DSS FaC Review Submission from Australian Red Cross (Palmerston and Tiwi Islands)

Recent and Emerging Impacts on Service Delivery

1. **How have you adapted service delivery in response to recent crises such as bushfires, drought, floods and Coronavirus pandemic? When has it worked and when hasn't it worked? How will this affect how you deliver services in the future? Have your service adaptations included better integration with other initiatives?**

On our part as an FP there was little adaptation needed since our regular work is to partner and maintain relationships with Community Partners while also monitoring CPs meet their agreement outcomes.

Our Community Partners (CPs) on the other hand had the greatest challenge to move swiftly to alternate modes of connection and if possible, delivery. Red Cross was very impressed with how quickly the early childhood providers moved to use various technologies to keep in touch with and support children and families.

What worked well was early childhood Child and Family Workers going to great lengths to keep in touch with children and families and supporting them with identified needs when they were within capacity. This was largely done through phone, Face Book and Messenger groups. Sometimes the calls resulted in drop-off of art and craft supplies to homes to support parents to engage their small children. In one case it also resulted in organising other families to drive by and toot to celebrate a playgroup child's birthday vicariously.

It was more challenging for our school aged child and family activities to continue to function. This was because.

a) NT schools moved to exclude non-teaching staff and activities from the school to reduce the risk of transmission
b) It being the first term the Kids Connect activity had the greatest connection with the child and less so the families of the children making phone contact difficult at first without further liaison with the school authorities.
c) The 8 week Kids FAST activities had not yet begun so there was not a client group to continue to relate to via alternative technologies.
d) Therapeutic Counselling for children on Bathurst Island was almost impossible as the area was declared a biosecurity zone by NT and Commonwealth governments meaning that only Permitted essential workers could travel there. This meant that the Darwin based qualified counsellor could not travel to deliver sessions. One Tiwi facilitator was eventually able to convene a few groups of children in a counselling setting near the end of term 2 as was his previous practice because he was already a resident of the island. It was term 3 before the Counsellor was able to resume travel to Bathurst Island.

e) Similarly, delivery of Bring up Great Kids on Bathurst Island had to be delayed until term 3-4 as the qualified facilitator was unable to travel.

One exception to this was the effort of the Menzies Play to Connect. Two Tiwi Baby FAST facilitators were able to do outreach visits to family homes at Wurrumiyanga on Bathurst Island. Initially this was to reach out and see if families understood COVID and COVID safe practices for their families and secondly to support families in carrying on engaging activities with their children through play, art and craft activity bags delivered to their homes. The quality of this outreach work definitely paid the dividend on many years of CfC investment in building the capacity of local Tiwi facilitators.

In future we will continue to emphasise the building of 'on Islands capacity' of Tiwi people to deliver activities. The goal ultimately is to reduce the cost of Fly In Fly Out workers and empower Tiwi workers with knowledge and skills that can be shared formally and informally in their own communities.

Our role as FPs were to keep abreast of what the situation was with each CP and their activity. We also relayed the information to our DSS FAM and sought his clarification on emerging issues e.g. how to record the activity in DEX given it was a different mode of delivery.

We also made our own assessment of whether the CP was using the funding for the benefit of local children and families in a somewhat different mode of delivery to deliver value for money. We appreciated DSS' flexibility around this as well.

Outcomes

2. **Are the proposed key outcomes for the families and children programs the right ones?**
3. **How can we include strengths-based outcomes that focus on family or child safety?**
4. **What tools or training would support you to effectively measure and report outcomes through the Data Exchange Partnership Approach?**

The headline outcomes of Family Relationships Flourish, Children and Young People Thrive, Empowered Individuals and Cohesive Communities meets with our general approval. However when we looked at them in detail we see there are some areas we recommend for amendment.

Firstly we would like to see each outcome use the language of *transformation* as activities are ideally assisting children and families with transformation if they are not currently doing well or affirmation if they are. This would contribute to a strength based approach.

In the circle **Family Relationships Flourish** we would like to see added 'positive connection to extended family and / or community supports' as an important aspect of family flourishing especially in the CALD and First Nations families, but by no means exclusive to them.

In the circle **Children and Young People Thrive** we would like to see 'enable physical health and wellbeing' as an outcome currently missing from this circle but surprisingly listed as a contextual factor. In the NT where there can be extraordinary numbers of children who fail to thrive there is much that activity providers can choose to do to enable physical health and wellbeing with education and other practical supports around nutrition that can be a part of another activity e.g. a playgroup if not the focus of an activity.

Also in the circle **Children and Young People Thrive** we would like to see some transformative language around 'improved mental health and wellbeing', 'positive /improved connections to

school', 'positive feelings about learning,' 'enable cognitive development', 'access to and use of appropriate services'.

In the circle **Empowered Individuals** we would add 'increased parenting confidence' to 'increased parenting knowledge.' This is an area frequently assessed by existing activities. Sometimes a parent just needs the affirmation of a skilled play group leader and their peer group to feel much better about what they are doing as a parent. Along a similar line we suggest 'improved' or 'enhanced mental and emotional wellbeing'.

Also in the circle **Cohesive Communities** we would add 'cultural identities are respected' as well as 'respect for elders', 'respect for people with different learning abilities/disabilities', 'respect for people with different socio-economic resources'.

When it comes to contextual factors we suggest that as well as recognition of 'employment' that the 'sufficient income', 'sense of purpose' be added and 'parents feel valued for their work in raising families'. We would like DSS FaC to not just rely of the cultural paradigm of employment which we think becomes a short cut to both 'sufficient income', 'sense of purpose'. We are aware from our work and from research that poverty in itself is not necessarily a 'sentence' for families and children nor is employment a guarantee that a person feels valued and can raise their children well.

Community Partners also asked if there could be room for articulating further service sub-outcomes achievable by their activities under the program outcomes articulated by DSS FaC. This could bring about greater recognition of the work on a qualitative basis.

With regard to Contextual Factors our activity providers in remote communities are vocal about their frustrations with the lack of stable/suitable housing available making some of their achievements with clients significantly harder if not impossible. 'Affordable housing' is also an important contextual factor. In Darwin and Palmerston we had the experience during the building of a gas plant in 2015-2019 that the lack of affordable accommodation pushed families out of urban centres to more rural towns and communities where less services were available to children and families and more challenges arose around transport and social and emotional supports.

DEX and Partnership Approach

With regard to the reporting outcomes through SCORE we recommend a 'rebuild' of the SCORE tools in collaboration with AIFS that align to the transformative outcomes decided upon and evidence based practices currently being used. It is the FaC Expert Panel that are best informed about the tools and evaluations being used. Those community partners currently adapting their evidence based evaluations to SCORE report difficulty reconciling their data with what SCORE requires.

Partners also request face to face training and support in aligning their evaluation tools to the SCORE. Most partners experience difficulty with online training tools provided by DEX.

With regard to the Extended Data Set part of the Partnership Approach we recommend that it be dropped from DEX altogether. This is because there are significant difficulties for our Partners in collection of the data and there is an extremely high risk of breaking the confidence and trust between service workers and clients in the collection of data. This is because clients consider the questions to be invasive, irrelevant to the service delivery and a breach of privacy. Another difficulty around collection is the time it takes to work through the questions with less educated people and further time and interpretation constraints with speakers of languages other than English. This time removes valuable time allocated for important and relevant transformative service delivery. It threatens to alienate the client which endangers the children in their care.

While it is clearly a requirement under DEX that Community Partners have not more than 15% unidentified clients there can be some frustration with this in especially vulnerable communities. This is because when vulnerable clients attend an activity for the first or second time it does not build their confidence if the facilitator pounces on them with a form to be completed. It is at this stage that a person should be able to remain and unidentified client. If they then go on to be a regular service user and a relationship develops between the service work and the client it is more acceptable then to collect the consent and the needed data for DEX. The more vulnerable the participants the higher the threshold needs to be to enable engagement confidence to build. Community Partners want to be trusted to make that judgement without negative judgements of them by FAMS and FPs.

Evidence

5. **Do you already have a program logic or theory of change outlined for your program? Did you find the process useful? If you do not have one, what has stopped you from developing one?**
   What capacity building support would assist service providers to develop program logics and theories of change?

As an FP we have not made a program logic of our own but relied on the FaC program logic I inherited as a CfC FP Coordinator in 2016. This is shared with our prospective Community Partners when we call for expressions of interest along with the existing Outcomes Framework and our local strategic plans.

Most of our CPs have their own Program Logic (P/L) and Theory of Change (ToC) if they are evidence-based or listed as Promising Program with AIFS.

We could develop our own FP program logic if required but currently we have our own internal Red Cross goals and measures.

However it is clear that CPs have limited capacity to develop a program logic/theory of change and acceptable evaluation plan. AIFS CFCA Expert Panel workers would be well aware of our CP struggles in getting the time and the resources to do this additional work as it took quite some time and resources to develop the documents that met with AIFS Expert panel approval for Emerging and Promising Practice. Sometimes this took 2 – 3 years. E.g. Menzies School of Health Research, Play to Connect activity began work in developing the PL /ToC in 2016-17 but was not accepted by the Expert Panel until November 2019. This is primarily because of resources. The funding allocated is based on the budget to deliver the service and there is little resource for extra work developing the logic, theory of change and evaluation plan. Collection of evaluation data is considered a normal part of service delivery.

CPs recommend that there be a quarantined amount of 5-10% in the budgets for M&E and another 5% PLUS access to a local evaluation consultant if they are required to compulsorily develop a PL/ToC and evaluation plan for an innovative new activity.

Based on our FP experience this makes sense. We as FPs have limited time to assist them while we are also managing and monitoring contracts, committees, strategic plans and networking across communities and CPs using existing funds. It is also recommended that CPs having direct access to the AIFS Expert Panel worker would also be of benefit instead of going through the FP gateway although naturally FPs need to be informed.

If a PL/ToC should become mandatory it is important not to expect new activities to immediately meet AIFS requirements as this will be a big barrier to innovation. Innovative projects should be valued. To give them value allow 2-3 years to work on a draft PL/ToC then use an Action Research model of trial and assessment cycles before they should be expected to reach an established PL/ToC and evaluation plan.

Certainty and Accountability

6. **As longer-term agreements are implemented, how can the department work with you to develop criteria to measure and demonstrate performance? How can the Data Exchange better support this?**

Firstly please note that CfC FP agreements have always been 5 years until the last two years of one year extensions. Within our FP domain and through our committees we have never offered 5 year agreements to CPs but 1-2 years. This is because we want to work with the local Committees to assess potential shifting trends in our communities.

Quite often the CP has been recontracted after the expiry of their agreement but that is at the discretion of the Committee as we operate as an FP. **We are totally conscious of the value of the CfC CP activity staff, many of whom have been working with the same community for over 5 years.**

We see that vulnerable clients really want to know and trust who they are working with. It can sometimes take 2 years for a worker to establish themselves as a trusted advisor in the community and even longer in remote communities. For this reason we aim to give plenty of lead time to enable **Expressions of Interest** (EOI) in Providing CfC Activities, **enable the Committee to assess those EOI** against our strategic plan, **enable price and outcome negotiations** since invariably EOI amounts requested amount to more than the Committee has available, **ratification of the committee decisions** after negotiation and final budget then **design of an agreement** with milestones and outcomes. The Activity Work Plan is the end result of this work but looks largely invisible to DSS.

This process needs to **begin in January in the funding year at the latest** if we are to be able to notify CPs and provide the draft Activity Work Plan (AWP) to DSS by end of April or May. For this reason our committees have been forced into a tokenistic holding pattern for the last three years when DSS have not provided sufficient certainty to FPs to use our full consideration process.

Just as we measure and require CPs to demonstrate performance through regular meetings and half yearly reports DSS FAMs could build and maintain relationships with FPs in order to assess our performance.

We invite our Funding Arrangement Manager (FAM) to all Committee meetings and supply them with all Committee agendas and minutes. We frequently, but not always, have conversations about the 6 months block of DEX data which is most often around problems with the data integrity rather than the success of the data integrity. Likewise you receive our annual AWPs and AWP reports and Financial Statements.

We would like it noted that ideally the Data Exchange would be a minor part of assessing our performance as FPs. It is noticeable to us and to some other FPs that we are in contact with that since the introduction of the Data Exchange our interaction with our FAMs is much less qualitative and more quantitate. We understand that the data exchange records outputs against our contract but there is more quality to what CfC FPs and CPs do than create outputs. We are never sure that this is being captured or appreciated.

It is our hope that the entry of our meeting data into the Data Exchange actually tells the story of our work but we have no evidence from our FAMs that they are at all cognisant of our FP data and the story it tells or doesn't tell. It is never discussed.

7. **What does success look like for your service, and how do you assess the overall success of your service?**

Success to us as an FP looks like provision of a range of free activities for children and /or their families that are well attended given the circumstances. E.g. a Postnatal Depression and Anxiety Playgroup could have too many participants meaning it is too stressful for anxious participants to join if there are too many people. We also like those activities to be available to populations in the most vulnerable locations (as assessed by AECD and SEIFA data) in accordance with our Strategic Plan.

These decisions about funding activities are made by our CfC Committees for which we act as Secretariat. Therefore effective convening and running of these meetings is another measure of success.

Success to us as an FP also looks like good partnerships and communication with the CPs so that we know that they are working in collaboration with other relevant local services providers and making appropriate referrals to other service providers as well as delivering activities.

Reciprocally we like our CPs to collaborate with us, as they have, to prepare this submission.

We also like them to be a part of other relevant community networks and child and family advocacy groups as are we. We are better able to fulfil the aim of improving service systems for children and families through networks, advocacy and collective impact groups.

Success also looks like us as a bigger organisation also supporting other service provider collaborations. E.g. Red Cross auspicing grants for the Palmerston Indigenous Network. We also annually host an NT FP forum to ensure we are abreast of the best practices and sharing ideas with our counterparts in other regions some of whom face the same issues in delivery of activities. Similarly participation in and attendance at Conferences like AIFS and AECD helps us to keep abreast of research and trends in child and family services.

Target and Accessibility

8. **Do you currently service cohorts experiencing vulnerability, including those at risk of engaging with the child protection system? If not, how does service delivery need to adapt to provide support to these cohorts?**

Our Palmerston and CfC activities currently do service at risk and vulnerable clients. We do this by targeting activities at the most vulnerable suburbs/areas. **Our collective estimate is 48.6% of clients are at risk.** While it may look attractive to increase the numbers all activity providers consider that there are benefits to mixed groups in order to reduce stigma and encourage role modelling and relationship building and support between at risk and less at risk users of the services.

We do still have concern about members of the communities who do not already attend our free early childhood activities. We know that in families where there is domestic violence, drug and alcohol addiction, and / or mental health issues it can be hard to attend a group where they may be

embarrassed and ashamed of their circumstances or worse concerned that they will come to the attention of the Child Protection authorities. In these cases we rely on referrals from baby and child health nurses, social workers, schools and more recently Parents Next contractors. These adaptations plus the targeting of the most vulnerable locations hopefully enabling easy access to activities is the best that we can do to enable vulnerable families to attend.

Financial incentive based rewards for participation in early childhood activities would go a long way toward breaking down barriers and encourage vulnerable families to participate in activities that will benefit themselves and their children rather than the oppressive and punitive approach taken by Parents Next.

Access to a budget to assist with transport for vulnerable families would also be of help. This is especially so in Palmerston where bus routes do not cross suburbs but instead go to a central interchange where a mother without a car would need to struggle with baby, stroller, bags AND another child or two to change buses to reach our activities if they don't already live in Driver, Moulden, Gray or Farrer. Unfortunately the bus interchange is not known as a safe place although thousands transit there safely every day. Some mothers do not have the energy to take the risk.

Collaboration and Coordination

9. **<u>If you are a Children and Parenting Support or Budget Based Funded service prove a Children and Parenting Support or Budget Based Funded service provider</u>, do you currently link with a Communities for Children Facilitating Partner or other regional planning mechanism to understand what other services are provided in the community and what the community identifies as their needs? How does this work in practice? Would you value the increased support of being attached to a local Facilitating Partner?**

We are not a CaPs or BBF funded organisation but would welcome any further collaborations for the benefit of children and families on our geographical areas. If these organisations exist locally they would be welcome to sit on our Committee(s). None have made themselves know to us in Palmerston or the Tiwi Islands.

10. **<u>For all providers</u>, are there other ways to improve collaboration and coordination across services and systems?**

There are many ways to improve collaboration across services and systems. Collaborations can be improved by the provision of information by DSS about other funded services. Collaborations between state/territory governments in the NT are just beginning due to the Productivity Commissions Review of Expenditure on Children in NT. FPs and CPs have a high level of accountability for strategy and operations however the overarching strategy of the State and territory agencies is generally not shared with us. Since the Royal Commission into Youth Detention there has been a greater level of transparency by the NT government through the Reform Management Office. State or commonwealth support for Collective Impact groups can enhance collaborations around a Common Agenda.

Co-convening of forums by Commonwealth and state and territory authorities may work to encourage greater collaboration. So too would the sharing of statistical data that correlates with our designated CfC areas. In Palmerston we found that the collation of available data to create the Palmerston State of the Children Report, (https://www.palmerston.nt.gov.au/sites/default/files/uploads/files/2018/Palmerston%20State%20of%20the%20Children%20Technical%20Report.pdf). A specifically designed version of the report

making it accessible to community enabled the sharing of the data with service providers and families and consideration of where to focus the collective energies. Grow Well Live Well - Palmerston's Collective Impact Initiative Story. https://vimeo.com/440498600

The Palmerston State of the Children Report identified data gaps where statistical were not publicly available related to Palmerston. 5 years later, the NTG in particular, still do not make available data related just to Palmerston around domestic violence, children in care and some other areas despite our requests. Similarly NTG data related to the Tiwi islands is lumped together into a Top End or Arafura region making it difficult to collate and share local data with the community and CfC Committee.

Palmerston went on to provide NT government grants that required collaboration across services in order for funding to be granted for youth services. A recent review of these Palmerston Youth Activity grants highlighted how much all participants value the collaboration and especially the young people.

We also write into our CfC agreements with CPS the requirement for collaboration with other service providers and regularly discuss how these are going.

Capability and Innovation

11. **The capability building support offered under Families and Children Activity programs has gone through several iterations. What works well? What do you think should change?**
12. **How can the department best work with you to support innovation in your services while maintaining a commitment to existing service delivery?**

In 2016 it worked well when Anglicare NT and Red Cross combined with DSS to provide a CP workshop on developing Program Logics, Theory of Change and Evaluation plans. The workshops were facilitated by Berry Street services and had the impact of inspiring at least 4 more non-evidence based services to try for Emerging and Promising Practice. However once inspiring them it was a hard slog to develop the activity program logics /theory of change and evaluation plans. This was largely because the practitioners needed more support in order to take time to write, check, discuss their work. Our CfC funds did not stretch further resources to support them.

The department could best work by providing additional funds targeting innovation and quarantine those funds for the support of innovations. At present the heavy emphasis on evidence based practice does not encourage new innovation. As previously stated the innovations need several years of Action Research based implementation in order to refine their work. We would encourage a special innovation fund with supports.