Final Report

Evaluation of the Attachment and Biobehavioral Catch-Up (ABC) program for supporting infant mental health in Queensland

May 2021 - May 2022

ehc
ENABLE HEALTH CONSULTING

Contents

Acknowledgement of Country

We acknowledge the Traditional Custodians of the land that we live and work on, the Jagera and Turrbal people. We pay our respects to all Elders and peoples past, present and emerging.

In being involved as evaluators on this project, we also want to acknowledge the strength and resilience of Aboriginal and Torres Strait Islander families who face disproportionate challenges to mental health as a result of past and current day colonial systems. We honour the strength of First Australian peoples and their rights to self-determination and sovereignty.

Document Version Control

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1.0 Background

The origin of the project

This pilot evaluation was borne out of conversations between a group of passionate professionals who were concerned about the lack of services for infant mental health (IMH) in Queensland. They wanted to investigate the programs that already existed, that had evidence to demonstrate impact and that could be adapted for Queensland families.

This project presented an opportunity to build stronger engagement between agencies in the IMH sector and to cut across sectors to advocate for innovative changes in IMH. An aim of this project was that the learnings will capture the attention of stakeholders from across mental health, child protection, early education and families and children health sectors. Then to use that attention to advocate strongly for reform in the IMH space.

The pilot

During 2021-22, Accoras piloted the Attachment and Biobehavioural Catch-Up (ABC) program with families in the Brisbane South, Logan-Beaudesert, Caboolture, Deception Bay, and Gold Coast regions. The ABC program is an internationally endorsed, evidence-based program for supporting caregivers and infants who have experienced adversity. The program is delivered in-home, immersed in daily household life. The opportunity to give contextualised, real-time feedback on caregivers' actions is proposed to be at the core of the success of the program.

Accoras and their partner stakeholders want to understand the impact of the ABC program among pilot infants and their caregivers, as well as the systemic considerations of offering this type of support program across Queensland services. Enable Health Consulting (ehc) were invited to work with the Accoras team delivering the ABC pilot and the pilot's Steering Committee (listed in Attachment A) to conduct an external evaluation. The evaluation was funded by the Queensland Mental Health Commission (QMHC) and aimed to capture both ABC program outcomes (to determine impacts of the program), as well as facilitate the engagement of key sector stakeholders to improve the depth of evaluation and increase understanding of the importance of IMH. This dual focus of evaluation at the program-level and strategic-level will enable Accoras, QMHC and their partner stakeholders to make evidence-informed decisions about the appropriateness of the ABC program for Queensland populations.

What is Infant Mental Health?

Infant mental health (IMH) is an interdisciplinary field which focuses on the social and emotional wellbeing of young children.[1] Whilst infants are not consistently described in the literature, with definitions ranging from 0-5 years,[2] for the purpose of this pilot evaluation, we have defined infants as 6-24 months. IMH relates to a child's capacity to express and regulate emotions, form interpersonal relationships with others and interact with the environments around them.[1] These social and emotional developmental capacities are largely impacted by the infants' relationship with their primary caregiver, because the sense of safety and confidence associated with positive caregiver attachments aid the infant's social, emotional, and cognitive development.[2] As such, healthy, nurturing, and supportive relationships with primary caregivers facilitate positive mental health outcomes in infants.[3] Therefore, IMH is understood to be synonymous with caregiver attachment.[1] This understanding has its foundations in Attachment Theory, a framework first developed by John Bowlby in the early 1950s.[4] The theory recognises that infants and young children need a sound and supportive relationship with their primary caregiver to aid healthy childhood development and guide longer-term positive relationships into adulthood.[4]

What are the impacts of poor Infant Mental Health?

Poor IMH can have many impacts for children, both in the short- and longer-term:

- In the short-term, stilted attachments with their primary caregiver can impact an infant's social and emotional development, including the infant's ability to learn and understand social cues and skills,[2] to perceive and recognise other people's emotions, as well as express and self-regulate their own.[1] It is also associated with an infant's ability to experience, explore, and learn from their environments, including the acquisition of knowledge about objects, people and events, their ability to play, and their capacity to interact and communicate with others.[1]
- In the longer-term, neglectful or traumatic relationships with an infant's primary caregiver can result in wide-ranging physiological disruptions, including alterations to the brain, immune, metabolic, and cardiovascular systems.[2] These changes can lead to physical health issues in adulthood, including cardiovascular disease, diabetes, and obesity.[2] Likewise, it is also associated with mental health concerns, such as depression, anxiety, and post-traumatic stress disorder (PTSD); as well as sleeping and eating disorders, alcoholism and substance abuse, relationships disorders such as physical violence, anger and hostility, and general emotional and social functionality such as communication, mutual attention, and engagement.[2]

To combat the significant implications of poor IMH, various programs have been developed to support positive and nurturing relationships between infants and their primary caregiver, including the ABC program.

The ABC program

The Attachment and Biobehavioral Catch-up (ABC) Lab at the University of Delaware developed the ABC program, which targets the formation of trusting attachments with caregivers and the development of adequate regulatory strategies. The ABC program was initially developed for parents providing foster care to infants in the United States.

Over 10 sessions, a trained ABC Parent Coach works with a caregiver to learn how to:

1) behave in nurturing ways when infants are distressed; (nurturance)
2) follow the lead when infants are not distressed (follow the lead);
3) avoid behaving in frightening or intrusive ways (intrusiveness); and
4) show delight towards the infant through caregivers' expressions and words (delight)

The 10 sessions are provided weekly to caregivers in their own homes. The sessions last approximately 60 minutes, and they are scheduled at times when infants are at home and able to be present and participate in the sessions. Sessions are video recorded, both for playback to families, and for supervision of the Parent Coach. Prior to each session, Parent Coaches collate videos from previous sessions that will allow the caregivers to see strengths and progress. The most important element throughout the sessions involves using the interactions observed between caregivers and infants to illustrate the intervention's main targets. Parent Coaches illustrate these targets through "In-the-moment" commenting. This immediate feedback is key for bringing caregivers' attention to the intervention targets. An "In-the-moment" comment includes the following components:

1. Specifically describe the behaviour. Examples:

- Nurturance: He bumped his head and you said, "Honey are you ok?"
- Following the lead: She handed that to you, and you reached right for it.
- Delight: You just lit up when he looked up at you.

2. Identify the intervention target. Examples:

- Nurturance: What a good example of providing nurturance when he needs it!
- Following the lead: What you did just then was following his lead.
- Delight: That is such a good example of your delighting in him.

3. Indicate what outcome that behaviour could lead to for the infant. Examples:

- Nurturance: He learns that he can rely on you; She learns you will be there for her when she is upset; He will develop trust in others.
- Following the lead: He learns he has an effect on the world; This helps him develop self-regulation; This helps her become more able to stay on task.
- Delight: She learns she is important and valued; This enhances her self-esteem.

The values underpinning the project

This pilot evaluation is grounded in shared values of the Steering Committee of:

- Advocacy- seeing this pilot as an opportunity for influence and engagement. With systems and services already stretched and pressured, this pilot brings an opportunity for engagement, not judgment.
- Cultural appropriateness- at the forefront of values was a strong desire for this evaluation to understand the program from the perspectives of Aboriginal and Torres Strait Islander families and culturally and linguistically diverse (CALD) families (as defined below). This value is heightened in the context of the ABC program because of its underlying westernised Attachment Theory principles and its inception from a North American culture.
- Pragmatism- we have a great deal to learn from the pilot and will use every opportunity to learn from all stakeholders involved.
- Translation of evidence- the findings from this pilot need to go beyond this program for the target population group and apply learnings to broader service offerings and systems.

Explaining our language

- **Caregiver:** the person who primarily cares for the infant in the ABC program
- **Infant:** the child (6-24 months of age) participating in the ABC program
- **Participants:** collectively referring to both the caregiver and infant
- **Parent Coach:** an Accoras staff member who has been trained to deliver the ABC program
- **Supervisor:** an employee of the ABC Lab trained to supervise the Parent Coaches
- **CALD caregiver:** in this pilot we have applied a definition of a CALD caregiver being a person who self-identified with an ethnicity other than Caucasian or First Nation Australian OR who did not have English as their main language spoken at home.

The logic behind the ABC Pilot

The Theory of Change: How we propose the change will happen

The challenge

A large minority of Queensland infants experience traumatic events significant enough to place them at risk of entering the child protection system.

This type of trauma impacts the developing brain and has lifelong social, emotional and health consequences.

While there are programs available for children at risk of entering child protection systems, there is currently no targeted IMH interventions for infants who have already entered the child protection system offered as standard practice across Queensland.

If we...

Bring to Queensland a brief, neurodevelopmentally derived, evidence-based intervention (the ABC program) and demonstrate it can be effective for the target population (the ABC pilot).

And ensure relevant policy makers and planners are supported to understand the importance of the individual and system benefits of early intervention in IMH, as well as practical approaches to supporting IMH

Then we will start to see...

Traumatised infants involved in the pilot returning to a more typical developmental trajectory with improved attachment to their caregiver, improved language ability & impulse control.

Caregivers with improved sensitivity who report reduced stress and more settled infants.

Accoras staff with increased skill and knowledge in IMH intervention.

The service community surrounding pilot families recognising that addressing infant trauma in the system is effective, does not need to be complex, resource-intensive or in the "too hard basket".

Policy and commissioning prioritisation in the IMH space.

Resulting in...

Caregivers who have the capacity to experience mutually rewarding relationships with their infants.

Happier, safer, and more stable families who are less likely to require the intervention of child protection authorities.

Infants with the neuro-developmental foundations to live happy and meaningful lives.

Eventually, early intervention mental health support for infants in the child protection system being delivered as standard, resulting in improved intergenerational outcomes and less demand for child protection services.

Table 1: Logic Plan for ABC pilot evaluation

Key Stakeholders (Who this is important to)	Inputs (What we will invest)	Activities (What we will do)	Outputs (What we will deliver)	Anticipated Outcomes (What we will achieve)
• Infants and their families in the areas serviced by Accoras who have experienced traumatic or adverse events • Accoras ABC trained staff and the ABC project manager. • Other services and community supports engaged with the infant and family. • Project Steering Committee (see Attachment A) • Other agency stakeholders who relate to the IMH sector (see Attachment C)	Human resources: • 0.5 FTE Project Manager • 6 practitioners trained in ABC, delivering it 0.2FTE Service resources: • All required technology for filming, coding and remote supervision • Service delivery budget including printing, travel and other misc expenses. • Executive Team support and advocacy. Other inputs: • Independent monitoring and evaluation reporting. • Oversight from the Accoras Clinical Governance Council.	• Train 6 Accoras staff in ABC (including a two-day initial training followed by 12 months of weekly supervision (90 minutes per week)) • Deliver ABC to participants • Follow this evaluation framework (actioned by ehc) • Follow-up with families offered the program, who did not take it up • Keep all stakeholders regularly updated	• Minimum 30 families take part in ABC program (ensuring some families identify as Aboriginal and Torres Strait Islander, and some as CALD families) • A minimum of 330 ABC sessions delivered (11 x 60-minute sessions per participant) • Project impact report based on this evaluation framework.	Short term outcomes • ABC gains a footprint in Qld • Participants benefit from reduced stress, increased caregiver sensitivity and reduced infant dysregulation. Intermediate outcomes • Evidence established for the potential impact of ABC in Qld. • Stakeholders in service community begin to consider the benefits of building in mental health supports for infants removed from their primary caregivers. Long term outcomes • Infants in the pilot are less likely to require the intervention of child protection services. • A greater number of infants experiencing trauma have access to an effective mental health intervention

The Assumptions we have made in creating our logic plan

- Participants will access ABC support and will engage with the 10-session program.
- Participants will find the program useful and will commit to undertaking the full 11 sessions.
- There will be sufficient referrals to achieve 30 completed cases over 12 months.
- Unforeseeable impacts of the COVID-19 global pandemic are an unpredictable externality; Accoras has invested in remote service delivery technology which allows continuity of service delivery as part of our Business Continuity Plan. ABC can train staff to deliver ABC remotely.
- Accoras can identify 5 suitable staff internally to train and take part in the pilot (staff commit to: 2 days initial training, followed by weekly supervision; seeing 6 families for 11 sessions over 12 months).
- Accoras will follow the data collection methods explained in this Evaluation Framework

The project governance

The pilot of the ABC program was delivered by Accoras, which they self-funded using retained earnings. The program was evaluated by the Project Steering Committee (see Attachment A) with support from external consultants from Enable Health Consulting (ehc). Funding for the evaluation was provided by the QMHC to support program and systemic enquiry.

The roles and responsibilities of the Project Steering Committee were to:

- Inform and guide evaluation approach and goals
- Approve evaluation EOI (seeking independent evaluation consultancy)
- Approve engagement of evaluator based on feedback and implication from Accoras
- Approve monitoring, evaluation and learning framework
- Oversight of pilot evaluation activities
- Provide access to key internal stakeholders who can inform the systemic aspects of the evaluation
- Support to contact external stakeholders who can contribute to systemic aspects of the evaluation
- Review final draft of pilot evaluation report
- Receive final evaluation report and discuss next steps

The roles and responsibilities of ehc were to:

- Work collaboratively with the Project Steering Committee to complete the evaluation
- Respond to feedback from the Project Steering Committee on evaluation processes and deliverables
- Collect the qualitative data required for the evaluation, in accordance with this framework
- Conduct the data analysis required for the evaluation, in accordance with this framework
- Ensure ethical processes are followed for keeping the evaluation data de-identified and protected from outside parties
- Create the reporting outputs for the evaluation, in accordance with this framework

The roles and responsibilities of the Accoras ABC pilot staff, regarding evaluation, were to:

- Collect quantitative data required for the evaluation and supply it to ehc
- Participate in the Parent Coach focus group to provide feedback on the pilot

Context: This delivery of the ABC pilot commenced in March 2021 and completed in April 2022. This was during the period of the COVID-19 global pandemic. There were also disastrous floods experienced in Brisbane, Australia during February 2022. These events were met with resilience by the pilot families and were overcome by Accoras in their delivery of the program.

2 .0 Methods

The evaluation aims and questions

There were two levels of evaluation in this project: program and strategic.

The **aim of the program-level** evaluation was to examine the effectiveness & acceptability of the ABC program in the urban Queensland context. This aim was met by addressing the following **evaluation questions**:

1. How was ABC delivered by Accoras?
2. Who participated in the ABC pilot?
3. Did participation in ABC:
    a. increase caregiver sensitivity?
    b. improve infant socio-emotional functioning?
    c. reduce caregiver depression?
    d. reduce infant and caregiver stress?
    e. improve reflective functioning?
    f. improve caregiver self-efficacy?
    g. improve caregiver beliefs about infant crying cues?
4. What was the experience of caregivers in the ABC pilot?
5. Did caregivers perceive there to be positive impacts from ABC, and were there any negative impacts?
6. Do caregivers perceive the impacts of ABC to be sustainable?
7. Were there different outcomes and experiences observed for different participant cohorts:
    a) Did Aboriginal and Torres Strait Islander participants or culturally and linguistically diverse participants experience unique impact(s)?
    b) Are there specific cultural considerations for Aboriginal and Torres Strait Islander participants? Or for culturally and linguistically diverse participants?
8. What challenges were encountered by Parent Coaches in delivering the program, how were these addressed; and were they effective?
9. What challenges were encountered by caregivers in participating in the program? And for those who did not choose to participate?

The **aim of the strategic-level** evaluation was to examine the implications for attachment-based early intervention approaches in Queensland.

This was achieved by addressing the following **evaluation questions**:

1. What is the view of stakeholders in the child protection, mental health and family-focused social services systems regarding ABC, and the introduction of additional infant mental health supports generally?

2. Where does attachment-based early intervention fit in the child wellbeing and protection service system?

3. What are the broader service delivery considerations for future support of attachment-based early interventions?

Data Collection

The ABC program was evaluated in a pre-post design embedded in Accoras service delivery. The evaluation used a mixed methods approach where qualitative and quantitative data were collected and interpreted together to build a narrative to answer the evaluation questions.

Participants

Eligible caregivers and their infants were identified through either:

- existing Accoras services, or
- referred from a Child Safety Service Centre

Eligible participants voluntarily enrolled in the pilot and were:

- A parent or primary caregiver with an infant between the age of 6 to 24 months old.
- A parent or primary caregiver that were willing to attend 10 sessions with their infant in the home (10 ABC sessions, plus 1 session to establish rapport, processes, and baseline data – explained in Section 3.1 'How ABC delivered the program')
- An infant that has experienced trauma, an adverse childhood experience, or is at risk of contact with the child protection system

Quantitative Data Collection Methods

Quantitative data was collected from caregivers during Session Zero with the Parent Coach. During this session, the Parent Coach:

- recorded the participants consent,
- interview-administered a series of questionnaires (see Table 2) and
- established the participant's expectations for the remaining ten sessions.

Table 2 details all the outcomes that were collected through the pre- and post-questionnaires. The questionnaires were entered into a secure electronic database by Accoras and securely sent to ehc. The database template was provided by ehc to guide the structure of the data entry.

Table 2: Quantitative data sources for ABC pilot evaluation

Outcome	Data Source	Outcome Details	Data type
Demographic characteristics of infant and caregiver	ABC Referral and Screening Form	age, postcode, country of birth, cultural background, Indigeneity, and referral information.	Categorical variables
Caregiver sensitivity	Filmed semi-structured play assessment	Caregivers scored 1-5 on three behaviours: • following the lead (sensitivity), • intrusiveness, and • delight (positive regard)	Continuous variable
Infant socio-emotional functioning	Ages and Stages Questionnaire (30 items)	Index score	Categorical variable: 1 – no or low risk 2 – monitor 3 – refer
Caregiver depression	Centre for Epidemiologic Studies Depression Scale (20 items)	Scale 0-3 per item. Total Index score (0-60)	Continuous variable.
Infant and caregiver stress characteristics	Parenting Stress Index – Short Form (36 items)	Scale 0-100 (percentiles) Across 3 subscales 1. Parental Distress 2. Parent-Child Dysfunctional Interaction 3. Difficult Child	Continuous variable
Caregiver reflective functioning	Parental Reflective Functioning Questionnaire (18 items)	Scale 1-7	Continuous variable
Caregiver self-efficacy[i]	Maternal Self Efficacy Scale (10 items)	Scale 1-4	Continuous variable

[i] This outcome was not captured in the pilot due to the tool items being mistakenly omitted from the survey

Outcome	Data Source	Outcome Details	Data type
Caregiver beliefs about cues	Infant Crying Questionnaire (43 items)	Scale 1-5 Five subscales 1. Attachment (infant) 2. Crying as communication (infant) 3. Minimisation (caregiver) 4. Directive Control (caregiver) 5. Spoiling (caregiver)	Can be analysed by subscale or averaged to yield overall infant-oriented and caregiver-oriented belief scales.
Number of sessions	Service delivery records	Number 1-11	Continuous variable
Number of sessions delivered by telehealth	Service delivery records	Number 1-11	Continuous variable

Measuring caregiver sensitivity

Caregiver sensitivity was determined using a 10- to 20-minute semi-structured play assessment of the caregiver-child interaction, which was filmed by Accoras Parent Coaches and scored between 1-5 by the University of Delaware. Caregivers were rated on their moment-by-moment and micro-level behaviours, across three domains of:

1. Following the lead – in which caregivers were scored on their responsiveness to their child's social gestures, expressions, and signals.

2. Intrusiveness (avoiding frightening behaviours) - in which caregivers were scored on their interactions being adult-centred and not child-centred (i.e., caregiver may impose their agenda on child despite signals of different activity levels, pace, or interaction needed)

3. Delight (positive regard)- in which the caregivers were scored on their expressed positive feelings towards the child (i.e., speaking in a warm tone, providing physical affection, praising the child, and showing general enjoyment in child).

Caregivers were rated from 1 (not at all characteristic) to 5 (highly characteristic) for each of the domains. An overall sensitivity was calculated by reverse coding 'intrusiveness' and combining the three outcomes into an overall mean score ranging from 1-5.

Measuring Caregiver self-efficacy

Caregiver self-efficacy was unable to be addressed, as the survey items were not administered during the data collection period due to administrative error

Measuring Infant socio-emotional functioning

Infant socio-emotional functioning was determined using the Ages and Stages Questionnaire (ASQ:SE2) appropriate for the age of the infant and the time of its' completion. The ASQ:SE2 is a questionnaire that is completed by the caregiver about their infant and is used to identify and screen for social and emotional behaviours in infants. There were five variations of the questionnaire depending on the age of the infant (i.e., 6 months, 12 months, 18 months, 24 months, 30 months), and each variation has a different range (due to increases in items across questionnaires) and clinical interpretation scores. To compare the ASQ:SE2 results across age groups and pre/post the ABC pilot, the results were recoded into categorical variables as per the appropriate interpretation requirements for each questionnaire. Once categorised, all variations were combined to create one overall ASQ variable regardless of age, with three categories: 1) no or low risk; 2) monitor; or 3) refer.

Measuring Caregiver Depression

Depressive symptoms were determined using the Epidemiologic Studies Depression Scale Revised (CESD-R-20). A total score for depressive symptoms was calculated by reverse coding the appropriate items and combining responses into an overall sum ranging from 0-60.

Measuring Infant and caregiver stress

Infant and caregiver stress was determined using the Parenting Stress Index – Short Form (PSI-4-SF). This questionnaire contains 36 items across three subdomains of:

1. Parental Distress – in which a high score may indicate the caregiver's difficulty in adjusting to parenthood
2. Parent-Child Dysfunctional Interaction – in which a high score may indicate a caregivers' feelings of disappointment, rejection, or alienation from their child, or lack of proper bonding.
3. Difficult Child – in which a high score may indicate that the child could be having problems with self-regulatory processes (either physical or temperamental).

Each subdomain was calculated by creating an overall mean score of the 12-items indicated as per scoring instructions.

Measuring caregiver reflective functioning

Caregiver reflective functioning was determined using the Parental Reflective Functioning Questionnaire, which identifies a caregiver's capacity to reflect upon their own internal mental experiences as well as those of their child. This questionnaire contains 18 items across 3 domains of:

1. Pre-mentalising modes – items capture non-mentalising stance, malevolent attributions, or an inability to enter the subjective world of the child (low score = high reflective functioning)
2. Certainty about mental states – items capture a caregiver's recognition of the opacity of mental states, in which caregivers may lack certainty or be overly certain about the mental states of their child (moderate score = high reflective functioning).
3. Interest and curiosity in mental states – items capture a caregiver's interest in their child's mental states, in which caregivers report an absence of interest or possible intrusive hypermentalisation (moderate score = high reflective functioning).

Each subdomain was calculated by creating an overall mean score from identified items indicated as per scoring instructions.

Measuring Caregiver beliefs about cues

Caregiver beliefs about cues were determined using the Infant Crying Questionnaire, which assesses beliefs about crying, in which two subscales are infant-oriented and three are parent-oriented (five subscales in total):

The Infant-oriented subscales include:

1. Attachment – items capture caregivers' intent to make their baby feel safe and secure.
2. Crying as Communication – items capture caregivers' perception that their baby is trying to communicate with them when they cry

The Parent-oriented subscales include:

3. Minimisation – items capture caregivers' perception that crying is highly inconvenient and potentially manipulative
4. Directive Control – items capture caregivers' belief that it is their responsibility to control, teach, and help their baby with their emotions
5. Spoiling – items capture caregivers' perception that attending to a crying baby is spoiling a child

Each subdomain was calculated into an overall score as indicated by scoring instructions, and overall infant-oriented beliefs and overall parent-oriented beliefs were combined into two overall scores for analysis.

Qualitative Data Collection Methods

Caregiver interviews: Caregivers who completed the program were invited to participate in a semi-structured one-to-one telephone interview. Accoras staff (Parent Coaches) initially presented the invitation to caregivers using a one-page introduction to ehc staff (including pictures), to facilitate a 'warm handover'. An ehc interviewer then sent a text message to the caregiver before calling (see Attachment D for example), to provide an opportunity for caregivers to indicate a preferred time for the interview; caregivers were otherwise called within 24 hours of the text message regardless of reply to text. This interview encouraged caregivers to tell their story about their experience of the ABC program. The interviews were audio-recorded and quotes were transcribed verbatim.

'Referrers' interviewers: Accoras provided a list of people who referred caregivers to the ABC Program. These 'referrers' were invited to participate in a semi-structured one-to-one interview (either in person or via telephone, based on their preferences). The interview aimed to understand how referrers 'pitch' the program to caregivers and explored their perceptions of why caregivers either chose or refused to participate. The interviews were audio-recorded and quotes were transcribed verbatim.

Parent Coach focus group and interviews: Three Parent Coaches participated in a focus group about their experiences of delivering the program. Two Parent Coaches participated in a one-on-one telephone interview. The focus group and interviews were audio-recorded and quotes were transcribed verbatim.

Steering Committee focus group and interviews: The project's Steering Committee were invited to participate in a focus group. Two committee members, who were unable to attend the focus group, participated in an interview with ehc staff. The focus group and interview were audio-recorded and quotes were transcribed verbatim. The focus group incorporated an individual reflection activity (facilitated by post-it notes), which aimed to encourage individuals to reflect personally on answers before the group discussed collective ideas.

Service stakeholder focus groups and interviews: The Steering Committee identified 13 sector stakeholders from child protection, mental health, and family-focused social services (see Attachment C). ehc invited them to attend a focus group, or an interview to suit their availability. These focus groups and interviews began with an overview of how the ABC program was delivered and key findings from the pilot evaluation. This overview provided stimulus for the focus groups to discuss perceptions of the ABC program specifically, and of IMH supports more generally. The focus groups and interviews also incorporated an individual reflection activity (facilitated by online Miro™ boards), aimed at encouraging individuals to reflect personally on answers before the group discusses collective ideas.

Case studies: Accoras identified caregivers to act as case studies in the evaluation narrative. These people were chosen from the sample of pilot participants who completed an interview. Their words and images were used to form case studies of experiences of the ABC program.

Data analysis

Quantitative data was analysed using IBM™ SPSS™. Questionnaire and scale data was cleaned for missingness, reverse scoring and summary scale calculations.

The sample size for this pilot (n=30 families) was based on convenience sampling and resourcing of the program, not to provide sufficient statistical power to detect certain effect sizes. Therefore, data analysis was primarily descriptive (i.e., describing the participants and their baseline characteristics, changes pre-to-post). Some data analysis was inferential (i.e., testing the differences between pre and post scores) and the interpretation of these tests was based on how meaningful the observed changes in outcomes were, and not solely on p values.

To test differences between pre and post outcomes scores for the whole participant sample, a paired t-test (or non-parametric Wilcoxon signed ranks test) was conducted. To compare outcomes between different sub-groups of the sample (i.e., participants from CALD backgrounds), a descriptive analysis examined the means and standard deviations of each sub-sample, and the differences were interpreted based on meaningful differences (rather than statistical differences, due to small sample sizes).

Qualitative data was thematically analysed by two independent consultants. These two analysts read the entire interview/focus group script and independently coded the qualitative data for meaning. The two coders discussed differences and similarities throughout this process as they built consensus on the descriptive codes and worked to develop latent interpretations within and across the data (i.e., identified themes). The purpose of this iterative analysis was to offer a deeper understanding of the pilot program guided by (and pushing beyond) the evaluation questions.

Data interpretation

An important aspect of this pilot was the comparison of findings from the Accoras-delivered ABC program to other evaluations of the ABC program. There have been many evaluations of the ABC program in other countries, states, and cultural contexts[5] (see Attachment E).

Previous evaluations of ABC were reviewed and used to contextualise interpretations of the pilot data. Of these evaluations, 4 are unpublished data sent by the University of Delaware. Where appropriate this previous evidence was used to make comparisons with quantitative measures that were directly comparable and also used to interpret findings and how other jurisdictions have experienced and dealt with delivery issues.

3 .0 Program-level Findings

How was ABC delivered by Accoras?

Accoras recruited Parent Coaches internally through both direct appointment and an Expressions of Interest (EOI) process. Staff who were interested in receiving the training were able to submit an EOI, and Parent Coaches were screened for training by the University of Delaware through a 30-minute interview to determine likelihood of success in both completing the training and delivering the ABC program. The delivery of the ABC program does not require pre-requisite qualifications for Parent Coaches, and as such, the opportunity to train as a Parent Coach was open to all Accoras staff. Parent Coaches completed a two-day training workshop covering theoretical and practical orientation to the intervention, "in-the-moment" commenting practice, a review of session content, and consultation regarding site-specific implementation. Following the training, Parent Coaches were provided with 90-minutes of weekly supervision (inclusive of 60 minutes of clinical supervision, and 30 minutes of "in-the-moment" commenting supervision) for a period of 12-months to maintain program fidelity. Accoras did not provide a formalised supervision process for the Parent Coaches, however, Parent Coaches informally discussed their progress and results with each other at weekly Parent Coach meetings, providing support throughout the training and accreditation process.

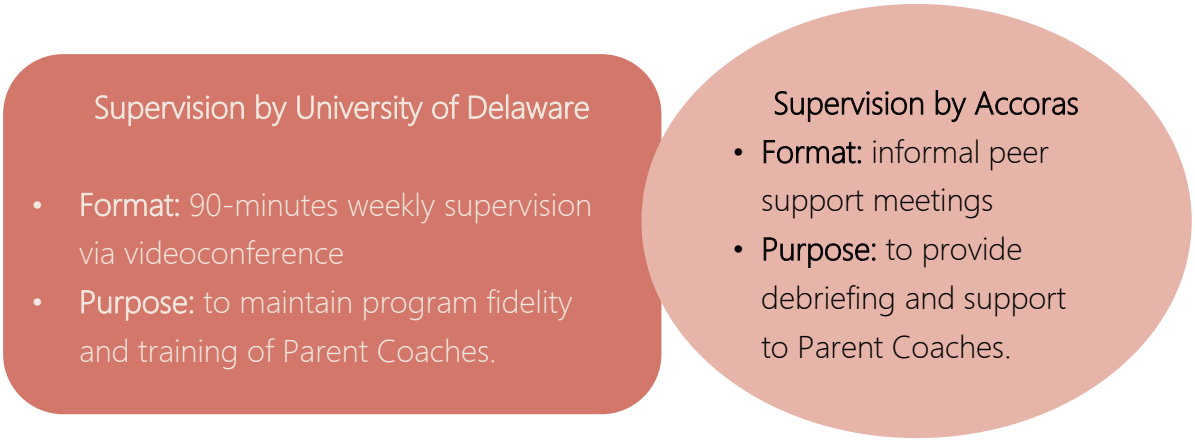

Figure 1: Parent coach supervision during the ABC pilot.

Table 3 highlights the age, gender, qualifications, and years of experience of each of the Parent Coaches. The Parent Coaches who delivered the ABC program to caregivers in this pilot had varying ranges of qualifications, with one holding no tertiary education, and others holding qualifications in public health, women's health, social work, and human services.

Table 3: Descriptions of the five Parent Coaches delivering the ABC program

Parent Coach	A	B	C	D	E
					
Age	30	29	31	56	46
Gender	Female	Female	Female	Female	Female
Qualifications	Bachelor of Health Science (Major in Public Health) Honours in Health Science (Women's Health and Mental Health) Youth Mental Health First Aid	Diploma Community Services Bachelor of Social Work	(incomplete) Bachelor of Applied Social Science	Bachelor of Social Science Master of Social Work	Bachelor of Human Services – Children and Families Advanced Diploma Children's Services
Indigeneity	Non-indigenous	Aboriginal	Non-indigenous	Non-indigenous	Non-indigenous
Years experience in IMH	5 years	1 year	1 year	5 years	29 years
Years experience in Social Services sector	6 years	9 years	10+ years in employment and community services	14 years	12 years

Referral into the ABC program

Referrals into the ABC pilot program commenced internally within Accoras in January 2021. Referrals from external services commenced in August 2021 (specifically community organisations who had previously known of Accoras as there was limited advertising), while Child Safety referrals commenced in September. Referrals from community organisations were not formalised and were ad-hoc.

Overall, it cost Accoras AU$241,000 to deliver the ABC pilot program (Table 4), inclusive of ongoing training and supervision of Parent Coaches, staffing costs (salaries and travel), and delivery costs (purchasing of equipment and toys).

Table 4: Costs associated with delivery of ABC pilot program

Item	Cost	Units	Total (AU, ex GST)
Training of Parent Coaches (2-day workshop + 1 year supervision per coach)	$10,000	6	$60,000
Staffing Costs (inclusive of FTE salary and on-costs – i.e. travel)	$175,000	NA	$175,000
Operational Costs (inclusive of toys, cameras, laptops)	$1000	6	$6,000
TOTAL			$241,000

Delivery of the ABC program

The program is delivered by Parent Coaches in the caregiver's home over 10 sessions (see Table 5 for overview of session content). The sessions last for approximately 60-minutes and are scheduled for times when the infant is at home and able to participate in the sessions. To build rapport with parents, and provide an introduction to the ABC program, Accoras included an additional session referred to as 'Session 0', bringing the total number of sessions to 11. The beginning of each session commences with videos of the caregiver's interactions from the previous session, for the purposes of highlighting their strengths and progress. At the end of each session, Parent Coaches rate parents on each of the targets and develop a plan to work with the caregiver to improve the target (i.e., nurturance, following-the-lead, delight, frightening behaviours). Additionally, caregivers are encouraged to complete 'homework', which encourages them to reflect on what they have learnt in the session, and requires caregivers to record the number of times their infant is hurt, scared, or upset, and identify:

- What they thought their infant needed from them
- What their [caregiver's] response was
- What was difficult about the interaction

Table 5: Overview of ABC session content

Session	Content Overview
0	Introduction and provision of baseline data collection methods
1	Rapport building and introduction to providing nurturance
2	Providing nurturance 2
3	Following the lead with delight
4	Following the lead with delight 2 (incl. an activity where the infant is involved in making a "pudding")
5	Decrease intrusiveness and frightening behaviour
6	Decrease intrusiveness and frightening behaviour 2
7	Voices of the past
8	Voices of the past 2
9	Consolidate learnings
10	Consolidate learnings

Who participated in the ABC pilot?

A total of 70 families were offered an opportunity to participate in the ABC program over the period of the pilot. These families were referred by Accoras (n=44), Child Safety (n=17), Intensive Family Support Services (n=4), and local community groups (n=4). Data for one caregiver was not available beyond referral source.

Figure 2, below, shows the flow of caregivers from referral to the ABC pilot program to completion. Of the 70 families offered the program, 64.3% accepted and started the program (attending session 0-1). Following consent to the program, 31 caregivers did not go on to complete the filmed interaction at session 1 (most of the withdrawal from the program occurred prior to the baseline primary outcome collection at session 1 – See Figure 2). A total of 30 caregivers were filmed for scoring on sensitivity by the University of Delaware.

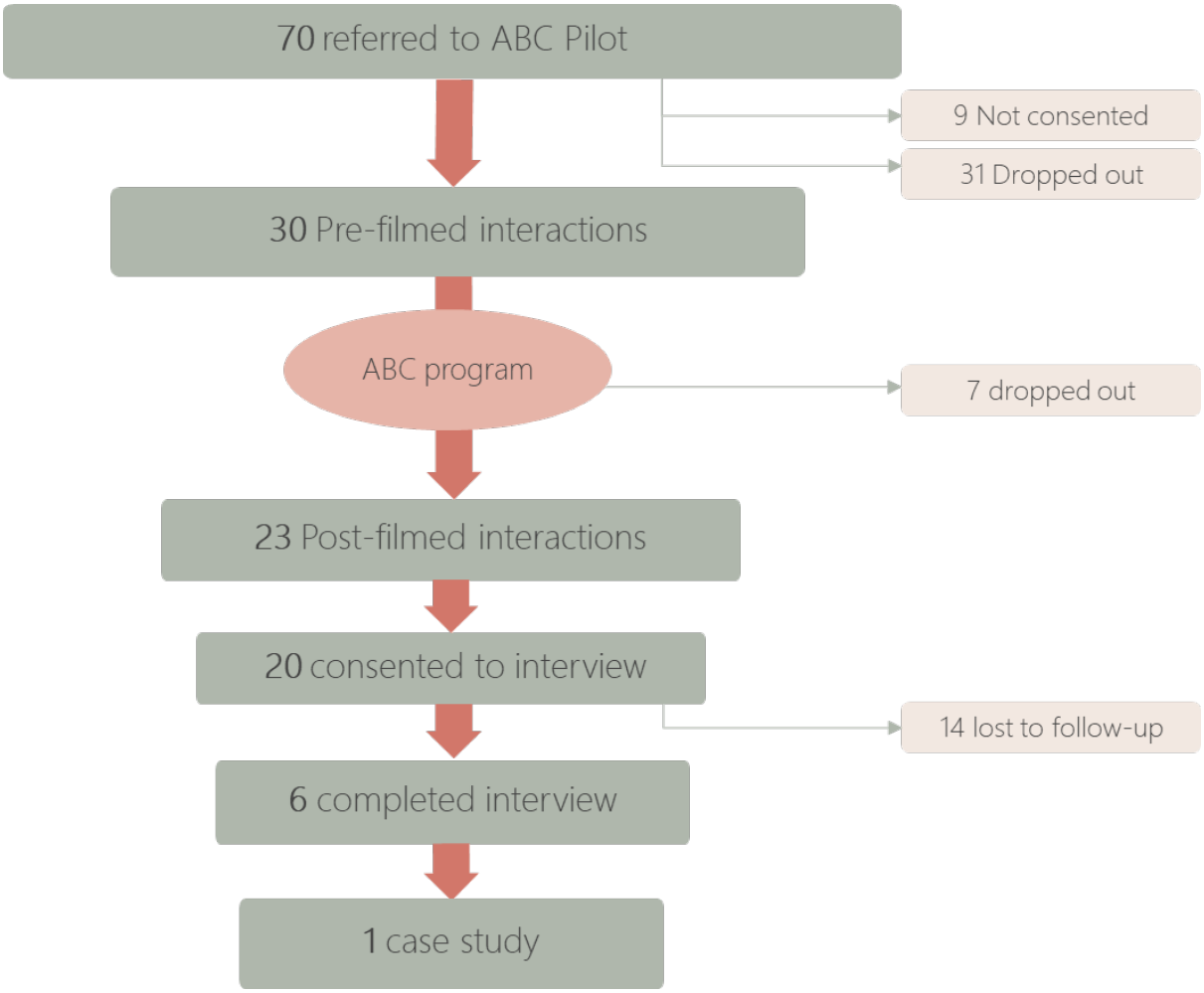

Figure 2: Flow of referred caregivers through the ABC pilot project.

After commencing the program, seven caregivers withdrew from the ABC program prior to completing Session 10. To better understand who withdrew from the pilot, the withdrawal rates were compared by referral source, age group and whether caregivers identified as Aboriginal, Torres Strait Islander or non-Indigenous. Figures 3 to 5 show the proportion of withdrawals that occurred from the point of referral through to Session 10 (program completion) for caregivers by referral source, age group, and Indigenous status.

The graphs below highlight that proportionally, caregivers who were: aged between 31-40 (Figure 3), referred from internal referrals from Accoras (inclusive of ParentsNext referrals; Figure 4), or Aboriginal and Torres Strait Islander caregivers (Figure 5), withdrew from the program more rapidly than other caregivers. However, the differences between caregivers who consented and completed the program, consented and did not complete the program, and those who did not consent to commence the program were not found to be significantly different within these three demographic subgroups.

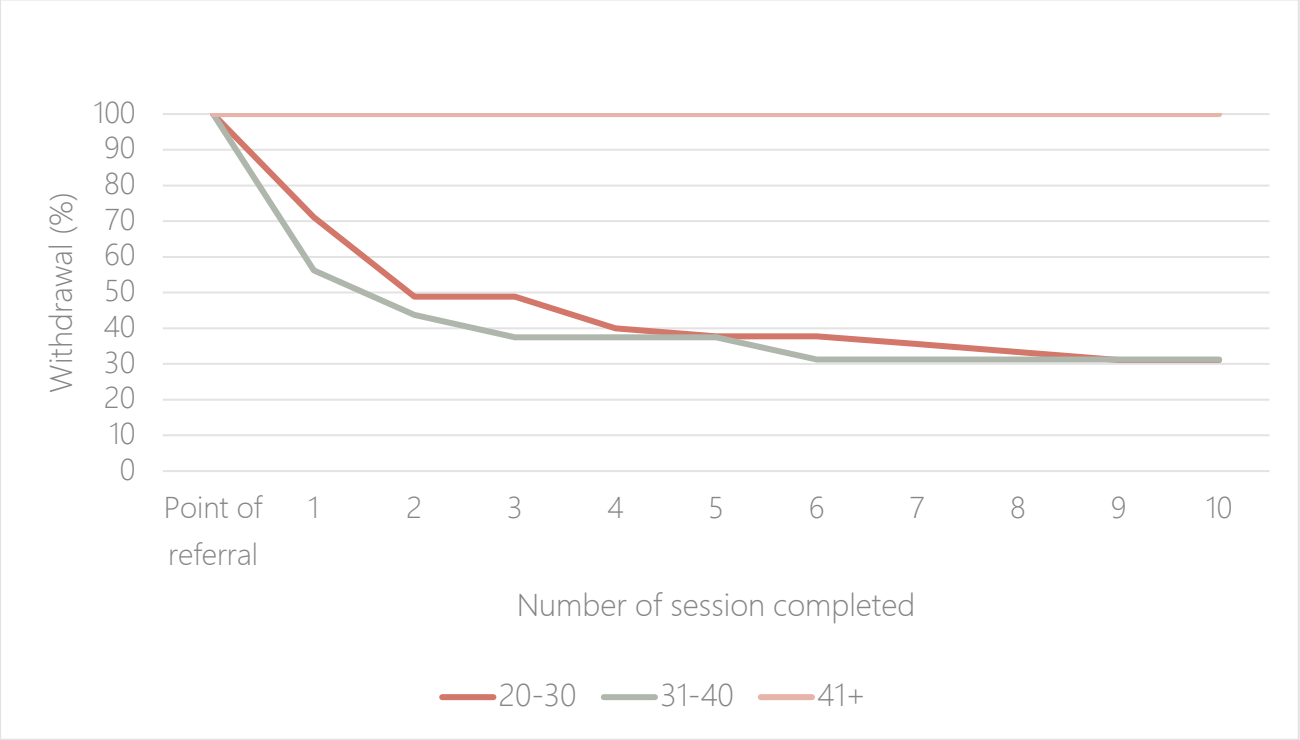

Figure 3: Withdrawal from pilot by age group.

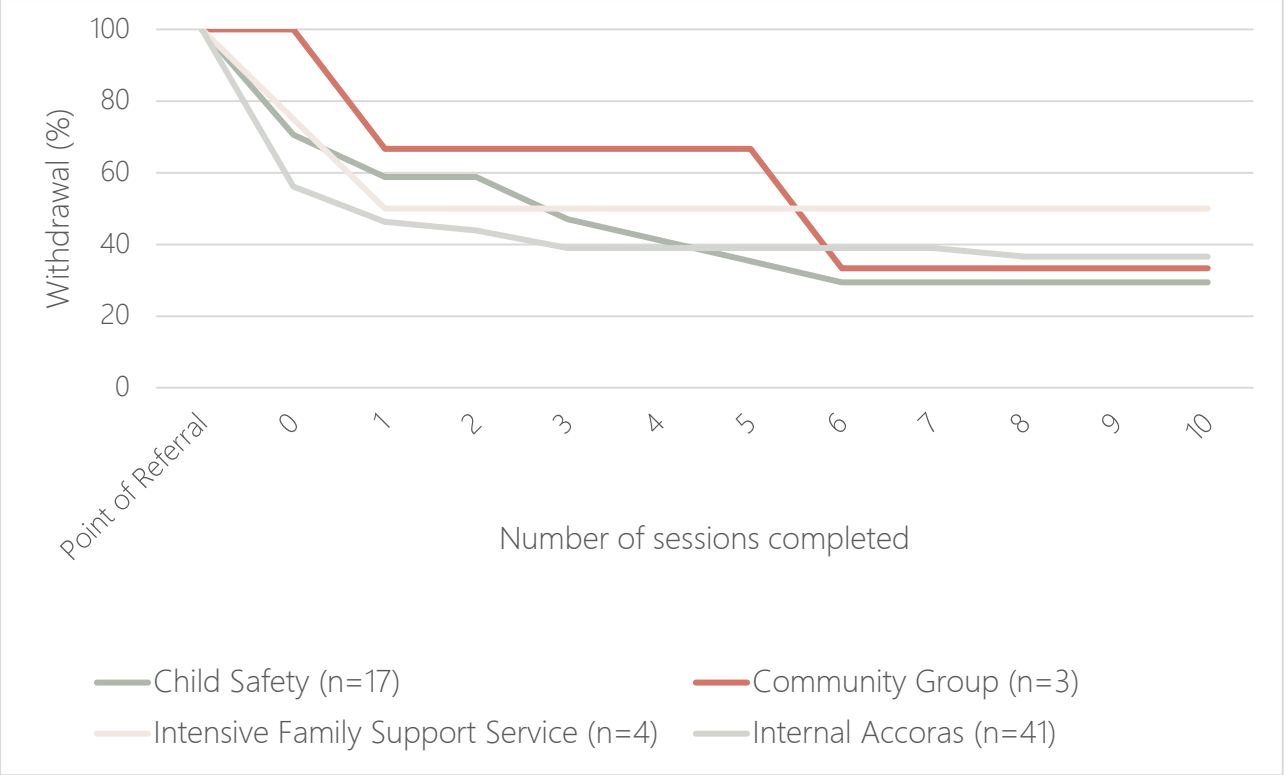

Figure 4: Withdrawal from pilot program by referral source.

Figure 5: Withdrawal among caregivers identifying as Aboriginal and/or Torres Strait Islander.

Table 6, below, provides descriptive demographics for both the referred sample of parents, and those who completed the program. Most of the caregivers who were referred to the program were primiparous biological mothers of a non-Indigenous background between 20-30 years of age (28 ± 6.87). The referred sample only included 4 biological fathers and 2 kinship caregivers.

Table 6: Demographics of the sample of participants who were referred to the program (n=70) and who completed the program (n=23).

	Referred sample (n=70)	Completers (n=23)
Age group	20-30 = 45 (69.2%) 31-40= 16 (24.6%) 41+= 4 (6.2%)	20-30 = 14 (60.8%) 31-40 = 5 (21.7%) 41+ = 4 (17.5%)
Gender	Female = 65 (92.8%) Male = 4 (5.7%) Unknown = 1 (1.5%)	Female =21 (91.3%) Male = 2 (8.7%)
Type of caregiver	Biological mother = 63 (90%) Biological father = 4 (5.7%) Caregiver = 2 (2.8%) Unknown = 1 (1.5%)	Biological mother = 19 (82.6%) Biological father = 2 (8.7%) Caregiver = 2 (8.7%)
Indigenous	Aboriginal = 11 (15.7%) Torres Strait Islander = 1 (1.4%) Neither = 54 (77.1%) Unknown = 4 (5.7%)	Aboriginal = 3 (13.1%) Torres Strait Islander = 0 Neither = 20 (86.9%)
CALD	CALD= 3 (5.7%) Are not CALD=66 (94.3%)	CALD= 0 (0%) Are not CALD= 23(100%)
Number of other children in care (i.e. siblings of the infant)	0 = 36 (51.4%) 1 = 14 (20.1%) 2 = 11 (15.7%) 3 = 4 (5.7%) NA=5 (7.1%)	0 =14 (60.9%) 1 = 5 (21.7%) 2 = 3 (13.1%) 3 = 1 (4.3%)

Of the 70 referred caregivers, only 23 went on to complete the ten sessions of the program. There was no significant difference found between demographics of the two groups (i.e. those that completed and those that did not complete the program) that could be used to predict retention in the program.

How caregivers participated in the ABC program?

The delivery of the ABC program is flexible in its delivery. The 11 sessions are not required to be completed within a specific period. Caregiver commencement dates were subtracted from their completion dates to determine the number of days spent in the program. Caregivers took an average of 127 days to complete the program, equating to roughly 4 months. This program duration ranged from 54 days to 219 days.

Due to the implications of the COVID-19 pandemic on face-to-face service delivery, the program was offered to parents via telehealth. However, of the 230 sessions delivered to caregivers in the pilot, only two were conducted via telehealth.

Did participation in ABC improve outcomes for caregivers and infants?

For the caregivers who completed the ABC program (n=23), we report here on what outcomes they and their infant experienced, including changes in:

- Caregiver sensitivity
- Infant socio-emotional functioning
- Caregiver beliefs about crying cues
- Caregiver depression
- Infant and caregiver stress
- Caregiver reflective functioning

Caregiver sensitivity

Overall caregiver sensitivity significantly improved for those who finished the program. Figure 6 shows changes in mean scores for caregivers before and after completing the ABC program.

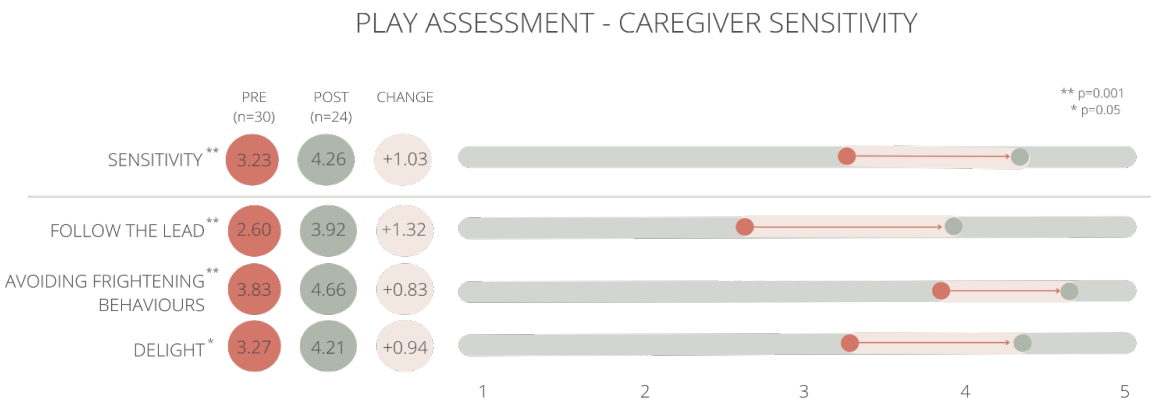

Figure 6: Change in caregiver sensitivity.

Overall sensitivity had increased significantly at the end of the ABC program (Z= -3.6, p=<0.001). When looking at change in the domains of sensitivity we can also see a significant increase in caregivers' ability to 'follow the lead' (Z=-3.8, p=<0.001), their ability to 'delight in their child' (Z= -3.2, p=<0.05), and reported intrusive (or frightening) behaviours (Z= 2.5, p=<0.001).

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Previous ABC evaluations have shown **improvements in Caregiver Sensitivity** between **0.5-1.5 on the 5-point scale** (see Attachment E for references). The magnitude of change depends on sample (i.e., foster-care, referred by child safety), sub-domain, and pre-ABC starting point. The pre-ABC starting point observed in this pilot was slightly higher than other community samples, however we saw similar improvements (References 4, 5 & 8 in Attachment E).

Infant socio-emotional functioning

There was an improvement in infant socio-emotional functioning, however this was not statistically significant. Figure 7 highlights the changes from pre- to post-ABC intervention, which highlights a higher proportion of infants with no risk of referral, a reduction in infants requiring monitoring, and a reduction in infants needing to be referred.

Figure 7: Changes in ages and stages categories pre- and post-ABC.

Figure 8 highlights that most of the improvement was seen in infants who moved from needing to be 'monitored' to 'no risk' following the program. Two infants worsened following the program, with one moving from 'no risk' to 'monitor', and one moving from 'monitor' to 'refer'. While there are improvements overall, these were not found to be significant (Z= -1.0, p=0.531).

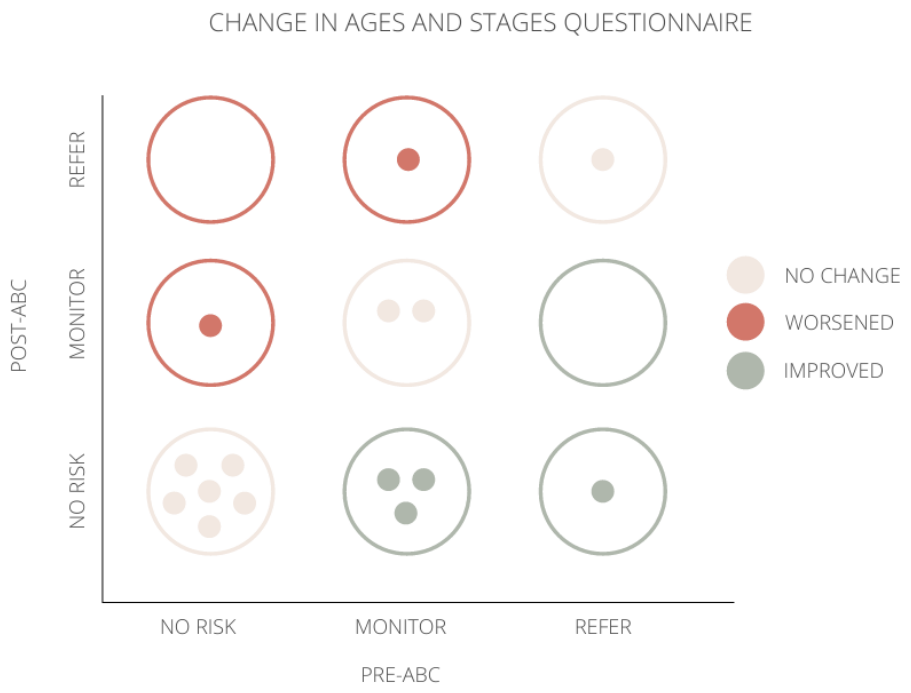

Figure 8: Individual change in ages and stages categories pre- and post- ABC.

Although the ASQ-SE has been used in two previous ABC evaluations (references 4 & 8 in Attachment E), the analyses were not comparable. This tool is used in clinical screening, with the clinical cut-offs set at different ranges depending on the version (i.e., age of infant). Because some caregivers in this pilot filled in different versions of the ASQ-SE pre-ABC and post-ABC it was only appropriate to interpret these data categorically. While the majority were in the 'No Risk' category post-ABC, many started in this category, indicating many infants in this sample were already on a normal socio-emotional developmental trajectory.

Parent and infant cues

Overall, there were no significant improvements in infant-oriented beliefs or caregiver-oriented beliefs.

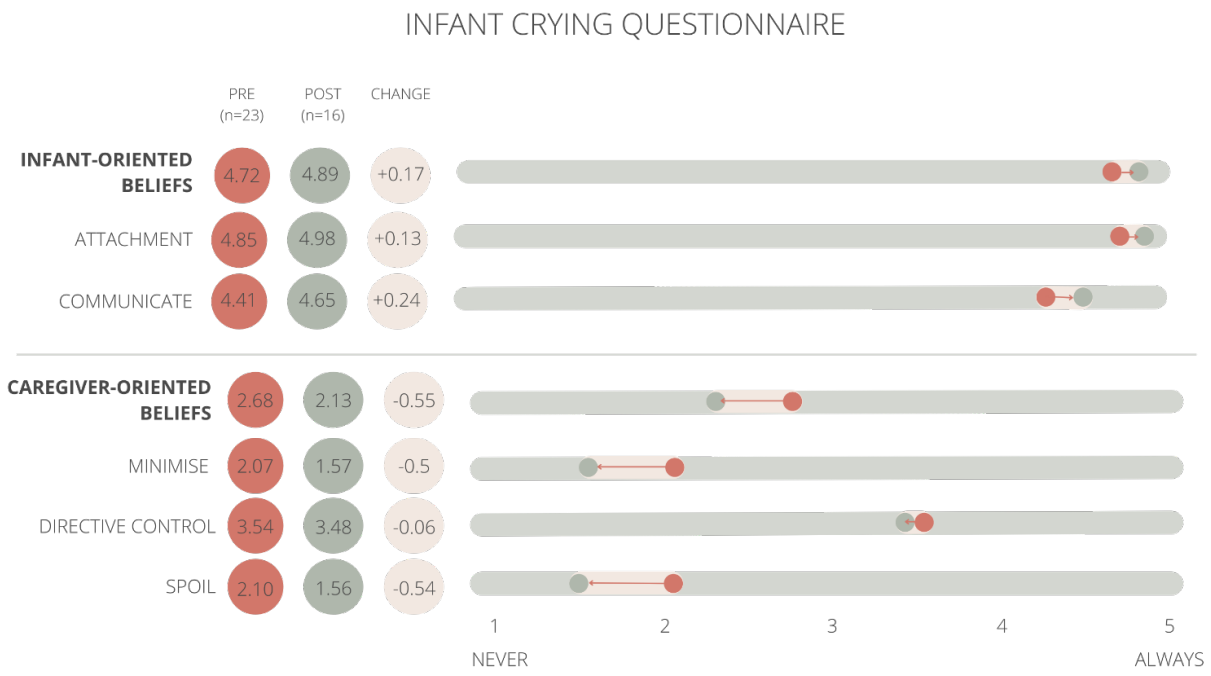

Figure 8: Change in caregivers' beliefs about infant crying cues.

Figure 8 highlights that despite improvements overall regarding caregiver-oriented beliefs and infant-oriented beliefs, they were not significant (Z= -1.1, p=>0.05, and Z= -1.3, p=>0.05 respectively). These findings were consistent in analysis of the subdomains of *attachment* (Z= 0.816, p=0. >0.05), *communication* (Z= -.54, p=0.688), spoiling behaviours (Z= -1.6, p=>0.05), minimisation (Z= -1.5, p=>0.05), and directive control (Z= -1.1, p=>0.05).

Only one previous ABC evaluation has used the Infant Crying Questionnaire to assess caregivers' beliefs about infant crying (reference 8 in Attachment E), however it was not appropriate to compare our results. Importantly, **pre-ABC scores in this pilot were already reflective of positive beliefs around infant crying**, leaving little room for improvement.

Caregiver depression

Overall, there were no significant improvements in depression amongst caregivers following completion of the program.

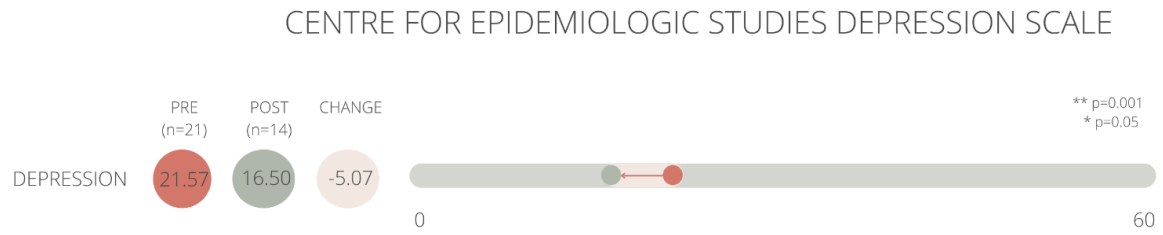

Figure 9: Change in caregiver depression.

Figure 9 highlights that despite a reduction in reported depressive symptoms, these were not statistically significant (Z= -1.051, p=>0.05).

Two previous ABC evaluations found non-significant decreasing trends in caregivers' self-reported depressive symptoms (references 3 & 10 in Attachment E), similar to this study. This tool is used to screen for clinical depression. **The average score in this pilot remained >16, which is clinically important because scores of 16 and above are indicative of risk for clinical depression**.

Infant and caregiver stress

Overall, there was no significant decrease in parenting stress following the ABC program.

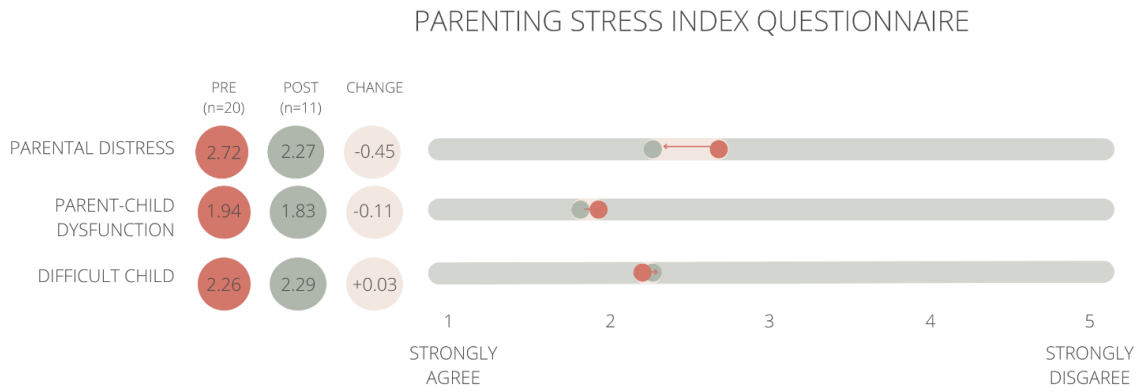

Figure 10: Change in parenting stress.

Figure 10 highlights that despite a slight decrease in parental stress overall, this change was not significant across the subdomains of parental distress (Z= -.420, p=>0.05), parent-child dysfunction (Z= -.339, p=>0.05), or difficult child (Z= -.677, p=>0.05).

Although there are two previous ABC evaluations that measure caregiver and infant stress using the Parenting Stress Index Questionnaire (references 4 & 10 in Attachment E), the analysis of this measure is not comparable as both studies reported findings differently (i.e., deciles, and mean/standard deviations of subdomains). As such, we have maintained consistency in analysis and reporting this in line with the rest of the analysis.

Parental reflective functioning questionnaire

Overall, the program did not result in improvements in parental reflective functioning.

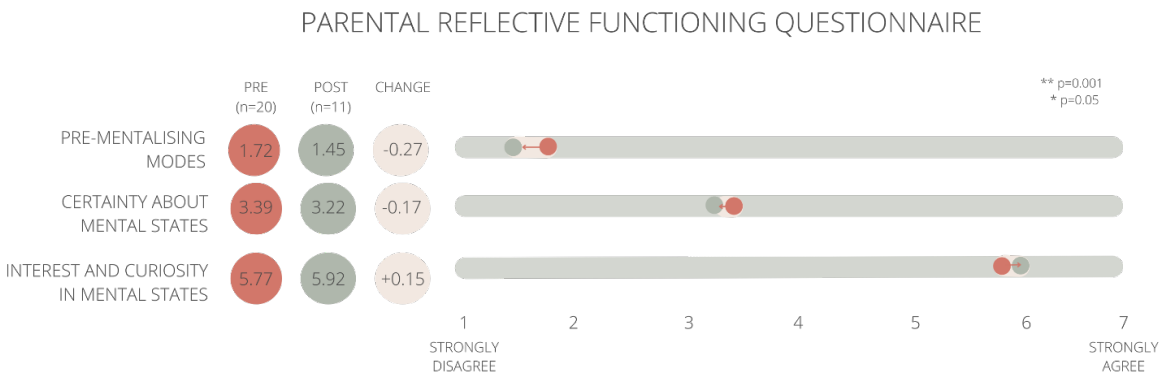

Figure 11: Changes in reflective functioning.

Figure 11 highlights that despite minor changes in parental reflective functioning, no significant changes were seen over any domains, including pre-mentalising modes (Z= -.272, p=>0.05), certainty about mental states (Z= -0.10, p=>0.05), or interest and curiosity in mental states (Z= -0.0, p=>0.05).

There are no other ABC evaluations available that include the Parental Reflective Functioning Questionnaire. **In this pilot, the sub-domain scores for pre-mentalising and certainty about mental states both pre- and post-ABC represent positive parental reflective functioning.**

What was the experience of caregivers in the ABC pilot?

The caregivers we spoke to (6, out of a possible 20) were overwhelmingly positive about their ABC experiences. Key themes that caregivers noted about their ABC experience included the: strengths-based approach of the program; comfort of being at home and present with their infant; and confidence it gave them to show they were providing good care.

- Strengths-based approach: caregivers spoke about the positivity of the program and the way the Parent Coaches focused on what they were doing well. This was described as receiving "*nothing but positivity*". This experience made caregivers feel supported and positive in their interactions with the Parent Coach.

  "Single mum's just need that little bit of support. You're not a bad person."
  "Nothing to knock you down. Everything was absolutely wonderful. She made you feel really good"
  [caregiver of 23-month-old]

- In-home and in comfort: Caregivers expressed that the in-home nature of the ABC program created a sense of ease and comfort for both the caregiver and their infant as it allowed caregivers to engage with their infant in a space which was familiar to them. They also expressed the enjoyment they gained from playing with their infants during the coaching sessions.

  "It felt good to be able to just interact [with infant] here at home"
  [caregiver of 9-month-old]

- Sense of "proving commitment" to parenting: there were caregivers who described their positive experience with ABC in terms of how it made them feel more confident in their ability to "prove" they were good caregivers. They talked about their ability to use completion of ABC as an informal sign that they were "*doing a good job*", and also formally in court as evidence for child custody cases.

Case Study

- Caregiver: Grandparent
- Parent Coach: C
- Infant: Male, 1 year 11 months

How did you find ABC?

"ABC helped me a lot. I learnt how to understand and communicate with [child], and now he knows the difference in how to ask for help, and how to apologise. I learnt different things and strategies, and it helped not only with [child] but all my grandchildren. It was a challenge as it was not like raising my children, raising these grandchildren is so different today".

How did ABC help you and your interactions with AJ?

"When he was throwing a tantrum, I wouldn't listen. [ABC] helped me to stop and explain to him 'you have to wait and I'll come and do it with you soon. He doesn't play us like he used to. I still do a lot of the ABC stuff. I pull the paperwork out when I am alone, it gives me reassurance I'm doing the right thing, and reinforces what ABC taught me."

What was the highlight of the ABC program for you?

"The communication between [Parent Coach], me, and [child]. There was a great bond, [Parent Coach] would watch and observe. She was great, she wouldn't knock you down and say 'that was wrong', she would always tell me I'm doing great. [Child] absolutely adored [Parent Coach]."

"I've got to give [Parent Coach] credit as she is the one who has helped us to get to here today. I miss her, and I know she has a job to do, and we all have to move on with our lives, but I also know she is out there doing a great job [delivering ABC]."

Did caregivers perceive there to be positive impacts from ABC, and were there any negative impacts?

Caregivers were able to describe positive and noticeable changes in their infant. Caregivers spoke about changes in their infant's: social skills to get along with peers, siblings and family; communication skills to express affection; and their relationship with the caregiver.

- Infant social skills: a key impact of the program on infants that caregivers noticed was their infant's improved social skills. They described them as "easier and happy go lucky child." They also talked about their improved ability to get along with peers or siblings and share when socialising. One caregiver described increased empathy displayed by their infant, which they attributed to the program.

  "He gets along with the others. He knows where he's done wrong now; says sorry and gives a hug to the person" [caregiver of 9-month-old]

- Infant communication skills: caregivers noticed improvements in their infant's ability to communicate what they wanted and in their own ability to communicate effectively with their infant. They also reported improvements in their infant's ability to express affection towards them.

  "The children have learned the word LOVE. How to say I love you." [caregiver of 23-month-old infant]

- Infant-caregiver relationship: caregivers expressed their closeness with their infant and how this was a "*stronger connection*" than before the program and that they felt "*inseparable*".

Adopting ABC "lingo"

An observation from the interviews was how some caregivers embodied the ABC program through using the language of "follow the lead" or "delight" when talking about their infants. Caregivers' use of this language was often an indicator of their positivity about the impacts of the program.

Challenging impacts of the program were rarely discussed, but when caregivers did raise issues that challenged them, they related to the impacts of dealing with reflections of the caregivers' childhood.

- Reflections about own upbringing: some caregivers expressed how challenging it was to talk with the Parent Coach about their own childhood, which is raised in Session 7 around "Voices of the Past". For example, a caregiver spoke about the shift in thinking for them from "telling" to "explaining" as a big learning.

  "asking questions meant you were stupid, when I was a kid." [Caregiver of a 24-month-old infant]

Do caregivers perceive the impacts of ABC to be sustainable?

Caregivers did not specifically talk about the longevity or sustainability of the impacts of the program. This evaluation question could be explored through longer-term follow-up of caregivers involved in the pilot.

Were there different outcomes and experiences observed for different participant cohorts:

a) Did Aboriginal and Torres Strait Islander participants or culturally and linguistically diverse participants experience unique impact(s)?

Twelve caregivers who identified as being **Aboriginal or Torres Strait Islander** were referred to the program, two did not consent, seven consented but did not complete, and three completed the program. Due to the small sample of people that had pre and post program data, we have not quantitatively compared the outcome of caregiver who identified and did not.

Three caregivers who identified as being **culturally and linguistically diverse** (CALD) were referred to the program, one did not consent and two consented but did not complete the program. Therefore, no caregivers who identified as CALD had pre and post program data.

With no consistent representation of a **First Nations' voice** on the Steering Committee, and minimal representation among the pilot participant groups, and as non-Indigenous evaluators we approach these set of questions (particularly relating to Aboriginal and Torres Strait Islander participants) with an awareness of the implications of who is representing First Nations' peoples, how and for whose benefit. The data we have access to, primarily quantitative data, we understand to be at odds with Indigenous ways of knowing and being (in which story and voice matter). Further, these data, we caution, do not hold the degree of complexity necessary to fully respond to such important questions for the ABC program.

b) Are there specific cultural considerations for Aboriginal and Torres Strait Islander participants? Or for culturally and linguistically diverse participants?

Whilst we're unable to answer the evaluation question above, we did learn a great deal from stakeholders thoughtful reflections about the cultural values and assumptions underpinning the program, much of which is steeped in Western values and culture.

> *"The program needs to be unpacked and interrogated by Aboriginal and Torres Strait Islander families before we even think about offering it to these families"*

We summarise these reflections in Table 7 and share these to inform future work that is required around the fit of ABC for Aboriginal and Torres Strait Islander families and CALD families.

Table 7: Reflections on cultural assumptions made in the ABC program

Program component	How it is approached in the ABC program	Reflections on cultural implications or assumptions
Setting	In-home	Assumes that there are no cultural obligations or protocol for visitor coming into the house that will change the nature of the dynamic between caregiver and coach
Therapeutic Framework	Childhood trauma experienced by the caregiver is lightly addressed	Assumes the potential level of childhood trauma experienced by a caregiver can be dealt with by the ABC provider. *"what if we are working with First Nations peoples, or CALD people? There's trauma there that I don't think is appropriate to unpack or even talk about without having a framework in place." [Parent Coach]*
Referral pathways	ABC Parent Coach referred to the family by external agency.	Assumes that sufficient rapport and trust is built within 1 session in order to begin delivery in the home the following week.
Content	Example: Session content 7: 'Voices of the past'	Assumes cultural appropriateness (and therapeutic readiness) of this conversation with someone outside of the family/community
		Language use comes from a US-context (e.g. use of the term "pudding") that assumes universality of

Program component	How it is approached in the ABC program	Reflections on cultural implications or assumptions
		language or direct translation in other cultural contexts.
Delivery modality	Verbal delivery	Assumes cognitive capacity to process high amount of verbal information (1 comment every minute) – particularly important for people whose first language is not English.
		Assumes culturally acceptable (non-intrusive) to receiving ongoing commentary.
		Assumes appropriateness of ongoing and detailed commentary from coach for people with history of trauma.
		Language use is steeped in jargon (e.g. "follow the lead", "nurturance") and US-context (e.g. "pudding") that assumes cultural relevance and comprehension for diverse Australian families.
Participant of focus	Parents/caregivers	Assumes that it is appropriate to talk about the infant but not to the infant.
		Assumes Westernised caregiver model of Attachment Theory, which may not reflect First Nations concepts of caregiving
Program deliverable	Video montage	Weekly video recordings assume acceptability of in-home recording of caregiver and infant interacting. The presence of a camera can bring another audience into the room (often explained in the context of a requirement for coaches' training). This aspect of the program is steeped in layers of surveillance that is assumed to be acceptable/appropriate for the family.
Measurement of impact outcomes	Survey tools and video play assessment from Western perspective	Assumes that the way survey items selected for capturing the impacts of ABC can capture cultural nuance and diversity in caregiver practices.

What challenges were encountered by Parent Coaches in delivering the program, how were these addressed; and were they effective?

When asked about the challenges of delivering ABC, some Parent Coaches found it difficult to identify challenges and generally had positive reflections on their experiences of delivering the program. However, when challenges were identified, they were considerable challenges and we have described these under the themes of *learning ABC* and *delivering ABC*.

Learning ABC

Over an intensive 12-month period, Parent Coaches learn the way of delivering ABC. Such that through training, experience with caregivers and supervision delivery becomes a practiced skill. This process (almost acculturation to the ABC way) was framed by the Parent Coaches as "*a steep learning curve*", often requiring a "*change in mindset*" that was multi-layered. This change in mindset required:

- Dropping defensiveness during the training and supervision delivered by the University of Delaware. Parent Coaches described finding it challenging to be heavily critiqued, as they were used to more empathetic ways of working together. Parent Coaches described the need to not internalise the point system used to provide feedback on 'in the moment commenting' so as to not create a competition between the Parent Coaches.
- Taking up the role as commentator required getting used to interrupting oneself during content delivery to engage in 'in the moment commenting'.

  "the penny dropped when I saw myself as a 'sports commentator'"
  [Parent Coach]
- Not focusing on the infant during the coaching sessions was difficult at first for the Parent Coaches. The program required the coaches to learn to not engage directly with the infant during the sessions. However, as evidenced in the case study (Page 38), the presence of the Parent Coach in the home led to rapport being developed between the coach and infant.

Delivering ABC

Coaches described a process by which they became comfortable with delivering ABC over time. At first it felt "manualised and scripted" and "unnatural", but it becomes "natural" and "something just clicks". The challenges experienced in delivering the program include:

- Holding two voices: the voice for in-the-moment commenting, and the voice for program content. Occasionally these voices interrupt one another. In fact, one voice is more important than the other – the in the moment commentator, who is not only considered a key ingredient

for the success of the program (and something that stands the program apart from other IMH interventions), but it is also the one that is given most attention in the training and accreditation process (where points are scored). In addition to the two voices within sessions, some Parent Coaches also struggled with the duality of holding two roles. Both coaches who held dual roles found training and delivery incredibly challenging, as ABC required them to hold a certain voice that did not sit easily with their other practices.

- Adapting to the context of the caregiver: we learned of the adaptations or "micro-changes" that the coaches make to their delivery depending on the context of the particular family or caregiver they are working with. These adaptations relied on a great deal of discernment on the coaches part, a high level of emotional intelligence and clinical judgement. These subtle adaptations were happening all the time and were often difficult for coaches to explain because they had become a normal part of their delivery. These micro-changes could be summarised as: *"meeting people where they are at"* and included:
    - Simplifying language: was required for many caregivers, especially the jargon of the program (e.g. nurturance, delight, follow the lead etc), which Parent Coaches felt they needed to "over-explain". They also described a need to adapt language for Australian context (e.g. Session 4: *what is pudding? - we don't feed infants sugar in Australia?*), and ensure the program was being understood by caregivers who had an intellectual disability or expressed difficulty in understanding the program content. This is particularly important given the highly verbal nature of the program and the caution expressed particularly by sector stakeholders around how this may be for caregivers with an intellectual impairment or learning disability.
    - Delivering in a culturally mindful way: Parent Coaches frequently described the subtle and varied ways they contextualised the manualised ABC program when delivering with families of non-Western or non-white cultures (e.g. stopping the camera during sessions). The Parent Coaches found this difficult to describe as there was no one way of adapting it, but that there needs to be understanding that the program requires a human-to-human connection that needs to be honoured.
    - Bridging into the "Voices of the Past" session: coaches described the extreme care required when approaching the 7th session "Voices of the Past", which requires caregivers to reflect on their own experiences of childhood. They needed to *"bridge into"* this session by ensuring caregivers knew it was coming, working on their rapport before the session and ensuring caregivers had time to process their reflections (which may have required postponing to the 8th session). Coaches also noted that the labelling of this session was not culturally sensitive, and they would often instead refer to *"what was your relationship with mum/grandparent like growing up"*.

Navigating caregiver readiness for ABC program

In addition to the challenges experienced in delivering the program, Parent Coaches commonly raised concerns about the "readiness" of caregivers to start engaging in the ABC program.

> *"Didn't feel comfortable with this family receiving the program – a lot of disagreement internally and with ABC people overseeing the program on the fit for the family. I had been in the home, I know the ABC model, this isn't appropriate for this family, and I pushed and pushed, and they still wanted to continue with it, and we tried to arrange sessions with the mum and she never responded and then later when reached she said she didn't want to participate." [Parent Coach]*

- Screening protocol: Some Parent Coaches discussed the screening approach taken during the pilot and felt that they would have benefited from more information from the referrer to assess readiness of family for the program. One coach created their own screening protocol (in addition to the Accoras protocol) and advocated for meeting the family before offering the program. Some of the low scores for depression and anxiety measures in the prequestionnaire (indicating significant depressive symptoms) were concerning, leading coaches to question:

> " *Where is she at capacity-wise to participate in this program?" [Parent Coach]*

> *"In order for a successful intervention, mum needs to have capacity to practice these things. She's not ready and I don't feel comfortable putting a program in front of someone when they are not physically or emotionally there." [Parent Coach]*

- Parent Coach emotional intelligence: We learned that coaches' emotional intelligence and clinical judgment is an implicit but necessary skill for safe and appropriate delivery of ABC. The coaches spoke of the ways they would *'read the room'* (who else is around, is the caregiver comfortable in the house, is this session content appropriate). In the context of family violence or other child safety circumstances, we observed that these nuanced judgements during a session were crucial to not only the appropriate delivery of the ABC (including if it was appropriate to deliver content at all) but also the safety of members of the household and the Parent Coach. There was also acknowledgment that the University of Delaware weren't always 'right' on making a judgement because they couldn't see who wasn't in the video frame with the caregiver and infant (the sole focus of the program).
- Lack of trauma-informed practice framework: Some Parent Coaches felt there was not enough trauma-informed practice wrapped around the delivery of the ABC program. Coaches noted that there is potentially triggering content in the program (e.g. Session 7:

Voices of the Past) and that caregivers often alluded to or directly spoke about their own trauma. This raised concerns by the Parent Coaches about who could deliver the program:

> *"Who are you asking to be Parent Coaches? People can do it absolutely, where there isn't family complexity, but I'm going back to the model where we are looking at foster care systems and kinship care. I had a number of cases with child safety involvement and risk" [Parent Coach]*

Trauma can arise from single or repeated adverse events that threaten to overwhelm a person's ability to cope.[7] When it is repeated and extreme, occurs over a long time, or is perpetrated in childhood by care-givers it is called complex trauma. Yet within current systems trauma is frequently unrecognised, unacknowledged, and unaddressed.[7] Many of those affected have been inadvertently re-traumatised in systems of care, which are lacking the requisite knowledge and training around the particular sensitivities, vulnerabilities and triggers of trauma survivors.

Program Rigidity

Some Parent Coaches expressed hesitancy towards the ABC program's rigidity and the requirement to maintain program fidelity. These coaches had trouble in finding their way through program delivery. This was felt in particular by one Parent Coach as far as *"ABC did not allow her to be a practitioner".*

- Tensions with coaches existing training and the "coaching" required for ABC program. Some Parent Coaches discussed a tension between their professional practice and what ABC was asking them to do. In one case, when a coach used her own clinical judgement about not delivering a certain part of the program (Session 7: Voices of the Past) because she feared it would trigger trauma for the caregivers, her approach was dismissed in supervision, and she was told to continue with the program content until the caregiver is comfortable. The Parent Coach responded, *"but I don't feel comfortable doing that",* and as a result of pushing on with this session, the caregiver almost withdrew from the program and the Parent Coach had to do a lot of work to regain trust following the Voices of the Past session.

  > *"There could be trauma there that I can't even unpack and I don't have the resources then to follow through unfortunately because I don't have contact with the external agency that's supporting her" [Parent Coach]*

- Not enough space in the program delivery to build relationships with caregivers; to properly screen for safety (especially when domestic violence concerns became apparent during the delivery); or to debrief or offload as a coach. The Parent Coaches all commented on the desire to have more time and sessions to cover these important aspects of delivery better.

What challenges were encountered by caregivers in participating in the program? And for those who did not choose to participate?

As discussed earlier, the caregivers were overwhelmingly positive about their ABC experience.

However, we wish to acknowledge the power differential in these caregiver interviews. As an external consultancy agency calling to conduct an interview about a program they had recently completed, we were relying on a high degree of capacity to not only have the time and space to talk, but also to reflect on their experiences of the program and simultaneously critique the program (e.g. interview prompt asked: "Was there anything you particularly liked or didn't like about the program?"). It is also important to note that caregivers were at times navigating their own layers of accountability and surveillance from government institutions. This oriented us to appreciating that it may not be fair or appropriate to assume caregivers have the time or capacity, or sense of safety to offer the kind of critique about the program that we sought. Careful interviewing techniques allowed us to 'read between the lines' of these interviews and listen out for such power differentials, to support where possible caregivers to speak up about their experiences, priorities and needs. With that, caregivers (with much prompting) oriented to possible improvements for the program, which included:

- Longer sessions for processing new information: one caregiver suggested 2-hour sessions instead of 1-hour sessions, especially to help with understanding the "following the lead" concept. They felt this would have given them more time for the caregiver to understand the concept but also to help the infant understand more. We later learnt that this caregiver has dyslexia and wanted more time to process information: *"the hour wasn't enough for me".*
- Longer duration of the program: a couple of caregivers expressed a desire for the program to go for longer than the 11 sessions. But also commented that it was good to have it finished in a set time too. They alluded to the idea that they wanted a follow-on support for the concepts of the program, not necessarily more ABC sessions.
- More support for "Follow the lead" concept: Some caregivers found the program message to "follow the lead" of your infant difficult to understand and execute in practice. This was highlighted several times:

  "Pretty silly to have to follow the lead of a child when you're the parent… but you learn eventually…" [caregiver of 9-month -old infant]

  "Re-teach me the follow the whole lead thing because I forget that". [caregiver of 24-month-old infant]

4 .0 Strategic-level Findings

What is the view of stakeholders regarding ABC, and the introduction of additional infant mental health supports generally?

Features of the ABC program

We asked sector stakeholders (n=13) and Steering Committee members (n=7), who were highly experienced in delivering, managing, or commissioning IMH services and programs, what they perceived to be the standout features or values of the ABC program.

Importantly, the stakeholders perceived the ABC program to be unique in the existing ecosystem of IMH supports. The key features of ABC that made it unique were:

- Delivered in context and in real time: ABC was seen as being grounded in the reality of the caregiver-infant relationship, where the focus is on the interaction in the natural home environment. Stakeholders felt that this delivery mode offered an efficient process of translating caregivers' learnings in the coaching sessions into practice. They also commonly raised that the real time feedback delivered through the in-the-moment commenting was excellent to support caregiver behaviour change.

  "It's a relational intervention working in the home" [mental health practitioner]

- Strengths-based: Stakeholders really valued the strengths-based focus of the in-the-moment commenting in ABC. They commonly spoke about their experiences working with vulnerable families that were accustomed to deficit-focused systems and services.

  "People come to you problem-saturated; it can be difficult for us as clinicians to get people to see the positives." [Steering Committee member]

- Program fidelity and quality assurance: The fact that ABC was held tightly by the University of Delaware and delivered under ongoing supervision by the university was seen positively by stakeholders. This control over program fidelity was seen to be important as there were other programs in the sector that stakeholder felt had been translated into practice with poor quality. There was also a perception that this program fidelity made the program safer for practitioners and caregivers.

Sector stakeholders also talked more broadly about this type of intervention (not specifically ABC) and highlighted that there is a "wide gap" to be filled in supporting IMH. In discussing how to fill this gap the stakeholders often focused on the benefits of an approach that is:

- Focused on "early" intervention: there was much discussion about what "early intervention" really meant in practice in IMH. Many of the practitioners spoke about the need to address caregiver-infant attachment issues early in two ways: 1) early in life during prenatal and early postnatal care; and 2) early in a prevention sense before infant adversity is experienced or among caregivers who are not experiencing difficulties. Firstly, they spoke about working with primary- and secondary-school aged children and that the links were often made back to early life experiences and poor attachment to primary caregivers. The stakeholders wanted to be able to work with families as early in an infant's life as possible (and saw this fitting with a continuum of care model that spanned life stages). Secondly, they spoke about having programs targeting infant-caregiver attachment on offer to all caregivers, regardless of their experiences of adversity. They felt this was appropriate for all caregivers, even the "worried well" (and saw this fitting in a continuum of care model that spanned from primary prevention to tertiary prevention).
- Time limited: there was also a perception that a program should have a defined duration with a start and end point. Stakeholders felt that this would be appealing to caregivers and to providers of a program.

Comparing ABC to other programs in the IMH space

We asked sector stakeholders to list other programs in the IMH space that they saw as filling a similar gap to what ABC addresses. The complete list is shown in Attachment B, but two programs were commonly raised: Circle of Security (COSP) and Triple P (Figure 12).

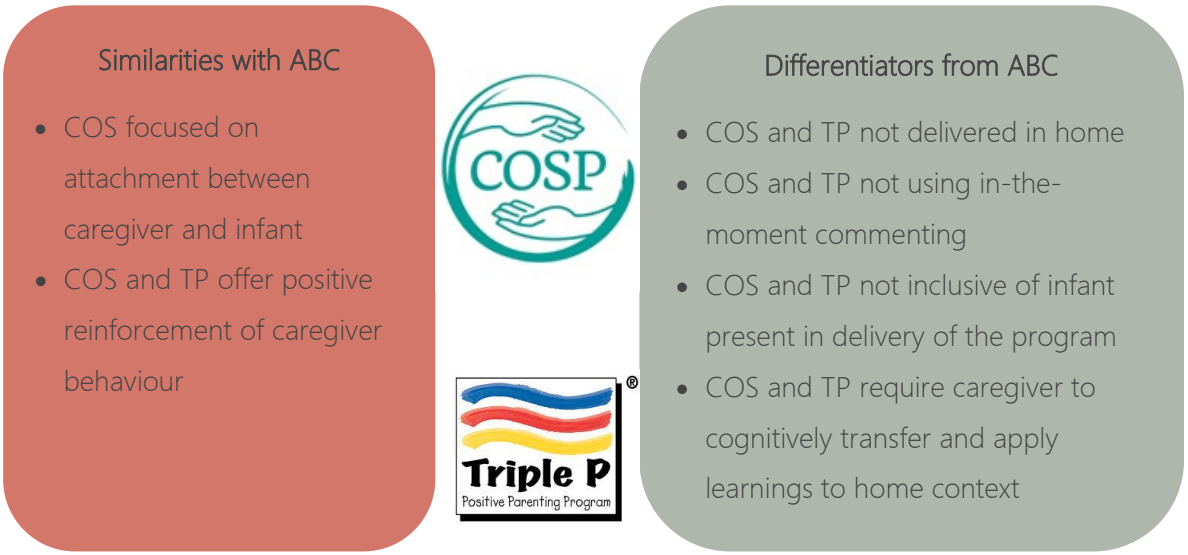

Figure 12: Comparison of key attributes of the ABC program compared to Circle of Security program (COSP) and Triple P.

Potential Issues with ABC implementation

Despite the celebrated aspects of ABC, what emerged through our interviews and focus groups was an **assumption about the flexibility and adaptability of ABC** in the ecosystem of programs. This commonly held assumption – by the sector stakeholders – was the notion that ABC could become '*another tool in a practitioners' toolbox*' or '*another string to the bow'*. Firstly, this not only assumes that ABC has the programmatic flexibility to be '*whipped out at any moment'* (which is not so – if it is delivered as intended), but secondly that there is theoretical coherence with the existing programs being delivered in this space (e.g. COS, Triple P).

Through the interviews, we learned that there is a ***theoretical tension*** **between ABC and other major programs** being delivered in the IMH space (COS, Early Years Education). What in ABC is seen as a key requirement to deliver the desired outcomes (i.e. directing a comment at the caregiver at least once every minute), in COS is seen as a form of 'rupture' to the attachment between infant and caregiver, and from an early years education perspective was seen as a missed opportunity for promoting engagement between infant and caregiver to facilitate attachment and language acquisition for the infant.

"I think it's disrespectful to talk about the child, but not to them" [Early Years Educator]

This theoretical tension also emerged in conversations with Parent Coaches about the nature of the coaching model of ABC and how that intersects with their prior training and experience, with coaches noting the shift in mindset required in learning to deliver ABC.

It is also important to note the modality upon which ABC is hinged – **a *highly verbal delivery*** in the form of in-the-moment commenting– another aspect which may produce tensions between other programs in the sector. The Parent Coaches demonstrated discernment around the caregiver's capacity to understand and take in the program content and language (especially around in-the-moment commenting). The highly verbal nature of the program led sector stakeholders to express caution around how this may be for caregivers with an intellectual impairment or learning disability.

Another key critique of ABC by sector stakeholders was the **minimal time to build rapport** between the Parent Coach and caregiver at the outset of the program. Many stakeholders spoke about their experience in needing multiple sessions, weeks, or months to build rapport with vulnerable families before being able to offer support.

"Rapport takes longer than 1 hour – 'real rapport' takes time" [Mental Health Practitioner]

Stakeholders noted some "red flags" that may block rapport building after watching the video excerpt of the Accoras-delivered ABC session, including wearing a lanyard, using articulate language, and sitting above the caregiver (on a couch). A common suggestion from stakeholders was to offer "pre-program" sessions as part of the ABC implementation. These pre-sessions might be in the home between Parent Coach and caregiver, but without video or content delivery; or could also be facilitated by a Parent Coach coming into an established group of caregivers (e.g. Playgroups, Parenting groups) to simply build rapport and become familiar with the concepts of the program.

Finally, many sector stakeholders raised awareness of the challenges of entering a client's home. Whilst this was also praised as a key strength of the ABC program (being delivered in the caregiver's home), it was also a constant point of conversation about the need for handling this delivery with care, in order to protect both the family and the Parent Coach. Stakeholders felt strongly about requiring intense home screening protocols for therapeutic suitability (i.e. who else is present, noise, space) and safety (i.e. domestic violence, animals). It is worth noting that Accoras had vast experience in delivering services in-home through outreach models before taking on ABC, and as such were experienced and skilled in managing the risks referenced by the sector stakeholders. Therefore, the sector stakeholders perceived there to be more of a barrier for ABC delivery for organisations without outreach experience.

Where does attachment-based early intervention fit in the child wellbeing and protection service system?

Firstly, stakeholders described the **current ecosystem as being fragmented and sparse** in terms of IMH supports. We heard that this fragmented system of support means that many times there is pressure placed on vulnerable families to meet the requirements of the multiple services they're engaging with, rather than for those services to meet the families where they're at. Stakeholders discussed the competing interests of many services and supports (in terms of funding but also in terms of service objectives) and the complexity in understanding the various referral pathways and eligibility of caregivers for certain supports.

Stakeholders prioritised **moving towards a continuum of care** that "*met people where they are at*". A continuum approach was seen as they "*the key to reducing the fragmented services we currently have*". This continuum would resemble a stepped care model that shifts up and down with the needs of the families at the time. The stakeholders discussed a program like ABC (i.e. in-home delivery focused on attachment before issues become acute) might work well for families experiencing low-to-mid levels of adversity, and referenced the often labeled "*missing middle*" [6]of services that are more intense than universal care but less than acute care. However, stakeholders also discussed potential for the core essence of programs like ABC (i.e. attachment focus, positive reinforcement of in-the-moment behaviour) being integrated into more preventive services like early years education, library groups, community health centres or playgroups. They also saw this preventive level of care as an opportunity to build warm pathways into ABC-like programs "*for those families who needed to step up their care*".

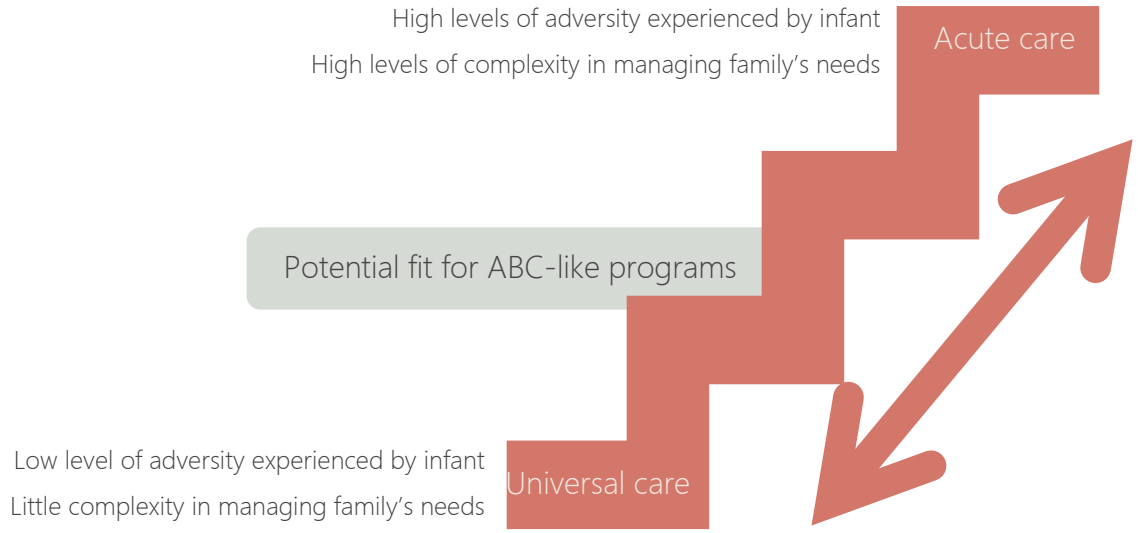

Figure 13: Stepped model of care for supporting IMH

We asked the sector stakeholders what they would see as barriers to implementing a program like ABC (i.e. in-home delivery focused on attachment) in an agency other than Accoras. The key issues they discussed that needed attention aligned closely with some that were experienced by Accoras during the pilot, and included:

- Managing risks for in-home delivery: The in-home delivery model was seen as the core value of the program but was also discussed as the key barrier to implementation. Managing risks was discussed from both a caregiver and Parent Coach perspective. They also discussed managing risks in terms of cultural considerations for what it means to welcome someone into your home and understanding these expectations before the Parent Coach attended the home.

- Funding training and delivery costs: the stakeholders raised many questions about who would carry the cost of training staff to do programs like ABC, and often raised concepts of having a centralised pool of practitioners trained in a program like ABC, but who were positioned in various agencies across the State (depicted in Figure 14).

  "we need a government wide commitment to valuing this type of early intervention and funding it properly. We need to share the cost and share the benefit"

  Yet there was also a lot of discussion about having the ABC training as yet another skill in a practitioners' suite of skills, which implies that training could be widely disseminated and potentially self-funded by practitioners or individual agencies.

- Reaching families across Queensland: Due to the vast geographical spread of the Queensland population, the stakeholders raised concerns about how to deliver meaningful in-home support to rural and regional families. The stakeholders were keen to point out that, from their experiences, delivering programs like ABC would not be easy via telehealth, since the in-moment-commenting was so contextual to the caregiver-infant interactions.

- Planning for workforce scalability: was raised by a number of stakeholders. This discussion questioned the scalability of a trained workforce in light of existing pressures on the mental health workforce. This concern was particularly heightened because of the perceived weight of the required training and supervision of the ABC program. Some stakeholders raised the possibility of training peer workforce to deliver the program and reflected on how this had worked well in other mental health services.

- Wrapping around supports: all stakeholders emphasised the need to not deliver any program in isolation from the broader system supports that exist. They talked about the formal and informal pathways that are required to connect a program like ABC to other services and supports. This was deemed essential for those caregivers experiencing higher levels of adversity or with potential trauma backgrounds.

  "The power would be multiplied if there was capacity to offer other aligned and collaborative services" as part of a "true consortium" that wraps around the family" [Steering Committee member]

Figure 14: Hypothetical service delivery structure discussed by stakeholders

What are the broader service delivery considerations for future support of attachment-based early intervention?

We were privileged to have highly experienced stakeholders engage in this project. These people offered insights into what they believe the IMH sector needs to be able to support the delivery of programs like ABC and to advance the efforts of all agencies and practitioners trying to support IMH. Before discussing the service considerations of the IMH sector, we must provide scope on who belongs to this sector. There is broad engagement in service delivery related to promoting IMH, as shown in Figure 15.

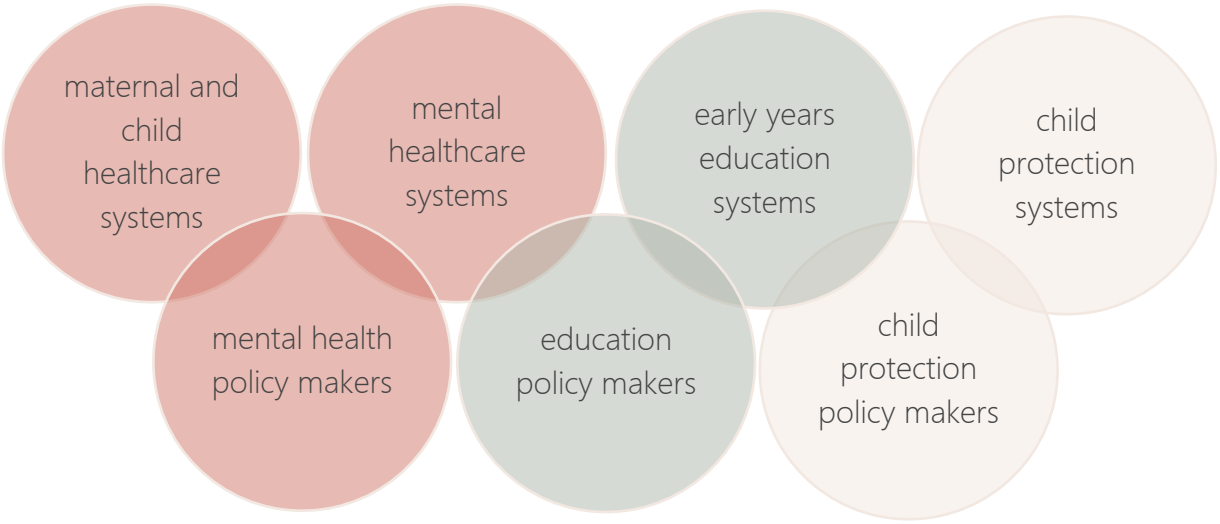

Figure 15: Breadth of the IMH sector

Our interactions with stakeholders throughout this project (outlined in Attachment C), identified the following themes as important directions for the IMH sector:

Sector Leadership is needed to drive change. Due to so many sectors being involved in IMH (Figure 15) there is a perception that many are invested but that joint governance and decision making is not happening. There needs to be a unified approach with clear responsibility for who is leading the way to progress IMH.

> *"This [IMH] is everyone's business, but no one's responsibility"*
> *[Steering Committee member]*

Advocacy and awareness: When we approached sector stakeholders to participate in this pilot, there were instances where the person wanted to clarify what we were actually referring to by "infant mental health". In our discussions it became apparent that there were different levels of understanding about what IMH is and what the long-term impacts of IMH are. We were having conversations with sector stakeholders about *"what I just learnt [about IMH] the other day"*. IMH was positioned as the *"new kid on the block"*. This is important to highlight given that the stakeholders invited to engage in this evaluation were deemed by the Steering Committee to be proximal to issues and knowledge of the IMH system. There is currently very low systemic understanding of what IMH is and why it is important in child development.

Workforce capacity and capability: There was detailed discussion about the characteristics of who needs to deliver programs in IMH. This was often positioned as being the responsibility of existing practitioners in the mental health space who "*are interested in IMH*", but often also branched out to professionals in other sectors such as early years education or maternal and child health nurses. A number of sector stakeholders saw this type of work as sitting within their professional roles, but also commonly noted that they were stretched beyond capacity in their current practices. Stakeholders were wary of just adding another program on top of existing workloads.

Reforming procurement processes for services: There was a discussion about the need to shift from procurement focused on outputs to a focus on outcomes for consumers. Instead of funding services based on the outputs they need to generate (i.e. serve xx families from xx communities) fund them based on the outcomes the service is targeting (e.g. xx families experiencing safe, secure relationships) and let the agencies come up with the *"how they generate these outcomes"*.

Re-orientation to people: Stakeholders discussed a need for government policy and services *"to service people as customers*". There were perceptions that some decisionmakers have lost focus on families being at the center of support and that there needs to be a focus on "*meeting them where they are at"*. This finding is also related to the earlier finding about the pressure placed on caregivers to have to navigate a currently fragmented system:

> *"Parents are expected to identify and navigate rather than access and receive". [Steering Committee member]*

5 .0 Implications

We have synthesised the findings from this pilot project and offer implications related to project-level and strategic-level actions (Figure 16).

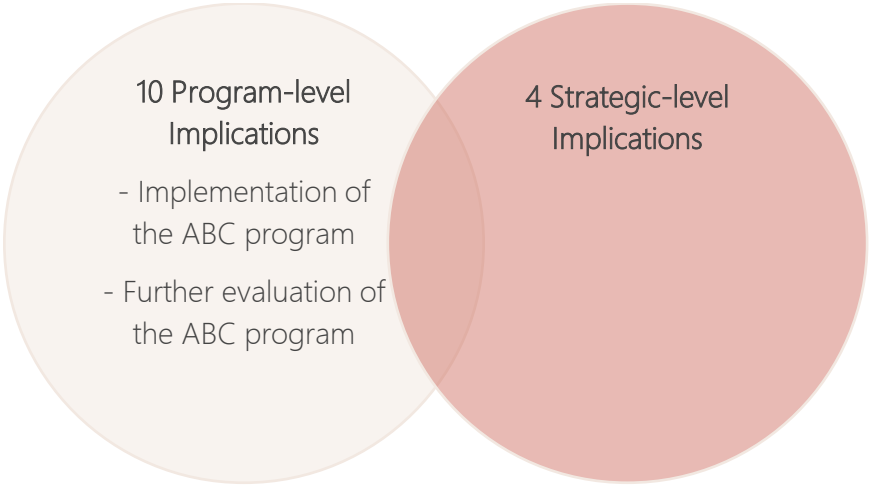

Figure 16: Implications from the ABC pilot evaluation project

Implications for the implementation of the ABC program

These implications relate to the delivery of the specific program components, not the broader service delivery model issues, which are addressed in the next section. However, we want to acknowledge that these program-level implications would be highly dependent on the broader system within which the program was delivered. We also want to acknowledge the tension created by making implications for changes to a program that is licensed from the University of Delaware and who maintain a strong focus on program fidelity.

Overarching Implication: This ABC program offered caregivers and infants a positive experience that led to meaningful improvements in attachment-related outcomes. The potential for this program to help many Queensland families is immense and the impacts could be far reaching for caregiver and infant. However, there are several critical implementation issues that require deep consideration by any agency offering ABC in the future.

Implication 1: Embed the ABC program in a 'Trauma-informed Practice Framework'

We recommend wrapping the delivery of the ABC program in a stronger Trauma-informed Practice Framework. Whilst the program was originally designed for infants experiencing trauma or adversity, this was often in the context of caregivers who may not have had these experiences (i.e. foster carers). Many of the pilot caregivers shared experiences of trauma or complex trauma with their Parent Coach. Whilst the program itself is trauma-informed, it is important that the rigidity of the program fidelity and supervision does not work against a Trauma-informed Practice Framework.

A Trauma-informed Practice Framework is founded on five core principles – safety, trustworthiness, choice, collaboration and empowerment as well as respect for diversity.[7] Trauma-informed services do no harm (i.e. they do not re-traumatise or blame victims for their efforts to manage their traumatic reactions), and they embrace a message of hope and optimism that recovery is possible. Trauma-informed services:

- attune to the possibility of trauma in the lives of everyone seeking support
- accommodate the vulnerabilities of trauma survivors including people from diverse backgrounds
- minimise the risks of re-traumatisation and promote healing
- emphasise physical and emotional safety for everyone
- recognise coping strategies as attempts to cope
- collaborate with clients, and affirm their strengths and resources
- recognise the importance of respect, dignity and hope
- focus on the whole context in which a service is provided and not just on what is provided.

Whilst the ABC program aligns with most of these core principles, there are other aspects of the program (i.e. enforcing inclusion of a the 'Voices of the Past' session) that do not align. It is essential that the program is supported by and connected to a Trauma-informed Practice Framework. This fundamental implication to wrap support around ABC underpins many of the subsequent implications.

Implication 2: The ABC program should be delivered by a professional workforce with experience in supporting families experiencing challenges

This Accoras-delivered pilot relied on qualified and experienced practitioners to deliver the program. The ABC program does not require Parent Coaches to have any prior experience or qualifications, as the in-the-moment commenting is considered the effective element.[8] However, based on the challenges experienced by the Parent Coaches in this pilot we believe that the program should be delivered by trained practitioners (from mental health

or social services sectors), with experience in or theoretical understanding of supporting families who are experiencing challenges.

We want to acknowledge the gains that could come from delivering the ABC program through peer Parent Coaches. This is a trend in mental health service delivery across Australia[9, 10] - as evidenced by being included in the terms of reference for the current Mental Health Select Committee into the opportunities to improve mental health outcomes for Queenslanders. Published evidence suggests that peer-delivered programs can help participants feel accepted and provide hope in their mental health journey.[10, 11] If future offerings of ABC were to use a peer workforce, then attention would need to be paid to:

- Defining who is a "peer" for the program: an extremely important first step is to define who would be a peer to the caregivers receiving the ABC program. People belong to many socially-identifiable communities or groups, and thus can be defined in many ways. So careful attention is needed into what constitutes a peer for delivering the ABC program, particularly in the context of cultural groups.
- Establish a strong Community of Practice: to support the group of peers who get trained in and deliver the ABC program to engage in Reflective Supervision. This community of practice would focus on the experience for the coaches in delivering the program and allow for debriefing of situations and refinement of processes across agencies, as well as the shared exploration of emotional content of infant and family work (as expressed in relationships between caregivers and infants, caregivers and practitioners, and practitioners and supervisors[12]). This would stand separate to the ongoing supervision offered from the University of Delaware, which focuses on maintaining program fidelity.

Implication 3: Define who the ABC program is suited to

There needs to be clearer definitions applied to caregivers and infants who are "ready" to experience the ABC program. For the pilot this was broadly defined as a caregiver with an infant within the target age range (6-24 months) who was willing to engage and who had "an infant that has experienced trauma, an adverse childhood experience, or is at risk of contact with the child protection system". We recommend setting out clear screening criteria for caregivers and their infants that need to be understood before the ABC program is delivered (see Implication 4). These screening criteria need to explore the level of adversity experienced by an infant and the readiness of the caregiver to receive the program. This process needs to ensure that the level of complexity experienced within family is not too great for the coaching scope intended in the ABC program.

Implication 4: Enable an additional 2-3 sessions to be offered by the Parent Coach before the ABC program commences

We recommend adding access to 2-3 "pre-sessions" that happen between the Parent Coach and caregiver before the program starts to build rapport and assess caregiver readiness for the program (see Implication 3). These pre-sessions are also seen as important for bridging between the referrer and Parent Coach.

Implication 5: Maintain flexibility in the cadence and content of the delivery of the ABC program

We recommend that the ABC program needs to maintain flexibility in how often the coaching sessions are delivered and the overall duration of the program. Caregivers have complex lives and demands and these need to be allowed for in the structure of the program delivery.

Implication 6: Embed monitoring and evaluation in program delivery

Whilst this pilot project has gathered a great depth of learning, we recommend embedding monitoring data collection and evaluative thinking into the delivery of the ABC program in the future (in addition to the caregiver sensitivity scoring of videos by University of Delaware). This data collection would not be as rigorous or burdensome as the measures used in this pilot, but delivery agencies should aim to have one or two key outcomes measured (for all caregivers and infants entering the program and at completion of the program), in addition to the demographics collected for all caregivers and infants at the point of service entry.

Implications for further evaluation of the ABC program

Whilst this pilot evaluation has given us a lot to consider, there is still more to do. It is important that the momentum gained from this pilot is not lost. We believe the Steering Committee holds invaluable collective knowledge of IMH and understanding of the ABC program. They are ideally positioned to continue to lead these future evaluation efforts.

Implication 7: Fund an exploratory study to examine how the ABC program may (or may not) work for Aboriginal and Torres Strait Islander families

We were unable to answer evaluation questions about the experiences of Aboriginal and Torres Strait Islander families of the ABC program in this pilot. The Steering Committee need to stay committed to exploring this question and should fund a stand-alone

evaluation of the program conducted by evaluators who identify as Aboriginal and Torres Strait Islander people to work with communities and families to fully interrogate the fit of the program with their values and practices. The Steering Committee also needs to secure the voice of a First Nation representatives in its membership to drive this process. We recommend that the committee be expanded to include a representative from Queensland Aboriginal and Torres Strait Islander Child Protection Peak and a clinician who identifies as Aboriginal and/or Torres Strait Islander.

Implication 8: Consider program adaptations for CALD families

Whilst we learned about potential adaptations the parent coaches could undertake for CALD caregivers, there was very little learned about the experiences of CALD families, due to their lack of enrolment in the program. There needs to be a thorough exploration of how CALD families experience the ABC program in future evaluations.

Implication 9: Conduct a targeted pilot of ABC for out-of-home carers (foster carers)

The ABC program was originally developed to support foster carers to develop attachment with the young infants that came into their care. The pilot attracted mainly biological caregivers of infants. The out-of-home care sector has great potential to learn from the ABC program and already has existing avenues for embedding a program like ABC. The Queensland Foster and Kinship Carers (QFKC) are a government-funded agency that supports the needs of carers, which in Queensland, is approximately 5,200 foster and kinship carers. QFKC already offer supports for carers and may be willing to work with the Steering Committee to examine the fit of the ABC program in the Queensland context.

Implication 10: Embed processes to identify parents who opt-out of the program after referral

We recommend embedding processes which capture data on caregivers who are referred to the program but who choose not to participate. In this evaluation we were unable to explore predictors of engagement in the program due to lack of data collection from those who did not progress through to pre-questionnaire data collection. This would assist in informing the appropriate caregivers for referral, refining eligibility criteria.

Implications for policy and planning reform in Queensland IMH sector

Overarching Implication: The need for IMH supports in Queensland is immense and the service delivery landscape is sparse. There is great potential for programs like ABC to have significant impact. However, a program cannot flourish without a system supporting it and a workforce with capability and capacity to deliver it (Figure 17). The sector must take responsibility for attracting attention to IMH, engaging in advocacy and maturing IMH policy.

"No single program can do it" "This [ABC] is not a magic wand"
[Steering Committee member]

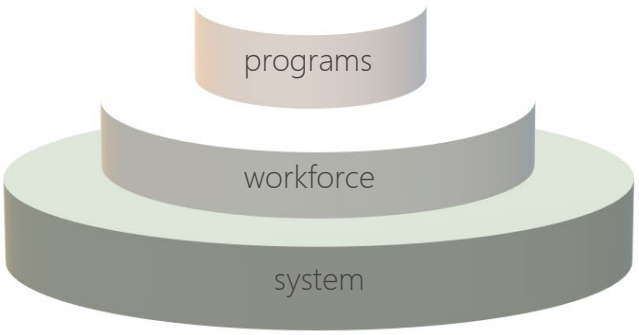

Figure 17: Required structures to support IMH reform and IMH program introduction.

Implication 1: Maintain momentum for building the IMH sector

This evaluation has created momentum with both the stakeholders of the Steering Committee and those involved in the data collection. We recommend that the Steering Committee is well-placed to be the conduit to maintain this momentum for IMH in Queensland. There are existing governance and planning bodies (such as the QMHC Strategic Leadership Group and Australian Association for IMH) that can drive action based on the implications of this work. But it will take clear and passionate advocacy from the Steering Committee to take this project's momentum to these bodies, which are also represented on the Steering Committee.

Implication 2: Advocate for IMH

We recommend the Steering Committee develop a detailed Advocacy Plan for advancing the IMH sector. Advocacy needs to be directed at specific audiences, and these should include service providers, media, government, and policy makers. Advocacy should focus on promoting that:

- infants need access to IMH support across their lifespan (in the home, day care centres, schools)
- IMH is not too complex and 'too hard' by providing practical ways to enter the IMH sector delivery (e.g. through gateway such as ABC training)
- the benefits of IMH supports can be life-long and profound for child development
- there needs to be a shift in perceptions of "early intervention" to be earlier in the life span and earlier in the prevention spectrum

Implication 3: Educate about IMH

We recommend identifying a broad range of settings in which professionals working with infants could increase knowledge and skills in IMH. The Steering Committee could work with the Australian Association for IMH to identify ways to 'educate professionals who work with infants and their families' as outlined in their Strategic Plan (2021-2024). This education needs to focus on the immediate and long-term benefits of healthy attachment for IMH, what this looks like, and how practitioners can build skills and confidence to enter this service delivery space.

Implication 4: Build IMH workforce capacity and capability

We recommend building workforce capacity and capability for practitioners to confidently address IMH in their practice. We acknowledge that this is not a singular professional group, but rather a collaboration of many professional groups from, for example, early years educators, nurses, psychiatrists, counsellors, social workers, and psychologists. The Steering Committee needs to engage with the various professional associations that support continued professional development for these sectors. Offering structured, supervised training in IMH offerings (such as with the ABC program) could be a gateway for these professionals to enter the IMH space.

Attachment A: Project Steering Committee Draft Terms of Reference

Purpose	To provide expert advice and input into the evaluation of the Attachment and Biobehavioural Catch-Up (ABC) Pilot Project.
Term	The ABC Evaluation Reference Group will be active from June 2021 to February 2022
Membership	• Simone Caynes, Director, Queensland Mental Health Commission • Jane Reid, Principle Advisor, Queensland Family and Children Commission representative • Rebecca Maurer, Mental Health Practice Leader, Department Children, Youth Justice and Multicultural Affairs • Libby Morton, Queensland Committee Member, Australian Association for Infant Mental Health Queensland Branch representative • Cate Rawlinson, Queensland Centre for Perinatal and Infant Mental Health • Suzie Lewis, General Manager, Accoras Critical friends: • Dr Viktoria Vibhakar, State-wide Leader - Community Partnerships and Integration, Queensland Transcultural Mental Health Centre
Secretariat	Accoras will provide all Secretariat support.
Chair	TBA based on steering committee consensus.
Roles and Responsibilities	• Inform and guide evaluation approach and goals • Approve evaluation EOI (seeking independent evaluation consultancy) • Approve engagement of evaluator based on feedback and implication from Accoras • Approve monitoring, evaluation and learning framework • Oversight of pilot evaluation activities • Provide access to key internal stakeholders who can inform the systemic aspects of the evaluation • Support to contact external stakeholders who can contribute to systemic aspects of the evaluation • Review final draft of pilot evaluation report • Receive final evaluation report and discuss next steps
Frequency of meetings	The steering committee will meet on an as-needed basis, determined by the stages and needs of the evaluation process. Flying minutes can be used when an issue requires urgent attention.

Agenda and Minutes	For scheduled meetings, the secretariat is responsible for circulating an agenda one week prior to the meeting. For ad-hoc meetings, the agenda will be provided to attendees at the meeting. Standing agenda items will include: • Program update • Evaluation updates • Any issues identified All members of the steering committee can ask for any item relating to the ABC pilot to be placed on the agenda. The secretariat is responsible for ensuring the minutes of each meeting are emailed to meeting participants within two weeks of the meeting.
Quorum	A quorum is necessary for a meeting to proceed. A quorum will consist of 60% of all members either in person or electronically.
Review	Any member can request a review of the Terms of Reference at any time.

Attachment B: Other programs in the Infant Mental Health sector

Program	Description	Objectives	Participants	Origins	Other information
Circle of Security Parenting (COSP) Program[13] Similarity to ABC: High	Circle of Security is an eight-week program designed for caregivers of children aged 0-5 years which focuses on building secure relationships between caregivers and their child.	The program aims to strengthen the bonds between caregivers and children. In doing so, it attempts to aid the child's sense of security, leading to enhanced self-esteem and capacity to handle emotions.	Whilst there are some differences amongst service providers, most programs are offered to parents of children aged 0-5 years.	COS International is based in the United States of America. It originated from John Bowlby's research on Attachment Theory.	Cost of participation in the program vary amongst service providers. There is currently no centralised agency or website which supports participants in finding the different service providers.
Positive Parenting Program (Triple P)[14] Similarity to ABC: Medium	Triple P is a program developed for caregivers of children up to 16 years of age. Primary Care Triple P is one of various subsystems within the program, where participants discuss their parenting one-on-one with an accredited facilitator for four 15–30-minute sessions.	The program's central goal is to encourage and improve positive behaviour in children. The program does not explicitly emphasise attachment between caregiver and child, nor its benefits.	Broadly, the different Triple P programs are available to parents and carers of children up to 16 years of age. However, Primary Care Triple P is for caregivers of children aged 0-12 years.	Triple P was developed at the University of Queensland. It is now disseminated internationally.	Participation in this program is funded by the Queensland Government, with no cost to the individual. The Triple P website supports participants in finding service providers.

Program	Description	Objectives	Participants	Origins	Other information
Parenting Under Pressure (PUP) Program[15] Similarity to ABC: High	PUP is a home-based program delivered on a one-on-one basis designed for families "under pressure", including those experiencing depression and anxiety, substance misuse, family conflict and severe financial stress. The program consists of 12 modules and generally runs between 3-6 months.	The aim of the program is to help caregivers facing adversity develop positive and secure relationships with their children, and to support nurturing environments for families.	The program is available for caregivers of children aged 0-12 years who are perceived to be "under pressure".	The program was developed by Griffith University in Brisbane. Whilst there is plenty of academic literature exploring the PUP program and its effectiveness, the program is not yet widely disseminated in practice.	Participation in the program is free for the individual. However, the program is yet to receive widespread funding. There is currently no centralised agency or website which supports participants in finding a facilitator.
Together in Mind[16] Similarity to ABC: Medium	The Together in Mind Day Program provides support for mothers of infants under six months of age who have been diagnosed with a moderate to severe mental illness.	The program aims to improve the caregiver's capacity to parent, by providing mothers with practical support related to babies' care, including informing mothers about infant mental health and secure attachment.	The program is designed for mothers of an infant under six months of age who have a diagnosed moderate to severe mental illness.	The program was developed by the Children's Health Queensland Hospital and Health Service and is now disseminated across 12 adult hospital and health services in Queensland.	The program is run in groups with mothers and babies and includes support from child health nurses and youth mental health clinicians.

Attachment C: Sector Stakeholders

This list includes sector stakeholders who participated in a focus group or interview during this evaluation.

Organisation	Name of representative
Brisbane North PHN	Kathy Faulkner Michele Hayes
Brisbane South PHN	Michelle Underhill Kier Leigh
Gold Coast PHN	Jacqui Greig
Mater Family Wellbeing Service	Grace Branjerdporn Den Davies-Cotter Constanze Schulz
Stride Kids	Chloe Robinson
Private consultant to child safety	Lauren Davis
Mater Parent Aid	Kris Saunders
Kids at Home Family Day care	Sharyn Flynn
Goodstart Early Learning	Marie Stuart

Attachment D: Example text message invitation to interview

Hi [caregiver name],

I'm [ehc team member] from Enable Health Consulting, and I am working with Accoras on the ABC program you have recently completed.

Is there a good time to call and book in a chat with myself, so I can hear how you found the ABC program?

If I don't hear from you, that's okay! I will attempt to call in the next few days. 😊

Look forward to hearing from you,

[ehc team member].

Attachment E: Previous Literature for ABC Evaluation Measures

		REFERENCES	Filmed semi-structured play assessment	Ages and Stages Questionnaire (30 items)	Centre for Epidemiologic Studies Depression Scale (20 items)	Parenting Stress Index – Short Form (36 items)	Parental Reflective Functioning Questionnaire (18 items)	Maternal Self Efficacy Scale (10 items)	Infant Crying Questionnaire (43 items)
UNIVERSITY OF DELAWARE	1	ACCORAS	x	x	x	x	x	x	x
	2	Caron EB, Weston-Lee P, Haggerty D, & Dozier M. Community implementation outcomes of Attachment and Behavioural Catch-up. 2016. Child Abuse and Neglect, 53, 128-137.	x						
	3	Perrone L, Imrisek SD, Dash A, Rodriguez M, Monticciolo E, Bernard K (2020). Changing parental depression and sensitivity: Randomized clinical trial of ABC's effectiveness in the community. Development and Psychopathology 1–15. https://doi.org/10.1017/S095457942000031	x		x				
	4	Unpublished. Centre for Child and Family Health (2016). ABC LEARNING COMMUNITY 2015-2016. Final all-team wrap up meeting.	x	x		x			
	5	Roben CKP, Dozier M, Caron EB, Bernard K. Moving an Evidence-Based Parenting Program Into the Community. Child Dev. 2017 Sep;88(5):1447-1452. doi: 10.1111/cdev.12898. Epub 2017 Jul 24. PMID: 28737839; PMCID: PMC5612504.	x						
	6	Unpublished. Schein, Roben, Costello, Dozier. Home Visiting Through Telehealth During a Pandemic: Transitioning to Virtual Visits with Effectiveness	x						
	7	Hepworth AD, Berlin LJ, Martoccio TL, Cannon EN, Berger RH, Harden BJ. Supporting Infant Emotion Regulation Through Attachment-Based Intervention: a Randomized Controlled							

		Trial. Prev Sci. 2020 Jul;21(5):702-713. doi: 10.1007/s11121-020-01127-1. PMID: 32388694.							
	8	Unpublished. Mendenhall. A, Byers. K, Grube. W, Sattler, P. (2020) Kansas ABC Early Childhood Initiative, KU School of Social Welfare	x	x				x	x
	9	In German. Zimmerman, Nemeth, & Kindler. Förderung sicherer Bindungsbeziehungen in Pflegefamilien mit dem Attachment and Biobehavioral Catch-Up (ABC)- Programm. 2021. Prax. Kinderpsychiat. 70: 239-254.							
	10	Unpublished. Buell Foundation/Kempe Foundation. Attachment and Biobehavioural Catch-Up (ABC) Intervention. 2021			x	x			
PUBLISHED LITERATURE	11	Dozier, M., Peloso, E., Lindhiem, O., Gordon, M. K., Manni, M., Sepulveda, S., Ackerman, J., Bernier, A., & Levine, S. (2006). Developing evidence-based interventions for foster children: An example of a randomized clinical trial with infants and toddlers. Journal of Social Issues, 62(4)							
	12	Dozier, M., Peloso, E., Lewis, E., Laurenceau, J., & Levine, S. (2008). Effects of an attachment based intervention on the cortisol production of infants and toddlers in foster care. Development and Psychopathology, 20, 845â€"859.							
	13	Dozier, M., Lindhiem, O., Lewis, E., Bick, J., Bernard, K., & Peloso, E. (2009). Effects of a foster parent training program on young children's attachment behaviors: Preliminary evidence from a randomized clinical trial. Child and Adolescent Social Work Journal, 26(4), 321â€"332.							
	14	Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carlson, E. (2012). Enhancing attachment organization among maltreated infants: Results of a randomized clinical							

		trial. Child Development, 83(2), 623â€"636. https://doi.org/10.1111/j.1467-8624.2011.01712.x							
	15	Lewis-Morrarty, E., Dozier, M., Bernard, K., Terracciano, S. M., & Moore, S. V. (2012). Cognitive flexibility and theory of mind outcomes among foster children: Preschool follow-up results of a randomized clinical trial. Journal of Adolescent Health, 51(2), S17â€"S22. https://doi.org/10.1016/j.jadohealth.2012.05.005							
	16	Bick, J., & Dozier, M. (2013). The effectiveness of an attachment-based intervention in promoting foster mothers sensitivity toward foster infants. Infant Mental Health Journal, 34, 95â€"103. https://doi.org/10.1002/imhj.21373	X – unable to extract change data						
	17	Lind, T., Bernard, K., Ross, E., & Dozier, M. (2014). Intervention effects on negative affect of CPS-referred children: Results of a randomized clinical trial. Child Abuse & Neglect, 38(9)							
	18	Bernard, K., Hostinar, C., & Dozier, M. (2014). Intervention effects on diurnal cortisol rhythms of CPS-referred infants persist into early childhood: Preschool follow-up results of a randomized clinical trial. JAMA-Pediatrics, 169(2), 112â€"119. https://doi.org/10.1001/jamapediatrics.2014.2369							
	19	Bernard, K., Simons, R., & Dozier, M. (2015). Effects of an attachment based intervention on child protective services referred mothers' event related potentials to children's emotions. Child Development, 86(6), 16731684. https://doi.org/10.1111/cdev.12418							
	20	Bernard, K., Lee, A. H., & Dozier, M. (2017). Effects of the ABC intervention on foster children's receptive vocabulary: Follow-up results from a randomized clinical trial. Child Maltreatment, 22(2), 174-179. https://doi.org/10.1177/1077559517691126							

	21	Lind T, Bernard K, Yarger HA, Dozier M. Promoting Compliance in Children Referred to Child Protective Services: A Randomized Clinical Trial. Child Dev. 2020 Mar;91(2):563-576. Epub 2019 Feb 28. PMID: 30815861;	X – no change data reported						

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