

BUILDING INTEGRATED EARLY CHILDHOOD AND FAMILY SUPPORT SERVICES: AN OUTCOMES-BASED APPROACH

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This paper draws on work done by the Centre for Community Child Health over the past seven or eight years in promoting the rethinking and reconfiguring of early childhood services in community settings. This work has resulted in the development of an outcomes-based framework for helping communities and service systems refocus services so as to achieve better outcomes for children and families. We have also developed a number of resources to promote collaboration between community-based services.

The paper begins by looking briefly at the rationale for greater collaboration and integration of early childhood services, and the different forms that collaboration and integration can take, from networking to full integration of services. Next, the rationale for focusing on outcomes is explored, and an outcomes-based approach to planning outlined. This involves 'beginning with the end in mind', and identifying the objectives, strategies and activities needed to achieve the agreed outcomes. The roles of evidence-based practice and program logic in the selection of strategies and activities are explained, and the ways in which the delivery of services and the outcomes achieved can be evaluated are outlined.

The paper will then describe the application of outcomes-based planning in two contrasting community-based projects. In one, CCCH was engaged by a local Early Years Committee representing Commonwealth, State, local government and non-government programs and agencies to help develop an action plan for early childhood services in a rural region. In another, a local council engaged CCCH to facilitate the integration of a number of early childhood services into a single integrated services hub. In each case, the clarification of goals and objectives was crucial to driving change.

Finally, relevant CCCH resources are described. These include conceptual models and a range of toolkits and guidebooks, to assist collaboration between community-based services, and various training packages for service providers working with young children and their families.

The paper concludes by considering some of the important issues to be faced when seeking to integrate services. We need to recognise that, while there are good reasons why we should be seeking greater service integration, the evidence to support the effectiveness of such moves is inconsistent. From an outcomes-based

perspective, the integration of services is a means to an end, not an end in itself, and our efforts to strengthen linkages need to be monitored to ensure that they improve outcomes for young children and their families.

INTRODUCTION

The frameworks and resources that this paper describes are the result of work done by an interdisciplinary group of staff at the Centre for Community Child Health (CCCH) over the past seven or eight years under the leadership of June McLoughlin (Manager, Policy and Service Development Unit) and Professor Frank Oberklaid (CCCH Director).

The frameworks and resources arise from experience gained by CCCH in working on a wide range of Federal, State and local government programs, such as Communities for Children, Best Start, Local Answers, Playford Project, integrated service hubs, and the Australian Early Development Index.

OUTLINE OF PAPER

- Rationale for reconfiguring the early childhood and family support service system
- Integrated and collaborative service approaches
- Outcomes-based service approaches
- Applying an outcomes-based approach to service integration: key issues
- Applying an outcomes-based approach to service integration: two examples
- CCCH resources to support integration
- Conclusions and challenges

THE RATIONALE FOR CHANGE

In the Centre for Community Child Health's efforts to address these issues, we have found it helpful to use the following questions as a framework:

- What are the 'good enough' conditions and experiences needed by infants and young children to develop well?
- What are the conditions and supports needed by families to enable them to rear young children as they (and we) would wish?
- What are the features and qualities of communities that enable families of young children to rear their children as they (and we) would wish?
- What contribution can government make to supporting communities and families in rearing young children as they (and we) would wish?

We believe there are pressing reasons to reconfigure the services we provide to young children and families in order to achieve better outcomes for young children, families and society.

There are **six main reasons why change is needed**:

- Major social and economic changes – international and local (Berger and Huntington, 2002; Giddens, 2002; Held, McGrew, Goldblatt and Perraton, 1999)
- Changes in families and family circumstances (de Vaus, 2004; Richardson, 2005), leading to an increase in the number of families with complex needs and parenting difficulties
- Service delivery issues – the traditional system of services is having trouble meeting all the needs of all children and families (Richardson and Prior, 2005; Zubrick, Silburn and Prior, 2005).
- Worsening or unacceptably high developmental outcomes for young people (Stanley, Richardson and Prior, 2005; Richardson and Prior, 2005) – these appear to be the unintended consequence of economic policies that have otherwise been remarkably successful
- New knowledge of factors affecting child development and family functioning (McCartney and Phillips, 2006; Shonkoff and Phillips, 2000)
- Evidence of the efficacy and cost effectiveness of early childhood and early intervention programs (Guralnick, 1997; Karoly, Greenwood, Everingham, Houbé, Kilburn, Rydell, Sanders and Chiesa, 1998; Karoly, Kilburn and Cannon, 2005)

In addition, there are the arguments now being put forward by economists regarding the social and economic benefits of investments during the early years (Cunha, Heckman, Lochner and Masterov, 2005; Heckman and Masterov, 2004; Lynch, 2004; Rolnick and Grunewald, 2003).

What form should this change take? We believe that there are three main ways in which change is needed: we need better integrated communities, better integrated services, and improved forms of dialogue between communities and services.

- **More supportive communities.** As a result of the pervasive economic, social and demographic changes that have occurred over the past few decades, there has been a partial erosion of traditional family and neighbourhood support networks. This has left a greater proportion of parents of young children with relatively poor social support networks and therefore more vulnerable. The evidence we have already considered about the importance of social support and social connectedness strongly suggests that one way in which we could address this problem is by providing families of young children with multiple opportunities to meet other families of young children. Complexity theory suggests that there is value in random encounters as well.
- **Better integrated services.** In the light of the difficulties that services have in meeting all the needs of all families effectively, the service system needs to become better integrated, so as to be able to meet the multiple needs of services in a more seamless way. We need to turn the system around so that it puts the customer first, tailoring our services to the needs and circumstances of families rather than the needs of professional and bureaucracies.

- **Improved forms of dialogue between communities and services.** For the service system to become more responsive to the emerging needs of young children and families, we need better ways of communicating, more constant feedback. This needs to occur at all levels, involving service providers in their dealings with individual families, agencies with their client groups, and service systems with whole communities. For individual professionals, this means using a service philosophy such as family-centred practice as well as needs-assessment procedures and tools that regard parent input as being as important as professional input. For service systems, it means developing skills in talking to communities of families – in other words, community-centred practice.

There are many strategies that can contribute towards achieving these goals. Only four will be mentioned here, and two of these we will examine in detail.

- First, we believe that there needs to be **a shift from treatment and targeted services to universal prevention approaches** (Centre for Community Child Health, 2006). The argument for the adoption of a universal prevention approach to service delivery has been most clearly stated by Richardson and Prior (2005):

‘Targeted policies and services to meet the special needs of children with chronic problems, or who face difficult circumstances, will always be required. However, such services will continue to consume an ever increasing proportion of public expenditure on social and other human services unless there is a substantial repositioning of policy from its current focus on remedial and treatment services towards increased investment in universal prevention for all children -- particularly in the early years. Without such investment, we are likely to see a continuation of the present trends of increasing inequality and localised concentration of an adverse outcomes for children and youth, including vulnerability to emotional and behavioural problems, substance use and abuse, alienation from school, and disengagement from or rejection of civic and social values and hopes for the future.’ (p. 318)

- Second, to address this challenge, we need to develop **a tiered system of universal, targeted and specialist services**. The evidence suggests that existing service systems may be too dependent upon scarce specialist expertise. To counteract this tendency, the capacity of universal services to cater for the needs of a broad range of children and families will have to be strengthened by creating a more tiered system of universal, targeted and treatment services, and to deploy the expertise of specialists more broadly. All three would have a prevention focus:
 - universal services directed to whole populations aim to strengthen capacity and reduce the incidence of developmental and other problems;
 - targeted services directed to individuals or groups identified as being at risk aim to reduce the numbers who develop problems; and
 - treatment services directed to those who have identified problems aim to reduce the sequelae or complications of the condition.

- Third, to achieve these ends and to address the difficulties traditional services are having in meeting the changed needs of families, ***services need to become better integrated.***
- Fourth, as a basis for enabling the service system to become more collaborative and better integrated, ***an outcomes-based approach to planning and service delivery is needed.***

We will now examine these last two in some detail.

INTEGRATED AND COLLABORATIVE SERVICE APPROACHES

As already noted, the current service system struggles to meet the changing needs of families. There are many problems:

- The service system is having difficulty providing support to all families who are eligible
- Services cannot meet all the needs of families that they do serve - no single service is capable of meeting the complex needs of many families
- Families have difficulty finding out about and accessing the services they need
- Services are often not well integrated with one another and are therefore unable to provide cohesive support to families
- Services have difficulty tailoring their services to meet the diverse needs of families
- Services are typically focused on and/or funded on the basis of outputs rather than outcomes, and therefore tend to persist with service delivery methods that may not be optimally effective
- Services are typically treatment-oriented rather than prevention- or promotion-focused, and therefore cannot respond promptly to emerging child and family needs
- The service system does not maintain continuous contact with families of young children during the early years
- Many families are isolated and lack supportive personal networks - extended family, friends or other families of young children
- The early childhood field is undervalued and underfunded, and has difficulty attracting and retaining staff
- Government departments, research disciplines and service sectors tend to work in 'silos', despite there being strong arguments for greater service integration and a 'whole of government' approach to service delivery
- Responsibility for provision of services to young children and their families is spread across three levels of government - federal, state, and local - with different planning processes and funding priorities
- Most specialist intervention services are already underfunded, and it is looking increasingly unlikely that they can ever be fully funded in their present forms

One way of addressing at least some of these problems is to seek to promote collaboration and integration of services. Valentine, Katz and Griffiths (2007) identify a number of reasons for greater collaboration and integration of services to children and families:

- From the perspective of families, service delivery needs to be seamless or holistic so that families do not have to deal with a lot of agencies or duplicate time and labour in informing agencies of their needs, going through assessments and so on.
- Collaborative and integrated work should be more efficient, simultaneously serving multiple needs through one service and saving labour for staff as well as time and effort for families.
- Expanded roles for significant and trusted family workers such as nurses, teachers and social workers should improve the quality and accessibility of services for families.
- Improved integration and communication between agencies should stop families 'falling through the cracks', as has happened in several catastrophic failures of services systems associated with child deaths or near deaths.

The service delivery issues identified above are evident in many developed nations and are not peculiar to Australia. In response to these problems, many governments and jurisdictions have looked at ways of integrating services more effectively. In the UK, these moves have taken the form of:

- *Every Child Matters* (HM Government, 2003)
- Children's Trusts (Hawker, 2006)
- Working in multidisciplinary teams (Chandler, 2006)
- Team Around the Child (Limbrick, 2004; Siraj-Blachford, Clarke and Needham, 2006)
- Sure Start Children's Centres (Whalley, 2006)

There have also been similar moves in Australia, as documented by Valentine, Katz and Griffiths (2007).

Integration can occur at several different levels: policy (or whole-of-government) level, regional planning level, and direct service delivery level.

- ***Policy (or whole-of-government) integration.*** According to Valentine, Katz and Griffiths (2007), the purpose of *policy integration* is to ensure that:
 - The program is 'owned' by all the relevant government agencies that have a stake in the wellbeing of children, rather than being seen as the domain of only one department or portfolio.
 - The tensions which are inherent in any such programs are minimised (for example, to ensure that data on newborns can be shared between health and non-government organisations).

- The bureaucratic obstacles to implementation of the program are addressed (for example, that schools can be opened at weekends to house family support programs).
- **Regional and local planning integration.** This may involve new governance structures, planning and management committees, or interagency working groups.
- **Service delivery integration.** At the direct service level, integration can take many forms. These are often depicted as falling along a continuum. For example, Turnbull and Turnbull (2000) identify the following continuum:
 - *Cooperation* involves a low-intensity, low-commitment relationship in which the parties retain their individual autonomy but agree to share information (eg. networking)
 - *Coordination* involves a medium-intensity, medium-commitment relationship in which the parties retain their individual autonomy but agree to some joint planning and coordination for a particular time-limited project or service (eg. regional referral committee)
 - *Collaboration* involves a high-intensity, high-commitment relationship in which the parties unite under a single auspice to share resources and jointly plan and deliver particular services
 - *Integration* involves a complete merging of services to form a new entity

Toronto First Duty *Indicators of Change* (2005) distinguishes between five levels of collaboration: coexistence, coordination, partial collaboration, extended collaboration, and integration.

According to the UK government's *Every Child Matters* website (<http://www.everychildmatters.gov.uk/deliveringservices/integratedworking/>), there are three general models for delivering multi-agency services:

- *Multi-agency panel* - practitioners remain employed by their home agencies, agreeing to meet as a panel on a regular basis to discuss children and young people with additional needs who would benefit from multi-agency input.
- *Multi-agency team* – this is a more formal arrangement than a multi-agency panel in which practitioners are seconded or recruited into the team, are generally line-managed by the team leader, but retain links with their home agencies through supervision and training.
- *Integrated services* - the key feature of an integrated service is that it acts as a service hub for the community by bringing together a range of services, usually under one roof, whose practitioners then work in a multi-agency way to deliver integrated support to children and families.

Valentine, Katz and Griffiths (2007) identify four models:

- co-location of services,
- community outreach from an existing service,

- multi-service centres or community hubs, and
- the expansion of multi-service agencies and working groups, to include more services or to change the activities of existing services

Building efficient integrated service systems has proved to be difficult. One factor that has been consistently identified as an important feature in promoting effective collaboration and integration has been the development of a vision, based on shared values and agreed outcomes.

We will now consider a process for achieving such a common vision – using an outcomes-based approach.

OUTCOMES-BASED APPROACH

What is the rationale for a shift to an outcomes-based approach?

There are several reasons for adopting an outcomes-based approach to planning and service delivery:

- First, there is a general recognition that we cannot expect to achieve positive outcomes if we are not clear what outcomes we want (Pollard and Rosenberg, 2002).
- A second reason for adopting an outcomes-based approach is that it has become increasingly apparent that there are negative consequences if we do not do so. Thus, if we are not clear about the outcomes we are aiming for, then
 - we will be less likely to achieve desired outcomes,
 - we will be unable to judge the efficacy of the service we provide,
 - we will be less likely to choose a methodology that is known to be effective in achieving desirable outcomes, and
 - we may persist with approaches and goals that are not achieving anything.
- A third reason is that the available ways of funding services do not guarantee positive outcomes and do not give governments ways of measuring whether the services they are funding are having the effects they intended.

How is an outcomes-based approach different from the approaches we have been using?

For the lack of any viable alternative, governments have funded services on the basis of inputs and/or outputs:

- **Inputs** are what is provided to enable an intervention or program to function. This includes funding, staffing, resources.
- **Outputs** refer to the amount of service provided, sometimes expressed in terms of the number of service delivery units.

However, neither inputs or outputs are necessarily related to achieving desired outcomes. Providing an adequate level of staffing and resources makes it more likely

that positive outcomes will be achieved, but does not guarantee them: the staff may not successfully engage the children and parents or use the most effective intervention strategies. Similarly, having a providing families with a certain level of service does not guarantee that the service is the one best suited to meeting the child and family needs, or that it is of a sufficient quality to be effective. Inputs and outputs represent necessary but not sufficient conditions for successfully achieving outcomes.

Another problem with the output-based approach is that it encourages service providers to focus on the service to be provided rather than the ultimate aims, thereby **confusing the means with the ends**. In the context of business, Levitt (1975) has shown that industries that become product-oriented rather than consumer-oriented inevitably decline and lose their customers. They are under the illusion that continued growth is just a matter of continued product or service innovation and improvement. But the consumers don't care about the products or services in themselves, only in what they can do for them. Industries or services that lose sight of that are at risk of losing their customer base.

According to Levitt, industries that thrive *start* from the customers' needs and work backwards – they focus on what the customers want and need and then tailor what they produce or deliver to meet those needs. They spend less time on the producing or refining the product or service itself and more time on staying in touch with customer desires.

Human services, including early childhood intervention, sometimes focus more on the product (service) than the outcome, that is, they are primarily concerned to deliver high quality services and to improve the ways in which they deliver services. Another way of putting this is that they think that the aim of early childhood intervention is to provide all the wonderful early intervention services that we are trained to deliver.

But that is to confuse the means with the ends. All our technical expertise and various forms of service are only a means to an end – to make some kind of change in the child and family. The question is what kind of change are we seeking? And exactly how does the services we provide achieve that change? Thus, we need to be clear about what we are trying to achieve as well as having a clear evidence-based model of how those goals can be achieved.

As a result of the deficiencies of the current output-based funding models, there have been increasing calls for human services to adopt a results-based or outcomes-based accountability approach to service planning and delivery (Centre for the Study of Social Policy, 2001; Chinman, Imm and Wandersman, 2004; Friedman, 2005; Schorr, Farrow, Hornbeck and Watson, 1994; Utting, Rose and Pugh, 2001).

This has been matched by efforts within the early childhood intervention field to identify child and family outcomes as a basis for shifting to an outcomes-based approach (Bailey and Bruder, 2005; Bailey, Bruder, Hebbeler, Carta, Defosset, Greenwood, Kahn, Mallik, Markowitz, Spiker, Walker and Barton, 2006; Bailey, McWilliam, Darkes, Hebbeler, Simeonsson, Spiker and Wagner, 1998; Bruder, 2000;

Conn-Powers and Dixon, 2003; Harbin, Rous and McLean, 2005; Parrish and Phillips, 2003).

What does an outcomes-based approach involve?

Outcomes-based approaches ‘start with the end in mind’, that is, they begin by identifying the outcomes to be achieved and work backwards from there (Anderson, 2005; Friedman, 2005; Moore, 2006). This approach is also known as backward mapping (Elmore, 1979-1980; Harris, 2005).

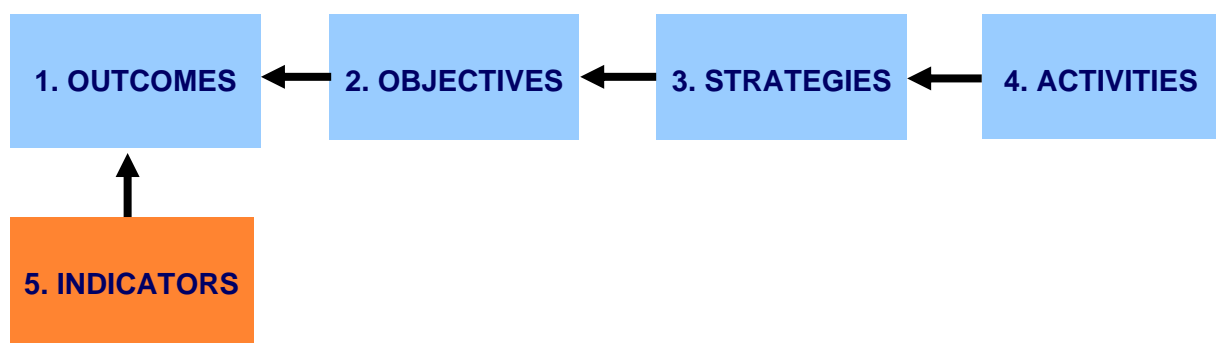
Accounts of the rationale for shifting to outcomes-based approaches have been provided by Schorr, Farrow, Hornbeck and Watson (1994) and the Victorian Department of Human Services (2006). In Victoria, the Department of Human Services (2006) has articulated a rationale for adopting an outcomes-based approach to services for children and families, concluding that a whole-of-government outcomes focus is essential when planning for children.

There have been a number of models developed to help service providers and systems adopt an outcomes-based approach (Centre for the Study of Social Policy, 2001; Chinman, Imm and Wandersman, 2004; Friedman, 2005). These various models all have certain features or steps in common. These have been incorporated into the following model developed at the Centre for Community Child Health, and incorporating work previously undertaken by Early Childhood Intervention Australia (Victorian Chapter).

Adopting an outcomes-based approach involves the following steps (as illustrated in Figure 1):

- Step 1: Identify the outcomes sought
- Step 2: Translate these outcomes into specific objectives
- Step 3: Select strategies for achieving these objectives
- Step 4: Translate the strategies into specific activities or programs
- Step 5: Identify indicators to measure the progress made

FIGURE 1: Starting with the end in mind



Step 1: Identify the outcomes sought

Outcomes are desired conditions of well-being for children, families, and communities. They answer the questions, 'What is it that we want for children and families?' Common outcomes include healthy children, economically self-sufficient families, and children ready to learn.

The first step in adopting an outcomes-based approach is to ask the question, *What do we want for our children?* The resulting statements are likely to be broad: most communities will have aspirations for their children that exceed the results that are currently measurable. But they have the great advantage of focusing on what people *want* for their children, before they get into the question of what is to be delivered or measured.

In identifying outcomes, it is important to distinguish between the services received and the benefits gained from them:

'A family outcome is not the receipt of services, but what happens as a consequence of providing services or supports. For example, sharing information with parents and about their child's condition is a service; if parents understand that information and use it to describe their child's condition to others, advocate for services, or respond effectively to their child's needs, a benefit has been experienced and family outcome has been achieved. Evaluating service quality or satisfaction reflects whether consumers like and appreciate the services received, but does not necessarily mean that benefit has been received.' (Bailey, Bruder, Hebbeler, Carta, Defosset, Greenwood, Kahn, Mallik, Markowitz, Spiker, Walker and Barton, 2006, p.228)

Outcomes may focus on children, families and/or communities. These are likely to be interdependent: 'positive outcomes experienced by the family serve to promote the child outcomes and outcomes achieved by the child benefit the family.'

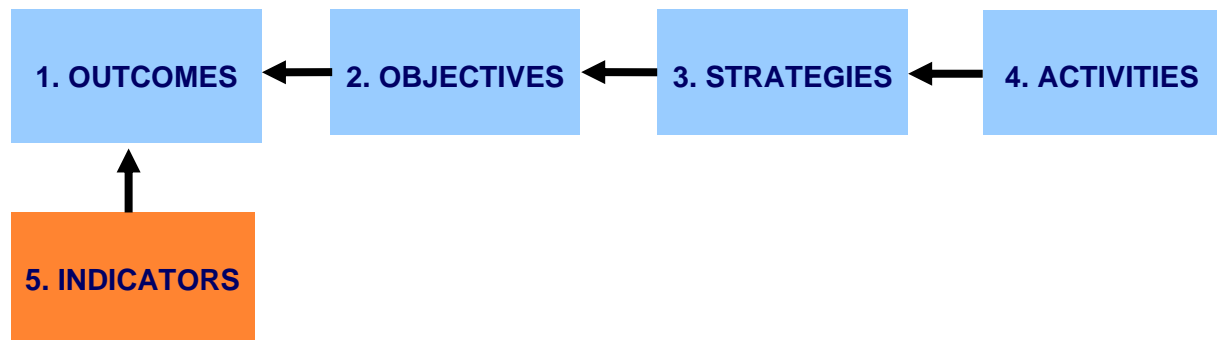
Framing outcome statements: In framing outcomes, the questions to ask are: *What is the overall effect that is being sought? What will be the end result? What is the ultimate purpose of the strategy? Why are we doing it?*

Outcomes should be framed in terms of the overall effect or state that is being sought, eg. *All children will be healthy and develop well*, or *All families will have positive social support networks*.

Outcome statements should not refer to or describe services to be provided (Friedman, 2005). One of the most important characteristics of a well constructed outcome statement is that it is not about data and not about services. The need for data is addressed by indicators, and services are best considered as means and not ends. Friedman gives the following example: *All preschool children receive high quality child care*. He points out that this is a strategy, not an outcome.

Step 2: Translate these outcomes into specific objectives

FIGURE 2: Translating outcomes into objectives



Objectives are the specific targets that need to be met in order for an outcome to be achieved. They address the question, ‘What do you want to achieve? To make progress to the expected outcomes, what do you need to achieve? Objectives need to be measurable, achievable and realistic. (Another term that often appears in the literature is **goals**. These are the same as objectives, and only the latter term will be used in this document.)

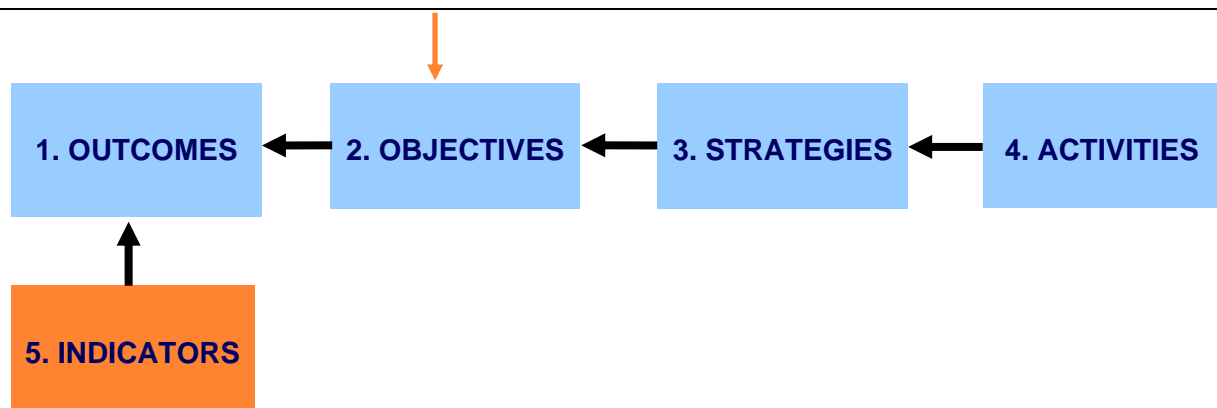
Whereas outcomes are broad statements about the conditions of well-being we are seeking for children, families, and communities, objectives are the specific targets that need to be met in order for these outcomes to be achieved. Each outcome can have one or more objectives.

Framing objectives: In framing objectives, the questions to ask are: What specifically needs to be done to achieve the broad outcomes that have been identified? What specific steps need to be taken to achieve the outcomes?

Objectives need to be measurable, achievable and realistic. To ensure this, they should be worded as *To increase ...*, *To decrease ...*, or *To establish....* Terms such as *strengthen* and *enhance* are to be avoided as these are not easy to measure.

Step 3: Select strategies for achieving these objectives

FIGURE 3: Translating outcomes into objectives



Strategies are long-term plans of action designed to achieve a particular objective or set of objectives. They describe how the objectives will be achieved, what will be done.

Whereas outcomes and objectives describe *what* is being sought, strategies and activities describe *how* these outcomes will be achieved. Strategies describe the components of a general plan of action aimed at achieving the objectives and outcomes. Activities translate the strategies into specific forms of service.

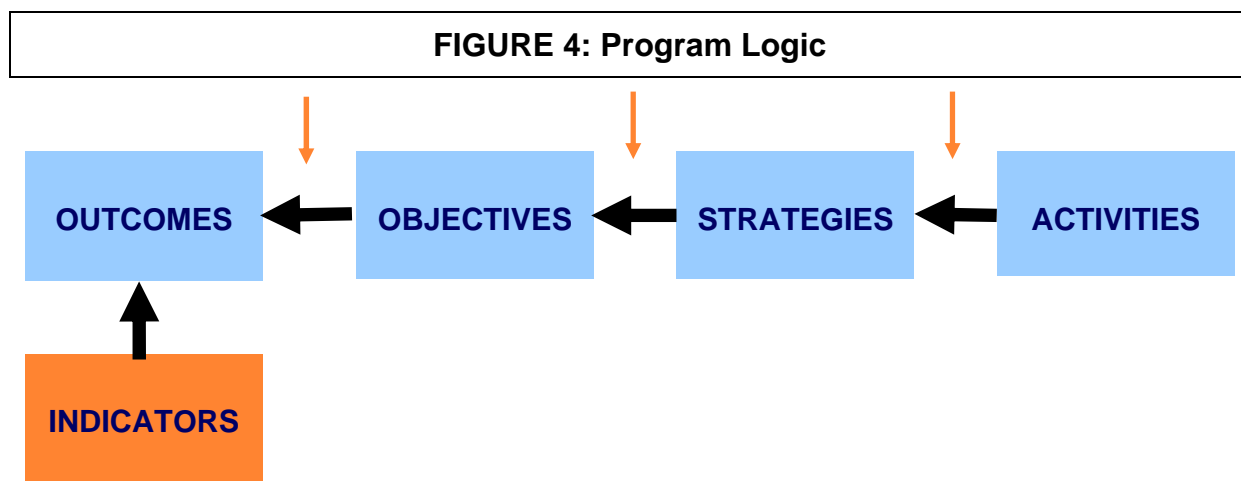
It is critical that services are able to demonstrate that the strategies and activities chosen are both logically related to the desired outcomes and known to be effective. Demonstrating the logical link between strategies and outcomes involves using *program logic* or *theories of change*, whereas demonstrating the effectiveness of interventions involves *evidence-based practice*.

Program logic and theories of change

These are related concepts:

- **Program logic** is a way of analysing a program, its components and the linkages between what a program does and what it is expected to achieve). A full logic model will show what service, at what intensity (or dosage), delivered to whom and at what intervals are likely to produce specified short-term, intermediate and long-term outcomes. A key characteristic of this model is that the means (what you do) and the ends (the results or outcome of what you do) are separated.
- A **theory of change** explains the process through which change occurs, and shows how the service or program that is delivered results in the outcomes that were intended. All forms of intervention should be based on a theory of change, that is, a model of how the intervention is expected to achieve the outcomes that have been chosen. This preferred theory may reflect a mixture of beliefs, assumptions and expectations, but ideally should be evidence-based.

Program logic is concerned with the links between the different elements of the outcomes-based model. In Figure 4, these links are indicated by the descending arrows).



Evidence-based practice

In addition to being able to demonstrate that the strategies and activities chosen are logically related to the desired outcomes, services also need to be able to show that the strategies are evidence-based and therefore known to be effective in achieving desired outcomes.

Why do we need evidence to back up what we do? There are at least two reasons. The first is that, if we do not have evidence to support what services we provide, then what we do will be based on what merely seems right, or on what we have always done. This can result in what Robin Sullivan (Children's Commissioner, Queensland) calls *cardiac evaluation* ('In my heart, I know what we do is good') or what UK paediatrician Leon Polnay calls *Biblical evaluation* ('We looked, and we beheld that it was good').

If services are not driven by clear outcomes and if the methods are not the ones best designed to achieve these outcomes, then they will be driven by other factors. These include

- habit or custom (this is how we have always done it),
- unproven assumptions (these particular children 'need' this kind of program), or
- community expectations (the tendency on the part of parents to over-value professional expertise and hands-on therapy).

Programs that base service delivery on any of these factors are less likely to achieve desirable outcomes than services that are clearly focussed on agreed goals and using proven methods of achieving these goals.

The second reason why we need evidence to back up what we do is that summaries of what make programs effective all conclude that effective programs are based on clear, scientifically-validated theoretical frameworks and methodologies which articulate how the services that are delivered achieve the desired outcomes (Bond and Carmola Hauf, 2004; Dunst, 1997; Halpern, 2000; Shonkoff and Phillips, 2000; Schorr, 1997; Simeonsson, 2000; Weissbourd, 2000). This need to be sure that we are using the most effective methods of achieving outcomes has led to calls for greater reliance on evidence-based practice.

What exactly is evidence-based practice? Buysse and Wesley (2006) define it as 'a decision-making process that integrates the best available research evidence with family and professional wisdom and values' — in other words, it is a balance of scientific proof, professional and family experience, and core values and beliefs.

Sackett, Straus, Richardson, Rosenberg and Haynes (2000) define evidence-based medicine as follows:

'Evidence-based medicine as the integration of best research evidence with clinical expertise and patient values.

- By *best research evidence* we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical

research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens.

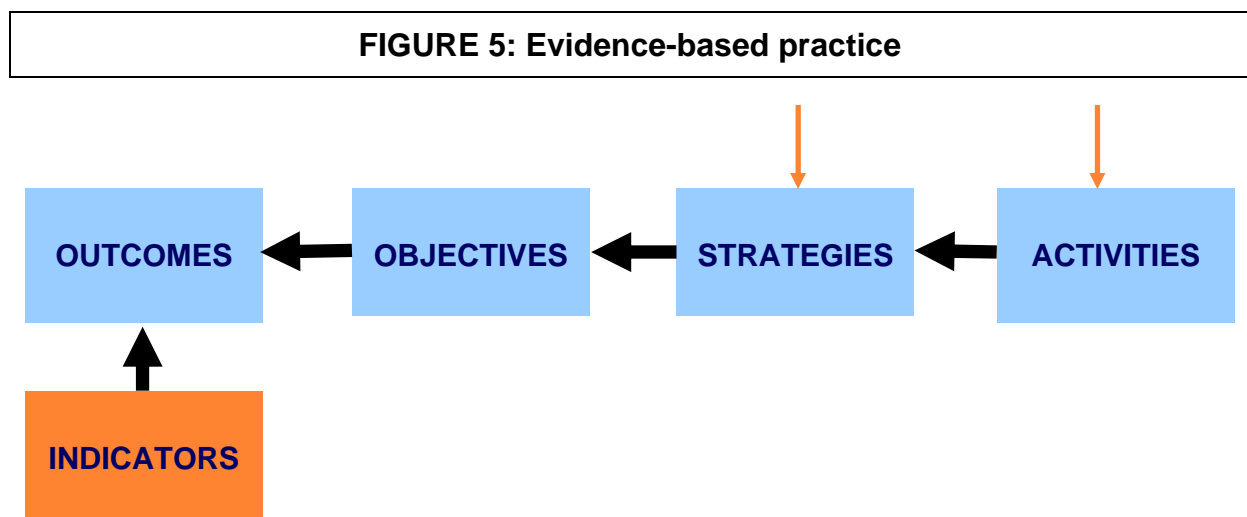
- By *clinical expertise* we mean the ability to use clinical skills and past experience to rapidly identify each patient's unique health status and diagnosis, the individual risks and benefits of potential interventions, and their personal values and expectations.
- By *patient values* we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient.

When these three elements are integrated, clinicians and patients form of diagnostic and therapeutic alliance which optimises clinical outcomes and quality of life.' (p. 1)

There are well established research protocols for determining which interventions or treatments are the most effective. These typically involve five levels of evidence, with the 'gold standard' being represented by studies involving large randomised control trials. This has led to a tendency to think that we should only be using interventions that have been proven to be effective using this methodology. However, there are many forms of intervention that have yet to be tested in this way and therefore have not yet been shown to be ineffective. A total reliance on interventions backed by randomised control trials might therefore exclude some effective interventions that have yet to be tested.

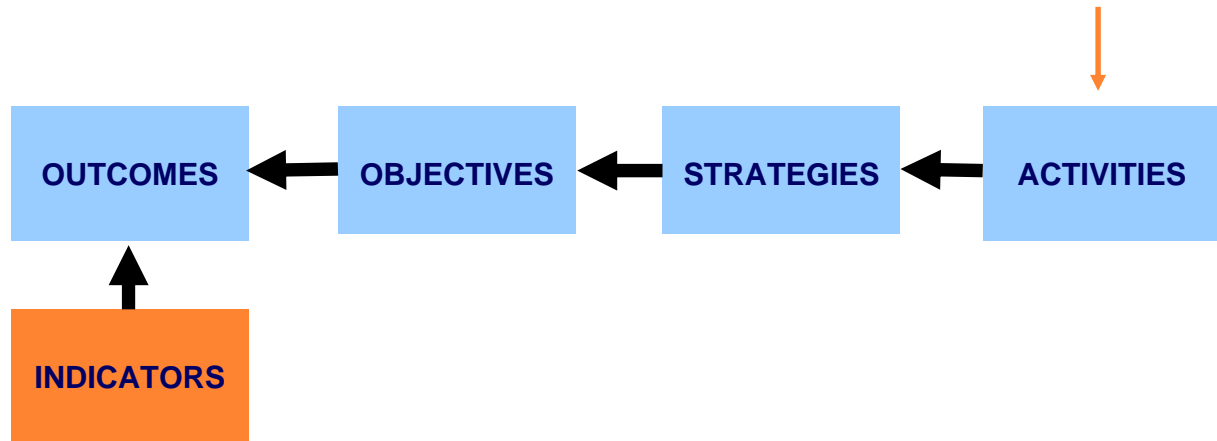
To incorporate family values, we need to draw upon ***practice-based evidence***. This involves getting continuous feedback about whether services are meeting people's needs effectively, and uses this information to make modifications to services so as to meet people's needs more effectively.

In Figure 5, the descending arrows highlight the two stages of the outcomes-based approach where evidence-based practice (in the broader sense just outlined) is critical.



Step 4: Translate the strategies into specific activities or programs

FIGURE 6: Translating strategies into activities and action plans



Activities are the actual services and programs provided. Activities translate the strategies into specific forms of service. In the outcomes-based approach, activities are the last element to be specified. In the more traditional service-based approaches, they are often the first. Thus, services have often begun by identifying the programs they plan to offer, based upon the available funding and the forms of service that they know best, rather than beginning with the outcomes they want to achieve and working backwards to objectives, strategies and activities.

Step 5: Identify indicators to measure the progress made

Indicators are measures of social and family functioning that are known to be on the causal pathways of these serious outcomes. They answer the question, 'How do we know we are making progress on this outcome?' Several indicators can pertain to each outcome. For example, indicators pertaining to healthy children could include immunization rates, rates of various diseases, and rates of exercise.

By virtue of being on the causal pathway to important outcomes, indicators tell us whether the strategies and activities being provided are having the desired effect and whether the recipients are on track to achieving positive outcomes in the long term. However, because outcomes are general statements of desired states, indicators can never be more than approximate representations of these outcomes. Nevertheless, some indicators are powerful predictors of later outcomes because, although relatively narrow in themselves, they act as proxies for clusters of indicators.

There are likely to be different outcomes and indicators at national / state and local levels - a single set of outcome measures is unlikely to be able to address all levels and purposes.

IMPLEMENTING AN OUTCOMES-BASED APPROACH

What has been described so far – the selection of program outcomes, objectives, strategies, activities and indicators – represents the first phase of adopting an outcomes-based approach. Although this phase is about conceptualising and planning the program, it is by no means a simple task. Services typically find shifting to an outcomes-based approach difficult. This is because of the prevailing service-based paradigm and a strong tendency to confuse means with ends. Human service providers often focus more on the product (ie. service) than the outcome, that is, they think that the reason the service exists is to provide support and intervention programs to children and parents. But that is to confuse the means with the ends: all the technical expertise and various forms of service are only a means to an end – to make some kind of change in the child and family. The question is what kind of change are we seeking? And exactly how does the services we provide achieve that change?

Once the hard work of identifying and agreeing on outcomes and strategies has been done, the next phase is to implement the chosen interventions. This involves the following steps:

- Delivering the activities and programs
- Evaluating the delivery of activities and programs
- Evaluating the impact of activities and programs
- Evaluating long-term outcomes

MONITORING AND EVALUATING OUTCOMES

How do we know when we have achieved our outcomes with families?

Evaluation involves systematically investigating the *effectiveness* of intervention programs with a view to improving policy and practice. This distinguishes evaluation from controlled experimental studies which measure the *efficacy* of interventions, that is, whether they can be shown to change children or families independently of other factors.

There are three distinct types of evaluation: process evaluation, impact evaluation and long-term evaluation.

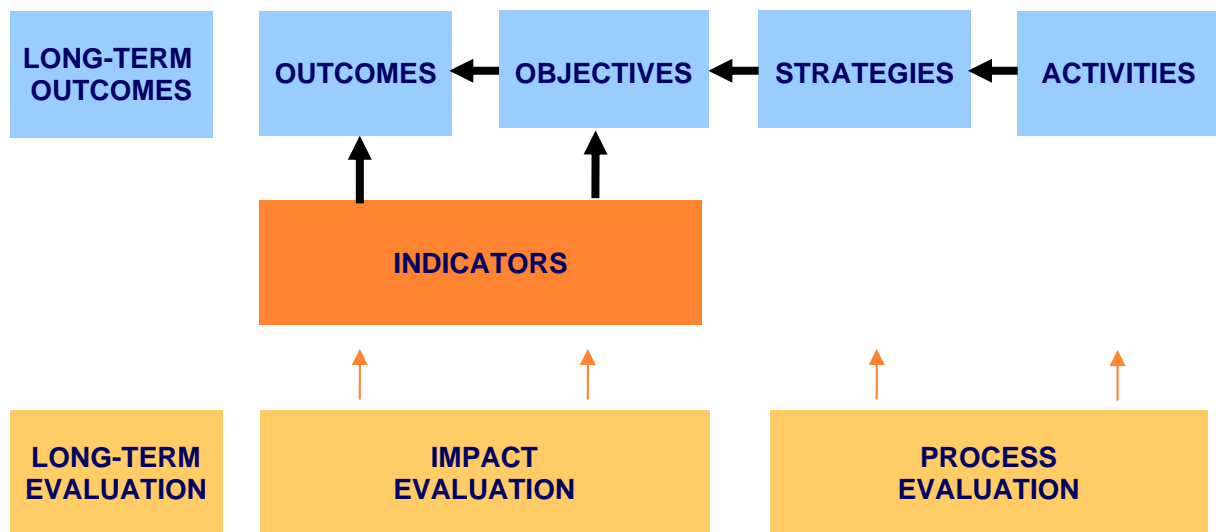
- **Process evaluation** involves evaluating the process of service delivery as it is being delivered. There are two aspects to process evaluation:
 - *Measuring what was delivered.* The key question to be addressed here is: Did we deliver what we said we would deliver? Answering the question is relatively straightforward, provided the services to be delivered were clearly identified in the action plan and routinely logged during delivery.
 - *Measuring how services were delivered.* The key question here is: Did we deliver service in the manner that was intended? This involves measuring if the services were delivered in ways that were consistent with best practice and with the philosophy of the program.

- **Impact (or short-term) evaluation** involves evaluating the immediate effect or short-term outcome of an intervention. It is conducted at the completion of an intervention, and addresses the question of whether the intervention had the immediate impact on the recipients that was expected.
- **Long-term evaluation** involves evaluating whether the intervention contributed to desired long-term changes in functioning. It is conducted months or years after the intervention has been completed and is the ultimate test of the program's efficacy.

Ideally, services ought to conduct all three forms of evaluation, but the evaluation of long-term outcomes is generally beyond their resources. However, process and impact evaluation are within the capabilities of most services and ought to be (but often are not) routine.

The relationship between the three forms of evaluation and the stages of the outcomes-based model are shown in Figure 7.

FIGURE 7: Forms of evaluation



APPLYING AN OUTCOMES-BASED APPROACH TO SERVICE INTEGRATION: KEY ISSUES

We have looked at two strategies for promoting improved services for young children and families: collaborative or integrated services systems, and using an outcomes-based approach to service planning and delivery. We will now try applying an outcomes-based analytical framework to integrated service building, to see what this tells us about how to ensure that this process is as effective as possible. This means that we will explore what the outcomes and objectives of collaboration and integrated service delivery are, what evidence-based and logic-based strategies there are, and what is involved in monitoring and evaluating our efforts at integration.

Outcomes and objectives

In seeking to integrate services for young children and families, the key question to address is what outcomes we are trying to achieve. If we are trying to make positive changes in child and family functioning, then the integration of early childhood and family support services is a *means to an end*, not an end in itself – in the outcomes-based model, integration is a *strategy* to achieve improved outcomes for children and families. From this perspective, the value of integrated service systems would lie in the contribution made to positive changes in children and families.

Might we want to build more integrated service systems even if there was little or no evidence of direct benefits to children? Could integration and collaboration be legitimate ends in their own right as well as means to achieving better outcomes for children and families?

When we adopt a particular policy or practice, we may do so for several reasons (Bailey, McWilliam, Buisse and Wesley, 1998):

- Legal reasons – because we are required by law to do so
- Values – because we believe that it is the right thing to do or because we believe that people have a right to this policy or practice
- Evidence – because there is evidence to support the policy or practice
- Rational – because there are logical grounds for thinking that this policy or practice will benefit people, even if there is not yet any evidence to support it

We are not required by law to create integrated / collaborative service systems, and the evidence for direct benefits for children at least is not strong. However, we still might view collaboration and integration as desirable on the basis of the other two types of reasons. Thus, on the basis of the particular values that we hold, we might decide that it is unfair to expect vulnerable families to try and obtain help from a poorly integrated and difficult to access set of services, and that we should therefore be seeking to simplify the job for them. Or we might decide that, although the evidence for the benefits of integrated services may be inconclusive, there are grounds for thinking that, if we can make access to services easier and prompt, then families will receive more comprehensive and responsive support that will benefit the family as a whole and have flow-on benefits for the children.

If we accept this line of thinking, then we could view building service collaboration and integration as a legitimate goal in its own right, and evaluate its impact in the ways described above. However, we also need to keep in mind that the ultimate aim of our policies and practices is to make a positive difference for children and families, so we should treat the outcomes of service integration efforts as interim service outcomes, one step on the way to achieving improved outcomes for children, families and communities.

Evidence-based practice

What is the evidence for the effectiveness of integration / collaboration? Reviews of the literature on coordination and strategic partnerships suggest the following conclusions:

- While partnership working is widely assumed to be a good thing, it can be difficult to put into practice successfully - it requires careful planning, commitment and enthusiasm on the part of partners, the overcoming of organisational, structural and cultural barriers and the development of new skills and ways of working. (Percy-Smith, 2005, 2006)
- Whether or not such partnerships have a positive impact on children and young people is unclear (Dunst and Bruder, 2002; Percy-Smith, 2005, 2006; Valentine, Katz and Griffiths, 2007). This is partly because

‘... it is virtually impossible to use the most rigorous research methods to measure outcomes of integrated services. In most cases it is neither feasible nor ethical to randomly allocate families to ‘joined up’ and ‘not joined up’ services and then compare outcomes.’ (Valentine, Katz and Griffiths. 2007)

Positive outcomes associated with service coordination include

- better flow of resources, supports, and services
- parent satisfaction with provision of needed services, and
- improved well-being and quality of life

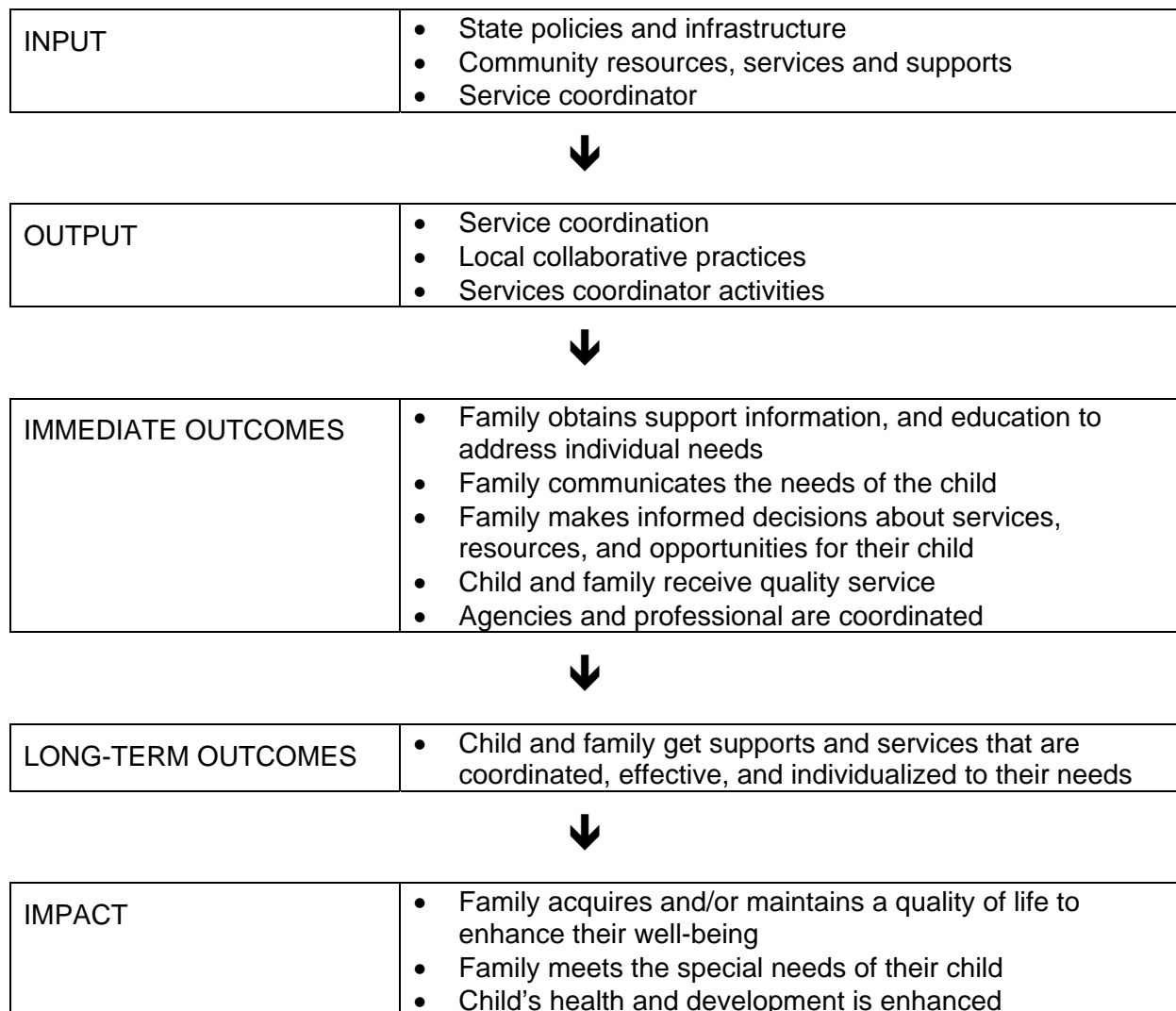
One of the key findings is that service integration only benefits children and families if it results in higher quality intervention (Valentine, Katz and Griffiths, 2007). This should come as no surprise: people – children and families – are changed by relationships with people who work directly with them, not by the policies or networks or agreements that professionals reach. Unless the policies and practices we develop to promote service integration and collaboration result in direct changes to the level, timing, relevance and quality of the services that children and families receive, we cannot expect them to show positive changes as a result.

- Despite the lack of rigorous research evidence for the benefits of integrated services, there is an emerging consensus or practice wisdom about what works in relation to establishing and developing strategic partnerships and integrated services (Billett, Clemans and Seddon, 2005; Department for Education and Skills, 2006; Einbinder, Robertson, Garcia, Vuckovic and Patti, 2000; Gardner, 2003; Hayden, Frederick and Smith, 2002; Johnson, Zorn, Tam, Lamontagne and Johnson, 2003; Leiba and Weinstein, 2003; Percy-Smith, 2005, 2006; Rawsthorne and Eardley, 2004; and Wolff, 2001).

Program logic

What is the program logic for seeking greater collaboration or integration of services? How does having better integrated services result in better outcomes for children and families? A fully developed program logic model of the service integration has been

developed by Bruder, Harbin, Whitbread, Conn-Powers, Roberts, Dunst, Van Buren, Mazzarella and Gabbard (2005) in the US. In a simplified form, the model contains the following elements:



We might quibble with some of the headings of this model – eg. the fourth box might be more appropriately labeled *service integration outcomes*, and the fifth box labeled *long-term outcomes* – but this model has the great virtue of describing the way in which integrated services can lead to the ultimate goal, ie. improved outcomes for children and families.

Monitoring / evaluation

Monitoring and evaluating policies and practices that aim to increase collaboration and integration involves answering both process and impact evaluation questions.

The first process evaluation question - *Did the initiative deliver what it intended to deliver?* – translates into questions such as:

- Did collaboration and integration happen at all (and if not why not)?
- To what extent did collaboration happen?

Answering these questions involves gathering data on what new governance arrangements were developed, what new joint protocols established, how many of the key stakeholders were regularly involved in joint planning and/or service delivery. Measures of change include the Toronto First Duty Indicators of Change (2005) which looks at local governance, seamless access, early learning environment, early childhood staff team, and parent participation.

The second process evaluation question – *Was the initiative delivered in the manner needed for effective integration?* – translates into questions such as:

- Were all the stakeholders fully engaged in building the partnership?
- Did those involved feel empowered by the partnership building process?

Answering these questions involves use of tools that evaluate partnerships, such as the Partnership Analysis Tool (McLeod, 2003) and the Partnership Self-Assessment Tool (<http://www.partnershiptool.net/abouttool.htm>).

The key impact evaluation question – *Did the services delivered have the impact that was intended?* – translates into questions such as:

- Did the quality and type of services delivered change?
- Did changes to service type and quality happen because of collaboration, or for some other reason?
- Did more people receive services, and did they receive them due to the effects of collaboration?

Again, the Toronto First Duty Indicators of Change (2005) can help answer these sorts of questions.

As Valentine, Katz and Griffiths (2007) point out, these questions only address whether collaboration was achieved, not whether there was any benefit for children and families. Ultimately, integration and collaboration efforts must be judged according to whether they produce benefits for children and families.

APPLYING AN OUTCOMES-BASED APPROACH TO SERVICE INTEGRATION: SOME EXAMPLES

We will now look briefly at two examples in which an outcomes-based approach was used in supporting greater collaboration and integration of services at a community level.

East Gippsland Early Years Committee

East Gippsland was one of the first Communities for Children sites, with a non-government agency (Kilmany) as the facilitating partner. The East Gippsland Early Years Committee (EGEYC) now incorporates representatives of various federal, state and local government initiatives, including Communities for Children, Best Start, Innovations, Municipal Early Years Plan.

CCCH's role has been the provision of a series of 'master classes', latterly working directly with the EGEYC. This work has used the outcomes-based framework outlined above, and has focused on identifying and ageing upon outcomes, objectives, strategies etc. – in that order. Considerable progress has been made – there has been agreement on vision, outcomes, objectives and strategies – but there is still work being done to translate these into a working action plan.

Lessons and issues that have emerged in the course of this work include:

- Using an outcomes-based approach for the first time is hard work and takes time
- Those who have always worked within a service-based model find it difficult to break free from the focus of services and think creatively about new ways of working
- There have been problems in maintaining a common core of members over a sequence of meetings to ensure continuity and ownership by all members
- The initial phase just discussed did not involve any parent representatives
- Once the vision and outcomes have been finalised, the EGEYC will face the challenge of communicating this vision and gaining the commitment of managers, colleagues, parents and the wider community
- There is also the challenge of ensuring sustainability of the EGEYC once the funding for the project coordinator finishes
- There appears to be a need for two complementary sets of outcomes etc: a set of service integration outcomes that applies to the work of the EGEYC itself, and a set of overall child and family outcomes that represent the ultimate goal the integration of services is designed to achieve
- There is value in having a facilitating partner with funding for a project coordinator to support the work of the EGEYC
- There is also value in having an independent consultant to work with the EGEYC in clarifying outcomes etc.

Another group that has been using the outcomes-based framework – the Shepparton Best Start Partnership – has also found that they needed to identify two sets of outcomes: one for the Partnership and one for the children and families that the Partnership serves.

Springvale Integrated Services Hub

The second example involves a local government initiative to bring several early childhood services (child care / preschool / toy library / maternal and child health services) into an integrated services hub. These services are separate incorporated bodies at present, and one of the aims is to bring them under a single governance structure. At the same time, a new building to house the new service is being planned and will be built.

CCCH's role has been to facilitate a series of workshops, run conjointly with the architect and landscape gardener, with the key stakeholders involved in the amalgamation. We have used an outcomes-based approach, beginning by getting

the group to articulate what kind of outcomes they would like the new service to achieve and what kind of services, staffing and building would be needed to achieve such outcomes.

Lessons and issues that have emerged in the course of this work include:

- The outcomes framework useful in keeping the group focused on the kind of service they wanted to achieve – they had no trouble developing a vision of the kind of integrated family-friendly service they would like to become
- However, the challenge of integrating the existing services (especially child care and education) into a single service has yet to be properly addressed
- Only a relatively small group of stakeholders have been involved in the workshops – the challenge will be how to involve all stakeholders
- This was a relatively straightforward exercise in that all the services were funded by a single entity (the local council), but still will take a long time and a lot of support to complete successfully.

Lessons from applying an outcomes-based approach to service integration

- The outcomes-based approach is readily understood and accepted by service networks, but challenging to implement at first
- It is difficult for networks to move beyond a focus on services and the need for more of them
- Outcomes-based approaches have the capacity to circumvent many of the barriers to integration that have been identified – keeping the end in mind at all times is way of avoiding unhelpful battles and turf wars
- Both EGEYC and Shepparton examples show that there is a need for integrated service outcomes to be defined as well as child and family outcomes
- The role of an independent facilitator is valuable in helping early childhood service networks work through the outcomes-based framework

Role of the CCCH facilitator

- To be effective in a facilitating role, it is important for the facilitator to develop a positive relationship with the key stakeholders
- The facilitator needs to respect the goals and outcomes identified by the group, and not shape them towards some ideal or standard format
- However, the facilitator should try to ensure that the groups' decisions and choices are informed, that is, that they are apprised of relevant research and other relevant initiatives
- The facilitator's role is to help the group choose outcomes and objectives that are measurable and achievable, and strategies and activities that are logic-based and evidence-based

At the Centre for Community Child Health, we have developed a number of resources to promote collaboration between community-based services.

CCCH RESOURCES TO SUPPORT INTEGRATION

Over the past six or seven years, a major focus of the work of the Centre for Community Child Health has been to develop a framework for reconfiguring early childhood and family support services so as to achieve better outcomes for children and families. We have also been developing a set of resources to enable communities to achieve this all-important task. This service redevelopment framework is a work in progress. Further elaborations of the framework and further resources will be developed as our thinking and experience evolve.

CCCH Platforms Service Redevelopment Framework

The current version of the framework looks at five phases:

- Raising awareness of early child development issues
- Engaging communities
- Planning
- Implementing
- Monitoring and evaluating

For each of these phases, CCCH has developed a series of tools and resources.

PHASE 1: RAISING AWARENESS OF EARLY CHILD DEVELOPMENT	
Objectives	<ul style="list-style-type: none"> ■ Disseminating research related to early childhood development ■ Analysing implications for policy, service delivery and professional practice
Resources	<ul style="list-style-type: none"> ■ CCCH Policy Briefs. These summarize current research that is related to early childhood development and makes recommendations on how improvements in policy can impact ECD ■ Seminars, workshops and media. Various seminars and workshops are held in the community promoting the importance of ECD and appropriate media coverage of ECD is supported

PHASE 2: ENGAGING THE COMMUNITY	
Objectives	<ul style="list-style-type: none"> ■ Identifying key government and non-government stakeholders ■ Identifying key policies, programs and initiatives ■ Profiling community demographics and major community issues
Resources	<ul style="list-style-type: none"> ■ CCCH Community Audit Tool. A set of guidelines for conducting a systemic audit of policies, initiatives, funding and key community issues in a particular locality

PHASE 3. PLANNING	
Objectives	<ul style="list-style-type: none"> ■ Identifying and building local resources and leadership ■ Mapping community resources and needs ■ Setting priorities and developing a detailed action plan
Resources	<ul style="list-style-type: none"> ■ CCCH Community Planning Toolkit. Guidelines and resources designed to assist communities in planning and refocusing services to emphasize prevention and early intervention to improve ECD outcomes. This involves linkages and improved coordination between different service types (e.g. child health and child care services). ■ CCCH Outcomes Framework. A guide to planning community-based services and service systems to optimize outcomes for ECD

PHASE 3. IMPLEMENTING THE ACTION PLAN	
Objectives	<ul style="list-style-type: none"> ■ Training providers and managers in key concepts related to ECD ■ Early identification of child health and developmental issues ■ Early identification of parenting and family issues ■ Provision of evidence-based interventions
Resources	<ul style="list-style-type: none"> ■ CCCH Training Modules. A set of training modules on core knowledge and skills needed by professionals working with young children and their families ■ Parent Evaluation of Developmental Status (PEDS) – Australian version. A brief questionnaire to assist those working with young children to elicit parent concerns about their child’s development or behaviour ■ CCCH Parent Engagement Resource. A resource to assist those working with families of young children to identify and address psychosocial issues that may adversely effect child development and family functioning ■ CCCH Practice Resources. A set of web-based resources detailing evidence-based practices in selected clinical areas such as language, behaviour, breastfeeding, literacy, and so on ■ Let’s Read. A comprehensive universal program that aims to promote literacy in young children aged 4 months to 5 years, especially those living in disadvantaged communities ■ Universal Language Promotion Resources. A universal language promotion strategy delivered to parents by Maternal and Child Health (MCH) nurses. The strategy aims to assist parents to improve the language and communication skills of their young children ■ Toddlers Without Tears. This parenting program aims to prevent mental health problems developing during early childhood

PHASE 5. MONITORING AND EVALUATING	
Objectives	<ul style="list-style-type: none"> ■ Measuring progress
Resources	<ul style="list-style-type: none"> ■ CCCH Monitoring and Evaluation Toolkit. A set of resources to enable community-based services and service systems to monitor and evaluate the delivery and impact of their programs ■ Australian Early Developmental Index (AEDI). An instrument used to assess key domains of a child's functioning that are considered important for 'school readiness.' The AEDI is completed by teachers in the first year of a child's formal schooling and is used to help communities in planning ECD services so as to improve school readiness in children.

As noted above, the changes that are needed to achieve better outcomes for young children, families and society take three main forms. The framework and resources outlined below address two of these – the need for better integrated services, and the need for improved forms of dialogue between communities and services.

The third form of change – the need for more supportive communities – has increasingly become a focus of governments and policy makers. Wiseman (2006) has analysed some of these efforts in Victoria and concludes that engaging and linking local communities can make a useful contribution to local social, environmental and economic outcomes. Key factors underpinning successful community strengthening programs include strong local ownership and leadership, backed by sustained government investment in the social and physical infrastructure priorities identified as important by local communities. However, there are limits to what such initiatives can achieve. As Wiseman points out, 'while local community strengthening strategies can lead to real improvements in community networks, infrastructure and capacity, they are no substitute for the inclusive and redistributive taxation, income security, service delivery and labour market policies needed to create the conditions for sustainable reductions in poverty, inequality and social exclusion.'

CONCLUSIONS AND CHALLENGES

Conclusions

- Moves to greater collaboration and integrations of services are based on strong rationale but limited evidence
- However, there is an emerging consensus about how to ensure effective integration
- Therefore, we need to evaluate integration efforts – but evaluation is only possible if the intended outcomes are clear
- Outcomes-based approach is useful in facilitating the development of a common vision and action plan

- We need to distinguish between service integration outcomes and child / family outcomes – integrated services is both an end in itself and a means to an end

Challenges

- ***Developing a common philosophy.*** Service systems incorporate common key principles at all levels of the system and are more efficient and successful than those that do not. A strong case can be made for using family-centred practice as the core set of values underpinning interagency collaborative efforts (Park and Turnbull, 2003; Walter and Petr, 2000).
- ***Integrating education and care.*** There are numerous philosophical, practical and employment issues to be overcome before early child education and care services can be effectively integrated, but there is a growing consensus that this is what we should be striving towards (Siraj-Blachford, 2007).
- ***Universal vs. targeted approaches*** (Centre for Community Child Health, 2006). Note that what works best in other countries may not work best in Australia – because of our relatively strong system of primary services, we have a better chance of building a truly inclusive and effective universal system.
- ***Creating an integrated tiered system of universal, secondary and tertiary services*** (Centre for Community Child Health, 2006). Among other things, this involves the system-wide use of surveillance tools (such as PEDS and CCH's Parent Engagement Tool), clear referral pathways, and adequate secondary and tertiary services.
- ***Involving and empowering parents in the planning and monitoring of services.*** Efforts to integrate services should be guided by those who use them – the parents and families of young children (Whalley, 2001, 2006).

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