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The Baby TALK model: An innovative approach to identifying high-risk children and families.

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Abstract

This research report examines the Baby TALK model, an innovative early childhood intervention approach used to identify, recruit, and serve young children who are at-risk for developmental delays, mental health needs, and/or school failure, and their families. The report begins with a description of the model. This description is followed by an analysis of participant and program data from the Baby TALK, Inc. demonstration program in Decatur, Illinois. The analysis concludes with a discussion of the relevance of the model for early intervention and school readiness, future directions for our research, and best practice implications for the early childhood field.

Overview

In the past several decades, growing research has focused on the importance of early intervention when risk factors are present in the lives of young children. In 2000, the Mental Health Foundations and Agencies Network outlined biological and environmental factors that predispose children to greater challenges in reaching developmental milestones (FAN Report, 2000). These risks include the following: (1) low birth weight and neurological delays; (2) difficult temperament and personality; (3) low level of maternal education; (4) immigrant status; (5) minority status; (6) low-socioeconomic status; (7) maltreatment; (8) insecure attachments; (9) and home, classroom and community settings. Early childhood professionals and policymakers alike have focused on early intervention (EI) models given these risks and the potential for negative developmental and educational outcomes. This focus is due to the belief that EI models ameliorate the risks that may negatively impact school readiness and overall child development.

While federal, state, and even local policies outline specific EI requirements, the components are relatively standard. EI involves a series of coordinated steps to identify a range of needs in young children. Once identification occurs through pediatricians, early childhood programs, and/or school systems, comprehensive assessments are administered. This is followed by referrals to services that will address whatever needs may be identified in the assessment process. The services can address physical, social-emotional, or informational needs and can be delivered either in the home or in school settings. Ultimately, the goal is early identification of needs in young children that may inhibit their ability to meet developmental milestones and undermine school readiness.

Both short- and long-term benefits have been associated with early childhood intervention. EI has been proven to positively influence early development and promote long-term prevention against risk factors that inhibit successful social-emotional, cognitive, and language developmental, and academic outcomes (Kirp, 2007; Olds, Sadler & Kitzman, 2007; Henry, Henderson, Ponder, Gordon, Mashburn, & Rickman, 2003). Participation in early childhood programs have also been linked to closing the academic gap between children of low-income and high-income families (Copple & Bredekamp, 2009;

Kirp, 2007; DHHS-ACF, 2005). Additionally, long-term social benefits can be gained for children accessing early childhood resources. As adults, at-risk children who have received some type of EI are at reduced risk of educational disability, unemployment, school drop-out, and even dependence on welfare assistance (Schweinhart, Barnes, & Weikart, 1993).

Like many states, Illinois has placed a great deal of emphasis on using research-based intervention models to target high-risk children who are at greater risk for developmental delays, mental health needs, and/or school failure. The efforts of the Illinois State Board of Education (ISBE) are illustrative. ISBE has implemented standards in early childhood settings serving the youngest populations and their families, with an emphasis on identifying those most in need of EI services (www.isbe.net, n.d.).

Currently, ISBE has recommended four models to be used in Prevention Initiative programs targeting at-risk children birth to three years in age: Baby TALK, Health Families America, Parents as Teachers, and the Prevention Initiative Center-based Model. Each model provides a unique approach to supporting young children through early childhood programming, increasing parent engagement, providing intensive intervention services to those who warrant that level of service, and providing training to early childhood professionals. The models are typically implemented by trained early childhood professionals and are administered in diverse settings such as the home, community, and in schools. Upon review of each model, we found that the Baby TALK model provided a unique intervention approach for identifying and

serving high-risk families. We found the approach to be innovative in its ability to support both the educational and non-educational needs of children and families. At the same time, the Baby TALK model had innovative strategies for identifying families who may be more difficult to locate for services. Given Baby TALK's unique features and our interests in documenting the effectiveness of early childhood service models, we decided to conduct an analysis of the Baby TALK model in practice.

Early identification is the critical first step for EI: To what extent is the Baby TALK model able to identify those young children and families most in need of both social and educational services early? In this report, we begin with a description of the model followed by an analysis of data on participants and programs within the Baby TALK demonstration program in Decatur. This report also includes an analysis of the first point of contact with mothers that lead to the enrollment in a variety of Baby TALK - affiliated intervention services. We conclude with a discussion of the relevance of the model for early intervention and school readiness, future directions for our research, and best practice implications for the early childhood field.

THE BABY TALK MODEL: AN OVERVIEW

Baby TALK, Inc. is a nationally-recognized organization known for its intervention model for supporting young children and their families. This model was developed in 1986 in Baby TALK's largest demonstration program in Decatur. The intervention model

employs a research-based intensive community-level approach to reaching families in need of early childhood services. Since 1986, this intervention model has been replicated in programs across 36 states and Canada. Baby TALK provides early childhood professionals from across the country with training, consultation, curriculum, and parent materials on its unique approach to working with high-risk families. As mentioned, ISBE has recommended the use of the Baby TALK model and related curriculum in early childhood settings because of its evidence-based approach to serving young children through the age of three years.

What is the model and how does it work?

The mission of Baby TALK is to positively impact child development and nurture healthy parent-child relationships during the critical early years. This mission is achieved through four components of the model:

(1) Building a staff of trained Baby TALK professionals to provide universal screening;

(2) Strategic placement of Baby TALK staff throughout the community;

(3) Creating a "trustworthy system of care" for participants; and

(4) Providing extensive early childhood curriculum to families through personal encounters.

Component 1: Building a staff of trained Baby TALK professionals to provide universal screening.

A fundamental goal of the Baby TALK model is to universally screen all families with young children within a community and provide interventions that will support the child and family unit. To reach this goal, a body of early childhood professionals is assembled and required to complete four days of training on the Baby TALK intervention model and related early development curriculum. The model suggests that professionals have a background in early childhood, social work, or nursing disciplines with a bachelor's degree. The model also suggests staff receive monthly reflective supervision with opportunities to meet with a program coordinator on a case-by-case basis. Once a staff is trained, these Baby TALK professionals are sent to critical locations in the community to screen families with young children who may be in need of services.

Component 2: Strategic placement of Baby TALK staff throughout the community.
The model's implementation format requires that trained Baby TALK professionals be a visible presence in the community. In the Baby TALK demonstration program, early childhood professionals are placed in prenatal clinics, hospital obstetric units, federally qualified health clinics and other public health clinics, at Women, Infant, and Child (WIC) programs, preschool programs, and in high school settings. Other programs using the Baby TALK model nationwide have placed trained professionals in libraries, community centers, and in religious institutions in addition to the locations used in the demonstration program.

The strategic placement of trained professionals is a unique feature of the Baby TALK model. Placing professionals throughout the community increases opportunities to encounter populations who may otherwise remain below the radar when it comes to social and educational services. This approach also enables the early identification of families. For example, professionals in prenatal clinics and hospital units can locate expectant mothers who may be in need of pre- and post-natal support services. Those supportive services can then be continued after new moms are discharged from the hospital. The idea is to place Baby TALK professionals in locations frequented by high-need families and help families make the first connection to early childhood services at those locations.

As such, the model focuses on "going where parents and children already are" and creating a "trustworthy system of care" starting from the first encounter (www.babytalk.org, n.d.). These two phrases are critical concepts of the model's approach. Baby TALK professionals build trusting relationships with families by being in the community, providing universal screening, and directing families to wrap-around services through a coordinated network of providers organized by the BT professionals.

Component 3: Creating a "trustworthy system of care" for participants.

Creating a coordinated network of support is an additional feature of the Baby TALK model. During the screening process and in identifying the locations frequented by families with young children, the Baby TALK

model helps early childhood professionals get a sense of the types of needs presented in their given community. Once needs are identified, Baby TALK provides guidance and tools to develop a "trustworthy system of care." To illustrate, the Decatur demonstration program serves high-risk families who are isolated and lack transportation. To address these specific barriers and get families access to needed early childhood services, the Decatur programs focuses on service delivery in the home and providing transportation to programming. This is one example of how programs using the Baby TALK model can adapt programs to meet specific client interests and circumstances.

At the same time, the goal of the trustworthy system of care is to coordinate information and resources throughout the community. The Baby TALK model makes it easier to achieve this goal because of the placement of Baby TALK professionals in community locations. In Decatur, professionals are placed at the Department of Health Services (DHS) office, WIC, New Life Pregnancy Center (an emergency support center for pregnant women), and Bright Start health services programs. Coordinating the resources at each of these social service offices is easier because Baby TALK staff is already at these locations, providing greater access and coordination of information for families.

Component 4: Providing extensive early childhood curriculum to families through personal encounters.

Lastly, the Baby TALK model provides an extensive curriculum on early development and age-appropriate strategies and
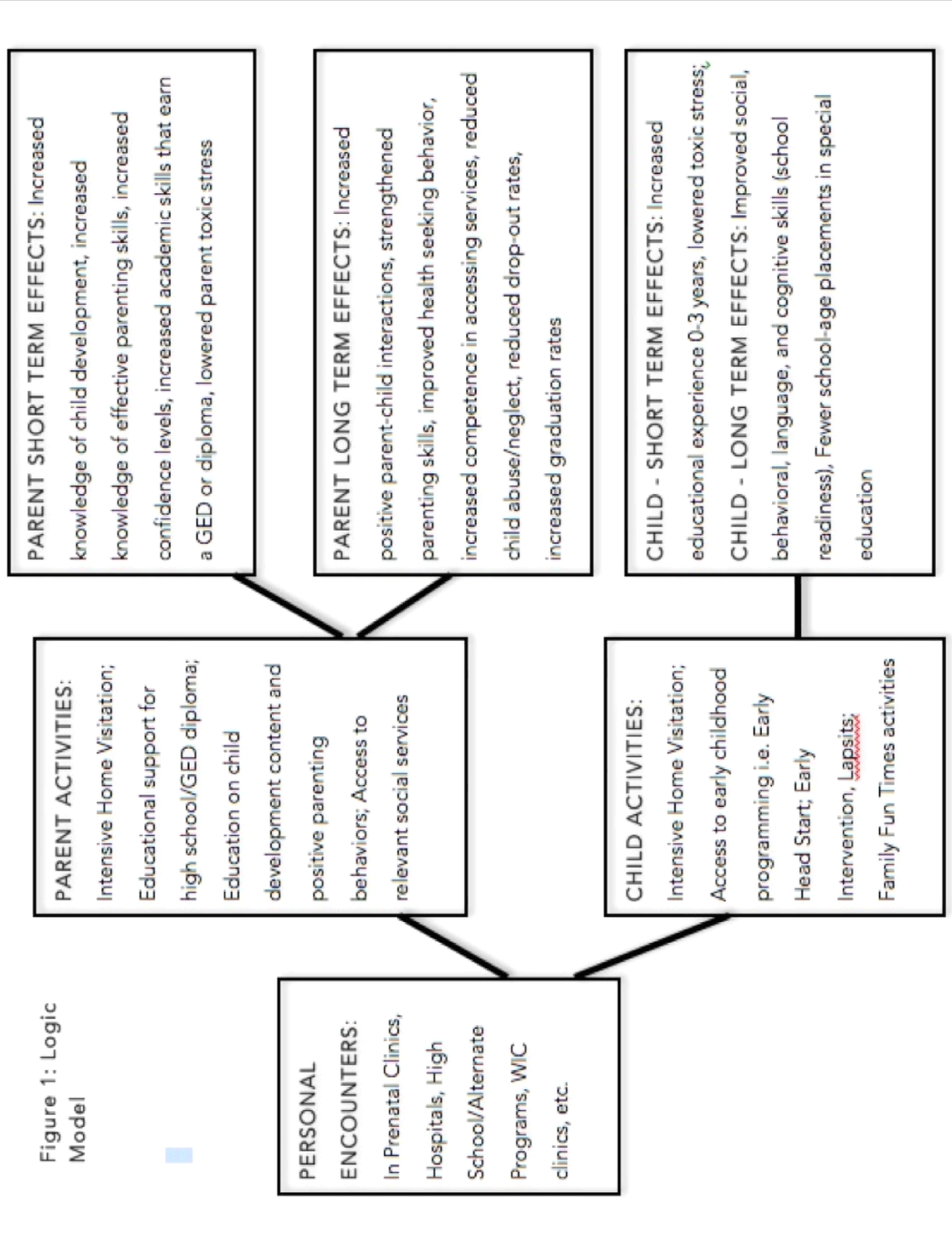
protocols for delivering interventions. The model also provides detailed guidelines to professionals who will share this information with families. To illustrate, the Baby TALK model provides professionals with protocols for home visitation and preschool programming to guide interactions with parents. In these settings, age-specific early child development curriculum is shared with the family. Baby TALK provides content that ranges from prenatal development (i.e. expectant mothers who are seven-nine months pregnant) through the school-age years (i.e. children age of five). The content provides information on typical developmental milestones and also methods to engage children and parents at each stage of development. When families present high levels of risk, protocols and curriculum can be tailored to provide the most detailed materials to parents. Similarly, protocols give professionals guidance on the level of support to be given to those families whose needs merit this level of service.

The Baby TALK Logic Model

The Baby TALK Logic Model (Figure 1) illustrates the flow of activity and the general timeline followed in the model. The model starts with identification and ends with anticipated child and parent outcomes. There are three stages in the Baby TALK intervention model. In Stage 1, the process begins with a "personal encounter" for screening and identification of families with young children. Again, this can happen in diverse settings throughout the community.

In Stage 2, screening takes place and the level of risk is assessed. Finally in Stage 3 and once screening is completed, appropriate intervention services are implemented based on the need of the child and family. These interventions take the form of parent- or child-focused activities, and appropriate social resources given to the family. Based on the activities, the model expects a variety of outcomes including short- and long-term outcomes for both parent and child.

Figure 1: Logic
Model

PERSONAL ENCOUNTERS: In Prenatal Clinics, Hospitals, High School/Alternate Programs, WIC clinics, etc.

PARENT ACTIVITIES: Intensive Home Visitation; Educational support for high school/GED diploma; Education on child development content and positive parenting behaviors; Access to relevant social services

CHILD ACTIVITIES: Intensive Home Visitation; Access to early childhood programming i.e. Early Head Start; Early Intervention, Lapsits; Family Fun Times activities

PARENT SHORT TERM EFFECTS: Increased knowledge of child development, increased knowledge of effective parenting skills, increased confidence levels, increased academic skills that earn a GED or diploma, lowered parent toxic stress

PARENT LONG TERM EFFECTS: Increased positive parent-child interactions, strengthened parenting skills, improved health seeking behavior, increased competence in accessing services, reduced child abuse/neglect, reduced drop-out rates, increased graduation rates

CHILD – SHORT TERM EFFECTS: Increased educational experience 0-3 years, lowered toxic stress;

CHILD – LONG TERM EFFECTS: Improved social, behavioral, language, and cognitive skills (school readiness), Fewer school-age placements in special education

Together, the approach to locating families with young children, the extensive protocols to guide encounters with families, and the subsequent coordination of services, sets the Baby TALK intervention model apart from other models used in the field. Most importantly, the model's approach to identifying at-risk families allow early childhood professional to identify high-risk participants *early* and implement supportive or intervention services *as soon as possible*. Analysis of the current data on participants using the Baby TALK model in Decatur illustrates this point. Our analysis shows that the model does identify a high-risk populations early in a child's life.

METHODS

Baby TALK maintains an extensive database for its demonstration program in Decatur. Indeed, the database houses records of over 20,000 Baby TALK participants. The data includes information on children, mothers, fathers, grandparents, and legal guardians, and spans from 2006 to the present. Records contain information about parent and child participants including levels of parent education, socioeconomic status, number of children in the family, racial/ethnic background, and attendance records in the various demonstration site programs. Cross-comparisons were made with other sources collecting similar demographic data at the local, state, and federal level. The purpose of analyzing the database was to obtain a descriptive picture of the population served in the demonstration program, and to compare the level of risk among Baby TALK participants with the wider community.

State and federal criteria for risk include, but are not limited to, income level, education level, marital status, and employment status. The same criteria was used to analyze the risk characteristics of Baby TALK participants using mother-specific data only. Three other sources were then compared to the mother-specific Baby TALK data:

(1) Illinois Early Childhood Asset Map (IECAM)[1] reflecting data for all Macon County, including Decatur;

(2) The U.S. Census Bureau reflecting data for Illinois and all county-specific data; and

(3) Head Start Family and Child Experiences Survey (FACES) 2003 database[1] reflecting data from a sample of Head Start programs, the nation's largest federally funded early intervention program for low-income children.

Sample sizes vary for each dataset and were noted in each table. To illustrate, the Baby TALK sample reflects responses from participants in the Decatur demonstration program. Macon County samples reflect information on all members living in the county (Table 3). Additionally, the Head Start data reflect a representative sample of all federally-funded Head Start programs across the country.

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[1] *All future references to county-level trends reflect data from the IECAM or the U.S. Census Bureau.*
[1] *All future references to* Head Start *reflects data from the FACES 2003 database.*

RESULTS

I. Risk Characteristics of Participants: Data Comparisons using Program-level, County, and National-level Datasets, 2003-2010

Maternal Education: Baby TALK vs. Head Start.

Table 1 illustrates a comparison between levels of education among Baby TALK participants and federal Head Start programs. While Baby TALK has a higher rate of participants with a Bachelor's degree or above compared to the federal trends (16.3% versus 3.7%), the data also shows 55.3% of Baby TALK mothers had a high school/GED diploma or less. Additionally, the Baby TALK model was able to identify a large percentage of mothers with less than a high school diploma (19.1%). These mothers were not attending high school programs and were identified in prenatal clinics, hospital units, or WIC offices. Without the community-based nature of the model, these young moms would have been difficult to identify for services.

Maternal Employment Status: Baby TALK vs. Head Start.

Table 2 compares the employment rates of Baby TALK participants (mothers only) and the average employment rates of participants recorded in the Head Start data. Baby TALK participants showed slightly lower rates for both employment and unemployment versus Head Start participants.

For unemployment/employment rates, Baby TALK participants ranked 50.8% and 42.2% respectively. This is in contrast to Head Start participants who showed 47.3% unemployment versus 52.8% employment among participants.

Marital Status: Baby TALK vs. Macon County vs. Head Start.

Table 3 illustrates a comparison of marital status among Baby TALK participants, Macon County residents (county-level data), and Head Start participants. The most striking numbers are reflected in those who identified as "single/never married." A resounding 53.1% of Baby TALK participants identified as single in comparison to 22.8% in all of Macon County and 40.9% reporting in Head Start. In this instance, data from Baby TALK matches more closely with national trends on low-income families than with local/state trends with the Decatur program serving a disproportionate concentration of single moms in Macon County.

Income Level: Baby TALK vs. Head Start.

Table 4 provides an illustration of varying income levels across Baby TALK participants and Head Start participants. Due to the sensitivity of this question, there was a great deal of data missing for Baby TALK participants, making it difficult to obtain an accurate picture of incomes levels for participants. To account for some of the missing data, we looked at specific programs that are open only to low-income participants (i.e. income below $20,000). This criterion was used to help supplement missing income data elsewhere in the database. Accounting for this adjustment, our analysis was still able to draw some

conclusions in the area of income. Parallel to Head Start trends, a high percentage (34.1%) of Baby TALK participants live on less than $10,000 in annual income. Baby TALK participants in other income categories remained behind Head Start income rates.

Interestingly, the Baby TALK findings suggest the program is serving a wide range of participants with varying degree of needs. 24.1% of Baby TALK participants made $50,000 or more annually compared to 2.6% of Head Start participants making that same amount. These findings add credibility to the Baby TALK model's universal screening approach and its ability to identify all families, regardless of income status, who could benefit and do access early intervention services and early childhood programming.

II. Early identification using the Baby TALK model

The Baby TALK model is said to "go where parents and children already are" (www.babytalk.org, n.d.). Our analysis also looked at the location where mothers were first identified, giving them entrance into the Baby TALK model's Trustworthy System of Care. The top three Decatur locations were: (1) Hospital settings; (2) A local social service settings for low-income mothers; and (3) A community health clinic.

An astonishing 56% of mothers (2,419 mothers) were identified at Decatur Memorial Hospital and St. Mary's hospital combined. 22% (937 mothers) were located at the Women, Infant, and Children (WIC) social service office and an additional 10%

(424 mothers) were identified at the Community Health Improvement Center (CHIC) office. Other locations included public libraries, the program office, and in early childhood programs throughout the community.

III. Early identification of young mothers

Young mothers under the age of 20 years were first encountered in the following top five Decatur locations: (1) Hospital settings; (2) A local WIC social service office; (3) A community health clinic; (4) High school and alternative high school programs; and (5) Local public libraries. 29% (168 young moms) were identified at Decatur Memorial Hospital and St. Mary's hospital combined; 30% (170 young moms) were identified at the WIC office; an additional 13% (76 young mom) were identified at the CHIC office; 11% (65 young moms) were identified at local high schools and alternative high schools, and 7% (40 young moms) were identified in public libraries. These numbers show that early identification in hospital settings and local health clinics is critical but more importantly, young moms are also identified in local community settings such as schools, the library and WIC offices. This is a valuable characteristic of the model, which identifies and creates a safety net for families throughout the community.

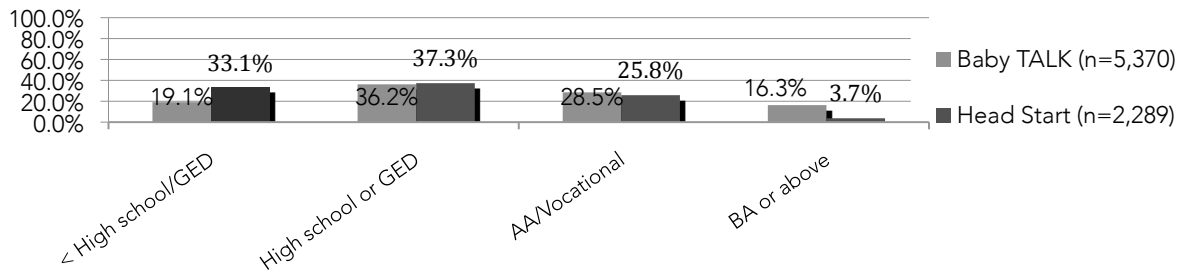## Table 1: Education Level of Mother

Baby TALK (n=5,370)
Head Start (n=2,289)

	< High school/GED	High school or GED	AA/Vocational	BA or above
Baby TALK	19.1%	36.2%	28.5%	16.3%
Head Start	33.1%	37.3%	25.8%	3.7%

Table 2: Employment Status of Mother
*(*Remaining percentages reported "other;" or "self- employed or student")*

Baby TALK (n=4,903)
Head Start (n=2,165)

	Employed	Unemployed
Baby TALK	50.8%	42.2%
Head Start	52.8%	47.3%

Table 3: Marital Status
*(*Remaining percentages reported divorced, separated, or widowed)*

Baby TALK (n=5,100)
Macon County (n=82,167)
Head Start (n=2,297)

	Married	Single	*Other
Baby TALK	42.4%	53.1%	4.5%
Macon County	59.9%	22.8%	17.2%
Head Start	40.6%	40.9%	18.5%

Table 4: Income Level of Mother

Baby TALK (n=2,960)
Head Start (n=2,315)

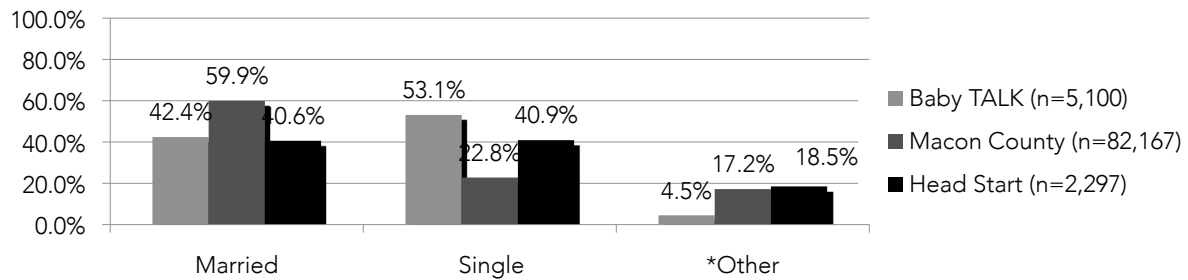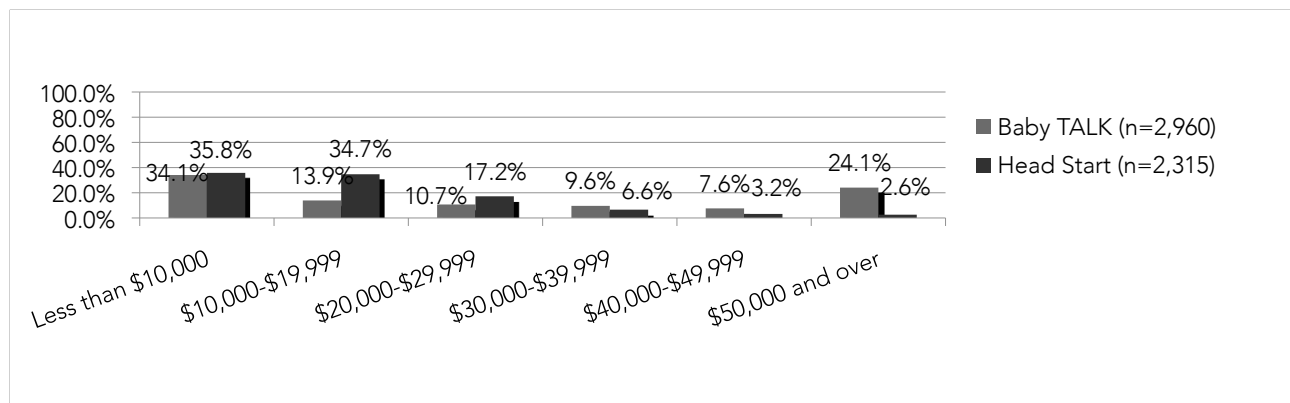|	Less than $10,000	$10,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000 and over
Baby TALK	34.1%	13.9%	10.7%	9.6%	7.6%	24.1%
Head Start	35.8%	34.7%	17.2%	6.6%	3.2%	2.6%

DESCRIPTIVE ANALYSIS

I. The Baby TALK model identifies a high-risk population

In this report, we analyzed several of the risk indicators for children noted in the FAN report (2000) – low level of maternal education, low socioeconomic status, single marital status, and unemployment. Research suggests these indicators can predispose children to greater challenges in reaching developmental milestones. Using this risk criteria, our analysis showed a population of high-risk participants being identified using the Baby TALK model. A substantial percentage of mothers identified were single (53.1%), unemployed (42.2%), making less than $10,000 annually (34.1%), and had a high school diploma or less (55.3%). The Baby TALK model was also able to identify young mothers below age 20. Our analysis shows 233 (5.8%) of participating mothers fell in this category. Overall, the characteristics of Baby TALK participants seemed to align with the characteristics of high risk families that were seen in county and federal data.

II. The Baby TALK model identifies participants in critical locations early

The Baby TALK model is able to identify mothers very early in a child's life. Based on the analysis, 56% of critical first encounters with moms in Decatur were in a prenatal or hospital setting either prior to or at the time of the child's birth, while 29% of encounters with adolescent mothers were in the same hospital locations. Fewer teenage mothers were identified in hospital settings. This, we mothers in the community before

believe, may be a result of identifying delivery. Given this early identification, the model was able to screen for risk from the start of a child's life and provide the necessary interventions soon thereafter. Early identification and intervention is critical when the goal is to lessen the potential harmful effects related to biological and environmental risk (FAN, 2000; Olds et al., 2007; Henry et al., 2003), and these steps are embedded in the infrastructure of the BT model.

SUMMARY

Why is the Baby TALK model relevant in early childhood populations?

Each child is not born with a ticket for success in life. Some children are born with biological deficits that predispose them to physical, social-emotional, or cognitive challenges as they mature. Others are born into harsh social environments that may also increase the likelihood of physical, social-emotional, and cognitive challenges. There is a constellation of variables that can positively and negatively impact a child's ability to reach developmental milestones, with implications for school readiness. Thus, the early years are considered critical and early intervention has been a tried and tested strategy for supporting overall development. As Meisel & Shonkoff (2000) state: it is not an issue of whether or not early childhood intervention is important, but the need to determine "how to capitalize on current knowledge and mobilize our collective resources to ensure better health and development outcomes" (p.26).

With this need to support better

health and developmental outcomes, we believe it is essential to analyze current intervention models for serving young children and families. Our analysis of the Baby TALK model, and the characteristics of clients served by the model, illustrates the value in this type of investigation. This report has focused on the critical first step of any intervention: early identification. The Baby TALK model is able to identify, recruit, and refer at-risk families to early childhood services early in a child's life. This report examines a framework for creating a network of support through the community as well. When time is of the essence, the Baby TALK model provides a good strategy for identifying needs quickly and getting resources efficiently to families who need it most. Based on our analysis, we believe the model was effective in identifying vulnerable populations.

Final Thoughts

The utility of the Baby TALK model is in its design. The training, the placement of early childhood professionals in the community, the collaboration with providers in the community, and the age-appropriate curriculum were developed in a manner emphasizing the importance of context and flexibility. Baby TALK professionals provide training materials and technical assistance to those interested in using the model to their respective early childhood settings with these two priorities in mind.

Context matters when tailoring an EI model to fit the needs of a specific population and thus, no two Baby TALK programs are ever identical. Early childhood professionals are provided intensive training and materials that allow them to adapt the

challenges and opportunities unique to each community. For example, a community with a high population of teen mothers could concentrate efforts by placing representatives in high schools and prenatal clinics. Once identified, the Baby TALK curriculum can focus on teen parenting and intensive home visits pre- and post-delivery to support young mothers. Regardless of topic of interest, all Baby TALK trained professionals are given access to an entire range of topics and resources to help adapt the program to each community's respective needs and concerns.

Flexibility in the model is also important and the Baby TALK model allows for adaptation to meet the contextual needs of any program/community. The model provides a structure and guidelines for identifying families and universal screenings but the program can tailor what materials will be shared and how materials will be delivered to parents and their children. The age-appropriate curriculum provides guidelines for engaging parents in their child's development. As much or as little of the suggested activities can be used at the discretion of the Baby TALK trained professional. Delivery methods can also be adapted. Work with families can be in the high school setting, in prenatal clinics, or in the home; the specific program decides the delivery method most appropriate for that given community and need.

When professionals and programs consider adopting new models of intervention, feasibility typically boils down to cost and the effort necessary to implement a new model, as some models require the maintenance of a license to use the model and payment of yearly

maintenance fees. Communities and early childhood programs interested have options if they are interested in the specific components of the Baby TALK model or implementing the entire model itself. According to Baby TALK's demonstration program, programs/individuals must participate in training. After training is completed, those individuals are granted access to Baby TALK materials and all the resources for those trained on the models which can be adapted to their given program without maintaining yearly licenses or fees. Trained Baby TALK professionals are encouraged to attend professional development sessions and seek technical assistance through the Baby TALK program, but the maintenance fees and training have not been seen as prohibiting programs from using the model. For these reasons, we believe strategies used in the Baby TALK approach can be adapted to other early intervention models currently used in the field without being cost prohibitive.

Given the promise and innovation that was evident in our research, we firmly believe the Baby TALK model is worth consideration in other early childhood settings and communities. Further research will help determine the educational and social benefits of the model, helping to further inform interested users in the field. For now, our analysis confirms the Baby TALK model is indeed able to identify a broad range of families with young children who are in need of EI and supportive services, high-risk families in particular. The model is an Illinois State Board of Education (ISBE)-approved model for working with children birth-to-three years in age in age in Illinois. And the model can be adapted to

early childhood programs by attending Baby TALK training sessions and receiving technical assistance through the demonstration program. Therefore, in a time of fiscal constraints and pressures for early identification, the Baby TALK model provides viable strategies for finding families and serving populations who need services most.

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The Baby TALK Research Collaboration

In January 2010, the Baby TALK Research Collaboration was established to support the organization's mission – to positively impact child development and nurture healthy parent-child relationships during the critical early years – through applied research. The Research Collaboration houses a broad range of evidence-based materials relevant to the Baby TALK model. Research efforts focus on the implementation of the Baby TALK model in various communities, the participants identified and recruited using the model, and specific programs that serve high-risk families with young children. The Collaboration also houses research on child and family outcomes tied to the Baby TALK model, and serves as an informational hub for those interested in relational models for serving vulnerable families.

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