage or delay help-seeking, supporting both child and family needs.

However, this Evaluation has also highlighted gaps in uptake for some priority populations, as identified in the Strategy and the Model

The Strategy identifies several priority cohorts who face structural and cultural barriers to accessing services, including Aboriginal and Torres Strait Islander families, CALD families, children with a chronic disease or disability, and LGBTQ+ families.

Kids Hubs are engaging Aboriginal and Torres Strait Islander and CALD families, with uptake particularly strong in locations where culturally specific workforce roles and partnerships with ACCOs are embedded. Nationally, approximately 17 per cent of families accessing Kids Hubs identified as Aboriginal and/or Torres Strait Islander, exceeding uptake seen in some comparable early-years services. However, uptake varies considerably by location, and remains lower in some jurisdictions, highlighting the importance of partnerships, place-based outreach, and culturally competent care.

In contrast, the Evaluation was not able to assess uptake or outcomes for LGBTQ+ families. This represents a significant evidence gap, given the known co-occurrence of mental health and wellbeing challenges and barriers to accessing appropriate support for this cohort. Addressing this gap should be a priority focus in the next stage of implementation.

8.1.3 Effective implementation of the Model is enabled by joint commitment, leadership, system integration, and multidisciplinary capability

Joint commitment from Australian and state/territory governments provides a strong foundation for effective implementation

The bilateral agreements operationalise the Model through a clear commitment to co-fund Kids Hubs on a 50:50 basis. This shared investment creates both shared accountability and 'skin in the

game' for both the Australian, and state and territory governments. The Evaluation found that co-funding is particularly important because it enables jurisdictions to actively support integration with local systems – they have the system knowledge to understand local service landscapes, workforce availability and gaps in provision, and can tailor the Kids Hub accordingly.

Importantly, commitment is not expressed through funding alone. It is reinforced through:

- **Bilateral agreements**, which set clear expectations while preserving flexibility in local delivery.
- **Community of Practice**, which supports shared learning, consistency of intent and peer problem-solving during establishment and early implementation.
- **Data collection and reporting arrangements**, which provide a shared mechanism for monitoring progress and reinforcing the Model's intent.

The Evaluation found that where jurisdictional commitment was strong, policy leads remained actively engaged in stewarding the Model, supporting ongoing problem-solving, and maintaining alignment with its original purpose.

Strong leadership across all levels reinforces the Model's intent

Effective implementation depends heavily on leadership at both the policy and service level that clearly understands the intent of the Model, and how it is designed to intervene within the broader child mental health system. The Evaluation found that where policy leaders and Kids Hub managers had a strong grasp of the Model's purpose – particularly its focus on early intervention, mild-to-moderate complexity and whole-of-family support – implementation was more coherent and consistent.

Effective leaders shared several characteristics:

- A clear understanding of the system context and where the Kids Hubs sit relative to other services.
- Credibility and authority to bring together multiple sectors, including health, education, and family services.
- Strong networks that enabled partnership building, problem-solving, and navigation of system constraints.

Integration with the local service system through governance and partnerships enables the Model to function as intended

The Evaluation found that effective implementation relies on the Model being genuinely embedded within the local service system, rather than operating as a standalone service. Co-design was consistently identified as the starting point for integration, enabling Kids Hubs to respond to local needs, build shared understanding, and avoid service duplication.

However, integration must be actively maintained through:

- **Governance arrangements** that give Kids Hubs sufficient authority and flexibility to work across organisational and sectoral boundaries.

- **Strong partnerships** with referrers and other service providers, including schools, health services, community organisations, and ACCOs.

The Evaluation showed that integration is achieved either by building on existing relationships and infrastructure or by investing time and resources to establish them. In both cases, integration required deliberate effort, sustained relationship-building, and adequate resourcing. Where this investment was made, Kids Hubs were better able to coordinate care, support warm referrals, and function as connectors in the system.

Access to a minimum multidisciplinary workforce capability is essential to effectiveness

The Evaluation found that the Model's effectiveness depends on access to a minimum level of multidisciplinary expertise to effectively address the complexity of the cohort. This capability may be located within the Kids Hub or accessed through reliable partnership and in-reach arrangements, but it should be consistently available. Minimum multidisciplinary capability includes access to:

- social work
- paediatric expertise
- psychology and/or psychiatry
- occupational therapy
- speech pathology
- Aboriginal health workers.

The Evaluation also found that capability is not defined by disciplines alone. In these roles, Kids Hubs should recruit staff with other key skills, including:

- expertise in working with children
- capability to support parents and carers
- skills to work on the parent–child relationship, not just individual presentations
- expertise and lived-experience to support specific priority populations and families from a range of backgrounds.

Investments in capability-building of the existing Kids Hub workforce to deliver culturally competent and trauma-informed care are also important (see Section 6.4). This includes both formal training programs and informal shared learning opportunities between multidisciplinary staff (e.g. bi-cultural pairing).

8.1.4 There are opportunities to improve access to supports and better target unmet need for families from under-represented cohorts

KEQ 5.3 | What are the opportunities to better target unmet needs and improve outcomes for children, their families and carers?

Kids Hubs can improve access and lower the threshold for priority families to engage through integration in trusted community settings and active outreach

Evidence collected across the Evaluation identified opportunities for Kids Hubs to remove barriers and increase access for families who would benefit from the service:

- **Bolder, more assertive outreach in community settings:** Involvement in community facilitates identification of need in children and families who might not typically engage with services, or who face barriers to access. It also increases likelihood that these families will engage with services by building awareness and trust of Kids Hubs. Outreach is facilitated through well-established partnerships and relationships with universal services (particularly schools) where challenges often first present.
- **More intentional partnerships and clearer communication of eligibility criteria:** Kids Hubs can reach under-represented cohorts through targeted partnerships with organisations with established connection to these communities. Effective partnerships require Kids Hubs to invest time in relationship-building and move at the partner organisation's pace.

  Clear and consistent eligibility criteria facilitated by ongoing communication with referral partners was identified as key to ensuring the 'right' families can access Kids Hubs. This ensures appropriate referrals for families that would most benefit from the service, including from target cohorts. This is enabled by strong consultation mechanisms (e.g. by email or phone) for referrers and community members to inquire about the Kids Hub and seek referral advice.
- **Carefully managing demand while opening entry pathways:** Findings of the Evaluation demonstrate the importance of continuing to closely manage demand and minimise waitlists as Kids Hubs begin accepting walk-ins. This ensures timely access to supports for families. Soft entry points such as group programs and other community activities provide a less formal and less daunting way for families to engage with the service, supporting initial connection and trust-building.
- **Targeted strategies may increase uptake among specific under-represented cohorts:** As outlined in Section 5 and Section 8.1.2, there remains low uptake of some target populations known to experience barriers to access services and would benefit from the Model. There is mixed evidence about how to best reach and support these cohorts.
- **Families living in regional and remote communities:** Most Kids Hubs are located in metropolitan areas and provide limited support for regional and remote communities. There is opportunity to reach and support these families as Kids Hubs scale up in more remote locations. These families are likely to engage better with coordinated multidisciplinary supports as this prevents the need to navigate multiple services over large distances. Kids Hubs can

facilitate this by leveraging existing remote outposts with staff that work across several programs.

The Mparntwe (Alice Springs) Medicare Mental Health Kids Hub effectively provides support to remote communities and overcomes transport barriers through flexible outreach and engagement, to 'meet families where they're at'. This includes delivering support in community settings rather than expecting families to travel to a central location.

- **CALD populations:** There is lower than expected uptake of CALD families across most Kids Hubs. This may be attributed to lower targeted access strategies for this cohort than other priority populations. Kids Hubs with lower uptake of CALD children and families should incorporate targeted strategies including building cultural competency of care, establishing partnerships with multicultural organisations, and targeting recruitment of staff with cultural expertise or who speak languages other than English (including dedicated interpreter roles).
- **Children under five:** The Strategy and EAG consultations emphasised the importance of engaging children aged 0–4 to support genuine early intervention. This is a critical development period in childhood and there are limited equivalent services available for this cohort. For some Kids Hubs, uptake for children under five is very low (as low as five per cent uptake).

  Kids Hubs that are successfully reaching these cohorts are doing so primarily through targeted partnerships and referral pathways, including early childhood and learning services, perinatal health services, and maternal health services. For several families, younger siblings were identified through older sibling engagement with the Kids Hub.
- **Children who identify as gender-diverse or have a family member who identifies as LGBTQI+:** The Strategy outlines that children who identify as gender-diverse or have a family member who identifies as LGBTQI+ experience increased risk of depression, anxiety, and suicidality. Quantitative data on this cohort was not collected through the Evaluation due to feedback from service providers, and consultations revealed limited evidence of targeted supports for these children and families. Future iterations of Kids Hubs' models of care should be explicitly inclusive of gender diversity. Supports must be respectful, strengths-based, and centred on identity and belonging.

8.1.5 Holistic, family-centred care with warm handovers to onward services supports sustainable outcomes for children and families

KEQ 5.3 | What are the opportunities to better target unmet needs and improve outcomes for children, their families and carers?

The Evaluation identified key activities that are likely to improve long term outcomes for children and families receiving supports at the Kids Hubs:

- **Whole-of-family interventions to drive sustainable outcomes for children:** Family-focused supports build parents' skills and confidence and equip them with practical strategies to use at home. This strengthens families' capacity to support children day-to-day, improves the home

environment, and sustains child outcomes after Kids Hub involvement ends. Supports that focus on relationships between the child and other family members further promote healthy family functioning and positive child and family outcomes.

- **Leveraging multidisciplinary teams to provide holistic assessment and interdisciplinary care:** Findings demonstrate the benefits of supporting children through a holistic, multidisciplinary lens (see Section 0 and Section 6.6). Evidence suggests that where multidisciplinary team staff work collaboratively to consider the whole child, Kids Hubs are better able to identify and address needs that cut across developmental, social, and mental health domains. This enables shared decision-making and more coordinated responses across disciplines, improving the fit and effectiveness of supports for children and families with complex needs.
- **Transition planning that begins at intake:** There are clear benefits of early thinking about transition planning. This prompts staff to consider what supports each family will need over the long-term and develop a clear plan for how they can support this transition upon service exit: "Where should this family end up and how can we get them there?" Early transition planning improves continuity of care, supports sustained engagement with onward services, and reduces the risk of families disengaging or cycling back into the Kids Hubs.

8.1.6 Nationally-consistent principles and local strategies can help the Kids Hubs to better reach and support Aboriginal and Torres Strait Islander children and their families, carers, and kin

KEQ 5.2 | What are the opportunities to better support Aboriginal and Torres Strait Islander children and their families, carers, and kin?

There's a set of overarching principles that should be embedded across all layers of services, governance, and partnerships

Ensuring Kids Hubs are meeting the needs of Aboriginal and Torres Strait Islander children and families requires cultural appropriateness to be embedded at all levels. Nationally-consistent cultural safety standards may be co-designed with ACCOs and Aboriginal community leaders and applied consistently across governance, workforce, and service delivery. Principles may include:

- Respect and centre Aboriginal and Torres Strait Islander ways of knowing, being and doing.
- Embed a Social and Emotional Wellbeing framework across the Model to support holistic responses that recognise the interconnections between culture, family, community, and wellbeing.
- Apply a kinship and family lens that considers family to include a child's extended family, community, and Elders.

This ensures the foundations of service design and delivery are embedded with cultural competency and increases likelihood that supports meet the needs and preferences of Aboriginal and Torres Strait Islander families.

Partnerships and outreach provide an opportunity to connect with Aboriginal and Torres Strait Islander families through trusted community relationships

Formal partnerships with ACCOs help Kids Hubs facilitate referrals, community engagement, and enhanced cultural competency. It's important that Kids Hubs take the time, space, and intention to establish relationships at the ACCO's pace. Partnerships may be formalised through co-designed agreements.

Outreach in-community (e.g. in schools with large Aboriginal and Torres Strait Islander populations) can also increase engagement with families. Involvement in community settings builds education, awareness, and trust of the Kids Hub and can reduce mental health stigma. Outreach in Aboriginal and Torres Strait Islander communities should ideally be undertaken by a trusted member of local communities. However, the power of partnerships is only realised if the Kids Hub is seen as a culturally safe service.

There is opportunity for Kids Hubs to build cultural competency of support for Aboriginal and Torres Strait Islander children and families

Cultural appropriateness of care is inconsistent across the Kids Hubs (see Section 6.7), and there is opportunity to improve through prioritisation of these key strategies:

- **Continue to adapt flexible engagements and supports to the needs of Aboriginal and Torres Strait Islander children and families**. Where possible, engagements should be tailored to meet needs of children and families, including by:
  - Deeply considering the role of connection to culture in therapeutic intervention.
  - Providing practical supports where appropriate, including transport.
  - Delivering supports offsite to engage families in preferred locations.
  - Flexibly involving family, kin, and community (e.g. involving broader community members where appropriate, or where parents prefer not to be involved).
  - Incorporating soft-entry, culturally grounded group programs as a core engagement and early intervention strategy. These programs should be co-designed with partner ACCOs.
- **Prioritise recruitment and retention of Aboriginal and/or Torres Strait Islander-identified position(s)**. All Kids Hubs should have at least one dedicated Aboriginal and/or Torres Strait Islander-identified position (e.g. 'Aboriginal care coordinator' or 'Aboriginal peer worker' roles). This enables Kids Hubs to build relationships, bridge gaps, and ensure cultural competency of care. Where possible, bi-cultural pairs can enhance service delivery and experiences/outcomes for Aboriginal and Torres Strait Islander children and families. Hubs should consider multiple roles, so individuals are not carrying cultural load, where resources allow.
- **Continue building and investing in cultural competency of staff**. All Kids Hub staff should receive formal training in cultural competency, particularly around Aboriginal and Torres Strait Islander Social and Emotional Wellbeing frameworks. Where possible, Kids Hubs should leverage opportunities for informal learning, including through shared delivery and collaboration between Aboriginal and/or Torres Strait Islander positions and other members of the multidisciplinary team (e.g. bi-cultural pairs, as above).

- **Create safe, welcoming spaces**. Kids Hubs should deliver supports in culturally suitable spaces, including outdoor spaces, partner facilities, or dedicated facilities co-designed with Aboriginal and Torres Strait Islander community Elders, where possible.

8.1.7 While flexibility is important to support local integration, national stewardship is needed to maintain the Model's intent

KEQ 5.5 | What have we learnt about the roles of the Australian Government, states/territories, PHNs, and other providers? And what are the opportunities to improve?

The Department provided early strategic direction and national stewardship to guide and support the first-year implementation of Kids Hubs

The Department played two key roles in the first year of implementation:

- Maintaining national oversight and assurance, including establishing broad definitions and expectations, reviewing and approving locally tailored models of care, and monitoring how states and territories interpreted and conceptualised the Model.
- Enabling collaboration and problem-solving across jurisdictions by convening the CoP and helping resolve early implementation questions that individual states/territories or providers couldn't address alone.

The Department's involvement evolved as implementation progressed and internal capacity shifted, which saw jurisdictions take the lead in implementation

As Kids Hubs progressed through implementation toward operation, the Australian Government's involvement gradually reduced, reflecting a decreasing need for hands on support. States and territories increasingly assumed operational ownership, taking on a clearer leadership role as local models became more established. This shift led to a more decentralised implementation approach, with jurisdictions driving most decision-making and problem solving. The Department maintained a monitoring and assurance role, providing light touch oversight rather than active direction.

States and territories took different approaches to early establishment and implementation

State and territory policy leads and Kids Hub leads undertook consultation and co-design to support the establishment of the Kids Hubs. Some jurisdictions (e.g. Tasmania, Queensland) established steering committees across government to support local model of care design and implementation as needed.

For example, Tasmania established a Statewide Kids Hubs Steering Group with senior representatives across education, early years, primary health, CAMHS, child safety, and Child Health and Parenting Service, enabling strong whole-of-government involvement. As a small jurisdiction with limited workforce supply, Tasmania needed to integrate existing systems to maximise efficiency and reduce duplication. Strong governance improved cross agency visibility and alignment. Early buy-in was seen as essential to create consistent statewide implementation and to engage sectors beyond health, in line with the local model of care.

Kids Hubs delivered through state funded health departments (e.g. LHDs in New South Wales) devolved accountability to service providers, with local decisions made on location, service models, partnerships, and workforce solutions.

For example, NSW Health chose to deliver all Kids Hubs through the LHD system to ensure integration and avoid gaps in service delivery. Strong pre-existing structures (LHD governance, demand modelling capability, integration mechanisms) made it easier for New South Wales to drive local implementation. NSW Health's involvement enabled state-wide consistency and alignment with other state initiatives. State-wide service guidelines were created to guide LHDs in forming their own models of care aligned with the national model.

Differences in PHN involvement shaped how effectively funding and operational decisions translated into practice

Differences in PHN involvement shaped how effectively funding and operational decisions translated into practice. In jurisdictions with direct PHN involvement, particularly the Northern Territory and Western Australia, PHNs played a substantive role in commissioning and coordination. This involvement supported alignment across services but also introduced additional layers of process. Where roles and responsibilities were unclear or not actively managed, PHN involvement contributed to delays, confusion over accountability, and increased administrative burden.

Where PHNs added the most value, governance arrangements and expectations were clearly set out from the start. Collaboration worked best when both the state/territory and the PHN jointly owned funding pathways, commissioning responsibilities, and communication processes. Clear decision-making structures helped translate policy intent into consistent operational practice.

Across all jurisdictions, policy level funding decisions made without local consultation created operational complexity. Decisions such as splitting funding across multiple sites placed pressure on local capacity, reduced efficiency, and blurred responsibility for delivery. In settings with PHN involvement, these issues were often more pronounced, as unclear policy signals compounded existing coordination and accountability challenges.

Stronger governance, opportunities for learning, and funding commitment should be a focus moving forward to enable integrated, locally responsive service delivery and continuous improvement

To achieve its intended outcomes, the Model should continue to focus on:

- **Stronger governance and learning infrastructure.** Invest in formal mechanisms that support regular sharing of learning, such as Communities of Practice and structured feedback loops across jurisdictions. Previous efforts to share insights back to the Australian Government were not progressed (see Section 4.8). This points to the need for a stronger focus on sharing learning across jurisdictions and Kids Hubs and ensuring it informs decision-making.
- **Funding models that support integration and local context.** Explicitly account for service integration and local contexts in future investment. Funding should be used to encourage collaboration and effective, place-based service delivery, rather than being driven mainly by political or administrative priorities.

- **Enduring collaboration structures, not ad hoc engagement.** Establish ongoing structures and processes for cross-government and cross-service collaboration, rather than relying on one-off consultations. Sustained improvement depends on continuous coordination, shared responsibility, and ongoing mutual learning.

8.1.8 Improved data collection and reporting can support a national view to support consistency to achieve the Model's intent

KEQ 5.4 | What are the opportunities to improve data collection and reporting, and support a future outcomes and economic evaluation?

Nationally consistent data collection provides greater insight to implementation, effectiveness, and cost-effectiveness

Establishing nationally consistent data collection, through a refined and clearly defined Minimum Data Set (MDS), would provide a stronger foundation for national oversight and evaluation of the Kids Hubs. Consistency in data collection is important to enabling meaningful national-level analysis of implementation progress, effectiveness, and cost-effectiveness over time.

Additionally, maintaining unit record data provides detailed insight to the role and impact of Kids Hubs. This includes understanding family demographics, co-occurring psychosocial vulnerabilities, services engaged, and referral pathways to build a complete picture of the child and family journey. Unit record data would also support a future longitudinal or economic evaluation, including analysis of outcomes over time and modelling of avoided downstream service use.

Priority data items will better demonstrate impact and reflect the intent of the Model

There is an opportunity to prioritise a set of high-value data items that align with the intent of the Model and reflect what the Evaluation found to be most informative. These include:

- **Family context |** The Evaluation consistently showed that children's presentations are important to understand in the context of parent needs and family circumstances. Data that captures family composition (including siblings), family context, and if multiple family members are being supported is critical to understanding demand, complexity, and outcomes of family-focused approaches.
- **Complexity of need |** Families accessing the Kids Hubs frequently experience multiple, co-occurring psychosocial vulnerabilities. The Evaluation demonstrated that complexity of need is a defining characteristic of the target cohort and a key driver for flexible, holistic service delivery.
- **Referral pathways |** Referral source and referral destination data are central to understanding how Kids Hubs are situated in different service environments. High use of 'other' referral categories limited interpretability. More granular and standardised referral data is needed to assess where families are coming from and to, and how Kids Hubs are functioning as connectors within the system.

- **System integration |** One of the strongest findings from the Evaluation was that Kids Hubs add value by improving coordination and navigation across fragmented systems. Data that captures referrals out, supported transitions, and referral success is necessary to evidence this contribution, and to support analysis of avoided or delayed escalation to more intensive services.
- **Services delivered |** The Evaluation highlighted the importance of non-clinical and enabling activities (e.g. care coordination, information and education, brief interventions), which are not always well captured in service data. Clearer categorisation of service types is needed to reflect what Kids Hubs deliver, and to link service mix to outcomes.
- **Multidisciplinary workforce |** Detailed data on workforce composition (including clinical, non-clinical, cultural, peer work, care coordination and administrative roles) is crucial. Understanding workforce mix is essential for interpreting variation in implementation, operational challenges and service outcomes.

Early evidence suggests the Kids Hubs are likely to generate economic value, but longer-term data is needed to demonstrate this

The Model is designed to generate economic value over time through earlier identification of need, improving care coordination, and reducing reliance on more intensive and costly crisis-driven services. As outlined in Section 7.5, indicative cost data and early outcomes suggest positive value, but stronger and more consistent data is required to demonstrate this.

A future economic evaluation of the Kids Hubs would require:

- **Longitudinal outcomes data** for children and families to observe changes in trajectories over time, including stabilisation or improvement in child and family wellbeing.
- **Service-use data** to quantify avoided utilisation and costs of other services and the extent to which early intervention prevents escalation to more intensive and costly supports.
- **Comprehensive program cost data**, including both establishment and recurrent operating costs. Evidence indicates that the Model requires significant upfront investment in co-design, workforce recruitment and training, and establishment and integration activities.

Section 7.5 outlines sample data and information required for this analysis.

Data collection and outcome measures can better reflect Aboriginal and Torres Strait Islander experiences and priorities

The Evaluation found that Aboriginal-led governance, ACCO partnerships, and culturally safe approaches are critical enablers of engagement and impact for Aboriginal and Torres Strait Islander children and families. However, existing data collection is largely oriented toward service-centric metrics and do not consistently reflect Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing. Outcomes such as pride in culture, identity, connection, and sense of belonging are foundational to wellbeing for children and families; yet are unlikely to be visible through assessments or short-term service measures. Broadening outcome measurement in this way would provide a more strengths-based understanding of impact and

ensure that improvements in wellbeing that occur outside service settings are recognised and valued.

Additionally, embedding Indigenous Data Sovereignty would allow Aboriginal and Torres Strait Islander communities to retain ownership over how data is collected, interpreted, and used to demonstrate impact. This is consistent with the Evaluation's findings that trust, community control and Aboriginal and Torres Strait Islander-led approaches underpin effective service delivery.

8.1.9 The Evaluation has identified core components of the Kids Hubs that enable delivery of the Model's intent, and improved outcomes for children and families

The **core components** are a set of nationally-consistent features that the Evaluation has demonstrated are critical to the effectiveness of Kids Hubs and achieving the intent of the Model. They were developed by building on evidence from comparable child and family hub models and findings from the Evaluation.

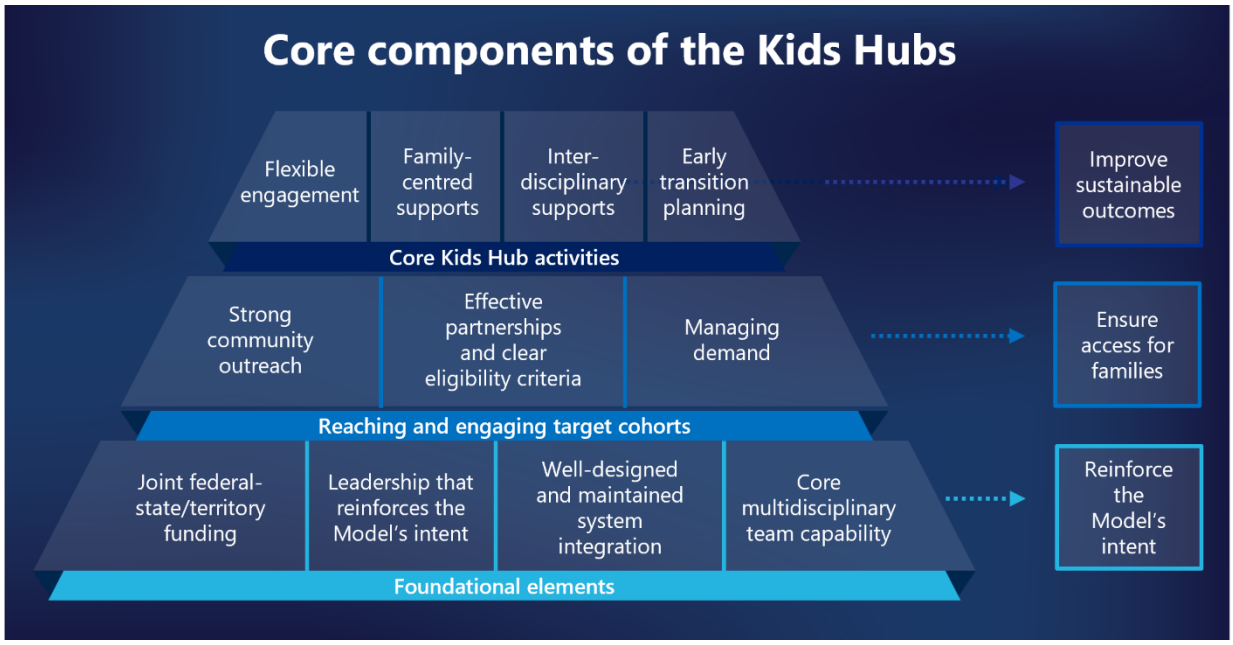
Across the Evaluation, local variations of the Model were assessed to understand the impact of distinct features across Kids Hubs. From this analysis, there were several lessons learnt about what enables effectiveness against the Model's intended mechanisms and outcomes. These include elements that were implemented consistently across Kids Hubs and identified as critical to effectiveness, as well as elements that varied between sites - where differences in how well they were embedded impacted effectiveness.

Through this process, a set of **core components** emerged as the key 'building blocks' that together enable the Kids Hubs to achieve their intended outcomes, as aligned to the Model. The **core components** are organised into three inter-related layers that reflect how effectiveness is achieved in practice. The layers build on and reinforce each other and should be considered together:

2. **Foundational elements required to establish and sustain the Model over time**. These elements enable Kids Hubs to embed within local systems and pathways, connect with other services, and reinforce the intent of the Model on an ongoing basis. Findings related to foundational elements of implementation of the Kids Hubs are found in Section 6, and lessons learnt about enablers of implementation are found in Section 8.1.3.
3. **Operational elements that enable Kids Hubs to identify and reach intended families**. Kids Hubs with these components achieve stronger access and engagement, particularly for families who are typically harder to reach or have previously faced barriers to support. See Section 6.5 for findings about how the Kids Hubs improve access to supports, and Section 8.1.4 for lessons learnt about opportunities to improve access.
4. **Activities at the Kids Hubs to support outcomes for children and families**. These are the key elements of service delivery that support positive impacts and sustainable outcomes for children and families who receive supports at a Kids Hub. Findings about how the Kids Hubs support outcomes for children and families are across Section 6, with lessons learnt for opportunities to improve outcomes in Section 8.1.

Where these features are consistently in place, Kids Hubs are able to integrate in local communities, reach children and families earlier, and support long term mental health, development and wellbeing outcomes. Figure 6 outlines the **core components** of the Kids Hubs.

Figure 6 | Core components of the Kids Hubs



[Detailed image description

This image is a pyramid diagram illustrating the core components of the Kids Hubs framework. It is divided into four tiers, each representing a different level of focus and activity. The tiers are arranged from the foundational elements at the base to the top-level activities, with arrows indicating the outcomes associated with each tier.

Foundational elements (base of the pyramid):

- Joint federal-state/territory funding: Collaboration between federal and state/territory governments to provide funding.
- Leadership that reinforces the Model's intent: Leadership committed to upholding the objectives of the Kids Hubs Model.
- Well-designed and maintained system integration: Ensuring systems are effectively integrated and maintained.
- Core multidisciplinary team capability: Building a capable team with diverse expertise.

Outcome: Reinforce the Model's intent.

Reaching and engaging target cohorts:

- Focuses on identifying and engaging the intended beneficiaries of the Kids Hubs.

Core Kids Hub activities (middle of the pyramid:

- Strong community outreach: Engaging with the community to build awareness and participation.
- Effective partnerships and clear eligibility criteria: Establishing partnerships and defining eligibility for services.

- Managing demand: Addressing and balancing service demand.

Outcome: Ensure access for families.

Flexible engagement and support (top of the pyramid):

- Flexible engagement: Adapting to the needs of families.
- Family-centred supports: Providing services tailored to families.
- Interdisciplinary supports: Leveraging expertise from multiple disciplines.
- Early transition planning: Preparing families for transitions.

Outcome: Improve sustainable outcomes.

End of detailed image description]

The core components of the Kids Hubs sit across three inter-connected layers shown in Table 53.

Table 53 | Core components of the Kids Hubs

1. Foundational elements to reinforce the Model's intent	• **Joint federal-state/territory funding commitment** to provide shared accountability and sustained stewardship, enabling equal co-investment and local tailoring to system gaps, workforce availability, and integration needs. • **Leadership that reinforces the Model's intent** to maintain fidelity, align partners, and position Kids Hubs clearly in the broader service system. • **Well-designed and maintained system integration** to embed Kids Hubs in the local service context, supported through governance, co-design, and strong partnerships with referrers and providers. • **Core multidisciplinary capability** of each Kids Hub to enable access to a minimum set of expertise, delivery of multidisciplinary supports, and interdisciplinary ways of working.
2. Reaching and engaging families to ensure access for target cohorts	• **Strong community outreach** to proactively identify and engage families who may not otherwise access services, building awareness and trust through visible presence in community settings and universal services such as schools. • **Effective partnerships and clear eligibility criteria** to ensure referrals reach the families most likely to benefit, supported by intentional relationship-building with trusted community organisations and consistent, well-communicated referral guidance. • **Managing demand** to balance open access with timely support for target cohorts, using controlled entry pathways and softer engagement options to minimise waitlists while supporting early connection and trust-building.

3. Core Kids Hubs activities to improve sustainable outcomes	• **Flexible engagement** to meet families where they are, including offering support in flexible locations and formats, and enabling families to disengage and re-engage when they are ready without losing connection to the Kids Hub. • **Family-centred supports** to build parents' skills, confidence, and capacity to support children day-to-day, strengthening relationships, and sustaining outcomes beyond the Kids Hub involvement. • **Interdisciplinary supports** delivered through intentionally shaped multidisciplinary teams, enabling holistic assessment, shared decision-making, and coordinated responses for children and families with complex needs. • **Early transition planning** to support continuity of care and sustained uptake and engagement of onward services.

9 Recommendations

This section presents the recommendations to improve implementation and delivery of the Kids Hubs

Australia is experiencing a significant child and adolescent mental health crisis. However, the way children's mental health, development, and wellbeing is understood and responded to remains narrowly framed. The system is heavily weighted toward crisis-driven and diagnosis-led responses that do not recognise the broader social, emotional, and developmental drivers of distress that often emerge early in life. In this context, early intervention models that improve access, strengthen family capability, and reduce downstream system pressure are critical.

The Model seeks to address these gaps by strengthening access to early, developmentally appropriate, mental health and wellbeing support for children and their families - without reliance on clinical diagnosis. It provides safe, free, multidisciplinary supports for children aged 0-12 and their families. The Model takes a family-focused and culturally appropriate approach to holistic assessment, timely identification of needs, therapeutic intervention, and care coordination. Through this approach, it aims to improve lifelong mental health and wellbeing outcomes, prevent escalation of distress, and reduce service duplication and silos across the system.

The Evaluation found that Kids Hubs directly address gaps in the system. Early evidence demonstrates that Kids Hubs are improving access to support, strengthening referral pathways, identifying needs earlier, and supporting families who would otherwise experience delayed or fragmented care. Families reported high satisfaction, improved confidence and capability, and strong engagement with services - while staff and Kids Hub partners observed early improvements in child functioning, emotional regulation, and school engagement.

As implementation of the Kids Hubs continues and matures, there is an opportunity to consolidate what is working well and address areas for improvement. The recommendations below build on the Evaluation's findings and lessons learnt to support the effectiveness, sustainability and future impact of the Kids Hubs. Table 54 provides a high-level summary of the recommendations and Table 55 outlines further detail, including the rationale, lead responsibility, and proposed timeframe for each recommendation.

Table 54 | High Level recommendations

Overall recommendation

Number	Recommendation	Timing
1	Continue the implementation of Kids Hubs nationally to strengthen early intervention and system integration.	Ongoing

Recommendations for the Australian Government

Number	Recommendation	Timing
2	Maintain an active stewardship role to maintain the focus and intent of the National Service Model.	Ongoing
3	Re-establish the national Community of Practice as a forum for regular sharing of learnings across states/territories and service providers.	< 6 months
4	Update the National Service Model to clearly define the core components required for effective Kids Hub implementation and sustainability, while preserving flexibility for local tailoring.	< 6 months
5	Continue and refine national data collection to monitor Kids Hub performance, maturity, and alignment with the intent of the Model.	6-12 months

Recommendations for state and territory governments

Number	Recommendation	Timing
6	Enable and fund ACCOs to deliver Kids Hubs as lead providers or formal co-providers.	6-12 months
7	Provide additional funding for Kids Hubs in remote areas, starting with Central Australia and Western Australia.	> 12 months
8	Consider how the Kids Hubs model sits alongside Thriving Kids, including how Kids Hubs enablers can support the implementation and success of Thriving Kids.	6-12 months

Recommendations for service providers

Number	Recommendation	Timing
9	Establish more partnerships with organisations and services supporting CALD communities and gender diverse children/LGBTQI+ families to increase engagement with unmet priority population groups.	< 6 months

Table 55 | Detailed recommendations

Overall recommendation

	Recommendation	Rationale	Lead	Timing
1	**OVERALL RECOMMENDATION: Continue the implementation of Kids Hubs nationally to strengthen early intervention and system integration.** Ongoing implementation of the Kids Hubs should be supported by: • Continuing the 50:50 funding model to drive shared accountability and balance integration. • Focusing on supporting children and families in regional and remote areas. • Updating the National Service Model to clearly define the Kids Hub model, who it is best suited for and what it aims to achieve, including how it operates alongside Thriving Kids. • Establishing the Kids Hubs model as a distinct service alongside Thriving Kids, acknowledging that its value is independent of other services.	• The Evaluation found the Kids Hubs Model is highly appropriate and directly addresses well-established gaps in Australia's child mental health system by providing early, multidisciplinary, family-centred support for children aged 0–12 with mild to moderate emerging complexity (KEQ 1). • The Model also demonstrates close alignment with the Strategy and supporting evidence about child mental health and wellbeing (KEQ 1). • The 50:50 funding model and national-state partnership were identified as key enablers of implementation, supporting shared ownership, local tailoring and system integration (KEQ 2). • There is evidence of early effectiveness, including improved access, high family satisfaction, strengthened referral pathways and improved identification of developmental, behavioural and psychosocial needs that would otherwise escalate (KEQ 3). • Early cost-effectiveness evidence indicates Kids Hubs are comparable in cost to similar child and family hub models and are likely to generate longer-term system value through avoided downstream costs, although further data is required (KEQ 4).	Australian Government	Ongoing

Recommendations for the Australian Government

	Recommendation	Rationale	Lead	Timing
2	**Maintain an active stewardship role to maintain the focus, definition and intent of the National Service Model.** This should involve: • Engaging regularly with states/territories in structured, periodic meetings to focus on local implementation of the Model and service delivery performance. • Maintaining and updating the National Service Model as required.	• Collaborative inter-governmental relationships were identified as a critical enabler of effective implementation, particularly during establishment (KEQ2). • Without ongoing national stewardship there is a risk of drift from the intended early-intervention focus, reduced national consistency, and variable interpretation of the Model across jurisdictions (KEQ 2, KEQ 5). • Ongoing stewardship is required to balance local flexibility with national coherence, particularly as the Initiative matures and interfaces with related reforms such as Thriving Kids (KEQ 5).	The Department	Ongoing
3	**Re-establish the national Community of Practice (CoP) as a forum for regular sharing of learnings across states/territories and service providers.** This should involve: • Establishing shared responsibility to ensure states/territories and service providers actively contribute to the CoP. • Structuring CoP agendas around operational challenges,	• The CoP played a valuable role during early implementation, supporting shared understanding of the Model, alignment across jurisdictions and problem-solving on common challenges (KEQ 2). • Service providers already share learnings informally and expressed strong interest in a more structured national forum to support continuous improvement and system learning (KEQ 5).	The Department	< 6 months

	Recommendation	Rationale	Lead	Timing
	implementation enablers and emerging best practice.			
4	**Update the National Service Model to clearly define the core components required for effective Kids Hub implementation and sustainability, while preserving flexibility for local tailoring.** This should involve: • Embedding the 11 evidence-based core components identified through the Evaluation. • Using the core components to support consistent implementation, monitoring and maturity assessment across jurisdictions.	• The Evaluation identified a consistent set of enablers that underpin effective implementation, yet these are not sufficiently explicit in the current Model (KEQ 2, KEQ 3). • Core components provide a way to maintain national consistency while preserving local flexibility, which was identified as essential to successful integration within diverse policy, operating and service contexts (KEQ 1, KEQ 2).	The Department	< 6 months
5	**Continue and refine national data collection to monitor Kids Hub performance, maturity and alignment with the intent of the Model.** This should involve: • Using national data to inform continuous improvement, accountability and future economic evaluation.	• Current data limitations constrain the ability to assess maturity, consistency and cost-effectiveness over time (KEQ 4). • Nationally consistent data is critical to support continuous improvement, accountability and future funding decisions, including an economic evaluation (KEQ 4, KEQ 5).	The Department	6-12 months

	Recommendation	Rationale	Lead	Timing
	• Building on early evidence about core components.			

Recommendations for state and territory governments

	Recommendation	Rationale	Lead	Timing
6	**Consider how the Kids Hubs model sits alongside Thriving Kids, including how Kids Hubs enablers can support the implementation and success of Thriving Kids.** This should involve: • Clearly articulating the different purposes, target cohorts and roles of Kids Hubs and Thriving Kids, with clear referral pathways to minimise confusion and duplication. • Leveraging Kids Hub enablers (including low-barrier access, multidisciplinary assessment, and local service coordination) to support effective Thriving Kids implementation.	• There is an opportunity for Thriving Kids to build on what's been achieved through Kids Hub model and consider what else is required to support universal access (KEQ 5). • Kids Hubs are already operating in complex reform environments – clear articulation of complementary roles is needed to manage demand, reduce duplication and strengthen system coherence as reforms mature (KEQ 1, KEQ 5).	State and territory governments	
7	**Enable and fund ACCOs to deliver Kids Hubs as lead providers or formal co-providers.**	• ACCO-led or partnered models were associated with stronger cultural safety, higher Aboriginal and Torres Strait Islander	State and territory governments	6-12 months

	Recommendation	Rationale	Lead	Timing
	This should involve: • Prioritising ACCO-led or co-designed delivery models where Aboriginal and Torres Strait Islander children and families are priority cohorts. • Supporting ACCOs with longer-term, stable funding arrangements that enable workforce development and relationship-based care. • Recognising ACCOs as system leaders, not just referral partners.	engagement, and more trusted service delivery, particularly where ACCOs held leadership roles (KEQ 2, KEQ 3). • ACCOs bring established community trust, governance and cultural capability that cannot be replicated through in-reach alone (KEQ 3).		
8	**Provide additional funding for Kids Hubs in remote areas, starting with Central Australia and WA.** This should involve: • Recognising higher costs associated with workforce recruitment, infrastructure and outreach. • Supporting innovative service delivery models (e.g. outreach, in-reach, shared staffing, partnerships).	• Remote and regional Kids Hubs face bigger workforce constraints and service gaps yet support populations with higher unmet need (KEQ 2). • Flexibility of the Model enables innovative outreach and partnership-based delivery, but targeted investment is required to ensure equity of access and sustainability in these contexts (KEQ 1, KEQ 5).	State and territory governments	6-12 months

Recommendations for service providers

	Recommendation	Rationale	Lead	Timing
9	**Establish more partnerships with organisations and services supporting CALD communities and LGBTQI+ families to increase engagement with unmet priority population groups.** This should involve: • Actively engaging specialist community organisations to co-design outreach and service approaches. • Embedding culturally responsive and inclusive practices across intake, assessment and therapeutic interventions.	• There is lower-than-expected engagement with CALD children and families, despite these groups being identified as priority cohorts (KEQ 3). • Gender-diverse children and LGBTQI+ families are identified as a priority cohort in the Strategy, with an identified need for earlier and more accessible support (KEQ 1). • Partnerships were consistently identified as a key mechanism for improving access, trust and uptake among priority populations (KEQ 2, KEQ 3).	Service providers	<6 months

Appendix A Key Evaluation Questions and Program Logic

1. Appropriateness
1.1 What need does the Initiative aim to meet, and what changes does it seek to achieve?
1.2 What is important to understand about the policy, operating, and service delivery context for implementation?
1.3 To what extent does the Initiative align to, and complement, other national and state strategies, policies, and programs/services?
1.4 To what extent does the design of the Model meet the needs identified in the National Children's Mental Health and Wellbeing Strategy and through local co-design processes?

2. Implementation
2.1 What activities have been undertaken to co-design and implement the Kids Hubs, and to what extent does this vary across Kids Hubs and states and territories?
2.2 What are the characteristics and needs of children, their families and carers accessing the Kids Hubs?
2.3 What are the barriers and enablers to effective implementation and how have they been addressed in different contexts?
2.4 What is the uptake by cohort and location and how do participation rates compare to other services?
2.5 What clinical governance has been established in each local context?
2.6 To what extent are the Kids Hubs using innovative approaches to address workforce shortages?
2.7 What partnerships have been established to support implementation?
2.8 To what extent are the Kids Hubs investing in partnerships with Aboriginal Community Controlled Organisations and communities?
2.9 To what extent is the Community of Practice working as a network to support learning and continuous improvement?

2. Implementation
2.10 How have the Kids Hubs been tailored to different contexts? What is similar/different and why?

3. Effectiveness
3.1 To what extent are children, their families and carers satisfied with the care they receive and their experience of the service?
3.2 To what extent are system stakeholders (multidisciplinary teams and external stakeholders) satisfied with the model and how it is working?
3.3 To what extent are the Kids Hubs complementing and enhancing the existing services in each location?
3.4 How effective is collaboration between the Kids Hub and other primary, secondary, and specialist care services?
3.5 To what extent do the Kids Hubs facilitate information sharing and collaborative care planning within the Kids Hubs?
3.6 To what extent does the model facilitate identification of issues/needs known to lead to poor mental health and wellbeing (neurodevelopmental, behavioural, developmental, mental, social)?
3.7 To what extent is the Model improving access to supports?
3.8 To what extent are the Kids Hubs facilitating appropriate transitions to new services for children, their families and carers? What has been the uptake and engagement of those services?
3.9 To what extent is the model providing culturally competent care for diverse population groups?
3.10 To what extent are the Kids Hubs supporting improvements in the mental health and wellbeing of children, their families and carers?
3.11 To what extent do the Kids Hubs support improvements in workforce capability and capacity (e.g. clinical supervision, professional development, and training opportunities for multidisciplinary teams)?
3.12 What (if any) are the unintended outcomes or consequences of implementing the Model?

4. Cost-effectiveness
4.1 What funding was allocated to support the implementation of Medicare Mental Health Kids Hubs initiative?
4.2 To what extent was the funding model appropriate and effective at supporting the aims of the Medicare Mental Health Kids initiative?
4.3 What other support or resources were required to deliver the Kids Hub services in each state and territory, and nationally?
4.4 How do the costs of the Kids Hubs compare to other child and family hub models?
4.5 How cost-effective is the Kids Hub model compared to other child and family hub models?
4.6 What data and information is required to conduct a cost-benefit analysis of the Medicare Mental Health Kids Hub model for a future economic evaluation?

5. Future opportunities
5.1 What have we learnt through implementation of the Model to guide continuous improvement:
5.2 What are the opportunities to better support Aboriginal and Torres Strait Islander children and their families, carers, and kin?
5.3 What are the opportunities to better target unmet needs and improve outcomes for children, their families and carers?
5.4 What are the opportunities to improve data collection and reporting, and support a future outcomes and economic evaluation?
5.5 What have we learnt about the roles of the Australian Government, states/territories, PHNs, and other providers? And what are the opportunities to improve?

Inputs	Activities	Mechanisms of change	Outputs	Short-term outcomes	Medium-term outcomes	Benefits
What will we invest?	What's involved in delivering the Hubs?	What is the evidence that supports how and why the inputs and activities will lead to change?	What will be produced because of the Hubs?	What will change look like? Who will do what differently?	What will change look like? Who will do what differently?	What larger, longer-term change does this contribute to?
Financial Australia and state/territory governments invest $84.85 million over four years. Knowledge and expertise National Service Model developed in consultation with Expert Reference Group.	Kids Hubs Core activities are: access and outreach initial assessment brief interventions care coordination supported transition. Australian Government Establish national policy, governance, and reporting requirements. Communication, promotion, and	Broader access and referral: By adopting a broad access and referral approach (not based on a diagnosis or ability to pay), vulnerable children do not experience delays and will get the help they need. By integrating and coordinating with other parts of the system (schools, primary care, other services), the Kids	Children and families Free and easily accessible Kids Hub service for children and families (particularly underserved groups). Improved referral pathways to other services for children and families. Culturally safe, and flexible care to meet the	Children and families More timely access to support services (particularly for underserved groups). Earlier identification and response to unmet mental health and wellbeing challenges. Positive experience of	Children and families Increased help seeking behaviour and reduced stigma. Increased planned engagement with appropriate and holistic services. Improvement in broader biopsychosocial drivers of poor mental health and wellbeing. Sector Improved multidisciplinary collaborative care in	Children and families Universal access to safe, multidisciplinary, and low-cost care. Improved mental health and wellbeing, behavioural and developmental outcomes. Better engagement with early childhood education and school. System

Inputs	Activities	Mechanisms of change	Outputs	Short-term outcomes	Medium-term outcomes	Benefits
Frameworks and models to support national establishment and implementation. Infrastructure Multidisciplinary teams. Client management and information sharing systems. Governance and reporting Local community co-design process. Local governance partnerships, Lead Providers. National Agreement and	stakeholder engagement. Alignment to national strategies and policies. States/Territories Establish state/territory policy, governance, and data reporting requirements. Co-design service models to meet local needs. Establish and operate Kids Hubs. Workforce (recruitment, development, retention). Communication, promotion and stakeholder engagement.	Hubs provide timely access and assessments of needs. Children, and families are more likely to receive effective early support that is holistic, considers all factors, and addresses root causes. By providing individualised and culturally appropriate care via multidisciplinary teams and local partnerships, children and families are more likely to engage in the service (particularly those who are more	needs of children and families. Sector Recruitment of multidisciplinary teams. Establishment of partnerships and relationships between Kids Hubs and local services including Aboriginal Community Controlled Organisations and local communities. Australian Government and states/territories Regular engagement	accessing the Kids Hub. Improved mental health literacy. Improved opportunities for connection. Sector Multidisciplinary team members have respect and trust for each other and a clear understanding of each discipline's roles, skills; and scope practice in supporting children and families. Kids Hubs establish agreed clinical governance	the Kids Hub's multidisciplinary teams and with external services. Staff have increased job satisfaction and job retention. Improved knowledge and capacity of the existing workforce to identify and respond to early signs of child mental health and wellbeing challenges. Expansion of mental health workforce. Australian Government and states/territories Improved evidence-base to inform service design and delivery for the mental health and wellbeing of children and families.	The service system is oriented around early intervention and prevention. Improved availability, sustainability and effectiveness of the mental health workforce and services. Reduced waitlists and pressure to the health system (e.g., reduced unplanned emergency department presentations). Improved integration/effective collaboration of governments and service providers to support the mental health and

Inputs	Activities	Mechanisms of change	Outputs	Short-term outcomes	Medium-term outcomes	Benefits
Bilateral Schedules.	Alignment to state and territory strategies and policies.	vulnerable, typically hard to reach or have had negative service-system experiences, including Aboriginal and Torres Strait Islander children and families). Through collaborative care coordination and planning, the Kids Hubs will support children and families to navigate multiple service providers or transition to new services. By doing this, children and families will be more likely to continue with care for longer periods.	between the Australian Government and states/territories. Formalised data capturing and reporting processes. Establishment of community of practice between Kids Hubs. Establishment of an innovative, place-based model of care.	structures as well as systems and protocols for communication, care coordination, and integration. Increased clinical supervision, professional development, and training opportunities for multidisciplinary teams. Increased work placements and training rotations for students. Australian Government and states/territories Co-design processes deliver	Improved funding/commissioning models to support the mental health and wellbeing of children and families. The National Service Model provides appropriate flexibility while maintaining some national consistency.	wellbeing of children.

Inputs	Activities	Mechanisms of change	Outputs	Short-term outcomes	Medium-term outcomes	Benefits
		The Kids Hubs provide additional workforce opportunities through multidisciplinary care teams, supportive opportunities for professional growth, and student placements. By building the capability of the service system to coordinate in meeting needs of children and families, this improves the capacity of the system to deliver appropriate care and support and contributes to a		place-based Kids Hub service delivery models that meet local need and complement existing services. Learnings in service delivery and implementation are shared.		

Inputs	Activities	Mechanisms of change	Outputs	Short-term outcomes	Medium-term outcomes	Benefits
		more effective service system. By investing in governance, data capturing/reporting, and communication at a national level, the Kids Hubs network will benefit from shared learnings that will support the collection and reporting of an evidence-base around the Kids Hubs Model.				

Appendix B Consumer data assumptions

Table 56 | Consumer data item translations where data was provided by Kids Hubs in a different format

Kids Hub	Consumer data item	Provided format	Method of translation
Brisbane Kids Hub	11. Financial stress	Postcode	Postcode to SEIFA score • SEIFA score 0-4 (bottom 40%) = Yes SEIFA score 5-10 (top 60%) = No
Brisbane Kids Hub	9. Source of referral	Different categories	Manually matched to prescribed categories **Note. Category match may be inaccurate**
Brisbane Kids Hub	11. Housing status	• Never an issue • Previous homelessness • Unstable or unsuitable housing • Unsure/unclear • Currently homeless	• Never an issue = 1. Living with primary carer • Previous homelessness = 1. Living with primary carer • Unstable or unsuitable housing = 4. Secondary homelessness • Unsure/unclear = n/a Currently homeless = 3. Primary homelessness
Gold Coast Kids Hub	9. Source of referral	Different categories	Manually matched to prescribed categories **Note. Category match may be inaccurate**

Kids Hub	Consumer data item	Provided format	Method of translation
Gold Coast Kids Hub	7. Refugee or asylum seeker status	Yes No	Yes = 1. Client is a current refugee No = 3. Client is not a current refugee nor asylum seeker
Gold Coast Kids Hub	8: Disability or chronic illness	Chronic physical health difficulties	Direct mapping
Gold Coast Kids Hub	11: Financial stress	Government financial support	Direct mapping
Victoria: Brimbank Melton Children's Health & Wellbeing Local, Children's Health and Wellbeing Local (Southern Metropolitan Melbourne), and Loddon Children's Health and Wellbeing Local	2. Age range of the child	Included age category 13+	Response '13+' = NA

Table 57 | Analysis proxies

Consumer data item	Proxy for analysis	Method of translation
Housing status	Housing instability	• Living with primary carer = 2. No • Living away from parents due to child protection involvement = 1. Yes • Primary homelessness = 1. Yes • Secondary homelessness = 1. Yes • Tertiary homelessness = 1. Yes • Other accommodation = 1. Yes
	Culturally and Linguistically Diverse (CALD) status	If: • Preferred language not 1. English *or* • Refugee or asylum seeker status = 1. Client is a current refugee or 2. Client is currently an asylum seeker *or* • Country of birth not "Australia" *And* • Aboriginal or Torres Strait Islander status is 2. No

Appendix C Kids Hub profiles

Kids Hubs have adapted the Model to respond to local needs and avoid duplication of services. Information about each Kids Hub is current as of 30 November 2025.

Table 58 | Example of the information in each Kids Hub profile as shown on the following pages[60 & 61]

Hub	Service provider
Operational date	-
Provider type	-
Catchment area	-
Priority populations	The priority cohorts or specific areas of need are targeted at each Kids Hub location.
Staffing composition	**Clinical:** Clinical and medical professionals and Therapeutic and allied health services. **Non-clinical:** Community and cultural engagement and Support and coordination services. **Management and admin:** Leadership and management and Administrative and operational support.
Key partners	Partnerships established to support design and implementation of the Kids Hubs and integration between the Kids Hubs and other existing services in the local context. Partnerships are categorised by the types of partnerships presented in Table 9 in Section 4.6.
Physical location	The physical location of the Kids Hub – Central location, co-location with different organisations or satellite sites.
Kids hub relationships	The Kids Hubs relationship with local CAMHS/CYMHS.
Scope of referrals	I.e.: Completely open and accept walk-ins, broad but managed pathways, tightly managed pathways.
Designated care coordination roles (FTE)	If there is a designated care coordination role.
Diagnostic capability	If the Kids Hub has a diagnostic function.
Referral sources	How the Kids Hub works with schools.

[60] Child and Adolescent Mental Health Services (CAMHS).
[61] Child and Youth Mental Health Service (CYMHS).

Hub	Central Coast Medicare Mental Health Kids Hub
Operational date	April 2025
Provider type	Government
Catchment area	1,853km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • Children with disabilities. • CALD families (incl. refugee/asylum seeker, migrant) • Children living in out-of-home care. • Families with DFV, substance use, financial stress.
Staffing composition	**Clinical:** 1.7 FTE **Non-clinical:** 4 FTE **Management and admin:** 2.6 FTE
Key partners	• **Health and mental health services:** Paediatric Behavioural Triage Clinic. • **Aboriginal and Torres Strait Islander services:** Eleanor Duncan Aboriginal Health Service and the Nigyang Aboriginal Pregnancy and Child and Family Health Service. • **Family and child protection services:** Karitane, Central Coast Family Support Services.
Physical location	Co-located next to CAMHS.
Kids hub relationships	The Kids Hub is a CAMHS-based service with CAMHS managing key implementation governance.
Scope of referrals	Walk-ins accepted
Designated care coordination roles (FTE)	Designated care coordination roles (2 FTE).
Diagnostic capability	No diagnostic function.
Referral sources	Schools are the primary referral source (32%); families are often referred onwards to school counsellors.

Hub	Illawarra Medicare Mental Health Kids Hub
Operational date	December 2024
Provider type	Government
Catchment area	4,567km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • Vulnerable and/or at-risk children and families. • Children whose families do not readily access universal services. • Children at increased risk of poor mental health, behavioural and emotional regulation difficulties.
Staffing composition	**Clinical:** 8.2 FTE **Non-clinical:** 0 FTE **Management and admin:** 6 FTE
Key partners	• **Health and mental health services:** ISLHD Paediatric and Child and Family Services. • **Aboriginal and Torres Strait Islander services:** Illawarra Aboriginal Medical Service (IAMS). • **Education and early childhood services:** Wellbeing and Health In-reach Nurse (WHIN) Coordinator program at local schools. • **Government and community services:** Coordinative (local PHN provider).
Physical location	Central location plus interim co-location in Grand Pacific Health's clinical space.
Kids hub relationships	Strong, well-established relationships, shared staff, co-design collaboration, and clear escalation pathways via referrals.
Scope of referrals	Targeted referral pathways; not open for walk ins.
Designated care coordination roles (FTE)	Designated care coordination roles (2 FTE).
Diagnostic capability	Diagnostic capability through stream established with existing Diagnostic and Assessment Service (ISDAS).
Referral sources	Accept referrals from WHIN teams (Wellbeing Health In Reach) at local schools (8% of referrals come from schools).

Hub	Orange Medicare Mental Health Kids Hub
Operational date	July 2024
Provider type	Government
Catchment area	Unknown
Priority populations	• Aboriginal and Torres Strait Islander families. • Children living in out-of-home care. • Children at increased risk of poor mental health, behavioural and emotional regulation difficulties.
Staffing composition	**Clinical:** 5 FTE **Non-clinical:** 5.4 FTE **Management and admin:** 3.6 FTE
Key partners	• **Health and mental health services:** CAMHS and Community Health. • **Aboriginal and Torres Strait Islander services:** Local ACCHOs (not further described). • **Family and child protection services:** Karitane, Orange/ Bathurst Family Support Services, Mission Australia, The Benevolent Society, CatholicCare, Barnardos. • **Education and early childhood services:** ODEEP (early intervention service), BECIS (early intervention service). • **Government and community services:** NSW Department of Communities and Justice, NSW Department of Education, CentreCare, Live Better, Uniting.
Physical location	Central location.
Kids hub relationships	Established partnership with regular liaison and shared stepped-care processes to manage continuity and transition of care.
Scope of referrals	Broad referral pathways (not further described).
Designated care coordination roles (FTE)	Designated care coordination roles (2 FTE as of November 2025).
Diagnostic capability	Diagnostic capability.
Referral sources	Close operational relationships through bidirectional referrals and on-site assessments and outreach.

Hub	Mparntwe (Alice Springs) Medicare Mental Health Kids Hub
Operational date	March 2025
Provider type	ACCO
Catchment area	1,710km^2
Priority populations	• Aboriginal and Torres Strait Islander families living in Alice Springs and neighbouring communities.
Staffing composition	**Clinical:** 1.7 FTE **Non-clinical:** 9.6 FTE **Management and admin:** 2 FTE
Key partners	• **Health and mental health services:** Women and Children's Services (incl. community paediatrics), Child Health and Parenting Service. • **Aboriginal and Torres Strait Islander services:** Tangentyere. • **Family and child protection services:** CAWLS (women's legal service), WoSSCA (domestic violence service). • **Education and early childhood services:** Yipirinya School. • **Government and community services:** Child Youth Mental Health Service (NTG), Department of Education, Larapinta Child and Family Centre.
Physical location	Co-located in an existing CAAC site alongside other child, family, and disability services.
Kids hub relationships	Established partnership with secondary consultations and stepped-care processes to manage continuity and transition of care.
Scope of referrals	Very open approach to referrals; walk-ins accepted.
Designated care coordination roles (FTE)	Care coordination is provided by caseworkers and Aboriginal Family Support Workers in a bi-cultural pair model.
Diagnostic capability	No diagnostic function.
Referral sources	Ongoing liaison with inclusion support staff and teachers. Main referral source (48%).

Hub	Brisbane Kids Hub
Operational date	January & March 2025
Provider type	Government
Catchment area	Unlimited
Priority populations	• Aboriginal and Torres Strait Islander families. • Families in areas with higher mental health burden. • CALD families (including migrant).
Staffing composition	**Clinical:** 10 FTE **Non-clinical:** 6 FTE **Management and admin:** 4 FTE
Key partners	• **Health and mental health services:** Child Development Service. • **Aboriginal and Torres Strait Islander services:** Family and Community Place Yarrabilba, Institute for Urban Indigenous Health (IUIH), Mununjali Housing Co Ltd. • **Family and child protection services:** Youth and Family Services (YFS), Act for Kids, Kingston and Corymbia FamilyLinq, Village Connect. • **Education and early childhood services:** Local primary and state schools. • **Government and community services:** Metro North HHS, Metro South HHS, Brisbane North PHN, Brisbane South PHN.
Physical location	Two central locations plus multiple satellite sites in schools, early childhood, and community organisations.
Kids hub relationships	Formal partnership through inclusion in the Steering Committee and broader consortia for co-design and governance.
Scope of referrals	Very open approach to referrals; walk-ins accepted.
Designated care coordination roles (FTE)	No designated care coordination role; clinicians share responsibility for managing families.
Diagnostic capability	Diagnostic capability.
Referral sources	Formal partnerships and on-site satellite clinics at local schools.

Hub	Gold Coast Kids Hub
Operational date	December 2023
Provider type	Government
Catchment area	Unlimited
Priority populations	• Aboriginal and Torres Strait Islander families. • CALD families (incl. refugee/asylum seeker, migrant). • Children with behavioural difficulties affecting school and relationships. • Families with DFV and financial stress.
Staffing composition	**Clinical:** 5.4 FTE **Non-clinical:** 5 FTE **Management and admin:** 2.25 FTE
Key partners	• **Health and mental health services:** Primary Care Community Service (PCCS) as the Head to Health Phone Service provider. • **Education and early childhood services:** Gainsborough State School. • **Government and community services:** Gold Coast PHN, CYMHS.
Physical location	Central location, co-location at two Child Development Services and a satellite site at a local state school.
Kids hub relationships	Operates under the governance of Gold Coast HHS CYMHS.
Scope of referrals	Very open approach to referrals; walk-ins accepted.
Designated care coordination roles (FTE)	No designated care coordination role; clinicians share responsibility for managing families.
Diagnostic capability	Diagnostic capability but not open to all consumers in attempt to manage demand.
Referral sources	On-site satellite clinic at local state school.

Hub	Jordan River Medicare Mental Health Kids Hubs
Operational date	March 2024
Provider type	Government
Catchment area	170km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • Children living in out-of-home care. • Families with DFV, substance use, financial stress, parental mental illness. • CALD families (incl. refugee/asylum seeker, migrant) • Children experiencing trauma.
Staffing composition	**Clinical:** 4 FTE **Non-clinical:** 0 FTE **Management and admin:** 0.6 FTE
Key partners	• **Health and mental health services:** Women and Children's Services (incl. community paediatrics), Child Health and Parenting Service (CHaPS). • **Family and child protection services:** Tagari Lia Child and Family Learning Centres, Child Safety Services. • **Education and early childhood services:** Local state primary schools, School Professional Support Services, School Wellbeing Teams. • **Government and community services:** Department for Education, Children and Young People (DECYP).
Physical location	Located within CYMHS South providing in-reach to CFLC, schools, and other child and family service settings.
Kids hub relationships	CYMHS is the statewide provider in partnership with Child and Family Learning Centres.
Scope of referrals	Targeted referral pathways; not open for walk ins.
Designated care coordination roles (FTE)	No designated care coordination role in the Kids Hub FTE. Care coordination is an integral aspect of the service model and managed by all clinical FTE.
Diagnostic capability	No diagnostic function.
Referral sources	Services delivered through in-reach to Child and Family Learning Centres, primary schools, and community sites.

Hub	Burnie Medicare Mental Health Kids Hubs
Operational date	May 2025
Provider type	Government
Catchment area	600km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • Children living in out-of-home care. • Families with DFV, substance use, financial stress, parental mental illness. • CALD families (incl. refugee/asylum seeker, migrant) • Children experiencing trauma.
Staffing composition	**Clinical:** 1.8 FTE **Non-clinical:** 0 FTE **Management and admin:** 0.6 FTE
Key partners	• **Health and mental health services:** Women and Children's Services (incl. community paediatrics), Child Health and Parenting Service (CHaPS). • **Family and child protection services:** Burnie Child and Family Learning Centres, Child Safety Services. • **Education and early childhood services:** Local state primary schools, School Professional Support Services, School Wellbeing Teams. • **Government and community services:** Department for Education, Children and Young People (DECYP).
Physical location	Located within CYMHS North West providing in-reach to CFLCs, schools, and other child and family service settings.
Kids hub relationships	CYMHS is the statewide provider in partnership with Child and Family Learning Centres.
Scope of referrals	Targeted referral pathways; not open for walk ins.
Designated care coordination roles (FTE)	No designated care coordination role in the Kids Hub FTE. Care coordination is an integral aspect of the service model and managed by all clinical FTE.
Diagnostic capability	No diagnostic function.
Referral sources	Services delivered through in-reach to child and family learning centre, primary schools, and community sites.

Hub	East Tamar Medicare Mental Health Kids Hubs
Operational date	July 2025
Provider type	Government
Catchment area	200km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • Children living in out-of-home care. • Families with DFV, substance use, financial stress, parental mental illness. • CALD families (incl. refugee/asylum seeker, migrant) • Children experiencing trauma.
Staffing composition	**Clinical:** 2.8 FTE **Non-clinical:** 0 FTE **Management and admin:** 1 FTE
Key partners	• **Health and mental health services:** Women and Children's Services (incl. community paediatrics), Child Health and Parenting Service (CHaPS). • **Family and child protection services:** East Tamar Child and Family Learning Centres, Child Safety Services. • **Education and early childhood services:** Local state primary schools, School Professional Support Services, School Wellbeing Teams. • **Government and community services:** Department for Education, Children and Young People (DECYP).
Physical location	Located within CYMHS North providing in-reach to CFLCs, schools, and other child and family service settings.
Kids hub relationships	CYMHS is the statewide provider in partnership with Child and Family Learning Centres.
Scope of referrals	Targeted referral pathways; not open for walk ins.
Designated care coordination roles (FTE)	No designated care coordination role in the Kids Hub FTE. Care coordination is an integral aspect of the service model and managed by all clinical FTE.
Diagnostic capability	No diagnostic function.
Referral sources	Services delivered through in-reach to child and family learning centre, primary schools, and community sites.

Hub	Midland Medicare Mental Health Kids Hub
Operational date	January 2025
Provider type	Consortium
Catchment area	1,042km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • Children with disabilities. • Refugee/migrant Families (CALD). • LGBTQIA+ families. • Children living in out-of-home care.
Staffing composition	**Clinical:** 4.8 FTE **Non-clinical:** 8.3 FTE **Management and admin:** 1.7 FTE
Key partners	• **Aboriginal and Torres Strait Islander services:** Koya Aboriginal Corporation. • **Family and child protection services:** Midvale Parenting Hub, Therapy Focus, Little School of Yoga, Baby Sensory and Baby Massage, Sing and Grow; Cahoots! • **Education and early childhood services:** Local Schools and Early Learning Centres. • **Government and community services:** WA Primary Health Alliance, Department of Communities, Sector professionals, City of Swan Community Development Team.
Physical location	Central location, co-located with consortium partners.
Kids hub relationships	Strained relationship with CAMHS with little collaboration.
Scope of referrals	Walk-ins accepted.
Designated care coordination roles (FTE)	Designated care coordination role (3 FTE).
Diagnostic capability	No diagnostic function.
Referral sources	Schools are referral partners and the Kids Hub is a member of the local schools' network.

Hub	Brimbank Melton Children's Health & Wellbeing Local
Operational date	November 2022
Provider type	NGO
Catchment area	651km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • CALD families (incl. refugee/asylum seeker, migrant). • Families with FDV, homelessness, financial stress, substance use, and parent illness or disability. • Children living in out-of-home care.
Staffing composition	**Clinical:** 9.425 FTE **Non-clinical:** 8.94 FTE **Management and admin:** 4.2 FTE
Key partners	• **Health and mental health services:** Western Health (Paediatric/medical/allied health provider), Royal Children's Hospital Mental Health Service (mental health and wellbeing provider). • **Aboriginal and Torres Strait Islander services:** Engaging Melton Families. • **Family and child protection services:** Early Help Family Services, Integrated Family Services, Community Child Protection service, Pathways to Good Health. • **Education and early childhood services:** Local primary schools, School Readiness Team, Early learning services. • **Government and community services:** Melton City Council, Foundation House, The Salvation Army.
Physical location	Co-located at IPC Health Community Health Centre.
Kids hub relationships	Minimal collaboration with CAMHS due to embedded mental health clinicians from Royal Children's Hospital.
Scope of referrals	Broad referral pathways; not open for walk-ins.
Designated care coordination roles (FTE)	Designated care coordination role (3 FTE).
Diagnostic capability	Diagnostic function through Royal Children's Hospital mental health capability within the Kids Hub.
Referral sources	Close relationship with schools, including consultations, parent program delivery, and direct referral pathways.

Hub	Children's Health and Wellbeing Local (Southern Metropolitan Melbourne)
Operational date	May 2023
Provider type	Government
Catchment area	1,283km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • CALD families (incl. refugee/asylum seeker, migrant) • Families with FDV and financial stress. • Children living in out-of-home care. • Children with a family member with mental illness, disability, or substance use issues.
Staffing composition	**Clinical:** 15.2 FTE **Non-clinical:** 6.9 FTE **Management and admin:** 2 FTE
Key partners	• **Health and mental health services:** Refugee Health, GPs. • **Aboriginal and Torres Strait Islander services:** Healthy Koorie Kids. • **Family and child protection services:** Windermere Family Services, FaPMI (Families where a Parent has a Mental Illness), Enliven. • **Education and early childhood services:** Local primary schools. • **Government and community services:** South East PHN.
Physical location	Two central locations plus co-location at three community health organisations.
Kids hub relationships	Collaborated during co-design of the model of care.
Scope of referrals	Broad referral pathways; not open for walk-ins.
Designated care coordination roles (FTE)	Designated care coordination roles (4 FTE).
Diagnostic capability	Diagnosis capability.
Referral sources	Close relationship with schools, including consultations, service design, and direct referral pathways.

Hub	Loddon Children's Health and Wellbeing Local
Operational date	July 2023
Provider type	NGO
Catchment area	19,026km^2
Priority populations	• Aboriginal and Torres Strait Islander families. • CALD families (incl. refugee/asylum seeker, migrant) • Children living in out-of-home care. • School disengagement. • Families with FDV, substance use, financial stress.
Staffing composition	**Clinical:** 7 FTE **Non-clinical:** 6.6 FTE **Management and admin:** 4.2 FTE
Key partners	• **Health and mental health services:** Maryborough District Health, Sunbury and Cobaw Community Health Services, Echuca Regional Health. • **Aboriginal and Torres Strait Islander services:** Dhelkaya Health, Bendigo and District Aboriginal Cooperative (BDAC), Njernda Aboriginal Corporation. • **Government and community services:** Go Goldfields, North Central LLEN.
Physical location	Central location plus multiple satellite sites across six local government areas.
Kids hub relationships	Mental health clinicians work part-time with the Kids Hub and CAMHS.
Scope of referrals	Targeted referral pathways; not open for walk-ins.
Designated care coordination roles (FTE)	Designated care coordination role (4.2 FTE).
Diagnostic capability	Formal diagnosis function.
Referral sources	Active liaison and outreach with schools and early childhood. 0.7% referrals from schools.

Appendix D Comparable Hub models

Comparable model	Service model	Referral pathways	Service uptake	Demographics
Early Years Places – Early Years Integrated Hubs (The Benevolent Society)	Integrated early childhood and family support hubs providing 'one-stop' access to multiple services under one roof. Early Years Places offer parenting programs, early learning activities (playgroups, early childhood education), child health clinics, nutrition and antenatal support, and family support services (like counselling, referrals for housing or employment assistance). The *Early Years Places Impact Report (2022)* was one of the first efforts to measure long-term outcomes of such hubs, indicating positive trends in child development and	Families learn about, or are directed to, Early Years Places via community health services, maternal and child health nurses, social service agencies, schools, or self-referral. No formal referral is required. Outreach efforts and partnerships (e.g. with local Aboriginal Controlled Organisations and multicultural community groups) help connect hard-to-reach families.[63]	The Benevolent Society operates Early Years Places in Queensland, delivering integrated early childhood and family support services. As of 2022, its Early Years Places collectively serve approximately 4,400 children (0–8 years) and their families per year.[64]	These centres cater largely to vulnerable and disadvantaged families. About nine per cent of families attending are Aboriginal and Torres Strait Islander and ~33 per cent are from CALD backgrounds, reflecting a focus on cultural inclusivity. Many participating families face risk factors such as low socioeconomic status, social isolation, or involvement with child protection.[65]

[63] Early Years Impact Measurement Framework | The Benevolent Society
[64] Early Years Impact Measurement Framework | The Benevolent Society
[65] Early Years Impact Measurement Framework | The Benevolent Society

Comparable model	Service model	Referral pathways	Service uptake	Demographics
	family wellbeing for participating cohorts.[62]			
Centre of Research Excellence (CRE) Child and Family Hubs	Child and Family Hubs co-locate paediatric healthcare (such as child and maternal health services) with family support, early childhood services, and social care on-site. The model's goals are early identification of family adversity (e.g. family/domestic violence, mental health issues, housing or financial stress) and providing wrap-around support to prevent problems from escalating. The CRE has co-designed and established two pilot Child and Family Hubs (since 2019) – one in Wyndham Vale, Victoria (with IPC Health) and one in Marrickville, NSW (with	Multi-entry referral system ('no wrong door'). Families are typically referred by maternal and child health nurses, GPs, hospitals, schools, or child protection services; but can also self-refer or walk in. A key feature is proactive outreach where the CRE hubs work with local partners and use community engagement to identify families in need who might not otherwise seek help.[67]	Unknown.	Unknown. The target population is families with children 0–8 who are experiencing adversity (e.g. socio-economic disadvantage, parental mental health issues, family/domestic violence, etc.). The hubs place special emphasis on reaching at-risk groups.

[62] New impact report shows long term value of early childhood support for disadvantaged families
[67] Child and Family Hubs - The Centre of Research Excellence in Childhood Adversity and Mental Health

Comparable model	Service model	Referral pathways	Service uptake	Demographics
	Sydney Local Health District).[66]			
Healthy Homes and Neighbourhoods (HHAN)	HHAN does not prescribe an age range as it offers 'whole-of-family' wrap-around support led by a multidisciplinary team. HHAN is not a single site, but rather a networked service model that assigns each enrolled family a care coordinator (clinical nurse consultants, social workers, etc.) who works with the family over an extended period (often 12+ months).[68]	Referrals are often initiated by health or social services. HHAN identifies eligible families through channels such as hospital social workers (e.g. in maternity wards for at-risk newborns), community health centres, mental health services, child protection agencies, and local NGOs.	In its initial year (2015–16), HHAN enrolled 65 families (145 individuals) for intensive care coordination in inner-city Sydney. The program has since expanded; by June 2024 HHAN had supported a total of 591 families dealing with complex needs. The annual caseload is relatively modest (hundreds of families) due to the intensive, long-term nature of support provided to each household.	HHAN focuses on families facing multi-generational disadvantage (e.g. interrelated health issues, poverty, housing instability). About 30 per cent of HHAN-enrolled families identify as Aboriginal and/or Torres Strait Islander. Many families come from culturally and linguistically diverse backgrounds, with many HHAN families residing in Arabic-speaking, Pacific Islander, and Southeast Asian communities (exact figures unknown).[69]

[66] Child and Family Hubs - The Centre of Research Excellence in Childhood Adversity and Mental Health
[68] Healthy Homes and Neighbourhoods | Social determinants of health | Agency for Clinical Innovation
[69] Optimising Healthy Homes and Neighbourhoods (HHAN) Collaborative Research Project | The George Institute for Global Health

Appendix E Funding additional data

E.1 Funding allocation

Table 59 | Detailed financial contributions from the Australian Government to Kids Hubs, by state and territory, per Bilateral Schedules FY2021-2026

S/T	2021-22 ($)	2022-23 ($)	2023-24 ($)	2024-25 ($)	2025-26 ($)	Total ($)	Difference to S/T funding
Australian Capital Territory	-	-	898,000	1,797,000	1,822,000	**4,517,000**	
New South Wales	-	3,505,000	3,544,000	4,504,000	6,390,000	**17,943,000**	-
Northern Territory	-	-	898,000	1,797,000	1,822,000	**4,517,000**	-103,000
Queensland	-	2,623,000	1,772,000	2,707,000	3,644,000	**10,746,000**	-
South Australia	-	-	5,337,000	3,431,000	3,512,000	**12,280,000**	+12,280,000
Tasmania	-	886,000	1,772,000	1,797,000	1,822,000	**6,277,000**	-
Victoria	-	6,131,000	5,315,000	5,390,000	5,465,000	**22,301,000**	-9,847,197
Western Australia	-	886,000	1,772,000	1,797,000	1,822,000	**6,277,000**	-
Total	**-**	**14,031,000**	**21,308,000**	**23,220,000**	**26,299,000**	**84,858,000**	

Detailed financial contributions to Kids Hubs from State or territory per Bilateral Schedules FY2021-2026

S/T	2021-22 ($)	2022-23 ($)	2023-24 ($)	2024-25 ($)	2025-26 ($)	Total ($)	Difference to S/T funding
New South Wales	-	3,505,000	3,544,000	4,504,000	6,390,000	**17,943,000**	
Northern Territory	-	-	898,000	1,900,000	1,822,000	**4,620,000**	
Queensland	-	2,623,000	1,772,000	2,707,000	3,644,000	**10,746,000**	
South Australia	-	-	-	-	-	**-**	
Tasmania	-	886,000	1,772,000	1,797,000	1,822,000	**6,277,000**	
Victoria	2,861,197	6,358,000	7,498,000	7,753,000	7,678,000	**32,148,197**	
Western Australia	-	886,000	1,772,000	1,797,000	1,822,000	**6,277,000**	
Total	**2,861,197**	**14,579,737**	**17,832,263**	**22,255,000**	**25,000,000**	**82,528,197**	

Table 60 | FY2024-2025 expenditure by cost indicator, by hub as a proportion of total hub expenditure (%)

Cost Indicator	VIC	VIC	VIC	QLD	QLD	NSW	NSW	NSW	WA	NT	TAS	TAS	TAS	TAS
Kids Hub	Loddon	Brimbank Melton	Southern Metro Melbourne	Brisbane	Gold Coast	Central Coast	Illawarra	Orange	Midland	Mparntwe (Alice Springs)	East Tamar	Burnie	Jordan River	Statewide[70]
Number of months operational in FY2024-25	12	12	12	12	12	5	4	0	6	4	0	2	4	
Practitioner, clinician and other service delivery staff salaries	58%	58%	58%	52%	64%	31%	22%	0%	31%	33%	79%	85%	82%	0%
Capital and rent costs	19%	19%	19%	5%	8%	48%	69%	53%	32%	17%	0%	3%	0%	0%
Management and administration staff salaries	0%	0%	0%	24%	26%	6%	0%	22%	18%	20%	0%	0%	0%	100%

[70] Not a Kids Hub site - this is a centralised expenditure item covering all Kids Hubs services in Tasmania.

Cost Indicator	VIC	VIC	VIC	QLD	QLD	NSW	NSW	NSW	WA	NT	TAS	TAS	TAS	TAS
Kids Hub	Loddon	Brimbank Melton	Southern Metro Melbourne	Brisbane	Gold Coast	Central Coast	Illawarra	Orange	Midland	Mparntwe (Alice Springs)	East Tamar	Burnie	Jordan River	Statewide[70]
Other office overheads	20%	20%	20%	0%	1%	0%	1%	0%	7%	2%	0%	1%	2%	0%
Service delivery activities	4%	4%	4%	16%	0%	0%	8%	0%	2%	4%	2%	1%	1%	0%
Other costs	0%	0%	0%	3%	0%	2%	0%	18%	6%	9%	2%	2%	3%	0%
IT costs	0%	0%	0%	0%	1%	0%	0%	5%	2%	11%	1%	2%	3%	0%
Professional development and training	0%	0%	0%	0%	0%	12%	0%	2%	1%	4%	15%	8%	10%	0%

E.2 Cost-effectiveness

Model	Description	Who they support
Early Childhood Hubs (ECHs)	A community centre where families with young children can access a range of services - including early learning, maternal and child health, allied health, and family support - all in one place. ECHs also act as a social space where families can connect with each other.	They support families with children aged 0–8, with a particular focus on those experiencing disadvantage, isolation, or barriers to accessing services.
Integrated Child and Family Hub (Wyndham Vale)	A 'one stop shop' where families can access a range of services and supports that improve child development as well as child and family health and wellbeing. The hub has two critical roles: improving access to a range of health, education, and social services using a family centred approach; and providing opportunities to build parental capacity and for families to create social connections	The hub supports children aged 0–8 years and their families experiencing adversity in low socioeconomic areas.

Table 61 | Definition of cost categories of different child and family hub models

Cost category	Subcategory	Kids Hubs	ECH	Integrated Child and Family Hub (Wyndham Vale)
Operating	**Glue**	Includes costs categorised under 'Management and administration staff salaries'.	Staffing costs for key integration roles (such as ECH coordinators, community connectors, and backbone support staff) that enable collaboration, coordination, relationship-building and governance as well as funding for glue operating expenses	Salaries for co-ordination and integration staff, i.e. salaries for co-ordination and integration staff.

Cost category	Subcategory	Kids Hubs	ECH	Integrated Child and Family Hub (Wyndham Vale)
			(such as travel and printing).	
Operating	**Services**	Includes costs categorised under: 'Practitioner, clinician and other service delivery staff salaries' 'Service delivery activities'	Staffing costs for Early Learning, Early Childhood Education and Care, Maternal and Child Health, Family Support Services, Community designated activities, and Allied Health and Medicine.	Salaries for staff providing core services in the hub.
Operating	**Infrastructure**	Includes costs categorised as: 'Capital and rent costs' listed as 'rent' or 'fit-out' costs 'Other office overheads' listed as 'repair', 'maintenance', 'depreciation' 'Other costs' listed as 'borrowing costs'	Annual costs for rent and maintenance for service, repair and renovation of premises.	Additional cost to the centre to allow it to accommodate the additional services required at the hub.
Operating	**Other**	Includes costs categorised under: 'Professional development and training' 'IT costs' 'Other office overheads' 'Other costs' 'Capital and rent costs' not explicitly	A flexible cost allocation to address other cost requirements of the ECH, including non-staff operating costs such as cleaning, gardening, IT related as well as glue related costs such as catering for events, local outreach travel, or	The cost of running training sessions for staff, and materials for community outreach and engagement.

Cost category	Subcategory	Kids Hubs	ECH	Integrated Child and Family Hub (Wyndham Vale)
		listed as 'rent' or 'fit-out' costs	design of promotional materials or publications.	
Capital	**Infrastructure**	Includes costs categorised under 'Capital and rent costs' incurred by sites located in new builds.	Initial once-off outlay costs for spaces not leveraging existing community infrastructure.	The cost of establishing the hub through infrastructure works.