Minding the Baby® (MTB) Denmark Replication Planning & Operations Manual

A guide for MTB implementation in Denmark

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Minding the Baby® (MTB) began as a collaboration among the Yale Child Study Center, Yale School of Nursing, Fair Haven Community Health Center, and Cornell Scott-Hill Health Center in New Haven, Connecticut.

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This purpose of this document, created specifically for Danish implementation, is to provide an overview of the basic components and planning process involved in replicating the *Minding the Baby*® (MTB) clinical model, while also providing implementation details pertinent to MTB replication in Denmark. This manual is intended for use by department heads, managers, and administrative staff involved in MTB replication. It includes details on the steps, protocols, and forms involved in replicating MTB. It is to be used in tandem with the training and consultation required for program replication provided by MTB National Office staff at Yale University. For questions about the model, the training, or the replication process, please contact Crista Marchesseault at crista.marchesseault@yale.edu.

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PART ONE

Program & Replication Overview

Introduction

This manual is for Danish coordinators, heads of department, and managers who are overseeing program replication of *Minding the Baby*® (MTB). It should be available to all program staff, but is intended primarily for program leaders, in tandem with the training and consultation required for program replication and provided by the MTB National Office at Yale. It includes a brief overview of the program model, history, and results. It also provides details on implementation processes, including the required training and consultation component.

MTB Overview

MTB is an evidence-based interdisciplinary, preventive home visiting intervention developed in 2002 to strengthen the health and early relationships of young, vulnerable, first-time parents and their families. MTB is the only home visiting intervention in the United States to offer low-income first-time parents both physical and mental health services. The model's unique emphasis on reflective parenting has helped first-time mothers and babies develop robust, secure attachments during the first two critical years of life, through a multi-generational approach. MTB supports early relationships and limits toxic stress, giving children and their parents the tools to overcome the adverse experiences that derail brain development, disrupt learning, and set the stage for a range of chronic health problems. By tipping the scales in favor of healthy growth and development, MTB strengthens families, and the communities in which they live, building a foundation for life-long health and wellbeing.

History: MTB grew out of a collaboration of nurses, mental health clinicians, community partners, and researchers at the Yale School of Nursing, the Yale Child Study Center, and two local community health centers. The MTB intervention is based on an integration of the Nurse Family Partnership home visiting model and the Infant-Parent Psychotherapy home visiting model. Nurses and social workers are paired to provide intensive, interdisciplinary in-home mental health and health care, parenting support, and anticipatory guidance to young, first-time parents and their infants. The first MTB Introductory Training Institute was offered in 2010, when a collaborative effort also began with the National Society for the Prevention of Cruelty to Children in the United Kingdom. This has involved a replication of the MTB clinical and research program across 3 UK sites, in Glasgow, Sheffield, and York. This full-scale replication includes an independently run randomized controlled trial (RCT).

A small-scale replication began in Miami, Florida in 2015 through the Young Parents Project at Florida State University. In 2016, a replication began in Frederikshavn, Denmark. Supported by grants from the Donaghue and W.K. Kellogg Foundations, the MTB National Office was also formed in 2016. Through the National Office, MTB senior clinicians continue to serve families in New Haven, Connecticut while also providing training and consultation to a growing number of replication activities. A new replication project supported by the Grossman Family Foundation began in July 2017 in Fairfield County, Connecticut, where families are now served in Norwalk and Stamford. In 2018, a new collaborative effort began with Metodecentret to expand MTB Denmark across multiple municipalities.

Goals: The core aims of MTB are to strengthen attachments and prevent potential obstacles to young children's health and development. MTB is distinct from other home visiting programs in: 1) its innovative interdisciplinary service model that targets both health and mental health outcomes in an effort to meet the complex and multi-layered needs of young at-risk families, 2) its emphasis on enhancing reflective parenting and the development of robust, secure parent-child attachments, both of which have been linked to positive developmental and socioemotional outcomes, and 3) its focus on emotional trauma and other forms of toxic stress, known to disrupt health and mental health well into adulthood. Beyond helping young parents mature into healthy, productive members of society, MTB's in-home support helps them provide the kind of parenting so crucial to their children's

physical, mental, and emotional development.

Results: MTB clinicians have served over 150 economically disadvantaged and ethnic minority families in the New Haven area. Research has been an essential part of MTB since its inception. Areas evaluated include a number of public health variables (rates of referral to protective services, maternal health and family planning, adherence with pediatric well baby care and immunizations, baby's growth and health), as well as the baby's developmental status, quality of the infant-parent relationship, quality of infant-mother attachment, and level of the mother's capacity to parent in a reflective rather than reactive way. Initial data from a pilot-phase randomized controlled trial (RCT) in New Haven indicated that MTB families showed improved outcomes compared with families receiving standard care.

Prominent health outcomes included higher rates of on-time pediatric immunization, lower rates of child protection referrals, and longer spacing between childbirths in young mothers. Relational outcomes included higher rates of secure attachment and lower rates of disorganized attachment in intervention children compared to the control group. Increases in mothers' abilities to parent in a reflective rather than reactive way were found over the 27 months of the intervention, especially among the most vulnerable mothers. In a follow-up pilot study, lower rates of maternally-reported externalizing disorders were found in intervention children.

Preliminary findings from a 5-year federally funded RCT completed in New Haven in 2016 confirm the pilot findings published in 2013. Of note are two general findings: we again found higher rates of secure attachment and lower rates of disorganized attachment in the intervention children compared to the control group. Initial analyses also indicate that MTB may help to prevent childhood obesity in toddlers. This is a powerful finding since obesity is a significant issue for low-income children in the U.S. and other many other countries. Evaluation data continue to be collected and analyzed on an on-going basis in the New Haven program, as well as at replicating sites.

The Model: Young mothers-to-be (largely teens in the U.S.) are recruited into the MTB intervention in the second or early third trimester of pregnancy. They are visited weekly through the child's first birthday, then biweekly until the child is two. The nurse and mental health clinicians work collaboratively to engage three generations of family members (grandparents, parents, child). Service delivery is highly flexible and responsive to families' needs. The nurse focuses on prenatal, pediatric, and maternal health issues and provides education as well as direct care. The mental health clinician focuses on working therapeutically with the parent-infant dyad, and monitoring both infant and maternal mental health. Please refer to the treatment manual for much more in-depth detail.

Training & Consultation

In order to replicate the MTB program, participation in a multi-phase, sequential training and consultation program through the MTB National Office at Yale University is required. The 6-year training and consultation plan for the MTB expansion in Denmark is outlined below. The implementation of the MTB expansion in Denmark will be divided into two waves of implementation. The first implementation wave will include 4 sites (municipalities), including the existing team in Frederikshavn, beginning in 2018. The second wave (beginning in 2019) will consist of the continuation of the first 4 sites and start-up for several new teams across 4 new sites.

Replication Phase 1: Planning & Start-up Consultation: This involves consultation and support from MTB National Office staff, including planning for national coordination in Denmark, site preparation, and hiring/ selection of Danish MTB staff. Research planning meetings are also a part of this phase, as is the set-up of data collection systems and planning for the initial introductory training for wave one Danish staff.

Replication Phase 2: Introductory Training: An intensive multi-day training to address specific needs of MTB model implementation will be delivered on-site in Denmark for all clinical and administrative staff for the first wave of implementation sites in August 2018, and for the second wave of sites in August 2019. MTB National Office trainers will be available for individualized consultation throughout the initial training.

Replication Phase 3: Ongoing Distance Supervision and Clinical Consultation: As the first MTB families are enrolled at new sites, all clinical staff involved in the MTB replication will begin regularly scheduled consultation/supervisory sessions through the MTB National Office. These sessions will be conducted via phone or videoconference and are valuable for ensuring program fidelity. This time is used to discuss cases, general program issues, and service delivery concerns. These sessions occur as four different types of consultation, as follows, and scheduled as mutually agreed through Metodecentret,

- Interdisciplinary (IDS) Calls: the local clinical team and their local supervisors meet approximately monthly for one hour with a Yale team (one nurse and one social worker) to present and discuss a case, hold a joint clinical discussion or conversation, or address an interdisciplinary issue surrounding service delivery.
- Discipline Specific (DS) Calls: the nurse meets approximately monthly for one hour with a Yale nurse. Separately, the social worker meets monthly for one hour with a Yale mental health clinician. Topics vary based on clinician need.
- Administrative Consultation: time for additional consultation with MTB National Office Directors, on approximately an every-other-month basis via phone or videoconference, in addition to administrative coordination for fidelity monitoring and logistical needs related to the on-going consultation.

Replication Phase 4: On-going Supervisory Consultation: As phase 3 begins, families are enrolled, and implementation gets underway, the nursing and social work supervisors will begin regularly scheduled consultation calls on a semi-monthly basis with MTB National Office consultants. These sessions initially focus on the intended purpose of the calls, the needs of the supervisors and their teams, implementation questions, and getting to know one another. Once cases are enrolled, topics vary from call to call based on the needs of the supervisors and the teams visiting the enrolled families, and the format is flexible.

Replication Phase 5: Distance Training and Train-the-Trainer Component: Within 3-6 months of the initial enrollment of families at new sites in both implementation waves, quarterly 90-minute distance learning sessions will be provided for all clinical and supervisory staff via videoconference. Topics are determined based on the implementation phase and needs of the team. These sessions will continue regularly, scheduled at a mutually convenient time approximately every three months, beginning with the first wave of sites and continuing through at least the first full 27-month intervention cycle of the second wave of sites. During this phase of implementation, a train-the-trainer component will also begin. Qualified Danish experts in the fields of Health/Nursing and Mental Health will be trained as MTB trainers and supervisors by MTB National Office staff. The aim of this training is to provide additional guidance in the MTB model and to address specific supervisory issues and ongoing hiring/training needs.

Replication Phase 6: Site Monitoring and On-going Consultation: MTB National Office trainers will conduct required site visits in line with the introductory trainings, with Frederikshavn in 2018, the first wave of sites in 2019, and then a return trip for the second wave of sites in 2020. The purpose and goals of these visits include presenting and discussing cases, providing information to the agency to help answer any questions or concerns, assessing implementation of the model (including a review of fidelity benchmarks and competencies as well as a discussion of gaps or needs), and addressing issues related to replication, including discussion of procedures and practices, and the required evaluation component. Specific goals and an agenda for each visit are developed in collaboration with site administration in advance of the site visits.

PART TWO

Planning & Implementation Start-Up

Essential Program Elements

There are a number of core elements of the MTB model that make the intervention distinct from other home visiting programs. These must be part of any replication in order for the program to be called *Minding the Baby®,* and to ensure fidelity to the model as it has been tested in the U.S. and proven effective in New Haven, Connecticut. MTB is a manualized and trademarked intervention, and fidelity to the model is key in achieving positive outcomes. While certain adaptations and modifications are necessary to fit the Danish cultural context, it is extremely important to follow the model as outlined in the treatment manual, complete fidelity requirements, and ensure that the following program elements are met.

- Service is delivered by an interdisciplinary nurse/social worker team working jointly to promote positive health, mental health, and parenting outcomes.
- First-time mothers are prioritized, and all families are enrolled prenatally, ideally between 16 and 30 weeks, allowing time for essential relationship building.
- Screen potential participants for serious street drug use and exclude those who are known to have a history of serious substance abuse, due to the additional complex needs related to recovery and treatment, referring these families to a treatment-focused service alternative.
- Focus service on prevention and the development of resources to limit the long-term impact of trauma, adverse childhood experiences, and toxic stress on current and later health and mental health.

Hiring Considerations & Clinical Competencies

As part of the hiring and staff selection process, it is important to assess formal education, clinical experience, personal characteristics, and interest in working with challenging complex families. Part of this process should also involve assessing an individual's openness to teamwork, and thinking about pairing two clinicians. It is also very important that the MTB National Office is consulted in the hiring process for clinical staff, and in the selection of supervisors. Sample job descriptions and detailed staffing guidelines (including some recommended interview questions) are provided in Appendix I, and competencies for clinicians and supervisors are provided in the MTB Treatment Manual. It is critical to review these guidelines and competencies prior to staff selection. MTB model developers are also available to assist in the review and/or screening of final applicants as requested.

Caseloads

A full-time caseload for a single home visiting team is approximately 22-24 families, resulting in around 10-12 home visits per week for each full-time clinician. However, a full caseload cannot be expected at the outset of program implementation, and there are several important factors to consider during initial enrollment and on-going caseload management. For example, home visits decrease in frequency to every other week during the second year of intervention, and – depending on the number of families enrolled and retained – this may lead to a larger number of families on a given caseload over time. Please refer to the treatment manual for additional details.

Supervision & Support

The MTB model involves several kinds of supervision. The individual mental health supervision component is based on a psychodynamic model, with an emphasis on mentalization. Reflective supervision is integral to this model. Nurses also receive regular supervision including these techniques. For team/interdisciplinary supervision including both nurse and mental health clinicians, dynamic/reflective supervision is blended with case management. Through this layered supervision model, both the nurse and the social worker receive different layers of input, in line with the interdisciplinary nature of the MTB model. Refer to the MTB Treatment Manual for additional detail on the MTB supervisory model.

Team meetings: Weekly team meetings are an important part of a successful interdisciplinary model. The MTB Clinical Team Meeting typically lasts between an hour and a half and two hours, and is attended by the program coordinator(s), the supervisors, and the clinicians. These meetings are focused on urgent case issues that have arisen since the last meeting, with time set aside for formal case discussions. These can take place in a variety of ways, including the following.

- Reviewing video recordings of home visits
- Discussing clinician summaries of work with the mother and baby
- Processing visits and mother's level of Reflective Functioning (RF)
- Developing strategies to enhance and support the attachment relationship between mother and infant
- Discussing emergencies such as domestic violence, homelessness, and mental or physical health issues
- Developing intervention plans for clinicians to implement

When cases are discussed, the team is constantly aware of how the clinicians are managing the stresses of supporting the families. The team is interested in how the clinician is feeling and thinking. Reflective supervision is part of these meetings, and there is also an element of case management, as these are families with a number of complex issues that require concrete support. Additional support can be provided if needed and difficult case discussions are often continued in individual supervision meetings. Team meetings should be scheduled at the same time and place every week so that it is predictable and team members can organize their schedules around them. This has two advantages — leading to enhanced attendance at the meetings and providing the clinicians and researchers with some predictability that can be lacking in their daily schedule. See Appendix II for a sample case discussion format.

Distance Training & Consultation: Regular phone and/or video conference calls for the clinical team(s) with the MTB National Office begin in phase three of the replication process. The types of monthly consultation calls are Interdisciplinary (IDS) Calls, Discipline Specific (DS) Calls, and Supervisory Calls. These are described in Part One. Sample call formats for the IDS calls are provided in Appendix II. The exact format of these calls is determined with each site and may evolve over time. Quarterly training or distance learning sessions are provided via videoconference using Zoom. These are focused on topics specific to the phase of intervention and are reflective of site needs.

Materials & Supplies

A variety of materials and supplies should be accounted for when budgeting and planning for the intervention. This includes office supplies, equipment, gifts for families, and materials for home visits. Other important materials may include handouts for home visits, appropriate to the reading and educational level of the population; toys for use and re-use at home visits; washable bags to carry clean toys to home visits; and toys to give to families to encourage appropriate play. In addition to secure, dedicated office space with adequate storage for supplies and materials, the following equipment is recommended for MTB replication.

- Laptop computers and/or tablets for clinical staff
- Cell phones for clinical & research staff with texting & GPS (smart phones preferred, especially for clinicians)
- Digital and/or video camera(s) for clinicians (if smart phones aren't an option)

Please refer to the treatment manual for details and suggestions with regard to gifts for families and toys for home visits. These may vary in Denmark from those in the U.S. but it is important to keep in mind that not all toys in the home may be most appropriate for the developmental stage of the child, or to encourage imaginative play.

Program Eligibility & Recruitment Guidelines

In the U.S., MTB is delivered as a voluntary and preventive intervention delivered to young, primarily English-speaking families living in resource-constrained urban neighborhoods. Medically low-risk pregnant women are eligible if they are between the ages of 14 and 25, expecting their first child, have no active serious drug use, and have no serious physical or psychotic illness. Some medically low-risk pregnant women in New Haven receive their prenatal care in groups that are conducted by certified nurse-midwives, while others attend individual prenatal appointments. The nurse-midwives at the two collaborating community health clinics ask eligible women in their 16th-20th week of pregnancy if they are interested in the MTB program, and give a brief informational flyer to those who are. These procedures vary from one implementing agency to another, and referral processes are determined collaboratively with the MTB National Office during the start-up phase of the replication process.

In Denmark, eligibility requirements have been agreed to as follows.

- Medically low-risk pregnant women:
    - between 16 and 32 weeks gestation (mothers who have already given birth are not eligible)
    - between the ages of 14 and 35
    - expecting their first baby (some second if the first is between 12-24 months)
    - with no active serious drug use
    - with no serious physical or psychological illness

Priority will be given to young women expecting their first child. Second-time parents may be considered if they are having a second child within 12-24 months of the first child being born. Families with multiple children or a first child over the age of 3 years will be deemed ineligible for MTB. No more than a third of cases in a given municipality will be second-time parents. Mothers may have mental health issues but those who are psychotic or actively abusing alcohol or hard drugs (i.e., heroin, cocaine, prescription medications) are not eligible for MTB. Mothers who are medically high-risk (i.e., have a terminal illness) are not eligible. Additional family characteristics may include:

- Limited or low reflective functioning
- Psychological reactions and symptoms (depression, anxiety or the like) caused or compounded by pregnancy
- An upbringing marked by various forms of neglect and traumatic experiences, and for whom the upcoming parenthood seems like a great challenge
- Social difficulties and unstable family relationships/partnerships

Recruitment procedures may vary in each municipality, and will be discussed at each site before being finalized. In Frederikshavn, midwives, doctors, or social workers refer eligible pregnant women (between 16 and 32 weeks gestation) to the MTB team. The team then contacts the pregnant woman. If she is eligible for MTB, she is invited to join. If she wishes to join, she is given a letter informing her of the collaboration with Yale University and the sharing of de-identified data. Mothers who have already given birth are not eligible for MTB.

PART THREE

Replication Process & Procedures

The MTB intervention proceeds in a series of phases, as does the training and consultation involved in replication, outlined in Part One. The first two phases of technical assistance (planning/start-up and the four-day training) occur prior to the first intervention phase, recruitment/consent and engagement/assessment. This is followed by six phases of the intervention proper: 1) prenatal phase, 2) delivery and postnatal phase, 3) first year phase, 4) transition phase, 5) second year phase, and 6) goodbye phase.

The third, fourth, and fifth training phases (on-going distance learning and consultation; supervisor training; and a site visit) occur sequentially during the first year of implementation, in line with the first three phases of the intervention proper. The last phase of training occurs during the second year phase of the intervention, during which regularly scheduled on-going consultation and supervision also occur.

The table below illustrates the progression of phases of the replication process layered with the phases of the intervention proper, across a 30-36 month period (or approximately one replication cycle for an initial cohort of families). A sample implementation calendar integrating these phases follows below the table.

<table>
<tr><th colspan="6">MTB REPLICATION PROCESS (TECHNICAL ASSISTANCE/TRAINING & CONSULTATION)</th></tr>
<tr><td colspan="2">Phases 1-2 (3-4 months)</td><td colspan="4">Phases 3-6 (27-33 months)</td></tr>
<tr><td colspan="2">Planning & start-up consultation & training</td><td colspan="4">Ongoing distance training & supervision including regular phone/video conference calls (approximately 4 per month)</td></tr>
<tr><td>Technical assistance on procedures & hiring</td><td>Introductory training (4 days)</td><td>Continued technical assistance</td><td colspan="2">Supervisor/train-the-trainer training</td><td>Site visit</td></tr>
<tr><th colspan="6">MTB INTERVENTION PROPER (MODEL IMPLEMENTATION)</th></tr>
<tr><td colspan="2"></td><td colspan="2">Phases 1-3</td><td colspan="2">Phases 4-6</td></tr>
<tr><td colspan="2"></td><td colspan="2">Recruitment/engagement & weekly visits prenatally through the child’s first year</td><td colspan="2">Transition to biweekly visits through the child’s second year</td></tr>
</table>

Sample Implementation Calendar

<u>*Year One*</u>

January	Begin planning and start-up consultation
August:	Hold introductory training with consultation
September:	Enroll first families (start-up)
	Begin distance supervision & consultation for minimum of 27 months
January:	Begin quarterly distance learning sessions
March:	Train the Trainer/Supervisor Training at Yale

<u>*Year Two*</u>

August:	Site Visit

Intervention Phases

The initial intervention phase is focused on engagement and assessment. When these visits have been completed, the intervention formally begins with the *Prenatal Phase*. During this time, mothers are seen weekly, on alternate weeks by each of the home visitors. This schedule continues through the *Delivery, Postnatal* and the *First Year Phases.* The *Transition Phase* begins several months before the baby turns one, when the clinicians assess the appropriateness of shifting a family to biweekly visits. During the *Second Year Phase,* mothers and babies are

visited once every other week, seeing the nurse and social worker each only once a month. Finally, during the *Goodbye Phase,* the goal is to graduate families just after the child's second birthday. Mothers are reminded of the impending goodbye at least four months before the last visit, so that they will have adequate time to say goodbye to each of the home visitors. Both home visitors come together for the last visit. More detailed descriptions of these phases with techniques used throughout these phases are provided in the MTB Treatment Manual.

On-Going Training & Consultation

As outlined in Part One, on-going training, technical assistance, and consultation are required as part of MTB program replication. Clinicians and supervisors should participate regularly in the various types of supervision and consultation calls, which will be scheduled through Metodecentret and conducted via Zoom.

Treatment Fidelity

As a federally designated evidence-based home visitation model, *Minding the Baby*® (MTB) is most effective in improving health and mental health outcomes when fidelity to the model is achieved. In order for the intervention to be rigorously conducted and replicated, treatment fidelity must be maintained and monitored. It is important to follow standardized approaches to monitor the work with young mothers, so that in all replication activities, the fidelity of the clinical intervention is ensured within the realities of constantly changing clinical and community environments (McGuire, DeLoney, Yeager, et al, 2000; Sidani, 1998). MTB treatment fidelity is measured, monitored, and enhanced across 4 domains (design, training, delivery, and receipt/enactment), as described in more detail in the treatment manual. Please refer to the Fidelity Checklist in Appendix V of this manual for additional requirements, including required checklists and self-assessments for clinical staff and agencies.

Data Collection & Submission

While evaluation research data will be collected as part of a separate randomized control trial through VIVE, fidelity data will be submitted to the MTB National Office at Yale directly from each municipality. This includes the Intervention Delivery Checklists for clinicians, as well as the self-assessments for supervisors and sites. The content of these forms is provided in Appendix V for reference. Instructions and on-line links to submit these data will be sent by e-mail as deadlines approach.

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APPENDIX I: START-UP RESOURCES

Mental Health Home Visitor Sample Job Description

Position Description: In collaboration with MTB National Office staff, serve as a mental health home visitor for *Minding the Baby®* (MTB), a home-based nursing and mental health intervention for young, first time mothers and their babies developed at Yale University. As part of an integrated mental health and nursing team, conduct assessments of infants, mothers, and their families; and deliver services ranging from consultations and case management to intensive crisis intervention.

Based on an applied research model grounded in attachment theory, MTB involves an integrated model of care that bridges primary care and mental health approaches to enhancing the mother-infant relationship. MTB clinicians receive training in the MTB model by the model developers, including a focus on supporting and enhancing parental reflective capacities, or Reflective Functioning (RF). Clinicians also receive weekly reflective and team supervision, as well as on-going training and technical assistance from the model developers at Yale.

Duties and Responsibilities:

1. Collaborate as part of a team with a nurse home visitor to provide home visiting services for families.
2. Communicate and collaborate with midwifery and pediatric clinicians where families obtain their primary care. Participate in prenatal and pediatric group sessions for families as appropriate/available.
3. Utilize knowledge of infant development, attachment processes, early emotional development, parent-child relationships and the special concerns of high-risk mothers, babies, and their families; provide infant-parent psychotherapy services and parenting support; link families to psychiatric resources and help them negotiate social service and mental health delivery systems.
4. Obtain clinical consent and research authorization for program participation in order to collect evaluation data and interview participants as part of the clinical and evaluation components.
5. Attend clinic orientation sessions as required, as well as training sessions describing the integrated home visiting model and weekly supervision sessions with the nurse, selected clinicians, and supervisors.
6. Complete paperwork and collect data required, complying with program and funding requirements.

Education and Experience: Master's Degree in Social Work or similar mental health field, and at least one year of experience in a psychiatric care setting, or the equivalent combination of experience and education. LCSW preferred.

Skills and Abilities:

1. Strong clinical and case management skills.
2. Organizational skills to coordinate home visiting component of project.
3. Strong writing skills for case notes and reports to Yale model developers as requested.
4. Conversant in infant and adult diagnostic systems.
5. Preferred: Ability to speak fluently in Spanish and English; training in mindfulness approaches to stress.

Nurse Home Visitor Sample Job Description

Position Description: In collaboration with MTB National Office staff, serve as a nurse home visitor for *Minding the Baby*® (MTB), a home-based nursing and mental health intervention for young, first time mothers and their babies developed at Yale University. As part of an integrated mental health and nursing team, provide intensive home visiting intervention, parent education, and counseling for young mothers and their families. Assess infants, mothers, and family members during home visits; and deliver services ranging from consultations and case management to intensive crisis intervention.

Based on an applied research model grounded in attachment theory, MTB involves an integrated model of care that bridges primary care and mental health approaches to enhancing the mother-infant relationship. MTB clinicians receive training in the MTB model by the model developers, including a focus on supporting and enhancing parental reflective capacities, or Reflective Functioning (RF). Clinicians also receive weekly reflective and team supervision, as well as on-going training and technical assistance from the model developers at Yale.

Duties and Responsibilities:

1. Collaborate as part of a team with a clinical social worker or other mental health specialist to provide home visiting services for families.
2. Communicate and collaborate with midwifery and pediatric clinicians where families obtain their primary care. Participate in prenatal and pediatric group sessions for families as appropriate/available.
3. Utilize knowledge of infant development, attachment processes, early emotional development, parent-child relationships and the special concerns of high-risk mothers, babies and their families; provide intensive home visiting intervention, parent education, and counseling for all study participants (infants, mothers, and family members). Assess infants, mothers, and family members during home visits with families in the project.
4. Obtain clinical consent and research authorization for program participation in order to collect evaluation data and interview participants as part of the clinical and evaluation components. .
5. Attend clinic orientation sessions as required, as well as training sessions describing the integrated home visiting model and weekly supervision sessions with the nurse, selected clinicians, and supervisors.
6. Complete paperwork and collect data required, complying with program and funding requirements.

Education and Experience: Active state Registered Nurse (RN) license, and at least one year of pediatric or family experience, or equivalent combination of experience and education.

Skills and Abilities:

1. Strong clinical and case management skills; knowledge about prenatal care; maternal and reproductive health and healthcare; maternal life course issues; teen mothers and their particular needs; pediatric primary care issues, particularly breastfeeding, infant nutrition, safety, common health problems, development, and anticipatory guidance.
2. Organizational skills to coordinate home visiting component of project.
3. Strong writing skills for case notes and reports to Yale model developers as requested.
4. Conversant in infant and adult diagnostic systems.
5. Preferred: previous home visiting experience; knowledge about mother-infant attachment processes, early mother-infant relationships, reflective functioning, family systems and dynamics, family strengths, stress, and coping; familiarity with resources and programs in the area.

Mental Health Supervisor Sample Job Description

Position Description: In close collaboration with the nursing supervisor, serve as a mental health supervisor for the *Minding the Baby*® (MTB) clinical team, consisting of mental health and nurse home visitors.

Duties and Responsibilities:

1. Provide ongoing reflective supervision for the MTB team
2. Support MTB clinicians in making dynamic formulations, relating these to practice
3. Participate in team meetings and telephone consultations with MTB National Office staff at Yale

Education and Experience: Master's degree (or equivalent) or higher in a mental health field; 2-4 years of experience with clinical supervision; training and background in Reflective Supervision, dynamic theory and practice, infant-parent psychotherapy or child-parent psychotherapy, parent and early child development, trauma, attachment, reflective functioning; current knowledge of mandated reporting requirements; home visiting experience preferred. Infant Mental Health Endorsement® (or equivalent) encouraged.

General Skills & Abilities:
MTB supervisors must have the ability to:

- Communicate effectively with strong verbal and written skills.
- Maintain strict confidentiality.
- Recognize signs of compassion fatigue and offer appropriate interventions.
- Discern among administrative, clinical/problem solving and reflective supervision frameworks.
- Highlight and integrate health issues (pregnancy, maternal, child) with parenting and other family, mental health, social, or situational crisis issues.
- Balance theoretical principles with the practical challenges clinicians face in real time.
- Support and expand upon mental health discussions from health and/or developmental perspectives.
- Create a calm holding environment that makes it possible for supervisees to take chances, ask questions, and explore how they feel about the work.
- Hold clinician's anxieties, fears, and range of strong emotions with an ability to process and explore how these feelings connect to the work (integration).

Nursing Supervisor Sample Job Description

Position Description: In close collaboration with the mental health supervisor, serve as a nursing supervisor for the *Minding the Baby*® (MTB) clinical team, consisting of mental health and nurse home visitors.

Duties and Responsibilities:

1. Provide ongoing reflective supervision for the MTB team
2. Provide health related discussions and clinical formulations based on evidence-based approaches and practice guidelines.
3. Participate in team meetings and telephone consultations with MTB National Office staff at Yale

Education and Experience: Minimum of a Bachelors of Nursing (BSN) with substantive clinical experience; Master's level or higher in nursing, public health, or a related field preferred; 2-4 years of experience with clinical supervision, pediatrics nursing, family health, or midwifery; training in Reflective Supervision; current knowledge of mandated reporting requirements. Home visiting experience preferred.

General Skills & Abilities:
MTB supervisors must have the ability to:

- Communicate effectively with strong verbal and written skills.
- Maintain strict confidentiality.
- Recognize signs of compassion fatigue and offer appropriate interventions.
- Discern among administrative, clinical/problem solving and reflective supervision frameworks.
- Allow time for reflection.
- Highlight and integrate health issues (pregnancy, maternal, child) with parenting and other family, mental health, social, or situational crisis issues.
- Balance theoretical principles with the practical challenges clinicians face in real time.
- Support and expand upon mental health discussions from health and/or developmental perspectives.
- Maintain current knowledge base for health care:
    - Prenatal care, contraception, STIs, and current practices
    - Neonatal, infant, and toddler pediatric primary care; adolescent primary care and women's health
    - Current knowledge of child maltreatment signs and symptoms, clinical assessment/decision-making, and legal issues/mandated reporting requirements

MTB Clinical Staffing Guidelines

Successful MTB implementation involves many key factors. One of the most important first steps involves hiring clinicians and engaging supervisors who are a "good fit" with the MTB model. Consideration of potential clinicians' suitability for MTB practice is quite important. This has become more evident with each passing year and each new MTB replication. MTB treatment proceeds most effectively when clinicians and supervisors fully understand and support the model's interdisciplinary, reflective approach which is also attachment-informed, diversity-informed, and trauma-informed.

Regardless of experience or skill in a particular area of practice, some clinicians are better suited to MTB than others. The purpose of this document is to outline some of the characteristics of effective MTB practitioners and supervisors. This goes beyond discipline- specific clinical competencies (i.e., a nurse experienced working with pregnant women or a social worker experienced with infant-parent psychotherapy) to include broader attitudes that help MTB clinicians to manage and be open to the complex processes that are central to the work. Since MTB is a relationship-based intervention, it is incredibly important to interview, hire, and train clinicians who can fully take advantage of the power of relationships, without becoming overly drawn into the stress and strife of families. Successful MTB clinicians have the ability to continue to be helpful and non-judgmental as they work through different crises with families.

General Considerations

While MTB is evidence-based and intensive training is required for implementation, the intervention does not follow a strict curriculum. Rather, guided by the MTB treatment manual, each clinician determines what to do in an individual session based on experience with the family, assessment of pressing issues and needs, diagnostic and treatment formulations, and consultation with the clinical partner. It is important to keep in mind that regardless of the clinician's plans for an individual session, things may change upon arrival at the home.

There are three levels of "fit" that are crucial for home visitors working within the MTB model. One is a fit with formal training/education level (which is covered in the job descriptions and competencies in the MTB Replication Operations Manual) and personal characteristics. The second is an ability to work closely and collaboratively with a clinician from another discipline. The third is the ability of the implementing agency to support this work at an emotional, procedural, and cultural level.

Personal characteristics: Working as an MTB clinician or supervisor requires flexibility and an openness to uncertainty. This can be difficult even for experienced clinicians, who may be accustomed to more traditional ways of working and find it challenging to tolerate the flexibility of the model. MTB clinicians should have experience working with high risk populations, and at the very least have an understanding of the core elements of a reflective, attachment-based approach. Good clinical work requires patience, tolerance, self-understanding, the ability to listen, to form warm relationships, and the capacity to care. It also requires good mentalizing skills, i.e., an abiding curiosity about what makes people unique, a willingness to suspend judgment, and an ability for wondering and openness. Perhaps most importantly, it requires self-compassion. Specifically, this includes the awareness that even the best clinicians may struggle with this, particularly when they are stressed. At times, everyone can be judgmental or rigid, but it is important to be aware of this, and be able to use teamwork, supervision, and self-care to work toward flexibility and openness.

Working collaboratively: Effective teamwork depends upon an openness to collaborate. This includes respect for one another and for each other's work. It also necessitates an ability to be open and communicate clearly, to be synchronous with each other, and to be able to keep one's team member in mind. Good teamwork also

depends upon a "good fit" between clinicians. Pairings play an important role in successful implementation. As clinical teams are being formed, it is helpful for supervisors and managers (who may already know the clinicians) to be thoughtful about matching partners' styles, and about their ability to come together as a team. This is particularly important given the interdisciplinary nature of the team.

The two members of the team need to be able to trust one another, listen to and talk to each other, open up to each other, support each other, and share both the successes and the painful experiences of the work. It is important to keep this in mind when matching clinicians, as is their ability to respect, understand, and be curious about their clinical partner's viewpoint and expertise. This involves a willingness to tolerate and understand differences in opinions and reactions, as well as to resolve conflict in a kind way.

A broader facilitating environment: Finally, it is important to think about the environment in which clinicians are working. Clinicians will be most successful when they feel supported by their supervisors, the team, and the implementing agency. While it can take time for supervisors and agencies to become comfortable with the MTB approach, an openness to the model and its uniqueness are essential. Supervisors may find it helpful to consult with their peers in the other discipline to provide sensitive interdisciplinary support.

Summary

As part of the hiring process, it is important to assess formal education, clinical experience, personal characteristics, and interest in working with challenging complex families. Part of this process should also involve assessing an individual's openness to teamwork, and thinking about pairing two clinicians – is this likely to be a good match? Are these two particular clinicians likely to be able to work together? Some recommended interview questions are provided on the next page to aid in this endeavor.

Recommended Interview Questions for MTB Clinician Applicants

- Have you had experience visiting families in their home? Tell us about one visit that stands out in your mind. Or if you haven't worked as a home visitor, tell us about an experience working with a whole family in a clinic or hospital setting.
- There are so many different kinds of families—from different cultures, different people who are considered family members, dynamics between people, etc. Think back to the families you've worked with - tell us about one that you found you worked with well. What made you able to work with them?
- Now think back to a family that was difficult to work with. What made this family difficult for you? How did you handle these difficulties?
- We all work in teams now and then. Tell us about a team that you were part of. What made things go well? In another team, what made it difficult to work together?
- What does it mean to you professionally to be part of a multi/interdisciplinary team?
- One of the most interesting parts of MTB work is that the clinicians have to be both active and reflective in their approaches. The families may have painful experiences to process, but they may also require help with basic needs. Have you had professional experiences like that? Tell us about one. If you haven't, tell us about what you think that would be like for you.
- What age groups (children, adolescents, and adults) have you worked with? Tell us about these experiences.
- What aspects of the work do you expect will be new or challenging for you?
- What unique personal characteristics or strengths do you bring to this role?

MTB Replication: Implementation Start-Up Check List

Prior to implementing MTB, there are several tasks that are completed by Metodecentret, municipality leadership, and/or MTB National Office staff. Planning and start-up tasks for municipality leadership are as follows. This is just a guide to help in the planning process and does not need to be completed or submitted.

Planning phase (in the months leading up to training)

- ☐ Identify key staff, clinical and administrative, integral to collaborative efforts and schedule initial meetings to build or strengthen relationships and community buy-in
- ☐ Assess current and needed resources for staffing, supervision, and other operational needs; develop a plan to cover or acquire needed resources
- ☐ If the program will involve collaboration with another agency, set up initial and/or regular meetings and introduce systems that will keep all partners informed
- ☐ Develop procedures and guidelines for recruitment, intake, treatment, tracking, retention, discharge, staffing caseloads, supervision, etc. (revisit in training & internally)
- ☐ Interview and hire staff in consultation with MTB National Office
- ☐ Plan for initial training with MTB National Office staff (4 days in August)
- ☐ Review and discuss Treatment Fidelity measures, including MTB Delivery Check Lists for Clinicians and Supervisors, and the Replication Site Self Assessment
- ☐ Plan for logistics/technology needs and schedule on-going training/supervision/consultation calls with MTB National Office
- ☐ Order equipment, materials, supplies, and gifts for families as needed

Start-up phase (months 3-6 of replication process, following initial planning, hiring, and training)

- ☐ Provide time for MTB clinicians and supervisors to review competencies; once self assessment is complete, meet with supervisor(s) to plan for additional time and resources for training in identified gaps
- ☐ Confirm supervision plan and finalize schedule of meetings and calls
- ☐ Organize and print/copy clinical forms as needed; determine process for clinicians to obtain blank forms as needed and return/file completed forms in a secure/locked location following each visit
- ☐ Create orientation materials for families and prepare/copy approved consent forms as needed

Enrollment and initial training phase (next 6-9 months of replication process)

- ☐ Start regular team meetings and use reflective supervision from the start to set a pattern of team collaboration and ongoing supervision
- ☐ Begin on-going weekly supervision and consultation calls with MTB National Office staff, in addition to quarterly distant learning sessions (via video conference)
- ☐ Start enrolling clients slowly and remember to account for the timing of the second year of visits, keeping in mind that caseloads may be small at the outset
- ☐ Schedule/plan site visit by MTB National Office staff (one year following the initial training)
- ☐ Conduct fidelity checks at regular intervals and submit fidelity measures on an annual basis,
- ☐ Complete first annual replication site self assessment; submit to MTB National Office via Qualtrics for review and feedback

On-going service and consultation (through the end of the 27-month service cycle):

- ☐ Continue regular meetings, supervision/consultation calls, and distance learning sessions
- ☐ Conduct fidelity checks at regular intervals
- ☐ Complete/submit additional annual replication site self assessment(s)

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APPENDIX II: SAMPLE DISCUSSION & CALL FORMATS

Sample MTB Team Meeting Case Discussion Format

1. Introduction and Case Summary *(10 minutes)*

    a. In a few words, what is the burning issue with this case? Do you have a question, thought, or struggle in mind? What do you need from the team for this case?

    b. Set context with brief demographic info and any relevant health or mental health issues.

    - Include mom's name, age, gender, relationship status, ethnicity, occupation, length of employment, age and gender of any children, and brief health/mental health family history/concerns. Note protective factors and evidence of resilience.
    - Touch upon mom's primary relationships and their quality. How do these affect her feelings about herself and her relationship with her baby? Wonder about possible ghosts in the nursery.

2. Key Relationships *(20 minutes)*

    a. Both practitioners have the floor to address the following questions:

    - How do you feel mother supports baby's proximity and care-seeking?
    - How does she support baby's exploration?
    - Does she recognize and regulate baby's fear?

    b. Reflect on the earlier identified burning issue and how this manifests itself in the mother's or child's relationship with you, e.g.:

    - What triggers you about this case?
    - What do you think the parallel is between your relationship with Mom & Mom's relationship with the baby and other significant people in her life?
    - What do you feel like when you're with Mom?
    - What role do you feel she wants you to play in her life?
    - What do you feel like when you observe the mother and baby? What comes up for you at these moments?

3. Clarifying Questions and Responses *(25 minutes)*

    a. Team members have an opportunity to ask questions and share their "felt response."

    b. Group participates in a general reflective discussion aimed at deepening exploration.

4. Final Comments *(5 minutes)*

Sample IDS Call Formats

MTB Replication:
Interdisciplinary (IDS) Consultation Call Agenda
TEMPLATE 1

I. Case Introduction & History (Consider and include data gathered from intake, psychosocial, PI, and observations in the home) (5 minutes)

a. health, mental health, and social history (employed, school, relationship with FOB, social supports, living arrangements, etc.)
b. pregnancy-related health and/or mental health concerns

II. Clinician Team and Supervisor Impressions re: (10 minutes)

a. Strengths of the family
b. Concerns/Worries family expresses (Notice this is structured address the family's worries and not the clinicians. I'd like the clinicians to hold their worries a bit until later in the discussion.)
c. Hopes and dreams of the family
d. What do you know so far about the family story? (Think about how the current situation connects with what you know about the mother's/family's history.)
e. One minute of silence at the end of the intro to process the case

III. Clinician Experience (20 minutes): Choose 1 or 2 questions for full group discussion

a. What does it feel like to be with this family physically? (sensations, bodily changes)
b. What feelings are triggered? Fears or worries the clinician has
c. What do you notice about the relationships between: you and mom, mom and dad, mom and baby, you and baby, etc. Any parallels?
d. Do you notice anything about the physical space of the home that seems important?
e. What is most challenging about working with this family? What is most promising/rewarding?
f. Have you seen any growth or potential for growth in your work with this family? Consider growth within family or within yourself.
g. Where do you see you and your partner agreeing/disagreeing about aspects of working with the family?
h. Do your thoughts/perceptions about the family change after talking with your partner?
i. What have you learned so far from working with this family?

IV. Listening Member Responses: Initial thoughts and reactions

V. Clinician Response (5 minutes)

a. Initial thoughts and reactions
b. Has anything changed in your thinking about this case?
c. Ideas or thoughts about next steps/directions?

VI. Pulling it all together (Holding the family and the clinician team): Closing thoughts

Intervention Strategies

Relationship Building:

1. Support, be empathic, reassure
2. Highlight & praise competencies (in RF & other areas); highlight mother's & baby's bond

Maintaining a Reflective Stance:

3. Validate mother's experience before offering alternatives
4. Always try to keep the baby in mind—search for ways to draw baby back into mind/conversation
5. Model and encourage curiosity and wondering ("not-knowing") about own and others feelings or thoughts
6. Use "what if?" stance—encourage family members to play with new ideas
7. Generate multiple perspectives—what else could be going on?
8. Reframe; use humor judiciously; be playful when it feels right
9. Ask moms to clarify and elaborate; gently challenge them when useful
10. Stay in the moment—stop, listen, look, stop, rewind, explore
11. Reflect the mother's feelings back to her; work to identify and label hidden feeling states
12. Speak for the baby—verbalize baby's perspective, talk to the baby, describe baby's world and experience to the dyad
13. Speak for the mother—sometimes mothers have limited feeling vocabulary or little practice putting their own feelings into words
14. Link feelings to behavior in mother and in child

Using Your Own Experience:

15. Know yourself—pay attention to your own reactions and feelings
16. Make use of yourself as a clinician, your own feelings, and your experience
17. Share your feelings when therapeutically useful
18. Acknowledge when, as a clinician, you do not know what to say or do
19. Acknowledge mistakes when they arise; pay attention to ruptures in the relationship
20. If overwhelmed with affect or content, step to the surface; put your feelings and thoughts into words

MTB Replication:
Interdisciplinary (IDS) Consultation Call Agenda
TEMPLATE 2

1. Case Presentation (15 minutes)

    a. What is the burning issue/dilemma/impasse that is concerning you with this family at the moment?

    b. What do you feel like when you're with the mother or other family members?

    c. What role do you feel the parents want to play in the baby's life?

    d. What do you feel like when you observe the parent(s) and baby?

    e. What are the family's strengths?

    f. How do you feel the parent(s) supports baby's proximity and careseeking? Exploration? Does she recognize and regulate baby's fear?

2. Supervisory Updates (10 minutes)

3. Yale Team Questions (5 minutes)

4. Yale Team Reflective Discussion (15 minutes)

5. Practitioner Discussion: Deepening Exploration (15 minutes)

APPENDIX III: TREATMENT FIDELITY FRAMEWORK & MEASURES

MTB Fidelity Framework: Assessment & Monitoring

As a federally designated evidence-based home visitation model, *Minding the Baby*® (MTB) is most effective in improving health and mental health outcomes when fidelity to the model is achieved. For the original program administered through the MTB National Office in New Haven, fidelity is assessed and monitored on an ongoing basis through analysis of home visit process data collected after each home visit as well as through quarterly review of progress in staff meetings, and more informally through regular supervision and team meetings. As is true of all intervention programs, positive outcomes can only be achieved with quality implementation and rigorous attention to model elements.

Home visit and replication process data are required as part of the replication process by implementing agencies, along with on-going training and consultation that includes technical assistance and addresses both effectiveness and fidelity. Important steps in ensuring fidelity to the model include adherence to the protocols and forms provided in this Operations Manual and in the on-going training and consultation provided by the MTB National Office. See the Treatment Fidelity Checklist on the next page of this manual for guidance in adhering to the required practices and procedures to enhance model fidelity.

For replication purposes, MTB model fidelity is measured, monitored, and enhanced across 4 domains, based on recommendations from the U.S. National Institutes of Health (NIH) for best practices (Bellg et al, 2004). These domains are: Design, Training, Delivery, and Receipt/Enactment. Resources, protocols, measures, and monitor checks for each of these domains are included in this Operations Manual. Additional information is available by request.

MTB Treatment Fidelity Checklist

This checklist covers general measures of treatment fidelity, as well as required practices and procedures for enhancing fidelity to the MTB model, including key steps to be taken prior to implementing program replication. In order to monitor and enhance treatment fidelity beyond initial training and start-up, the second portion of the checklist should be revisited by implementing agencies at least every three months (quarterly). This checklist is provided as a guide for municipality leadership in the implementation process.

Prior to replication start-up:

- ☐ Consultation with MTB National Office staff around start-up planning, including hiring
- ☐ Participation of all staff in the initial introductory training
- ☐ Close and careful review of the MTB Replication Operations Manual and Treatment Manual

Throughout all phases of replication:

- ☐ Careful and ongoing review of competencies for clinicians and supervisors
- ☐ Completion of the Home Visit Process Variables (HVPV) Form (or similar form provided by VIVE) following each home visit
- ☐ Adherence to MTB clinical protocols & procedures
- ☐ Completion of home visit progress notes following each visit
- ☐ Participation in weekly reflective supervision and team meetings with case discussion
- ☐ Participation in the on-going training and consultation required for full MTB replication
- ☐ On-going study and review of the MTB Operations Manual and Treatment Manual
- ☐ Use of the Clinician's Quick Reference Guide for a refresher of approaches in the field
- ☐ Regular review of MTB Treatment Fidelity Monitoring section of the Treatment Manual
- ☐ Annual submission of MTB Treatment Fidelity Clinician Checklists, Supervisor Self-Assessment, and Site Self Assessment to MTB National Office
- ☐ Participation in systematic and on-going monitoring through consultation calls and site visits

MTB Treatment Fidelity:
Intervention Delivery Checklist For MTB Nurses

Replication Site: ____________________________________ **Date:** _____________

This form is intended for use in tandem with the MTB Treatment Fidelity Monitoring: Intervention Delivery Self Assessment in the MTB Treatment Manual. MTB clinicians are asked to review the self-assessment on a regular basis for selected families (at least every three months), and to complete this form to submit to the MTB National Office annually (on-line via Qualtrics), beginning three months after the first families are enrolled into the replication program.

Directions: Please select a family that is representative of your current caseload and respond to each item using a scale from 1-3, where 1 = I do this regularly, 2 = I do this sometimes, and 3 = I am not yet doing this.

A. Intervention Procedures			
1. Follow protocols for informed consent, intake, obtaining health history, and home visit documentation (including HVPV form)	1	2	3
2. Meet weekly with clinical partner to discuss families	1	2	3
B. Family Engagement			
3. Build a therapeutic alliance by providing a warm supportive presence	1	2	3
4. Create a 'safe place' in the home to meet and talk	1	2	3
5. Respect cultural and family beliefs	1	2	3
6. Demonstrate ability to use concrete service needs as a "port of entry"	1	2	3
C. Observation & Assessment			
7. Assess for safety risks	1	2	3
8. Screen for normal child development	1	2	3
9. Assess social supports and concrete resources	1	2	3
10. Observe maternal-child attachment system	1	2	3
11. Observe other caregiving relationships available to the child as optimal, or potential risk or protective factors	1	2	3
D. Nursing Role			
12. Coordinate mother's and baby's healthcare as needed	1	2	3
13. Apply the concept of "dyadic" work in MTB nursing	1	2	3
14. Obtain maternal health history and status	1	2	3
15. Individualize and prioritize content for each family	1	2	3
16. Assess for barriers to care plan implementation for family	1	2	3
17. Use nursing approaches as described in MTB Treatment Manual (Chapter 8)	1	2	3
18. Document health education, health problems, and approaches	1	2	3
F. Interdisciplinary Teamwork			
19. Communicate with partner(s) in other discipline(s), checking in regularly	1	2	3

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20. Build a trusting relationship by valuing each other's perspectives/experience	1	2	3
21. Understand roles and knowledge base/scope of practice of partner	1	2	3
22. Acknowledge and coordinate work with partner in overlapping domains	1	2	3
23. Coordinate and collaborate with clinical partner and family's medical home in any additional health needs	1	2	3
G. Clinical Approaches			
24. Maintain a reflective, wondering stance	1	2	3
25. Hold the perspectives of both parent and child	1	2	3
26. Speak for the baby with goal of promoting parent's understanding of the child	1	2	3
27. Speak for the parent with the goal of promoting understanding of own feelings and behavior	1	2	3
28. Help parent understand child's behavior as communication	1	2	3
H. Use of Clinical and Reflective Supervision			
29. Protect regularly scheduled time for supervision	1	2	3
30. Be present, open, curious; ready to share and explore thoughts and feelings	1	2	3
31. Provide a clinical formulation[1] that evolves over time	1	2	3

[1] At the end of a period of assessment, the clinician integrates what she has learned about the mother (and the infant and family, if appropriate) and formulates an understanding of the clinical situation. If relevant, she may also arrive at one or more diagnoses. She is guided in her formulations by theories that help make sense of the clinical picture. These formulations guide treatment planning, using best practices or evidence-based practice guidelines to form the initial care plan for a patient or family. The formulation and treatment plan can be modified as often as new information leads either to new understanding or new treatment approaches.

MTB Treatment Fidelity:
Intervention Delivery Checklist For MTB Social Workers

Replication Site: ________________________________ **Date:** ____________

This form is intended for use in tandem with the MTB Treatment Fidelity Monitoring: Intervention Delivery Self Assessment in the MTB Treatment Manual. MTB clinicians are asked to review the self-assessment on a regular basis for selected families (at least every three months), and to complete this form to submit to the MTB National Office annually (on-line via Qualtrics), beginning three months after the first families are enrolled into the replication program.

Directions: Please select a family that is representative of your current caseload and respond to each item using a scale from 1-3, where 1 = I do this regularly, 2 = I do this sometimes, and 3 = I am not yet doing this.

A. Intervention Procedures			
1. Follow protocols for informed consent, intake, obtaining psychosocial history, and home visit documentation (including HVPV form)	1	2	3
2. Meet weekly with clinical partner to discuss families	1	2	3
B. Family Engagement			
3. Build a therapeutic alliance by providing a warm supportive presence	1	2	3
4. Create a 'safe place' in the home to meet and talk	1	2	3
5. Respect cultural and family beliefs	1	2	3
6. Demonstrate ability to use concrete service needs as a "port of entry"	1	2	3
C. Observation & Assessment			
7. Assess for safety risks	1	2	3
8. Screen for normal child development	1	2	3
9. Assess social supports and concrete resources	1	2	3
10. Observe maternal-child attachment system	1	2	3
11. Observe other caregiving relationships available to the child as optimal, or potential risk or protective factors	1	2	3
E. Mental Health/Social Work Role			
12. Obtain maternal mental health history and status	1	2	3
13. Individualize and prioritize content for each family	1	2	3
14. Be prepared to use a variety of intervention strategies in dealing with trauma, anxiety, domestic violence, etc.	1	2	3
15. Assess barriers to treatment plan implementation for family	1	2	3
16. Apply clinical approaches described in MTB Treatment Manual (Chapter 9)	1	2	3
17. Document mental health history, problems, and approaches	1	2	3

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F. Interdisciplinary Teamwork			
18. Communicate with partner(s) in other discipline(s), checking in regularly	1	2	3
19. Build a trusting relationship by valuing each other's perspectives/experience	1	2	3
20. Understand roles and knowledge base/scope of practice of partner	1	2	3
21. Acknowledge and coordinate work with partner in overlapping domains	1	2	3
22. Coordinate and collaborate with clinical partner and family's medical home in any additional maternal and child health needs	1	2	3
G. Clinical Approaches			
23. Maintain a reflective, wondering stance	1	2	3
24. Hold the perspectives of both parent and child	1	2	3
25. Speak for the baby with goal of promoting parent's understanding of the child	1	2	3
26. Speak for the parent with the goal of promoting understanding of own feelings and behavior	1	2	3
27. Help parent understand child's behavior as communication	1	2	3
H. Use of Clinical and Reflective Supervision			
28. Protect regularly scheduled time for supervision	1	2	3
29. Be present, open, curious; ready to share and explore thoughts and feelings	1	2	3
30. Provide a clinical formulation from a dynamic perspective	1	2	3
31. Provide a diagnosis if/when appropriate	1	2	3

MTB Treatment Fidelity:
Supervisor Self-Assessment Form

Replication Site: ___________________________________ Date: _____________

Responding Supervisor: ☐ **Nursing** ☐ **Mental Health**

This form is intended for use in tandem with the MTB Treatment Fidelity Monitoring: Intervention Delivery Self Assessment in the MTB Treatment Manual. MTB supervisors are asked to review the full framework with clinician supervisees on a regular basis for selected families (at least every three months), and to complete this form to submit to the MTB National Office annually (on-line via Qualtrics), beginning three months after the first families are enrolled into the replication program.

Directions: Please respond to each item using a scale from 1-3, where 1 = I do this regularly, 2 = I do this sometimes, and 3 = I am not yet doing this.

A. Interdisciplinary Teamwork			
1. Communicate with supervisor(s) in other discipline(s), checking in regularly	1	2	3
2. Build a trusting relationship by valuing each other's perspectives/experience	1	2	3
3. Understand roles and knowledge base/scope of practice of other discipline	1	2	3
B. Clinical Supervision			
4. Maintain a reflective, wondering stance	1	2	3
5. Hold the perspectives of both parent and child	1	2	3
6. Encourage clinician(s) to speak for the baby with goal of promoting parent's understanding of the child	1	2	3
7. Encourage clinician(s) to speak for the parent with the goal of promoting understanding of own feelings and behavior	1	2	3
8. Encourage clinician(s) to help parent understand child's behavior as communication	1	2	3
C. Reflective Supervision			
9. Protect regularly scheduled time for supervision	1	2	3
10. Be present, open, curious; ready to share and explore thoughts and feelings	1	2	3
11. Provide quiet, private space	1	2	3
12. Create an environment of emotional safety that facilitates authenticity	1	2	3
13. Be present, open, curious, and calm	1	2	3
14. Hold a non-judgmental stance	1	2	3

MTB Replication Site Self-Assessment

The items below are included on an on-line form intended for use in tandem with the MTB Treatment Fidelity chapter in MTB Treatment Manual. MTB administrators complete this form (on-line via Qualtrics) to submit to the MTB National Office annually, beginning approximately one year after the first families are enrolled into the replication program. Items on this form are provided below for review prior to on-line completion.

Directions: Please provide the following information for your MTB site/location only via the on-line link provided by the MTB National Office. This should take no more than 15-20 minutes to complete. Once you have answered each section with numerical responses, you will have an opportunity to provide additional information or clarification as needed. Thank you!

A. Administrative Implementation & Essential Elements (Process Fidelity)

Please enter the current total number for each of the following MTB program elements.

TOTAL number of MTB home visitors...
- 1a. trained at/before start-up
- 1b. trained since/after start-up
- 2. currently serving MTB families
- 3. are graduate level clinicians
- 4. have left the program temporarily
- 5. left the program permanently
- 6. positions currently vacant

Number of MTB local supervisors...
- 7. trained at start-up
- 8. have left temporarily
- 9. left permanently
- 10. positions currently vacant

11. Number of currently active home visitor TEAMS (nurse + mental health clinician)

TOTAL number of families...
12. to be served annually (target number)
13. served since the start of the implementation (all cohorts)
14. currently enrolled
15. graduated from the program (across all cohorts)
16. withdrawn from the program (across all cohorts)
17. on the current average caseload per clinician
18. on the highest caseload any team has carried at one time (across all cohorts)
19. Please provide any comments or clarification on any of the above items.

Please indicate whether none , some, most, or all of the families served...
20. have participated voluntarily
21. had the same home visitor team throughout the intervention
22. were enrolled prenatally
23. received at least two home visits prenatally
24. mothers were first-time parents
25. Please provide any comments or clarification on any of the above items.

B. Organizational Climate & Implementation Process (Treatment Fidelity)

Please rate the following items on a scale of 1-5, where 1=very poor, 2=poor, 3=average/neutral, 4=good, and 5=very good.

26. Quality of agency relationship with community, including neighborhoods, other non-profits, and clinics
27. Effectiveness of agency organizational structure in promoting an efficient and well-organized program
28. Effectiveness of supervisors in providing a balance of administrative, clinical, and reflective supervision
29. Effectiveness of agency organizational climate in providing a supportive and safe environment for all staff
30. Level of adherence to MTB model requirements, including careful and on-going review of the Operations and Treatment Manuals
31. Level of compliance with fidelity processes and measures, including regular review of MTB manuals as well as completion of the MTB Treatment Fidelity Checklist and related materials/forms
32. Level of adherence to MTB clinical protocols and procedures, including use of required clinical and/or research forms (e.g., HVPV)
33. Please provide any comments or clarifications on any of the above items.

C. Adherence to Treatment Model (Content Fidelity)

Please indicate the frequency of the following items, i.e., never, sometimes, most of the time, always.

34. All clinicians meet the required MTB clinical competencies as outlined in the MTB Replication Operations Manual
35. All supervisors meet the required MTB supervisor competencies as outlined in the MTB Replication Operations Manual
36. Weekly (or bi-weekly if agreed) on-site team meetings including case discussion are held regularly
37. All team members (including both clinicians and supervisors) attend and participate in the majority of regular on-site team meetings
38. All clinicians receive regular (preferably weekly) reflective supervision sessions with local or regional MTB trained supervisors
39. All team members participate regularly in required training and consultation with MTB National Office
40. Quality case presentations and in-depth case discussions are embedded into team meetings, supervision sessions, and consultation with the MTB National Office
41. All team members review and refer regularly to the MTB Operations and Treatment Manuals
42. All clinicians review and refer to the Clinician's Quick Reference Guide for a refresher of approaches in the field

43. Please provide any comments or clarification on any of the above items.

D. Status of Evaluation Data Collection & Submission

Please indicate the frequency of the following items, i.e., never, sometimes, most of the time, always.

44. The MTB Home Visit Process Variable (HVPV) form is completed following each home visit
45. Evaluation data have been and continue to be collected on all families as agreed and on schedule (whether through the MTB National Office or via independent RCT data collection)
46. Data have been submitted to the National Office at regular intervals or as agreed OR data are collected via an independent RCT as agreed
47. Please provide any comments or clarification on any of the above items.

E. Feedback to the MTB National Office

48. How helpful are the written training materials (operations/treatment manuals and Quick Reference Guide), and in what ways are they useful?
49. How might these training materials be more helpful/useful?
50. What support, training, or technical assistance from Yale MTB National Office staff has been most helpful to date (e.g., monthly consultation calls such as IDS, DS, Supervisory, Distance Learning)?
51. What are your site or team training goals (related to MTB) for the upcoming year?
52. What sort of additional support, training, or consultation would be helpful to receive from the MTB National Office?
53. Please provide other feedback or comments to share with the MTB National Office, including whether there are certain areas you feel your agency has been particularly successful in replicating MTB or in which there is room for growth.

REFERENCES

Achenbach, T., & Rescorla, L. *Child Behavior Checklist/1.5-5*: www.aseba.org.

Bernstein, D., & Fink, L. (1997). *Childhood Trauma Questionnaire*. San Antonio, TX: Pearson Education.

Gross, D., Fogg, L., Young, M., Ridge, A., Cowell, J. M., Richardson, R., & Sivan, A. (2006). The Equivalence of the Child Behavior Checklist/1 1/2-5 across Parent Race/Ethnicity, Income Level, and Language. *Psychological Assessment, 18*(3), 313-323.

Luyten P, Mayes LC, Nijssens L, Fonagy P. (2017).The parental reflective functioning questionnaire: Development and preliminary validation. PLOS ONE. 2017;12(5):e0176218. doi: 10.1371/journal.pone.0176218 (open access)

McGuire DB, DeLoney VG, Yeager K, et al.(2000) Maintaining study validity in a changing clinical environment. *Nursing Research;* 49:231–235.

Sadler, L.S., Slade, A., Close, N., Webb, D.L., Simpson, T., Fennie, K., & Mayes, L.C. (2013).

Minding the Baby: Improving early health and relationship outcomes in vulnerable young families in an interdisciplinary reflective parenting home visiting program. *Infant Mental Health Journal, 34*(5), 391-405.

Sidani S.(1998) Measuring the intervention in effectiveness research. *Western Journal of Nursing Research;* 20:621–635.

Slade A, Grunebaum L, Huganir L, Reeves M.(1987) The pregnancy interview. New York: The City University of New York.

Slade A, Bernbach E, Grienenberger J, Levy D, Locker A.(2005) *Manual for Scoring Reflective Functioning on the Parent Development Interview.* New York: The City University of New York.

Slade A, Sadler LS, de Dios-Kenn C, Webb D, Ezepchick J, Mayes LC. (2005)Minding the Baby: A reflective parenting program. *Psychoanalytic Study of the Child;* 60:74–100.

Slade A, Grienenberger J, Bernbach E, Levy D, Locker A.(2005) Maternal reflective functioning and attachment: Considering the transmission gap. Attachment and Human Development.

Squires, J., Twombly, E., Bricker, D., & Potter, L. (2009). The ASQ-3™ User's Guide. Baltimore, MD: Paul H. Brookes Publishing Co., Inc.