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CHANGES IN HOME VISITING SINCE THE START OF THE PANDEMIC

Lessons from the Child First Program

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At the start of the COVID-19 pandemic, home visiting programs were faced with an unprecedented challenge: How do you deliver home visiting services without visiting homes? One home visiting model — Child First — quickly pivoted to telehealth, offering caregivers the option to receive services virtually. Child First has since resumed delivering services primarily in person, but some pandemic-driven implementation changes remain. To understand the impact of the pandemic on the Child First model, the study team conducted surveys and interviews with Child First staff members, and interviews with caregivers who received Child First services, to answer the following research questions:

- To what extent did the implementation of Child First services change since the start of the pandemic?
- How did Child First staff members report implementing core components of the model since the pandemic began?
- How did Child First caregivers report on Child First services that they received since the pandemic began?

For these questions, the study team focused on three time periods: **before the pandemic began** (prior to March 2020), **early in the pandemic period** (March 2020 through June 2021), and Child First's **return to in-person services** (summer 2022, which is when many Child First sites were conducting at least 75 percent of visits in person, through April 2023,

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which was the end of data collection for this study). Overall, the study team found that the implementation of the Child First model following the first three years of the pandemic remains largely consistent with pre-pandemic implementation, despite the unique challenges to home visiting posed by the pandemic. For instance, the number of referrals that Child First programs received decreased early in the pandemic, but those numbers returned to pre-pandemic levels once Child First returned to delivering services primarily in person.[1] Interestingly, telehealth is more prominent now than it was before the pandemic began, and professional development and communications with referral providers have also remained largely virtual. These data are being used to inform the broader home visiting field about how and whether Child First was implemented with fidelity and how the model was adapted during the pandemic.[2] Additionally, these data can aid researchers and Child First staff members in understanding and interpreting the impacts of Child First, which are being estimated in a broader randomized controlled trial (RCT) of the program.[3]

Background

The Child First Model

Child First is an evidence-based program that provides in-home therapeutic interventions paired with care coordination services to caregivers of children younger than 6 years old. The model supports families that are facing acute and significant challenges, such as maternal depression, poverty, and child behavioral issues. What makes Child First unique is its team approach — families are served by a clinician who provides therapeutic supports to the caregiver-child dyad (for example, through child-parent psychotherapy), as well as a care coordinator who connects caregivers to needed resources in the community and supports caregiver and child executive functioning through the use of interactive games and reading, in addition to helping caregivers engage in language-rich conversations with their child.[4] Through this approach, Child First aims to stabilize families and improve the health and well-being of caregivers and children and ultimately strengthen the caregiver-child relationship.

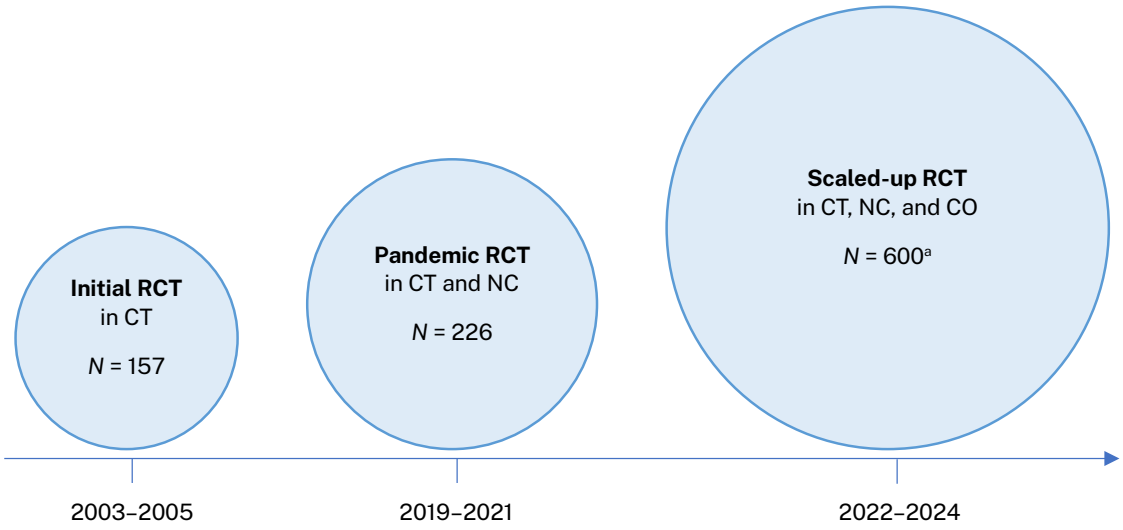
An **initial RCT** of Child First that began in 2003 found that the program improved children's social-emotional skills and language development, improved mothers' mental health, reduced families' involvement with child protective services, and increased families' connections to services and support.[5] However, this study had a limited sample size and was conducted at only one site in Connecticut. To test the contemporary impacts of the program when implemented at scale, MDRC began conducting a second RCT of Child First in 2019. The study team aimed to enroll 600 caregiver-child dyads across multiple states and agencies. The study team enrolled 226 families between June 2019 and March 2020, but subsequently put the study on hold at the start of the pandemic.

Starting in March 2020, Child First adapted its model, shifting from providing most services in person, in families' homes to offering a hybrid mix of in-person and telehealth services. MDRC also shifted the research plan for the RCT to study the impacts of this hybrid version of Child First, using enrollment and outcome data collected between 2019 and 2021. This **pandemic RCT** found positive impacts for a small subset of outcomes: Child First reduced caregivers' job losses,

residential mobility, and self-reported substance abuse. Additionally, the program increased caregivers' receipt of virtual services during the pandemic.[6]

The Child First model has since returned to providing in-person services as its primary approach. In 2022, MDRC restarted its efforts to understand Child First's impacts through a **scaled-up RCT**. By scaling up, the study team can examine the long-term and subgroup impacts of Child First. (See Figure 1 for an overview of the different RCTs.)

Figure 1. Child First Studies and Caregiver Samples



NOTES: CO = Colorado, CT = Connecticut, NC = North Carolina.
RCT = Randomized controlled trial. A randomized controlled trial is a study design in which individuals or groups who are eligible for a program are randomly selected to enter either a treatment group or a control group.
[a]Represents target enrollment.

Overview of the Child First Implementation Study

The Child First Implementation Study, conduct ed by MDRC with funding from The Duke Endowment, aims to understand how the Child First program pivoted following the onset of the COVID-19 pandemic and to assess the extent to which services offered since the start of the pandemic differ from the pre-pandemic model. Understanding Child First's implementation since the start of the pandemic is critical for interpreting findings from the scaled-up RCT. Additionally, the field of home visiting could benefit from more robust data examining how programs have evolved following the necessary and significant adaptations made during the pandemic.

Sample and Methodology

The study team conducted surveys and interviews with Child First staff members, and interviews with caregivers that participated in Child First. The team collected these data in reference to three distinct time periods:

- **Before the pandemic began:** prior to March 2020.

- **Early pandemic period:** March 2020 through June 2021. This includes the start of the pandemic and the months leading up to when vaccines became widely available to the public.[7]

- **Return to in-person services:** summer 2022 through April 2023. By summer 2022, many sites were conducting at least 75 percent of visits in person. Data were collected through April 2023.[8]

Child First Staff Members

For this study, the research team recruited Child First staff members from the sites enrolled in the scaled-up RCT. (See Table 1 for a description of the participating sites.) Three types of staff members participated in the survey:

- **Care coordinators** aim to connect families to services, enhance caregiver and child executive functioning, support caregivers in implementing language-rich interactions with their children, and support parental guidance. Each care coordinator is paired with a clinician to form a Child First home visiting team.

- **Clinicians** are mental health professionals who provide trauma-informed therapeutic interventions to strengthen the caregiver-child relationship. Each clinician is paired with a care coordinator to form a Child First home visiting team.

- **Supervisors** provide administrative and reflective supervision to Child First clinicians and care coordinators.[9]

Staff Member Surveys

Sixty-four Child First staff members participated in an online survey to describe their experiences delivering Child First services before the pandemic, early in the pandemic, and following the return to in-person services. The study team administered the surveys in September 2022 during an in-person training session for the ongoing, scaled-up RCT. All attendees agreed to participate. Although the sample does not reflect the full breadth of Child First sites, staff members included in the survey effort represent the perspectives of staff members across different states and roles, and with varying lengths of employment, as shown in Table 1.[10]

Staff Member Qualitative Interviews

The study team recruited nine Child First staff members across different roles and states to participate in individual, in-depth, semi-structured interviews between March and April 2023. The goal of the interviews was to better understand staff members' experiences delivering the Child First model before the pandemic began, early in the pandemic, and following the return to in-person services. The study team sent an email invitation to seven supervisors, inviting them and their staff members to participate. Three supervisors, five clinicians, and four care coordinators expressed interest. The study team selected all interested supervisors. The team then selected three care coordinators and three clinicians on a first-come, first-served basis. Participants joined a one-hour semi-structured interview via Zoom. See Table 1 for staff members' characteristics.

Table 1. Characteristics of Staff Member Survey and Interview Samples

Characteristics	Survey Sample (N)	Interview Sample (N)
Agency location		
Colorado	10	2
Connecticut	28	5
North Carolina	26	2
Role		
Care coordinator	26	3
Clinician	27	3
Supervisor	11	3
Years of experience in home visiting[a]		
Mean	5.35	6.63
Standard deviation	5.72	6.86
Years of experience at Child First[a]		
Mean	2.78	4.26
Standard deviation	2.92	3.86
Highest educational attainment[a]		
Bachelor's degree	21	2
Master's degree	40	5
Doctorate	3	1
Woman[a]	57	8
Race/Ethnicity[a]		
Hispanic	18	1
Non-Hispanic, Black	10	1
Non-Hispanic, White	30	6
Non-Hispanic, other/multiracial	4	0
Sample size	64	9

SOURCE: Data from staff member surveys.

NOTE: [a]Respondents did not always answer all survey questions. Therefore, the sum of all responses to a given question may not equal the sample size.

Child First Caregivers

The study team recruited three groups of caregivers from two RCT samples. From the pandemic RCT, the study team created two groups of caregivers:

- **Pre-pandemic participants**. This group of caregivers enrolled in the study on or before November 2019 and received Child First services for about nine months on average. These caregivers had at least a few months of in-person services before the pandemic began, and received some

in-person, telehealth, or hybrid services during the height of the pandemic in spring and summer 2020.

- **Early pandemic participants**. This group of caregivers began Child First services in February 2020, one month before the pandemic began. These caregivers received services for an average of 10.5 months; thus the bulk of their time with Child First was during the early part of the pandemic.

From the scaled-up RCT, the study team created one group of caregivers:

- **Return to in-person service (or "RI") participants**. This group began Child First services after October 2022, several months after most Child First agencies had returned to delivering services primarily in person. As of the start of the interviews, participants had received services for an average of 3.5 months.

Caregiver Interviews

To reflect the caregiver experience, between February and April 2023 the study team interviewed nine caregivers to learn more about their experiences receiving Child First services. (See Table 2 for caregivers' characteristics.) The study team invited 153 caregivers to participate over email and by telephone. Twenty caregivers expressed interest and the study team selected nine to join one-hour, semi-structured, individual interviews via Zoom videoconference.

The study team asked caregivers to describe their experiences receiving Child First services. Given when pre-pandemic and early pandemic participants began Child First services, some caregivers reported on both their pre-pandemic and early pandemic experiences. The study team coded these responses accordingly. RI caregivers reported on their experiences with Child First since the program's return to in-person services — all starting after October 2022. One caregiver received services at two time points: before the pandemic began and following the return to in-person services. The team asked this caregiver to report on her experiences during these two separate time periods.

Implementation of Child First Since the Start of the Pandemic

About the Model

Child First provides a combination of therapy and care coordination services to caregivers with young children. Services are primarily provided in the home, but caregivers also have the option to meet in an office or in a community space if they prefer or if the staff members deem it necessary to successfully conduct the visit. Outside agencies and organizations send referrals to Child First for families that may be eligible for Child First services. After vetting the referrals, Child First supervisors assign each family to a Child First team made up of a clinician and a care coordinator.

Child First services are provided in three phases: an assessment phase, a treatment phase, and a termination phase. (See Box 1 for more information on the assessment and treatment phases.)

Table 2. Caregiver Interview Sample Characteristics

Characteristics	Interview Sample (N)
Receipt of Child First services	
Pre-pandemic	2
Early pandemic	3
Return to in-person	3
Pre-pandemic and return to in-person[a]	1
State in which caregivers received services	
Colorado	2
Connecticut	5
North Carolina	2
Caregiver	
Mean age in years	35.81
Race/ethnicity	
Hispanic	3
Non-Hispanic, White	4
Non-Hispanic, Black	2
Non-Hispanic, other/multiracial	0
Marital status	
Married or living with partner	2
Divorced or separated	3
Single, never married	4
Widowed	0
Work status	
Unemployed	5
Part-time employment	3
Full-time employment	1
Highest level of education attained	
Less than high school degree	2
High school degree or GED	2
Some college	3
Bachelor's degree or higher	2
Number of caregivers	9

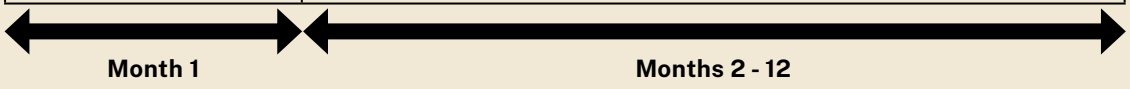
SOURCE: Baseline survey data from initial and scaled-up randomized controlled trials.

NOTE: [a]One family participated in Child First before the pandemic and following the return to in-person services. This caregiver was asked about both experiences.

Box 1. The Child First Model

Child First work is done primarily in the home, but caregivers also have the option to meet with teams in an office or in a community space if they prefer. Child First staff members may also opt to meet outside of the home if it is necessary to maintain the integrity of the therapeutic space for the family. Families receive Child First services for a period of nine months to one year, though caregivers may be discharged sooner or later than that depending on when they complete their treatment plan. The first two phases of Child First services are provided as follows:

Assessment Phase	**Treatment Phase**
The clinician and care coordinator team meet with families for one hour, twice a week, to complete caregiver and child assessments, observe the caregiver-child relationship, and develop a treatment plan for families based on their needs and goals.	The Child First team meets with families weekly for one hour. The clinician will engage in play therapy with the caregiver and child according to the treatment plan. Specific activities vary according to each family's needs, but a clinician might focus on, for instance, addressing a caregiver's trauma or helping a caregiver understand and react to a child's emotions. At the same time, the care coordinator supports caregivers by connecting them to services and providing them with resources. Such services could include helping caregivers complete job applications or sign up for utility assistance programs, among other things. They also work to enhance caregiver and child executive functioning and language-rich interactions between the caregiver and child.



During the assessment phase, the Child First team meets with families to assess the caregiver and child across different areas (for example, caregiver depressive symptoms and child behavioral problems). This information is used to build the treatment plan. During the treatment phase, the Child First team and family work on following the treatment plan. This involves a mix of play therapy with the caregiver-child dyad and clinician, and care coordination services with the caregiver and care coordinator. Some visits may involve both play therapy and care coordination, and some visits may only involve one activity, depending on each family's need. Families work with their Child First team to determine the ideal discharge process and timing during the termination phase.

When the pandemic began, Child First shifted to a hybrid in-person and telehealth model to continue providing services amid pandemic restrictions. Despite this change, the core components of the model remained largely the same as the pre-pandemic model: survey data show that the frequency and length of sessions were still about the same, and staff members reported taking similar approaches to their clinical work and care coordination as before the pandemic. However, the interviews and surveys also highlighted several notable differences in service provision and receipt since the pandemic had begun. During interviews, supervisors indicated changes in the number of families referred to their program. Survey data also showed that although several Child First agencies had returned to providing in-person services for most of their visits by the summer of 2022, agencies continued to provide virtual services for families and virtual professional development for staff members — the most noticeable changes since the start of the pandemic.

Referrals and Caseloads

Before the Pandemic Began

Child First sites typically receive referrals for families from a variety of organizations, such as child welfare agencies, health care providers, and childcare providers. Of the supervisors who worked at Child First before the pandemic began, all of them listed child welfare agencies as their top referral source. (See Table 3.) Across all types of referrals, supervisors reported on the survey that they received an average of 10.5 referrals per site for families per month before the pandemic began. These referrals are used to fill teams' caseloads, or the number of spots they have available to serve families. Typically, Child First teams provide services to between 12 and 15 families, though this can vary depending on circumstances. Teams may sometimes have a smaller caseload if, for instance, they are new or if they have other duties they are working on, such as volunteer work during the holidays, as noted by two Child First staff members. By giving teams a smaller caseload, supervisors avoid overwhelming their staff members.

Early Pandemic Period

Child welfare agencies remained a top referral source early in the pandemic, but referrals from other organizations decreased, such as those from schools and health care providers for adults. Given school closures and the decrease in outpatient visits during this time, it makes sense that Child First would see fewer referrals from these providers.[11] It might also explain why self-referrals increased, since there may have been reduced accessibility and engagement with public sector organizations during the pandemic lockdown.[12] Additionally, supervisors noted that referrals decreased to an average of 8.4 referrals a month during this time. With fewer referrals, teams also had smaller caseloads — 10 families on average across staff members, according to the survey.

Return to In-Person Services

While child welfare agencies are still top sources of referrals, supervisors report that they currently receive more referrals from child health care providers than they had before the pandemic. Additionally, the number of referrals each month has returned to roughly pre-pandemic levels. According to supervisors' survey responses, there have been 11.1 referrals per month since the return to in-person services, compared with 10.5 referrals per month before the pandemic.

However, interviews with supervisors showed variation in whether referrals increased or decreased for each Child First site. One supervisor shared that referrals to her program increased. She explained that this may be because families are experiencing more challenges since the pandemic and have increased needs related to financial insecurity, food insecurity, and housing, for instance. Thus, families need more support now than before the pandemic. However, the two other supervisors reported a decrease in referrals. One supervisor attributed it to staff member turnover: Child First staff members who previously had relationships with referral partners are no longer at the agency, breaking the link between Child First and the referral partner. The supervisor recalled,

> Internally, we've had a lot of turnover. And so, some of the supervisors that had relationships with community partners don't work for [our site] anymore. And I think that has a lot to do with [the decrease in referrals].

Table 3. Top Referral Sources Before the Pandemic Began, Early in the Pandemic, and After the Return to In-Person Services

Top Referral Sources (%)	Before the Pandemic	Early Pandemic	Return to In-Person Services
Child welfare/child protective agencies	100	100	90
Self-referrals (e.g., directly from the caregiver)	25	60	27
Health care provider for children	25	40	63
Health care provider for adults (e.g., clinics and hospitals)	25	0	0
Mental or behavioral health care provider for children	50	60	45
Mental health care provider for adults	0	0	0
Schools	25	0	27
Childcare centers and providers	25	20	27
Early intervention	25	20	0
Other services that your own agency provides	0	0	9
Other	0	0	9
Number of supervisors	4	5	11

SOURCE: Data from the staff member implementation survey.

NOTE: An item was selected if supervisors indicated that the referral source was one of their top three referral sources.

The third supervisor noted that the wide adoption of remote work has further complicated referrals. Before the pandemic began, local community organizations used to get together to network in person. But these events are now held virtually, limiting the supervisor's ability to build rapport with potential referral partners (despite supervisors spending slightly more time building referral sources since the return to in-person services than they did before the pandemic began, according to their survey responses). The supervisor reported,

> So, we have… [an event] … in our county that joins a lot of like-minded providers together. So that was a place where we were able to come together in person and we were doing activities or listening to presentations together. But then before and after the meetings, of course, we're chatting with each other, passing business cards around. Now, that's on Zoom. And we just don't have the ability to have that same sort of connection.

The story around caseloads is also mixed. Half of the care coordinators and clinicians indicated during the interviews that their caseloads are roughly the same as before the pandemic began or at typical levels for their agency. However, survey data show that staff members reported having a smaller caseload since the return to in-person services (8.4 families) than they did before the pandemic (11.2 families). These different experiences may be because of the difference in time between when the survey was administered (September 2022) and when interviews were conducted (February through April 2023). Given the mixed responses on this point, it will

be important to continue examining the variations in staff members' caseloads as the pandemic recovery continues.

In-Person Versus Telehealth Supports and Services

Before the Pandemic Began

Before the pandemic began, Child First staff members delivered clinical supports and care coordination services almost exclusively in the home. According to survey data, roughly 76 percent of Child First staff members had never used telehealth services before the pandemic. Of the respondents, 76 percent reported spending at least 11 hours a week conducting visits in the home before the pandemic began.

Early Pandemic Period

The pandemic changed business-as-usual implementation for home visiting providers across the board. A national survey of home visitors found that more than two-thirds of home visits happened virtually in 2021.[13] Similarly, for Child First, the circumstances required that staff members provide services via telehealth rather than their typical in-home approach. Telehealth consisted primarily of meeting through videoconference software, such as Zoom, but also included telephone calls, as confirmed by Child First service data, which consist of information recorded by Child First teams each time they provide services (for example, visit date, length, and format). During this time, telehealth became the primary mode of contact between Child First staff members and families. Most Child First staff members found themselves providing telehealth services at least 11 hours a week. Nearly half of Child First staff members reported not conducting in-home visits at all during this time.

Caregivers confirmed this switch; those who started services in person said they were able to switch to telehealth. But initial telehealth services looked different from the in-person services provided before the pandemic began. Three caregivers who received services early in the pandemic period noted that their cases closed sooner than expected, limiting their opportunities to get the full benefit of the program. One caregiver who reported having shortened sessions explained,

> We ended earlier than we originally planned, because then COVID hit, and they weren't able to come into the home. And Zoom was not at all helpful for my daughter, probably a lot to do with her age. But when it became over Zoom, she really didn't even understand what was going on because it's like, they would be on one end [of the screen] with the toys, and then we're sitting here [in a different space]… She had no interest in coming to be on the screen and didn't really want to talk. So, it wasn't helpful at that point.

This change in engagement with children was something that other caregivers noted as well. Two caregivers reported that the telehealth sessions at the start of the pandemic were shorter than the typical session. In both cases, this seemed to be because the child struggled with adapting to the telehealth format, so the sessions were cut short. Additionally, four caregivers shared that telehealth interactions with the Child First staff members were primarily focused on working with the caregivers directly and less time was spent interacting with their children. This pattern aligns with evidence from a national home visiting survey that found that it was difficult for home visitors to

engage children via telehealth, and that home visitors spent more of their time asking or providing information to caregivers than modeling caregiver-child interactions during telehealth sessions.[14] As such, two caregivers said these sessions were not helpful for their children. One caregiver shared,

> It was basically over the phone. I think we had done a Zoom [but]…we only did that one time because when they realized [the child] didn't want to be on the virtual screens, they were just trying to make her comfortable. So, they just said, 'Maybe we could just talk on the phone, maybe she'll do better with that,' which she didn't. But we just…kept in touch to see how everybody was doing.

However, these experiences were not consistent across caregivers. Two caregivers who started services right before the pandemic and continued thereafter reported that their sessions lasted an hour and occurred weekly. This aligns with the Child First model, as well as survey results from staff members that show that session lengths were the same before the pandemic began and early in the pandemic (both 60 minutes). This suggests that it may have taken a while for Child First teams to adapt to providing services via telehealth. For most staff members, this was their first time providing services via telehealth and they were suddenly required to do so because of the pandemic. Thus, at the very start, sessions may have been shorter because of the sudden shift. But after some time, it seems the teams adapted and were able to hold sessions for similar amounts of time as before the pandemic.

Despite the shift to virtual services, some things did remain the same during this time. For instance, most Child First families continued to receive some in-person services during this time, as found in the pandemic RCT.[15] Two caregivers gave an example of receiving services in the home or outdoors. Additionally, survey data show that the Child First program continued to offer its core services — clinical supports and care coordination — at close to typical levels. There were also caregivers who said that they still benefited from the adapted model. Three caregivers shared that the program supported their well-being during this time and two caregivers said that they could still access the services and referrals the team made. One caregiver shared,

> [I am not in a familiar] environment to make a ton of connections… so, [the Child First team has] definitely been a huge resource to community connections and where to get help for my kids and stuff.

Return to In-Person Services

Since summer 2022, Child First sites have provided services both in person and via telehealth. The staff member survey showed that teams are spending slightly less time in the home since the return to in-person services (41 percent spent at least 11 hours a week) than they did before the pandemic began (76 percent spent at least 11 hours a week) and more time delivering services via telehealth (18 percent spent at least one hour before the pandemic began compared with 56 percent spending at least an hour a week since the return to in-person services). Additionally, whereas telehealth visits were uncommon before the pandemic, caregivers now have the option to request telehealth for their sessions, according to five staff members and one caregiver. However, internal data collected by the Child First National Service Office (NSO) in summer 2023 suggests that teams are now providing in-person services close to 100 percent of the time.

Although telehealth is a new option available since the start of the pandemic, staff members emphasized that in-person visits remain the priority, and telehealth is not a common occurrence. Two staff members stated that the typical family does not receive more than one telehealth session a month, and families are encouraged to participate in person. For some sites, the government no longer supports telehealth services despite having done so early in the pandemic. For example, Medicaid no longer reimburses visits conducted via telehealth in North Carolina, as reported by one supervisor. Most caregivers who participate in Child First in North Carolina do so through Medicaid, meaning that telehealth is not an option for them. In this way, Child First sites in North Carolina are more aligned with their pre-pandemic operations.

In the occasional instances when telehealth is used, staff members reported in the survey that families are more comfortable with telehealth than they were before the pandemic. Telehealth may also be easier for caregivers to navigate since more families have access to technology at home, such as laptops, tablets, and iPads, compared with before the pandemic, according to staff members' survey responses. Similarly, the survey data showed that teams reported feeling more effective at providing telehealth services since the return to in-person services compared with the period before the pandemic began.

In addition to increased comfort with telehealth, staff members and caregivers also reported that telehealth offers them more flexibility. Three staff members reported during their interviews that telehealth is useful when scheduling conflicts come up or families are sick. Before the pandemic, sessions would get cancelled in these situations. All three of the caregivers who received services since the return to in-person services emphasized that their busy schedules make it difficult for them to schedule sessions and to follow through with referrals and recommendations, but with telehealth, they have more flexibility. One caregiver shared why she appreciates the general availability of telehealth for services, such as the services and resources recommended to her by the Child First team,

> I honestly think that from where I'm sitting, the pandemic made [accessing other services] better because before the pandemic there's no way that between a full-time job, these kids, dad working full-time… There's no way I would've had time to get down to an office.

Despite the flexibility of telehealth, interacting with children via telehealth is still an obstacle. For instance, caregiver-child activities, such as child-parent psychotherapy, are more challenging to do via telehealth because young children are harder to engage in virtual formats. According to four staff members, children have a hard time paying attention and focusing when activities are done virtually. One staff member shared that,

> If the child is involved in the session, which they usually are, I think there is a general consensus that in person is more effective, right? Parents are like, 'I can't keep my kid looking at the screen. They get distracted, they walk away.' A lot of parents prefer in person to virtual when the kiddo is gonna be involved, which we want them to be.

Thus, the majority of Child First staff members (five of the nine staff members interviewed) reported that telehealth sessions are only focused on the caregiver. These sessions take the form of a collateral session — that is, a one-on-one session between the clinician and caregiver — or a session with the care coordinator. Two staff members thought that some caregivers prefer telehealth for these kinds of sessions where the caregiver is the sole focus.

Training and Supervision

Before the Pandemic Began

Care coordinators and clinicians receive extensive training when they join Child First. Training is organized by both the Child First NSO and the agencies that house the Child First program. Beginning in 2017, NSO offered Child First teams hybrid training options where in-person attendees could join training at a central location and remote attendees could join the same training via a Zoom videoconference. Training sessions provided by NSO include the following:

- **Child-Parent Psychotherapy (CPP),** which trains Child First clinicians on how to deliver this service. Staff members participate in this training over the course of several months.

- **The Learning Collaborative,** which focuses on a variety of topics, such as the benefits of attachment and the effect of trauma on children. Both care coordinators and clinicians participate in four Learning Collaborative sessions over the course of six months spread throughout the year.

- **Absorb,** which is a platform with online modules that focus on a variety of topics, such as assessments and case formulation, as well as refresher training. Overall, one supervisor estimates that these trainings take about a month for clinicians and care coordinators to complete.

NSO also hosts training focused on different approaches, such as Circle of Security and Abecedarian.[16] In addition, agencies also host their own training sessions, which may focus on administrative requirements, such as data entry, or interests expressed by Child First teams.

Teams may complete these training sessions as part of their onboarding process, or supervisors may choose to hold these sessions during scheduled supervision meetings. Before the pandemic began, supervision was entirely in person. In interviews, supervisors noted that they provided staff members with individual supervision, team supervision, and group supervision weekly. (See Box 2 for more information.)

Early Pandemic Period

As with home visits, Child First pivoted to providing staff member training and supervision virtually during the early part of the pandemic. Training and supervision took place via videoconference, such as Zoom, according to supervisor interviews. Some training sessions were also available online as self-paced modules. Despite this shift, the level of supervision remained the same; most care coordinators and clinicians (81 percent) reported spending between one and five hours a week in supervision early in the pandemic period, similar to the time spent before the pandemic began (87 percent). Training provided by supervisors also remained the same, with most providing

Box 2. Types of Child First Supervision

Child First care coordinators and clinicians receive three types of supervision.

- During **individual supervision,** supervisors meet with the care coordinator or clinician individually. This time is used for reflective supervision, providing individual staff members with a space to talk about what they are seeing in their cases. The time is also used to discuss administrative topics, such as reminders to upload case notes.
- During **team supervision,** the supervisor meets with the care coordinator and the clinician together. This time is also used for reflective supervision. It allows the supervisor to see how the teams are working together and to support their work as needed—for example, by thinking about how to coordinate home visits between the care coordinator and the clinician.
- During **group supervision,** the supervisor meets with all of the Child First teams together. This time is used to encourage learning across teams. For instance, teams may be asked to present a case study to share with other teams. Group supervision time is also used to provide training to teams and discuss administrative topics.

at least one hour a week of training before the pandemic began (75 percent), compared with the early pandemic period (80 percent).

Return to In-Person Services

Although Child First teams have resumed in-person activities as usual, training and supervision remain largely virtual, according to interviews with staff members. A benefit to this shift is that, as one staff member noted,

> More [training sessions] are available online than ever before, and we could do them in the comfort of our home.

However, two supervisors said they are trying to hold more in-person meetings or activities, recognizing that teams spend less time in person now than they did before the pandemic began. Teams have fewer opportunities to connect, which one supervisor noted is important to staff members' job satisfaction. She explained,

> As a supervisory team, we're putting a lot more emphasis on thinking through how to create relationships within the team because we're all virtual.... Nobody is just chatting after a meeting or going to grab lunch together anymore because if we're all on Zoom, that's just not something that's going to naturally occur. So we've had to really think through, like, how do we encourage people to have these relationships, have these peer relationships with one another, that leads to better job satisfaction.

Despite the virtual format, the frequency of virtual supervision remains the same during this time as it did before the pandemic began. However, supervisors are spending more time providing supervision since the return to in-person services (63 percent spending 11 to 20 hours a week)

compared with before the pandemic period (50 percent spending 11 to 20 hours a week), according to the survey data. This may be due to changes that supervisors have noticed since the pandemic began. For instance, one supervisor said that she is addressing a lot more team "stress and anxiety" since the start of the pandemic. Another supervisor explained that one of the current goals of supervision is to "really reduce burnout, reduce kind of secondary traumatic stress… and have the team member[s] really feel like they are being held, especially with these really hard trauma cases." Thus, supervisors may be using more supervisory time to focus on their staff members' mental health.

Conclusion

Despite the challenges presented by the COVID-19 pandemic, Child First teams managed to adapt to continue serving families shortly after the start of the pandemic.

- Referrals and caseloads decreased early in the pandemic but have returned to pre-pandemic levels since the return to in-person services.

- Child First programs switched to a hybrid approach early in the pandemic period, providing services both in person and via telehealth. Although Child First returned to serving families primarily in person around summer 2022, telehealth remains an option for families.

- Training and supervision switched to virtual early in the pandemic period and both remain largely virtual since the return to in-person services.

Overall, however, the implementation of the model remains the same as it was before the pandemic began. These findings help inform the field's understanding of how home visiting programs have adjusted following the pandemic and how these changes are delivered by Child First teams and received by the caregivers they serve.

Notes and References

1 For the purposes of the study, early in the pandemic is defined as the period from March 2020 to June 2021.

2 Implementation fidelity is the extent to which a program is delivered as intended. If a program is not closely following the intended model, then it has low fidelity to that model. If a program is closely following the intended model, then it has high fidelity to that model.

3 A randomized controlled trial (RCT) is a study design in which individuals or groups who are eligible for a program are randomly selected to enter either a treatment or control group. Those in the treatment group will receive the program, and those in the control group will not receive the program but can still access other services. This design allows researchers to measure the impact of a program.

4 Executive functioning is a set of mental skills that allow people to accomplish important everyday tasks. In adults, this can include regulating emotions, making plans, and multi-tasking. In children, this can include paying attention, displaying self-control, and following directions. See https://www.childfirst.org/our-work/home-based-intervention/executive-functioning.

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7 U.S. Department of Health and Human Services, "Covid 19 Vaccines," (website: https://www.hhs.gov/coronavirus/covid-19-vaccines/index.html, 2023).

8 Staff surveys were administered in September 2022 and staff members were prompted to consider their experiences over the past few weeks and months as their most current experience. Staff member and caregiver interviews were conducted in spring 2023, and they were asked about their experiences over the past few weeks and months.

9 In reflective supervision, supervisors meet with home visitors to help them process the emotions and stress that may come with working with at-risk families and children. During this time, supervisors encourage home visitors to reflect on the program's goals and their role as a home visitor to help them better serve families. Victor J. Bernstein and Renee C. Edwards, "Supporting Early Childhood Practitioners Through Relationship-Based, Reflective Supervision," *NHSA Dialog* 15, 3 (2012): 286–301.

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15 Xia et al. (2023).

16 Circle of Security is an intervention that focuses on promoting secure attachments between the caregiver and child. Abecedarian is an intervention that promotes child executive functioning through interactive games and rich conversations between the caregiver and child.

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