murdoch children's research institute

Centre for Community Child Health

Ampe Rlterrke Amangkeme – *Growing up strong children*

The policy case for integrated child and family centres in remote central Australia

FINAL REPORT

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The Centre for Community Child Health is a department of The Royal Children's Hospital and a research group of the Murdoch Children's Research Institute.

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Title

Ampe Rlterrke Amangkeme* – Growing up strong children*: the policy case for integrated child and family centres in remote central Australia

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The Centre for Community Child Health acknowledges the Traditional Owners of the land on which we work and pay our respect to Elders past, present and emerging.

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A note on language

In keeping with Congress conventions, we refer to Aboriginal people living in Mparntwe/Alice Springs and the greater central desert region as Aboriginal and use Aboriginal and Torres Strait Islander when describing First Nations people living across the Northern Territory. First Nations is used to refer to Indigenous people living across the Australian continent, and non-Indigenous to refer to people not descended from the traditional custodians of these lands.

Glossary

“3a”	Abecedarian Approach Australia
ACCO	Aboriginal Community-Controlled Organisation
ACCHS	Aboriginal Community-Controlled Health Service
ACFS	Aboriginal Child and Family Service
AEDC	Australian Early Development Census
ANFPP	Australian Nurse Family Partnership Program
ANC	Antenatal Care
AHP	Aboriginal Health Practitioner
APONT	Aboriginal Peak Organisations NT
BBF	Budget based funding
CaFIS	Child and Family Intensive Support
‘the Commission’	Productivity Commission
CCS	Child Care Subsidy
CCCF-R	Community Child Care Fund - Restricted
CFC	Child and Family Centre
‘Congress’	Central Australian Aboriginal Congress
CLC	Central Land Council
CYATS	Child and Youth Assessment and Treatment Service
DSS	Commonwealth Department of Social Services
ECLC	Early Childhood Learning Centre
ECEC	Early childhood education and care
ECT	Early Childhood Teacher
ECDPP	Early Care and Development Policy Partnership
FaFT	Families as First Teachers program
ICFC	Integrated Child and Family Centre
IRSD	Index of Relative Socio-Economic Disadvantage
IFSS	Intensive Family Support Service
NDIS EI	National Disability Insurance Scheme Early Intervention
NQF	National Quality Framework

NT	Northern Territory
NPYWC	NPY Women's Council
MACS	Multipurpose Aboriginal Children's Service
MRRC	MacDonnell Ranges Regional Council
PRP	Congress's Preschool Readiness Program
RSTO	Restacking the Odds
SNHV	Sustained nurse home visiting
SCfC	Stronger communities for children
TPF	Children and Families Tripartite Forum

Executive summary

'When we have power over our destiny, our children will flourish'.[1]

Children growing up on Country have the right to be born and remain healthy, to be loved and nurtured by strong families and strong communities so they can thrive in their early years. But too many children and their families are living with the ongoing harms of colonisation: dispossession and dislocation from traditional lands, intergenerational trauma, violence, and poverty.

The Closing the Gap strategy commits governments to raise the proportion of First Nations children developmentally on track according to the Australian Early Development Census (AEDC) to 55 per cent by 2031. Yet in remote parts of the Northern Territory, the gap is still widening. In 2021, just six per cent of children in very remote communities were assessed as on track, compared to 16.4 per cent of Aboriginal and Torres Strait Islander children, and 49.8 per cent of non-Indigenous children across the NT.

Yet **the social and economic determinants of developmental vulnerability are well understood, as are the interventions that help to counter them**. There is an extensive evidence-base demonstrating that when families can access a range of high quality, high impact supports in the early years, the odds of their children achieving their developmental potential increase significantly. Moreover, when these supports are 'stacked' through integrated service delivery, the potential to shift developmental trajectories is even higher.

The proportion of young children living in very remote areas accounts for over 20 per cent of the Northern Territory's preschool aged population. Yet the provision of early years supports in remote communities is fragmented and uneven, and even when services are funded, they are often unavailable, inaccessible, and of varying quality. This means that fully **1 in 5 children** aged 0 to 4 in the NT **do not have reliable access to the basic services that we know give children the best start in life.**

Closing the gap in the NT requires governments to address the inequality of access to fundamental early childhood supports, through **both new investment to improve the quality and quantity of remote services** *and* **reform of how supports are funded and delivered.**

About this paper

The purpose of this paper is to argue for the feasibility of a new approach which can significantly improve access to more effective early years' support.

The paper makes the policy case for expanding an integrated approach into remote communities in the central desert region beyond Mparntwe/Alice Springs, while simultaneously learning from known implementation challenges. It combines **an overview of current service provision** in the region with **a distillation of the evidence base developed by the Centre for Community Child Health at MCRI**, to offer an analysis of the scope of need and the feasibility of an integrated approach.

Congress has a long-standing interest in the potential of integration to improve health and development outcomes for Aboriginal children based on the insight that the 'best way to 'close the gap' is to make sure it is not created in the first place'.[2]

Congress is therefore well-placed to leverage its relationships within the Northern Territory's Aboriginal community-controlled sector and with governments to lead this advocacy effort.

About the structure of this paper

This paper aims to provide an evidence-informed platform from which Congress and its allies can prosecute and win an argument for both new investment and a shift in how services are funded and delivered. As such, it is structured into three sections.

The first section draws on AEDC data to establish the need for a new approach. It considers how the current fragmented approach to funding is driving inefficiencies in both provision and access, then moves to present the case for focusing investment on **five key strategies** identified by **Restacking the Odds** and **changing how services are funded** to enable integrated delivery.

The second section reviews current funding of key early years' supports in the region to identify major gaps in provision and offers community-level detail on what services are funded and by whom.

The **third section** draws on research from the **National Child and Family Hubs Network** to propose **a flexible model for integrated child and family centres in remote communities** based on the evidence around impact and quality and adapted to a remote community setting.

Lastly the paper considers **key enablers and barriers to sustainable implementation** and draws on the available literature to make recommendations for how governments can realise an integrated approach.

1. The case for a new approach

1.1 The current funding approach is not closing the gap

For the first time since 2009, the 2021 AEDC captured a national decline in the proportion of all children on track in all five domains from 55.4 per cent in 2018, to 54.8 per cent. Losses for First Nations children were more marked, with this percentage falling from 35.2 to 34.3 per cent.

First Nations children in the NT are faring far worse than their peers in other jurisdictions but developmental outcomes also worsen with **each degree of remoteness**: 21.4 per cent of Aboriginal children in remote urban areas were assessed as on track, compared to **6 per cent** in very remote areas.

Access to resources is also strong predictor of how children fare. While 41.2 per cent of Aboriginal children from the least disadvantaged quintile were assessed as on track, only 7 per cent of children from the most disadvantaged group met this benchmark.

Data linkages using AEDC data have established an association **between poor developmental outcomes and lack of access to clinical care and other early years supports.** Developmental vulnerability at school age is positively correlated with maternal and childhood anaemia, gestational age and weight at birth, gestational diabetes, and hearing impairment due to untreated otitis media. Families with multiple and complex needs are 1.7 times more likely to have a child with developmental concerns.

Despite the more than $500 million spent each year on children's services in the Northern Territory, a lack of coordination and integration has created a system that is **complex, fragmented, and difficult to navigate**. In 2018-19, nine distinct government agencies funded more than 500 service providers through 280 individual grants.[3] In response, governments were advised to adopt a more collaborative approach, and progressively redistribute funding to the Aboriginal community-controlled sector so that services and programs better reflect the needs and aspirations of remote communities.

1.2 Evidence for impact in the early years

Focusing investment on a select range of evidence-based early childhood services including **antenatal care, sustained nurse home visiting, early childhood education and care, parenting programs** and the **early years of school** has been found to make a significant difference to children's developmental trajectories. Furthermore, 'stacking' multiple supports, that is ensuring that all five are provided to an individual child, **amplifies the benefit** of each intervention, and helps **sustain this impact** through childhood and beyond.

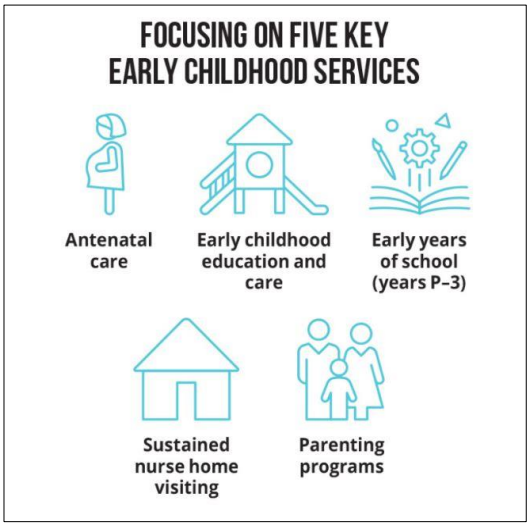


Figure 1: Five key early childhood services.

The **Restacking the Odds** platform (RSTO) developed by Centre for Community Child Health aims to improve population level access to quality services by helping to identify gaps in provision and target resources to where they are most needed.

RSTO uses a framework of evidence-based indicators to assess the likelihood that locally available services will make a difference to children's trajectories, with specific indicators developed for each service type around:

Quantity – do families have physical access to services?

Quality – does delivery align with evidence-informed best practice?

Participation – are children and families using the service enough to benefit?

Detail about the specific benchmarks that need to be met for each of the five key supports can be found in the body of this report.

1.3 Evidence for an integrated early' years system

There is also evidence that **integrating early childhood services improves both access and outcomes**. Integration refers to the process of building connections between different types of services to make support more holistic, accessible, and responsive to families' needs. Integration typically takes the form of a child and family 'Hub' or 'Child and Family Centre' with the goal of creating **a single point of contact** for families. This is sometimes called a 'single front door' or 'no wrong door' approach.[4]

The Aboriginal community-controlled sector has long advocated for **integration to help counter the social and economic determinants of developmental vulnerability** and integrated services have been found to be more effective at reaching and sustaining engagement with First Nations families.

Enablers of successful hub implementation include high-level authorisation from governments to allow cooperation and resource sharing across agencies, and funding that is both secure and flexible with dedicated resourcing of the 'glue' that makes integration work in practice.

2. Overview of the remote early years' service system

This section surveys the current state of service provision in select remote communities and applies the indicators developed by RSTO to assess probable effectiveness and identify key gaps.

Mapping carried out for this paper indicates that while each of the **five core services that underpin optimal early childhood development** are provided in some form across the region, they are not funded in the quantity, or to the level of quality needed to make a measurable difference to children's outcomes.

The lack of coordination between governments and between agencies means that there are areas where funding overlaps and others where there is little provision at all.

Significant gaps in the region identified here include,

- Limited access to **antenatal care** and **sustained nurse home visiting**.
- Unreliable access to centre based **ECEC**, uneven provision of **preschool** and no dedicated funding for **preschool readiness** or **school transition** programs; and
- No access to early intervention **parenting programs** or other universal parenting supports.

An analysis of the adequacy of each core service is given below.

2.1 Current investment in remote service provision

Antenatal care is not widely available outside of Mparntwe/Alice Springs. Although pregnant women may access care through remote health services there is no support for women to birth on Country and an expectation that women are required to travel to Alice Springs Hospital to access screening, foetal monitoring and specialist care.

Sustained nurse home visiting is available in the region through Congress' **Australian Nurse Family Partnership Program (ANFPP),** but eligibility is limited to first-time mothers of Aboriginal babies in Ntaria, Ltyente Apurte, Mparntwe/Alice Springs and outstations within 100km. The ANFPP is based on a model which meets evidence-based indicators for quality, but current funding levels mean that there is not program capacity to expand delivery across the region.

Funding for **Early Childhood Education and Care** is split between the Commonwealth and NT Governments and provision is fragmented and uneven across the entire Central region.

Centre-based ECEC programs in remote communities were historically block-funded by the Commonwealth but since 2018 have received a combination of grants for remote operators and the Child Care Subsidy (CCS). The transition to subsidies has **severely impacted the quality, accessibility, and sustainability** of ECEC across the region.

MacDonnell Ranges Regional Council (MRRC) is the principal provider of centre based ECEC. MacKids' Early Childhood Learning Centres (ECLCs) offer **a range of long-day care, occasional care and playgroups** depending on the needs of the community. Prior to 2024, a number of ECLCs across the region were closed due to staffing shortages. Barriers to accessing the CCS in remote communities means that centres operate at a loss.

The NT Government delivers facilitated playgroups, such as the **Families as First Teachers (FaFT)** Program and Stay Play Learn both of which utilise the "3a" Approach, and preschool programs. Provision of both FaFT and preschool is highly uneven to the **difficulty recruiting and retaining Early Childhood**

Teachers. Where preschool is offered, programs are typically delivered by local Teaching Assistants who do not hold teaching qualifications but who are able to deliver content in language.

Parenting programs range from primary **early intervention** programs designed to help families address concerns before abuse and/or neglect occur, to **secondary targeted** programs designed to prevent formal child protection involvement, up to **tertiary or intensive** programs which work with families where there is a real and present risk of children being taken into statutory care.

Contrary to the public health approach, only **intensive family support** is funded in communities outside of Mparntwe/Alice Springs. Formerly IFSS, **the DSS-funded Children and Families Intensive Support** program (CaFIS) is funded is delivered by Waltja Tjutangku Palyapayi (Luritja for 'doing good work with families') to the north and west, and the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women' Council to the south. Though participation is voluntary, access is through referral only. There is no option to self-refer for parenting support.

Primary school education is universally available although attendance rates in remote schools are significantly lower than in Mparntwe/Alice Springs. Therefore, while remote schools meet evidence-based indicators for quantity, they fall short on participation.

Detail about what is **funded in each community** is provided on pages 41-51.

3. Realising integration in a remote community setting

The final section of this paper draws on research from the **National Child and Family Hubs Network** to propose **a flexible model for integrated child and family centres** adapted to a very remote setting.

The theory of change animating this proposal is that when core supports are readily available and of sufficient quality, and are delivered in ways that are both accessible and culturally appropriate, they will make a measurable difference to children's developmental outcomes.

3.1 A flexible model for integrated support

The role of ICFCs is to improve children's access to the core services that we know will help them reach their full developmental potential.

The model for remote **integrated child and family centres** (ICFCs) proposed in this section brings together research on Hubs with the evidence base on what works in remote community contexts.

It is designed to be flexible, with scope to adapt delivery to community needs and preferences and as such reflects SNAICC's principles for culturally safe integrated services. [5]

An integrated child and family centre in a remote community may well look different to a Hub in an urban or regional setting. Nonetheless, the research on what makes integrated service delivery work identifies some **core components** that every ICFC needs to be effective, including:

- Quality early childhood care and education
- A range of health and social supports
- Parenting support
- Being a natural place to go for families
- Mapped referral pathways

- Wellbeing coordinator or navigator.
- Focus on the social determinants of health; and
- Culture and self-determination (Aboriginal community-controlled centres)[6]

3.2 What should remote integrated centres look like?

The section below draws on the available evidence to make concrete suggestions about the resources and personnel that remote ICFCs will need to functionally improve access for families.

Physical infrastructure

There are a variety of potential options for housing ICFCs in remote NT communities. Whether located in newly built or refitted buildings, it is important sites be viewed as neutral, and **not as traditionally belonging to any particular clan or skin group**, so that all members of the community can use it.

ICFCs work most best when they function **both as formal service front-door** and a **social hub**, becoming a 'natural place' for local families to spend time and socialise.[7] In addition to office space and consulting rooms, centres need to create **welcoming informal 'drop in spaces'** with basic facilities (tea and coffee, microwaves to warm baby food), toys and craft activities. When well-used these spaces can be used by practitioners to share information about child health and build trust with families.

The range of services and facilities available in remote communities should reflect local needs. For example, centres could purchase washing machines or provide shower facilities and toiletries to enable good hygiene, or make computers and Wi-Fi available, with support on hand to help families manage life-admin or complete further study.

Funding

In addition to the **capital costs** required to build or repurpose a suitable premises, it is vital that ICFCs should receive both **block funding** for core services and integration ('the glue'), and **flexible funding** to be used for community engagement and/or to purchase additional services *not* already funded via agreements between providers and/or government agencies.

Figure 2 below indicates how this might work in practice: it shows **four of the five** key early childhood supports as core block-funded services, but with the centre linked to external service infrastructure (schools, clinics) and universal visiting specialists and targeted programs. It is proposed that block funding be administered by the Commonwealth Department of Education.

Core-funded services

In most cases new funding can build on existing provision. The four core services that should be grant funded include **antenatal care**, **sustained nurse home visiting, ECEC** and **parenting programs**, with preschool readiness providing a bridge to **school**.

In terms of **antenatal care**, there is scope for the ANFPP to expand into desert communities using remote ICFCs as a base to connect with pregnant women and as an alternative setting to the home to deliver **sustained nurse home visiting** where appropriate.

It is critical that ECEC **reflects local community needs, values, and beliefs** about raising children. Research from community-controlled ICFCs suggests that **a mix of ECEC options works well** for Aboriginal families**,** and the ECLCs operated by MRRC offer long-day care alongside occasional care and formal and informal playgroups where families stay to socialise. There is scope to block-fund these services and deliver all early learning programs within new or renovated ICFCs.

In relation to parenting support, the successful implementation of a culturally adapted version of the **Triple P Positive Parenting Program** in the Fitzroy Valley demonstrates the feasibility of adapting Triple P for use in remote NT communities.[8] Triple P can be delivered as both an early intervention or more intensively. Accredited trainers undertake a three-day training course with an annual refresher.

There is also scope for ICFCs also support children's **transition and engagement in the early years of primary school by enabling and promoting participation in quality ECEC and preschool**. In the NT participation in ECEC and preschool is incidentally a strong predictor of Aboriginal children's readiness for school and subsequent attendance.[9] Establishing links between local schools and ACCO-run ICFCs in remote NT communities therefore has the potential to strengthen families' connection to education by enabling teachers to establish a continuous relationship with families from their children's infancy through to school age, helping to build trust with educators.[10]

Schools may also offer **a ready-made administrative backbone** to support ACCO-led operation as is the case at WA Child and Parent Centres in Halls Creek and Fitzroy Valley.

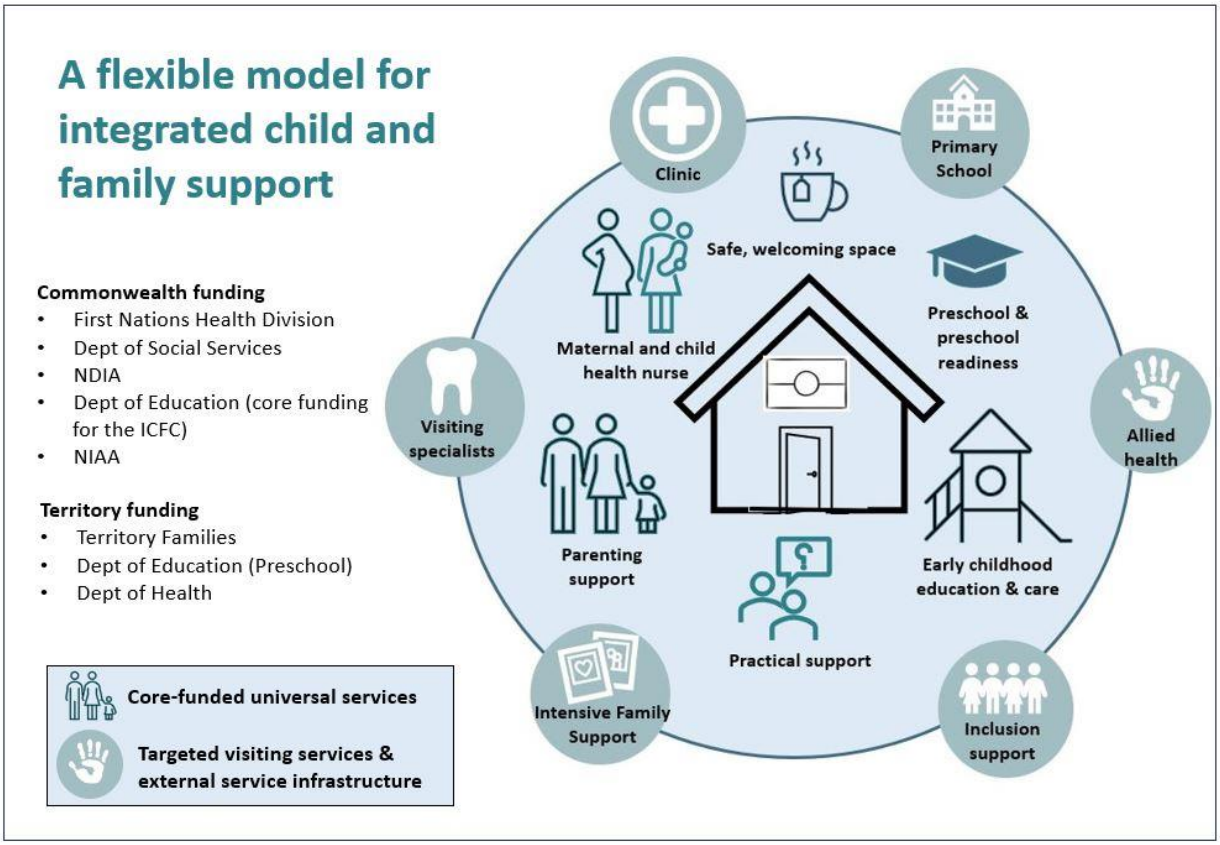


Figure 2: Flexible model for remote integrated child and family centres

Flexible funding for visiting and targeted services

In addition to core services ICFCs should lead coordination and integration with external agencies and specialist services.

Whether or not ICFCs are operated by ACCHS, there is **scope for centres to work with health providers to improve child health outcomes** by facilitating health checks, supporting families to navigate the health system and developing the health literacy of staff and families.

ICFCs also offer a means of improving children's access to specialist health and allied health services by hosting **paediatricians, audiologists** (Hearing Australia), **optometry and ophthalmology, ear nose and throat, oral health, and dietitians.**

Provision of therapeutic early intervention has been identified as **a substantial gap in the early years' service system nationally**, with integrated centres offering a practical means of facilitating greater access for the children who need it most.[11] There is an opportunity to improve access to early intervention in the region by making allied health a regular service offering in remote ICFCs, whether by supporting families to access the NDIS or purchasing therapies and assessments on behalf of families.

While ICFCs should offer all families regular opportunities to participate in **evidence-based parenting programs** such as a culturally adapted version of Triple P, centres may also refer families experiencing complex challenges to DSS-funded **intensive family support services**.

Funding for integration

Integration does not happen without dedicated resourcing for 'the glue' that enables coordinated care and collaboration between services. Each ICFC will need a key **coordinator position to oversee operations and lead integration**, in addition to funding for an **administrative staff member** and time-relief for educators and other centre staff to collaborate and participate in professional development.

Staffing

All integrated centres require the leadership of a **Centre Coordinator** who fulfils the conventional duties of a manager, in addition to driving the integration of services and programs.

Centres operated by ACCHS might wish to employ **an onsite MCH nurse** or **ANFPP practitioner** and/or an **Aboriginal Health Practitioner** trained in child health, possibly shared with a local health service.

However, to be sustainable **remote centres will rely on the employment of local Aboriginal women** as educators and health and social wellbeing practitioners. Ultimately local staff will need to **lead planning and delivery of ECEC, as well as parent support and health promotion** and education activities. This is not just because of the nature of remote labour markets, but because supports will be most effective when they are **designed and delivered, in language**, by people who are **known and trusted**.

Investment in local workforce development will be essential. Local people will need to be offered real opportunities to undertake on-the-job training as educators, therapy assistants and parent coaches, with support and funding available to progress to formal qualification if desired. The ultimate goal is to **build local capability** to the point where **communities can run centres for themselves**.

3.2 Enablers of effective implementation

The small scale of delivery, combined with substantial distances, and chronic workforce issues across the region also present unique implementation challenges.

Collaborative governance is essential to authorise integration

Successful implementation of ICFCs in remote communities requires nothing less than **a transformation of the way in which early years' services are funded and delivered**. If governments are serious about closing the gap in developmental outcomes, they need to break out of the 'business as usual' mindset

that has led to the current fragmented, broken and ultimately ineffective, system of early childhood service provision, and develop effective strategies for collaborative governance.

Between them the members of the Tripartite Forum already have the power to authorise their respective Commonwealth and Territory agencies to work together to integrate remote early years' services.

Potential levers for change could include arrangements for agencies to pool funding to block-fund ICFCs and commissioning core early childhood supports with both community control and long-term sustainability and workforce development in mind.

Community empowerment underpins effective implementation

For remote ICFCs to be valued and accepted by families it will be vital for communities to feel they have **ownership and control of centres** and the supports they provide. There is therefore a strong case for ICFCs to be operated by ACCOs or ACCHS, with support from local government schools and health services as appropriate.

Implementation will also require **real opportunities for community members to participate in consultation and co-design**, as well as involvement in **ongoing governance** and **day-to-day decision making** about centre operations.

Community governance will offer a means for services and program content **to be tailored to community needs and preferences**.

A recent review of health and social care interventions for Aboriginal children by D'Aprano et al. identified a number of **key practice features that were found to enable effective implementation**, and which may help to guide implementation of remote ICFCs:

- Regular collection and auditing of project information and service data
- Ongoing review, reflection, and adaptation of diverse stakeholder views
- Aboriginal leadership, codesign and participation throughout
- Project governance and advisory groups
- Holistic relationships across organisations, practitioners, and families
- Codesigned and relevant project tools
- Cross-organisational partnerships and collaboration
- Resourcing to support local implementation (staffing)
- Capacity building, training, and mentoring tailored to local context and needs.[12]

Growing local workforce capability is the key to sustainability

The sustainability of remote ICFCs will hinge on both the retention of qualified practitioners and the development of a local early years' workforce.

The evidence base is clear that the effectiveness of interventions is heavily dependent on the expertise of qualified health and social care professionals, while research on integrated hubs suggests that the presence of trained specialists is equally critical.

Reviews of the international literature identify a range of strategies proven to improve retention of remote clinical staff. [13] These include **incentives and support for students** to specialise in remote healthcare, **system-wide reforms of remote healthcare provision** to improve infrastructure and

working conditions and retain local Aboriginal health practitioners, as well as **greater support for remote healthcare workers** including **tailored financial incentives**, psychological support, and extended access to paid leave to prevent burn out.[14]

Nonetheless, the sustainability of remote ICFCs will ultimately depend on the development of a local early years' workforce who can lead planning and delivery of core services.

There are a range of evidence-based policy levers available to governments to address workforce issues in the region. The CLC and APONT have made a number of submissions to governments proposing concrete measures to **both create decent jobs that support community wellbeing** and **increase the supply of skilled workers** in the region.[15]

Specific measures to support the development of a remote early years' workforce include:

- Strengthening the capacity of the Aboriginal community-controlled sector to support community-led development of the education, health and social care sectors.
- Funding Aboriginal community-controlled organisations to create real opportunities for young people to gain work experience, and culturally appropriate training such as paid traineeships in key service sectors such as ECEC, social and emotional wellbeing support, and education.
- Reform of VET in the NT to increase the availability of training on Country, including the development of culturally appropriate content and practical assessment in language.
- Reinstating provision of secondary schooling in remote communities up to Year 10.

Recommendations

1. Leverage existing mechanisms for collaborative governance, E.g. the Children and Families Tripartite Forum, to enable shared decision-making and investment.
2. Block fund remote Aboriginal community-controlled child and family centres to deliver core services that meet minimum evidence-based indicators for effectiveness.
3. Include dedicated funding for 'the glue' that enables integration to work in practice.
4. Provide flexible funding to enable ICFCs to tailor services, programs and facilities to local community needs and purchase supports for families where appropriate.
5. Facilitate local leadership and strengthen accountability by making community governance arrangements a core deliverable of funding agreements.
6. Develop and implement a remote workforce development plan in consultation with communities and the Aboriginal community-controlled sector.
7. Work with the community-controlled sector to create real opportunities for local Aboriginal people to develop the capability to lead service delivery.

Introduction

Target 4 of the national Closing the Gap strategy commits governments to raise the proportion of First Nations children developmentally on track in fall AEDC domains to 55 per cent by 2031. But in the Northern Territory, the gap is still widening.

By the time they are due to start school, Aboriginal children in the NT are significantly more likely to experience developmental vulnerabilities than their non-Indigenous peers. The gap widens the more disadvantaged families are, and the farther they live from regional centres. The 2021 AEDC assessed just 6 per cent of children in very remote NT communities as developmentally on track, compared to 16.4 per cent of Aboriginal children, and 49.8 per cent of non-Indigenous children across the NT.

The cruelty of these statistics is unscored by fact that the social and economic drivers of developmental vulnerability are well understood, as are the interventions that help to counter them. There is, in fact, an extensive evidence base that demonstrates that when families access a range of high quality, high impact supports in the early years, their children's chances of achieving their developmental potential increase significantly. Moreover, when these supports are 'stacked' through integrated service delivery, the potential to shift developmental trajectories is even higher.

Closing the gap in the NT requires governments to address the inequality of access to fundamental early childhood supports, through both new investment to improve the quality and quantity of remote services *and* reform of how supports are funded and delivered.

Significant reform in this area requires a shared commitment to working more collaboratively at both Commonwealth and Territory level. Measurable gains in children's developmental outcomes will not automatically flow from increased investment unless there are meaningful improvements in how services are delivered.

Opportunities within the policy context

A range of developments in the current policy environment at Commonwealth and Northern Territory level present an opportunity to shift the dial on remote service delivery. These include:

- The **NT Children and Families Tripartite Forum** which has the potential to facilitate collaborative decision-making between Commonwealth and Territory agencies to align policy commitments and authorise inter-agency collaboration and flexible funding arrangements. E.g. allowing ACCOs and ACCHs to pool funding to enable integration.
- The **Early Childhood Care and Development Policy Partnership** chaired by SNAICC, with representation from Commonwealth Department of Education, Department of Health and Aged Care, and the National Indigenous Australians Agency. The ECCDPP seeks to cohere effort around improving developmental outcomes for First Nations children.
- The appointment of the first **Aboriginal and Torres Strait Islander Children's Commissioner**.
- The new **Commonwealth Early Years Strategy 2024-2034** which affirms support for the National Agreement on Closing the Gap and recognises the primacy of culture in underpinning children's wellbeing in the years 0 to 5 and the role of community controlled services.[16]

- The final report of the **Productivity Commission Inquiry into ECEC** which notes the underrepresentation of First Nations children in ECEC programs nationally. To address this gap the Commission recommends that governments,
  - Co-design a of sustainable funding model for ACCO-run ECEC and integrated centres that recognises their knowledges and expertise to deliver the ECEC priorities of their communities and create the conditions for Aboriginal and Torres Strait Islander children to thrive.
  - Undertake a joint-decision making process with the community-controlled sector and communities to design an appropriate approach to regulation of ACCO-led services out-of-scope of the NQF that recognises the unique characteristics and challenges of these services.
  - Trial and evaluate new pathways for Aboriginal and Torres Strait Islander people to obtain ECEC qualifications. [17]
- The **NT Preschool Review** which puts forward a roadmap for improving the quality and accessibility of preschool for all children in the Territory in the two years before school, including an option for integration of preschool with other ECEC, health and parent supports, as well as the expansion of the NT Government's integrated **Child and Family Centres**.[18]
- The expansion of **Congress' Child and Youth Assessment and Treatment service** to identify and treat children with neurodevelopmental disorders as part of the *Better, Safer Future for Central Australia* fund, which offers the opportunity to deliver services remotely.
- The recommendation of the recent **NDIS Review**[19] that State and Territory Governments take back responsibility for delivering foundational supports for children with developmental delay in educational settings, which may release funding for allied health services via remote schools.

Together these developments signal a convergence in favour of system reform and dedicated investment to help close the gap in early childhood outcomes. The backdrop to these commitments is the Priority Reform Areas agreed to under the National Agreement on Closing the Gap, which commit governments to shift delivery of targeted services for Aboriginal and Torres Strait Islander children and families to the community-community controlled sector.

Scope of this paper

The purpose of this paper is to argue for the feasibility of a new approach which can significantly improve access to more effective early years' support.

Most of the core services that underpin early childhood development are already provided in some form in the region, but are not funded in the quantity, or to the quality, that they need to be to make a measurable difference to children's developmental outcomes, while the fragmented nature of the sector creates multiple barriers to participation.

Congress' long-standing interest in the potential of integration to improve health and development outcomes for Aboriginal children provided the impetus for this policy paper. Since 2017, Congress has pursued an integrated approach to supporting children's learning and development in the early years based on belief that the best way to 'close the gap' is to make sure it is not created in the first place. [20] Congress' approach combines **primary prevention** for all children with **targeted secondary interventions** for children with developmental concerns.[21] In addition to primary health care, Congress delivers a range of early childhood and family services, including maternal and child health, ECEC, a

preschool readiness program and child-focused allied health, with the goal of 'stacking' these evidence-informed interventions to help counter the impact of social and economic disadvantage.

Congress has tested this approach through *Ampe Rlterrke Amangkeme,* 'children growing up strong' in Arrernte, known locally as the Child Health and Development Centre (CHAD), located in Mparntwe/Alice Springs. The service combines educational programming based on the "3a" Approach with a holistic approach to health and wellbeing in a culturally adapted learning environment. Findings from consecutive evaluations of the service by MCRI align with an evidence-base showing that the integration of high-quality early learning with clinical and allied health and practical family support, has the power to help children reach their full developmental potential.[22] These include the value of integrated support being delivered by community-controlled organisations, with the retention and development of Aboriginal early childhood workers underpinning perceptions of cultural safety and supporting family participation. Evaluations have also highlighted ongoing implementation challenges: the difficulty of making integration work in practice, of retaining Aboriginal educators in a tight labour market, and securing sustainable funding.

This paper makes the policy case for expanding this integrated approach into remote communities in the central desert region beyond Mparntwe/Alice Springs, while simultaneously learning from the challenges to the implementation of this approach. It combines **an overview of current service provision** in the region with **a distillation of the evidence base developed by the Centre for Community Child Health at MCRI**, to offer an analysis of the scope of need and the feasibility of an integrated approach.

Congress has a long-standing interest in the potential of integration to improve health and development outcomes for Aboriginal children and is therefore well-placed to leverage its relationships with governments and within the Northern Territory's community-controlled sector to lead this advocacy effort.

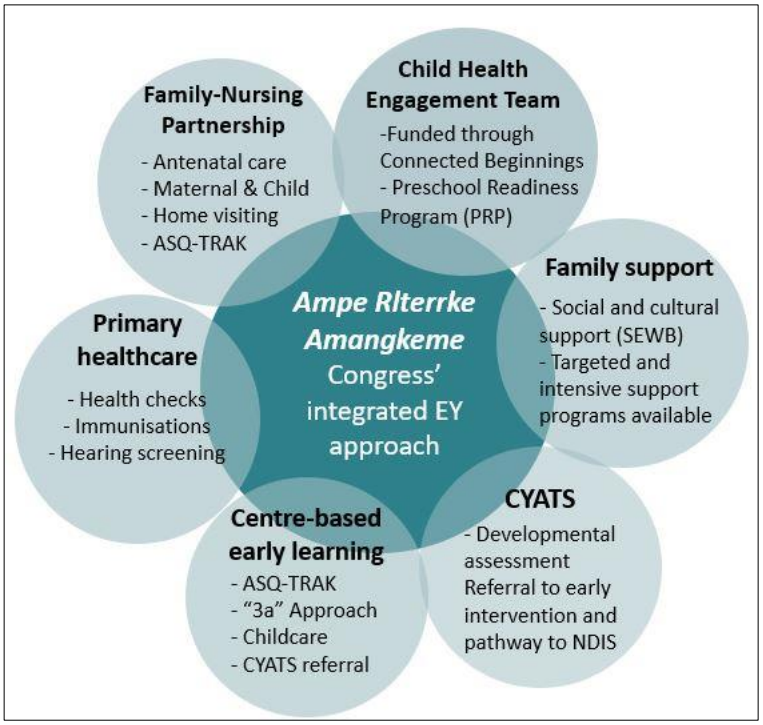


Figure 3: Congress' suite of integrated early years services

Structure of this paper

This paper aims to provide an evidence-informed platform from which Congress and its allies can prosecute and win an argument for both new investment and a shift in how services are funded and delivered. This case is structured into three parts.

The first section draws on AEDC data to highlight the **the scale of inequity in remote NT communities**. It considers how the current fragmented approach to funding is driving inefficiencies in both provision and access, then present the case for focusing investment on **five key strategies** identified by **Restacking the Odds** and **changing how services are funded** to enable integrated delivery.

The second section reviews current funding of key early years' supports in the region to identify major gaps in provision. It offers community-level detail on what services are funded and by whom. Mapping included all early learning programs, centre based ECEC, preschools, and facilitated playgroups, and, for the purposes of assessing scope for integration, also considered clinical and allied health provision, schools and programs to support attendance, and family support services.

The third section proposes a flexible model for integrated child and family centres in remote communities based on the evidence around impact and quality. It draws on research from the **National Child and Family Hubs Network** to identify the key components of an effective ICFC, including infrastructure, staffing, flexible funding for the 'glue' and for the core universal services that need to be block-funded. It also considers how these might be adapted for a remote setting.

Finally, the paper addresses key enablers and barriers to implementation of an integrated approach. Drawing on available research and policy literature it proposes principles to guide sustainable implementation and makes broad recommendations for governments to drive change.

Geographic scope of this paper

The central desert takes in a vast part of the Australian continent, encompassing more than twenty distinct Aboriginal language groups and multiple government jurisdictions, stretching from the far east of Western Australia to the far west of Queensland, and down into South Australia. This paper focuses on a smaller subsection of this region centred around Mparntwe/Alice Springs, roughly bounded by Kaltukatjara/Docker River in the west, Atitjere/Harts Range to the north-east, and as far south as Mutitjulu. In all this region encompasses some 16 distinct communities and many satellite outstations populated by speakers of no fewer than seven Aboriginal languages including Central, Eastern and Southern Arrernte, Western Aranda, Luritja, Pintupi, Pitjantjara and Yankunytjatjara. The principal reason for focusing on this region is that it roughly takes in Congress' sphere of influence, both as a service provider and as an advocate for community controlled primary health provision. This region is indicated by the map below.[23]

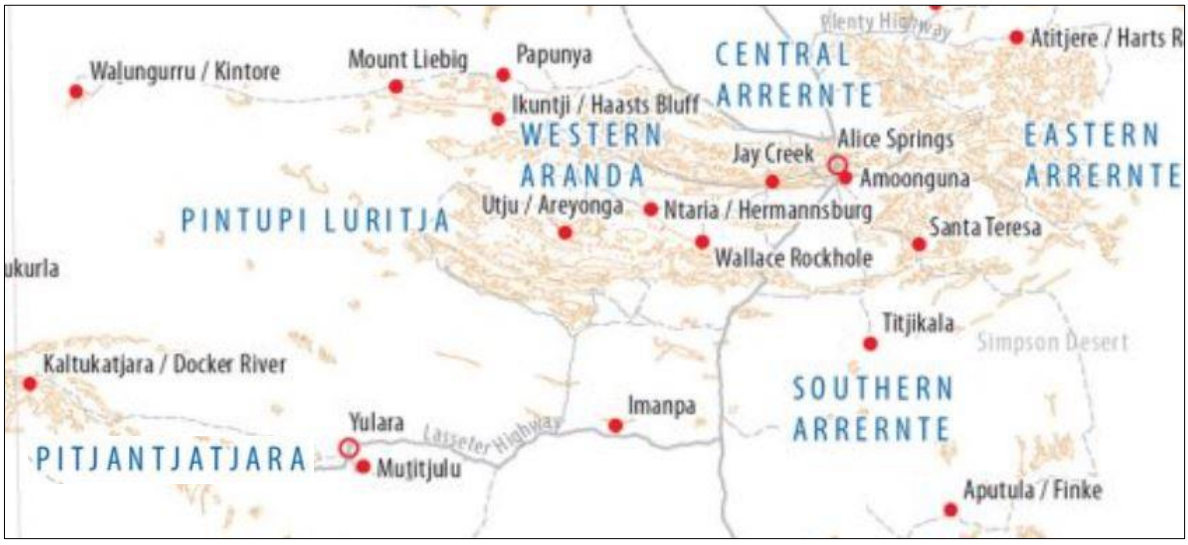


Figure 4: Central Land Council language map of Central Desert Region.

Method and limitations

This paper attempts to provide a comprehensive overview of early years' service provision in the region, but resource constraints and time pressures mean that there are notable gaps.

One major limitation is the lack of real opportunity to travel to communities to learn first-hand about the services delivered on the ground and consult with community representatives. Executing field research in the proper way requires time and resources which were beyond the remit of this project. Moreover, seeking community input at this stage would have been premature. If there is an opportunity to pursue this work, then community consultation will be the logical next step.

In the absence of field research, mapping relied on desktop scans, especially the NT Government's BushTel directory, supplemented by whatever information about local operations could be gleaned from face-to-face consultations with providers and local government based in town. Therefore, while efforts have been made to verify the scope of service delivery on the ground, the information provided here should be used as a guide only. The volatility of staffing in the region means that the availability of services is highly variable, with services often forced to close for up to weeks or months at a time.

Again, consultation with the principal service providers in the region to gain a clearer picture of operations in each community would be a necessary next step to build a coalition of support for integration. In fact, integration will not be possible without the buy-in of a broad coalition of local service actors including Shire Councils and other ACCOs and ACCHS with a major stake in the provision of child and family services in the region.

Acknowledgements

The mapping work undertaken for this paper was supported by staff from the following organisations who generously took the time to share their intelligence: Central Australian Aboriginal Congress, MacDonnell Ranges Regional Council, Anglicare Communities for Children, Early Childhood Australia, Children's Ground, Larapinta Child and Family Centre, and the NT Department of Education.

1. The case for a new approach

1.1 The current funding approach is not closing the gap

The National Agreement on Closing the Gap commits states and territories to lift the proportion of Aboriginal and Torres Strait Islander children assessed as 'on track' in all five domains of the Australian Early Development Census to 55 per cent by 2031. The NT is one of three jurisdictions in which outcomes have worsened since baseline in 2018. In 2021 only 16.4 per cent of First Nations children in the NT were assessed as on track, with much of this decline due to an increase in the proportion of children in very remote areas developmentally vulnerable in two or more domains.

This decline has not happened in a vacuum. Worsening of developmental outcomes for children living remotely in the NT has taken place in the context of a widening gap in employment outcomes for Aboriginal people in the region and as a result, a deepening of poverty and disadvantage.[24]

Though numerically small, the proportion of young children living in very remote areas accounts for over 20 per cent of the Territory's preschool aged population. Yet the provision of early years supports in remote communities is fragmented and uneven, and even when services are funded, they may be unavailable, inaccessible, and of varying quality. This means that 1 in 5 children aged 0 to 4 in the NT do not have reliable access to the basic services that we know give children the best start in life.

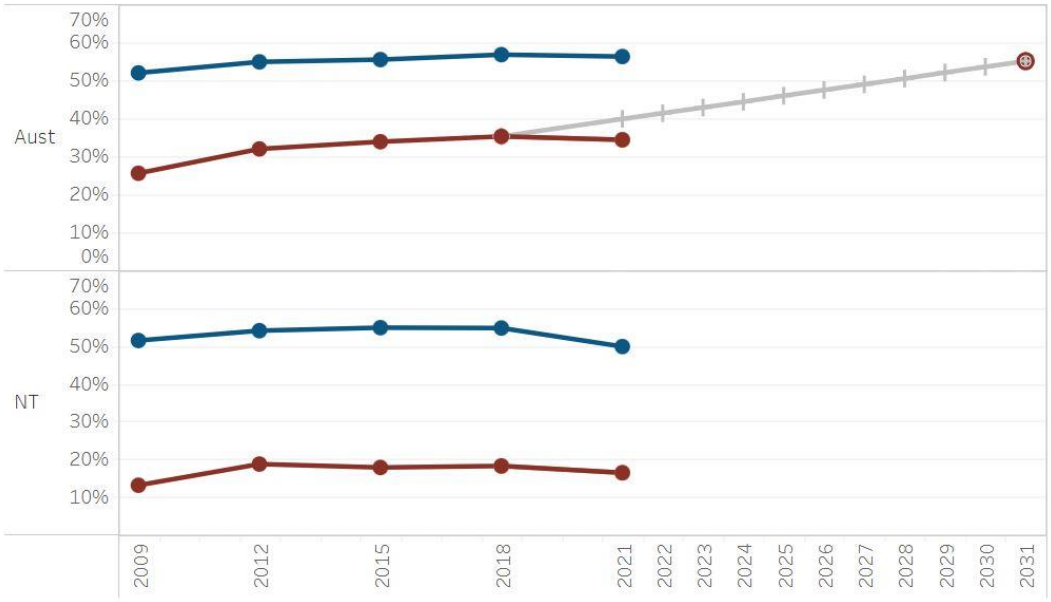
Insights into developmental inequality from the AEDC

The Australian Early Development Census (AEDC) is a triennial assessment of children's development in their first year of school. An Australian version of the Early Development Instrument is distributed to teachers to complete, and the data used to take a population-level 'snapshot' of how children are developing in localities across Australia. This information can be used by researchers and policymakers to better understand what is working and where further investment is needed.

The AEDC collects information about five domains: physical health and wellbeing, social competence, emotional maturity, school-based language and cognitive skills, and communication skills and general knowledge. A higher proportion of children assessed as 'on track' in all five domains indicates that families in that area have ready access to resources, while a higher proportion of children assessed as at risk or vulnerable on one, two or more domains, is an indicator of disadvantage. To assess where more work is needed to improve equitable access to resources, the AECD collates data on Aboriginal and Torres Strait Islander children and children with a language background other than English (LBOTE) and breaks down location data by SEIFA ranking and geographic remoteness.

The 2021 AEDC found a small but significant increase of 0.3 in the proportion of all children developmentally vulnerable on one or more and two or more domains, and, for the first time since baseline in 2009, a decrease in the proportion of children on track in all five domains, down from 55.4 in 2018 to 54.8. These results capture the impact of the pandemic on families' capacity to access ECEC and other services. The losses for Aboriginal and Torres Strait Islander children are more marked, with the proportion on children on track declining from 35.2 to 34.3, and the proportion developmentally vulnerable in one or more and two or more domains increasing from 41.3 to 42.3 and from 25.8 to 36.5 respectively. Despite some small improvements in communication and social competence, these were occluded by a 3.2 per cent decline in the proportion of children assessed as on track in language and cognitive skills. Therefore, even within the context of a nationwide decline the developmental gap between First Nations and non-Indigenous children still widened.

Figure CtG4.1 Children assessed as developmentally on track in all five domains of the Australian Early Development Census (a)



Source: Productivity Commission, Closing the Gap dashboard, table CtG4A.1

Figure 5: Children assessed as developmentally on track on all five domains of the 2021 AEDC.

These results reflect the multiple barriers families face in gaining access to the resources and opportunities that most non-Indigenous families take for granted. Nonetheless, this decline was unevenly distributed across jurisdictions. Increases in the proportion of First Nations children assessed as on track were recorded in Victoria, Queensland, South Australia, Tasmania, and the ACT, with NSW, WA, and the NT responsible for the nationwide decline.

Yet the NT remains an outlier, with First Nations children faring worse than their peers in other jurisdictions, and children living in very remote parts of the NT faring worst of all. In 2021 only 16.4 per cent of First Nations children in the NT were assessed as developmentally on track, compared to 34.3 per cent nationwide, 31.3 per cent in WA and 33.8 and 31.3 per cent for Queensland and SA respectively, all states with significant remote populations.

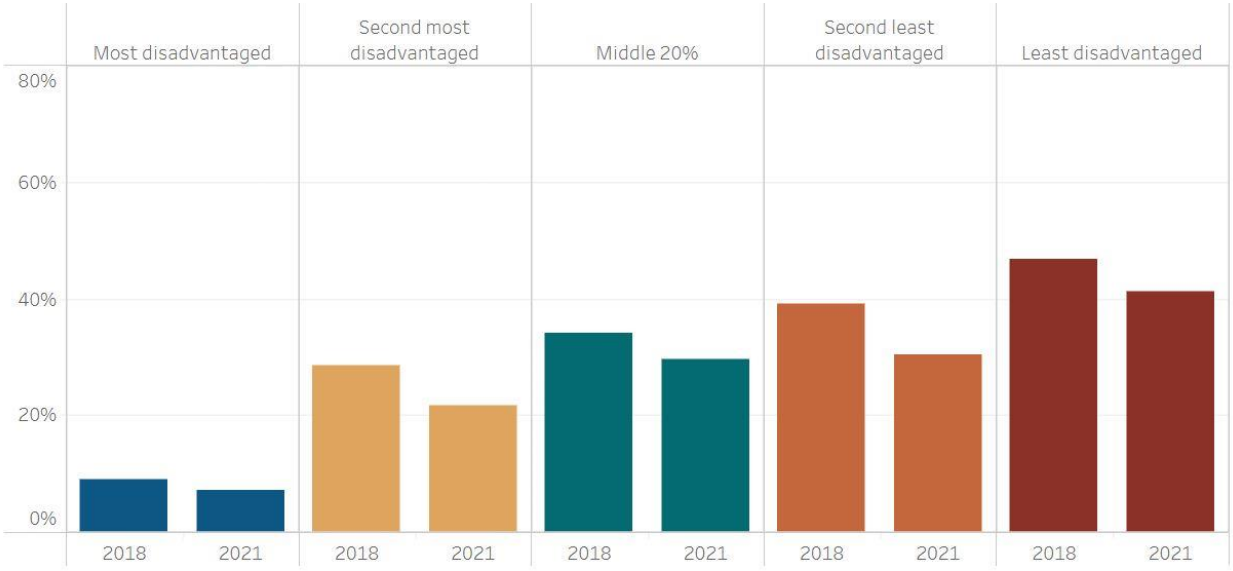
The gap becomes even starker when broken down according to where children live. Developmental outcomes worsen with each degree of remoteness: 21.4 per cent of Aboriginal children who live in remote urban areas were assessed as on track, compared to just 6 per cent of children in very remote areas. In Sandover-Plenty, one of the few very remote localities in the central region to return sufficient valid AEDC data, 73.1 per cent of children were assessed as developmentally vulnerable in one or more domains, and 53.8 on two or more. This is compared to 42.3 and 26.5 per cent respectively for Aboriginal and Torres Strait Islander children nationally.

These results are striking compared to both WA, where 18.6 per cent of children in very remote areas were assessed as on track, and Queensland, where 27 per cent of children in very remote communities were assessed as on track. Queensland was in f the only state which recorded a significant overall *improvement* in the outcomes of children living very remotely, with the proportion on track increasing

from 23.1 per cent in 2018. This shows there is considerable scope therefore room for governments to at least bring outcomes in very remote parts of the NT into line with other jurisdictions.

Figure CtG4.4 **Children assessed as developmentally on track in all five domains of the AEDC, Aboriginal and Torres Strait Islander people, NT**

By Index of Relative Socio-economic Disadvantage (IRSD) quintile, by year



Source: Productivity Commission, Closing the Gap dashboard, table CtG4A.5

Figure 6: Aboriginal and Torres Strait Islander Children assessed as developmentally on track by IRSD quintile and year, NT.

AEDC data also confirms that access to resources is a strong predictor of how children fare. The table above shows a stark variation in development based on relative socioeconomic disadvantage.[a] While 41.2 per cent of Aboriginal children from the least disadvantaged quintile were assessed as on track, only 7 per cent of children from the most disadvantaged group met this benchmark, largely overlapping with the figure in very remote areas. The high proportion of better off children on track, though still lower than the 49.8 per cent of non-Aboriginal children in the Territory, also shows that where families have the economic means to at least partially override the structural impacts of racism, their children are significantly more likely to meet their developmental potential.

Broken down in this way AEDC data suggests that the developmental gap is not determined either by Indigenous status or where children live. Families' capacity to access fundamental supports in the early years is a significant predictor of development trajectories, and policies that enable families to access services, can and do make a difference. Much of the marked gap in developmental outcomes for First Nations children in the NT can therefore be accounted for lack of access to essential services in remote communities relative to remote provision in other jurisdictions.

[a] This aligns with findings of the NT Data Linkage Study which found Aboriginal status had no significant effect as a predictor of AEDC developmental vulnerability: 'In other words, the main influences predicting children's developmental outcomes were their experiences of early life health and sociodemographic factors—regardless of their Aboriginal or non-Aboriginal status'. See Silburn et al 2018, p. xv.

Access to basic services underpins healthy development

Data linkages using AEDC data have established an association between poor developmental outcomes and lack of access to clinical care and other early years supports in Aboriginal and Torres Strait Islander cohorts; risk of developmental vulnerability at school age is correlated with maternal and childhood anaemia;[25] gestational age and weight at birth;[26] gestational diabetes;[27] and hearing impairment due to untreated otitis media.[28] Families with multiple and complex needs are 1.7 times more likely to have a child with developmental concerns as are children born to younger mothers.[29]

Conversely AEDC data linkages suggest that attending ECEC and preschool has a protective effect,[30] though the quality of programs appears to matter more than quantity of hours.[31] Both Guthridge et al.[32] and Dadi et al.[33] found that not attending preschool was a significant predictor of developmental vulnerability for Aboriginal children in the NT as well as school attendance, though the effect appears to 'fade out' if children do not receive adequate support to make a successful transition to universal education.[34] Incidentally, speaking an Aboriginal language at home was correlated both with developmental vulnerability and lower incidence of participation in ECEC and preschool, most likely reflecting both the lack of provision of ECEC in very remote communities as well as a lack of bilingual support in schools and preschools.[35]

Current policy settings are inadequate and in some cases are making the problem worse

AEDC data indicates a strong correlation between developmental vulnerability and lack of access to resources and basic services and supports the case for both new investment and an overhaul of how remote services are funded and delivered.

It is critical that governments learn from the policy failures of the recent and not so recent past. The exposure of child mistreatment at the Don Dale Youth Correction Centre and the subsequent Royal Commission into the Protection and Detention of Children in the Northern Territory focused national attention on the deficits in service delivery in the NT and generated momentum for reform of the service systems tasked with keeping children 'safe and well'.

A 2020 study report by the Productivity Commission into expenditure on children and families in the NT found that despite significant investment – a total of $538 million spent in 2018-19 alone- a lack of coordination between Territory and Commonwealth agencies had contributed to a service landscape that was complex, fragmented and difficult for families to navigate.[36] In total the Commission calculated that programs were commissioned by no fewer than nine government agencies, with funding flowing to more than 500 individual service providers. This total included $55 million to fund 136 separate grants for early childhood programs, $23 million to fund 69 grants for remote health and nutrition, and $60 million on 75 distinct grants for family support services. Furthermore, the Commission found that expenditure was not targeted either to the needs of local communities, nor did piecemeal funding enable service providers to develop an evidence-base about 'what works' in a remote context.

The Commission has proposed that governments streamline investment by developing a more collaborative needs-based approach to commissioning, consulting with communities to develop regional plans setting out commitments in key service areas. The Commission further suggested that agencies be allowed to pool funding to provide integrated supports, rather than being obliged to cobble together an operating budget from multiple grants. The Commission also suggested ways to reduce the

administrative burden of compliance for service providers, including lengthening the default contract term to seven years, funding the true costs of remote service delivery (e.g. staffing, housing) and contracting arrangements designed to develop the operational capacity of ACCOs and ACCHS, including support to strengthen governance and upskill local people.

The opportunity for reform: The Children and Families Tripartite Forum

The Commonwealth originally intended that the Commission's study report would help to inform the work of the Children and Families Tripartite Forum. Established in July 2018 to pursue 'wide-reaching, whole-of-government, cross-sectoral reforms' aimed at reducing the numbers of children entering the Territory's child protection and youth justice systems, the Forum brings together representatives of the Commonwealth and NT Government, Aboriginal Peak Organisations NT (APONT), NT Council of Social Services (NTCOSS) and the North Australian Aboriginal Justice Agency (NAAJA). The mission of the Forum is ongoing, though it is yet to be seen how the re-election of the Country Liberal Party in mid-2024 will reshape consensus for reform at the Territory level.

Over the last thirty years there have been countless inquiries, but little measurable improvement in wellbeing outcomes for Aboriginal children and families in the NT. The Commission itself acknowledges that though Governments may be quick to accept recommendations, momentum too often evaporates before meaningful change can be implemented. Nonetheless, the creation of the Tripartite Forum offers an unprecedented opportunity for reform.

But where should investment be focused, and what are the key interventions proven to make a difference to children's developmental trajectories?

1.2 Evidence for impact in early childhood

Breaking the cycle of developmental vulnerability: Restacking the Odds

The experience of adversity in early childhood reproduces inequality by contributing to lower levels of educational attainment, poorer mental and physical health, and lower lifetime earnings.

But there is compelling evidence that combining or 'stacking' multiple effective supports across the early years (0 - 8) can make a significant improvement to children's health, development, and wellbeing. The Restacking the Odds (RSTO) platform developed by the Centre for Community Child Health at MCRI helps to target investment in services to ensure that vulnerable children and families can access a combination of high-quality, evidence-informed services where and when they need them.

The premise of RSTO is based on a wealth of evidence that indicates that by 'stacking' supports—that is, ensuring all five are provided to an individual child—there will be a cumulative effect, amplifying the benefits of individual supports and helping sustain the impact for longer. These five fundamental supports include:

- antenatal care

- sustained nurse home visiting
- early childhood education and care
- parenting programs
- the early years of school.

The efficacy of each service is supported by a strong evidence base. Individually, each service has proven benefits, but when delivered together and in sequence, these services significantly increase the odds of a child fulfilling their developmental potential. These interventions comprise a subset of the possible services families may access but have been selected by RSTO because they satisfy key inclusion criteria. In combination, this suite of services is *longitudinal*, with services delivered across the span from pregnancy to eight; *ecological*, in that they support both the child and their family; *evidence-based*; able to be *targeted* to support families in the 'bottom 25 per cent', and *already available* in some form in most communities.

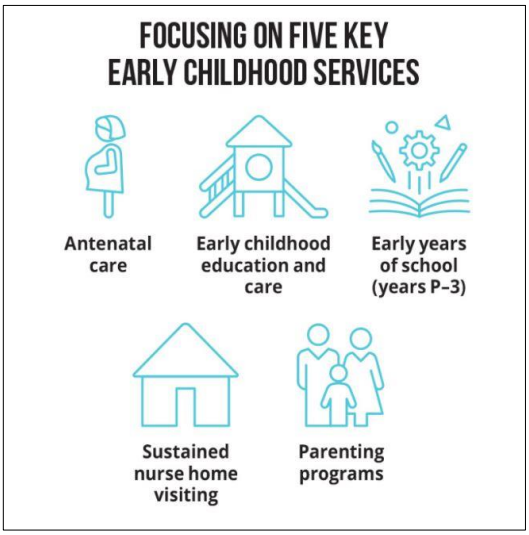


Figure 7: Five key early childhood services.

RSTO aims to improve access to quality services by making it easier for policymakers and advocates to identify what supports are available in a community, and where there are gaps in both service provision and service quality that require further attention or investment. RSTO uses a framework of evidence-based indicators to assess the likelihood that locally available services will make a difference to children's trajectories, with specific indicators developed for each service type around:

Quantity – do families have physical access to services?

Quality – does delivery align with evidence-informed best practice?

Participation – are children and families using the service enough to benefit?

Antenatal care

RSTO focuses on antenatal care (ANC) which meets evidence-based clinical practice guidelines and processes. ANC is defined as 'the universal health platform designed to optimise maternal health and foetal development during pregnancy and minimise adverse outcomes for all women'.[37] Although adverse pregnancy outcomes may occur regardless, there is an association between risk factors such as maternal smoking, drug use, diabetes, hypertension and stress due to family violence or poverty, and poor foetal outcomes such as low-birth weight and pre-term birth, which are in turn associated with poorer cognitive and physical outcomes. Women who receive high quality ANC have been found to enjoy better health, fewer interventions in late pregnancy and improved child health outcomes.

Key features of best practice clinical care identified from a systematic review of international practice guidelines include foetal monitoring, provision of medical care, timely screening and assessment and education and awareness.[38] RSTO's indicators for assessing the **quality** of ANC are based on the UK National Institute of Clinical Excellence's (NICE) Quality Statements on antenatal care, with the optimal rate of **participation** identified as no less than 10 clinical appointments for first pregnancies, and 7 for subsequent pregnancies, with at least one occurring during the first trimester.

Unlike quality and optimal dose, the required **quantity** of ANC services in a given community is a function of the size of the local population, the proportion of residents needing care and the resources required to deliver the optimal standard of care. In the absence of a broad evidence base on which to develop an indicator of optimal quantity, RSTO uses criteria from the WHO Service Availability and Readiness used to assess provision in low- and middle-income nations, which are nonetheless highly relevant in the remote central Australian context. Indicators include the existence of 'sufficient health infrastructure' including ANC facilities such as clinics and maternity beds, and a 'sufficient health workforce' measured in the number of GPs and midwives locally available.

The desires outcomes of antenatal care are for children to be born at a healthy weight with good brain health and receive appropriate care and adequate parenting.

Sustained nurse home visiting

Nurse home visiting (NHV) programs aim to promote health and equity through a focus on disadvantaged and vulnerable families, defined as parents in low-SES households, early school leavers, young people <20 years of age, and sole parent families.[39] NHV programs typically deliver multiple services and interventions in the family home, targeting risk factors and promoting protective factors associated with maternal and child wellbeing. By providing these services in the home NHV aims to improve access, create opportunities for individual practitioners to build trust with caregivers, and provide support that is tailored to families' needs and circumstances. It is important to note that delivering NHV interventions in the home may not be appropriate for many families in remote central desert communities.

Based on a systematic review of the evidence, RSTO found that the **quality** of NHV programs is closely associated with both the number of home visits and their duration over time, so that to be effective, visiting must be *sustained*. They also found that programs delivered by qualified nurses were more effective than those delivered by nurse-practitioners, which has ramifications for combining quality and cultural safety in remote areas. RSTO identified seven sustained nurse home visiting (SNHV) programs with clear, consistent evidence of benefit, including both the Family Nursing Partnership program, delivered by Congress in the central region as the ANFPP.

Indicators of optimal **participation** included at least three visits per month for targeted programs, with at least 24 separate visits lasting from 60 to 90 minutes, sustained from the last trimester up to 24 months postnatally. Sufficient **quantity** is indicated by the number of SNHV places available relative to the population of eligible parents and the availability of qualified nurses to maintain quality.

The desired outcome of sustained nurse home visiting is for parents to develop parenting skills.

Early childhood education and care

RSTO defines ECEC broadly as 'any arrangement providing education and care for children from birth up to the first year of formal schooling regardless of setting, funding, opening hours or program content'.[40] There is a wealth of evidence showing that participation in high-quality ECEC has an impact on long-term outcomes in cognition, resilience, health, and wellbeing. However systemic issues around affordability and supply, as well as quality and cultural safety, mean that many children miss out. AEDC data shows that children from the most disadvantaged quintile are three times more likely to be identified as developmentally vulnerable on two or more domains than their peers in the highest quintile.

Following Eadie et al.[41] RSTO distinguishes between *structural* quality as defined in the National Quality Framework (NQF) and *process* quality, or the practices that occur within an ECEC setting. These include support for learning and the quality of relationships between educators and children, with indicators of

quality based on the Classroom Assessment Scoring System PreK and the revised Early Childhood Environment Rating Scale. To be assessed as of sufficient **quality** by RSTO, ECEC services must be assessed as exceeding the NQS in Quality Areas 1, 4 and 5, that is respectively in programming, staffing arrangements and relationships with children.

In relation to **participation**, RSTO identifies the optimal duration as at least 15 hours of attendance in the two years before school for children in the general population, but three years for children experiencing disadvantage, with a greater benefit is associated with evidence-based programming such as the Abecedarian "3a" Approach.

In relation to **quantity**, RSTO identifies infrastructure – the supply of ECEC services and preschools relative to the number of preschool aged children – and the supply of qualified ECEC educators as critical. Although supply is highly uneven, with many rural, regional, and remote communities unable to access ECEC of any kind, there is no national indicator for measuring service availability. RTSO therefore uses workforce data on the proportion of qualified educators in accredited services and the number of primary teachers delivering preschool programs as a proxy for the number of available ECEC places.

The desired **outcome** of ECEC is for children to be on an optimal developmental pathway and once they reach compulsory school age, ready to start school.

Parenting programs

Research has shown that the quality of parenting children receive in the first decade of life is the single most important influence on children's behaviour, in turn shaping their capacity to cope and adapt to stresses over the life course.[42] Significantly, poor parenting in early life – e.g. parenting that is abusive, controlling, neglectful or rejecting – is twice as likely to negatively impact on developmental outcomes as other environmental risk factors such as poverty. Poor parenting is associated with increased incidence of both externalising behaviours such as oppositional defiance, antisocial behaviour, and aggression, as well as internalising behaviours such as anxiety and depression.

Intervening early to improve parenting reduces the risk of behavioural issues becoming entrenched and can have a positive and lasting effect, with greater parental warmth and more effective coping strategies especially beneficial for children experiencing disadvantage. Furthermore, effective parenting programs are highly cost effective, with evidence-based interventions focused on mentoring, developing parenting skills and strengthening attachment, found to be cheaper and more effective than tertiary responses involving statutory intervention (noting that $260 million of the total $538 million spent on child and family services in the NT in 2018-19 was directed to child protection).

RSTO considers only those parenting programs with 'well defined curriculum of interventions' where a clear and replicable series of actions, tasks and behaviours is linked to measurable outcomes. 'Parent' in this context is defined as any adult taking on a primary caregiving role, whether a biological relative or a foster carer. Only nine of the 89 programs identified met RSTO criteria for **quality,** that is with results that were able to be replicated and sustained for more than six months. Supported programs included the Triple-P Parenting program, Circle of Safety, Incredible Years, Parent Child Interaction Therapy and Tuning into Kids, all of which are widely delivered in the Australian context. The Parenting Under Pressure program delivered by Congress did not meet the RSTO benchmark.

While the rate of attendance associated with positive benefit varied across programs, RSTO prescribes an attendance rate of at least 85% of all sessions to satisfy the requirement for **participation**. As in other service areas, the RSTO indicator for the necessary **quantity** of available parenting programs is calculated as the number of parenting program places available per defined population (here given as 12% of children aged between 2 and 6 years. Programs must also be facilitators by accredited practitioners to meet this benchmark.

The desired **outcome** of parenting programs is to remedy emerging behavioural issues.

Early years of school (Transition to Year 3)

Educational attainment is a strong social determinant of health and wellbeing over the life course but is heavily skewed by socio-economic status. NAPLAN data consistently shows that performance in literacy and numeracy is strongly tied to household wealth, level of education. First Nations children, especially those learning in remote and very remote schools, may also have significantly higher support needs.[43]

Access to quality universal education can significantly reduce the degree of inequality in performance. Because primary schooling is universal and full-time school attendance compulsory, RSTO has not developed indicators to measure **participation** or **quantity.** There is also no comparable evidence base to establish clear indicators of **quality** in primary school education, which has prevented RSTO from developing indicators of quality for disadvantaged students. Nonetheless a systematic review identified 13 domains of quality, of which five were Well Supported by evidence, and four Supported. From these 13 domains, from which 37 discrete indicators of quality were developed, relating either to school processes (evidence informed practices and teaching strategies) and the competence of teaching staff (primarily whether teachers have completed formal training to effectively implement evidence-based teaching strategies). A complete list of quality indicators available on the RSTO website.

1.3 Evidence for an integrated early years' system

Integration enables stacking of effective early childhood supports

There is a robust body of evidence indicating that integrating support during children's formative years has positive impacts for children and families: integration of early childhood education with primary healthcare has been found to enhance school readiness and educational attainment, earlier identification and intervention for developmental delay, improved health outcomes and increased family engagement with support services.[44]

Integration refers to the process of building connections between different types of services to make support more holistic, accessible, and responsive to families' needs. It occurs along a continuum from communication between providers to coordination, collaboration and ultimately, integration. Integration typically takes the form of a child and family 'Hub' or 'Child and Family Centre', though colocation of services under one roof does not automatically confer integrated support. Whatever the location, the aim is to reduce barriers to access by creating a single point of contact for families sometimes called a 'single front door' or 'no wrong door' approach.

Effective integrated child and family centres improve children's outcomes by helping to:

- Identify and support a child's learning and development needs
- Provide access to early intervention supports

- Identify broader issues that may affect a child's wellbeing, such as poverty and family violence
- Provide support, referrals, and appropriate services in response
- Provide a safe space for families to build connections.[45]

Integrated provision works better for Aboriginal children and families

First Nations communities have long advocated for integration as a means of countering the social and economic determinants that increase the risk of developmental vulnerability. Integrated and culturally safe holistic support delivered by ACCOs and ACCHS has been found to be more effective at reaching and then sustaining engagement with Aboriginal and Torres Strait Islander families than mainstream providers.[46] The Aboriginal community-controlled sector established the first integrated centres in the 1980s as a means of providing culturally safe healthcare and social services.[47] These were then funded by the Commonwealth as Multifunctional Aboriginal Children's Centres (MACS) though responsibility for determining the mix of services and activities was delegated to communities. Individual MACS therefore offered a range of ECEC including occasional care as well as long-day care, playgroups and parenting support, alongside spiritual and cultural activities.[48]

Research on this first wave of integrated child and family centres noted that successful services offered Aboriginal and Torres Strait families supports not available from mainstream ECEC. Key features of effective practice that were found to attract Aboriginal families included:

- **Holistic, or 'ecological', support**, including childcare, playgroups and family support but also practical help with health and social and emotional wellbeing, education and training, employment and housing, with specialist practitioners on hand to work with families;
- ECEC that is **affirming of cultural identity**, with educators drawn from the local community, and often related to children, helping to ensure cultural safety and build trust with families. This was found to be especially important in remote contexts;[49]
- Infrastructure and facilities being deemed **culturally appropriate**, inviting, and **easily accessible** e.g. 'pram pushing distance' from home.[50]
- **Strong community governance**, enabling input into the range of supports on offer, with adequate resources for ongoing support and community capacity building and community development.

By the late 2000s this model of integrated community-controlled child and family services was widely recognised as best practice for overcoming Aboriginal families' distrust of mainstream provision, and in 2009 the Labor Government expanded funding to an additional 38 centres as part of its commitment to Closing the Gap in developmental outcomes.[51]

Unfortunately, many of the early gains made in culturally responsive and integrated family support were undone by the Coalition Government's decision to abolish block funding as part of its Childcare Package reforms in 2017-18. This process has been documented by SNAICC as the peak advocate for the community-controlled sector.[52] The loss of block funding, and the flexibility it enabled, meant that centres were required to reinvent themselves as ECEC providers, with the bulk of operating revenue coming from the Child Care Subsidy (CCS) for long-day care.[53] This has both reduced the range of

supports that can be offered and diluted scope for centres to cater to communities' needs and preferences, arguably *increasing* service barriers for many First Nations families and children.

Principles for integrated early years services

SNAICC has consistently advocated for the Commonwealth to enact 'large scale funding reform' to enable ACCOS to deliver integrated early years services in line with the evidence on best practice. SNAICC maintain that fit-for-purpose funding must allow ACCOs flexibility to tailor their offerings to community needs and cultural preferences, and define five principles to guide program design:

1. **Certainty**, to ensure that services have confidence and assurance that funding commitments are both enduring and commensurate with the full cost of high quality integrated early years services that embed culture in all aspects of service delivery.
2. **Control**, such that communities and/or services can flexibly direct funding resources to their highest and best use given the needs of the local community.
3. **Reliability**, such that the integrated services and supports that children and families require can be accessed and utilised in a timely and predictable manner.
4. **Responsiveness**, such that funding levels recognise and respond to variations in need across and within communities.
5. **Administrative simplicity**, such that the costs and administrative burden of accessing and utilising funding are minimised.[54]

There is evidence that these arguments are gaining traction with policymakers. Since 2022 SNAICC has chaired the Early Childhood Care and Development Policy Partnership (ECCDPP) which brings together representatives from the Commonwealth, state and territory governments and First Nations controlled community sector to advance the objectives set out in the National Agreement on Closing the Gap.[55] Economic modelling commissioned by SNAICC to consider the viability of a range of funding models found that only a dedicated 'needs-based' funding stream outside of the system architecture of the CCS would meet all five principles for ACCO-led service integration.

The model proposed by SNAICC would reinstate block funding for ACCO-run integrated centres, covering the cost of providing a range of ECEC options and ancillary support services, with dedicated funding to cover capital costs and maintenance of facilities, professional development and training, and community capacity building. The Productivity Commission's Final Report on ECEC has broadly approved SNAICC's recommendations in regard to block-funding for ECEC in rural and remote areas where market-based provision is unsustainable, with flexibility for ACCOs to deliver culturally safe and responsive integrated early years services.[56]

Barriers to service integration: the limitations of collective impact

There is now a broad consensus across governments in favour of integration as a means of addressing system fragmentation and improving access to a holistic range of supports. Both Commonwealth and State and Territory Governments express in principle support for strengthening service integration as a means of counteracting the impact of childhood adversity. The promise of integration has seen governments in all jurisdictions set up integrated child and family hubs of some kind.[57] There is evidence that these hubs have improved access for communities and enabled pockets of collaborative practice, but investment has so far been small scale and piecemeal, and without secure funding or dedicated

resources to enable collaborative practice, many so-called 'hubs' may amount to little more than services sharing office space.

The experience in the remote NT is instructive. Over the past decade the Commonwealth has commissioned several place-based initiatives in the central region designed to enable service integration at the local level. These include Communities for Children and Stronger Communities for Children (DSS) and Connected Beginnings (Departments of Health and Education). But while these initiatives may have enabled pockets of collaboration, the effect on the ground in Mparntwe/Alice Springs has, ironically, been to add new layers of complexity to an already fragmented early years' service system.[58]

These initiatives were based on the 'Collective Impact' model developed by Harvard-based consultancy firm FSG which was taken up by philanthropists and governments in the US and Australia during the 2010s as a policy solution to complex social problems.[59] Loosely defined, collective-impact type initiatives bring together a range of actors around a shared change agenda under the coordination of a 'backbone organisation'. The backbone agency is responsible for enabling continuous communication between providers, coordinating mutually reinforcing activities and collecting data to measure impact.

A decade on there is little evidence to support the claims made by its proponents[60] but rather more on its shortcomings.[61] In addition to the observation that many collective impact-type initiatives tend to cede very little control to the communities they seek to help, critics point out that the approach ignores the ways in which policies and system structures work to 'hold problems in place'.[b]

The limitations of collective-impact approaches are evident in Mparntwe/Alice Springs. Although the first iteration of Connected Beginnings enabled the formation of Child Friendly Alice in 2018, momentum subsided once funding for a coordinator position (formerly based at Braitling Primary School) was discontinued. Key members of the original Child Friendly Alice continue to meet without government recognition or resources, while the tangle of multiple funding streams from multiple agencies, each with their own program accountabilities, makes collaboration difficult even though stakeholders may be delivering comparable services to the same population.[c] This confusion mirrors the fragmentation of service delivery on the ground both in town and its satellite communities. To cite just one instance, both Connected Beginnings and Communities for Children are funded to improve system integration, but without coordination between their respective Commonwealth funding bodies, there are no formal mechanisms for cooperation or collaboration.

[b] This criticism has been subsequently addressed by FSG's work on systems change. See Kania, J., Kramer, M., & Senge, P., 2018 The water of systems change available at https://www.fsg.org/wp-content/uploads/2021/08/The-Water-of-Systems-Change_rc.pdf. Accessed 12/09/2024

[c] At present membership includes representatives of Larapinta CFC (NT Education), Tangentyere, who deliver family support (TF) and child and family centre programs (NT Education), Congress who deliver Connected Beginnings (DoE), family support (DSS) and CHAD (DoH) on behalf of the Commonwealth and Anglicare NT who are the Facilitating Partner for Communities for Children (DSS).

Making integration work in practice: findings from current Hub research

The experience of the early years' sector in Mparntwe/Alice Springs is emblematic of the practical challenges that service providers and frontline practitioners face in trying to provide an integrated experience for families. But while there is a strong evidence base for the benefits of integration, there is still a lack of robust research on what is required to successfully implement and sustain integrated practice. Developing this evidence base and communicating these findings to funders is one of the objectives of the **National Child and Family Hubs Network**. This research effort informs the following discussion of the key enablers and barriers to making integration work in practice. Enablers include:

High-level authorisation for cross-agency collaboration

The system architecture that governs how service systems work was set up to regulate specific sectors such as health, education, or social welfare. This means that even when governments state a commitment to integration, structures tend to reproduce and reinforce siloed ways of working. Making integration work on the ground therefore requires **a collaborative approach to policy development** at the top to develop funding arrangements that enable integration downstream.

Multi-agency governance and inter-agency coordination between departments as well as between Commonwealth and Territory governments, reduce the risk of worsening duplication and system fragmentation and send a signal to public sector managers that collaborative ways of working will be supported and enabled. This in turn helps to create favourable conditions for providers to implement collaborative practice in integrated service settings. The key is to make collaboration with stakeholders **the 'core business' of what agencies do**, rather than a 'nice extra' when resources allow.[62]

There are already several such governance bodies in the First Nations child and family space, including the Tripartite Forum, the Joint Council on Closing the Gap, and the ECCDPP. Nonetheless, there is more work to be done to translate a general commitment to cooperation into practical coordination and integration between government agencies. Official authorisation for agencies to work together is essential to resolve practical barriers to integration (E.g. agreeing to protocols for information sharing, investing in IT system compatibility), or develop workarounds to systemic barriers.

Funding that is both secure and flexible

Making integration work requires service managers and practitioners from different agencies to build relationships based on trust, both with one another and with the community they serve. However, **building trust takes time.** The available literature indicates that inadequate, short term and/or insecure funding undermines integration in several ways, including by making it difficult for providers to plan ahead, harder to attract and retain qualified staff, and by creating a disincentive to invest in staff capability or community capacity building activities.[63] Effective integration therefore requires **secure, long-term funding** for both capital costs (e.g. maintenance of infrastructure and facilities), core services (e.g. ECEC, child health nurse, family support worker) and additional funding that can be used flexibly to respond to community needs.

Long-term, secure, and sustainable funding is especially important for ACCO-led integrated services and others working with First Nations communities because providers must be able to provide **certainty** and demonstrate **reliability** in order to develop a service that is perceived as culturally safe.

As well as enabling stability, it is equally important that funding arrangements offer sufficient **flexibility** to allow centres to adapt supports to community needs and preferences and afford some degree of community control. Funding agreements that prescribe particular activities or outputs tend to mitigate against integration unless collaborative activities are also a specified output.

Investment in 'the glue' to enable integrated service delivery

Being committed to the idea of integrated services is not enough. Governments also need to allocate dedicated funding for the activities and practices that allow providers to work well together.

This is sometimes described as 'the glue': 'the elements of a service system that enables a comprehensive, holistic and integrated service response for children and their families – incorporating the people, partnerships, knowledge and systems that are essential to improving children's outcomes in the places where children live, learn and grow'.[64] Based on the available evidence, the key components of 'the glue' that need to be resourced to make integration work include:

Business oversight, for example having clear governance arrangements in place setting out the roles and responsibilities of all partners. Hubs may have a single lead agency accountable for performance measures and sub-contracting to partner providers.

Staff supports such as a Hub **coordinator** who can lead and schedule collaborative activities and sustain relationships with external services and community stakeholders. Supports also include funded time for information and practice sharing, ongoing workforce development and adequate funding for key operational supports (admin, data entry) so other practitioners can focus on working with families.

Community engagement includes co-design and ongoing consultation with families and the broader community as part of a positive cycle of continuous improvement and adaptation. Resourcing for should include the costs of practical support (transport, food vouchers, emergency brokerage) as well as informal activities that support engagement E.g. food for cooking and sharing, art and craft supplies.

Shared outcomes and data management with aligned reporting requirements so practitioners don't have to choose between meeting performance indicators and working for the common good. The data collected needs to practically help practitioners improve quality and encourage mutual accountability for child and family outcomes.

2 Mapping the early years' service system in remote central Australia

2.1 Current investment in remote service provision

Although the RSTO framework enables a place-based lens on service provision, it assumes that communities will have a certain population density, a minimum level of infrastructure and a reasonable supply of qualified professionals to fulfil minimum standards of quality, quantity, and participation.

This assumption does not apply to the very remote communities of the central desert region, where provision of basic early years services would, on any measure of adequacy, be found wanting. [65]

Nevertheless, all of the five strategies identified by RSTO *do* exist in some form in most communities, while the relatively small number of families means that, despite the distances between service centres, the *scale* of the task involved to improve both quality and access, is relatively modest.

This section provides an overview of Commonwealth and Territory expenditure on those basic services which have the proven potential to improve children's developmental health.

Commonwealth expenditure in remote central desert communities

The lack of coordination between levels of government and agencies means that there are areas where funding overlaps, as well as others where there is no provision at all.

Commonwealth investment in the region is primarily through funding flows from the National Indigenous Australians Agency (NIAA), formerly a division within Prime Minister and Cabinet, and the Department of Social Services (DSS) which funds a number of programs via its Families and Communities division. ACCHS, and Congress in particular, receive the bulk of their funding from the Indigenous Health division of the Department of Health and Aged Care. Smaller amounts of funding, such as those designed to counter low rates of school attendance, also flow via the NIAA.

Territory Government service provision

Compared to the Commonwealth, the NT Government is far more active in direct service delivery with formal responsibility for the universal provision of compulsory education and primary healthcare. The NT Department of Education operates schools in communities across the region while the NT Department of Health operates clinics both in its own right, and in partnership with local ACCHS.

However staffing constraints mean that many clinics operate with part-time hours, and in recent years several clinics effectively closed. This had the effect of 'emptying out' communities and pushing families to larger centres and into Mparntwe toc access basic healthcare. Since mid-2023 Congress has taken over operation of some of these clinics.

In 2018, the NT Government released a ten-year strategy to address this gap. *Starting Earlier for a Better Future* was developed in consultation with an Expert Reference Panel co-chaired by now Congress CEO Donna Ah Chee and advances a holistic approach to improving early childhood outcomes for all children in the NT. Specific actions in the fields of health and education in the four years to 2022 included $11.4 million to establish 11 new community-controlled Child and Family Centres (CFCs), with a further $6 million to expand the range of health services at the Government's six existing CFCs. These include new

ACCO-run centres in Katherine and Tennant Creek, and CFC funding for Tangentyere Town Council to integrate early childhood services in town camps in Mparntwe, but no new investment in infrastructure or integrated early childhood services for the greater central region.

Antenatal care and nurse home visiting

Theoretically, all pregnant women in the region can access free ANC through their local health service, whether operated by Congress, another local ACCHS or NT Department of Health. A lack of provision for women to give birth on Country means that women requiring monitoring or investigation must travel to Mparntwe/ Alice Sprtings to access these services at the Alice Springs Hospital (ASH).[66] Travel to and from town to access antenatal care may be reimbursed via the Patient Assistance Travel Scheme travel and accommodation after 37 weeks gestation are free. More than 800 babies are born at ASH each year.

Congress offers ANC in Mparntwe through its Alukura Women's Health Service and has partnered with the Molly Wardaguga Research Centre in the College of Nursing and Midwifery at Charles Darwin University to implement a Midwifery Group Practice model to improve continuity of care.[67]

The Commonwealth funds Congress to deliver the Australian Nurse Family Partnership Program (ANFPP) in the central region of the NT. Delivered with support from the ANFPP National Support Service based at the Molly Wardaguga Centre, registered nurses and Aboriginal family partnership workers visit women fortnightly from the end of their pregnancy until their child turns two. Nurses and Aboriginal practitioners work with young families to promote healthy practices and educate parents about child health and development.

In 2022, Congress received over $350k to deliver ANFPP services to first-time mothers in Mparntwe/Alice Springs, Ntaria and Ltyente Apurte and outstations within 100km of town. When delivered faithfully by qualified nursing staff, the program meets RSTO's guidelines for quality, but would not meet indicators for quantity since eligibility is restricted. Program guidelines state that places are reserved for first pregnancies, although staff may use their discretion if a woman pregnant with a second or third child has not accessed the service before. Furthermore, restrictions on program capacity and reach – nurse home visiting is not available for women residing outside of Congress' health service footprint – reduce accessibility and opportunities for participation.

Early childhood care and education

The National Agreement on Closing the Gap obliges state and territory governments to ensure that children have access to early high-quality and culturally appropriate early childhood education[68]. Yet many Aboriginal children in remote and very remote parts of the NT are missing out. Poor quantity – outside Darwin there are 0.1 available ECEC places per child – combined with prohibitive costs, lack of cultural safety and support for first languages, underpins low participation. In 2021, only 79.4% of Aboriginal children in the NT children aged four years were enrolled in ECEC, well below the target of 95% by 2025; a target which has been met elsewhere in Australia[69]. The comparable figure for non-Indigenous children enrolled in ECEC in the NT was 99.8%[70].

Commonwealth funding for ECEC

The sustainability of ECEC provision in the region has long been subject to cyclical shifts in Commonwealth government ideology and political priorities. There is a long history of First Nations communities establishing integrated service families, with the first major injection of Commonwealth

funding came in 1987 with the establishment of the Multifunctional Aboriginal Children's Services (MACS) which included Congress' own *Ampe Kenhe Apmere* Centre in Alice Springs.[71] In 2003 the MACS were consolidated into the Budget Based Funding (BBF) program. The BBF was specifically designed to fund services where 'mainstream or conventional childcare services were either not available or viable' and gave ACCOs the flexibility to offer services that met the needs and aspirations of the communities they served.[72] A further 38 Aboriginal Children and Family Centres (ACFS) were funded following the National Partnership Agreement on Indigenous Early Childhood Development in 2009. The ACFS were designed to raise the number of Aboriginal and Torres Strait Islander children participating in ECEC and act as a 'trusted one-stop-shop' for families who might otherwise not seek support from families. The Larapinta Child and Family Centre in Alice Springs was established at this time.[73]

In 2017 the Coalition Government's 'Jobs for Families' Child Care Package ended block funding through the BBF and compelled remote centres to either transition to subsidy-based funding or seek state and territory government support. The reforms also introduced an Activity Test which tied subsidised care to caregiver's participation in work or training. These changes placed remote centres under considerable strain, with services compelled to charge fees of over $100 to cover costs, while the tighter eligibility requirements made it harder for families to claim subsidies. A 2021 evaluation of the changes found that over 65% of former BBF funded services – many of them serving regional and remote Aboriginal communities- had been disadvantaged by the 2018 reforms, with many operating at a loss.[74]

Those centre-based ECEC services still operating in very remote communities rely on a combination of grant funding through the Commonwealth's Community Child Care Fund Restricted program (CCCF-R) and whatever amounts of Child Care Subsidy (CCS) they are able to claim on behalf of families. Families eligible for subsidised care are also required to pay the 'gap' between the maximum rate of CCS and the daily centre fee. Families who cannot pay, or who are unable to claim CCS, accumulate a debt, though some providers choose to write debts off rather than stop children attending.

In addition to funding pressures, ECEC services in remote communities struggle to maintain infrastructure and recruit and retain staff, making it difficult to meet the National Quality Standard which is a precondition of CCS eligibility. Hitherto CCCF-R services have been allowed to operate as CCS approved services under 'Minister's Rules', with centres only required to meet diluted quality standards. Centre managers and educators need only be 'working towards' an approved qualification, with allowances for inadequate physical infrastructure.

In mid-2023, the Commonwealth commissioned NT Education to undertake a review of CCCF-R services in remote communities to collect information on whether there is scope for individual services to be accredited via the NQF or be block-funded via another funding stream. Although the findings of this review have not been made public the Productivity Commission has recommended a tightening of the circumstances under which services may operate 'out of scope' of the national regulatory framework.

Territory funding for ECEC and preschool

The NT Government delivers two early childhood education programs in the region: Preschool and Families as First Teachers (FaFT), as well as its pared down version, Stay Play Learn. While the latter is targeted at families with younger children, smaller numbers and the scarcity of staff mean that in many communities, delivery of FaFT and preschool programming is intertwined.

The NT Government's recent review of preschools found that only 54.3 per cent of children in very remote areas attend the recommended 600 hours in the year before school, with a third attending for less than 10 hours per week.[75] Barriers to preschool in very remote communities include lack of service availability (several of the communities in scope have no preschool program), lack of cultural safety, lack of first

language support and the compounding effects of disadvantage, such as a lack of access to transport or lack of food at home to provide a packed lunch.

The quality of preschool across the region is also uneven. Many preschool programs throughout the region operate with an Assistant Teacher drawn from the local community rather than a fully- qualified early childhood teacher. Assistant Teachers are not required to have completed formal schooling, though preschool teaching requires fluent English and basic English literacy. Prior employment and a track record of reliability are prerequisites.

Remote communities must record an enrolment of >11 to be in scope for funding of a full-time Early Childhood Teacher (ECT), although once this is met, funding is continued. However, recruitment of qualified ECTs is dependent on other conditions, including the availability of housing – which DoE provides for employees moving to remote communities. Retention is also a challenge: teachers working in very remote communities receive the same rate of remuneration as teachers in urban remote and suburban schools so there is little financial incentive. DoE has previously experimented with offering a mobile playgroup as a means of addressing retention but has since discontinued the program.

Because FaFT is delivered at a time and at a place that meets the needs of families' sessions tends to be offered during late morning to midday, leaving the afternoons available for staff to attend to integration activities such as referrals and follow-ups. Training for FaFT practitioners is delivered annually by an accredited "3a" affiliate in Mparntwe/Alice Springs over three days.

Local government programs

The communities included in this mapping exercise fall within Macdonell Ranges Regional Council (MRRC) or Central Desert Regional Council. Through MacKids, MRRC is the primary provider of ECEC services in remote communities in the region. The southern part of the region falls within the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, though some of this Country formally remains under the governance of MRRC.

Parenting programs

Family support services generally fall into *intensive* programs, which are a tertiary intervention for families already under a child protection order, and targeted or *early intervention* programs designed to help families address concerns before formal child protection involvement. Only intensive support is currently funded in the region outside of Mparntwe/Alice Springs.

The Children and Families division of DSS currently funds two ACCOs to deliver intensive family support services within the region: Waltja Tjutangku Palyapayi (Luritja for 'doing good work with families') and the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women' Council which offers the Waltjapiti program through its Child and Family Wellbeing Service. Though participation is voluntary, access is through referral only. Several communities within the region south of Mparntwe are serviced by both organisations, while Waltja Tjutangku Palyapayi is the sole provider to the north and west.

Prior to 2021, the program was known as Intensive Family Support Services (IFSS) and delivered within communities by non-Aboriginal-controlled faith-based service providers. A 2020 evaluation of IFSS found that the program model was not sufficiently responsive to the needs and values of the individual communities where it was delivered, and the program has since been redesigned as Children and Families Intensive Support (CaFIS). CaFIS is described as 'evidence informed, locally adapted, child

centred, strength-based [and] trauma informed' with supports tailored to meet the specific needs of families.[76] Compared to IFSS, CaFIS has greater focus on culture, on extended kinship and on working with the whole community, not just with parents, with funding able to be spent more flexibly. Supports that may be funded through CaFIS include community healing education, return to country activities for children, and engagement with traditional healers and healing practices, alongside more conventional specialist trauma-informed therapies. CaFIS is delivered via a bi-cultural worker model with non-Aboriginal team leaders and local Aboriginal family support workers.

IFSS was originally commissioned by the Labor Government in 2010 as a targeted response to high rates of substantiated child abuse and neglect notifications in the Northern Territory and APY Lands. The program model was based on a random controlled trial of a cultural adaptation of the Triple P Parenting Program[77] delivered to Indigenous families which found that 'parents receiving the intervention reported significantly lower reliance on dysfunctional parenting practices, particularly, use of long reprimands and talking rather than taking action, and lax or permissive discipline'. Despite the issues identified above, this finding was supported by the 2020 evaluation of IFSS. CaFIS is therefore an adaptation of an adaptation of the Triple P program to the needs of remote central desert communities.

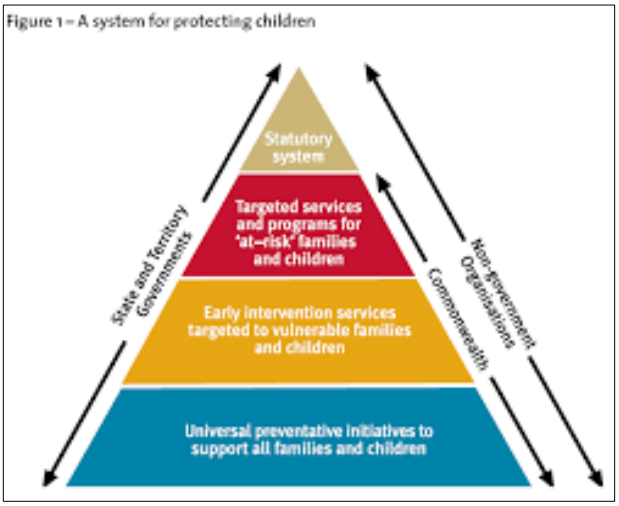


Figure 8: Public health model of child welfare

Within the public health model of family support interventions, CaFIS belongs to the secondary tier of targeted programs and services (the red section shown in Fig. 8) directed at families deemed 'at risk' following a substantiated notification of abuse or neglect. Both the National Framework on Protecting Australia's Children 2009-2020 and its successor are based on this tiered approach, under which the majority of funding and effort is ideally focused on intervening to prevent abuse. However this approach has proven difficult to implement in practice meaning that the bulk of expenditure on family support in all Australian jurisdictions remains concentrated in the statutory system.

This is especially evident in the NT, where the combined amount currently spent by Territory Families on statutory child protection services and out of home care ($157 million in 2022-23), dwarfs the $26 million allocated to non-statutory family support. In the central region the NT Government funds just two organisations – Tangentyere Council and Akeyulerre, which specialises in Arrernte healing practices – to deliver early intervention support to families, neither of which services communities out of town.

The lack of investment in early intervention is also evident in the proportion of Commonwealth expenditure on CaFIS - $7 million to Waltja Tjutangku Palyapayi and $9 million to NPY Women's Council, while Congress receives a mere $90k to deliver the TFSS early intervention service.

However, increasing the quantum of funding for parenting programs in the region will not improve access unless there are real opportunities for local people to access training and employment. High staff turnover was identified as a barrier to program effectiveness in the IFSS evaluation, and development of the local workforce is an ongoing focus for the sustainability and effectiveness of CaFIS.

Early years of school

Every one of the communities in scope has a school which offers primary education up to Grade 6, yet school attendance across the region is significantly lower than attendance in Mparntwe/Alice Springs. In Term 4 2023, 43.5 per cent of the 1,045 Aboriginal children enrolled in very remote NT Government schools attended, compared to 59.6 per cent of Aboriginal children in town. The average attendance rate for non-Indigenous children in Mparntwe/Alice Springs was 81 per cent.[78] Therefore while remote schools meet evidence-based indicators for quantity, they fall far short on participation.

Increasing rates of school attendance is a priority focus of the Closing the Gap agreement and since 2014 the Commonwealth has funded a series of measures through the Remote School Attendance Strategy (RSAS) totalling over $206 million up to 2021.[79] The program is currently administered by the NIAA. Under the RSAS local providers are funded to work with local communities to deliver activities that promote school attendance, engagement, and educational attainment.[80] Yet despite taking a flexible place-based and community-oriented approach, the effectiveness of the RSAS is unclear. A 2018 evaluation found that RSAS activities aimed at helping families overcome practical barriers were appreciated by families already convinced of the benefits of school but were not reaching those who were unsure or disconnected.[81] Pointing to the decline in rates of school attendance in remote NT communities since 2013, critics argue that the policy has failed because the 'education on offer is not grounded in what communities value'.[82] This critique broadly aligns with the advocacy of the late MK Turner for an alternative First Nations education system which informs the program model and practice of Children's Ground based in Mparntwe/Alice Springs.[83]

However, investing in children's health and education during the early years has a positive effect on school attendance. Research findings from the NT Data Linkage Study conducted by a team at the Menzies School of Health found significant associations between a range of early life circumstances and later school attendance.[84] While poor attendance was associated with younger and less educated parents, low-birth weight, overcrowding and speaking language at home, the study found that participation in preschool was a strong predictor of good school attendance.[85] These findings suggest that measures which enable families to access high-quality preschool programs in remote areas, and then support children during the transition to school, are likely to have a longer term benefit .

The Commonwealth also funds the School Nutrition Program administered by the NIAA. [86] The program aims to improve school attendance and learning outcomes by subsidising the provision nutritious food to pupils during the school day and creating employment opportunities within the community. Participation is voluntary with parents contributing to the cost of meals via the garnishing of Centrelink payments, though an evaluation found that providers routinely feed all children regardless. The program is delivered by a range of providers across the region.

2.2 Mapping of service provision by community

The following section maps the range of early years' services funded in each of the communities in scope. It has been compiled using a combination of desktop scans (using the NT Government's BushTel directory, publicly available Commonwealth grant listings and provider annual reports) and consultations with local service providers. Conversations with local providers and other service stakeholders have been especially important because of the often-significant gap between what is

funded, and the services that are delivered on the ground. These consultations have also highlighted the many complex operational challenges agencies face in implementing programs designed with an urban or regional context in mind.

Ntaria

The community of Ntaria, also known as Hermannsburg, is located 125 km west of Mparntwe/Alice Springs in the traditional lands of the Western Arrernte people. Ntaria is home to around 550 people, some 90 per cent of whom are Aboriginal. Of those who speak a language other than English at home, 80 per cent speak Western Aranda, followed by Arrernte, Eastern Arrernte, Luritja and Walpiri. At the 2021 Census, children under 4 made up 10 per cent of the population, a total of 58 children, all but two of whom were Aboriginal. Sixteen children were enrolled in preschool and 65 in primary school.

Congress provides primary health care in partnership with the Western Aranda Health Aboriginal Corporation via the Ntaria Health Service. Child health checks and immunisations are provided through Lukura Women's Space which also houses the Ntaria ANFPP. In 2022-23 Congress NDIS Remote Community Connectors made ten visits to Ntaria.

The NT Department of Education runs the Ntaria School which offers education from pre-school to secondary level but is classed as a Limited Program school in recognition that the secondary curriculum on offer is incomplete. Secondary school age children are eligible for ABSTUDY and Youth Allowance to continue their education elsewhere. Pupils at Ntaria School have access to food through the School Nutrition Program. In Ntaria this is delivered by the Tjuwanpa Outstation Resource Centre. The Centre also provides transportation for children to travel from the outstations to school in Ntaria.

Ntaria School auspices the Ntaria Preschool program which is delivered by a trained early childhood teacher. Ntaria School also hosts the FaFT program in a building adjacent to the preschool.

MRRC operates an Early Childhood Learning Centre in Ntaria through its MacKids division offering centre-based long day care. The centre is subsidised through a CCCF-R grant but nominally operates on a fee for service basis. As a former BBF service the Centre is out of scope for NQS accreditation and is regulated under Minister's Rules. Ntaria has a high proportion of working and non-working families registered with Centrelink, and the centre receives CCS funding from these families. Families not registered for CCS may still attend but are charged the full fee amount. Both CCS families and non-CCS families accrue a nominal debt, which in practice is waived, and then recorded as a loss by Council. MacKids operate using a 'two-educator' rule – usually the full-time Centre coordinator and another casual educator- meaning that centres must have at least two educators in attendance to open. When a second educator cannot be found, the centre remains closed, impacting on working families.

MacKids partner with Ntaria School to offer flexibility for families to access FaFT at the pre-school and then spend the rest of the day at the ECLC. Once children turn three and a half are eligible for free preschool, they tend to transition to the preschool full-time.

Since 2013 Ntaria has been the recipient of a Stronger Communities for Children (SCfC) grant funded through the NIAA. SCfC is a place-based initiative to support the wellbeing, safety, and development of children in remote Indigenous communities. Activities are focused on keeping older children engaged in education through sport and pathways to vocational training and employment. Decision-making and control over how the funds are invested is devolved to local community-controlled organisations with implementation support from NintiOne. Wanta Aboriginal Corporation is the facilitating partner in Ntaria.

DSS funds Waltja Tjutangku Palyapayi a community-controlled organisation run by Aboriginal women, to deliver intensive family support services (CaFIS) in Ntaria and surrounding outstations.

Wallace Rockhole

Congress also services the smaller Western Aranda community of Wallace Rockhole 30 minutes' drive south-east of Ntaria. At the 2021 Census the population of Wallace Rockhole was 87, all but five of whom were Aboriginal, making up a total of 22 households. The NT Department of Education operates the Wallace Rockhole School. In 2021, 21 pupils were enrolled at the census date. There is no preschool program and no other early learning programs are locally available.

Kaltukatjara

Also known as Docker River, the community of Kaltukatjara lies seven hours west of Mparntwe 7km from the Western Australian border. Three quarters of the almost 400 permanent residents of the community and its outstations identify as Aboriginal, with Pitjantjatjara the main language spoken. At the 2021 Census, the population included 35 children under nine, of which 20 were under four. Three children were reported as enrolled in preschool.

Primary and secondary education in Kaltukatjara is delivered by the independent Nyangatjatjara College established by the Anangu Nyangatjara Aboriginal Corporation in 1997. The College is a member of the Association of Independent Schools in the NT (AISNT) and provides secondary education in the across the Anangu communities of Imanpa, Yulara and Mutitjulu. Docker River Primary has two classes: Transition to Year 2 and Years 3 to 6. It is classed as a Limited Program school. The NPY Women's Council has oversight of local School Nutrition Program funding.

MacKids operates an Early Childhood Learning Centre in Kaltukatjara. As at other remote sites in the region, the Centre was compelled to close in 2022 due to staffing issues but has recently reopened. The Centre itself is comprised of three repurposed 'dongas' with a single toilet.

Congress has managed the Kaltukatjara clinic since mid-2023 under an agreement with the Northern Territory Government. Services include child health checks and immunisations. NT Government allied health professionals and specialists visit Kaltukatjara semi-regularly.

The Commonwealth Department of Social Services funds two agencies, the NPY Women's Council and Waltja Tjutangku Palyapayi, to provide CaFIS in Kaltukatjara and surrounding outstations.

Amoonguna

The community of Amoonguna or Amengkwerne is located 20 km south-east from Mparntwe off the Ross Highway and has a population of between 200 and 250 people. At the 2021 Census, 10 percent of residents were aged 0 to 4. Most people speak Central or Eastern Arrernte, though a third speak English at home. Two-thirds of households do not own a registered motor vehicle and rely on private taxis to access services located in town.

Congress works with the local community to deliver primary healthcare through the Amoonguna Health Service and provides patient transport to and from the clinic. Allied health professionals, including child health nurses visit regularly to conduct child health checks and immunisations. However, service delivery is dependent on staffing with Congress clinics throughout the central region affected by a chronic short

supply of General Practitioners and Remote Area Nurses. In 2022-23 Congress NDIS Remote Community Connectors made five visits to Amoonguna. Amoonguna falls within the area serviced by Congress' Family Support Service and the ANFPP.

The Amoonguna School run by the NT Department of Education offer primary education from Transition to Grade 6. Older children must travel to town to access secondary schooling. There is no preschool. Amoonguna is serviced by Tangentyere Council but no local playgroup is offered. In recent years Children's Ground has been partnering with families to facilitate early learning programs in the community with children from birth to age 8. Children's Ground has previously partnered with Congress clinical staff to promote child health checks.

Ltyente Apurte

The community of Ltyente Apurte or Santa Teresa is located 85 km southeast of Mparntwe/Alice Springs in the traditional country of the Eastern Arrernte people. Ltyente Apurte has a permanent population of about 600 people of whom more than 90 per cent are Aboriginal. Most households speak either Arrernte or Eastern Arrernte, followed by English, Walpiri and Pitjantjatjara. At the 2021 Census, there were 55 children under 4, all of whom were Aboriginal. Ten children were enrolled in pre-school, and 99 in the local primary school.

From the 1950s Ltyente Apurte was the site of a Catholic Mission run by the Order of the Sacred Heart. Administration was handed over to the local community in 1976, though over 80 per cent of residents still identify as Catholic and the local school is operated by Catholic Education NT. FaFT is not currently offered. Ltyente Apurte Catholic School nominally offers educational programming from preschool to Year 12 but like other remote schools in the region, is classed as offering a Limited Program from Years 7 to 12. Catholic Education NT also delivers the NIAA-funded School Nutrition Program which provides meals and transport for pupils to attend.

MRRC operates an Early Childhood Learning Centre in Ltyente Apurte in a built-for-purpose facility. The Centre had been closed for much of 2023 due to staff shortages but reopened in early 2024. MacKids have recently partnered with a small local social community organisation, Blakdoll to offer a 'mums and bubs' playgroup onsite.

Congress delivers primary health services in Ltyente Apurte in partnership with the Mpwelarre Health Aboriginal Corporation. Services available at the Mpwelarre Health Service include child heath checks and immunisations. However, provision is dependent on the retention of skilled health professionals. At the time of writing, Mpwelarre Health Service had multiple vacancies for remote area nurses and allied health practitioners. In 2022-23 Congress NDIS Remote Community Connectors visited ten times.

Ltyente Apurte is also a recipient of SCfC funding. The local facilitating partner is the Atyenhenge-Atherre Aboriginal Corporation (AAAC). AAAC also receives funding from the NIAA via the Alternative Educational Engagement Program which aims to encourage school attendance and pathways to vocational training and employment. AAAC oversees Santa Teresa Enterprises, a community development initiative that supports local industry and employment.

Catholic Care NT was formerly funded by DSS to deliver IFSS, but the contract for CaFIS has since been taken over by Waltja Tjutangku Palyapayi.

Titjikala

The land on which the community of Titjikala exists was formerly part of the Maryvale Pastoral Lease southeast of Mparntwe/Alice Springs. When pastoralists seized the land in the 1940s, the traditional owners were permitted to live at Maryvale where they received rations in return for their labour. Today, Titjikala has about 200 residents over 95 per cent of whom are Aboriginal. The principal languages spoken at home are Yankunytjatjara and Pitjantjatjara.

MRRC operates an Early Childhood Learning Centre in Titjikala. The NT Government operates the Titjikala School which also offers a preschool program led by an Assistant Teacher. At the 2021 Census the school had 35 enrolments. FaFT was previously provided by a mobile team but is not currently offered.[87]

The Titjikala Clinic is operated by the NT Department of Health.

Waltja Tjutangku Palyapayi is funded by DSS to provide CaFIS in Titjikala.

The community store is operated by Outback Stores, a Commonwealth-owned not-for-profit which operates 54 remote stores across the continent including 34 in the NT. Stores are expected to be commercially self-sufficient, with profits reinvested in the community, although many stores consistently operate at a loss. Nonetheless Outback Stores have been criticised for price gouging with some staples costing more than twice as much in its remote stores as in urban supermarkets.[88]

Apatula

The community of Apatula grew out of the workers' camp established at the Finke siding in the 1920s to maintain the old Ghan railway line linking Adelaide to Darwin. From the 1930s to the 1950s the population of Finke grew as the railway became critical to the local pastoral industry. Once the railway was moved westwards in the 1970s many non-Aboriginal people moved away.

Today Apatula is home to about 200 permanent residents with Yankunytjatjara the principal language spoken, followed by Pitjantjatjara, Arrernte and Luritja.

The NT Government operates both the Finke Health Centre and the Finke School. There is no preschool program or FaFT. MRRC operates a busy Early Childhood Learning Centre, which works closely with the local health service to improve access to clinical services and health checks, and also delivers the local School Nutrition Program.

Apatula is close to the north-eastern boundary of the traditional Anangu territories and the NPY Women's Council plays a prominent role in local community service provision. The Council is funded by DSS to deliver CaFIS in Apatula, as well to provide disability advocacy services and specialist support for families of young children with developmental concerns under the Early Childhood Outreach Initiative.

The Finke Community Store is owned by the community, trading as Apatula Aboriginal Corporation.

Imanpa

The community of Imanpa is located 270 km south-west of Mparntwe and is home to over 120 people. Most Aboriginal residents speak Pitjantjatjara, although Arrernte, Luritja, Warlpiri and Yankunyjatjara are also spoken. Imanpa was established at the site of a camp known as Mt Ebeneezer following the

expulsion of Pitjantjatjara families Angas Downs Station in the wake of the 1965 Equal Wages decision which required station owners to pay wages to their Aboriginal stockmen.

The first school was opened at Imanpa in the 1970s. The NT Department of Education runs the present Imanpa School which offers primary education from Transition to Grade 6. At the 2021 Census there were 22 children enrolled. Secondary education is provided by Nyangatjatjara College at their Imanpa campus.[89] There is no preschool program and no MacKids early childhood program in Imanpa, though there is a vacant community centre which could feasibly house an ICFC.

Congress took over management of the Imanpa Health Clinic in mid-2023 as part of an agreement with the NT Government. NT Government health and allied health professionals make scheduled visits. In early 2024 visits included optometry, audiology and podiatry.

MRRC delivers the local School Nutrition Program in Imanpa as well as in the neighbouring community of Areyonga. The NPY Women's Council receives funding from the NIAA to provide additional support for school attendance under the RSAS.

Both the NPY Women's Council and Waltja Tjutangku Palyapayi are funded to deliver CaFIS.

Areyonga

The community of Areyonga, or Utju, is situated 220km west of Mparntwe. Both Areyonga and nearby Haast's Bluff were established as rations outposts of the Hermannsburg Mission after a series of droughts in the 1920s and thirties drove Pitjantjatjara people east.

Ninety percent of the 236 residents registered at the 2021 Census were Aboriginal. Eighty per cent of residents speak Pitjantjatjara, though Western Aranda and Arrernte are also spoken, reflecting close relationship with families in Ntaria.

Lutheran Missionaries opened the first school at Areyonga in 1950. Today the NT Department of Education runs the Areyonga School which offers primary education from Transition to Grade 6. At the 2021 Census 37 children were enrolled. Areyonga School hosts one of the longest-running bilingual education programs on the continent.[90]

There is no preschool program. MRRC MacKids division operates an Early Childhood Learning Centre in Areyonga for preschool aged children reopened in April 2024. FaFT was previously delivered in Areyonga by a mobile team but is not currently offered.[91]

Congress delivers primary health care in partnership with the Utju Health Service Board. Services available include child health checks and immunisations, with NT Government allied health professionals and specialists making scheduled visits. In early 2024 health visitors included Ophthalmology, Optometry, Audiology, and a Paediatrician. In 2022-23 Congress NDIS Remote Community Connectors made 11 visits to Areyonga.

Waltja Tjutangku Palyapayi are funded by DSS to deliver CaFIS in Areyonga.

Mutitjulu

The community of Mutitjulu is located at the eastern end of Uluru. Though the rock itself has long been an important site for Anangu people, a permanent community was only established at Mutitjulu in the 1970s when tourism to Uluru opened up. Before the development of Yulara, Mutitjulu was the central service hub, with Pitjantjara people from Kaltukatjara and Areyonga relocating there to take up

opportunities created by the tourist industry. However, the first school was only established in 1984, the year before management of Uluru was formally returned to Anangu hands.

At the 2021 Census over 80 per cent of the 296 permanent residents were Aboriginal, with Pitjantjara the main language spoken at home (67 per cent), followed by English, Walpiri, Arrernte and Luritja. Of the thirty or so children under school age, four were reported to be enrolled in preschool, with 17 out of 41 children aged 5 to 14 enrolled in primary school.

Unlike those communities closer to Mparntwe, Mutitjulu has an accredited ECEC, the Mutitjulu Itiku Munu Tjitjiku Ngura Childcare Centre. The Centre is operated by Australian Regional and Remote Community Services (ARRCS), a division of UnitingCare which provides services across the Territory, primarily aged care, but also a school nutrition program in Mparntwe/Alice Springs. The Centre caters to a mix of Aboriginal and non-Aboriginal families and delivers an 'emergent curriculum' delivered in Pitjantjara and English and based on the principles of 'two-way' or 'malparara' learning.

The NT Government operates Mutitjulu School which offers a primary curriculum to Grade 6. At the 2021 Census the school had 37 enrolments. Secondary education is offered by Nyangatjatjara College at their Mutitjulu Campus, which is located 20km away outside the resort town of Yulara.

The School Nutrition Program is delivered by the NPY Women's Council who are also funded by DSS to provide CaFIS and Early Intervention Outreach services.

Congress operates the Mutitjulu Health Service in partnership with the Mutitjulu Health Service Board. The clinic offers immunisations and child health checks. Visits by clinical and allied health practitioners in early 2024 included Hearing Australia, ophthalmology, obstetrics, and gynecology. In 2022-23 Congress NDIS Remote Community Connectors made four visits to Mutitjulu.

Yulara

The resort town of Yulara was developed to service the tourist industry around Uluru. Management of the town was handed back to the Anangu traditional owners in 1992 and now falls under the remit of the Central Land Council. The demographics of Yulara are starkly different to other very remote communities due to the dependence of tourism on migrant workers. At the 2021 Census only 20 per cent of Yulara's over 853 residents identified as Aboriginal. Over 60 per cent of the town's population speak English only at home, followed by Nepali, Filipino, Tagalog, Spanish and Vietnamese.

Yulara has a privately operated accredited ECEC provider, the Yulara Child Care Centre. Historically the centre catered to the families of the town's non-Aboriginal professionals and service workers, but since the establishment of the National Indigenous Training Academy (NITA), a Registered Training Organisation operated by the Indigenous Land Corporation that manages the resort, the number of Aboriginal people employed in tourism has increased. The Centre is also used by families from the neighbouring community of Mutitjulu. Although the Academy does not offer qualifications in early childhood, NITA has also served as a pathway for graduates to take up roles in childcare. In 2020 some 40 per cent of Centre staff were Aboriginal.

Like other accredited centres, Yulara Child Care Centre is funded through the Child Care Subsidy and parental fees. Since 2018 the Centre has also received multiple grants through the Community Child Care Fund to the value of $728K to support attendance by children classed as vulnerable and disadvantaged.

The NT Government operates Yulara's only school which nominally offers education from preschool through to Year 12, although most secondary school age children are enrolled in School of the Air or leave to attend boarding schools. At the 2021 Census, 35 children were enrolled at Yulara School.

Congress operates the Yulara Medical Centre which provides primary healthcare and allied health services to both Aboriginal residents and non-Aboriginal residents and visitors to the Ayers Rock Resort. Immunisations and child health checks are available.

Ikuntji

Also known as Haasts Bluff, Ikuntji is located 250km west of Mparntwe/Alice Springs and is home to some 150 residents. Luritja-Pintupi the main language spoken at home, followed by Pitjantjatjara and Walpiri. The community was established by the Lutheran Mission in 1946 as a ration outpost of Ntaria.

The NT Government operates the Ikuntji Health Centre and the Haasts Bluff School which includes a preschool program but does not offer FaFT. At the last Census in 2021 the school had a total of 15 enrolments. MRRC reopened their Early Childhood Learning Centre in mid-2024 after a lengthy closure. The Council are also funded by the NIAA to deliver the local School Nutrition Program

Waltja Tjutangku Palyapayi, is funded by DSS to provide CaFIS

The community-controlled organisation the Centre for Appropriate Technology holds a grant of almost $7 million awarded by the NIAA to work with the Luritja-Pintupi communities of Ikuntji, Papunya and Walungurru create social and economic benefits from sustainable development of traditional lands.

Papunya

Also known as Warumpi, the community of Papunya is 240km northwest of Mparntwe/Alice Springs and is home to over 400 people most of whom speak Luritja though Pintupi, Warlpiri and Arrernte are also spoken. Papunya was established as an official settlement in 1959 for the purpose of socialising displaced Luritja and Pintupi people into the European-settler way of life.

By the 1970s Warumpi/Papunya community had grown to over a thousand and during the 1980s was at the centre of the contemporary Western Desert Art movement. However, conflict between family groups led some Pintupi people to move westwards to establish new communities at Walungurru/Kintore and Watiyawanu/Mt Liebig. Art continues to be central to the social and economic life of the community.

Papunya is better served than many communities regarding early learning programs. MRRC operates an ECLC, and the local school offers both preschool and the Families as First Teachers (FaFT) program. The preschool program is currently delivered by a qualified Early Childhood Teacher.

The Northern Territory Department of Health operates both the Papunya Clinic and the Papunya School. At the 2021 Census the school had 106 hundred pupils enrolled.

Waltja Tjutangku Palyapayi, is funded by DSS to provide CaFIS and Papunya Community Store is funded by the NIAA to deliver the local School Nutrition Program.

Watiyawanu

Also known as Mt Liebig and in Anangu, as Amunturrngu, the community of Watiyawanu and its outstations are home to around 250 people. Like the neighbouring communities of Warumpi/Papunya and Ikuntji, most locals are Pintupi-Luritja people who speak the Luritja language. The site of a Bore sunk by pastoralists, the community of Watiyawanu was founded in 1982 as an outstation by Luritja people

keen to leave behind the unrest at Papunya. The Central Desert Store has been owned by the community since 1988 and delivers the local School Nutrition Program.

MRRC operates an ECLC which has recently reopened. Watiyawanu School is run by the Northern Territory Department of Education and had 68 pupils enrolled at the 2021 Census. The school offers a preschool program subject to the availability of staff, and secondary classes up to Year 9.

The Amunturrngu Community Health Centre is operated by the NT Department of Health. As in neighbouring communities, Waltja Tjutangku Palyapayi, is funded by DSS to provide CaFIS

Walungurru

Also known as Kintore, the community of Walungurru lies 530km west of Mparntwe/Alice Springs and has a population of over 400, ninety per cent of whom are Aboriginal, with Luritja, Pintupi and Walpiri the main languages spoken at home. Like Watiyawanu, Walungurru was settled in the 1980s as an outstation of Warumpi/Papunya.

Walungurru School offers classes from Transition to Year 9. It also hosts a preschool program and the Stay Play Learn Program, both delivered by an Assistant Teacher. At the 2021 Census, Walungurru School had 68 enrolments. The ECLC formerly operated by MRRC remains closed due to an ongoing legal dispute following the drowning death of a toddler in December 2020.

Primary healthcare is delivered by Pintupi Homelands Health Service who also provide aged care services under the Commonwealth Support Program. Pintupi Homelands have been awarded a grant by the NIAA to build a multi-purpose community space.

Waltja Tjutangku Palyapayi, is funded by DSS to provide CaFIS.

Atitjere

The community of Atitjere is adjacent to the former mining centre of Harts Range 215km northeast of Mparntwe, now part of the Mount Riddock pastoral lease. Following the discovery of minerals in the late nineteenth century, the traditional owners worked alongside mostly Italian miners in return for rations, and later provided labour for the pastoral industry. Today Atitjere and its outstations are home to about 100 people, most of whom speak Arrernte or Eastern Arrernte.

The NT Government operates both the Atitjere Health Centre and the Harts Range School which offers both preschool and the Stay Play Learn program delivered by an Assistant Teacher. At the 2021 Census the school had a total of 53 enrolments.

Central Desert Regional Council operate the Atitjere Creche as well as after school programs for school-aged children and young people. The local School Nutrition Program is delivered by Rainbow Gateway, a corporate not-for-profit based in Mt Isa which holds multiple Commonwealth contracts for running the Community Development Program in remote communities.

Children's Ground holds a small grant from the NIAA to deliver Stronger Communities for Children in Atitjere in partnership with Ninti-One. Waltja Tjutangku Palyapayi is funded by DSS to provide CaFIS.

The Atitjere Community Store is owned and managed by the community, trading as Atitjere Homelands Store Corporation.

3 Realising integration in a remote community setting

3.1 A flexible model for integrated support

This section proposes a model for integrating early years supports in a very remote community context. The model brings together the evidence synthesised in the sections above with the available evidence on the enablers of effective service delivery in very remote communities and is designed to be flexible with scope to adapt delivery to community needs and preferences.

Though a model designed for implementation in a very remote central desert community may look very different to a Hub in an urban or regional setting, there are foundational core components that all hubs need to be effective. Centres will also need to reflect SNAICC's principles for culturally safe integration.

The model proposed is for what are referred to here as remote **integrated child and family centres** (ICFCs). The emphasis on *integrated* here distinguishes this model from child and family centre models implemented in other states, as well as from the CFCs that already exist across the NT. While the Larapinta CFC in Mparntwe/Alice Springs was found to have embedded an integrated approach in practice, it was beyond the scope of this paper to conduct extensive consultations to evaluate how integration is working across Territory CFCs as a whole.

The small scale of delivery, combined with substantial distances and chronic workforce issues across the region also present unique implementation challenges. This section identifies the core supports remote Hubs will need and draws on the available literature to considers how some of these implementation challenges may be addressed.

The role of integrated child and family centres in very remote communities

The primary aim of establishing ICFCs in remote communities is to improve children's access to the core services that will help them reach their full developmental potential. While they may exist in some form, current levels of provision are too piecemeal and uneven, to make a difference to children's developmental trajectories. What is needed is for these supports to be consistently and readily available to all families, and of sufficient quality, that when delivered sequentially, as needed, they have a measurable impact on children's outcomes.

Integrated hubs represent the **evolution of social infrastructure** for this century. Whereas in the twentieth century governments built schools, clinics, and welfare offices in communities, governments are belatedly recognising the need for comprehensive early childhood supports. ICFCs, each offering a suite of services under one roof, are a necessary policy innovation.

It is important to recognise that **some degree of coordination** between services already happens **organically** in many remote communities. The scale of provision, catering to a population of a few hundred and with a handful of known to each other by sight, lends itself to relational ways of working, whether funded or not and during consultations we heard many examples of local providers working together on behalf of children and families. The point of an integrated model is to create formal structures to make collaboration a core part of what services are contractually obliged to deliver on.

Core components of ICFCs

Although hubs across Australia occur across a range of settings (primary schools, ACCOs, primary health services, community service providers) researchers at CCCH identify a number of foundational core components common to all successful ICFCs:[92]

- Quality early childhood care and education
- A range of health and social supports
- Parenting support
- Being a natural place to go for families
- Mapped referral pathways
- Wellbeing coordinator or navigator
- Focus on the social determinants of health
- Culture and self-determination (hubs that serve First Nations communities)[93]

These components are integral to the identity and purpose of integrated child and family centres. In addition, many ICFCs have a particular emphasis that reflects the mission of their parent agency: ICFCs nestled within ACCHS may have access to a greater range of primary and allied health supports, while centres co-located with primary schools may focus on educational enrichment. Depending on how they are commissioned, centres in very remote NT communities may be operated by government or by the local community via an ACCHS or ACCO as happens in other jurisdictions.

Integrated child and family centres already operate in several remote towns and communities across northern Queensland and WA. The WA Department of Education operates Child and Parent Centres in the state's remote north-west in partnership with local ACCOs and ACCHS, with backbone support from local schools.[94] The centre in Halls Creek is operated by the Wunan Foundation, and the Baya Gawiy centre in Fitzroy Crossing by Marninwarnikura Women's Resource Centre. Queensland's Early Years' Places[95] are also funded by the state Department of Education and operated by local ACCOs in Doomadgee/Dumadjii, Mornington Island and at four sites on the Cape York Peninsula. These centres typically offer 'Mums and Bubs' playgroups and some form of pre-school readiness program, parent support groups and a range of visiting clinical and allied health services delivered in partnership with a local health centre or ACCHS.

3.2 What should remote integrated centres look like?

In addition to the **capital costs** required to build, or repurpose an existing building, the available evidence suggests that ICFCs should receive both **core funding** for core services and to support integration ('the glue'), in addition to **flexible funding** to be used for brokerage, community engagement and capacity building. Where communities are within a few hours' drive one another (approximately 100 to 300km), it may be feasible for centres to pool both types of funding to purchase shared resources.

Figure 2 below indicates how this might work in practice: it shows **four of the five** key early childhood supports as core block-funded services, but with the centre linked to external service infrastructure (schools, clinics) and universal visiting specialists and targeted programs. It is proposed that block funding be administered by the Commonwealth Department of Education.

Physical Infrastructure

ICFCs can and have been established in a range of physical settings. In Tasmania, where Child and Family Learning Centres are run centrally by the Tasmanian Department of Education, centres are primarily purpose built adjacent to primary schools. In other states, where the fragmented nature of funding arrangements means that centres are hosted by a mixture of community health and community service providers and local councils, ICFCs operate from both repurposed and new-built premises.

There are a variety of potential options for housing ICFCs in remote NT communities. In communities where MRRC already operate ECLCs it may be possible to extend existing facilities, while in others there are vacant buildings (including some built by the Commonwealth to house ACFS more than a decade ago), that could be refitted as integrated centres. In others it may be more desirable and cost-effective to build new infrastructure to reflect the specific needs of that community. Whatever is decided, it is important sites be viewed as neutral, and **not as traditionally belonging to any particular clan or skin group**, so that all members of the community can use it.

Whether located in newly built or refitted buildings, research stresses that ICFCs work most effectively when they function **both as formal service front-door** and a **social hub**, becoming a 'natural place' for local families to spend time and socialise.[96] Informal social spaces also create a 'soft entry' point for families who need help but are wary or unsure. In addition to office space and consulting rooms, centres need to create **welcoming informal 'drop in spaces'** with basic facilities (tea and coffee, microwaves to warm baby food), toys and craft activities. When well-used these spaces can be used by practitioners to share information about child health and local opportunities with families.

Research on what works in remote settings emphasise the need for centres to be adapted to local community mores and preferences. One study of children's services in the remote NT found that several communities preferred centres to appear 'open, emphasising visual and physical access to the surrounding community'. This openness enabled members of the local community to call out to children and staff at the centre or drop in spontaneously at morning tea time or to chat through the fence about community business.[97] This may be different from ECEC in urban settings where centres are designed to keep children out of sight and safe from members of the general public.

When created in partnership with the community, the creation of a safe and welcoming drop in space in has tremendous potential to engage families. The range of services and facilities available should also reflect community needs. For example, it may be useful for centres to purchase washing machine and provide showers and toiletries to support good hygiene habits; computers that families can use to manage Centrelink and NDIS admin or to complete further study. Flexible funding may also be used to purchase food and food vouchers, and brokerage for one-off items or supports. Some remote hubs in WA also offer parent education such as free cooking classes to promote good nutrition.

Funding for integration

Integration does not happen without dedicated resourcing for 'the glue' that enables coordinated care and collaboration between services. As in larger urban hubs, ICFCs in remote community setting will need a key **coordinator position to oversee operations and lead integration**, in addition to funding for an **administrative staff membe**r and time-relief for educators and other centre staff to collaborate and participate in professional development.

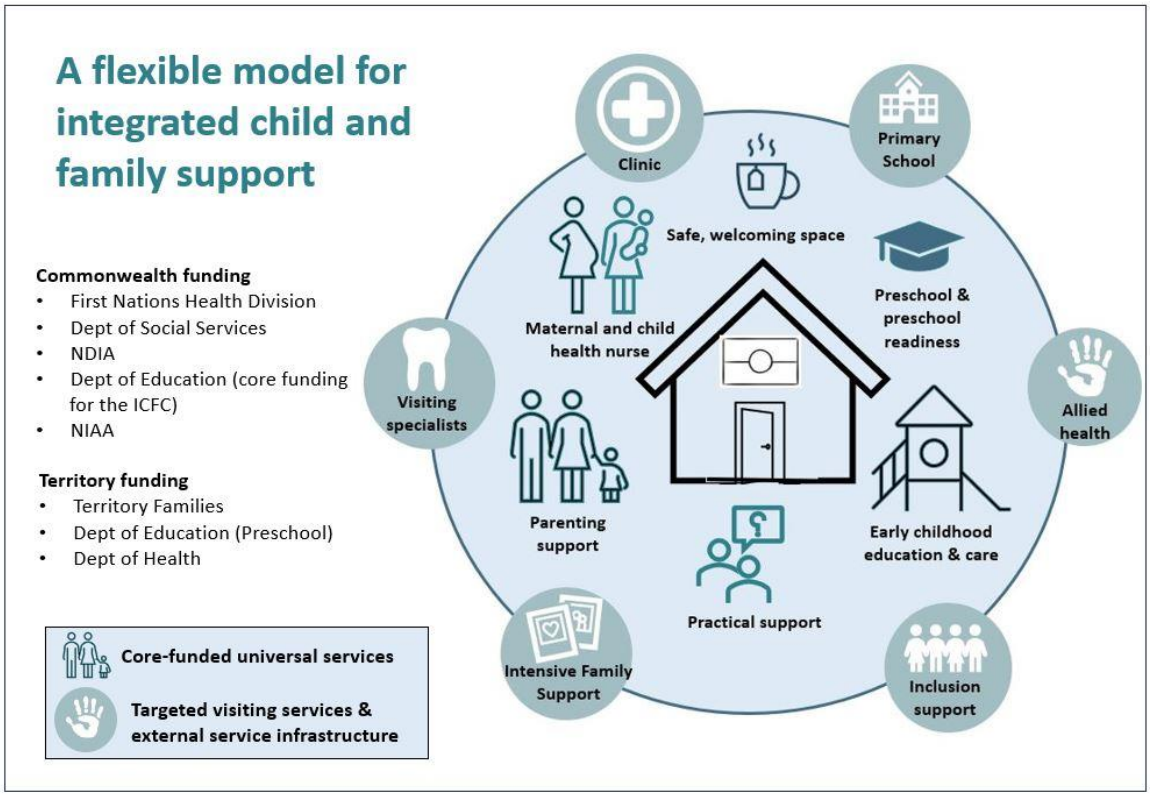


Figure 9: Flexible model for remote integrated child and family centres

Core-funded universal services

It is proposed that the core services funded should align with the five key early years' strategies identified by RSTO as most effective in supporting healthy childhood development.

Antenatal care and nurse home visiting

Access to antenatal care outside of Mparntwe/Alice Springs is currently uneven. Limited antenatal care is available from primary health services, but access is contingent on the availability of visiting clinicians. Given the lack of options for women to give birth on Country, there is an expectation that women will travel to Mparntwe/Alice Springs for specialist appointments. This level of service cannot fully leverage the potential of antenatal care as a 'universal health platform' to address known risk factors associated with poor foetal outcomes.

Sustained nurse home visiting is currently only offered in Ntaria and Ltyente Apurte through Congress' ANFPP, and then only to first-time mothers. This program is well established in the region and has developed a practice model that is valued and accepted by Aboriginal families.

With additional investment and capacity building, there is an opportunity for the Commonwealth to expand the reach of the program throughout the greater central desert region using remote ICFCs as a base to connect with pregnant women and as an alternative setting to the home where appropriate.

Expansion could be operationalised in a variety of ways: ANFPP clinical staff could remain tied to Congress headquarters in Mparntwe/Alice Springs, with Aboriginal engagement staff based at individual remote ICFCs, but moving between communities within a few hours' drive.

Early childhood education and care

The evidence is unanimous that market-based provision of ECEC does not work in remote communities. Only **secure, long-term block funding can deliver the reliable and culturally safe ECEC** that children and families need. Funding for remote ICFCs must therefore include **dedicated core funding for education and care** with the flexibility to adapt the range of programs offered to local preferences.

ECEC in remote communities needs to **reflect local community values, beliefs and preferences** about the proper way to raise children. Although it is sometimes asserted that remote communities do not want or value long-day care, research suggests that **a mix of ECEC options works well**, and the ECLCs operated by MRRC offer long-day care alongside occasional care and formal and informal playgroups where families stay to socialise. Core funding of ECEC also enables greater adaptability to local needs.

In communities where FaFT or Stay Play Learn is offered, local agencies will need to decide whether to continue to run playgroups via schools or ICFCs. Where centres are operated by ACCOs or ACCHS, hosting these programs at the centre may be a more attractive for hard-to-reach families wary or unfamiliar with the local school. Where preschool programs are not currently offered by the NT Department of Education it may be appropriate for ICFCs to also host preschool. There is also a strong case for the Commonwealth to expand its Pre-School Readiness Program to include remote desert communities as preschool attendance is a strong predictor of later school attendance.

The evidence is equally unanimous that the sustainability of ECEC in remote settings is entirely dependent on the development of a remote Aboriginal early years' workforce.[98] Research on community-controlled children's services shows that the presence of Aboriginal educators strengthens cultural safety and encourages families to participate.[99] This is especially true in remote contexts, where educators who are connected to the community play a fundamental role in establishing the trustworthiness of a service, Employing local educators community ensures centres are 'always embedded in the particular values and practices of their local culture', though care must be taken to ensure the mix of staff is representative of all local family groups and skin names.[100]

This presents a difficulty for remote ECEC seeking accreditation under the NQS, since educators are required to hold or at a minimum be 'working towards' Certificate III level qualifications. While Aboriginal and Torres Strait Islander educators hold certificate III level qualifications on parity with their non-Aboriginal peers, though they are less likely to progress to higher level vocational or degree-level qualifications.[101] Barriers to pursuing further study include a lack of culturally appropriate training pathways, cost and for people living in rural and remote areas, the need to relocate away from family and Country. For this reason, SNAICC has called for ACCO-controlled services to be subject to a distinct quality framework which recognises the value of culture and traditional child-rearing practices. Evidence on workforce retention and development in remote settings are discussed further below.

Parenting programs

Despite strong evidence that universal prevention an early intervention are more cost effective in the longer term, most expenditure on family support in the NT continues to be focused on targeted and intensive interventions focused on keeping children out of statutory care. DSS only funds intensive family support in the central desert region, while Territory Families only offers early-intervention programs in Mparntwe/Alice Springs. As a result, there is a significant gap in the provision of parenting support

The recent implementation of a culturally adapted version of the Triple P Positive Parenting Program in a remote WA community demonstrates both the effectiveness of this intervention in a remote context and the feasibility of delivering the program in remote communities across the Territory.[102] The effectiveness of Triple P in reducing the risk of abuse and neglect and strengthening protective factors has been demonstrated in a range of contexts, both in Australia and internationally and is one of nine parenting programs that meet RSTO quality indicators.[103] Triple P can be delivered in a variety of formats and levels of intensity, from level 1, which is suitable as a universal parenting intervention, up to level 5, which provides intensive support for families with complex needs. It can therefore be delivered both as a form of early intervention and as a targeted program.[104] Triple P is already delivered as a parenting program in ICFCs in WA, Queensland and Victoria and since 2021 the Commonwealth Department of Health and Aged Care has made it available to all Australian parents and carers via a free online course. However Triple P remains largely inaccessible to families in remote parts of the NT.

In 2019 the Marninwarntikura Women's Resource Centre (MWRC) initiated a trial of Triple P in the Fitzroy Valley in response to the the high incidence of FASD and other behavioural issues. MWRC developed a culturally adapted version of Triple P via community consultation called Jandu Yari U ('For All Families' in Bunuba) which was offered to all local families with children under 16 via the Baya Gawiy Child and Parent Centre in Fitzroy Crossing and local schools.

A mixed-methods evaluation of Jandu Yari U conducted by the University of Sydney found significant reductions in unhelpful parenting strategies, carer anxiety and challenging child behaviours and significant increases in parenting confidence and prosocial child behaviour which were sustained at follow up (8 month post completion).[105] The evaluation makes clear that community leadership and control of the project was fundamental its acceptance as culturally appropriate. Not only were Triple P materials adapted and translated into local languages, but MWRC recruited and trained 38 accredited parent coaches (24 of whom were Aboriginal) from local ACCOs and schools who then provided practical support to families during and after the program.

The success of Jandu Yari U in Fitzroy Valley demonstrates the feasibility of adapting Triple P for use in remote NT communities for delivery via ICFCs. While Fitzroy Crossing is more densely populated, there is considerable overlap in terms of the effects of intergenerational trauma and the incidence of FAS-related behavioural issues. A culturally adapted version of Triple P could conceivably complement the more intensive family support provided via CaFIS. Unlike CaFIS, which is based on a case worker working

intensively with a handful of families, Triple P can be delivered face to face to groups by accredited practitioners who undertake an initial three-day training course, and yearly refresher training thereafter.[d]

Early years of primary school

The relationship between primary schools and ICFCs varies across jurisdictions according to the particular funding arrangements in place. In the NT, WA, Queensland, and Tasmania centres are centrally funded through Education and generally collocated with schools, while in NSW child and family centres are funded via the Department of Health. Building centres near schools aims to make access easier and establish a clear relationship between early learning and later academic success. Thus, the WA Department of Education website states that co-location 'gives schools the opportunity to work with families from the time children are born, through to starting school and beyond'.[106]

Regardless of where they are located or how they are funded, **ICFCs support children's transition and engagement in the early years of primary school by enabling and promoting participation in quality ECEC and preschool**. In the NT, participation in ECEC and preschool is a strong predictor of Aboriginal children's readiness for school and subsequent attendance.[107] Establishing links between local schools and ACCO-run ICFCs in remote NT communities therefore has the potential to strengthen families' connection to education by enabling teachers to establish a continuous relationship with families from their children's infancy through to school age.[108] Because they are already established in communities, schools also offer **a ready-made administrative backbone** as well as a convenient site through which the governments can provide practical support to ICFCs, as happens in remote communities in WA.

On the other hand, there is a risk that a strong association between ICFCs and schools may discourage some families from accessing centres. Qualitative research on remote school attendance highlights the complexity of reasons why families choose to disengage from mainstream education.[109] Families who feel ambivalent about school or have made an active choice to prioritise traditional learning and ways of knowing may be inclined to avoid early learning activities perceived as culturally inappropriate, while families who are fearful of child protection involvement may stay away if a centre is identified with the Territory Government.[110] Families who have had negative interactions with RSAS workers may also worry that they will be shamed for not sending older children to school.[111] For these reasons it is advisable for operation of ICFCs to be led by ACCOs or ACCHS.

Flexible funding for visiting and targeted services

There is also potential for ICFCs to facilitate coordination with external agencies and specialist services. ICFCs in other jurisdictions typically host visiting services and link families to specialist and targeted services via established referral pathways. Some of these services will be publicly funded, while others may need to be purchased by the ICFC on behalf of families.

Primary health services

Primary health care in the remote central region is provided by a mix of ACCHS and NT Government clinics. Whether or not ICFCs are operated by ACCHS, there is **scope for centres to work with health providers to improve child health outcomes**, both directly by physically facilitating child health checks and follow-up with clinicians and **supporting families to navigate the system**, and indirectly, by

[d] Triple P was developed by the University of Queensland. Individual Triple P training and accreditation costs $1,855 AUD but is free for practitioners working in Queensland. See https://triplep.net

developing the health literacy of families and staff around the prevention and treatment of common skin infections, anaemia, otitis media and rheumatic heart disease.

Where clinics do not have the capability to do so, **flexible ICFC fundin**g could also be used to train local para-professional health workers to **administer the ASQ-TRAK screening tool** and liaise with ICFC staff to coordinate referrals to specialists and facilitate access to NDIS Early Intervention (EI) services.

Visiting health and allied health specialists

ICFCs also offer a means of improving children's access to specialist health and allied health services. A broad range of NT Health specialists currently visit remote communities, including **paediatricians, audiologists** (Hearing Australia), **optometry and ophthalmology, ear nose and throat, oral health, and dietitians**, and it would be logical for some or all of these services to be hosted by ICFCs. Aboriginal ICFC staff could also support access by liaising with families ahead of visits, providing transport to and from outstations and accompanying families on the day.

Unfortunately making these services accessible via children's centres will not address the system-level barriers to access across the region. A recent review of children's health services in remote northern WA identified **a host of systemic barriers to the adequate and consistent provision** of specialist health and allied services to children. These included **inadequate supply of health professionals**, the limited capacity, experience, and cultural competency of visiting specialists, combined with **a lack of Aboriginal Health Practitioners (AHPs)** to enable culturally safe care and help families plan around a 'complex and variable' visiting schedule.[112] These system-level issues are also evident in the remote central NT.

The authors conclude that while some issues – long travel distances, high-staff turnover, the complexity of families' lives – may be integral to remote service delivery, others can be remedied by governments working with ACCHSs to develop and implement '**an overarching framework or model for child health and development service delivery'** in remote areas to improve coordination and consistency of care.

Allied health and Inclusion support

It is well established that that early identification of developmental issues followed by targeted early intervention and support is necessary to allow children to reach their developmental potential.[113] Yet even when issues are picked up, access to **developmental assessments** and **early intervention** in the region is severely restricted by a chronic scarcity of qualified allied health professionals.

Provision of allied health early intervention has been identified as **a substantial gap in the early years service system nationally**, with integrated centres offering a practical means of facilitating greater access for the children who need it most.[114] There is an opportunity to improve access to early intervention in the region by making allied health a regular service offering in remote ICFCs.

The NPY Women's Council is funded to provide the NDIS EI Outreach Program south of Mparntwe/Alice Springs, while communities within Congress' service footprint can access support through the NDIS Remote Community Connectors Program. It is also expected that **the expansion of Congress' Child and Youth Assessment and Therapeutic Service** (CYATS) will enable greater access to speech pathology and occupational therapy for communities outside of Mparntwe/Alice Springs.There may also be some scope for CYATS practitioners to train ICFC staff to **deliver basic therapeutic interventions** as therapy assistants, though the ongoing clinical supervision and capacity development will be required to maintain quality.[115] ICFCs could also facilitate access to some therapies via telehealth with Aboriginal staff acting as navigators to provide language support and ensure cultural safety.[116]

While children identified as at risk of developmental delay may be eligible for NDIS access, long processing times and administrative hurdles create barriers to accessing timely support.[117] Flexible ICFC funding could ameliorate the impact of these system-level barriers both by hosting regular 'drop in' clinics and purchasing allied health services, e.g. clinical assessments, from private providers on behalf of individual families. Flexible funding could also be used to purchase **low-cost Assistive Technology**.

There is also an opportunity for the Commonwealth to **expand the remit of the Inclusion Support Program** to support the inclusion of children with disability and developmental delay into preschool and school via ICFCs. At present Early Childhood Australia[118] is funded only to support ECEC within Commonwealth subsidised ECEC services. This would complement the Territory Government's On Country Learning Measure which funds allied health practitioners to provide capacity building supports for educators in remote schools.[119]

Intensive Family Support Services

While ICFCs should offer all families regular opportunities to participate in **evidence-based parenting programs** such as a culturally adapted version of Triple P, centres may refer families experiencing complex challenges to DSS-funded **intensive family support services**.

Staffing requirements for ICFCS

Remote conditions dictate that the staffing model for ICFCs will need to be lean, with an emphasis on leveraging the expertise that already exists in place and building the capability of local Aboriginal staff to lead the delivery of ECEC, health promotion and parenting programs. Core positions will nonetheless be required to keep centres open and operational.

All integrated centres require the leadership of a **Centre Coordinator** who fulfils the conventional duties of a manager in addition to driving the integration of services and programs. It is the role of the coordinator to develop and maintain relationships with local and visiting practitioners and local community stakeholders, managing centre staff from the local community and building trust with local families. Coordinators may hold a tertiary qualification in social care or a related discipline or equivalent experience of working in a practice setting, with experience from an integrated or remote setting ideal.

Centres operated by ACCHS might wish to employ **an onsite MCH nurse** or **ANFPP practitioner**, or an **Aboriginal Health Practitioner** trained in child health, possibly shared with a local health service. There may also be scope for ICFCs within a few hours' drive of one another to share healthcare workers, while CYATS team members and other allied health practitioners could operate from town. Both forms of work require a degree of mobility and flexibility incompatible with typical patterns of family life and/or caring responsibilities and would need to be adequately remunerated to be competitive.

Lack of both suitable overnight accommodation and housing for remote service workers has also been identified as a barrier to retaining qualified staff.[120] It is therefore recommended that capital and core funding for ICFCs include the cost of building and maintaining suitable housing for the Centre Coordinator as well as short-term accommodation for visiting specialists.

To be sustainable remote centres will ultimately **rely on the employment of local Aboriginal women** as educators and health and social wellbeing practitioners. This means that local staff will need to **lead planning and delivery of ECEC, as well as parent support and health promotion** and education activities. This is not primarily because of the nature of remote labour markets, but because supports will be most effective when they are **designed and delivered, in language**, by people who are known and trusted.

Investment in local workforce development will be essential. Local people will need to be offered real opportunities to undertake on-the-job training as educators, therapy assistants and parent coaches, with support and funding available to progress to formal qualification if desired. The ultimate goal of is to build local capability to the point where communities can run centres for themselves.

The section below reviews what we know about what works to support the retention and professional development of Aboriginal practitioners in remote communities and considers the lessons for the implementation of remote ICFCs.

3.3 Enablers of effective and sustainable implementation

This section draws on the evidence base on health and well-being interventions in remote communities to highlight key lessons to guide implementation of ICFCs.

Collaborative governance is essential to authorise integration

Successful implementation of ICFCs in remote communities will require **a transformation of the way in which early years' services are funded and delivered**. If governments are serious about closing the gap in developmental outcomes they will need to break out of the 'business as usual' mindset that holds the current fragmented, broken and ultimately ineffective, child and family service system in place

Collaborative governance brings 'brings public and private stakeholders together in collective forums with public agencies to engage in consensus-oriented decision making', often around complex policy problems that no one agency can address singlehandedly.[121] The literature on collaborative government underscores that collaboration requires agencies to be committed to a common purpose which transcends differences in power and resources. Enablers of successful collaboration include face-to-face dialogue, building trust through the demonstration of commitment, and a shared understanding of the nature of the problem to be addressed. Collaboration works best when collaborative forums focus on "small wins" that deepen trust, commitment and generate goodwill.

While governments broadly accept the need for services to be more integrated, most services and programs are still commissioned and funded in ways that reproduce and reinforce a siloed approach to policy development and implementation.[122] Even when governments attempt to address fragmentation through collective impact initiatives, backbone agencies may find themselves working with dozens of providers, each with their own reporting requirements and accountabilities which create practical barriers to cooperation and collaborative service delivery. Collaborative governance on the other hand, has the potential to enable integration by removing obstacles to collaboration and creating incentives for providers to work together to achieve shared outcomes.

A suitable collaborative platform to improve outcomes for Aboriginal and Torres Strait Islander children and families in the NT already exists: the **NT Children and Families Tripartite Forum**. While early childhood is not prioritised under the Forum's '10 Year Generational Strategy[123], there is a strong case for a dedicated effort to close the gap in developmental outcomes for Aboriginal children living in remote parts of the NT. As it stands, **the Strategy commits governments to ensure Aboriginal children living in the NT have 'developmental equality' but does not specify measures to achieve it.**

This paper has sought to address this gap by setting out the policy case for reforms to increase access to the fundamental early years services that we know underpin healthy development. Between them the

members of the Tripartite Forum already have the power to authorise their respective Commonwealth and Territory agencies to work together to integrate remote early years' services.

Potential levers for change could include arrangements for agencies to pool funding to block fund ICFCs and commissioning core early childhood supports with both community control with long-term sustainability and workforce development in mind.

Recommendations

1. Leverage existing mechanisms for collaborative governance, E.g. the Children and Families Tripartite Forum, to enable shared decision-making and investment.
2. Block fund remote Aboriginal community-controlled child and family centres to deliver core services that meet minimum evidence-based indicators for effectiveness.
3. Include dedicated funding for 'the glue' that enables integration to work in practice.

Community empowerment underpins effective implementation

Evidence for the effectiveness of community-controlled interventions

The lived everyday experience of colonialism in central Australia means that top-down policy approaches which aim to 'fix' inequalities in remote communities, whether through compulsion or browbeating people into using services, are destined to fail. Moreover, conventional technocratic approaches to policy implementation are entirely at odds with the evidence indicating that policy approaches which foreground remote communities' control and ownership of interventions tend to be more successful.[124]

Community development and social work literature make a distinction between policies and programs that 'do things *to* or *for*' people as opposed to '*with* them': the former assumes little agency or competence on the part of service users and risks reinforcing people's sense of their own powerlessness, while the latter seeks to grow their sense of agency and competence.[125] Programs which start by recognising people's innate strengths and the value of their lived experience are also able to harness their intrinsic motivation for themselves and their family and community to thrive.[126]

Fortunately, the National Agreement on Closing the Gap is helping drive a shift towards community control. This is evident in the recommissioning of intensive family support services, the commissioning of ACCO-run CFCs and the progressive handover of remote clinics to ACCHS, as well as Commonwealth initiatives such as Empowered Communities in the NPY Lands[127] and the Barkly Regional Deal[128], both of which place community control at the centre of community development efforts.

There is a wealth of research underscoring the need for initiatives related to the wellbeing of children to be led by local Aboriginal people.[129] Not just because Aboriginal leadership is essential for building trust with families – although community control is consistently found to increase both participation and retention – but because when Aboriginal people are empowered to lead codesign and implementation, the interventions they lead are more effective.[130] Community-leadership and control is instrumental even when the effectiveness of programs has already been demonstrated by a strong evidence base. Prior to the successful adaptation of Triple P in the Fitzroy Valley, attempts to test the cultural appropriateness of Triple P with Aboriginal parents were confounded by the high attrition rate of participants (30 to 80 per cent). In one case, was in spite of a deliberate attempt to tailor materials to be culturally acceptable to an Indigenous audience,[131] while in another the program was subsequently deemed a poor 'cultural fit'.[132] Compare this to the one hundred per cent completion rate achieved by Jandu Yari U.[133]

Community leadership and control of ICFCs

There is a strong case for ICFCs to be operated by ACCOs or ACCHS with support from local schools and health services. However, for remote ICFCs to be valued and accepted by families it will be vital for communities to feel they have **ownership and control of centres** and the supports they provide. Implementation will therefore require **real opportunities for community members to participate in consultation and co-design**, as well as involvement in **ongoing governance and day-to-day decision making** about centre operations.

There are a range of models for community governance of children's services: in Yuendumu the Yurrampi CFC is operated by Yuendumu school but is accountable to the Marlpa Jungu Jintangka (Early Childhood Reference Group) made up of female elders who fulfil the role of 'kurdungurlu' (guardians in Walpiri) ensuring that services and programs actively uphold the value of Walpiri learning.[134] The Baya Gawiy Child and Parent Centre in the Fitzroy Valley is operated by the Marninwarntikura ('big mob of women coming together') Women's Resource Centre and forms one pillar of a suite of community-led initiatives countering the impact of FASD on children's development.[135]

As well as creating formal mechanisms for communities to hold government agencies and providers to account, community governance bodies create a means for ICFCs to **tailor services and program content to community needs and preferences**. Community leadership is also critical to ensure that ECEC and preschool programming, and initiatives which promote school attendance, reflect, and are perceived as reflecting, community perspectives and aspirations around education to avoid deterring families who may initially be sceptical about the value of 'western' schooling.[136]

A recent review of health and social care interventions for Aboriginal children by D'Aprano et al. identified a number of **key practice features that were found to enable effective implementation**, and which may help to guide implementation of remote ICFCs:

- Regular collection and auditing of project information and service data
- Ongoing review, reflection, and adaptation of diverse stakeholder views
- Aboriginal leadership, codesign and participation throughout
- Project governance and advisory groups
- Holistic relationships across organisations, practitioners, and families
- Codesigned and relevant project tools
- Cross-organisational partnerships and collaboration
- Resourcing to support local implementation (staffing)
- Capacity building, training, and mentoring tailored to local context and needs.[137]

Recommendations

4. Provide flexible funding to enable ICFCs to tailor services, programs and facilities to local community needs and purchase supports for families where appropriate.

5. Facilitate local leadership and strengthen accountability by making community governance arrangements a core deliverable of funding agreements.

Growing local workforce capability is the key to sustainability

The sustainability of remote ICFCs will ultimately hinge on both the retention of qualified practitioners and the development of a local early years' workforce. This section reviews lessons from the available evidence on what works and considers the implications for implementation of remote ICFCs.

Recruitment and retention of qualified professionals

The evidence base is clear that the effectiveness of interventions is heavily dependent on the expertise of qualified health and social care professionals, while research on integrated services suggests that the presence of trained specialists are critical to the effectiveness of hubs.

To be effective in closing the gap in developmental outcomes ICFCs will need to integrate high quality maternal and child health care. However, there is an endemic shortage of clinical and allied health professionals across remote parts of the NT and high rates of staff turnover among remote workers in all sectors. ACCHS delivering primary healthcare in the region have described the current situation as a remote 'workforce crisis'.[138] A 2017 study of staff retention in remote health centres found 'extremely high' turnover among nurses and Aboriginal Health Practitioners, with only 20 per cent of staff remaining at any clinic for more than a year, and half leaving after four months.[139] It also found that remote clinics were heavily dependent on agency staff and were mostly unable to fill Aboriginal practitioner roles locally and that endemic staffing difficulties were leading to **high servicing costs**. These were ultimately unsustainable and almost certainly contributing to **sub-optimal care** and **compromised health outcomes**. Based on these findings the authors recommended that NT Health invest in staffing models to stabilise the remote primary care workforce 'as a matter of priority'.

Reviews of the international literature identify a range of strategies proven to improve retention of remote clinical staff.[140] These include **incentives and support for students** to specialise in remote healthcare, **major policy reforms of remote healthcare** to improve infrastructure and working conditions and attract more local health practitioners, as well as **greater support for remote workers** including **tailored financial incentives**, psychological support, and extended access to paid leave to prevent burn out.[141] There is also evidence of slightly improved retention among Aboriginal health practitioners employed by ACCHS.[142] While remote staffing is likely to remain a perennial challenge, researchers argue that attrition can be partly addressed through these measures. The problem is not lack of knowledge, but '**an implementation gap'** which governments lack the will to close.

Government responses to the remote workforce crisis to date have focused on creating incentives for health professionals to work in remote locations. The Commonwealth's Bonded Medical Program provides HECS-funded places in healthcare courses in exchange for graduates working in an eligible remote location for three years, despite research suggesting that Return of Service (ROS) type programs do not improve retention in the longer term. The NT Health Strategic Plan 2023-2028 proposes a range of 'workforce solutions' to improve retention of skilled staff and opportunities for Aboriginal people to enter

the healthcare workforce.[143] The Graduate Certificate in Remote Health program offers paid training for early career nursing graduates and the Transition to Remote Practice Program to prepare experienced registered nurses for working in remote settings.[144] NT Health has also devolved operation of remote health services to ACCHS. However, none of these measures are likely to achieve the scale of change required to improve health provision in remote communities.

Remote workforce challenges are probably the single greatest threat to the feasibility and sustainability of remote ICFCs. Nonetheless, a political commitment by Commonwealth and Territory governments to close the gap in developmental outcomes in the region could also be a catalyst for system-wide reform of how remote healthcare and other basic services are funded and operated.

Development of an Aboriginal early years' workforce

Ultimately both the sustainability and the effectiveness of remote ICFCs will depend on the development of a local early years' workforce who can lead planning and delivery of core services.

There are currently **multiple barriers to remote workforce development**, many of them exacerbated by policy decisions made in Canberra and Darwin which have **measurably reduced opportunities for local Aboriginal people to gain employment**. Across the NT employment rates for Aboriginal residents have declined from 42.8 per cent in 2011, to 34.3 per cent in 2021.[145] The Central Land Council (CLC) attribute much of the loss in remote jobs to the abolition of the CDEP as well as the 2008 amalgamation of 53 remote local councils, many controlled by Aboriginal communities, into eight centralised shires. They also point out that NT Government support for industry in the region has been **focused on the mining and pastoral sectors, at the expense of the health, social care, and education** sectors. Changes in the funding model for Vocational Education and Training (VET) have also led to 'a noticeable **decline in the availability, quality, and appropriateness of training opportunities'** in remote areas. Training that requires travel away from home, is delivered in English and based on written assessment, sets remote students up to fail, while decisions to discourage bilingual instruction and limit remote provision of secondary schooling, have further increased barriers to formal education.

Current funding arrangements for remote services also mitigate against retention and development of local Aboriginal practitioners. The systemic issues which drive the attrition of non-Aboriginal health sector workers also impact Aboriginal staff. Documented barriers to the retention of Aboriginal health practitioners included culturally unsafe working environments, heavy workloads and poorly defined roles and responsibilities, low wages and perceptions of salary disparity, and the stress of maintaining appropriate work/life boundaries when working with one's own community.[146] **A lack of culturally appropriate training acts as a further barrier to career progression**.[147] In the remote ECEC sector the shortfall between centre operating costs and the revenue from CCS means that educators are often employed on a casual or fixed-term basis with little opportunity for skill development or role progression. Salaries for educators are so low that those who do manage to gain qualifications often leave the sector to take up better paid teaching roles in local schools.

Conversely employment conditions that are experienced as culturally safe and supportive have been found to support the retention of Aboriginal practitioners.[148] A 2021 study of strategies to support health and wellbeing staff in an ACCHS documented a broad range of effective practices, including **a culture of mutual accountability** with open bi-directional communication between decision-makers and employees, the **embedding of Aboriginal ways of doing things**, guidance from **cultural mentors, and**

regular supervision and feedback, all of which helped build confidence and capability.[149] Recognition emerged as particularly important, with participants citing **feeling valued and trusted** by managers to work autonomously as underpinning high levels of job satisfaction.

These insights accord with findings from a recent DSS evaluation of the implementation of intensive family support in the APY Lands and central remote region.[150] While all providers struggled to fill vacancies due to local workforce constraints, those who were successful in building an effective team were community-controlled, had **strong cultural governance**, and **actively supported Aboriginal workers through reflective practice, opportunities for debriefing and skill development**. Several providers reported that they had staff who were keen to undertake the training required to become social workers and counsellors but were unable to offer real opportunities for progression because suitable training pathways did not exist. A **lack of culturally appropriate training pathways** and of planning for local workforce development generally, were identified as major barriers to having Aboriginal people lead program delivery even though this was recognised as highly desirable.

Therefore, while the scale of the challenge may be daunting, there are a range of evidence-based policy levers available to governments to address workforce issues in the region. The CLC and APONT have made a number of submissions to governments proposing concrete measures to **both create decent jobs that support community wellbeing** and **increase the supply of skilled workers**.[151] Most of these overlap with the Priority Reforms agreed to under the National Agreement on Closing the Gap.

Specific measures to support development a remote early years' workforce include:

- Strengthening the capacity of the community-controlled sector to support community-led development of the education, health and social care sectors;
- Funding community-controlled organisations to create real opportunities for young people to gain work experience and culturally appropriate training, such as paid traineeships in key service sectors such as ECEC, social and emotional wellbeing support, and education.
- Reform of VET in the NT to increase the availability of training on country, including the development of culturally appropriate content and practical assessment in language.
- Reinstating provision of secondary schooling in remote communities up to Year 10.

These proposals align with the Commonwealth's Remote Jobs and Economic Development Program which commits to support the creation of 3,000 new jobs in the central region by strengthening community control of economic and community development. Nonetheless, reinvestment and reform of remote education and VET will require this commitment to be matched by the NT Government.

Recommendations

6. Develop and implement a remote workforce development plan in consultation with communities and the Aboriginal community-controlled sector.

7. Work with the community-controlled sector to create real opportunities for local Aboriginal people to develop the capability to lead service delivery.

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