Minding the Baby® Home Visiting (MTB-HV) Replication Operations Manual For Implementing Agencies

Prepared By:
Crista Marchesseault, MAT, MA

Contributing Authors:
Nancy Close, PhD
Lois Sadler, PhD, PNP-BC, FAAN
Tanika Simpson, PhD, LCSW
Arietta Slade, PhD
Denise Webb, MSN, APRN, PNP

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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.

MTB Co-Founders: Lois S. Sadler, PhD, PNP-BC, FAAN and Arietta Slade, PhD

Address for correspondence: Crista Marchesseault, MTB Operations Director, Yale School of Nursing, P.O. Box 27399, West Haven, CT 06516-0972; crista.marchesseault@yale.edu

This operations manual is intended for use by implementation agencies entering into a contract with the MTB National Office to replicate the *Minding the Baby®* Home Visiting (MTB-HV) clinical model. It serves as a more in-depth follow-up to the MTB-HV Replication Planning Guide with more explicit details on the steps, protocols, and forms involved in implementing MTB-HV. It is intended for use primarily by program administration, 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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Betsy Houser, MSW
Karen Klein, PNP
Linda Mayes, MD
Andrea Miller, BA
Patricia Miller, BS, Grad Dip Psych
Kate Mitcheom, CNM
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PART ONE

Implementation Start-Up

Introduction

This manual was developed for program administrators and coordinators who are overseeing program replication of the *Minding the Baby*® Home Visiting (MTB-HV) model in collaboration with the MTB National Service Office (NSO), via contractual agreement. It is intended to serve as a more in-depth follow-up to the MTB-HV Replication Planning Guide, with more explicit details on the steps, protocols, and forms involved in replicating the clinical model. It is intended for use primarily by program administration, in tandem with the training and consultation required for MTB-HV implementation and provided by the MTB NSO. However, it may also be useful to all team members when embarking on implementation, and as a reference throughout the process.

To some extent, this is a working document, as it is updated at least annually with on-going research results, program expansion details, and related updates to forms and procedures. To ensure that you are reviewing the most recent version of this manual and related forms, please check the password-protected web portal for MTB implementing agencies available on our website at the following link: http://bit.ly/mtbagencylogin. You should have received your agency login information with this guide, but it is always available by request. There is some intentional overlap among the planning guide, this manual, the web portal, and the treatment manual, the latter of which provides much more in-depth background on the model and clinical work. Please refer to the Planning Guide for a general overview of the program model, history, results, implementation considerations, and replication training phases.

Hiring

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. It is also very important that the MTB NSO 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 Treatment Manual. MTB-HV model developers and senior clinicians are also available to assist in the review and/or screening of final applicants, and truly welcome this opportunity. Additional details with regard to the various roles involved with MTB-HV implementation follow.

Administrative Roles: As mentioned in the Planning Guide, some of the recommended staff and support positions may be shared or overlapping depending on the size of the agency and/or funding level. Administrative roles may include a Program Coordinator/Director, a Program/Research Assistant, and/or an Administrative Assistant. It is important that these staff members participate in the training provided by the MTB NSO and that the Coordinator/Director maintains regular and on-going contact with the MTB NSO, especially during the early phases of replication. The Coordinator should ideally have an advanced degree in a related field and experience with program evaluation. It is integral that the Coordinator understands the underlying principles of the program, is able to support the clinicians in the difficult work of engaging clients and maintaining contact, and is aware of the difficulties that may be experienced by both clinical and administrative staff in conducting this work. These may include problems of maintaining contact with some families as well as the emotions that can be evoked when working with young families with many needs.

Supervisory Roles: These important roles include at least one Mental Health Clinician and one Advanced Practice Registered Nurse (or professionals in these disciplines with an equivalent mix of credentials and experience). Both should hold advanced degrees and have knowledge of and experience with the population served. It is also

extremely important that they understand and use reflective supervision techniques. Although the supervisory positions are typically part-time, MTB-HV Clinical Supervisors must be available for team meetings and weekly individual supervision, able to provide not only clinical supervision, but also reflective support for the clinicians. This requires understanding the particular challenges of home visiting and the MTB-HV model. Supervisors must be available and responsive to clinicians for support or clinical advice needed between regular scheduled supervision sessions as well. This is particularly important when a clinician first starts the work, but is also important in an on-going way to prevent clinician burnout.

Clinical Roles: Each home visiting team consists of a credentialed mental health clinician (in the United States, this is typically a Licensed Clinical Social Worker) and a licensed nurse or certified nurse practitioner. While the original MTB-HV model included advanced practice nurses, the intervention is typically delivered by nurses with at least one year of pediatric or family experience, or equivalent combination of experience and education. Likewise, the mental health component of the program can be delivered by a social worker, psychologist, or other professional with training appropriate to this role (such as, in the United Kingdom, a child psychotherapist). The training and background of the mental health provider is more important than the specific discipline (i.e., social work). Ability to provide services to young, high-risk individuals is essential. The mental health clinician must be competent to provide infant-parent psychotherapy, therapy for parents, parenting support, and knowledge to link families to social service and mental health delivery systems. In addition to an ability to care for the physical needs of the clients, the nurse must be able to address mental health needs of the mothers and infants and should be able to provide intensive home visiting intervention. This may include parent education and primary care management or referral for care of selected health conditions for all participants (infants, mothers, and family members). Experience with home visiting, teenagers, and multi-ethnic urban families is desirable for both positions.

Staff Orientation and Competencies

The MTB-HV model is complex, and it is integral that all staff members are fully oriented before they begin to see clients. While all staff members require orientation to some of the program components, individual roles require specific training. Each implementing agency will also have its own individual set of orientation and training requirements, and there may be additional research training requirements due to the evaluation data that is typically collected and submitted to the MTB NSO at Yale as part of the implementation process. Clinical orientation and training should be aimed at making home visitors familiar with MTB approaches. This should be done in a timely fashion after hire and prior to working with the families. Refer to Appendix I for sample job descriptions and to the MTB Treatment Manual for detailed competencies for clinicians and supervisors.

Caseloads

As outlined in the Planning Guide, a full-time caseload for a single home visiting team typically builds to approximately 22-24 families by the second year of implementation, resulting in around 10-12 home visits per week for each full-time clinician. 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. Since home visits decrease in frequency to every other week during the second year of intervention, this may lead to a larger number of families on a given caseload over time. Other considerations include long distances between homes, heavy traffic in certain urban areas, or other issues individual to certain geographic areas or agencies.

When assigning caseloads, it is also important to allow for time to attend meetings, complete paperwork, and participate in supervision. As a rule of thumb, each home visit typically involves around 20 minutes of preparation, lasts approximately one hour, and requires around 20 minutes of paperwork following the visit, though this will vary from agency to agency depending on individual administrative or research requirements. Minimizing duplication and streamlining paperwork procedures is helpful whenever possible, ensuring a reasonable (and not

burdensome) amount of paperwork. For nursing notes, a simple checklist using the Care Plan included in the Treatment Manual may be useful. It is important to also consider additional time for follow-up phone calls, referrals, and information gathering. Travel time from one home to another will be dictated by the geographic spread of the clients' homes. Ample time should also be allowed for the clinical team to discuss their visits with each other and plan for the direction of the intervention. Frequent discussion between clinicians will help prevent triangulation and provide clients with a coherent approach.

Working as an Interdisciplinary Team

MTB-HV implementation involves teamwork across a variety of roles within multiple disciplines, including clinicians, supervisors, researchers and/or support staff, program administrators, and community partners. Essentials for the MTB interdisciplinary team include the following components.

- Training in one's core discipline
- Reflective supervision
- Interdisciplinary supervision
- Role definition and understanding
- Regular team meetings
- Regular staff retreats and/or professional development activities
- Regular meetings and phone contact between clinicians to discuss mutual clients
- Team cohesion through shared rituals such as birthday and holiday celebrations

The teamwork also involves staff from collaborating agencies and the community, who may include Advanced Practice Nurses, Nurse Midwives, Clinical Social Workers, Physicians, Psychologists, Speech Therapists, and others. Each discipline has its own domains, language, and point of view. It is important to provide opportunities for open communication in order to ensure understanding among the participants. MTB-HV clinicians must establish and maintain a working relationship with the providers in the community if they are to present the young women with consistent, coherent information. The goal of MTB-HV providers should be to establish a respectful collaborative relationship with other providers to allow for consistent and effective care for the families served.

Supervision & Support

It is vital that clinicians receive ongoing supervision and support. The MTB-HV model involves several kinds of supervision. The individual mental health supervision component is based on a psychodynamic model, with an emphasis on mentalization, also with a focus on transference and countertransference. Integral to this type of supervision is a model known as "reflective supervision" in the United States (described briefly below). MTB-HV 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-HV model. Refer to the Treatment Manual for additional detail on the MTB-HV supervisory model.

Administrative supervision: While this should not be the focus of all supervision, it is a natural part of the supervision process within any clinical service or implementing agency. This may include time off requests, case management, professional development approvals, etc. Much of this type of supervision can be provided via e-mail or informal meetings with the Program Coordinator and should not be a primary focus of individual clinical supervision or team meetings. Both administrative and reflective supervision are critical elements in setting parameters around program culture and expectations. Some amount of administrative supervision will naturally be a part of individual clinical supervision meetings, interdisciplinary supervision, and team meetings.

Reflective Supervision: This is a dynamically oriented form of supervision that is vital to the type of work carried out by MTB-HV clinicians. Individual supervision meetings between the clinical supervisor and clinician must be focused primarily on this type of practice. The goal of reflective supervision isn't to problem solve, analyze, teach, advise, or evaluate performance – this may feel strange at first, but take comfort in knowing that there are plenty of mechanisms already existing to serve these purposes. An optimal reflective process allows the clinician to feel supported, validated, and fortified so that she may return to the work in the face of the unknown and the unsolvable, knowing that her relationship with the mother-infant dyad holds meaning and significance. The reflective supervisory relationship is the very sort of relationship clinicians strive to model and transfer to the mother-baby dyad. Essential components of reflective supervision include the following.

- Regular time
- No distractions
- Non-judgmental approaches to clinicians, families, and treatment decisions
- A "holding" environment where it is safe to discuss concerns and questions
- Active listening
- Honest attempt to understand feelings
- Ability to sit with uncertainty

Team meetings: Regular team meetings (preferably weekly) are an important part of a successful interdisciplinary model. The MTB-HV Clinical Team Meeting typically lasts between an hour 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 mothers and babies. 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. The team meeting is a place to express and explore the reactions clinicians are having to families, to express frustration in regard to the various challenges of the work, and to receive support from colleagues. Reflection about all aspects of the work is emphasized in team meetings and can serve as a means of support to the clinicians in and of itself. It is easy for even experienced clinicians to doubt their clinical skills when faced with the often complex, challenging, and dysregulated lives of the program participants. It is crucial to have time during team meetings to reflect and process.

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. Samples of a team meeting agenda and case conference log are available by request, and a suggested case discussion format is available through the web portal for implementing agencies (see: http://bit.ly/mtbprotocols).

Distance Training & Consultation: As outlined in the MTB Replication Planning Guide, regular phone and/or video conference calls for the clinical team(s) with the MTB NSO begin in phase three of the replication process.

There are three types of consultation sessions that occur approximately 10 times per year (on a semi-monthly basis): Interdisciplinary (IDS), Discipline Specific (DS), and Supervisory. See Appendix III of the Planning Guide or log in to the web portal for implementing agencies for detailed descriptions (direct link: http://bit.ly/2JIwkFM). The exact format of these calls is determined with each individual site and may evolve over time. A sample call format is typically distributed by e-mail about 2-3 months into implementation and is also available through the web portal (see: http://bit.ly/mtbprotocols). In addition to the IDS, DS, and Supervisory sessions, quarterly 90-minute "Distance Learning" training sessions are provided via video conference. These sessions are focused on topics specific to the phase of intervention and are reflective of individual site needs. Regular phone or video conference calls also occur between the site coordinator(s) at the implementing agency and the MTB NSO Operations Director, to discuss administrative and logistical details, as well as evaluation planning and data management if applicable.

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 the following.

- Handouts for home visits, appropriate to the reading and educational level of the population
- Copies of blank clinical forms (refer to the web portal at: http://bit.ly/clinicalforms)
- Toys for use and re-use at home visits, and washable bags to carry clean toys to home visits
- Toys to give as gifts to encourage appropriate play
- Diapers, if local Diaper Bank or similar resource is available
- Hand sanitizer
- Routine office supplies, e.g., magnets/laminating pockets for business cards, color paper in a variety of bright/pastel colors, cards for birthdays/other occasions, bright notepaper/envelopes to use for notes to participants

Equipment: In addition to secure, dedicated office space with adequate storage for supplies and materials, the following equipment is recommended for MTB-HV implementation.

- Laptop computers and/or tablets for clinical staff
- Mobile phones for clinical & program staff with map app (smart phones preferred, especially for clinicians)
- Digital video camera(s) for clinicians (if smart phones aren't an option)

Gifts for Families: It may be helpful to have books, toys, and greeting cards on hand for families throughout the intervention. These gifts and cards can be used in some cases to mark special occasions such as baby showers, births, and birthdays. The clinicians can also use the gifts to encourage parent-child interaction and to demonstrate the baby's increasing abilities, such as shaking a rattle, throwing a ball, or turning pages in a book. Particular emphasis is put on reading to the child and creative use of other materials. The following gifts (or similar) may be given to participating mothers at the indicated suggested stages.

- At recruitment: rubber duck with water temperature indicator
- At birth: soothing musical toy
- At 3-4 months: colorful rattle
- At 5-6 months: waterproof bath time book
- At 7-9 months: appropriate sized baby spoons
- At 8-9 months: book with textures to explore
- At 12 months: 2-piece puzzle or similar item
- At 24 months: an individualized gift meant to be used for imaginary play; a ball to roll, throw, and kick; or an age-appropriate board book

Toys for Home Visits: Aside from gifts, MTB-HV clinicians also bring their own toys to use with the baby during the visit. It is useful to have a brightly colored tote bag that is large enough to accommodate any resources, teaching materials, and toys. As babies grow into toddlers, they begin to identify this bag with enjoyable activities and toys. Sometimes a second tote bag for the child to carry, empty, and fill is useful and fun. To prepare for a full day of home visits, the clinician will need multiple bags of toys. Toys can be lost behind furniture, a toddler may be unwilling to relinquish a toy at the end of a visit, and occasionally a mother will misunderstand and believe a toy is a gift. For these reasons, it is important to replenish supplies on an on-going basis. The contents of the toy bag may include the following items, or similar.

- stacking rings
- nesting cups
- push toys
- a plastic baby doll and bottle
- plastic animals and people
- puzzles
- blocks
- books
- cars and trucks

When selecting toys, the following factors should be considered.

- safety
- age-appropriateness
- cost
- ease in cleaning with 10% bleach solution or in a dishwasher after each use

Ordering Items: Individual implementing agencies will have their own guidelines and procedures for purchasing the above items. Some sample gifts, toys, and other resources are included on an amazon.com wish list (see: http://bit.ly/mtbgiftideas). This is, of course, only one of a number of potential vendors from which to purchase such items, and while this is not a comprehensive or exhaustive list, it is intended as a resource for administrators as implementation gets underway. The Baby Basics book (referred to in the Nurse Competencies in the MTB Treatment Manual) may be purchased at https://www.whattoexpect.org/order-materials.

Other Considerations

There are many considerations for staff at all levels working in a home visiting program. Among other things, working in a home-based program can result in a blurring of the boundaries more easily maintained in a center-based program. Refer to the Treatment Manual for more detail on setting and maintaining boundaries with families, including providing program participants with clear instructions about the availability of clinicians at the time of enrollment, along with information about how to access services outside of clinicians' working hours. It is often helpful to give each of the participants a small laminated card with contact information and times of availability on one side and the phone numbers of appropriate community providers on the other.

Safety: It is important for home visitors and other program staff conducting home visits to keep safety precautions and measures in mind at all times, and for administrative and support staff to be sensitive to these issues. The Treatment Manual addresses safety issues in more detail, including important precautions to keep in mind.

Preventing Burnout: The work of MTB-HV clinicians cam be intensive and stressful. They have many demands on their time, and progress with clients is often slow with many reversals on the way. At times, clinicians may feel overwhelmed and ineffective. To support clinicians and prevent burnout, it is important to maintain and revisit the

related program components, many of which are discussed throughout this guide and also addressed in the Treatment Manual. These include reflective supervision, team meetings, team retreats, time for clinician-to-clinician discussion, clarity of expectations, opportunities to attend relevant continuing education or professional conferences, help and support in maintaining boundaries with families, and support through celebrations.

Vacation Coverage: Understandably, clinicians should inform clients when a vacation will be taken. The timing of this notification should be discussed in supervision; typically, it is advisable to give at least two weeks' notice of an upcoming vacation. It is important to provide explicit instructions regarding who to contact if the family has a medical or mental health need while the clinician is not available. The team partner who is not on vacation, and who is thus still available to the client (i.e., the nurse if the social worker is on vacation and vice versa), should be prepared to meet needs that may be outside of the area of expertise or refer the mother to the appropriate healthcare provider. When there are multiple teams at a given agency, a clinician of the same discipline from an alternate team can provide coverage and serve as a resource to the other clinician. Clinical supervisors should also be readily available at these times.

Clinician Transition: In the natural course of events over time, clinicians will leave the program. These departures can be temporary, as in the case of a maternity leave or some other leave of absence, or permanent due to resignation or lay-off. Because they have likely formed a bond with the clinician, families may be reluctant to accept a new person in their place. It is not unusual for famlies to avoid saying goodbye and to resist meeting the replacement. It is often helpful to give clients plenty of time to process imminent changes and to express their concerns. If possible, the replacement clinician can attend home visits with the transitioning clinician before the leave begins. If this is not possible, the second home visitor can bring the new clinician to the visits to provide an introduction and ease the transition to working with a new clinician. A detailed protocol to follow and a sample transfer form that may be useful in these situations are available via the web portal (see: http://bit.ly/mtbprotocols).

Confidentiality and Protected Health Information: All of the usual requirements for maintaining the security of personal health information (PHI) must be maintained throughout implementation. Each implementing agency and/or country will have its own regulations or laws in regard to health information and participation in evaluation or research activities. In the United States, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 stipulates strict regulations protecting the confidentiality and security of healthcare information. Home visiting programs present some unique challenges regarding confidentiality and health information. If home visitors keep notes or other information on a laptop or other electronic device, it must be encrypted. For both safety and privacy concerns, laptops should not be left unattended in a car or other place where the clinician may not have control of it. The same applies to any other equipment such as a smart phone, video camera, digital camera, and digital recorders.

Personal information collected/documented at or following a home visit should not have identifying information on it. Each subject must have a confidential subject ID number assigned at enrollment and the key linking the number to identifying information should be kept in a secure, locked file. All data stored on a computer should be password protected on a secure network. Clinical charts should be kept in a locked office file cabinet within a secure, locked office or storage space. Clinical, research, and administrative staff will inevitably need to carry information between the office, the field, and their homes. If at all possible, this information should not have identifying information such as names, dates of birth, etc. The information should be kept in a folder and stay in the staff member's possession at all times. It should never be left in a parked car or left out where it can be read by a casual passerby.

PART TWO

Replication Procedures

As introduced in the Planning Guide, MTB-HV proceeds in a series of phases, as with the training and consultation required for implementation. The first two phases of technical assistance (planning/start-up and the initial 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. These are described briefly below. Refer to the Treatment Manual for more specific and detailed content for nursing and mental health visits, and to the Implementation Start-Up Check List provided in the Appendices and through the web portal (direct link: http://bit.ly/mtbstartupchecklist) to guide the implementation start-up process.

Recruitment & Consent

Recruitment procedures are determined in collaboration with the MTB NSO and any applicable community agencies. This is discussed and documented during the start-up phase of implementation. In general, if a mother indicates interest in learning more and potentially joining the program, the team makes an appointment, at which time the home visitors together describe the program to the mother in more detail, and answer any questions that the mother and other family members may have. Most future visits will take place with individual home visitors, but meeting both members of the team conveys, in a vivid way, the unified nature of the intervention. This visit (which may sometimes be extended to a second visit) is also important because it is here that first impressions as to the nature and focus of the intervention will be formed. Home visitors provide information and materials that mothers usually find helpful, giving them a sense of what MTB has to offer.

Once mothers have agreed to participate, individual clinical consent and/or research authorization forms are signed. Individual implementing agencies may not follow this process in exactly the same ways; nevertheless, the principles of approaching potential clients from a place of trust, gradually engaging them and addressing all of their and their family's questions before enrollment, should be observed. If the process is not observed, there are likely to be problems with client's willingness to continue in the program at a later point in the process. Program administrators and supervisors must support clinicians in this process and not place pressure on them to increase or speed up enrollment.

Due to the fact that evaluation measures and data are collected as part of the evaluation component, clinicians or other program personnel must also obtain informed consent and/or research authorization from interested participants. Consent is only truly informed if the consent form is explained in detail to the subject and is in a language that the subject understands. Since many participants may be bilingual, it is essential that the content of the consent process is presented in terms they will understand. Ample time must be allotted for the process to ensure that the participant has time to consider the information, and both verbal and non-verbal language should be noticed. When consenting minors, special care must be taken to ensure that they have understood the document. Participants should also be aware that they are not obliged to sign the consent because the clinician has spent time with them, but that consent is required to participate in the program, and they can decide not to participate at any time. All participants should receive a copy of the signed consent for their records.

Informed consent is a process. However, the consent form/document is also important and should include a clear description of the program and what the participant can expect from the clinicians and what the clinicians will be asking of them. The form should also specify the expected length of the client's participation and a description of any procedures that may be asked of the participant. The voluntary nature of the program should be explained so that participants know that they have control and can decide to withdraw from the program at any time. Contact information of someone who can answer questions or receive complaints (e.g., the Program Coordinator) should be on the form and indicated clearly to the subject. Individual implementing agencies may have their own guidelines.

Intervention Phases

The initial intervention phase is focused on engagement and assessment. The first visits by the nurse are aimed at conducting a health assessment of the mother. The visits conducted by the social worker are aimed at obtaining a psychosocial history. (See http://bit.ly/clinicalforms for sample intake forms.) In the third trimester (late second pending when the mother is recruited), ideally 4-6 weeks before the EDD, the Pregnancy Interview (PI) is administered by the social worker and observed by the nurse (when practical). When these visits have been completed, the intervention formally begins, moving through the following phases, all of which are described in more detail in the Treatment Manual, including techniques used during each of the intervention phases.

- Prenatal Phase
- Delivery & Postnatal Phase
- First Year Phase
- Transition Phase
- Second Year Phase
- Goodbye Phase

Home Visits

From the moment preparation for the home visit begins until the moment the clinician enters the home and begins assessing the situation and the mother's readiness to engage, the home visitor is considering how best to maintain this focus on the mother-child relationship. This challenging task is described in detail in the Treatment Manual. There is an intrinsic structure and process to all home visits, whether they are nursing or social work visits, conducted jointly by both clinicians, with mother only, or with other family members attending. The general outline for home visits follows four stages that include preparation, assessment, engagement, and ending the visit. Refer to the Treatment Manual for detail on these stages, and the following elements of the work.

Intensity & Flexibility: Integral to and woven into all of these stages is the families' need for intensity and flexibility, which are the hallmark of the MTB-HV intervention. Because many families struggle with chaos at so many internal and external levels, they need intensive services, and they need flexible services. Without willingness to be flexible in establishing the duration, format, and content of the visit, therapeutic relationships and progress will suffer. This kind of flexibility defies prescription, and yet is vital to reaching hard-to-engage and stressed families.

Preparation, Duration, & Scheduling: Clinicians complete a number of tasks in preparation for a home visit, all of which surround the current situation and developmental stage of the child and mother. Handouts, teaching materials, or any props that might be needed for the visit are also selected, along with appropriate toys or activities for children who may be in the home during the visit. If the family has agreed, a phone call (or text message) may be made to remind them of the previously arranged time for the visit. This phone contact before the visit allows for rescheduling if needed, but is more likely to ensure that the home visitor is able to find the family home and carry out the actual visit. See the Treatment Manual for more on visit preparation.

Missed appointments, no-shows, cancellations, and rescheduling are regular and common. The home visitor needs to be very flexible in these situations, although there are times when resistance has to be addressed directly for the sake of preserving the treatment relationship. Giving each mother a datebook or calendar to help them to remember appointments can be helpful. MTB-HV families are never dropped due to no-shows. Every effort should be made to re-establish contact with a mother regardless of how difficult it may be to maintain contact. This can be a challenge with certain funding requirements, but is an essential part of the model, the relationship between the clinicians and the families, and the program outcomes.

Location: Most visits take place in the home. There may be circumstances, however, when parents prefer that home visitors not come into the home (e.g., when there are many visitors staying in the home and there is no place for the visit to take place, or if the family is in a transitional or temporary housing situation and not in their own home). In these situations, the visit setting may be negotiated with the family. Other acceptable settings might be a public setting such as the children's playroom of the public library, a coffee shop, or an empty room in the community health center.

When mothers have returned to work or school, they may have difficulty scheduling visits. Visitors can then arrange to meet mothers during a lunch break at work or school, or conduct the visit while driving in the car to an appointment or home from work or school. These types of visits can serve as helpful and trust-building outward demonstrations of commitment on the part of the program toward the mother. Such extenuating circumstances are usually temporary and the regular visits in the home setting resume, but this is flexible and individually determined.

Maintaining Contact: The following methods may be used to assist in maintaining contact with mothers.

- Calendars can be given to each mother before the baby is born, and at the end of each calendar year. Clinicians can encourage the mother to use this to keep track of MTB-HV and other important appointments.
- At intake, mothers can be given a laminated card or magnet showing the type and timing of home visits and/or research appointments to be done over the course of the program's two and a half years.
- A laminated and/or magnetic business card including clinician contact information and emergency numbers can be provided for families.
- If acceptable to the family, a phone call or text message before the appointment often helps with attendance or allows for rescheduling.
- While only some have regular access to e-mail, it can be a useful way to stay in touch for those who do.
- Notes and cards left at the home are helpful; brightly colored notepaper and envelopes often help to grab young parents' attention and can be more inviting than a business envelope.

Extra Sessions: There may be times when families call the clinicians to ask for information or advice between home visit appointments, or when the clinicians themselves call to relay information to the mother outside of a visit. Implementing agencies should provide both home visitors with cell phones that families can call or text to reach them on a regular basis. However, the intervention is not designed to provide 24-hour coverage; therefore mothers must be advised on ways to respond in emergencies without requiring the support of MTB-HV clinicians. (See http://bit.ly/mtbprotocols for details regarding off hours and cross-discipline coverage.)

PART THREE

Research Evaluation & Fidelity

Research Overview

As referenced in the Planning Guide, unless an independent RCT is underway, implementing agencies are required to collect specific data for evaluation and fidelity purposes, and to submit these data to the MTB National Service Office. While consistency across sites is ideal, each implementing agency has an individualized evaluation plan, as agreed upon with the NSO. Suggested and required measures are described below, and a quick reference list and at-a-glance administration timeline for the full evaluation plan is available through the web portal (see: http://bit.ly/mtbevaluation). Additional variables or measures may be selected (or required by funders), and the final plan is open to discussion with the MTB NSO. The measures listed below were selected with the expectation that MTB-HV clinicians can administer most, although many can also be administered by a trained program assistant if preferred/possible. The Exit Interview should be administered by someone other than the MTB-HV clinicians.

Evaluation Variables & Measures

The following outcome measures are used as part of MTB-HV implementation in various locations. Some need to be purchased or downloaded by the implementing agency, while others are provided through the web portal at http://bit.ly/mtbresearchforms or via e-mail by request.

- Home Visit Process Variables (HVPV) at each visit, beginning at intake
- Demographic, Health, and Life Course Outcomes (Maternal and Birth/Child) at intake, 12, and 24 months
- Child Trauma Questionnaire (CTQ) at intake
- PTSD Check List-Civilian (PCL-C) at intake and 24 months
- Edinburgh Postnatal Depression Scale (EPDS) at intake and 24 months
  ~or~ Center for Epidemiological Studies Depression Scale (CES-D) at intake and 24 months
- Ages and Stages Questionnaire (ASQ-3) at 6 and 16 months
- Child Behavior Check List (CBCL) at 24 months
- Parental Reflective Functioning Questionnaire (PRFQ) at 24 months
- Evaluation of Home Visits: Participant Exit Interview at 24 months

The recommended schedule for collecting required measures is outlined in Table 1 below. Each evaluation measure and associated variables are described in the following the table. Descriptions of each measure are provided on the following two pages.

Table 1. Schedule for Administering Required Research Interviews and Instruments.

Subject	Variables	PREGNANCY	6 MONTHS	12 MONTHS	16 MONTHS	24 MONTHS
Mother & Child	Demographics	Demographics Form		Demographics		Demographics
Mother	PTSD	PCL-C				PCL-C
Mother	Reflective Functioning					PRFQ
Mother	Trauma Exposure	CTQ				
Mother & Child	Health Outcomes			Record Review*		Record Review*
Child	Abuse and Neglect		ASQ-3	CPS Referral*	ASQ-3	CPS Referral*
Child	Mental Health					CBCL
Home Visits	Process & Evaluation	HVPV (every visit)	HVPV	HVPV	HVPV	Exit Interview

*Data obtained from clinic/provider health record; CPS = Child Protective Services

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Home Visit Process Variables (HVPV): Encounter and relationship variables are measured through the use of a form developed specifically for this project. The HVPV form is completed by each home visitor immediately after each visit. Encounter variables include the length of visit in minutes, the family members who participated, and the breakdown of issues covered during the home visit. Operational definitions for the topics covered are included on the reverse of the form to assist with inter-rater reliability on this variable. These definitions and the HVPV form are available to view and print through the web portal, here: http://bit.ly/mtbresearchforms.

Demographic, Health, and Life Course Outcomes*:* General demographic, medical history, and life course outcome information is collected at baseline (30-36 weeks of pregnancy). Additional data collection and a review of changes are carried out at 12 and 24 months after the baby's birth. A sample data collection form is available by request. Maternal outcomes include education (highest grade level completed), contraception use, pregnancy within 12 months, and childbirth within 24 months. Birth and child health outcome indicators are collected through review of the mother's hospital record and the child's pediatric health record. A list of sample demographic items is available via the web portal, here: http://bit.ly/mtbresearchforms.

Childhood Trauma Questionnaire (CTQ): Trauma exposure in adolescents and adults is identified through this 28-item screening tool. It yields 5 scales: physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect, as well as a Minimization/Denial scale that can be used to identify individuals who are underreporting traumatic exposure. It has been validated on a range of diverse samples, and is very stable over time, reliably linked to other established trauma measures (Bernstein & Fink, 1997). The CTQ takes 5 minutes to administer. The form is available for purchase through Pearson Education, Inc. (http://www.pearsonclinical.com/)

PTSD Check List – Civilian (PCL-C): This 17-item screener is closely based on the DSM-IV criteria for PTSD. Respondents rate each item from 1 (not at all) to 5 (extremely) to indicate the degree to which they have been bothered by the index symptom in the past month. The measure can be scored in two ways: subjects can be evaluated in light of their overall score, which is highly correlated with a PTSD diagnosis, or individual variables that align with DSM criteria can be assessed. The PCL-C has shown good psychometric properties, high rates of internal consistency, and is highly correlated with other measures of trauma symptoms.

Center for Epidemiological Studies Depression Scale (CES-D): (Comstock & Heising, 1976; Radloff, 1977). The CES-D was developed by the Center for Epidemiologic Studies at the National Institutes of Mental Health specifically to meet the need for a brief, inexpensive measure of depressive symptoms suitable for use in community surveys. The CES-D consists of 20 items that were selected from other depressions scales, including the Beck Depression Inventory, the Schedule for Affective Disorders, and the Minnesota Multiphasic Personality Inventory. Six major symptoms areas were identified and several items from each of the above scales were selected to identify each category. The areas include depressed mood, guilt/worthlessness, helplessness/ hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance.

Ages & Stages Questionnaire, Third Edition (ASQ-3): This developmental screening tool is designed for use by early educators and health care professionals. It relies on parent report, creating a snapshot that can help catch delays and celebrate milestones. Reliability studies completed on the ASQ-3 include test–retest reliability, and inter-observer reliability (Squires, Twombly, Bricker, & Potter, 2009). The ASQ is available for purchase through Brookes Publishing Co. (http://www.brookespublishing.com/)

Child Behavior Check List (CBCL) 1.5-5: A parent questionnaire for children ages 18 months to 5 years, the CBCL contains 99 items plus three open-ended questions for parents to describe behavior not previously listed, with a 5th grade reading level. Parents are asked to report on various behaviors on a 3-point scale. There are two scales within the CBCL: "Internalizing" problems (36 items) and "Externalizing" problems (24 items) (Achenbach & Rescorla). The CBCL was found to be largely equivalent across various races and income levels, with reliability ranging from .77-.91 (Gross et al., 2006). The form is available for purchase on-line at www.aseba.org.

Parental Reflective Functioning Questionnaire (PRFQ): The mother's interest in and curiosity about her child's mental states, interest and curiosity in her own and other's mental states, and ability to recognize the opacity of mental states is assessed through this 18-item questionnaire developed to measure Reflective Functioning. In addition, the scale assesses non-mentalizing modes characteristic of parents with (severe) impairments in parental reflective functioning (e.g., malevolent attributions, inability to enter into the subjective world of the child). Initial reliability and validity studies have been promising (Luyten, et al., 2017). The PRFQ is available to download at: http://www.tandfonline.com/eprint/yNP4FcGWU5zweBjaC4dy/full.

Evaluation of Home Visits: Participant Exit Interview: Participants' evaluation of home visits, their relationships with the home visitors, services provided, and the program as a whole are measured through the use of a form that was developed specifically for MTB-HV evaluation. The Exit Interview is given with the final demographics questions at the 24-month time point, and may be best given by an administrative or program assistant rather than one of the home visitors, though this appointment should be scheduled collaboratively regardless. This form is available to view and print through the web portal, here: http://bit.ly/mtbresearchforms.

Treatment Fidelity

As a federally designated evidence-based home visitation model, MTB-HV 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 families, 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).

For replication purposes, MTB-HV model fidelity is measured, monitored, and enhanced across four 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. A chart listing all measures and their corresponding domains is available by request. Additional detail regarding fidelity, and fidelity monitoring, is included in the Treatment Manual.

To fully monitor intervention fidelity, the below listed steps must be followed. Refer to the Fidelity Checklist at http://bit.ly/mtbfidelitychecklist for more detail and additional requirements, including required checklists and self-assessments for clinical staff and agencies.

1. Base home visitation intervention on the most recent version of the Treatment Manual, provided by the MTB National Service Office with initial training in the MTB-HV model.
2. Ensure that all clinicians are thoroughly trained on the MTB-HV model and approaches, following the replication phases required by the MTB NSO.
3. Provide ongoing joint (nursing and mental health) supervision and discussion of the intervention among clinicians and research staff.
4. Monitor the program through assessment and calculation of dosage for each home visit, as well as for their combined and total number of visits.
5. Interview clinicians and subjects to determine effectiveness and program satisfaction, especially with respect to each mother having relationships with both members of the home visitation team (McGuire, DeLoney, Yeager et al., 2000; Goldfried & Wolfe, 1998).

Data Collection & Submission

The evaluation component is explained to families by the clinicians when consent is obtained. If another program staff member is collecting some of the required data, this individual meets the mother as soon as the clinicians indicate that it is appropriate. At this time, the person collecting the data can explain the evaluation component and related activities in more detail.

A designated clinician may collect all of the evaluation data, or it may be divided among clinicians and administrative or other program staff; the PCL-C, CES-D, CTQ, and ASQ may be administered by either the nurse or mental health clinician. The HVPV form is completed by each clinician after every visit. A clinician or an administrative/program staff member who has been trained to collect data in a standardized manner may administer the Demographics Form, PRFQ, and Exit Interview. An overview of evaluation measures is included as part of the introductory training, and additional support documents (including guidance on introducing the CTQ) is available on the web portal (direct link: http://bit.ly/mtbprotocols).

It is important to be flexible about the time and location of evaluation-related visits. While not required for replication, providing small payments (subject incentives) for completion of evaluation measures outside of regular home visits, and/or offering a small toy for the infant, may help to increase compliance with the data collection that is part of the evaluation component. If dedicated evaluation/program staff members are available to collect data, the MTB-HV clinicians explain these other team member roles to families and sometimes arrange to call the office with the parents to make the initial connection and/or make appointments.

When possible, parents are called (or sent a text) the afternoon before the appointment for morning appointments and in the morning for afternoon and evening appointments. If evaluation visits are being conducted by other staff members, the clinicians should be informed of these appointments so they can remind families and answer questions as needed. Many MTB-HV participants have complex lives and have difficulty being punctual for appointments. Clinicians and other program staff should model punctual behavior but not express frustration with tardiness. Regardless of punctuality, they thank participants for coming to the appointment and provide praise for any attempts to let them know that they were running late. This is an important part of the relationship building process and provides a sense of respect.

Data collection forms should be collected immediately following completion and stored in a locked file cabinet at a secure, central office location. Data can then be entered and submitted to the MTB NSO through a secure on-line data collection system (Qualtrics), or in an alternative secure and agreed upon system. It is helpful to establish a procedure for tracking when research is due and completed. Clinician codes and premade labels are also helpful tools, and it is important to separate consent forms from research data (filed in separate file cabinets). All of this is discussed in more detail as part of training during the start-up phase of replication.

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APPENDIX I: SAMPLE JOB DESCRIPTIONS

Program Coordinator Sample Job Description

Position Description: In close collaboration with MTB National Office staff, serve as Program Coordinator for *Minding the Baby*® Home Visiting (MTB-HV), a home-based nursing and mental health intervention for high-risk first time mothers and their babies.

Duties and Responsibilities:

A. *Program Coordination:*
   1. Manage, oversee, coordinate, and assess day-to-day operation of the program, beginning with start-up activities for the replication of this evidence-based model, through 27 months of implementation (pending continued funding). Work in collaboration with MTB National Office staff to finalize and implement protocols for recruitment, data collection, data analysis, and team communication.
   2. Coordinate the implementation of evaluation protocols in coordination with MTB National Office staff. Ensure the integrity and validity of study coordination, including data collection and submission. Oversee the maintenance of accurate study records for recruitment, intervention delivery, data collection, and data management.
   3. Oversee and coordinate clinical and research/administrative staff. Manage interface between interdisciplinary teams, scheduling and running meetings as needed.
   4. Coordinate the logistics of program implementation and evaluation, ensuring fidelity to the MTB-HV model and implementation process and including oversight of on-going training and consultation with the MTB National Office.
   5. Oversee strategies for recruitment, retention, and follow-up of participants. Monitor and provide reporting on recruitment goals. Monitor, assess, and modify strategies to accomplish goals.
   6. Maintain accurate communication with the IRB and/or the MTB National Office as required. Monitor, document, and report adverse events as applicable. Assure compliance with HRPP and HIPAA requirements as needed.
   7. Set and disseminate meeting agendas based on needs of staff and on research and clinical demands.
   8. Manage contractual arrangements as applicable, overseeing program operating budget and providing reports as required.

B. *Staff Training and Supervision:*
   1. Supervise a multidisciplinary team; organize, manage, coordinate, and integrate staff activities.
   2. Solve day-to-day problems, including personnel issues, data collection, coverage issues, and logistics.
   3. Recruit, interview, and hire new staff and oversee completion of legal requirements. Provide orientation and supervise training of new team members. Approve time off requests assuring adequate staffing.

Education and Experience: Master's Degree in a related discipline and two years of experience; or an equivalent combination of education and experience; demonstrated knowledge of program evaluation and data collection; competency with MS Office; experience overseeing complex clinical research projects.

Skills and Abilities: High level of independence and decision making abilities; highly motivated in recruitment and retention; ability to work well with diverse personalities, varied cultural backgrounds, and clinical disciplines; excellent supervisory, organizational, and writing skills; ability to relate positively to patient populations that include individuals and families from multiple ethnic groups and ages; ability to communicate well interpersonally and orally. Clinical and reflective supervision skills and experience are a plus, as this role could potentially overlap with one of two MTB-HV Supervisor roles.

Program Assistant Sample Job Description

Position Description: Under the supervision of the MTB-HV Program Coordinator and in close collaboration with MTB National Office staff, serve as Program Assistant for *Minding the Baby*® Home Visiting (MTB-HV), a home-based nursing and mental health intervention for high-risk first time mothers and their babies. Provide a high level of programmatic assistance, as well as general clerical support. Assist with coordination of activities among the local clinical team, collaborating clinical site(s), MTB-HV model developer team, and collection of evaluative research data. Manage data collection and forms, enter data as needed, monitor quality and security of database(s) as requested, and submit data to Yale University via secure web-based data entry system.

Duties and Responsibilities:

1. Collaborate and communicate as needed with midwifery and pediatric clinicians where families obtain their primary care. If applicable, obtain consent and research authorization for study participation in order to collect data and interview subjects for research.
2. Collect, enter, and monitor program evaluation data; organize the storage and maintenance of secure data files; monitor quality and security of the database(s) as needed.
3. If applicable, pull demographic data (with form) from MTB-HV participant clinical files.
4. Upon request, assist with grant writing and editing, including proof-reading, copy-editing, compiling reference lists, etc.
5. Prepare/submit routine business forms or invoices related to the conduct of the program.
6. Assist with arranging and distributing agendas and minutes for team and collaborator meetings.
7. Assist with setting up and scheduling data collection sessions as needed, contacting parents, arranging for transportation, meeting with participants, etc.
8. Perform routine mailings (cards, reminders, birthday and holiday cards) to program participants.
9. Provide general administrative and clerical support as needed/requested.

Education and Experience:

1. Six years of related work experience, four of them in the same or similar field, and a high school level education; or four years of related work experience and an Associate degree; or 1-2 years of experience and a Bachelor degree in a related field; or an equivalent combination of experience and education.

Skills and Abilities:

1. High level of expertise with a variety of computer software, including MS Word, Excel, PowerPoint, and web-based data entry systems.
2. Excellent organizational and interpersonal skills.
3. Proven ability to encounter and handle highly confidential matters with discretion.
4. Demonstrated oral and written communication skills. Ability to interact with a variety of professionals and families.

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*® Home Visiting (MTB-HV), 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-HV involves an integrated model of care that bridges primary care and mental health approaches to enhancing the mother-infant relationship. MTB-HV clinicians receive training 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 University.

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*® Home Visiting (MTB-HV), 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-HV involves an integrated model of care that bridges primary care and mental health approaches to enhancing the mother-infant relationship. MTB-HV clinicians receive training 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 University.

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*® Home Visiting (MTB-HV) clinical team, consisting of mental health and nurse home visitors.

Duties and Responsibilities:

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

Education and Experience: Master's degree (or equivalent) or higher in social work or a related mental health field (LCSW or PhD in Psychology or similar field preferred; 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-HV supervisors must have the ability to:

- Develop and sustain the capacity to listen carefully
- Give positive before negative feedback
- Be organized, predictable, and reliable
- Use *reframing* rather than corrective comments about clinical approaches
- Consistently use tolerance, compassion, and self-reflection
- Stay gentle, calm, non-judgmental, aware, curious
- Be curious about how emotional reactions affect the ongoing work
- Resist the temptation to dwell upon the minute details of a case with a home visitor, except when necessary for safety or important clinical questions/decisions
- Experience and training in reflective supervision or working reflectively
- Understand the importance of collaborative discussions and working relationships with other supervisors and clinicians
- Maintain a sense of humor as appropriate
- Establish and maintain good relationships with other supervisors on team
- Highlight and integrate health issues (pregnancy, maternal, child) with parenting and other family, mental health, social, or situational crisis issues (health issues sometimes get buried by other crisis oriented work)
- Balance theoretical principles with the practical challenges clinicians face in real time
- Comfortably balance reflection, clinical problem solving, and administrative mandates
- Support and expand upon mental health discussions from health and/or developmental perspectives
- Help clinicians to make dynamic formulations and relate these to practice
- Guide clinicians with psychiatric diagnoses; when to recommend medication or psychiatric consultation
- Balance dynamic approaches with supportive approaches, crisis intervention, and case 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*® Home Visiting (MTB-HV) clinical team, consisting of mental health and nurse home visitors.

Duties and Responsibilities:

1. Provide ongoing reflective supervision for the MTB-HV 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 University.

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, pediatric 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:

- Develop and sustain the capacity to listen carefully
- Give positive before negative feedback
- Be organized, predictable, and reliable
- Use *reframing* rather than corrective comments about clinical approaches
- Consistently use tolerance, compassion, and self-reflection
- Stay gentle, calm, non-judgmental, aware, curious
- Be curious about how emotional reactions affect the ongoing work
- Resist the temptation to dwell upon the minute details of a case with a home visitor, except when necessary for safety or important clinical questions/decisions
- Experience and training in reflective supervision or working reflectively
- Understand the importance of collaborative discussions and working relationships with other supervisors and clinicians
- Maintain a sense of humor as appropriate
- Establish and maintain good relationships with other supervisors on team
- Highlight and integrate health issues (pregnancy, maternal, child) with parenting and other family, mental health, social, or situational crisis issues (health issues sometimes get buried by other crisis oriented work)
- Balance theoretical principles with the practical challenges clinicians face in real time
- Comfortably balance reflection, clinical problem solving, and administrative mandates
- Support and expand upon mental health discussions from health and/or developmental perspectives
- Maintain the balance between reflective parenting help and health related issues for mother, father, child, and other involved family members
- 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
    - Experience using a reflective stance with clinicians regarding organizing/pacing visits and difficult issues

APPENDIX II: MTB-HV CLINICAL STAFFING GUIDELINES

Successful MTB-HV 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 model. Consideration of potential clinicians' suitability for MTB-HV practice is quite important. This has become more evident with each passing year and each new implementation. MTB-HV 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-HV than others. The purpose of this document is to outline some of the characteristics of effective MTB-HV 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-HV clinicians to manage and be open to the complex processes that are central to the work. Since MTB-HV 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-HV clinicians have the ability to continue to be helpful and non-judgmental as they work through different crises with families.

General Considerations

While MTB-HV is evidence-based and intensive training is required for implementation, the intervention does not follow a strict curriculum. Rather, guided by the 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-HV model. One is a fit with formal training/education level (which is covered in the job descriptions and competencies in the MTB-HV 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-HV 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-HV 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-HV 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?

APPENDIX III: MTB-HV IMPLEMENTATION START-UP CHECKLIST

Prior to implementing MTB-HV, there are several tasks that should be completed. Refer to the MTB-HV Replication Planning Guide and Replication Planning Check List for initial steps and considerations prior to implementation. Once the decision to proceed with implementation has been made and the planning and hiring phases are complete, the following steps are to be taken. Visit the web portal for the most up-to-date version of this form, also printable in google docs (direct link: http://bit.ly/mtbstartupchecklist).

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

- ☐ Review MTB-HV Replication Operations Manual for Implementing Agencies and discuss replication requirements, general procedures, protocols, and forms with MTB NSO staff
- ☐ Finalize procedures and guidelines for intake, treatment, tracking, retention, discharge, staffing caseloads, and supervision
- ☐ Confirm supervision plan and determine schedule of meetings and calls
- ☐ Order equipment, materials, supplies, and gifts for families as needed
- ☐ Develop tracking system and process for completion and submission of paperwork, including consent forms and research measures, following HIPAA and IRB regulations to ensure confidentiality and secure storage of Protected Health Information (PHI) and research data (see Operations Manual for additional details and tips)
- ☐ Organize and print/copy clinical forms and research forms (see Operations Manual; individual pdf files are available by e-mail and many are available via the web portal); determine process for clinicians to obtain blank forms as needed and return/file completed forms in a secure/locked location following each visit, to be kept separately from data/completed forms
- ☐ Create orientation materials for families and prepare/copy approved consent forms
- ☐ Address logistical, administrative, and technology needs surrounding evaluation data collection, data entry, and data submission to the MTB NSO
- ☐ Address fundraising needs and sustainability efforts in an on-going manner/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
- ☐ Schedule and begin on-going weekly supervision and consultation calls with MTB NSO 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
- ☐ If applicable, begin collecting evaluation data and determine a plan for regular data submission to the MTB NSO (preferably regularly via Qualtrics, or at least twice per year if entered elsewhere)
- ☐ Schedule/conduct site visit by MTB NSO staff (typically 10-14 months after the first families are enrolled)
- ☐ Conduct fidelity checks at regular intervals and submit fidelity measures to the MTB National Office on an annual basis, or as requested
- ☐ Complete first annual replication site self-assessment; submit to MTB National Office via Qualtrics for review and feedback
- ☐ Prepare for 12-month mother-infant video interaction (if applicable) and determine a process for checking out and returning recording equipment if needed, as well as a protocol for the secure transfer and storage of the digital video file (which may contain PHI)

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

- ☐ Continue regular meetings, supervision/consultation calls, and distance learning sessions, as outlined above
- ☐ Continue data collection and regular submission of data as agreed; revisit and revise IRB/HIC materials/protocols as needed
- ☐ Conduct fidelity checks at regular intervals
- ☐ Complete additional annual replication site self assessment(s); submit to MTB NSO via Qualtrics for review and feedback
- ☐ Address fundraising needs and sustainability efforts in an on-going manner/as needed

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