The Baby TALK Model

Description:

Baby TALK is a community systems model designed to build collaborations, screen every family, identify family needs and then deliver appropriate services which include information, activities and support to expecting parents and families with children prenatally to three years.

Purpose:

Baby TALK's mission is to positively impact child development and nurture healthy parent-child relationships during the critical early years.

Editors, Shonkoff and Phillips (2000) stated:

> The scientific evidence on the significant developmental impacts of early experiences, caregiving relationships, and environmental threats is incontrovertible. Virtually every aspect of early human development, from the brain's evolving circuitry to the child's capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning early in the prenatal period and extending throughout the early childhood years. The science of early development is also clear about the importance of parenting and of regular caregiving relationships more generally. The question today is not whether early experience matters, but rather how early experiences shape individual development and contribute to children's continued movement along positive pathways. (p. 6)

Model Framework:

Build a system.

Identify others interested in serving young families in your community. Learn about their goals and services, and discover opportunities to assist each other in meeting goals for families.

In their review of literature for home visiting best practices, LPC Consulting Associates, Inc. (2007) found:

> Home visiting programs cannot solve all societal problems. Therefore, they must build collaborative relationships with other local community programs that target at-risk families. Home visitations programs must collaborate with other programs to provide some type of "wrap-around service," in conjunction with the intervention. (p. 8)

Gomby (2005) stated:

> High quality home visiting programs can play a part in helping prepare children for school and for life. Together with other services such as center-based early childhood education, joint parent-child activities, and parent groups, home visiting can produce meaningful benefits for children and families. For that reason, home visiting services should be embedded in a system that employs multiple service strategies, focused both on parents and children. (p. 44)

Screen every family

Cast a net over your targeted population in order to identify who is raising children. Use Baby TALK's Encounter Protocol to learn about families' risk factors. This may include outreach to hospitals, WIC, clinics or other community locations where families may be found.

- Obstetric Unit Newborn Encounters using the Newborn Behavioral Observation tool
- Community-wide children's developmental screening using a global developmental tool such as HELP, ASQ, ASQ-SE, Batelle, etc.
- Community clinics using the Baby TALK Encounter Protocol and Baby TALK Eligibility Screening Tool
- Community collaborations for referrals

Center on the Developing Child at Harvard University (2007) found:

> In order to provide appropriate services in a timely manner, it is important to have effective screening and referral mechanisms in place in a variety of settings in which young children and their families are seen regularly. These can include doctors' offices, childcare facilities, and preschools, among others. Once specific needs are identified, it is essential that prescribed services are sufficiently prepared to address them, particularly for those families facing the greatest challenges. (p. 22)

Funding sources may dictate the programmatic design of a universal screen and the targeted population to serve.

Identify the need

Use this screening to identify which families are most at-risk, which ones are already being case managed by other agencies, and which ones have needs which can be addressed either through your resources or other community resources. Make referrals or connections immediately to establish trust with parents.

Deliver appropriate services *(See also Appendix A)*

- Funding sources and the degree and scope of desired outcomes of home visiting programs usually drives the expected frequency, durations and length of home visits.
- Families most at-risk may enter a system of case management with purposeful, frequent personal encounters/home visits.
- Families with fewer risk factors may be served by group encounters through the community's resources, with ongoing efforts to re-examine the development of risk factors over time.
- Current review of literature provides varied evaluations related to frequency durations and length of home visits.

Jones Harden (2010) summarized the work of Nation, M., Crusto, C., Wandersman, A., Kumpfer, K. L., Seybolt, D., Morrissey-Kane, E., & Davino, K. (2003) and Daro, McCurdy, Falconnier, & Stojanovic, (2003) by stating:

> "High levels of intensity have been identified as an essential characteristic of effective prevention programs. . . and may be even more critical for home visiting programs servicing high-risk families."

In the article, Assessing Home Visiting Quality: Dosage, Content, and Relationships, Paulsell, Boller, Hallgren, Exposito (2010) synthesized the work done by others when stating:

> There is evidence that home visiting programs with a range of dosage requirements are effective at improving targeted outcomes (Gomby, 2005; Stoltzfus & Lynch, 2005). Moreover, positive effects have been found even when participants dropout before completing the program (Olds et al., 2004). Some studies of home visiting have varied the dosage and found that less exposure yielded outcomes comparable to those found when targeted exposure was greater (Depanfilis & Dubowitz, 2005).

The National Human Services Assembly (2007) states the following in its article "Home visiting: Strengthening families by promoting parenting success":

> 'High-quality' home visiting programs maintain a high level of engagement (i.e., intensity of visits and duration of service) with the family. Preliminary research indicates that families must be visited once a week for three to six months to yield benefits, and regular visits for two years are optimal.

For Baby TALK programs serving vulnerable families with multiple risk factors the recommended minimum frequency and intensity of engagement with a family is 2 times per month for a 60 minute encounter. Optimal frequency and intensity of engagement for vulnerable families with multiple risk factors is 1 time per week for 60 minutes.

Some studies have suggested that planned frequency of visitation may need to be increased to two weekly visits. It is to be noted that frequency and intensity of engagement is only one characteristic of "high-quality" programs leading to effectiveness. Gomby (2007) articulated the benefits of home visiting programs are contingent upon program content, service alignment with program goals, the family and community context, the use of evaluation for program improvement, and how well the program is implemented.

Critical Concepts:

The following foundational **Critical Concepts** support the creation of the Baby TALK culture for an individual professional and for an organization. Baby TALK programs will:

- Have a **mission statement** which includes impacting child development and parent-child relationships during the critical early years.

Jones Harden (2010) states:

> Enhancing parent-child interaction is a key strategy for home visitors to use to achieve positive child outcomes (Barnard, 1998, Jones Harden, 2002; Peterson, Luze, Eshbaugh, Jeon, & Kants, 2007). All intervention programs must have a clearly articulated theory of change which identifies the mechanisms by which home visiting staff achieve programmatic goals.

- Create and support a community system joining services into a **seamless system of care**.
- Create a culture of demonstrating professional mutual relationships with families, colleagues, and collaborators.

Jones Harden (2010) summarized the work of others with the following:

> In relationship-based home visiting programs, relationships—among staff and between staff and families—are based on trust, empathy, and responsiveness (Saul & Jones Harden, 2009). Positive relationships between families and program staff are essential for the quality of home visiting services. For example, family engagement with home visiting programs is related to the home visitors' capacity to develop a positive helping relationship with families (Korfmacher, Green, Spellman, & Thornburg, 2007), and to home visitor conscientiousness and persistence with families (Brooks, Summers, Thornburg, Ispa & Lane (2006).

- Demonstrate an outreach approach to services by **going where families are** both physically, in location of program, and emotionally, by honoring their expertise as parents.
- Build leadership skills in professionals by instituting "compassionate confrontation" as a method to **face difficult issues** and have hard conversations with parents, colleagues and collaborators.

The National Commission to prevent Infant Mortality (1989) suggests characteristics for home visitors. In the article "Home Visiting: Opening Doors for America's Pregnant Women and Children" the Commission notes:

> "Experts agree that several personal characteristics of home visitors make them successful across programs. These characteristics include strong skills in observing, organizing, listening, supporting, probing, interpreting, prompting, and gently confronting."

- Recognize and identify the **parallel processes** occurring in the layers of relationships: parent-child, parent-professional, professional-collaborator and professional-professional.
- Bring to each interaction the foundational concept that each parent is the expert on his/her own child and allow the parent to lead the direction of the encounter. Using language such as **"Tell me about your baby"** exemplifies this concept. This facilitates their effective parenting rather than prescribing a parenting approach for them to follow.

Jones Harden (2010) found:

"Home visitors' nonjudgmental, optimistic attitude about parents is more likely to lead to increased family participations and positive family outcomes (Beeber et al., 2007)."

Paulsell, Boller, Hallgren, Exposito (2010) found:

Although home visiting models vary in their recommendations for developing the parent-home visitor relationship, a few general principles drawn from social systems, family systems, and empowerment theory provide a foundation for implementing a strengths-based approach—such as developing rapport and trust, assessing strengths and needs regularly, honest and respectful communication, and a focus on empowering clients to identify solutions and actions (Dunst, Trivette, & Deal, 1994; Roggman et al., 2008; Wasik & Bryant, 2001)

- Create and support a culture of professional learning and growth. Each member of the Baby TALK team desires to **"become ever better."**

Jones Harden (2010) stated:

An essential component of quality home visiting programs is staff who are trained, monitored, and supported to intervene with the particular risk factors that psychologically vulnerable families present. Because home visitors in most programs address the needs of the "whole" child and family, their knowledge and skill regarding child and parent physical and mental health must be enhanced.

Jones Harden(2010) also stated:

Reflective supervision, with the consistency and continuity of support it offers, would provide home visitors with the opportunity to improve their skills in a neutral, reflective context. Supervision should entail "in-vivo" observations and feedback of home visitors' work. Supervisors can accompany staff on home visits, or observe and provide feedback through reviewing a videotape of a home visit.

- **Value each family's culture** and traditions and honor these traditions in program functions.

Gomby (2005) notes:

Parenting practices are strongly bound by culture. Parents of different cultures possess strongly held beliefs about the best approaches to handling sleeping, crying, breastfeeding, discipline, early literacy skills, and obedience and autonomy in children. Further, it appears that the same parenting practices can yield different results for children from different cultures. These differences in parenting practices across cultures may render home visiting less effective with some families. . .if the advice offered by the home visitors is not consonant with the family's beliefs about parenting.

- Build a "trustworthy system of support" through **collaborations** with community partners.

In Chapin Hall's Issue Brief, Embedding Home Visitation Programs within a System of Early Childhood Services, Daro discusses key components of a system of early intervention services stating:

Despite its promise for improving the circumstances and thus the development of newborns, home visitation must not be seen as the single solution for preventing child maltreatment or for promotion healthy family dynamics. Home visitation is, however, a key component of an effective system of care. Other components include medical care, broad risk assessments, system of home visitation, linkages to childcare and early education programs. Children develop along a continuum, and each component addresses only one point along that trajectory. Taken together, early intervention services share a common set of objectives focused on promoting children's healthy development and positive parent-child relationships as well as preventing harm.

Protocol:

Baby TALK professionals will use the following **Protocol** as the framework for personal and group encounters:

Preparation

Physical preparation of materials and mental preparation recognizing the needs of the family or group.

Assessment

What is the physical environment? What is the emotional availability of the family for the encounter?

Affiliation

You are making a human connection.

Use OPERA listening:

Open- ended questions
Pause
make **E**ye-contact
Repeat
Avoid judgment, **A**sk opinion, **A**dvise last

In their qualitative analysis of why intended outcomes where not achieved in home visiting, Hebbeler & Gerlach-Downie (2002) noted the following:

> "Less effective home visitors praise the parent, and demonstrated activities, rather that jointly planning, implementing, and reviewing activities."

Observation

Parents are more interested in looking at their babies with us—than in listening to us talk.

The National Commission to prevent Infant Mortality (1989) suggests characteristics for home visitors. In the article "Home Visiting: Opening Doors for America's Pregnant Women and Children" the Commission notes:

> "Experts agree that several personal characteristics of home visitors make them successful across programs. These characteristics include strong skills in observing, organizing, listening, supporting, probing, interpreting, prompting, and gently confronting"

Developmental Behaviors

Wonder about and describe developmental behaviors the child is demonstrating so that the parent has the opportunity to share the meaning he/she is making of that behavior at this particular developmental stage.

The article by Paulsell et al. (2010), Assessing Home Visit Quality: Dosage, Content, and Relationships, cites the work of Peterson et al. (2007) when stating:

> "Mothers were more engaged when the home visit focused on child development or family dynamics and less engaged when home visitors discussed community resources and referrals"

System of Support

Who is supporting you in the care of your baby? Pay attention who the parent "brings in the room" by mentioning others in conversation.

Introduction of the Baby TALK system of support

How can Baby TALK support you today?

Reflection

Ask yourself, did I make a connection with this family?
At what point in the visit did that happen?
What did I learn in this encounter?

In Chapin Hall's Issue Brief, Embedding Home Visitation Programs within a System of Early Childhood Services, Daro (2009) noted:

> Building relationships with vulnerable families with risk factors may require more patience, creativity, and persistence that with other families (e.g., returning to the home multiple and varying times to catch the family at home). Providing concrete reminders that they have been "held in the mind" of home visiting staff may be necessary, such as when staff brings tangible resources to the home visiting session (e.g., diapers).

Keeping families engaged in home visitation services is one of the greatest challenges programs face. Jones Harden (2010) notes the work of Ammerman et al. (2006) in regard program involvement:

> "Parents are unlikely to stay engaged with a home visitation program, unless they are convinced that services will meet their family's needs and a decrease in family engagement by a family may indicate that program modification is necessary."

Documentation

This helps us "hold this family in our mind" and will provide a starting point for our next encounter with this family.

Funding sources may dictate the type and amount of documentation for each family at each encounter.

Staffing:

- Baby TALK professionals should have a bachelor's degree or an associate's degree with a high level of experience in education, nursing, or social work. Baby TALK professionals have the mind of a scholar and the heart of a servant.
- Baby TALK professionals should display a high degree of empathy, knowledge and willingness to learn about a family's needs and culture. Where possible, Baby TALK professionals should reflect the culture of the communities they serve.
- Baby TALK professionals must be certified by Baby TALK through the 4-day Baby TALK certification training. In addition, they must be recertified annually by Baby TALK, Inc. through the Baby TALK Professional Association.
- Individual programs will provide supervision of Baby TALK professionals. Supervisors will participate in the Baby TALK supervisor's network.

Jones Harden (2010) noted:

> The role of staff in the delivery of high-quality home visiting programs is obviously critical. Which staff characteristics are linked to quality is not as transparent. There is ambiguity in the field as to whether home visitors need to have college degrees to deliver high-quality services. Olds(Olds et al., 2004; Olds et al., 2002) found that although paraprofessional-delivered services do have positive impact on families, these effects are not the same magnitude and type as those resulting from professional home visitation (i.e., nurses). Notably, there has been not research about the benefit to families of that compares paraprofessionals with other types of professional home visitors, such as social workers or child development specialists.
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> Staff competence, particularly in regard to addressing the issues that high-risk families face (e.g., mental illness, substance use, and family violence), also influence program quality…The psychological characteristics of home visitors also affect their performance. Home visitors may experience the secondary trauma and burn-out that is common among many human service providers, particularly those serving high risk families. To address home visitors' limitations in intervening with high-risk families and their own vulnerability, a higher level of supervision and support is necessary (Scott Heller & Gilkerson, 2009; Saul & Jones Harden, 2009). Reflective supervision, with the consistency and continuity of support it offers, would provide home visitors with the opportunity to improve their skills in a neutral, reflective context.
>
> Home visitors' nonjudgmental, optimistic attitude about parents is more likely to lead to increased family participations and positive family outcomes (Beeber et al., 2007).

Paulsell, Boller, Hallgren & Esposito (2010) noted:

> Many home visiting programs try to match visitors to families on the basis of important characteristics that may support relationship-building. Language is one factor, and some research supports the practice of matching based on characteristics such as race, ethnicity, and age. (Wasik & Bryant, 2001)

Staff Caseloads

- Following screening/outreach services, caseloads will be 15-25 families per full-time (I.0 FTE) staff member depending on the intensity of services.
- Following screening/outreach services, caseloads will be 6-15 families per part-time (.5 FTE) staff member depending on the intensity of services.

Appendix A — Flexibility within the Model

The Baby TALK Model is a community systems model defined by the 12 Words, Critical Concepts and the Encounter Protocols. The flexibility within the model is often defined by the funding source and the entity delivering the services to the community.

While much of the information in this document is applicable across funding streams, community agencies, and field disciplines, it was developed with the lens of intensive home visiting. The 12 Words may be interpreted along a spectrum of intensity of services and with varying demographic populations:

- The Baby TALK trustworthy system will be the overarching umbrella for all agencies (medical, social services, library, etc) within a community providing services to families of young children.

- As part of the larger community system of care, any community agency (library, family literacy program, health department, community clinic, social service agency, pediatricians, early care and education, hospital obstetric staff) is able to implement the Baby TALK model, approach, and curriculum in delivery services to families of young children.

- The Baby TALK 12 word model will also be implemented within the context of services to an individual family. Providers need to be a part of the family system to screen for the identification of needs in order to provide the most appropriate services for each family.

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