CENTRAL AUSTRALIAN ABORIGINAL CONGRESS
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Central Australian Aboriginal Congress

Submission to the Senate Education and Employment Committees

Inquiry into State of Australia's Early Childhood Education and Care System in Rural, Regional and Remote Communities

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ABN 76 210 591 710 | ICN 7823
PO Box 1604, Alice Springs NT 0871
(08) 8951 4400 | www.caac.org.au

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Recommendations

Recommendation 1 - The Commonwealth and Northern Territory Governments expand Aboriginal community-controlled Integrated Child and Family Centres across remote and very remote Northern Territory.

Recommendation 2 - The Commonwealth and Northern Territory Governments fund and roll out bicultural workforce models in all ECEC centres in Aboriginal communities that has qualified teachers working alongside locally trained Aboriginal educators.

Recommendation 3 - The Commonwealth and Northern Territory Governments expand access to quality preschools in remote communities by establishing preschool as a core, funded component of all early childhood education and care services, rather than an optional or secondary program.

Recommendation 4 – All Integrated Child and Family Centres implement the Abecedarian early-intervention approach to build school readiness and maximise potential for positive educational and social outcomes in young adulthood.

Recommendation 5 - That long-term block funding be administered by the Commonwealth Department of Education 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.

Recommendation 6 - That the existing Children and Families Tripartite Forum is the collaborative governance mechanism to enable shared decision-making and investment regarding long-term block funding.

Recommendation 7 – The Commonwealth and Northern Territory Governments work with the community-controlled sector to create real opportunities for local Aboriginal people to develop the capability to lead service delivery.

Recommendation 8 - That the Commonwealth and Northern Territory Governments prioritise Aboriginal Community Controlled Organisations as the preferred providers of integrated early childhood education and care services in remote and very remote Aboriginal communities and transfer funding, decision-making authority and service delivery responsibilities accordingly.

Recommendation 9 - To redirect fragmented early childhood funding into Aboriginal-led, community-controlled Integrated Child and Family Centres that embeds pre-school, child health checks, developmental screening, allied health and family support within ECEC settings.

Background

Central Australian Aboriginal Congress

1. Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care and a strong advocate for the health of our people. Since the 1970s, we have developed a comprehensive model of primary health care that includes:

    - multidisciplinary clinical care,
    - health promotion and disease prevention programs, and
    - action on the social, cultural, economic and political determinants of health.

2. Congress delivers services to more than 15,000 people[1] living in Mparntwe/Alice Springs and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu, Kaltukatjara (Dockerriver), Imanpa, Yulara and Amoonguna.

3. Over the last few decades, the community-elected Congress Board of Directors has focused on improving the developmental outcomes of Aboriginal children. This has led to the creation of an innovative model for the delivery of child and family services, based on the belief that the best way to "close the gap" is to make sure it is not created in the first place.

The effect of low socioeconomic status on early childhood outcomes

4. The nurture and care of children is at the heart of Aboriginal culture. For tens of thousands of years, our diverse peoples raised healthy, resilient and creative children. Today, many of our families continue to do so.

5. However, contemporary Aboriginal families have been deeply affected by the processes of colonisation including dispossession and impoverishment; the forcible removal of children and its intergenerational effects; the suppression of culture and language; and the experience of racism and discrimination. Aboriginal families continue to live with these effects of colonisation which challenge their capacity to care for their children. In spite of this, our people know they need to continue to find ways to build family life to ensure that all of our children grow up well nurtured and care for.

6. Children living in more unequal wealthy countries experience poorer outcomes across physical health, mental wellbeing and skills, therefore, addressing poverty, inequality and inequity must be a core part of any serious early childhood strategy for remote and very remote Australia[2]. These inequities are particularly clear for Aboriginal and Torres Strait Islander children living in remote and very remote areas. In 2021,

1 Congress uses the term 'Aboriginal' as the most appropriate term for the Central Australian region.

[2] *UNICEF Office of Strategy and Evidence – Innocenti, Unequal chances: Children and economic inequality,* Innocenti Report Card 20. *UNICEF Innocenti, Florence, 2026*

average gross weekly equivalised household income for Aboriginal and Torres Strait Islander adults was highest in major cities at $982, where it is close to half this amount in very remote areas at only $459[3].

7. These conditions are directly relevant to early childhood development and the current model is not closing the early childhood gap assessed at age 5. The Closing the Gap (CTG) dashboard shows that in 2024, only a third (33.9 per cent) of Aboriginal and Torres Strait Islander children commencing school were developmentally on track across all five Australian Early Development Census (AEDC) domains while over a quarter were developmentally vulnerable on two or more domains[4][5]. This is a decline of 1.3 per cent when compared to 2018 data. The data is much, much worse in very remote areas where majority of children are developmentally vulnerable on two or more domains. **This cannot be allowed to continue or worsen.**

Relationship to the reform agenda and broader policy

8. This inquiry should be considered within the broader reform agenda established through the National Agreement on CTG. The Agreement recognises that governments cannot close the gap in outcomes for Aboriginal and Torres Strait Islander peoples without working in genuine partnership with Aboriginal and Torres Strait Islander communities and their representative organisations.

9. For Aboriginal children and families living in remote communities, improvements in early childhood education and care will not be achieved through further investment in fragmented and program-based approaches alone. Despite significant government investment across multiple portfolios, developmental vulnerability among Aboriginal children in remote communities remains unacceptably high. This demonstrates the need for structural reform rather than additional stand-alone initiatives.

10. Consistent with the CTG Priority Reforms, governments should:

    - strengthen shared decision-making arrangements with Aboriginal and Torres Strait Islander organisations (Priority Reform One),
    ii. invest in the growth and sustainability of the Aboriginal community-controlled sector (Priority Reform Two),
    iii. reform funding and commissioning systems that perpetuate fragmentation and duplication (Priority Reform Three), and
    iv. improve the sharing and use of data to support community-led planning, accountability and continuous improvement (Priority Reform Four).

[3] *Australian Institute of Health and Welfare and National Indigenous Australians Agency, Measure 2.08 Income,* Aboriginal and Torres Strait Islander Health Performance Framework website. *Australian Government, 2023.*
[4] *Australian Early Development Census, AEDC National Report 2024. Australian Government, 2025.*
[5] *Productivity Commission, Socio-economic outcome area 4: Aboriginal and Torres Strait Islander children thrive in their early years. Closing the Gap Information Repository, Australian Government, 2026.*

Remote Aboriginal children are missing out on the services that support healthy development (Terms of Reference 1, 4 and 6)

11. The current early childhood system is not delivering reliable, accessible or integrated services for Aboriginal children in remote Central Australia despite strong evidence that early childhood supports are essential to lifelong health and development. Under the CTG, governments were committed to raise the proportion of Aboriginal and Torres Strait Islander children developmentally on track according to the AECD. **Despite this pledge, in 2021 it was recorded that 16.4 per cent of Aboriginal children across the NT and only six per cent of children in very remote communities were assessed as developmentally on track across all 5 AECD domains compared to 49.8 per cent of non-Indigenous children across the Territory**[6]. The CTG target is 55 per cent by 2031. Governments must recognise that a significant part of the gap in all CTG outcomes between remote and urban areas is due to the higher proportion of Aboriginal and Torres Strait Islander children in remote and regional areas.

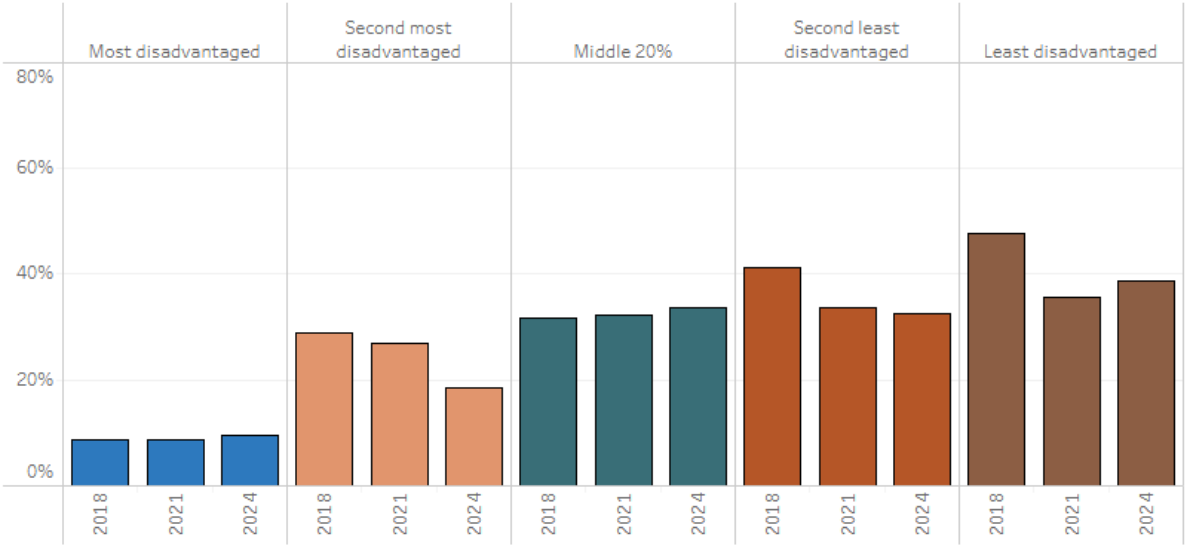
12. The unacceptable developmental outcomes for remote and very remote Aboriginal children living in the NT is not happening in a vacuum. A worsening gap for Aboriginal employment outcomes in the region correlates with worsening levels of poverty and disadvantage for Aboriginal communities. Unsurprisingly, poverty rates are increasing in remote Aboriginal communities who have among the highest poverty rates in the country[7]. As demonstrated in the table below, a strong predictor of a child's development is correlated with their socioeconomic disadvantage[8].

[6] *Goldfeld S, Eades S, and Thornton D,* Ampe Rlterrke Amangkeme – Growing up strong children: the policy case for an integrated approach to early childhood support in remote central Australia*. Centre for Community Child Health MCRI, Parkville: Vic, 2024.*

[7] *Biddle, N. and Markham, F., Area-level socioeconomic outcomes for Aboriginal and Torres Strait Islander Australians in the 2016 and 2021 Censuses. Centre for Aboriginal Economic Policy Research (CAEPR) Working Paper No. 144, Australian National University, Canberra, ACT, 2023.*

[8] *Productivity Commission 2024, Closing the Gap Information Repository, Outcome Area 4: Aboriginal and Torres Strait Islander children thrive in their early years, Table CtG4.4A.5, Australian Government, Canberra, viewed 29 September 2026.*

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 1: Aboriginal and Torres Strait Islander Children in the NT assessed as developmentally on track by IRSD

13. It reflects the fact that many families do not have reliable access to the basic services that support healthy development. The *Growing Up Strong Children* report (attached with submission) found that early years supports in remote communities are fragmented and uneven and that even where services are funded they are often unavailable, inaccessible or of varying quality. The report concludes that one in five children aged zero to four in the NT do not have reliable access to the basic services that give children the best start in life.

14. In addition to this, domestic, family and sexual violence (DFSV) remains far too prevalent in many families and this, along with alcohol and other drug use and parents with a mental illness or low levels of education, is continuing to impact unacceptable developmental outcomes. Congress utilises an ecological family assessment tool called the Family Strengths and Needs Analysis (FSNA) where this tool ranks in order the issues which will have the most harmful impact on child development. These are alcohol and other drug use, DFSV, parental mental illness, parental education and overcrowding.

15. These experiences along with too much sorry business from parental bereavement including suicide, loss of a parent due to incarceration and other adverse experiences are described in what is known as the Adverse Childhood Experience literature: About Adverse Childhood Experiences | Adverse Childhood Experiences (ACEs) | CDC

16. The most adverse experience of all is chronic under-stimulation which is not neglect. This is where a child is not exposed to daily conversations in the home and being read to daily. Children in families where parents have tertiary level education are exposed to an estimated 32 million more words by age 5 than children in

families where parents do not have year 12 education[9]. This word exposure disparity has a major impact on children's development.

17. Prof Sir Michael Marmot also presented in the British childhood cohort study, the key factors that promoted healthy brain development and these included:

    - providing responsive care to meet immediate needs quickly;
    - being read to every day;
    - having an iron rich meal daily,
    - having a regular sleep routine;
    - being physically active; and
    - partaking in a regular playgroup[10].

Many children who are born with all the potential they need for healthy development do not progress as they should because they do not experience the key factors needed in their early years. In addition, when children do not have these positive experiences, they are often compounded by the negative impact of the adverse early childhood experiences which is in many ways a "double whammy" that leads to unacceptable developmental delays. These delays, often unnoticed in early childhood, have consequences later in life and are observed in low educational attainment, poor health outcomes, substance misuse, significant mental health concerns and higher incarceration rates.

What reform should look like: Aboriginal community-controlled remote flexible model for integrated child and family centres (Terms of Reference 1)

18. **The best way to close the gap is to make sure it is not created in the first place by not waiting until a child is at schooling age to intervene.** By waiting for a child to reach around five years old they miss many critical periods for developmental milestones[11]. For example, the critical period for the development of emotional regulation is six months to two years and if this skill is not developed in this critical period it becomes harder and harder to acquire considering by age four their developmental trajectory is then set[12]. Only through intensive rehabilitation and support can these skills be acquired and by age seven it becomes extremely difficult to make an impact. In many ways, the first two years of schooling is the last window of opportunity and the intensive services needed are simply not available.

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[9] *Weisleder A and Fernald A, 'Talking to children matters: early language experience strengthens processing and builds vocabulary', Psychological Science, vol. 24, no. 11, 2013, pp. 2143–2152.*

[10] *World Health Organization, United Nations Children's Fund & World Bank Group, Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential, World Health Organization, Geneva, 2018.*

[11] *A. D'Aprano, S. Silburn, V. Johnston, G. Robinson, F. Oberklaid and J. Squires, 'Uptake of the culturally appropriate ASQ-TRAK developmental screening tool in the Australian Aboriginal and Torres Strait Islander context', Child: Care, Health and Development, vol. 48, no. 5, 2022, pp. 736–745*

[12] *Ah Chee D, Boffa J, and Tilton E, 'Towards an integrated model for child and family services in central Australia', Medical Journal of Australia, vol. 205, no. 1, 2016.*

19. Congress has been advocating for an integrated child and family service model for more than a decade, based on our experience in comprehensive primary health care, early childhood development, child health, family support and community-controlled service delivery.

20. An integrated child and family service model has all services delivered under one connected provider to support children and families to access care that best meets their needs as referrals are easier with less barriers. Not only does this model advance children and families' outcomes but also improves their access to services, makes better use of resources, is more cost-effective and reduces duplication of services offered[13].

21. Investing in a child's early years is critical to improve their trajectory of health and wellbeing and positive engagement across social and education domains. Family health and wellbeing can also have a significant impact on a child's development, particularly if there are multiple adverse circumstances including the critical early life experiences of bonding and attachment[14]. Nobel Laureate Professor James Heckman has championed substantial evidence that demonstrates the greater investment in early childhood can reduce alcohol and other drug use and youth incarceration, improve school retention and deliver broader economic and social benefits[15]. **A child's lifelong success is greater when they engage in evidence-based early skill development programs as early as possible.**

22. An integrated model that identifies the signs a child is struggling and then provides the necessary support and intervention to the child and broader family has the potential to improve the course of that child's mental health and wellbeing for life. Consequently, this support can reduce future demand for young people, adults and older adults' mental health and wellbeing services.

23. An integrated model is evidence based and ensures the *5 fundamental supports* are provided sustainably and in sequence to every child who is classified as being in "the bottom 25 per cent" and their family. These supports are listed in the *Ampe Rlterrke Amangkeme – Growing up strong children: the policy case for an integrated approach to early childhood support in remote central Australia* report[16]:

    - **antenatal care** to optimise foetal development during pregnancy and maternal health while minimising adverse pregnancy outcomes;
    - **sustained nurse home visiting** from the last trimester up to 24 months postnatally and at least three visits per month for targeted programs;

[13] *Ah Chee D, Boffa J, and Tilton E, 'Towards an integrated model for child and family services in central Australia'*, Medical Journal of Australia, *vol. 205, no. 1, 2016.*
[14] *O'Dea, B., Roe, Y., Gao, Y., Kruske, S., Nelson, C., Hickey, S., Carson, A., Watego, K., Currie, J., Blackman, R., Reynolds, M., Wilson, K., Costello, J. & Kildea, S. (2024). Breaking the cycle: Effect of a multi-agency maternity service redesign on reducing the over-representation of Aboriginal and Torres Strait Islander newborns in out-of-home care: A prospective, non-randomised intervention study. Child Abuse & Neglect, 149, 106664.*
[15] *J.J. Heckman, The Heckman Equation, Center for the Economics of Human Development, University of Chicago, viewed 8 October 2026*
[16] *Goldfeld S, Eades S, and Thornton D,* Ampe Rlterrke Amangkeme – Growing up strong children: the policy case for an integrated approach to early childhood support in remote central Australia. *Centre for Community Child Health MCRI, Parkville: Vic, 2024.*

- **early childhood education and care** from birth to first year of formal schooling to influence long-term outcomes in resilience, health, cognition and wellbeing with qualified early childhood education and care (ECEC) educators;
- **parenting programs** to shape their ability to cope and adapt to stressors and foster greater parental warmth that will positively impact their child's development; and
- **early years of school** given educational attainment is a strong social determinant of health and wellbeing.

Studies involving Aboriginal and Torres Strait Islander communities have shown improved outcomes where children and families have access to the *5 fundamental supports* and that the most effective early childhood systems are those that provide coordinated support across the first five years of a child's life[17][18].

24. Congress already operates an integrated model in Mparntwe / Alice Springs for Aboriginal families and children that should be referred to as an example when replicating similar models in remote and very remote Aboriginal communities. These services are listed below.

- Starting Strong Family Support is a voluntary early-intervention outreach program for families starting from 30 weeks of pregnancy through birth and until the child turns three. The focus is to build strong parenting skills, strengthen family connection to culture and support understanding of early childhood development while also collaborate with other agencies to promote tailored approaches to meet each family's needs.
- Child Health Outreach Program (CHOP) Ampe Mwarre uses a case management model of care to coordinate the care of children aged between 0-15 with chronic and complex health care needs and whose families' social circumstances are compromising their ability to meet the health care needs of their child.
- Preschool Readiness Program (PRP) to help parents and families with three- to four-year-olds get ready for preschool through child health checks including developmental assessments and bi-cultural play-based learning in a classroom environment.
- Congress Kids Apmere to provide free health and development checks, immunisations and links to other health services in hospital and in the community for children aged up to 12 years old, as well as supporting families about parenting, healthy lifestyles and other general health.
- Kids Strong Minds operates as a secondary level child mental health and wellbeing service targeting mild to moderate emerging complexity for children aged up to 12 years old.

[17] *Ah Chee D, Boffa J, and Tilton E, 2016.*
[18] *Gamarada Universal Indigenous Resources Pty Ltd 2023, Aboriginal-led early support programs for Aboriginal children, young people, families and communities: A review of the evidence base, prepared for the NSW Department of Communities and Justice, Sydney*

- Child & Youth Assessment & Therapeutic Service (CYATS) to assess, diagnose and provide treatment for neurodevelopmental, speech and language development disorders, including Foetal Alcohol Spectrum Disorder.
- Targeted Family Support (TFS) Service for Aboriginal families with children aged between 0 and 18 years where neglect and/or emotional abuse is a concern to provide voluntary early intervention service (i.e. pre-child protection involvement).
- Intensive Family Support (IFS) for families with children aged between 0-12 years who have a child protection order in place.
- Congress childcare centres to improve child development outcomes through the delivery of enriched caregiving, local language inclusion and early learning programs led by qualified Early Childhood Teachers and educators in a safe and nurturing environment.

25. Congress goes beyond the *5 fundamental supports* by including allied health and NDIS navigation services and having specialists visit communities. Most importantly, as our supports are 'stacked' through integrated service delivery we have the capability to schedule and then conduct child health checks, when their clinical file flags that they are due, at any point of contact with a Congress service. This is the same for scheduling and conducting a developmental screening using Ages and Stages Questionnaire – Talking about Raising Aboriginal Kids (ASQ-TRAK) and Parents' Evaluation of Developmental Status (PEDS).

26. While these programs have been individually successful, collectively they have provided the details of a concerning developmental trajectory well underway by age three for many children.

27. Many of our program's effectiveness depends on our bi-cultural model of practice facilitating greater family support. A staff member who is equipped with theoretical knowledge and relevant experience and/or qualifications works alongside a trained Aboriginal staff member who brings their cultural expertise, local knowledge and experiences to support each family. Each Aboriginal staff member uses their cultural insights to support their pair to understand the family dynamic and context. In addition, they come into the program with strong existing connections to the local community and culture, with some staff being fluent in local Aboriginal languages. The collaborative approach aims to streamline access and engagement with the family, support Aboriginal and non-Aboriginal ways of knowing and doing come together to create a high functioning space for knowledge co-creation and holistic practice.

28. This model requires shared care planning, clear referral pathways, multidisciplinary collaboration and a dedicated coordination function so that families do not have to navigate separate programs, eligibility rules and service systems. Ultimately, this model removes access barriers by having a 'no wrong door' approach.

Recommendation 1- The Commonwealth and Northern Territory Governments expand Aboriginal community-controlled Integrated Child and Family Centres across remote and very remote Northern Territory.

Recommendation 2- The Commonwealth and Northern Territory Governments fund and roll out bicultural workforce models in all ECEC centres in Aboriginal communities that has qualified teachers working alongside locally trained Aboriginal educators.

Preschool must be core business, not optional (Terms of Reference 1 & 4)

29. Preschool must be core business in any remote Integrated Child and Family Centre. It should not be left to uneven local arrangements, short-term funding or whether a remote school can recruit and retain staff.

30. There is a growing body of research providing evidence of the benefits of educational programs and practice for child developmental outcomes that supports their cognitive, academic and social emotional development. Furthermore, the amount and duration of quality ECEC must be greater for children who are experiencing vulnerabilities[19].

31. The CTG target on preschool enrolment is important, however, enrolment alone does not show if children are attending often enough to receive the benefits. Participation in ECEC and preschool is a strong predictor of Aboriginal children's readiness for school and later attendance. The focus needs to shift from enrolment alone to attendance, participation, duration, quality and developmental outcomes.

32. In 2023, the NT Government reviewed preschools and reported that in the NT, 48 per cent of Aboriginal and Torres Strait Islander children, 40 per cent of children living in very remote areas and 38 per cent of children in the most disadvantaged socio-economic quintile had attended the legislated 600 hours (15 hours per week) of preschool per year. **Only a third of children living remote and very remote in the NT attended less than 10 hours per week in 2023, as indicated in the below figure**[20]. These children missed out on important developmental opportunities that could have significantly supported them for their schooling period and beyond.

[19] *C. Molloy, P. Quinn, C. Harrop, N. Perini and S. Goldfeld, Early childhood education and care: An evidence based review of indicators to assess quality, quantity and participation, Communication Brief, Restacking the Odds, Murdoch Children's Research Institute, Melbourne, 2019*

[20] *Northern Territory Department of Education, NT Preschool Review: Final Report, Northern Territory Government, Darwin, 2023*

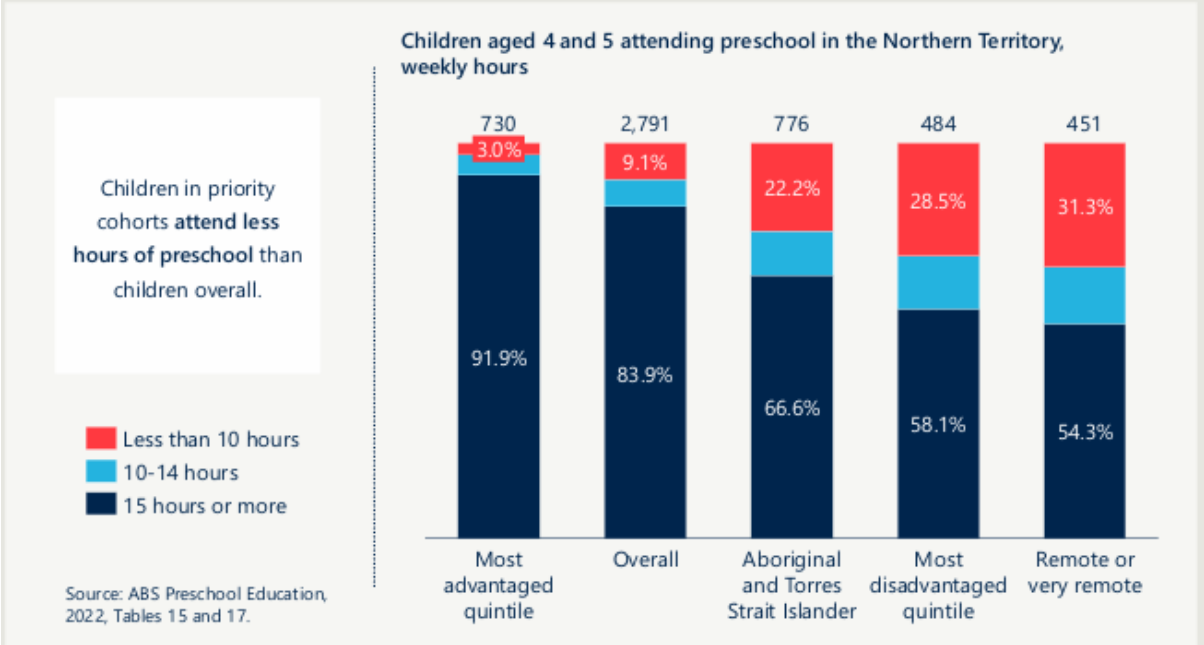

Figure 2 Hours of preschool attended per week, by priority cohort[21]

33. It should be acknowledged that there are a number of factors contributing to low remote preschool attendance, including, a lack of cultural safety, consistent service hours or availability, first language support, trust in government institutions, access to transport or food to provide a packed lunch[22].

34. Congress supports continued investment in Families as First Teachers (FaFT) as an important early childhood engagement program. FaFT can provide an important entry point for families who may not otherwise engage with education or support services and can help build trust and confidence in early childhood programs. However, participation in FaFT is voluntary and attendance can be inconsistent due to competing family responsibilities, cultural obligations, sorry business, housing instability, transport barriers and workforce disruptions.

35. As a result, children may only attend intermittently and miss out on the intensity and continuity of early learning experiences needed to support school readiness and developmental outcomes. **FaFT is not designed to deliver the equivalent of a quality preschool or centre-based ECEC program**.

36. The *Growing Up Strong Children* report found that many remote communities rely heavily on FaFT despite the absence of more comprehensive ECEC and preschool options which results in children receiving limited exposure to structured early learning. Congress is concerned that in some remote communities FaFT has become the default early childhood offering because it is easier to fund and deliver than centre-based ECEC or preschool.

[21] *NT Preschool Review, 2023, p. 33.*
[22] *Goldfeld, Eades and Thornton, Growing Up Strong Children, 2024.*

37. Integrated child and family centres must implement the Abecedarian (pronounced Ab-a-sa-dare-ee-an) model of educational day care. The Abecedarian model of educational day care provides a centre-based, preventative intervention for children who are known to be at high risk of developmental delay that involves learning games, conversational reading and enriched care. In several respects, this model parallels traditional childcare. Specifically, children receive access to quality care during normal working hours, which normally involves contact from Monday to Friday, between 8am to 6pm.

38. Abecedarian and traditional childcare models are functionally distinct despite being structurally and operationally similar. Historically and literally, childcare as an institution provides a safe and caring environment for children to access to provide parents and caregivers the time to engage in other activities. Childcare solves the question of is 'who will look after children while the primary carer cannot?'. The Abecedarian model goes beyond offering an environment that supports normal growth by purposefully engaging with children whose developmental needs are unlikely to be met without intervention.

39. The Abecedarian model has been developed specifically for, and evaluated against, long term effects for developmentally vulnerable children. There are a number of randomised controlled trials that have conducted follow-up investigations with participants from the original Abecedarian interventions at various points through to age 30[23]. Studies have consistently reported positive outcomes across educational, social and health domains.

40. The model could be utilised in service provision in several ways, including the following:

- **As a 'curriculum' introduced to an existing childcare centre -** the Abecedarian approach represents a replicable framework that is known to be effective in improving developmental outcomes for developmentally at risk children. This would be expected to do no harm to the children who are of low to no risk and is likely to have major benefits to those who are at risk. This approach may be used to improve services in existing centres who work with a high portion of children at risk of developmental delay (i.e., children come from homes where there are several factors of risk to healthy child development or where childcare centres house a large number of children in out of home care due to child protection intervention).
- **As a centre that specifically targets children who are developmentally at risk -** the Abecedarian model has been specifically developed, applied and evaluated as an effective way to ensure children at risk receive the stimulation required for healthy development. When used in this way, the Abecedarian approach provides a preventative service for developmentally vulnerable children who would not otherwise access any form of childcare. Children who fit in this category will be from multi-risk families and have parents who are dependent on welfare services. This approach is important for mobilising children from environments of poor stimulation into environments of enriched stimulation.

41. In remote communities, governments must fund both the core services and the coordination, administration and workforce development that provide the 'glue' for genuine integration.

[23] *Campbell, F.A., Pungello, E.P., Burchinal, M., Kainz, K., Pan, Y., Wasik, B.H., Barbarin, O.A., Sparling, J.J. & Ramey, C.T., 'Adult outcomes as a function of an early childhood educational program: An Abecedarian Project follow-up', Developmental Psychology, vol. 48, no. 4, pp. 1033-1043, 2012.*

Recommendation 3 - The Commonwealth and Northern Territory Governments expand access to quality preschools in remote communities by establishing preschool as a core, funded component of all early childhood education and care services, rather than an optional or secondary program.

Recommendation 4 - All Integrated Child and Family Centres implement the Abecedarian early-intervention approach to build school readiness and maximise potential for positive educational and social outcomes in young adulthood.

The funding system is fragmented and the Child Care Subsidy is not enough (Terms of Reference 3, 4 & 5)

42. The Child Care Subsidy (CCS) has an important role in improving affordability for many Aboriginal families. However, the CCS is poorly suited to remote early childhood service delivery when used as the main funding mechanism and it has increased barriers for Congress, and many Aboriginal Community Controlled Organisations (ACCO), to provide quality ECEC services.

43. 2017-18 saw block funding abolished by the Coalition Government as part of their Childcare Package reforms. Block funding had given service providers the needed autonomy to tailor core services to remote communities' specific preferences and needs[24].

44. With the introduction of CCS, funding has been insufficient and has led to ACCHS and ACCOs to draw from multiple complex funding streams to continue offering services. The administrative burden of these numerous funding streams is significant with different reporting and acquittal processes. When securing new funding, it has made grant and tender processes more competitive and frequent that are time intensive.

45. Remote communities have small populations, high operating costs, workforce shortages, transport barriers and low or variable family income. These conditions mean that a market-based model, dependent on fee-paying demand and subsidy claims, is not a reliable way to fund services.

46. The fragmented funding has created a patchwork of siloed services offered in communities that has reduced quality, impact and reach. Remote communities do not need more disconnected programs. They need one

[24] *SNAICC – National Voice for our Children, ACCO Integrated Early Years Services: Funding Model Options – Final Report, SNAICC, Melbourne, 2024, p. 95.*

coherent strategic service system that families can actually use and know their children will receive the care they need under the one roof.

47. Long-term block funding needs to be reinstated for ECEC in rural and remote areas where market-based provision is unsustainable. Funding should be flexible to support ACCHSs and ACCOs to run culturally safe and responsive integrated centres. The costs of delivering a range of ECEC options and ancillary support services must be covered that includes dedicated funding over capital costs and maintenance of facilities, professional development and training and community capacity building[25].

48. Commonwealth and Territory block funding must be governed through the Children and Families Tripartite Forum (CFTF). The CFTF was established to provide strategic advice to the Commonwealth and Territory governments, including cross-government, inter-agency and inter-sectoral cooperation to reform services for children and young people experiencing vulnerability and achieve integrated funding [26]. In the eight years of the CFTF meeting there has yet to be a successful integrated funding model. CCS, Connected Beginnings, Strong Families and FAFT funds would be more impactful being block funding for the CFTF to manage. This change would remove the onus of parents signing up to CCS and support a strategic service system that offers free ECEC for a minimum of three days a week.

Recommendation 5- That long-term block funding be administered by the Commonwealth Department of Education 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.

Recommendation 6- That the existing Children and Families Tripartite Forum is the collaborative governance mechanism to enable shared decision-making and investment regarding long-term block funding.

Workforce reform is essential (Terms of Reference 2)

49. It is a matter of priority to stabilise remote primary care workforce. A key barrier for Congress is to recruit and retain qualified teachers, educators and staff due to the geographic remoteness. There are a range of challenges remote workforce experience, such as, the social and professional isolation, extreme weather, reduced leisure activities available and poor housing or workplace infrastructure[27].

[25] *Goldfeld, Eades and Thornton, Growing Up Strong Children, 2024.*
[26] *Northern Territory Government Reform Management Office, Tripartite Forum, Northern Territory Government, Darwin, viewed 7 October 2026*
[27] *N.K. Budhathoki, D.J. Russell, Y. Zhao, L. White, S. Hines, S. Zhao and J. Wakerman, 'Improving health workforce retention in remote Australia: A best-worst scaling study', BMC Health Services Research, vol. 26, article 993, 2026.*

50. There is a workforce crisis in Central Australian remote communities with high rates of staff turnover in a number of sectors. In 2017 only 20 per cent of nurses and allied health professionals remained in a remote NT clinic for more than a year with half leaving within four months[28]. Congress reports in 2023, that up to 50 per cent of nurses located in Central Australian remote communities left every three months. In September 2026, Congress' total vacancies across all remote clinics were recorded as 40.5 FTE, excluding casual employees.

51. With government block funding, remote qualified staff can be incentivised to work in one community long-term with competitive salaries, retention payments, fly-in fly-out options, increase annual leave and flexible time-off and support for higher education or research opportunities. Especially for Aboriginal staff retention it was found that Aboriginal leadership, paid professional development and increased opportunities for advancement and promotion was valued the most[29].

52. The staffing model for integrated ECEC services in remote and very remote Aboriginal communities will access the expertise of local Aboriginal people and help build their capacity to lead the delivery of parenting programs and ECEC[30]. The ultimate aim would be to have local people employed in meaningful roles so communities can operate the centres themselves. This aim would require opportunities for local people to undertake on-the-job training as educators, therapy assistants and parent coaches and for them to be offered opportunities to progress to formal qualifications if desired.

53. Aboriginal Peak Organisations NT has made a number of submissions to governments proposing measures to increase the number of skilled workers and decent jobs that support community wellbeing to address workforce issues in the region that are available to governments[31].

Recommendation 7 – The Commonwealth and Northern Territory Governments work with the community-controlled sector to create real opportunities for local Aboriginal people to develop the capability to lead service delivery.

Remote and very remote Integrated Child and Family Centres must be Community Controlled

54. For remote and very remote early childhood services to be trusted and used, communities must have real control over how services are designed, governed and delivered.

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[28] D.J. Russell, Y. Zhao, S. Guthridge, M. Ramjan, M.P. Jones, J.S. Humphreys and J. Wakerman, 'Patterns of resident health workforce turnover and retention in remote communities of the Northern Territory of Australia, 2013–2015', Human Resources for Health, vol. 15, 2017, pp. 1–12

[29] Budhathoki et al., 'Improving health workforce retention in remote Australia: A best-worst scaling study', 2026

[30] SNAICC, ACCO Integrated Early Years Services, 2024.

[31] Aboriginal Peak Organisations Northern Territory, Fair Work Strong Communities 2023: A proposal for remote development and employment, APO NT, Darwin, 2023.

55. 'Community control' is the principle that Aboriginal communities have the right to participate in decision making that affects their lives which was taken away from them through historic and ongoing processes of colonisation. Congress does this by incorporating cultural values into our care model and work to mend the negative impacts of the historical and ongoing systemic inequities experienced by Aboriginal people when they engage in state-run systems[32].

56. This model provides the greatest level of Aboriginal community participation in service delivery and is considered best practice for Aboriginal health as it gives each community ownership over their care with mechanisms in place to provide input into their community's aspirations, needs and priorities through some form of board or advisory group[33].

57. This outcome is captured in article 23 of the UN Declaration on the Rights of Indigenous Peoples where it is expressed that Aboriginal people have the right to be actively involved in developing and determining health programmes[34]. As Congress states, it places "Aboriginal health into Aboriginal hands".

58. Congress' *Making History: Transforming Aboriginal health in Central Australia,* documented major improvements in some key health indicators for our communities in Central Australia over half a century such as infant mortality, life expectancy, years of life lost, alcohol-related hospitalisations and low birth weight. The evidence is clear that ACCHS are the most effective primary health care service model for Aboriginal and Torres Strait Islander health and operating remote Integrated Child and Family Centres will be no different.

59. The Federal Government has committed to build the community-controlled sector in Priority Reform Two of CTG[35]. This requires governments actively relinquishing control of service delivery and proactively working with the Aboriginal community-controlled sector to build and strengthen their capacity through the transfer of funding, resourcing and decision making.

Recommendation 8- That the Commonwealth and Northern Territory Governments prioritise Aboriginal Community Controlled Organisations as the preferred providers of integrated early childhood education and care services in remote and very remote Aboriginal communities and transfer funding, decision-making authority and service delivery responsibilities accordingly.

[32] *O. Pearson, K. Schwartzkopff, A. Dawson, C. Hagger, A. Karagi, C. Davy, A. Brown and A. Braunack-Mayer, 'Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia', BMC Public Health, vol. 20, article 1859, 2020.*
[33] *Australian Institute of Health and Welfare & National Indigenous Australians Agency, Measure 3.13 Competent Governance: Aboriginal and Torres Strait Islander Health Performance Framework, Australian Government, Canberra, 2026.*
[34] *United Nations, United Nations Declaration on the Rights of Indigenous Peoples, United Nations, New York, 2007*
[35] *Coalition of Aboriginal and Torres Strait Islander Peak Organisations & Commonwealth of Australia 2020, National Agreement on Closing the Gap: Priority Reforms, Department of the Prime Minister and Cabinet, Canberra, viewed 6 October 2026.*

How an integrated child and family centre in remote Aboriginal communities should look like (Terms of Reference 1 & 4)

60. Remote communities require more than access to childcare or preschool alone. Congress proposes that Integrated Child and Family Centres should be delivered through Aboriginal community-controlled to ensure children and families access the services they need with a 'no wrong door approach'.

61. An integrated centre should provide:

- long day care and preschool delivered by qualified early childhood teachers;
- regular opportunities for iron-rich, nutritious meals and physical activity;
- culturally responsive and trauma informed early learning programs;
- parenting support and family strengthening programs;
- maternal and child health services;
- developmental screening and monitoring;
- allied health outreach;
- family support and case management;
- strong transition-to-school programs; and
- connections to broader community services.

62. Importantly, these centres should not operate as stand-alone childcare services. They should function as community hubs where educators, health professionals and family support workers work together around the needs of the child and family where the open hours are tailored for each community's preferences.

The early childhood education model must offer:

- language-rich environments;
- frequent and intentional adult-child interactions;
- conversational reading;
- enriched caregiving;
- individualised learning activities; and
- active engagement in learning throughout daily routines[3637].

63. The evidence underpinning this model is reflected in the rigorously evaluated Abecedarian Approach. Congress has already adopted this approach at our *Arrwekele Akaltye-Irretyeke Apmere* Early Childhood Learning Centre based in Mparntwe/Alice Spring as it has one of the strongest evidence bases internationally. Longitudinal studies have demonstrated improvements in educational attainment, employment outcomes, health, social participation and reduced risk-taking behaviours among children who

[36] *C.T. Ramey, J.J. Sparling and S.L. Ramey, Abecedarian: The ideas and principles behind the approach, Sparling Center for Research and Innovation, Lewisville, North Carolina, 2012.*
[37] *Abecedarian Approach Australia, Abecedarian Approach Australia: Program Overview and Implementation Framework, Abecedarian Approach Australia, Brisbane, 2018.*

participated in the program[38]. Children from the most disadvantaged backgrounds experienced the greatest benefits.

64. A key feature of the model should be a bicultural workforce. Remote Aboriginal children are entitled to the same quality early learning opportunities as children elsewhere in Australia and quality must be delivered in ways that are culturally responsive.

    Therefore, each centre should combine:

    - qualified Early Childhood Teachers;
    - Aboriginal Early Childhood Educators;
    - Aboriginal Family Support Workers;
    - Aboriginal Health Practitioners;
    - community language speakers; and
    - visiting allied health and specialist staff.

65. Integrated centres should support universal developmental monitoring and early identification of developmental concerns.

    Children attending the centre should receive:

    - routine child health checks;
    - hearing and vision screening;
    - nutritional assessment;
    - Developmental monitoring and screening using tools such as PEDS and ASQ-TRAK; and
    - referral pathways for further assessment where concerns are identified.

66. The proposed model is consistent with the Northern Territory Aboriginal Health Forum commissioned work[39] that identified the core services required to improve Aboriginal child development outcomes and Congress' Arrwekele Akaltye-Irretyeke Apmere Early Childhood Learning Centre Evaluation prepared by the Baker Heart and Diabetes Institute and the Centre for Community Child Health[40]. The chart below summarises this submission's recommended centre-based integrated model for child and family services, comparing primary and secondary prevention, centre-based and home-visiting supports and child-focused and carer-focused interventions.

	Primary Prevention	Secondary Prevention
	Targets children with no current problems but are at risk of developing problems. Risk is usually identified	Targets children with current problems identified early in life who are most likely to respond to

[38] *C.T. Ramey and S.L. Ramey, 'Early learning and school readiness: Can early intervention make a difference?', Merrill-Palmer Quarterly, vol. 50, no. 4, 2004, pp. 471–491.*
[39] *S. Goldfeld, S. Eades, J. Lennox, R. Highfold, L. Gubhaju, A. Gibberd and D. Thornton, Congress Early Childhood Learning Centre Evaluation: Final Report, prepared for Central Australian Aboriginal Congress, Centre for Community Child Health and Baker Heart and Diabetes Institute, Melbourne, 2019.*
[40] *S. Goldfeld, S. Eades, J. Humphreys, A. Brown, S. Campbell, V. Briggs and M. Jones, What Are the Key Core Services Needed to Improve Aboriginal Childhood Outcomes in the NT?, Centre for Community Child Health, Melbourne, 2016.*

	based on low SES or maternal education level.		intervention before issues worsen. Identified through screening or referral.	
Centre	**Child Focused** **Abecedarian** Immunisations, Child health checks, and Developmental screening	**Carer Focused** Health advice to parents (e.g. nutrition, brushing teeth, toilet training)	**Child Focused** Child-centred play therapy, Therapeutic day care, Preschool readiness program, and Antibiotics	**Carer Focused** Filial Therapy, Circle of Security, Parenting advice/programs, and Parent support groups
Home Visitation	**Child Focused** Mobile play groups	**Carer Focused** Nurse Home Visitation and Families as First Teachers (home visiting, learning activities)	**Child Focused** Child Health Outreach Program, and Ear Mopping	**Carer Focused** Targeted Family Support / Intensive Family Support, Case management models for children at risk, and Parents Under Pressure

Kaltukatjara as a first demonstration site to rollout an Aboriginal-led integrated child and family centre

67. The community of Kaltukatjara is seven hours west of Mparntwe where three quarters of the approximate 400 residents (including nearby outstations) identify as Aboriginal. In 2021, there were 35 children under nine years of age. Out of the 20 children under four, there were only three children reportedly enrolled in preschool[41].

68. Mid 2023, the Kaltukatjara Health Centre transitioned from NT Government operation to Congress under the Local Decision Making framework to increase Aboriginal community control of comprehensive primary health care services in community. Governments recognised the transition as supporting greater community involvement in planning and delivering culturally responsive local health services[42].

69. Kaltukatjara has had many of the core components required for an Aboriginal-led integrated child and family centre model. The community has an Early Childhood Learning Centre run by MacKids that is comprised of three repurposed 'dongas' and one toilet. MacKids provide Early Learning programs as well as programs that cover, healthy eating and nutrition, language and culture, protective behaviours, physical activities and school readiness. The centre operates five days a week with operational hours tailored to suit community needs. The Centre also acts as a shared space where NPY Women's Council and Waltja Tjutangku Palyapayi can deliver intensive family support services funded by the Commonwealth Department of Social Services

[41] *Goldfeld, Eades and Thornton, Growing Up Strong Children, 2024, p. 45.*
[42] *Northern Territory Government, Kaltukatjara Health Centre transitions to Aboriginal community control, media release, 16 July 202*

while Congress offers child health checks, immunisations, visiting allied health services and health promotion activities.

70. The integrated child and family centre model proposed by Ah Chee, Boffa and Tilton was built on the principle that developmental vulnerability is best addressed through coordinated service delivery across health, parenting support, early learning and the transition to school[43]. Kaltukatjara already offers many of these individual service elements and would be an ideal demonstration site to show how existing investments could be reorganised into a genuinely Integrated Child and Family Centre.

Recommendation 8- That the Commonwealth and Northern Territory Governments prioritise Aboriginal Community Controlled Organisations as the preferred providers of integrated early childhood education and care services in remote and very remote Aboriginal communities and transfer funding, decision-making authority and service delivery responsibilities accordingly.

Conclusion

Congress would like to thank you for the opportunity to contribute to the Inquiry and would welcome the prospects to provide further information face to face during consultations on any aspects of our submission.

[43] *Ah Chee D, Boffa J, and Tilton E, 2016.*