A review of Best Beginnings as part of a Child Protection strategy focussed on engaging earlier with vulnerable families

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About the Berry Street Childhood Institute

The Berry Street Childhood Institute (BSCI) was commissioned by the Department of Child Protection and Family Support to undertake this review. The BSCI is part of the Victorian based Berry Street, which is a large community service organisation working to support vulnerable children and families. The BSCI is a Knowledge-to-Action centre for improving childhood, which seeks to contribute to; increased understanding and awareness of what sustains a good childhood and wider and more effective action directed at the amelioration of adverse childhood experiences.

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## Contents

Executive summary.................................................................................................................. 4
  Background and scope.......................................................................................................... 4
  Review findings................................................................................................................... 4
  Adapting Best beginnings for families where children are considered at risk of maltreatment or who have been notified to protective services for child maltreatment.............................................................................................................................. 5

Background.......................................................................................................................... 7
  Best Beginnings program model.......................................................................................... 7
  Purpose and scope of review............................................................................................... 9
  Context of review................................................................................................................ 9

Review Method...................................................................................................................... 11
  Document review.............................................................................................................. 11
  Program theory evaluation................................................................................................. 11
  Consultation...................................................................................................................... 11
  Literature review.............................................................................................................. 12
  Limitations....................................................................................................................... 12

Review Findings................................................................................................................... 12
  Best Beginnings as part of a continuum of services increasing the offer of protection........ 12
  Is Best Beginnings suited to working with families with risk factors for child protection involvement?.............................................................................................................................. 14
  Is the Best Beginnings model culturally responsive?......................................................... 17

Adapting Best Beginnings for families where children are considered at risk of maltreatment or who have been notified to protective services for child maltreatment................................................................. 20
  Do evidence-based home-visiting models exist for families with risk factors for child maltreatment?.............................................................................................................................. 20
  Core principles of evidence-based parent support programs............................................. 22
  Framework to inform adaptation and innovation............................................................... 23
  Association with statutory Child Protection.................................................................... 25
  Visit frequency and duration............................................................................................ 26
  Service approaches.......................................................................................................... 27
  Adapting Best Beginnings to Aboriginal culture............................................................... 30
  Workforce capability and implementation support......................................................... 32
  Governance and accountability......................................................................................... 34

Concluding comments....................................................................................................... 34

References.............................................................................................................................. 35
Executive summary

Background and scope
This report presents the results of a 2016 review of the Western Australian Best Beginnings program commissioned by the Department for Child Protection and Family Support (DCPFS). Best Beginnings is an intensive home visiting service for parents of children up to two years old and pregnant women.

Best Beginnings began in 2000 and has expanded to new locations over its 16-year history to the extent that it is now provided in each of the 17 districts of DCPFS across the State. At 30 September 2015, Best Beginnings had 466 open cases, of which 27 per cent were Aboriginal.

The purpose of this review was to explore whether Best Beginnings is fit for working with highly vulnerable pregnant women and families where the infant is at risk of maltreatment and whether the current program theory and design is fit for this purpose or whether adaptations are required. Special regard was given to the appropriateness or otherwise of the program for Aboriginal families. Specifically, the review explored the following questions:

- Is Best Beginnings currently working with families with child protection risks?
- Is its model, structures and systems equipped to do so?
- Is the Best Beginnings model suitable and culturally responsive to Aboriginal families?
- What in Best Beginnings needs to be adapted to work effectively with families even further into the tertiary system, including Aboriginal families?

The Department’s Earlier Intervention and Family Support Strategy was critical context for the review. The Strategy aims to intervene earlier with families to avoid crisis and involvement with the statutory Child Protection and out-of-home care (OOHC) systems and to better target and assist vulnerable Aboriginal families.

The review employed program theory evaluation, consultation, document review and literature review as its key methods. A total of 52 people were involved in the consultation process.

Review findings
The review found that Best Beginnings is an early intervention program in that it is positioned to help divert families away from the Child Protection and OOHC systems. It is also an early in life intervention program given its focus on antenatal and perinatal care. While Best Beginnings began as a prevention and health promotion service targeting families who had difficulties or needed additional support, it has shifted over time such that it is currently targeting the most “at-risk” and “hard to reach” families in Western Australia. Program data suggest the current Best Beginnings cohort involve a high proportion of cases with risk factors for child maltreatment. Almost half (44%) of closed cases were notified one or more times to DCPFS before, during or after involvement with Best Beginnings. A very high proportion (67%) of Best Beginnings cases involve a parent with depression and/or anxiety; a key driver for child protection involvement.

The conclusion drawn from the program theory evaluation is that Best Beginnings in its current configuration is not designed or adequately equipped to respond to families where the child is at risk.

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1 At the time of the review there was a Best Beginnings role in each of the 17 DCPFS districts with 31.6FTE in total; of which 27.1FTE was through DCPFS and 4.5FTE was through the Department of Health.
of maltreatment. If its focus was on more imminent high risk it would be even less equipped. As well as the program theory, service approaches, workforce capacity and isolation from professional peers, governance structure, accountability and mechanisms for identifying and responding to risk all need addressing to enable it to better respond to a higher risk target group.

One of the main drivers for this review was the concern that fewer than expected Aboriginal families were accessing the Best Beginnings program especially in the metropolitan areas. The review found that the position of Best Beginnings within DCPFS was a major barrier to the engagement of Aboriginal families and prevented referrals from Aboriginal specific services. Another reason suggested for fewer Aboriginal referrals was that they were more complex and the risks were already too high for the Best Beginnings threshold. Some of those consulted also suggested that lack of suitability of the model for working with Aboriginal families was an issue. Little evidence was found in the program documentation and evaluations to suggest that Aboriginal cultural practice directly informed the model development (theory of change) or application of the model in practice (theory of action). Best Beginnings evaluations have also identified difficulties over the years in recruiting and retaining an Aboriginal workforce.

Adapting Best beginnings for families where children are considered at risk of maltreatment or who have been notified to protective services for child maltreatment

In the absence of conclusive evidence to suggest that adoption of any particular “evidence-based” child and family home visiting model will be effective with families with risk factors for maltreatment or who have been notified to Child Protection for maltreatment, research and development is needed to improve Best Beginnings’ underlying program model and implementation system and thus strengthen its effects. This approach would maintain the value of the current Best Beginnings workers within DCPFS, although the role of the Department of Health would need to be clarified.

While the evidence does not point to a specific “program”, there are several best practice principles that have been consistently associated with positive interventions that aim to support parents, (including a growing evidence-base on effective parenting support programs for Aboriginal families) as well as evidence-based processes contained in effective human service programs that need to guide program development.

Preliminary ideas for modification of Best Beginnings that are informed by research and stakeholder consultation include:

- Greater integration with Child Protection work
- Scope for more frequent visiting in the antenatal phase and up to 12 months after the child’s birth to reflect the higher risk status of the target group
- Stopping the program at 12 months after the child’s birth (with flexibility to continue beyond twelve months) unless program data suggests this is needed to sustain impacts on the mother-infant relationship and establish family and community connections
- Developing a new language to explain how Best Beginnings differs from, and is the same as, statutory Child Protection work rather than emphasising the voluntary nature of the program as a platform for engagement
- Refocussing the antenatal phase of the program around pre-birth Child Protection planning
- Improving implementation fidelity of attachment-based interventions
- Integrating enhanced program elements to respond to co-existing difficulties, including mental health problems and intimate partner violence as well as safety planning and risk assessment
• Research to understand the reasons for early case closure to inform decisions around retention, program length and effectiveness of elements design to strengthen family and community connections
• Examination and potential adaptation of each aspect of the Best Beginnings theoretical framework, in particular the application of attachment theory, from a cultural perspective utilising a co-design approach
• Strengthening workforce capability (including cultural competence) and implementation support and
• Strengthening program governance and accountability.

These suggestions need to be reviewed and refined through stakeholder input and subject to broader feasibility and acceptability testing. This requires an understanding of “core intervention components” or features of the current program that are essential to efficacy to ensure adaptations do not jeopardise outcomes. Going forward, will also be important to understand where it is possible to incorporate “flexibility within fidelity”, for example, incorporating the worker’s own style and methods in engaging clients and giving more flexible control of visit frequency and content to families.
Background

This report presents the results of a 2016 review of the Western Australian Best Beginnings program, commissioned by the Department for Child Protection and Family Support (DCPFS). DCPFS is the statutory agency with the ultimate responsibility for assessing and responding to allegations of child abuse and neglect, and is primarily concerned with the protection, wellbeing and safety of children. The intent of this review is to contribute to the planning by the Western Australian government as part of their broader Earlier Intervention and Family Support Strategy.

Best Beginnings program model

Best Beginnings is an intensive home visiting service for parents of children up to two years old and pregnant women. Best Beginnings began in 2000 and has expanded to new locations over its 16-year history. At the time of the review there was a Best Beginnings role in each of the 17 DCPFS districts with 31.6FTE in total; of which 27.1FTE was through DCPFS and 4.5FTE was through the Department of Health. At 30 September 2015, Best Beginnings had 466 open cases, of which 27 per cent were Aboriginal (DCPFS, 2016).

Best Beginnings was informed by the Queensland Department of Health’s Family CARE model (Armstrong, Fraser, Dadds, & Morris, 1999) and the Nurse Family Partnership (NFP) model (e.g. Olds, Henderson, & Kitzman, 1994; Olds, Henderson, Tatelbaum, & Chamberlin, 1986). It emphasises the ecological perspective2 (Bronfenbrenner, 1979), self-efficacy3 (Bandura, 1977) and attachment theory4 (Bowlby, 1969). The Best Beginnings program logic is presented in Fig. 1.

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2 The ecological perspective provides a lens that the child’s development will be influenced by the mother who is in turn influenced by her social environment.

3 Self-efficacy theory emphasises that individuals will choose behaviours they believe lead to certain outcomes and that they believe they can achieve, which in turn emphasises the need for choice and a strengths-based approach.

4 Attachment theory provides an understanding of the infant’s search for proximity and nurturance in times of stress and the maternal responsivity to this helping to build a positive model for trust and empathy in later life (Clark, 2002; Olds et al., 1999).
The first formal evaluation of Best Beginnings described the six milestones within each intervention (Robson & Clark, 2004):
1. Establishing a trusting relationship with the mother
2. Encouraging positive maternal-child attachment
3. Ensuring access to community resources
4. Building the mother’s knowledge base about child health and development
5. Reinforcing positive parenting practices and
6. Encouraging longer term thinking and planning.

According to the Best Beginnings Practice and Procedure Guide (no date) and the online DCPFS Case Practice Manual, there are four phases of the Best Beginnings model. Table 1 outlines these phases along with the applicable outcomes for each phase. Team conferences occur fortnightly initially and then reduce in frequency as the frequency of visits reduce.

<table>
<thead>
<tr>
<th>Phase / child’s age</th>
<th>Focus</th>
<th>Frequency of visits</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal / engagement phase</td>
<td>Engages with parent/s, assesses appropriateness of parent/s for service and service for the parent/s, and discusses benefits and limits of service</td>
<td>2 to 3 visits over a possible 3 month period prior to birth (monthly)</td>
<td>Engagement</td>
</tr>
<tr>
<td>First 6 months</td>
<td>Assisting parent/s to meet baby’s physical and emotional needs</td>
<td>Weekly up to 7 weeks of age; then fortnightly till 4 months</td>
<td>Child health and wellbeing</td>
</tr>
<tr>
<td>Second 6 months</td>
<td>Builds on parenting skills already attained, and supporting parent/s to be</td>
<td>Monthly from 4 months to 8 months</td>
<td>Parent wellbeing and family</td>
</tr>
<tr>
<td>Phase / child’s age</td>
<td>Focus</td>
<td>Frequency of visits</td>
<td>Outcomes</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------</td>
<td>--------------------</td>
<td>----------</td>
</tr>
<tr>
<td>prepared and sensitive to child’s rapidly changing development and stimulation needs</td>
<td></td>
<td></td>
<td>functioning</td>
</tr>
<tr>
<td>Second year</td>
<td>Assisting parent/s to independently access community resources for themselves and child; help them identify life goals; develop a plan and take practical steps towards meeting goals</td>
<td>Bi-monthly from 8 months</td>
<td>Social connectedness</td>
</tr>
<tr>
<td>Closure</td>
<td>Linking family to appropriate community services and supports (also occurs throughout the program)</td>
<td></td>
<td>Transition</td>
</tr>
</tbody>
</table>

**Purpose and scope of review**

The current review was not about determining whether or not Best Beginnings is a valued or beneficial program. Rather, the aim was to explore whether Best Beginnings is fit for working with families where the infant is at risk of maltreatment and whether the current program theory and design is fit for this purpose or whether adaptations are required. Special regard was to be given to the appropriateness or otherwise of the program for Aboriginal families. Specifically, the review explored the following questions:

- Is Best Beginnings currently working with families with child protection risks?
- Is its model, structures and systems equipped to do so?
- Is the Best Beginnings model suitable and culturally responsive to Aboriginal families?
- What in Best Beginnings needs to be adapted to work effectively with families even further into the tertiary system, including Aboriginal families?

**Context of review**

The Western Australian Government is developing a reform agenda for supporting vulnerable children and their families. This agenda includes a process to develop an *Earlier Intervention and Family Support Strategy*, hereafter referred to as ‘The Strategy’ (DCPFS, 2016). The Strategy “… aims to coordinate how the Department, along with other government and community sector agencies, works with families whose children are most vulnerable to poor life outcomes, including being removed from their parents’ care and/or entering the youth justice system” (p. 3).

Two imperatives emanating from the Strategy underpin this review focussed on the Best Beginnings program. These are the need to:

- Respond effectively to the risks for children and the needs of families and
- Be accessible, responsive and tailored to work with Aboriginal children, families and communities.

Relevant statistics show an increase in demand for statutory Child Protection services over the past few years. The number of Western Australian children receiving Child Protection services per 1,000 has increased from 24.0 in 2012-13 to 27.0 in 2014-15 (AIHW, 2016). The number of children per 1,000 on care and protection orders and in OOHC has also increased in this time (AIHW, 2016).

While the number of Western Australian children per 1,000 who were the subject of a Child Protection substantiation of notification in 2014-15 and who were in OOHC at 30 June 2015 was
relatively low compared to other Australian jurisdictions (5.7 and 6.7 respectively), the rate ratio (Indigenous/non-Indigenous) was 12.3 and 16.3; the highest in the country\(^5\) (AIHW, 2016). The proportion of Aboriginal children in OOHC (52%) is particularly alarming.

Fig. 2 below shows the increase in the number of young Aboriginal children aged 0-2 years entering OOHC compared to non-Aboriginal children over the past decade.

![Image of Child Entering Care Aged 0-2 Years](image_url)

**Fig 2.** Western Australian children aged 0-2 years entering out-of-home care 2004-05 to 2014-15

Aboriginal children represent a small proportion of the workload in some Best Beginnings sites and the proportion of Aboriginal children in the Best Beginnings program overall is considerably lower than their proportion in OOHC.

The challenge to respond to increasing demand in the Child Protection and OOHC systems as well as the relatively low percentage of Aboriginal clients in some Best Beginnings sites compared to the high percentage of Aboriginal children entering OOHC is important context for the current review. So too is the fact that the Western Australian economy is contracting. The end of the mining boom and Royalties for Regions funding (disproportionately affecting country areas), along with a growing population has led to fiscal constraints across government departments.

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\(^5\) Equal to the ACT for substantiation of a child protection notification.
Review method

Multiple methods were used to address the key review questions identified earlier; document review, program theory evaluation, consultation and literature review. A project management approach was adopted to ensure that timelines and tasks were completed in accordance with the milestones. A specific governance group was not required as the DCPFS Early Intervention Working Group incorporated the governance of this project into their meetings.

Document review

DCPFS provided the project team with reports and other documents about the Best Beginnings program and the broader policy context in Western Australia. An annual report prepared by the two Best Beginnings Senior Practice Development Officers (SPDOs) also provided useful insight as an overview of each site in 2015.

Data analysis and reporting undertaken by DCPFS was also incorporated into the review. DCPFS prepared data about Best Beginnings closed cases from the DCPFS Assist database, extracted 18 March 2016. Supplementary data were also provided by DCPFS upon request, such as data regarding FTE positions and caseloads.

Program theory evaluation

Program theory evaluation (Brousselle & Champagne, 2011) was used to examine what Best Beginnings is trying to do and what evidence suggests that this is likely to be successful (Funnell & Rogers, 2011).

Consultation

Interviews were scheduled by the DCPFS Policy, Family Support and Reporting Branch. Most consultations were undertaken face to face in Perth or through video conferencing in the week of 18 April. The project team sent emails to those who had expressed interest but had been unavailable for the week of interviews to offer a further opportunity for a phone interview or to provide their thoughts via email.

Overall, the project team conducted 16 interviews with groups and individuals and received two additional emails with comments. A total of 52 people were involved in the consultation process. Within DCPFS, 18 participants were from central office and 15 from a district office. Six of those from a district office were from a rural district.

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6 Data were available from this database since July 2009 thereby providing data over a 6 year and 8 month time period. Although data from the Department of Health and DCPFS were entered on the same Assist database, due to some miscoding it was not possible to distinguish which cases were Health and which were DCPFS. There was also considerable missing data for some key fields, such as whether the child was Aboriginal. As such, some of the analysis is indicative rather than conclusive.

7 Program theory has two component; theory of change (mechanisms by which change is believed to occur) and theory of action (how the program is constructed to activate the theory of change) (Astbury & Leeuw, 2010).
Literature review
A rapid targeted review of the literature regarding the David Olds’ Nurse Family Partnership (NFP) model and associated programs as well as systematic reviews of home visitation programs provided a point of reference for considering whether the current Best Beginnings model was suitable for a higher risk cohort and for formulating enhancements to the Best Beginnings model.

Limitations
Due to the tight timeframe for this project it was only possible to invite a select group of Best Beginnings workers to participate in the consultation process. Further, it was not possible to consult directly with families or their networks involved in the program.

Review findings
The overall purpose of the review was to consider whether Best Beginnings is fit for working with families where the infant is at risk of maltreatment and what, if anything, needs to be adapted to work effectively with families even further into the tertiary system. There was a particular focus on Aboriginal children given the level of over-representation in OOHC and the relative underutilisation by Aboriginal families of Best Beginnings in some sites.

Best Beginnings as part of a continuum of services increasing the offer of protection
The conclusion of this review is that Best Beginnings is an early intervention program in that it is positioned to help divert families away from the Child Protection and OOHC systems. It is also an early in life intervention program given its focus on antenatal and perinatal care. This does not mean it does not work with complex and high risk families, but that its focus is prevention of actual harm.

Best Beginnings began as a prevention and health promotion service (Robson & Clark, 2004). A decade later, Price Waterhouse Cooper (PWC) (2014) described Best Beginnings as targeting the most “at-risk” and “hard to reach” families in Western Australia, whom professionals consider to be most in need of services yet least likely to access them.

There have been four recent infant deaths among the Best Beginnings client group. Although there is no assumption that these deaths were preventable, this emphasises the degree of risk that the program is holding.

Notwithstanding some differences between country and metropolitan sites, the results from the consultations were unequivocal that the complexity of the families had increased over time and that Best Beginnings was currently working with a large percentage of high risk families.

“Massive shift in family types over the past 5 years...more referrals from front-end Child Protection teams.”

“...the population has really changed...serious mental health issues.”

“...the referrals that are coming in are for the group where we have identified a greater level of risk...also the threshold of what we accept has changed.”

The data analysis of closed cases also supports the conclusion that Best Beginnings works with families faced with a range of vulnerabilities and risk factors, including key risk factors for Child
Protection involvement such as family violence, parental mental health problems and parental substance abuse problems (DCPFS, 2016, Brandon et al., 2008).

Overall, 44 per cent of infants had been notified one or more times to DCPFS before, during or after being involved with Best Beginnings. Specifically:\(^8\)

- 13 per cent of referrals to Best Beginnings were made by DCPFS
- 23 per cent of children referred to Best Beginnings had a prior notification to DCPFS
- 16 per cent had a notification to DCPFS during Best Beginnings involvement and
- 18 per cent had a notification post Best Beginnings involvement.

Data entered by Best Beginnings workers demonstrates that although most families had a number of vulnerability factors such as low income and financial stress at time of entry, two-thirds (67%) had a parent with depression and/or anxiety and one-third (34%) had experienced family violence. More detailed analysis undertaken by Robson and Clark (2004) reported that 83 per cent of families had more than four risk factors at time of entry.

Fig. 3 below represents the shift that appears to have occurred for Best Beginnings since its inception 16 years ago.

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\(^8\) These were not always mutually exclusive, with some families being the subject of multiple notifications at different stages.
Is Best Beginnings suited to working with families with risk factors for child protection involvement?

**Best Beginnings program theory and model design**

The conclusion drawn from the program theory evaluation is that Best Beginnings in its current configuration is not designed or adequately equipped to respond to families where the child is at risk of maltreatment. If its focus was on more imminent high risk it would be even less equipped. This is not to suggest that Best Beginnings is not achieving positive outcomes with many of the families and children with whom it works, but its model, structures and systems are not sufficiently designed for the shift that has already occurred in terms of working with families with risk of maltreatment, let alone greater risk levels.

The Best Beginnings model is explicitly designed for first-time mothers and the structures of the visits deliberately aim to address questions posed by a first-time parent. As such, there is a limited evidence-base to suggest that the Best Beginnings model is fit for families with risk factors for child protection involvement.

“If the young mum, so she’s young and she’s been in care herself and this is her first child or she’s had a child already with a poor outcome; then we know that she has a much higher risk that her child will end up in care. So there is evidence around that, I’m not sure there is evidence that a program like this would reduce that risk.”

The importance of adding a trauma-informed and Infant Mental Health lens to the model to enhance its suitability for a higher risk cohort was raised several times in the consultations.

“If worked with women with a care history would need to be more trauma-informed.”

“...should develop a clearer Infant Mental Health theoretical framework.”

“Lack of trauma theory. We need to understand these families in trauma context and intergenerational trauma.”

Feedback from the consultations also suggest that workforce capacity and isolation from professional peers, governance structure, accountability and mechanisms for identifying and responding to risk all need addressing to enable it to better respond to a higher risk target group.

**Risk and safety**

Concerns were raised about the program’s capacity to hold the level of risk it is currently working with without clear protocols and systems in place. At the operational level, some noted a confused level of authority within the program to respond to risk, not just at time of referral but also throughout the program where the nature and degree of risk can change. There does not appear to be protocol

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9 It should be noted, however, that these concerns seemed based on a view that Best Beginnings would be working with families instead of other services, rather than working in collaboration with specialist services when required, such as mental health services, alcohol and other drug services and family violence services.
within DCPFS between the roles of Best Beginnings and Child Protection to clarify expectations regarding communication, decision-making and when there is a difference of opinion.

There was a consistent picture that Best Beginnings workers were usually transparent and timely in speaking to families about their responsibilities to report concerns to other parts of DCPFS if they considered a child to be at risk. This was not limited to their mandatory responsibility under the legislation regarding child sexual abuse but any areas of concern pertaining to the safety of the child. This was equally the case for Health and DCPFS Best Beginning workers. However, instances were described in the consultations where Best Beginnings workers attempted to talk with their DCPFS colleagues and have not felt their level of concern regarding risk has been shared, perhaps due to their paraprofessional background. On other occasions, Best Beginnings workers were described as having an important perspective to share about issues to do with risk, unmet needs and the child’s wellbeing.

**Association with Child Protection a barrier to engagement**

The consultations revealed a strong emphasis on the program being voluntary as a major platform for engagement. The association that Best Beginnings has with Child Protection, or more specifically, involvement in Child Protection processes was thought to affect parent’s perception of the voluntary nature of the program and, in turn, their level of engagement and trust in the Best Beginnings worker.

“The attachment to Best Beginnings workers is what produces results and making the program mandatory (like writing it into safety or pre-birth plan) could compromise trusted relationship.”

Along similar lines, some people involved in the consultations expressed concern in relation to the visibility of client records to Child Protection.

“Want to be able to keep some conversations confidential.”

“...when I speak to Best Beginning workers and SPDOs who feel very responsible for program integrity this [information sharing] is an issue.”

There were obvious tensions surrounding the role of Best Beginnings in assessing risk and safety.

“...there is a really fine line between being able to deliver the integrity of the program and...being there as the person to identify when risks occur...looking out for risks along the way...to me that’s where the tension probably lies at the moment.”

“Best Beginnings is not set up as an ongoing assessment process...I think it would compromise the program if they are being asked to make continuous assessments.”

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10 It was noted that the Children and Community Services Act 2004 provides protections for information sharing about the safety and wellbeing of a child.
Workforce capacity
The question of worker qualifications, skill and experience arose often during consultations in relation to risk and complexity of cases. Best Beginnings workers (Health and DCPFS) were described by themselves and others as not having the knowledge and skill base to respond to some of the risk issues such as parental mental health problems.

“...I don’t think expecting Best Beginnings workers to do that work themselves is realistic, not with the current skills they have. They’re not Child Protection trained and they’re not DCPFS work, it gets bandied about that DCPFS work is the parent support, that it will be very little change. It’s bullshit, the reality is that DCPFS work is sincere Child Protection work and I think it can go hand in glove with Best Beginnings or Parent Support. But I don’t think it’s the same thing.”

It does not appear that a decision was made at the outset of the model to purposefully employ paraprofessional staff within DCPFS, but that this arose from necessity in some areas due to difficulties in recruitment and expanded throughout the DCPFS service through changes to the salary classification system in 2011. The initial plan was apparently for the workforce to be multidisciplinary. This has occurred to some extent where Health and DCPFS are in partnership. The multidisciplinary nature is in evidence through the regular team conferences involving a range of roles including the Best Beginnings workers (DCPFS and Health when applicable), Child Health Nurses, psychologists and social workers.

“The program was intentionally set up to be multidisciplinary. That didn’t mean qual or not qual. The intent was to get away from the medical or social work model. We have a multidisciplinary team coming to the team conferences. It works really well.”

The training currently provided to Best Beginnings workers (and their supervisors) includes a four day training program that is primarily procedural, followed by a site visit by one of the central Best Beginnings SPDOs. There are monthly meetings where workers and supervisors can join in person or via video conferencing. Some workers noted that they had limited ability to attend these meetings as they were not a priority to access the video conferencing facilities in their office. These meetings were considered by all as optional, rather than a requirement. There is an annual service day which is provided for all Best Beginnings workers and supervisors. The role of the SPDOs also includes linking into the team meetings approximately once a month. As this is 17 teams covered by 1.0FTE this is not always possible.

Some comments were made regarding supervision and whether or not the supervisors were always equipped to provide a sufficient level of clinical rather than administrative supervision. Given the workforce is less qualified than originally planned, and somewhat isolated, there would appear to be a greater need for clear supervision support. The issue of cultural supervision and support was also raised.

Comments were also made about difficulties in recruitment in some country areas recognising that some positions have been vacant for considerable time. Others noted that if the worker was not a good match for the area, this was reflected in fewer referrals. This changed when a new worker filled the role. There were also comments that country areas had a higher turnover of staff.
"It’s about getting the right worker in the right town."

**Governance**

DCPFS and the Department of Health have both committed resources to Best Beginnings, but the integration of governance across Departments was unclear. Comments were also made during the consultations about the lack of a clear line of authority within Best Beginnings and the need to strengthen governance arrangements. Currently, authority and control exists within the District line management (or the Department of Health) and the central Senior Practice Development Officers (SPDO) role. Many spoke of the value of the central SPDO roles in supporting fidelity with the model and consistency across districts, providing the training, consultation regarding complex cases and conceptualising changes required to the model. However, there was a view that there was a “disconnect” between central and local authority and that decentralised governance arrangements would enhance local legitimacy of the program.

"Currently disconnect between central and Districts."

"Do we locate supervision in Districts?"

"Decentralised model will enhance local legitimacy of program."

**Governance and accountability**

Consultations that focussed on the DCPFS review of three of the four recent infant deaths highlighted the lack of access to client records for the purposes of accountability and quality review. This also raised questions as to how to be across the whole program when two separate government departments are involved. The call from some to bring Best Beginnings within the Child Protection area appears partly as a strategy to gain more knowledge and assurance about its day to day operation.

"...we need to be really clear about are we getting those outcomes..."

"...room for making sure we do know the pathway of families through the program over two years."

**Is the Best Beginnings model culturally responsive?**

One of the main drivers for this review was the concern that fewer than expected Aboriginal families were accessing the Best Beginnings program especially in the metropolitan areas.

The under-representation of Aboriginal families in Best Beginnings presented in two ways; first, Aboriginal families were a lower than expected percentage of the client group for some sites and second, even where they were nearly 100 per cent of the site’s workload, sites struggled to get referrals.

Although some Aboriginal families may be appropriately seeking Aboriginal specific services, especially in the metropolitan areas where Aboriginal services are less scarce, the most common constraint identified in the consultations for Aboriginal families in accessing the service was the position of Best Beginnings within DCPFS. The view was that the more affiliated Best Beginnings is with DCPFS the more difficulties the program will have in engaging Aboriginal families and receiving referrals from Aboriginal services.
“The other aspect is when Health Departments make referrals to Best Beginnings and Best Beginnings is a DCP worker then game over.”

“I think you’d have more success with those referrals if [Best Beginnings] was outside the Department. It would stop a lot of the problems of coming and having any type of contact with the Department.”

There were comments that some Aboriginal Medical Services refused to make, or made very few, referrals to Best Beginnings due to its alignment with DCPFS. Although there was a view that country areas tended to have stronger collaborative relationships with Aboriginal services compared with metro areas, one of the areas of greatest difficulty mentioned was in a country region.

This challenge is also reflected in the literature. The seemingly entrenched pattern of over-representation of Aboriginal children in the protection and care system contributes to a perpetual cycle of reinforcing to Aboriginal families their justification of being concerned they will lose their children if they become involved with services. This can lead to reluctance to access any primary or secondary services, which means they have less opportunity to prevent moving into the tertiary system.

Another reason suggested for fewer Aboriginal referrals was that they were more complex and the risks were already too high for the Best Beginnings threshold. Best Beginnings evaluations have also identified difficulties over the years in recruiting and retaining an Aboriginal workforce and this also came up through the consultations.

“You really need your Aboriginal person giving the explanation about the program...it would be really challenging if you didn’t have an Aboriginal staff member...the important bit is who is proving that care...if you just have the nurse it won’t work.”

There was minimal discussion in the consultations of the need for Aboriginal cultural competence training. Although there was some discussion of cultural consultation for Best Beginnings workers by the Aboriginal Practice Leaders this was rarely mentioned by others. There was also concern that the workload for the Aboriginal Practice Leaders would not enable a huge role. Some teams appeared to have Aboriginal Practice Leaders at the intake meetings and team conferences and others did not.

The potential for collaborations with Aboriginal community controlled organisations was mentioned in a couple of consultations, such as the possibility of co-location, co-working or the service being provided by an Aboriginal organisation.

Some of those consulted also suggested that lack of suitability of the model for working with Aboriginal families was a barrier for families being referred. The cultural relevance of Best Beginnings for Aboriginal families was a specific focus of the review.

There was little evidence in the program documentation, evaluations or in the consultations to suggest that Aboriginal cultural practice directly informed the model development (theory of change) or application of the model in practice (theory of action). The areas where this was most apparent was the reliance on attachment theory, the emphasis on the mother-child dyadic relationship, and the difficulties in recruiting Aboriginal workforce or in some areas linking in with Aboriginal services.
The Best Beginnings model’s emphasis on attachment assumes a Western dyadic understanding of healthy infant development and does not take into account the multiple relationships and roles that are often part of an Aboriginal community. There is significant scope for misunderstandings when applying attachment theory across cultures (this was not mentioned by anyone directly involved in the Best Beginnings program). One Aboriginal worker noted that in some communities the mother may have more of an indirect role with her child than a grandmother for the first year or so of life, particularly if she is a young mother. Attachment theory is a very relevant and useful conceptual framework when working with Aboriginal families but how this is informed by a cultural lens was the question.

“The thing about the Aboriginal child rearing, there’s been a discussion about that recently because of the high number of Aboriginal kids in care and the concept that a sole care giver isn’t necessarily the only one responsible for raising that child and particularly if it’s a very young Aboriginal Mum that in fact her family would be responsible. So when we look at intervening with Aboriginal families should we be taking a broader approach? So the attachment theory issue which is that primary care giver attachment, do we have to look at that in a different way for an Aboriginal family with a young mum?”

“There is so much of the program that doesn’t fit with Aboriginal parenting, caring and attachment…we are trying to make Aboriginal people, young mums, and young dads, fit into a model that is based on the western way of parenting.”

Adaptations of the model for work with Aboriginal families were mentioned in the consultations. Some adaptations appeared to have happened intuitively by workers, such as changing intensity and longevity of the visits. Some reference was made to using Aboriginal specific diagrams and questionnaires (e.g. Kimberley Mum’s Mood Scale, ASQ Trak). This is a positive step to assist engagement. The St John of God model of Circle of Security currently under development may involve more substantive changes but that was not clear. There was also discussion about working with more than the mother-child dyad.

The plans underway to redesign some of the documents and tools to reduce paperwork and be more engaging with Aboriginal families are likely to be useful adaptations, but would need to occur in concert with a broader examination of the model from a cultural perspective. As the literature cautions against tweaking mainstream models to fit Aboriginal families a comprehensive examination and development of the model from an Aboriginal perspective appears necessary. Re-examining the overarching program theory including theory of change and theory of action with Aboriginal children and families would be beneficial. It should also take into account the variations between metropolitan teams to those working in rural or remote areas. In particular there is an opportunity to co-design this model with Aboriginal consultants.

“We need to think more broadly and do it differently and not make assumptions about just adapting diagrams, models etc.”

One Aboriginal person consulted for the review felt the Best Beginnings model should be adapted by Aboriginal people, preferably Aboriginal staff who have delivered the program. The Department of Health senior staff spoke of the Australian Nurse Family Partnership Project (ANFPP), which is
explicitly adapted for work with Australian Aboriginal families, although commented that the program had mixed success to date.

The lack of trauma-informed aspect to the Best Beginnings model was reflected in limited reference to intergenerational and community trauma and how these can contribute to difficulties in learning new skills, establishing trust and continuing past traumas into the future. Although not limited to Aboriginal families, trauma and its many consequences have particular relevance from a historical and current perspective within Aboriginal communities. Further, the Best Beginnings program theory currently does not overtly mention prevention of maltreatment or Aboriginal families. Any revision of the program theory would benefit from exploring what would be possible mechanisms for change to support the goal of preventing maltreatment with specific reference to Aboriginal families.

Adapting Best beginnings for families where children are considered at risk of maltreatment or who have been notified to protective services for child maltreatment

Societal changes, such as decreasing employment opportunities for people at the lower end of the socio-economic spectrum, gaps in educational achievement and social inequalities combined with changes in family structure and stability, racial discrimination, intergenerational trauma and disadvantage and other life circumstances are having devastating effects on some families. Helping parents to support very young children growing up in families facing adversity so as to reduce the likelihood of child maltreatment and of their developing serious emotional and behavioral difficulties is a considerable challenge for modern Child Protection systems.

In the light of increasing complexity, home-visiting models such as NFP have progressively been applied for the purpose of reducing incidents of child maltreatment and entry into the Child Protection system. This appears to be the situation with the Western Australian Best Beginnings program, which began in 2000 as a health promotion service, but is currently targeting the most at-risk families in Western Australia, including families with multiple vulnerabilities and risk factors for child maltreatment and who have been notified to protective services for maltreatment.

Evidence from this review suggests that Best Beginning’s design and implementation system is not equipped to serve Western Australian families with risk factors for child maltreatment or who have been notified for maltreatment. By the same token, there is no conclusive evidence to demonstrate that any well-designed or evaluated home visiting program would be highly effective with this population group.

Do evidence-based home visiting models exist for families with risk factors for child maltreatment?

While almost 50 years of program evaluation, meta-analyses and literature reviews suggest that “evidence-based” home-visiting programs produce favourable impacts on outcomes such as maternal parenting practices, the quality of the child’s home environment, child development and school readiness, there is growing sentiment that many evidence-based child and family programs in existence today were not developed to combat contemporary social and economic challenges and do not produce robust impacts for highly vulnerable or multi-challenged families (Centre on the Developing Child, 2016).
Although studies of the NFP model have demonstrated successful outcomes in reducing the overall frequency of maltreatment (Olds et al., 1997; Zielinski, Eckenrode, & Olds, 2009), especially for neglect, systematic reviews have been cautious to conclude that home-visiting programs directly prevent child abuse and neglect (Howard & Brooks-Gunn, 2009). A U.S. Department of Health and Human Services review of evidence of effectiveness of home visiting (Hom VEE) published this year is particularly instructive (Avellar et al., 2016).

The Hom VEE review examined the research on 44 home visiting program models with studies published between 1979 and 2014. Of the 11 home visiting program models with high- or moderate-quality evaluation studies that measured reductions in child maltreatment, seven had favourable effects on primary outcome measures\(^{11}\) and three had favourable effects on secondary outcome\(^{12}\) measures. However, in interpreting these findings, it is critical to examine the overall number of studies conducted for each program. For example, 25 evaluation studies of the NFP model examined child maltreatment as an outcome measure. Of those 25 studies, only seven showed favourable effects (that is, 18 showed no effect).

The conclusion that can be drawn from the Hom VEE review is that very few home visiting models can claim effectiveness in reducing incidents of child maltreatment and that replication of positive impacts is uncommon (Avellar et al., 2016, p.9). Further, while favourable impacts of evidence-based home visiting programs are not limited to subgroups based on particular characteristics, there is little evidence that existing child and family programs with high quality impact studies are effective in reducing child maltreatment among Aboriginal families with a history of maltreatment or where there are risk factors for maltreatment.\(^{13}\)

These are important messages for Western Australia, especially given its geographical constraints, unique service system aspects and the high proportion of Aboriginal clients to be served by an intensive home visiting service.

\(^{11}\) An outcome measured through direct observation, direct assessment, administrative data or data collected using a standardized instrument.

\(^{12}\) An outcome measured through self-report, excluding self-reports using a standardized instrument.

\(^{13}\) SafeCare is a possible exception. SafeCare is a well-designed “evidence-based” in-home parenting program for families with children aged up to five years who are involved with the Child Protection system for reasons of child neglect. It takes place over 18 sessions and targets three skills; positive parenting, home safety and child health. Prevention of subsequent substantiated child maltreatment reports, including among Native American Families, have been found in evaluations in the U.S. SafeCare has recently been adapted for the Australian context with access to accredited training and coaching from the purveyor organisation (Parenting Research Centre, no date).
In the absence of conclusive evidence to suggest that adoption of any particular “evidence-based” child and family home visiting model will be effective with families with risk factors for maltreatment or who have been notified to Child Protection for maltreatment, research and development is needed to improve Best Beginnings’ underlying program model and implementation system and thus strengthen its effects. This approach would maintain the value of the current Best Beginnings workers within DCPFS, although the role of the Department of Health would need to be clarified.

Core principles of evidence-based parent support programs
While the evidence does not point to a specific “program”, there are several best practice principles that have been consistently associated with positive interventions that aim to support parents (Centre on the Developing Child, 2016, p.22). These are:

- Staff members establish a trusting relationship with caregivers and support them in their ability to engage in successful parenting
- Special efforts to engage families who are at-risk of maltreating their children, or families who have been notified to protective services for child maltreatment
- Individualised coaching/behaviourally-based strategies to modify dysfunctional parenting practices and promote emotionally attuned parent-child interactions, predictable parenting and positive reinforcement of good behaviour
- Significant adversities or co-existing difficulties are addressed\(^\text{14}\)
- Specified visit and content or curricula
- Structured, pre-service training for staff
- Standards for visit frequency, staff supervision and implementation and
- A system to monitor adherence to the program model.

In a recent working paper from the Centre for Community Child Health, Moore (2016, p.23) identified a number of “evidence-based processes”\(^\text{15}\) contained in effective human service programs, regardless of the focus if the content or the intervention. Specifically, effective programs are:

- Relationship based
- Involve partnerships with professionals and parents
- Target goals that parents see as important
- Provide parents with choice regarding strategies
- Build parenting competencies
- Are non-stigmatising
- Demonstrate cultural awareness and sensitivity and
- Maintain continuity of care.

Augmentation of Best Beginnings
Recent publications about the NFP have focussed on adaptation and continuous quality improvement in enhancing program impacts outside research settings and for more diverse populations, declaring that evidence-based programs are rarely “final products” (Olds et al., 2013). In the same way, “innovation” is considered an important stage of the implementation process to ensure evidence-based programs that have been taken to scale with integrity produce excellent effects (Fixsen et al.,

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\(^{14}\) These include family poverty, parental mental health problems, parental substance abuse, children’s special needs and intimate partner violence.

\(^{15}\) Also referred to as evidence-based kernels and core intervention components (Moore, 2016).
2005). There are also proponents within the implementation science field of “flexibility within fidelity” (Kendall et al., 2008); that is, adapting features of “model” programs to suit the values and circumstances of individual families.

While the evaluation of Best Beginnings undertaken by Robson and Clark (2004) concluded that Best Beginnings had been implemented with high fidelity, the consultations undertaken for this review highlighted different perspectives as to whether the program was implemented with integrity to the model or more flexibly applied. Some saw this as a struggle to maintain program integrity. Others saw this as a struggle to ensure the program was tailored to the individual family’s and the system’s needs. It did seem that the model was open to interpretation and that some sites were more independent than others.

“It’s a very high fidelity program, it’s very tight, and it’s in line with the evidence base.”

“I keep in mind how the visits should be structured but I work to their schedule.”

“We have a model and scope to be flexible.”

The struggle to maintain integrity in program implementation points in part to the need for innovation and adaptation of the Best Beginnings model to work more effectively with a high risk population and to provide greater clarity on where “flexibility within fidelity” can and should be applied. There was clear support among some people involved in the consultations for enhancing or redesigning the Best Beginnings model around a higher risk cohort.

“...if we get the function right and what we want to achieve, we can build the model around that...it’s about starting with the logic first and building on that.”

“Let’s look at that cohort and think what they would really benefit from.”

**Framework to inform adaptation and innovation**

Olds et al., (2013) have advanced a framework to inform NFP program development and innovation, comprising five steps (Fig. 4).

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16 The differences in practice were influenced by the referral pathways, the proportion of Aboriginal clients, the nature of the workforce, whether it was a metro or country site, whether it was a sole worker or part of a broader Best Beginnings team and worker/supervisor judgement. Some of the adaptations described included duration and intensity of the program and specific adaptations made with Aboriginal families.
The first step as shown in Fig. 4 is to understand program challenges. The overriding challenge for Best Beginnings going forward is to address the complexities of working with a higher risk population in order to maximise take-up and improve the magnitude of program impacts (respectful and supportive partnership relationship between the home visitor and the parents and family, maternal use of resources, mother-infant relationship, increased child safety and corresponding decreases in child maltreatment over time).

Preliminary ideas for modification of Best Beginnings are outlined below and centre on:

- Association with Child Protection
- Visit frequency and program duration
- Service approaches
- Adapting Best Beginnings to Aboriginal culture
- Workforce capability and implementation support and
- Governance and accountability.

These aspects have been informed by research and other information gathered for the review. It should be noted, however, that identifying targets for program improvement is not a precise science, as the research does not point to a consistent pattern of effective components across specific outcome domains (Filene et al., 2013). As outlined in Fig. 4, suggested innovations need to be reviewed and refined through stakeholder input and subject to broader feasibility and acceptability testing. This requires an understanding of “core intervention components” or features of the current program that are essential to efficacy to ensure adaptations do not jeopardise outcomes. Going

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17 For example, in the context of fewer resources it may not be feasible to implement an enhanced Best Beginnings program at its current scale.
forward, will also be important to understand where it is possible to incorporate “flexibility within fidelity”, for example, incorporating the worker’s own style and methods in engaging clients and giving more flexible control of visit frequency and content to families.

### Association with statutory Child Protection

There is a question going forward as to whether enhanced Best Beginnings should be fully *integrated* into statutory Child Protection or whether it should remain *interfacing*. There are strengths/opportunities and weakness/challenges of both approaches. Other suggested innovations for enhanced Best Beginnings included here would also need to be evaluated in the light of its association with Child Protection. It is likely, however, that the Best Beginnings model will be more prescriptive if it remains interfacing with Child Protection work with more scope for individual tailoring if the program is fully integrated into Child Protection.

**Integrated** Best Beginnings would be a program within the intake or family support teams that have an earlier intervention function within DCPFS, focussing on higher risk families, in particular; children in care who become parents (especially those who may also have had periods of incarceration), families with multiple presentations for families support, families who have other children in care, Aboriginal families, parents (or parents to be) with cognitive disabilities and clients who require pre-birth planning with DCPFS.

Intake for Integrated Best Beginnings would be through Child Protection. The Best Beginnings paraprofessional workforce skilled in supporting families at risk would work alongside Child Protection workers to help prevent children coming deeper into the statutory system. Best Beginnings workers would work alongside a Child Protection worker for the duration of the open period of contact with frequent case consultation in a multi-disciplinary team context. A major strength of this approach is that Best Beginnings workers would be less isolated and more supported in their work. Family support within the Western Australian statutory Child Protection system lends itself well to this way of working.

Some people who were involved in the consultations indicated strong support for the Integrated Best Beginnings model.

“Child Protection caseworker doing the assessment and Child Protection decision-making and Best Beginnings worker working alongside and attending Signs of Safety mappings and pre-birth mappings and working together.”

“...a proposed model where a Best Beginnings worker working alongside a Child Protection worker in an earlier intervention type team...the referrals would come through intake...child centred family support but with a Best Beginnings focus for infants...Child Protection worker would hold case management.”

**Interfacing** Best Beginnings would serve a higher risk client group, including clients involved in pre-birth planning with DCPFS. Intake would most likely sit across Health and DCPFS, preferably separate to Child Protection. At some point Interfacing Best Beginnings may be placed in family support networks or within an Aboriginal Community Controlled Organisation.
A clear protocol between Interfacing Best Beginnings and Child Protection roles within DCPFS will be necessary to provide clarity around interfacing arrangements and to support communication. The protocol could include assessment and referral, decision-making, definitions of risk and information sharing.

**Visit frequency and program duration**

As discussed above, effective home visiting programs have specified visit and content or guidelines that are explicitly linked to a theory of change. Table 1 (earlier) shows Best Beginnings focussing, in a sequential fashion, on relationship building (antenatal period), mother-infant attachment relationship (first year) and positive family and community connections to become self-managing (second year).

The higher risk population of enhanced Best Beginnings necessitates some rethinking of both visit frequency and program duration based around the outcomes to be achieved. This may involve more intensive visiting in the pre-birth phase and in the first 6-12 months following birth of the child, where the focus is on building trusted relationships, participation in the pre-birth planning process with Child Protection and developing the mother-infant attachment relationship after the birth of the child.

In the case of high risk populations, the worker who enters the home and assists the mother with issues relating to pregnancy, parenting and child development is, in many instances one of the few people who has shown him- or herself to be trustworthy and reliable in the support s/he provides. As Best Beginnings families are likely to have minimal reason to trust anyone, let alone someone working for DCPFS, it is critical to provide the time and the intervention context for this relationship to develop.

The number of visits needed to positively change maternal sensitivity and infant attachment is an open question. In their review and meta-analysis, Bakermans-Kranenberg, van IJzendorn and Juffer (2005) found that intervention strategies for at-risk families that positively changed maternal sensitivity and infant attachment rarely involved more than six visits. However, some attachment interventions with maltreating mothers and mothers who had an unresolved attachment status and trauma-related symptomatology did not effect change even after extensive involvement. It is also unclear how long positive impacts last, and what types of interventions are needed to sustain positive effects.

Although impacts will likely vary according to the extent of the mother’s trauma symptoms, it would not be unrealistic for DCPFS to expect favourable impacts on maternal-infant attachment and infant development and safety after 12 months of program implementation after the child’s birth. However, it unrealistic to expect impacts beyond these stated outcomes if the intervention stops when the infants is 12 months (for example impacts on school achievement). Whether, and for what duration, the program extends beyond 12 months should depend on the durability of impacts on the mother-infant relationship and the goals of the program in terms of establishing family and community connections for self-management. It is an option to extend the program beyond 12 months on a case-by-case basis depending on the capacity of the family for self-management.

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18 Often found in mothers who were maltreated themselves as children.
19 In excess of 20 visits.
Service approaches
Suggestions for adapting the Best Beginnings model centre on the three phases of intervention and associated outcomes as well as enhanced features that may strengthen program impact for multi-challenged mothers.

Theoretical framework
The Best Beginnings program model currently emphasises ecological, self-sufficiency and attachment theoretical perspectives. The current focus of Best Beginnings on higher risk families includes mothers who may not have had the opportunity to develop the foundations for trusting relationships in their own early years, Aboriginal families who are likely to have experienced intergenerational and community wide trauma, mothers who have high rates of current exposure to trauma (such as intimate partner violence) and infants who are at risk of trauma exposure, or toxic stress. This speaks to the importance of adding in a trauma-informed lens to the model and ensuring workers are able to recognise trauma signs and symptoms. This would contribute to the understanding of barriers for engagement, potential barriers for trust and for learning new information and for understanding the meaning behind some maternal interactions with their infants. An infant mental health lens is also highly relevant and would contribute understanding of the growth and structure of the brain, the consequences for infants of exposure to trauma and the critical importance of eliminating toxic stress in the infant.

Trust and relationship building
As is the case for most interventions with high-risk populations, relationship building is a core intervention component of Best Beginnings. The review found a strong emphasis on the program being voluntary as a major platform for engagement, while associations with Child Protection were considered antithetical to building a strong therapeutic relationship.

Although the program would continue to be voluntary (especially in the antenatal phase where there is no legal capacity to mandate someone about an infant who is not yet born), as this is perceived as a mixed message given its place within DCPFS, a new language needs to be developed within the model, along with training, to explain how it differs and how it is the same as statutory Child Protection work. From a Child Protection practice perspective, it is recommended that clarity be given in each case about the choices each family has before them, the limits of any choice, the possible consequences of any choice and the degree to which the suggested program aims to help the family achieve their goals.

It is not usually beneficial to mandate a family to attend a program unless court action has already occurred. It is however important for DCPFS to have a transparent discussion of realistic choices that the family and DCPFS need to make. It should not be whether the family agrees to work with Best Beginnings, but whether they can demonstrate in actions their willingness and ability to make certain changes in order to keep the child safe and well (of which engaging with a service is a sign but not proof).

Other engagement strategies should be used rather than relying on the voluntary nature of the Best Beginnings program. Learnings from family preservation would be relevant here as well as building on the depth of experience within Best Beginnings.

Refocussing the antenatal phase of Best Beginnings around pre-birth Child Protection planning
There was ample evidence from the consultations that Best Beginnings involvement in the pre-birth Child Protection planning process had been productive and should be extended.
A protocol for pre-birth planning between maternity hospitals, Legal Aid Western Australia and DCPFS has been rolled out across Western Australia for collaborative information sharing and decision-making when there are concerns for the child when born. The process of pre-birth planning involves meetings to identify risks, strengths and solutions to be implemented. Meetings are scheduled to occur during pregnancy at 20 weeks, 26 weeks and 32-34 weeks. Meetings are attended by the hospital social worker, DCPFS caseworkers and team leader, Legal Aid and community-based agencies providing counselling and support services. By 36 weeks gestation a decision is made about the extent of DPCP involvement once the child is born. A detailed explanation of the pre-birth planning process is outlined in Harrison and O’Callaghan (2014).

The antenatal aspect of the Best Beginnings model could be productively refocussed towards provision of services, support and advice around pre-birth planning processes, such as helping to establish and maintain meaningful and empowering relationships with families, ensuring maternal-foetal attachment and developing the collaborative model of strengths-based, child-centred family focussed care during pregnancy. Further model development research will be required.

**Attachment-based intervention**

Best Beginnings integrates two evidence-based approaches to enable them to keep the parent-infant relationship at the forefront of their work; *Seeing is Believing*\(^{20}\) and *Circle of Security* (Cooper, Hoffman, & Powell, 2003). In the stakeholder consultations, the use of video interaction guidance through Seeing is Believing was largely acclaimed, whereas the response to Circle of Security was mixed. Ambivalence towards Circle of Security appeared related to decision-making surrounding adaptation of the Best Beginnings model as well as a perception that the Circle of Security protocol was not being applied with integrity; that is, the Circle of Security diagrams (Fig. 5) were being used as a teaching aide with families.

![Circle of Security diagram](image)

*Fig. 5. Circle of Security diagram*

\(^{20}\) Seeing Is Believing was originally developed and evaluated at the University of Minnesota as part of the STEEPTM program (Steps Toward Effective, Enjoyable Parenting) (Erickson & Egeland, 2004).
Seeing is Believing and Circle of Security are well accepted “evidence-based” attachment interventions that are widely used in Australia and seem appropriate for integration within Best Beginnings as part of a broader approach that is underpinned by a long-term supportive relationship and a home-visiting service strategy. However, to be effective, structural components, especially the use of video-taped parent-child interactive tasks, must be implemented with integrity. The most effective programs are those that have staff who are specialised in health and social services, with additional specific training in the key concepts of the program (Tarabulsy et al., 2008).

Ensuring that Seeing is Believing and Circle of Security are implemented with integrity should be a key target for program improvement. If a broader review of attachment-based interventions were to be undertaken for integration into Best Beginnings, systematically designed and implemented interventions for enhancing maternal sensitivity that employ a home visiting strategy worthy of examination include Attachment and Biobehavioral Catch-Up (ABC; Dozier, Peloso, Lewis, Laurenceau, & Levin, 2008), Promoting First Relationships (PFR; Kelly, Zuckerman, Sandoval & Buehlman, 2008), Child-Parent Psychotherapy (Lieberman & Van Horn, 2004), a brief attachment based intervention (Moss, Dubois-Comtois, Cyr, Tarabulsy, St-Laurent, & Bernier, 2011) and Parent-Child Interaction Therapy (PCIT; Chaffin et al., 2004).

Responding to co-existing difficulties
Aspects that enable home-based parenting programs to be effective when being delivered to multi-challenged mothers have yet to be pinpointed, but NFP adaptations are instructive. Specifically, the NFP program found that when family violence was present, this added a number of complexities to the work and was a major constraint to achieving positive outcomes, especially in relation to prevention of maltreatment (Eckenrode et al., 2000; Jack et al., 2012).

The response of NFP has been to add core components to directly address family and domestic violence elements, as well as universal components tailored to each woman’s readiness for change and safety planning and risk assessment (Olds et al., 2013). These new components have been embedded into subsequent NFP guidelines, training and supervision approaches.

Likewise, mental health consultation has also been successfully integrated with exiting home visiting services in the U.S. (including NFP in New York and HIPPEE in Milwaukee) to respond to mother’s unmet mental health needs (Goodson, Mackrain, Perry, O’Brien & Gwaltney, 2013).

Given the high proportion of closed cases involving a parent with depression and/or anxiety (67%) or family violence (34%) on program entry, it is an option for Best Beginnings to integrate new, cost effective components focussing on these aspects, including tools and resources to prevent or address intimate partner violence. Strengthening multidisciplinary teamwork through the team conference process and collaboration with community agencies will also be important. Decisions around these aspects may vary according to location, workforce capacities and the availability of community services to address mental health problems and family violence.21

There is also the potential to implement “flexibility within fidelity” in relation to the frequency of visits across individual caseloads depending on families’ risk and strength profile. This will require integration of a method of risk assessment, such as the Common Assessment Framework used in

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21 For example, some sites may “bolt-on” an enhanced element focussing on mental health problems whereas others may wish to strengthen consultation with community-based mental health services.
Family Support Network services. Safety planning will also need to be a feature of Best Beginnings whether or not it is fully integrated into Child Protection work, as integration with Child Protection would not in itself ensure its capacity to respond effectively to risk.

Social and community connection
Program data suggest the need for rethinking elements intended for implementation in the second year of the child’s life. Currently, few Best Beginnings cases are open for the full two years of the intended program duration and 45 per cent of cases last six months or less. More (74%) Aboriginal families are involved with Best Beginnings for 12 months or less than non-Aboriginal families (51%) (Fig. 6). Further, the Best Beginnings model only specifies six visits in the second year of the program, which is considerably less than comparable programs such as NFP, which specifies 21 visits in the second year after the birth of the child.

Implementation research is recommended to better understand reasons for case closure and program attrition, particularly among Aboriginal families and to understand the impacts of visitation in the second year of the program on sustaining impacts in the mother-infant attachment, strengthening family and community connections and encouraging family self-management. This will inform final decisions about the length of the program, offer suggestions for improving retention and determine whether new elements for promoting family and community connections need to be designed or adopted.

![Fig. 6. Best Beginnings length of service (July 2009-2016)](image)

Other program elements
The review highlighted other areas where model development could be focussed into the future, including the participation of fathers to address intimate partner violence, elements to improve pregnancy planning and aspects that better serve multiparous women. As Olds et al., 2013 notes “The changes (in NFP) required to serve multiparous women are significant because women with other children and previous births often have unique concerns, challenges, and aspirations that must be reflected in the evolving NFP program materials”.

Adapting Best Beginnings to Aboriginal culture
There is little in the published literature to draw from about the effectiveness of home visiting programs for Aboriginal families and the factors that are related to program success (Mildon & Polimeni, 2012). However, effective parenting support programs for Aboriginal families generally include the following aspects:
• Use of cultural consultants in conjunction with professional parent education facilitators and home visitors
• Workers being from a similar cultural background
• Long-term rather than short-term programs
• A focus on the needs of both parents/carers and the child
• Including extended family members
• A supportive approach that focuses on family strengths and
• Use of structured early intervention program content while also responding flexibly to families.

This resource also cautioned that; programs need quality structured content and sound delivery methods, mainstream programs should not be adapted for Aboriginal families without community involvement or consultation and that if voluntary programs are associated with Child Protection the message of their voluntary nature can be lost. Bowes and Grace (2014) also warned against discounting Aboriginal people’s knowledge of what works, of parenting and of caring for children, assuming that mainstream programs will be successful with Aboriginal people, assuming that if a program is relevant to one Aboriginal community it will therefore fit the other Aboriginal communities without consideration of local needs and strengths and not including good evaluation mechanisms in work with Aboriginal communities.

Although there is effort within Best Beginnings currently to develop, adapt or adopt more Aboriginal specific forms and tools, this does not address the underlying question of the model. Each aspect of the Best Beginnings theoretical framework requires examination from a cultural perspective. Particular attention should be given to the application of attachment theory, such as the concept of attachment networks within Aboriginal communities rather than a primary focus on the dyadic mother-child relationship (Coade, Downey, & McClung, 2008). The model is also likely to include an understanding of Aboriginal practices in relation to pregnancy, motherhood, fatherhood and parenting.

Learning from what is working from the adaptations made to the NFP model for the ANFPP model is particularly relevant to the process of adapting Best Beginnings to Aboriginal culture. The ANFPP is an authorised adaptation, under licence, of the NFP program to address the needs and aspirations of Australian Aboriginal and Torres Strait Islander families. A number of adaptations have been made in

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22 Although attachment behaviours are present across all cultures, they are interpreted within a cultural framework and so can be misinterpreted if the cultural context is misunderstood (Jackson, Waters, Meehan, Hunter, & Corlett, 2013). For example, in Aboriginal culture, a toddler’s exploration and reunion with the caregiver may look different from many Western cultures. Another difference is that Aboriginal parents may be more likely to anticipate the child’s needs through checking regularly rather than responding to the child’s distress signals. If misunderstood, this could appear as if the parent is overly clingy or under-responsive, whereas neither may be the case (Yeo, 2003).

23 The Australian Nurse Family Partnership Program (ANFPP) is an example of an authorised adaptation of the NFP program implemented for use in Indigenous communities. Adaptations include the addition of an Aboriginal community worker alongside the nurse visitor role that are equally valued, the referral criteria including multiparous mothers (not just first-time mothers), adaptation of the materials to use with families, and some visits with the family not occurring in the home (Ernst & Young, 2012).

24 It is funded through the Commonwealth Department of Health and delivered through local Aboriginal Community Controlled Health Organisations in Queensland, NSW and Northern Territory. It has the same overall goals as NFP and aims to achieve outcomes in the areas of maternal health, increased knowledge of the maternal role, improved maternal life course development, increased access to other supports and services,
order to fit the Australian Aboriginal context. These include the addition of an Aboriginal community worker alongside the nurse visitor role that are equally valued, the referral criteria including multiparous mothers (not just first-time mothers), adaptation of the materials to use with families, some visits with the family not occurring in the home and potentially deeper adjustments to program content and nurses’ ways of building collaborations with families and communities (Ernst & Young, 2012).

Model revision would need to be informed through consultation with parents of Aboriginal children, Aboriginal workers and services (Mildon & Polimeni, 2012). DCPFS has an opportunity to invite Aboriginal services to a genuine co-design process to maximise the accessibility and capacity of the service to respond effectively to Aboriginal families where the child is at risk of maltreatment.

Workforce capability and implementation support

Improving services is influenced as much by the process of implementing innovative practices as by the practices selected for implementation (Aarons, Hurlburt & McCue Horwitz, 2011). The issue of training, supervision and recruitment were raised during the consultations in relation to the level of risk the program is currently holding and the desirability to have workers that were from the same cultural background as families.

The question of who should deliver home visiting programs is an issue some debate among researchers. The NFP program found that families in Denver who were visited by qualified nurses had more favourable outcomes than families who were visited by paraprofessionals (Korfmacher, O’Brien, Hiatt, & Olds, 1999; Olds et al., 2002). Olds et al., (2002) also argue that the failure of the other programs to meet their intended aims relates to their use of paraprofessionals, rather than trained nurses. However, other researchers argue that the relationship between the home visitor and the parent is more central than the education level of the visitor, and that well supported, resourced and trained paraprofessionals can be equally as effective as nurses (Gomby, Culross, & Behrman, 1999).

In the current review, comments made regarding the Health Best Beginnings workers emphasised their high level of qualifications, experience and confidence as strength of the model. However, in relation to DCPFS staff, characteristics including attitudes, experience and approach were highly valued and were considered integral to program effectiveness. Some people involved in the consultations also suggested the emphasis in workforce development is better placed on capabilities than on professional qualifications. The recommendation from this review is to ensure that the capabilities of the Best Beginnings workforce and the level of clinical supervision, reflective practice and training match the challenges they are asked to address. A capability overview towards clinical expertise (Fig. 7) seems a useful framework for ensuring the capabilities of staff are consistent with program goals.

improved environmental health, newborns raised in a safe environment and infants and toddlers being healthy with age appropriate development and behaviours.

25 Visitors with no professional qualifications but specific training related to their home visiting role.
Pre-service training needs to be more theory driven as well as practical/procedural. As mentioned during the consultations, the introduction of the Australian Association of Infant Mental Health Western Australian Competency Guidelines (Matacz & Priddis, 2015) is a potential way to provide a means by which Best Beginnings worker’s capabilities could be recognised and built upon.

In terms of ongoing training, there was evidence from the consultations that access to ongoing training among the workforce was ad hoc and optional (for example, monthly meetings are optional and some workers cannot access training via video conferencing as they will not have priority access from their office). Priority needs to be given to all Best Beginnings workers accessing the monthly training and team development sessions, such as ensuring access to videoconferencing. Ongoing training also needs to be capability focused and include coaching as well as didactic learning.

It was not clear from the consultations whether Circle of Security is being attempted in accordance with the evidence-base for that model or as a useful set of principles with some strategies. Worker participation in accredited Circle of Security training is essential if this is (or evolves into) a core element of the model.

Best Beginnings also requires a stronger system (enhanced capacity) for implementation support, program integrity monitoring and quality improvement. Clinical supervision is a particularly pressing issue. The evidence-base (e.g., NFP and others) is unequivocal that home-visiting programs (especially those that work more in the tertiary space) need clear clinical supervision and reflective space structures. This needs to be undertaken by staff trained in the model as well as clinical (not just administrative) supervision. Comments were made during the consultations that simply being part of a broader team will not meet this requirement on its own.

**Cultural competence and culturally specific workforce**

The consultations suggested Aboriginal specific roles within DCPFS were used well to advise some Best Beginnings workers, although the workload of the Aboriginal practice leaders appeared to be an issue. However, to be effective with Aboriginal families, Best Beginnings requires an increased emphasis on cultural competence and efforts to build a culturally specific workforce. Cultural
competence is a key strategy for reducing inequalities in access to services and improving the quality and effectiveness of care for Aboriginal people (Moore, 2016).

Some general principles of culturally-informed and respectful practice that have relevance to Best Beginnings include:

• Aboriginal definitions of health and social and emotional wellbeing are inclusive and holistic (Bamblett, Frederico, Harrison, Jackson, & Lewis, 2012)
• Organisation and worker cultural competence is a cornerstone to enhancing children’s social and emotional wellbeing (Bamblett et al., 2012) and
• When a family’s culture is not recognised or understood, this can exacerbate potential for isolation and alienation and exacerbate barriers for families to access services (Hepburn, 2004).

Governance and accountability

The consultations highlighted the need to strengthen governance of Best Beginnings. A priority issue is to clarify decision-making between the central SPD0 role and District line management (or the Department of Health). Many involved in the consultation spoke of the value of the central SPD0 roles in supporting fidelity with the model and consistency across districts, providing the training, consultation regarding complex cases and conceptualising changes required to the model. However, proposals for model adaptation and outcomes monitoring may need to work through a high level governance committee for greater rigour and transparency and to provide confidence about the program at the senior DCPFS level.

As a matter of urgency, clarity of process and systems need to be in place to ensure that anyone in the line management hierarchy, as well as other designated roles with review, monitoring, accountability and performance management responsibility can access a Best Beginnings client file without delay or technical constraint.

Concluding comments

Twelve years ago Best Beginnings was described through an independent evaluation as “…located in the ‘right’ agency, using the ‘right’ staff, seeing the ‘right’ people, and doing the ‘right’ things” (Robson & Clark, 2004, p.38). Since that time the target population has shifted, calling into question the ‘rightness’ or ‘fitness for purpose’ of program elements for the work ahead.

For Best Beginnings to achieve favourable impacts for high risk families it must innovate and adapt. Such work is challenging but feasible, and holds considerable promise for improving the lives of vulnerable children and families. This review has formulated some suggested innovations. However, it is important not assume there is an absolute “right” model but to use a structured innovation process that helps to ensure any changes are made with eyes open to the predictable and unpredictable issues that arise along the way. The challenge is to capture and build on the many valuable elements that comprise the Best Beginnings program whilst scaffolding and strengthening its foundations through more robust and transparent governance and systems and redesigning its framework and practice through co-design and collaboration with key informants in the Aboriginal community along with others.
References


Ernst & Young (2012). *Stage 1 Evaluation of the Australian Nurse Family Partnership Program: Final Report* Department of Health and Ageing, Canberra: Ernst & Young Australia.


