LISTENING TO PARENT VOICES:

How Technology Changed What's Possible in Home Visiting & Infant Mental Health Programs

CASE STUDY:
Family Nurturing Center

Acknowledgements

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Summary of Key Findings and Recommendations

The onset of the COVID-19 global pandemic led infant mental health and home visiting programs to shift to providing services using remote strategies and technology. To inform the quality of these services moving forward, we spoke with 100 parents/caregivers and early childhood service providers from seven diverse programs across the United States. These interviews focused on understanding what worked well, what needed improvement, and how these experiences can inform the future implementation of these important early childhood programs. Here we provide a high-level summary of the most important takeaways for informing program practices and policies at a time when in-person and/or hybrid services are beginning to resume. The full report contains a detailed description of study methods, findings and recommendations, and highlights the compelling words of parents and caregivers as they shared their personal experiences and insights about how services helped them and their children through this often stressful and difficult time.

What Changed for the Better in Remote Service Delivery?

This study identified aspects of service provision that worked particularly well using remote technologies, and ways that non-remote early childhood services might be improved. These included:

- **Increased flexibility:** Programs were able to change previously existing service delivery requirements related to duration and location of services. This flexibility enabled providers to maintain connections and supported improved family engagement and participation.
- **Logistical improvements:** Virtual visits increased reduced travel time, made visits more accessible and convenient, and, for some families, increased their overall comfort about meeting with staff. This shift was seen as an improvement by many families and providers.
- **Increased provider creativity:** Providers found new strategies for engaging children and opportunities for encouraging engagement between families, using innovative ideas for working with families.
- **Increased support for parent-child interactions:** The virtual format required staff to focus on how to coach and support parents to directly interact with their children, putting parents firmly in the "driver's seat".
- **Expanded focus on adult mental health:** The stress of the pandemic increased the need for adult mental health support, and providers shifted their approach to address this.
- **Improvements in office- and clinic-based infant mental health services:** For infant mental health services typically provided at a clinic or office, parents and staff both described considerable benefits of remote services that allowed sessions to incorporate families' home settings into activities, and allowed staff to better understand infant and parenting behaviors in a more naturalistic setting.

What Didn't Work and What Needs Improvement?

Across the sites, there were several recurring themes about aspects of service delivery that were more challenging with technology-enabled services. First, however, it is important to emphasize that like previous research, issues reflecting the digital divide that undermines connectivity in rural and urban areas and disproportionately impacts BIPOC and under-resourced communities were a commonly-shared frustration. Whether it is access to reliable broadband, devices, or data plans, families and staff articulated concerns about when and how the technology itself was a barrier to high quality infant service delivery. These issues have been highlighted in other research, and have begun to draw policy attention to the need to improve national infrastructure for high-speed broadband. Other key challenges that were identified include:

- **Difficulty engaging the youngest children:** Parents and staff both reflected that it was difficult to engage effectively with babies and toddlers, due to their developmental capacities.

- **Challenges in developing and maintaining relationships between parents and providers:** The multi-faceted stressors facing families and staff sometimes prevented regular and/or high-quality relationship building interactions critical to these infant mental health-related services. These relationships were even more difficult for families who started services during the pandemic and did not have a prior relationship with staff.

- **Concerns with confidentiality and safety:** Many families lacked private spaces for visits, and staff in particular shared concerns about parent confidentiality and even safety during discussions of sensitive topics in the presence of others.

- **Difficulty doing developmental and other assessments:** The hands-on nature of many developmental assessment tools made conducting these assessments, which are an important aspect of infant and toddler services, challenging for parents and staff.

Conclusions & Recommendations for Improving Service Quality

1. **Program models would do well to increase flexibility around service implementation requirements,** especially those related to frequency and duration of visits. In particular, programs should seek more input from families about their preferences and individualize services so that it authentically puts families at the center of how programs are delivered.

2. **Implement improved pre-and between-visit supports** that were provided during remote service delivery in order to enhance parent engagement, such as more frequent reminders about "homework" and engaging in regular parent-child activities, checking in more often with parents via text and brief phone calls, and doing more co-planning with parents about upcoming visits.

3. **Develop and implement hybrid approaches** that incorporate effective aspects of remote/distance services while maintaining other service components that may be best done face-to-face. These may be particularly important for infant mental health services previously provided in clinic or office-based settings, although home visiting programs would also do well to consider more remote options for families.

4. **Build on approaches used by providers to more intentionally focus on and support caregiver-child interactions.** Because providers could not model or demonstrate activities directly with children, many developed improved techniques for coaching parents as they interacted with their infants and toddlers during services. This centered the parent-child interaction more directly as the focus of services.

5. **Increase availability of, and connection to, adult mental health services through telehealth.** The need for adult mental health services for parents/caregivers in home visiting and other infant/toddler services has been well-documented, and telehealth was seen as an important and viable option to increase accessibility.

6. **Expand availability of Infant and Early Childhood Mental Health Consultation (IECMHC) to infant and toddler programs.** This evidence-based enhancement could provide additional mental health support for families to build staff skills and capacity for supporting positive parent-child attachments.

7. **Prioritize and rethink strategies for meeting families' basic resource needs.** Family needs during COVID-19 expanded dramatically, and the field of early childhood may want to continue to take a more direct role in providing resources, recognizing that family instability and lack of basic food, shelter, and safety harms children and parents, and reduces parents' capacity to work on longer-term goals.

8. **Develop and/or expand provision of group-based opportunities for families,** including both remote and in-person parenting education and parent support groups.

9. **Increase and strengthen ongoing organizational supports for staff,** many of which were expanded during COVID-19, such as more flexible work schedules; more frequent check ins between staff and supervisors; more planned opportunities for professional shared learning; and expanded supervisory support for holistic staff well-being, in contrast to task-oriented, administrative supervision.

10. **Create and strengthen openness** among program staff, funders, and policy-makers to make changes in program models and implementation by actively listening to parents and responding to their needs.

Reflections and Moving Forward

A final reflection on the experiences of these parents and staff during the COVID-19 pandemic is the importance of recognizing what it took for these early childhood services to more fully actualize a truly family-centered and family-driven approach - namely, a global pandemic that led to broad societal shifts in personal, social, and work-related behavior. While previously, these evidence-based models required adherence to a relatively strict set of implementation guidelines thought to enhance program effectiveness, suddenly there was a need - and willingness - to change practices and to "do what it took" to respond to families' needs. To be effective in this context, programs and staff were called upon to make changes in how, how often, and in what ways they provided services. Thus, the pandemic created an opportunity to change long-standing assumptions rooted in White-positivistic ways of knowing about what it takes to provide effective services. During the pandemic, programs changed these standards and challenged these assumptions in ways that perhaps more fully realized core values of relationships, responsiveness, and family-centered, in ways that may actually promote broader program effectiveness. As society moves on from the pandemic, keeping this lesson in the forefront - and moving forward in a way that advances a truly equity-oriented approach without falling back on standard, white dominant models and requirements will require collective will to continue to make changes and question assumptions about what is important to families.

Introduction

The importance of early, relationship-based home visiting and other supports for families has been well-documented, with evidence of positive outcomes in a variety of domains including child health, improved parental mental health and economic stability, and reduced risk for child abuse and neglect[1]. Fundamental to these services is the ability of providers to establish strong working relationships with parents and/or caregivers and to work closely to support infant-parent attachment[2]. Whether these programs would be able to effectively continue to work with families using remote and technology-supported implementation during the COVID-19 global pandemic was, and continues to be, a pressing question for the field. To address this question, Perigee Fund contracted with a team of researchers from Portland State University, the University of Connecticut, and Georgetown University in the summer of 2020 to learn more about how programs providing relationship-based infant and toddler services were shifting their strategies to support families using remote or distance technologies. In particular, Perigee and the study team identified **a critical need to hear more from parents** about their experiences during this shift, and how - or if - these programs were able to engage them and their young children during this challenging time. By understanding parents' experiences, we also sought to learn about what these young children were experiencing during this time of increased social isolation and multi-faceted community and family stress.

The research team partnered with home visiting and infant mental health programs in seven different communities across the country: Healthy Families America Arkansas, Southeast Kansas Community Action Program, Brockton Healthy Families in Massachusetts, Inter-Tribal Council of Michigan, Family Building Blocks and Family Nurturing Center in Oregon, and Mary's Center in Washington D.C., using a case study approach. This design was chosen in order to provide a contextualized understanding of service delivery in communities characterized by different social, political, and cultural characteristics. Programs all served families with children ages 0-3[3] and used a variety of different program models and curricula. Many provided some form of home-based early childhood services using a relationship-based approach while a few also provided direct infant mental health services in clinical/office settings. Telephone or video interviews were conducted with the program director at each site, up to 7 staff, and up to 14 families (two families per staff). A total of 100 interviews were conducted between February and June 2021. Based on these interviews, a case study was developed for each program, which in turn was analyzed to identify key cross-site findings.

As of this writing, as restrictions are increasingly being lifted to allow more in-person services, there are important lessons to be learned about the role of remote or technology-supported services moving forward. This study begins to provide some of these lessons by highlighting what it took to effectively engage families, what worked well and warrants further support, where inequities in service provision occurred, and what was lost in terms of quality or effectiveness in providing relationship-based home visiting and infant mental health services to families with very young children.

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[1] Duffee, J. H., Mendelsohn, A. L., Kuo, A. A., Legano, L. A., Earls, M. F., & Committee on Child Abuse and Neglect. (2017). Early childhood home visiting. Pediatrics, 140(3).

[2] Zeanah, C. H. (Ed.). (2018). Handbook of infant mental health. Guilford Publications.

[3] Some also served somewhat older children.

Study Design & Methods

The research team used a case study approach and coordinated with seven (7) programs to conduct in-depth telephone or video interviews with 43 staff members and 57 of the families that they work with (see Appendices C, D & E for interview protocols). In addition, a short online survey was developed to capture demographic information as well as quantitative data about staff and families' level of interest and engagement in remote services. Additionally, we worked with two groups of Parent Research Consultants to provide family input into our research methods, questions, and interpretation of findings.

About the Programs

Seven programs were included in this study (see Table 1). Programs were purposefully selected to represent different infant/toddler program models, geographic regions, and community and family characteristics [4]. Programs were provided with an organizational stipend of $2,000 in return for participating; gift cards were also provided to individual study participants (family members and staff).

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[4] For more information about programs and local community contexts, please see the individual Community Case Study reports, available at: perigeefund.org/parentvoicestudy

Table 1. Participating programs and program characteristics.

State	Program name	Rural/Urban	Families Served	Services offered	# of Families Served	Ages of Children Served
AR	Healthy Families America Arkansas	RURAL	Young Parents Program 1: Mostly White (96%) Program 2: Mostly African American (71%) and White (25%)	HV, IMH, PCIT, PCG	81	Program 1: 0-36 months Program 2: 0-48 months
KS	Southeast Kansas Community Action Program Early Head Start	RURAL	Mostly White 85%	HV, ECS, PCIT, PCS, PCG	214	Prenatal - 5 years
MA	Greater Brockton Healthy Families Home Visiting	URBAN	First-time parents Mostly Cape Verdean/Black (80%) and Latinx (14%)	HV, ECS, IMH	80	Prenatal - 36 months
MI	Inter-Tribal Council of Michigan - Home Visiting	RURAL	Mostly American Indian/Native Alaskan (90%)	HV, IMH, PCS	600 (organization overall)	Prenatal - 5 years
OR	Family Building Blocks Healthy Families of Oregon	RURAL & URBAN	Mostly Latinx/Hispanic (46%) and White (24%)	HV, ECS, BH Bilingual/ bicultural	800 (organization overall)	Prenatal - 5 years
OR	Family Nurturing Center	RURAL	Mostly White (81%)	HV, IMH, ECS, PCG, Respite Care	100	Prenatal - 5 years
Washington, D.C. Silver Springs, MD	Mary's Center - Early Childhood Behavioral Health	URBAN	Mostly Latinx/Hispanic (62%) and African American/Black (21%)	IMH, BH, PCIT, Play Therapy	50	Birth -12 years

Study Participants & Data Collection

Parents/Caregivers

Sixty-seven (67) parents/caregivers were contacted and recruited by program staff, of whom fifty-seven (57) chose to participate in this project. Fifty-three (53) completed a demographic survey to provide background information (see Figure 1 below). These families had between 1 and 5 children living in the home; children ranged in age from several months to 18 years of age. On average, families had 2 children living in the home, all had at least one child under the age of six and 86% had children younger than three. Most (93%, 52) participants were mothers, three (6%) were fathers, and one identified as a grandparent. Five (5) of these people were also stepparents, grandparents, and/or foster parents to a child (or children) in their home.

Staff

We interviewed forty-three (43) staff, including eight (8) program directors/managers and thirty-five (35) direct service staff across all of the sites. Of the 35 direct service staff, 32 of them chose to complete a participant survey that collected demographic and other information (see Figure 1 below). Almost all (97%, 31) identified as women and one identified as a male. Slightly more than two-thirds (68%, 22) had at least a Bachelor's Degree and most (82%) were over the age of 30. Almost all of the direct service staff had been with the organization since before the pandemic and had at least three years of experience with the organization and in the field of early childhood.

Figure 1 & 2: Parent/Caregiver and Provider Race/Ethnicity and Home Language

Parent/Caregiver and Provider Race/Ethnicity

Parents/Caregivers (n=53): White 43%, Black/AA 9%, Latinx 28%, Pacific Islander 2%, American Indian 8%, Multiracial 8%, Self-Identify 2%

Providers (N=32): White 59%, Black/AA 13%, Latinx 19%, Multiracial 9%

Parent/Caregiver and Provider Language

Parents/Caregivers (n=53): English 62%, Spanish 26%, Both English and Spanish 6%, Other 6%

Providers (n=32): English 84%, Spanish 6%, Both English and Spanish 9%

Data Analysis

All interviews were transcribed and entered into ATLAS.ti for coding and analysis. All members of the research team individually read a subset of interviews and identified initial themes using a question-by-question content coding approach. These themes were then reviewed collectively and shared definitions were developed. Following this, all researchers independently coded a set of interviews and met to resolve any differences or inconsistencies. Once an acceptable level of agreement was reached, interviews were coded independently, with 1 out of every four coded in pairs to ensure ongoing consistency. Members of the team who had conducted the original interviews were included in the coding and analysis team to help ensure coding accurately reflected the information provided in the interviews. Coding teams met weekly to discuss any questions, add new codes that emerged, and to ensure ongoing consistency in use of codes. After coding was complete, reports were generated that compiled coding and data for each key question; these were then used to synthesize the qualitative data and develop reports for each site. Case study reports were prepared and shared with participating programs and families for input on interpretation and to obtain feedback. Individual case study reports are available here: perigeefund.org/parentvoicestudy. Following this, the case studies were reviewed by the lead researchers to identify the cross-site findings presented in this report.

Results

Drawing on information collected from program directors, staff and family members, below we provide a summary of their experiences receiving or providing services during the COVID-19 pandemic. First, we briefly describe the COVID-19 context for service delivery, and family and staffs' general comfort and perceptions of technology-enabled services. Following this, we highlight results in four key areas: (1) The **value and benefits** to parents in receiving early childhood services during the pandemic; (2) The factors that **contributed to more successful technology-enabled services** for both parents and staff; (3) Aspects of service delivery that **worked well remotely**, and what changes in services could be retained moving forward; and (4) **What was lost** in the transition to remote services.

While many findings were remarkably consistent across the seven program sites, there were other experiences, innovations, and lessons learned that suggest how these services were different, and may need to be tailored, for specific communities or program types. We include these findings in "Spotlights" throughout this report. In presenting the key findings, we have attempted to highlight the examples, themes, and experiences that supplement what prior research has begun to describe, with an emphasis on issues that are relevant for policy and practice.

COVID-19 Context & Remote Services Provided

The global health crisis caused by the COVID-19 pandemic exacerbated the profound inequities in the nation's healthcare system, with data indicating that nondominant racial/ethnic populations are at greater risk for severe illness and death from COVID-19[5]. The communities selected for this study represent some of the populations profoundly and disproportionately affected by COVID-19. All of the programs in this study stopped in-person services in March of 2020 and implemented a variety of strategies to support families remotely. Only one, Mary's Center, had a model for telehealth in place prior to the pandemic. Programs rapidly pivoted to remote service provision, with initial efforts focused on maintaining contact with families by phone, text, email, or dropping off supplies. As it became clear that widespread shut-downs were going to continue, programs incorporated video conferencing and social media into their service delivery. Home visits, counseling, PCIT, playgroups, and parent support groups were all offered remotely with the large majority of parents engaging via Zoom either on their phones (most common) or using computers. However, sites experienced a range of different state- and local-requirements for pandemic-related safety protocols (e.g., masking, social distancing, remote service provision) which lasted for varying lengths of time. Some sites provided only remote services for the duration of our study; others had been limited to remote services only very briefly, and had since returned to providing mostly face-to-face services, or to a hybrid model (offering face-to-face and/or remote depending on individual family preferences or needs).

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[5]Centers for Disease Control. Health Equity Considerations and Racial and Ethnic Minority Groups. Retrieved August, 2021 from

https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

Overall Family Retention, Comfort & Satisfaction with Technology-Enabled Services

Across all the programs in this study, staff reported that they generally had not lost contact with a significant number of families as a result of the shift to remote services. This was attributed both to the persistent and diligent work of staff to connect with families using any means available, and supported by programs providing families with resources to ensure access to WiFi, adequate phone data/minutes, and/or devices. At the same time, connectivity was often a challenge in terms of the quality of services that could be delivered, as programs could not improve the systemic lack of high-speed broadband for many families, resulting in frequent service disruptions, inability to connect via video conference, and low-quality connectivity in general. Some families could only be supported through phone, text, and social media with much more limited ability to provide video conferencing. Moreover, most programs were able to continue to enroll new families, although this often came with challenges, described further below.

In response to a brief survey, most parents in the study (84%) agreed that it had been easy for them to engage in services remotely, over half (56%) agreed that they *liked* receiving remote services and two thirds (67%) would like to continue to receive some supports remotely after face–to–face visits are reinstated. Staff similarly reported high levels of comfort providing remote services (78%). Most (87%) felt supported by their agency to shift to remote services and although only a quarter (25%) agreed that providing services remotely is as effective, two-thirds (68%) would like to continue offering

Many Parents and Staff Would Like to Continue Some Remote Services After Face-to-Face Services Resume
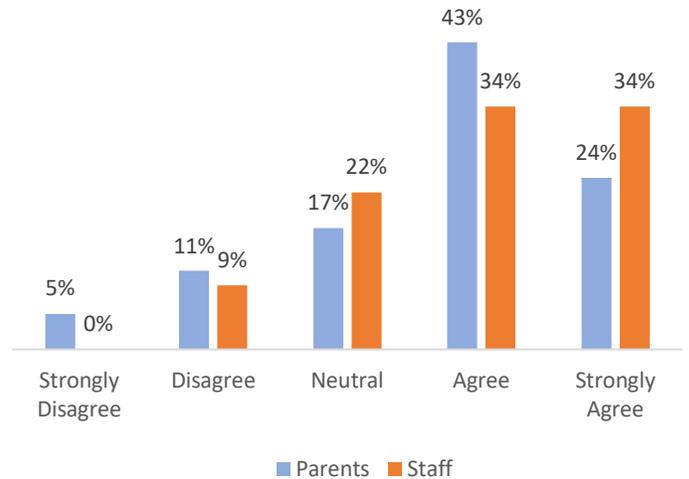
remote services in the future.

Value of Early Childhood Services During Crisis

Across the seven programs, we heard story after story that reflected the valuable supports being provided to families through virtual and technology-enabled home visiting and infant mental health programs. The aspects of services that were seen as most important for families fell into four basic categories; each of these is described in greater detail below.

1. The ability to **continue to receive valued child development,** parenting, and parent-child interaction supports that had begun pre-pandemic
2. The expanded supports to **meet families' basic needs** such as housing, medical care, food, and other material resources. Meeting these needs, although a challenge for many families even pre-pandemic, were exacerbated by the job losses, food shortages, loss of school and child care (often a source of food support for low-income families) and medical needs during the pandemic
3. Both informal and more formal **emotional and social supports** during a time of incredible family stress, social isolation, and community and political unrest, including:
    a. Informal emotional and social support directly from the provider
    b. Opportunities to connect with other adults and families, often through virtual parenting education, parent-child play groups, and support groups
    c. Mental health counseling and stress reduction resources and activities
4. Providing **information and advice around COVID-19** and related health and safety concerns

Continued Early Childhood and Parenting Supports

Parents shared that continuing to receive parenting supports from their provider during the shutdown provided valuable continuity and stability for their family in times of turmoil. Many of the families we spoke with had long standing relationships with their providers, and providers were described as "*part of the family*." Parents told us that this ability to continue providing services also helped the children feel like things were "*a little more normal*" and "*provided some stability for them.*"

Often, these supports included providing materials to support parent-child interaction and early learning at home:

"… eso nos ha ayudado mucho porque como hemos estado más tiempo en la casa, esta vez era nuestra este actividades que podemos hacer, libros que puedo leer con las niñas y eso es algo muy valioso que ellos han hecho para mí, para mi familia" [(Our home visitor) has helped us a lot because, as we have spent more time at home, the home visitor brings us activities that we can do [at home], books that I can read with the girls, and that is something very valuable that they have done for me and my family.] – Parent/Caregiver

Some parents shared that having these activities to support children during these times kept them motivated to continue to engage with services:

"To be honest, during the pandemic, I was like, I don't know if I really even want to do this anymore. It's just on the phone and I'm just telling them about him. They're not really seeing him. So, I was contemplating ending the program. But I noticed, they do help a lot with just making sure he's on track with his progress, making sure that he's meeting the milestones. They do a little program for him. If we read him books and stuff and send them pictures, we get put in drawings and stuff… And that's why I love it, because they are always… I don't know how to explain it they're always willing to work with the kids. They're always trying to have fun, engaging activities for them to do…So, I can't just cut off his fun and happiness because I don't want to do it anymore." – Parent/Caregiver

Supporting Families' Basic Needs

Both parents and providers spoke repeatedly about the efforts made to connect families with resources to meet their basic needs for food, housing supports, medical services, and child-related items such as diapers and clothes. These types of services, while important prior to the pandemic, were even more crucial during this period; needs were also described as particularly acute for some communities. Specifically, in one program providers shared that for many of the primarily Latinx, undocumented families that they served were especially in need of cash supports and rental assistance. Many of these families worked in the service industry, experiencing disproportionate rates of job loss. One provider reported, *"there were a lot of tangible [needs] like cash assistance. I referred three different families to cash assistance - straight up checks, money in the mail."* Situations with housing also led another program to provide access to pro bono lawyers around eviction awareness.

The clear importance of programs for helping families to connect with basic resources warrants reflection on this role for in the future. There has been a frequent refrain heard

One of the program sites, located in a heavily mountainous, rural area of southern Oregon, not only faced the challenges of the global COVID-19 pandemic, but was heavily impacted by the most destructive wildfire season on record in the state of Oregon. In September of 2020, fires burned over 1 million acres, displaced 40,000 people due to evacuation orders, and destroyed 2,800 structures in Jackson County alone.[1] The value of, and need for, early childhood and family support - already elevated because of COVID-19 - was suddenly compounded. In particular, displaced families needed food, shelter, clothing, and basic materials for children. One staff member we spoke with described the stressors for families at this time as *"astronomical."* This program was able to respond to these increased needs through creative use of technology.

For example, to meet the dramatically increased needs for basic and material resources, the program established a "Warm Link" -- a website that allowed families and program staff to request these resources - and which provided responses within 48 hours.

"Having the ability to ask for help when and if I need it, say with diapers or wipes, or when my youngest was tiny, and I didn't have that many newborn clothes, […] I was able to reach out through their website connection, and someone would bring it to my home and set it at my door." – Parent/Caregiver

In addition, being able to continue to provide Parent-Child Interaction Therapy (PCIT) remotely enabled the large number of displaced families to be able to continue to participate in these services, as this parent described:

"We lost our home in the fire and that had a huge impact on us, too. Not only COVID, then we lose our house. […] We were displaced and had to go to CA […], but I kept in touch with [provider]." – Parent/Caregiver

among the home visiting practitioner community that responding to emergent crises for families (often related to housing, legal, or other unanticipated destabilizing events such as wildfires and natural disasters, and the precarious financial situation of many families) often requires significant time and energy. This use of staff resources is sometimes

framed as detracting from providers' "more important" role in supporting parenting and child development. Rather than seeing these services as "taking away from" this other role, programs could explore embedding legal and/or other services as are done in medical-legal partnerships and community resource centers to address these needs as an essential wrap-around support that augments the effectiveness of parenting-related services. Medical-legal partnerships are a growing practice model across the country and have lawyers working with health care partners to address so-called health-harming legal needs of clients.

These innovative models would require additional resources to supplement early childhood providers' expertise, time and skills.

Emotional & Social Support

Informal Emotional & Social Support from Early Childhood Providers

One of the most important sources of support described by families was the emotional/social support that they received from these programs. Parents in almost every program that we spoke with mentioned that staff had increased the frequency of check-ins with families, using text messages and phone calls to reach out to families more often than was the case pre-pandemic. Parents in one program specifically mentioned a shift in the types of conversations they were having with their provider, describing that staff spent more time listening to concerns and questions beyond their children's health and development. The home visitors' ongoing responsiveness and availability to parents reflected a way to continue to be present with families, despite being physically distanced.

> *"Familia sí tengo, pero no convivo con ellos. Mi papá y mi mamá trabajan. Mi esposo trabaja. Y estoy aquí en casa todo el día con mis hijos no tengo con nadie con quien convivir y a veces ese ratito que platico con ella pues aparte de que me entretengo un ratito, como que me despejo la mente, aunque sea sólo como para dar información, decir oye, ¿cómo te fue el fin de semana, que hiciste? Es algo que me gusta."* [I do have family, but I do not interact with them…And I am here all day with my children and I have no one to interact with and [the time] that I talk with [HV] other than being entertaining for me for a bit, I clear my mind, even if it is only to get information, to say: 'Hey, how was your weekend? What did you do?' It is something I like.] *– Parent/Caregiver*

Providers reflected that they felt that their therapeutic relationship with parents was deepened by the sense of going through a shared experience.

> *"They [families] were like 'Are you going through this too? Because I feel like I'm alone.' and I'm like 'Absolutely not, I am right there with you. I can relate. I am there. Don't worry about it, it's okay to need a minute.' […] I think the emotional support was huge."* – Staff/Provider

As illustrated in the quote above, families and staff both felt that they saw their experiences as parallel to each other's experiences, and that this positively impacted their relationship. They "*were going through the same crisis. They were going through the same pandemic. They had the same questions.*" Providers were able to empathize with families and this shared experience fostered a sense of togetherness.

Social Connections

In addition to support provided directly by their relationship with the home visitor/provider, some parents talked about how programs helped them to **connect with other adults/parents** during a time of social isolation. This took several forms including virtual **parent-child playgroups, parenting education classes, and parent support groups.**

> *"When we initially went remote, I was like, 'We have to stay connected, how are we going to do [playgroups]?'…Had groups up and running by the week after, so we went headfirst…We created. We did a paint night, [and] really did some painting to promote that care support and social connection."* – Staff/Provider

> *"I like the group activities a lot because, especially like I think it was four, four weeks ago where we did painting and stuff and well I did it with [child] and she was super happy and excited to do it, and she was helping me. And you also get to communicate with other moms and the workers and stuff. So, you get to know everyone, not just [home visitor], you get to experience and get to know everyone."* – Parent/Caregiver

Mental Health Supports for Adults

A few of the programs included in this study provided direct mental health therapy/counseling to families. For some, the ability to receive these services from the same organization broke down important barriers to families for engaging in mental health supports. Others felt strongly that the ability to provide remote adult mental health services increased the accessibility for families, increasing the likelihood of participation.

> *"This program was also able to continue to provide individual counseling for adults during the pandemic. Those receiving virtual counseling services during COVID expressed how beneficial and extremely important it has been for them, especially during these challenging times."* – Staff/Provider

Providing Supports in Latinx and Tribal Communities

Two programs that we worked with provided services to culturally-specific populations. One team worked exclusively with Latino/a/x families (including many seasonal migrant workers and undocumented family members); another program supported several tribal communities. In these communities, it seemed especially important that home visitors were able to provide social connection and support when families' natural social networks were disrupted due to social distancing and safety concerns. In both these programs, families described the tremendous sense of loss they experienced because they were unable to be in contact with their broader community and extended family, and the importance for them of the program provider's role in filling in some of this important emotional and social support. Traditionally both Latino/a/x and Native American/American Indian communities have a strong core value for family and a more collectivist approach to community than is reflected in mainstream, White-dominant norms. Thus, these losses, while significant for everyone during the pandemic, were perhaps experienced more deeply and substantially by these families.

"A lot of parents, during this pandemic, feel isolated with their kids so a lot of them do look forward to our phone calls. For some of my families, I'd be the only person checking in with them weekly. Sometimes they just wanted to let me know what they've been up to" – Staff/Provider

A key difference between these two programs, however, was the vital role of the larger tribal organizations in helping to fulfill families' needs for basic resources and material support. Tribal organizations were clearly a significant source of support for food, supplies, hygienic and safety equipment, and other critical supports for the families in this study:

"I think that the tribe really does have services for just about everything... people are pretty well taken care of. And most of the clients are pretty appreciative of that. We heard that numerous times in the beginning of the pandemic [... that families] weren't having to try to find resources. They're a very close community, a tight knit community. I feel like not everyone has that. We were comparing and talking about how some people in town [not on the reservation] who have absolutely nobody. It's so hard for us to understand that sometimes here because they put out a memo at the beginning of the pandemic that the tribe would get them food. And we have people that would run and do all those things, whether it be getting a gallon of milk late at night... They're taken care of." – Staff/Provider

Latino/a/x families, however, were often less able to access key resources than prior to the pandemic, as many were either not eligible for additional COVID-specific benefits and supports due to their undocumented status, or were fearful of attempting to access these services even if documentation of immigration status was not required (as was the case in Oregon). For these families, the early childhood programs provided critically needed support during a time of expanded economic instability and job loss.

Information About COVID-19

In addition to offering emotional support around parents' very real fears of getting or transmitting the COVID-19 virus, home visitors and other providers were a vital source of information about local COVID-19 restrictions, regulations, and health and safety protocols. Staff also helped parents talk to their children about the pandemic, and why families needed to social distance, wear masks, and be safe. One program provided families with a storybook for kids to help parents better explain these things to their children. Home visitors described the benefits of being able to provide regular communication to families about the constantly-changing COVID-19 information and restrictions. One provider discussed how the Family Spirit program created lessons and educational materials about how to help families

through COVID-19, for example[6]. Especially for families with more limited access to health care services, having a trusted person to go to for information and guidance about these matters likely helped to bridge inequities in the healthcare system.

"Pues pienso que toda la información que nos da, porque a veces que decian que solamente podíamos usar las máscaras afuera, también lo tienes que usarlos en casa, en la tienda o en lugares públicos, como en el parque." [I think all the information that she provides [is valuable], because sometimes they would say that we only have to use the masks outside, you also have to wear them in the house, in the store, in public places, like the park] – Parent/Caregiver

"I believe it's support, and also normalizing their fears, maybe? Just let them know that this unknown place that you're in, that's what we're all in it together. I'm going to support you in whatever you need. If I don't know, I'm going to get some information and we're going to work this out and find out together. Normalizing the fear and the uncertainty of what's going on and happening in the world today, and reinforcing their importance as a mom to provide that safe environment for themselves and their child." – Staff/Provider

Parents' Perspectives: What Helps Remote/Distance Services to Work Better?

Families described a number of things that providers and programs did, in addition to providing devices, internet resources, and other technological supports, that they felt were most important to making remote services work better. These included:

- **Provider characteristics,** such as patience, flexibility, ability to adapt and individualize, warmth and empathy, and ability to engage very young children in virtual visits
- Building from an existing strong relationship between the parent/caregiver and provider
- **Intentionally preparing** for the visit, engaging the parent in being actively involved in preparing for the visit, and communicating more frequently ahead of planned visits
- **Specific changes in service structure and/or providers' approach,** such as providing more verbal instruction and including more time for rapport-building

Provider Characteristics

Flexibility & Ability to Individualize Approaches

Families reported that their providers' flexibility in how they offered support was a key factor in making the virtual visits successful for them and their children. Parents shared that they felt that providers were more accommodating to family preferences, such as by allowing parents to choose their preferred method of contact, schedule virtual home visits (even in the evenings) and reschedule their visits as needed was critical to their ability to continue to participate.

"… a veces sí se acomoda, como hay veces que tengo a las niñas que están inquietas… Ella se acomoda. Ella se da el tiempo de terminar la videollamada y hacer la cita. La visita por teléfono, por llamada de teléfono. Y eso es algo que este nos está ayudando mucho, porque se ajusta a lo que las necesidades de las niñas" [She does accommodate to what we need. There are times when my girls are restless… (My home visitor) takes the time to finish the video call and changes the visit to a phone call. She adjusts to the needs of my girls very well so we can have our visit with her.] – Parent/Caregiver

Many programs offered multiple options to connect remotely with their staff (i.e. via phone, video call using WhatsApp or their preferred method of contact). Providers reported that due to families' varying levels of comfort with technology, they needed to figure out what worked best for each family. For example, several staff talked about how they pivoted to using WhatsApp instead of Zoom because many of their Latinx families use it to connect with their families and are comfortable with it. Staff shared that they felt that their ability to be creative and flexible in their approach to working with families was critical, and described how they adapted and tried out different strategies such as parent-only sessions or meeting with the family instead of just the child and adapting along the way to best meet the needs of families. Finally, some providers talked about how they normalized the difficulty of using remote technologies as a way to increase families' engagement with the services and increase their comfort with these modalities.

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[6] Note that home visitors in this program, unique to those we spoke with, were trained nurses.

Implications for Young Children's Experiences During Remote Services

While this study did not directly observe parent-child interactions, based on what parents and staff shared it is possible to extrapolate about how experiencing these supports during COVID-19 may have changed the experiences of infants and toddlers. While these are somewhat speculative, and research that might directly observe these interactions is an important next step, we offer the following reflections:

- Parents/caregivers who were less stressed about meeting basic needs may have been better able to provide the warm, nurturing care important to young children.
- Parents/caregivers who were able to participate more actively in child-focused activities had more opportunities to practice skills during visits, perhaps leading to increased likelihood that these changes would be sustained.
- Frequent opportunities to check in with staff provided more changes to ask emergent questions about infant/toddler behavior, development or other issues.
- Helping parents address their own fears and mental health needs more often during services may have better identified and supported adult mental health, which is critical for effective and responsive parenting.

One strategy for this was to explicitly acknowledge that "*sometimes it's going to be hard*", sharing that by doing this providers felt that they were able to allow space to find out what works or doesn't work for families, and that they were working this out together. Providers also talked about the value of slowing down and being *"as patient as you've ever been in your life"* because it allows for the essential provider-family connection without letting "*the perfect be the enemy of the possible."* Involving families from the beginning in deciding what would work best for them was named as critical for success in engaging the family.

Warm, Responsive and Skilled Providers

Another staff characteristic that parents frequently described as important during remote/distance services was the ability of their provider to be warm and empathetic. Parents described how important it was to have someone who listened and was empathetic – characteristics important for home visitors and other early childhood providers generally

that were made even more so during the pandemic. Parents also noted that it took effort on the part of both families and providers to stay connected.

> *"Her listening and her presence really helped us. If it was probably anybody else and I didn't feel like I was listened to or heard, I probably wouldn't have stuck it out, because it was challenging to be over a video. It's hard, and since she made me feel so comfortable, that's why we stuck it out and we were a good team and it worked for us." – Parent/Caregiver*

Ability to Engage Children

The ability to creatively engage children in visits was mentioned by a number of parents (and at the same time was mentioned as one of the most difficult aspects of providing virtual services). Parents described their appreciation for providers who were able to "*draw [the child's] attention back*" to activities for these very young children. Providers who were particularly attuned to children's emotions, attentional focus, and interests were described as being able to successfully follow the child's lead and to skillfully switch activities when interest waned.

> *"She definitely tries to keep him engaged. If it's not something that he immediately has an interest in, he likes to go and grab a bunch of toys and then come and play with them in front of the computer and ignore whatever she's saying. Then she'll switch how she's doing things and she'll focus on whatever he has, over what she had had planned, so then it still works out and at least you're engaged in something."* – Parent/Caregiver

> *"In face-to-face, we would try to have it consistent. We would sit down, we connect, we do a calm down method, we go through these steps. Whereas via Zoom, I'm like 'What would you guys like to do first?' and 'What would you like to do next?' because they're disconnected. I'm not there, and they don't have that routine. It has to be something that they [children] feel like they're in control [of] because things are out of control. They're not in control of what they usually do or know." – Staff/Provider*

Existing Strong Relationship

Several parents reflected that they felt like having an existing, strong relationship was essential to their decision to stay engaged in remote services. While some families were newly enrolled to services during the pandemic, providers felt this was often more challenging in terms of engagement. This suggests that in thinking about a hybrid model, having opportunities to build a relationship face-to-face before moving to distance/remote options may be important.

"[...] it is so important that you connect with the person [HV]. That's what I see worked out because we had already established that connection in-person. In my case, that has already been established, and it has worked well. I would say that establishing trust and connection, will take longer…. that personal interaction is very difficult to substitute."
– Parent/Caregiver

More Preparation for Visits

Providers noted that they did more intentional work to prepare themselves and the family for the visit. This included more frequent check-ins and reminders, as well as other shifts in how they connected with families during and in between visits. Providers also reported doing more preparation with families, such as giving families more direction on how to set up their video call in order to maximize the provider's view of the child and parent.

One provider explained that virtual service delivery requires more self-awareness for them and parents in figuring out how to make visits work. This requires communicating clearly and at times more directly with parents such as asking them to *"set up the phone, so I can see you guys on the floor together?"*

Along with preparing the physical space for the visit (computer/phone charged), home visits included helpful tips for making sure technology was working and provided visit materials for review before the visit via email or mail. This idea of more intentionally preparing families for home visits, with check-ins, reminders, planning may be something to explore even beyond remote service delivery as a way to increase effectiveness and family engagement in home-based services.

"You also need to make sure that you have a plan if there are potential problems with technology. That's frustrating for you and for clients. Communicating with your client, 'If something happens during the visit or we get disconnected, the plan would be for me to call you or if you would prefer if something happens that we can just reschedule or whatever.' Making sure that you have that plan in place."
– Staff/Provider

"She is great about contacting you and saying, 'Remember we're going to meet on such and such day.' Mondays are our days, but she'll say, 'We're going to meet on Monday, and remember I sent you these papers. Did you all go over them? Did you look at them? Make sure you've looked at them and have tried these activities with [child].'" – Parent/Caregiver

Shifts in Structure and/or Content of Visits

Other providers talked about how they had to learn to communicate and do other things differently in virtual visits. For example, with assessments, they had to learn how to communicate verbally about things they normally could demonstrate physically. Enrolling new families virtually also required communicating *"clearly when you make that first connection and making sure that you go fully through the orientation process with them and that they're feeling comfortable with you."*

Providers also described the need to spend more time building rapport at the beginning of a virtual visit before *"jumping"* into the visit content.

"I try to you know still find out, you know what they've been up to, asking about you know, different things in their day, not just jumping straight into 'this is what we're going to cover in this visit" – Staff/Provider

Staff Perspectives: What Helps Remote/Distance Services to Work Better?

In addition to describing what they felt helped remote services work better for families, providers reflected on what helped them to shift their practice to a remote service environment. Most importantly, providers described the various ways that their supervisors and/or the organization were working to:

- **Allow unprecedented levels of flexibility and support for creativity** for staff in how they deliver remote services, including increasing flexibility about requirements for delivering some components of evidence-based programs (e.g., reducing duration of visits)
- Focusing more strongly on supporting **provider self-care and mental health**

- Providing more frequent opportunities for supervision and peer-to-peer support

Flexibility for Staff

A number of staff noted that the increased flexibility provided by programs was critical. This included both flexibility in schedules, as well as being more open to staff trying different approaches to providing services and to really *"think creatively"* when issues arose. Some staff described how supervisors encouraged them to keep trying new approaches, learning from their mistakes and failed efforts, without becoming discouraged. One noted that her supervisor intentionally created space for them to shift their mindsets about providing remote services, helping them to get away from initial skepticism and frustration related to

thinking, *"'we do relational work, and so [now] we can't do relational work.'"* Another staff described it this way, saying that the *"enduring support and encouragement to do whatever I needed to do as far as to feel safe physically, mentally, emotionally"* provided by their supervisor and organization was essential for these practice pivots to roll out successfully. Others talked about having program support for shifting work hours and days to balance work and family needs, and *"letting our schedule work as best as we can based on what our family's needs are and our bandwidth."* By supporting staff to be flexible in both the logistics (timing, duration, scheduling) and approach to service delivery they were able to provide what families told us they needed for services to work.

SPOTLIGHT
Parallel Process in Action - Programs that Elevated Supports for Staff

Some programs appeared to be more proactive in increasing the frequency and number of supports for their staff, including by facilitating easy access to direct mental health services provided within their own program. For example, some supervisors increased the frequency of their meetings with staff, sometimes checking daily, to provide support, encouragement, and just an opportunity to connect. Other programs increased the frequency of group supervision and/or created more opportunities for staff to meet with each other informally to share their challenges and learn from each other about delivering remote services.

"An extra step that I feel like my supervisor is taking... [is a] 30-minute little meeting over Zoom every morning except Fridays. It's not necessarily to talk about work, but just check-in and talk to somebody else. That way, they know how we're doing. We know how they're doing. In our little group, there's I think four people right now. We get to still keep connected and know how everybody is doing." – Staff/Provider

In other programs, while staff voiced that they felt that they "could" ask for additional support, there was less evidence of proactive attempts to create structures such as these; and in these programs staff often voiced greater levels of personal struggle and stress.

Support for Staff Self-Care

Staff from several programs felt that the program had focused much more intentionally on ensuring staff were attending to their own self-care needs during the pandemic. The most common strategies they mentioned were supporting staff to set boundaries around their work schedules, nurturing their own mental health, and embracing community. Several staff talked about setting boundaries for themselves, such as not working in the evenings and even *"turning the phone off outside of work hours."* That said, families also shared that feeling a reduced sense of professional-family boundaries that emerged both from the more frequent check-ins and the sometimes less formal dynamic of video calls delivered from providers homes was helpful in strengthening the therapeutic relationship. The question of what is and is not appropriate and necessary for boundaries between staff and families is one key question emerging from the shift to remote services that warrants further exploration.

One program offered mental health groups as well as individual counseling for staff. The program made these services readily available to staff during the pandemic.

"Nos ofrece el servicio. Como decía algún momento, 'no necesitas esperarte otro mes. Si ocupas ayuda en este momento estás necesitando apoyo emocional o que no sabes qué hacer o que te sientes demasiado estresada. Háblame y ya vemos agendar una visita, una cita o en ese momento si yo tengo la chance, yo puedo contestarte y si es de emergencia puedo cancelar mi cita si puedo atenderte a ti.'" [The (counselor) offers us the service like, 'You don't need to wait another month. If you need help right now, if you are in need of emotional support, or you don't know what to do or you feel too stressed, talk to me and we'll see. We schedule a visit or an appointment, or at this time if I have the chance, I can answer you and if it is an emergency, I can cancel my appointments and I can attend to you.']
– Staff/Provider

More Frequent Supervision

Expanded supervision was described as one of the most critical supports for staff, who shared that supervisors made themselves more available for check-ins and encouraged flexible schedules, mental health days, and reduced hours as needed for staff.

"My supervisor has been very present, very available. One of the big shifts was that all therapists started receiving an hour of supervision every week, no matter what. That was a very big decision for them to make because it can shift and impact people's productivity. That was really good and helpful. I don't meet with her once a week anymore, but earlier on, it

was just so helpful to have a space to look at her and be like this is what I'm doing." – Staff/Provider

More Opportunities for Peer Support & Learning

In some programs, staff described efforts that were being made to increase opportunities for peer support and collaboration was important.

"In our organization, we have once a month CPP consult calls. I believe there's also a PCIT consult call, there's a therapy consult call. That is a peer supervision, where we're like, 'What are the challenges that are coming up? Have you found any resources? I watched such and such video, and this was helpful to me.' It's not a new thing, but it is a thing that's kept going during the pandemic that I have found helpful. That's been good."
– Staff/Provider

What Changed for the Better in Remote Service Delivery?

The process of pivoting to technology-enabled services and understanding family and staff experiences in doing so provides an opportunity to identify aspects of service provision that worked particularly well using remote technologies, as well as ways that non-remote provision of these kinds of early childhood services might be improved. Families and staff described aspects of services that worked well - and in some cases represented improvements over how services have been provided in the past. These included:

- **Increased flexibility** in program delivery requirements related to duration and location of services: Flexibility enabled providers to maintain connections and supported improved family engagement and participation.
- **Logistical improvements:** Virtual visits increased reduced travel time, made visits more accessible and convenient, and, for some families, increased their overall comfort about meeting with staff. This shift was seen as an improvement by many families and providers.
- **Increased provider creativity:** Providers found new strategies for engaging children and opportunities for encouraging engagement between families.
- **Increased support for parent-child interactions:** The virtual format necessitated working more directly with parents.
- **Expanded focus on adult mental health:** The stress of the pandemic increased the need for adult mental health support, and providers shifted their approach to address this.

Increased Flexibility in Program Requirements & Delivery Location

A key takeaway from this study was that increased flexibility in the duration, location, and even content of services was beneficial to keeping families engaged during the pandemic - and possibly ongoing. Most programs reduced mandatory duration for visits, which prior to the pandemic ranged from 60-90 minutes. This generally resulted in shorter visits, but

more frequent contacts between providers and families. Some families told us their home visitors were checking in as frequently as daily at some points during the pandemic, which was seen as a significant shift from past practice.

"[Before} home [visits] only counted as visits if you were in the home physically. Now they've changed it to where visits can be...as short as I want...say 15 minutes, as long as you're talking about certain aspects of health or safety, for it to count as a visit. That can be via email, phone call, text, if you're constantly exchanging texts back and forth discussing information or child development, that can count as a visit now as well." – Staff/Provider

Providers were more flexible in how often they communicated with families, and how accessible they were to family requests. Parents mentioned having more frequent check-ins with their home visitors and that providers were more available to answer and respond to their phone calls and text messages.

"... Tal vez para bien. porque ella, pues se ha comunicado más con nosotros, como por ejemplo de que hay recursos de la comunidad y ella nos manda muchos mensajes de pues si necesitamos algo y nos manda información, mucha información. Y de hecho pienso que he hablado más con ella porque antes nada más era como la visita a la casa. Una vez al mes. Pero pues ahorita como igual trae, trae actividades, aunque desde lejos, pero viene a dejarnos actividades que algún libro, o papeles para firmar Y pues sí, pienso que hemos estado más en contacto ahora que antes." [our communication] has increased for good, because she has communicated more with us. For example, there are community resources, and they send us many messages, asking if we need anything, and they send us a lot of information. In fact, I think I have talked more with her [home visitor], because before, it was only the visit to the house once a month, but now she brings activities, books or papers to sign,

and I think we have been more in contact now than before.] – Parent/Caregiver

Providers also described how they tried to be more available to families. One provider stated that she told parents:

"If you ever need anything, we are here. If I don't know, I will find it.' I feel this has helped me to have that connection with the families...I was there to tell them 'I am here whenever you need me.'"
– Staff/Provider

Increased staff availability demonstrated a willingness to be present with families which was especially helpful for families who were initially reluctant to engage in remote services. One home visitor explained it this way,

"Siento que esa conexión de saber que no está sola, que hay alguien que. 'Que aquí estoy si me necesitas. No sé todo, pero trabajo en una organización que tiene mucho que ofrecer.'" [I believe that connection of knowing that they are not alone, that there is someone there who says 'I'm here if you need me. I don't know everything, but my organization has a lot to offer.'] – Staff/Provider

Moreover, some parents appreciated that virtual visits tended to be shorter and more focused**.** As a result, they found them easier to manage, especially with a baby or young child who might *"get upset and antsy"* during longer visits. Virtual infant mental health visits (which formerly were provided in-office) were described as being more focused and manageable:

"They are very convenient, and you have more flexibility also with the virtual ones, because once you go for an in-person meeting, it has to be a length of time. Virtually, you can have it adjusted and customize it. I will say they could be much targeted, and sometimes you don't need the entire half an hour, 45 minutes. You just need a quick chat or intervention. In that case, they are great."
– Parent/Caregiver

Many parents appreciated that remote visits allowed them to participate from different locations, with the requirement that visits be delivered "in home" waived. The convenience of remote services was especially appealing to working parents, although some parents shared that they had even participated in visits from their car.

"It is easy to pick up a telephone and do a visit. I've had people that are driving and do the visit while they're in their car, and they don't have to take extra time off of work. They can do it on their lunch break."
– Staff/Provider

SPOTLIGHT
Shifting the Center of Visits to Parent-Led Developmental Activities

At one program site, parent and staff experiences suggested that prior to COVID-19, home visiting services and activities typically had a strong emphasis on the home visitor interacting directly with the child, doing activities and modeling interactions for parents. These parents (largely stay-at-home mothers), relative to other parents we spoke with, expressed more concerns about the loss, for their children, of having these direct interactions with staff. They also noted that for them, one of the important aspects of face-to-face visits for themselves was having an opportunity to step back from daily caregiving activities.

"Seeing that my youngest girl is having to experience everything through a computer, makes me feel a little sad, because she does not get the full experience of what a home visitor is; them coming to do activities with her, or them teaching her to do new things...Now there are only activities at home and watching the home visitor on the computer. There are times when the home visitor is doing an activity and my little girl does not look at her or the computer, there are times when she looks at the computer and other times when she doesn't, and she misses parts of those activities." – *Parent/Caregiver*

At the same time, staff in this program (as well as others) felt this shift actually benefited the quality of family engagement in visits.

"It forced the parent to engage with the child. I know that probably sounds silly. In our job, a lot of times, we can model it first. Then, we have the parent model it or the parent do it with the child. This way, it made it where the parent was 100% having to do it with the child. We can role play it through [zoom], but for the activity, they had to do it. It really helped push that back to this parent." – Staff/Provider

"It's a lot easier, especially for the moms that work. Instead of trying to squeeze a visit somewhere in their week, they can say, 'Oh, I can call you on my lunch break or I can video chat you on my lunch break.' That's been really nice. I hope to keep that especially because I'm a single mom myself... The mom's at

work the same hours as me, it's hard to get a visit in because then I have to get a babysitter to go see them after hours. That's been nice to be able to do that, for me personally, and for them, I think. That is one benefit." – Staff/Provider

Reduced Travel Time & More Convenient Scheduling

Programs supported broader flexibility in work schedules, which allowed for more flexibility in scheduling and conducting visits. Parents expressed appreciation for these changes, noting that virtual home visits were significantly easier to schedule and reschedule since home visitors had more flexibility from not having to travel. Others remarked on the benefit of still being able to join a visit late after receiving a reminder text from their home visitor in cases where they forgot about a visit. Providers recognized that *"remote is easier for families to access"* and had contributed to a *"decrease in no shows."*

> *"I like phone calls better. I do like being in person, but where we can't go outside and do an activity...I like being on the phone better than just sitting in a room and talking...It's definitely more convenient"*
> *– Parent/Caregiver*

> *"It was easier for me not to worry about having to get home in time for things because we could still do it somewhere else." – Parent/Caregiver*

Parents shared that they felt that there were more opportunities to schedule with in-home providers because they were no longer spending time in transit:

> *"The time, convenience, and scheduling. There is a lot more available because when we had to go in, this might be harder on the therapists or the social workers as well, but there's a lot more time that they can schedule people because they're not driving back and forth." – Parent/Caregiver*

Many parents and staff engaged with in-office infant mental health services noted that reduced travel time increased their participation and made the services more accessible by eliminating the need for transportation and childcare services:

> *"[Families] who prefer video conferencing because they have kids they're taking care of, they can't leave the house, they don't have transportation or childcare, so for them, tele-therapy is really a better option because there's better access...Teletherapy breaks down some of those barriers." – Staff/Provider*

Finally, in-home providers shared that because they weren't traveling from home to home, they felt *"more organized"* because *"everything that I need is in this one place."* In addition to increasing organization, remote home visiting

also streamlined paperwork processes and helped them better prepare parents for visits.

> *"When we take our education and our handouts and stuff, instead of printing them out and handing them to them, we have the option to text it to them... I could text the document before the visit and say, 'Hey, I sent this to you. This is what we'll be talking about today. You can read over it or save it for later,' which was a really great tool, and that we could still at least educate virtually, anyway." – Staff/Provider*

In large part due to increased convenience enabled by some of these changes in program requirements, providers reported seeing a lower number of cancellations and 'no shows' visits**,** sharing that families were less likely to miss their virtual visits and are more willing to do them over the phone or video call then before.

> *"Being able to do appointments over the phone and through video has decreased the no show/cancellation rate [for families]." – Staff/Provider*

> *"[Parents] miss less visits when we have been doing them remotely just because we're doing them over the phone. I feel like if my family's out at the park, and we want to do a visit with them, and they forgot, and I call them, they're still, 'Yeah, I'll take the call. Sit down with my child.' Then, we'll do that visit. If they're on their way somewhere, and they're, 'Oh, I was on my way here, but I'll stop. I have my child here. We'll do the visit over the phone.'" – Staff/Provider*

Overall, staff in therapeutic programs reported that providing remote services, and the increased level of contact with families related to that shift, had strengthened their work with parents and noted that they would likely continue to have more contact with parents virtually going forward.

> *"Staff probably will retain [increased parent contact] more than they did previously and in having more parent contact, I think our parent work in general is stronger as a result of this [shift to virtual services." – Staff/Provider*

Increased Family Comfort with Virtual Sessions

Providers also noticed that some families appreciated the option for virtual service as these provided them with a sense of safety during the pandemic.

> *"They felt a lot more comfortable and they would prefer to do Zoom over face-to-face just because of how things were and their [own health-related] risks. It provided them with the opportunity to feel safe and not have to do something that they weren't 100% confident or comfortable with." – Staff/Provider*

Other families preferred virtual visits due to their increased social comfort:

"I like it because I am more of an introverted person, so I don't have to see them face to face. And I can just go through the phone which kind of eases a lot of my anxieties about it." – Parent/Caregiver

"It seemed like I could talk more to her over the phone than face-to-face. I don't like talking face-to-face... I guess it makes me nervous." – Parent/Caregiver

"And another thing is, I have a toddler so my house isn't always clean there's always toys everywhere...so if I'm on the phone you don't necessarily think that my house is that dirty." – Parent/Caregiver

One parent noted that virtual services were easier for her child because with virtual visits, their child doesn't realize that he's at an appointment, increasing his comfort and the quality of the session.

"My son hates going to his doctor. It might be because he's had shots there, and now he has bad feelings when he goes in the place, but he's unaware that he's even doing therapy because it's in his own house. It's been so much easier to do it online." – Parent/Caregiver

Increased Provider Creativity

The shift to virtual services required providers to be creative in engaging families and children. In general, engaging children in virtual visits was seen as a challenge by many providers, but some had found innovative ways to maintain children's interest.

"I did more music videos, and then engaging them in those, instead of me trying to sing. I'll usually try to provide song lyrics to fun songs to my children, my families each week, and then we do those." – Staff/Provider

One provider was able to explore the advantages of virtual services and used the functions available on Zoom to find new and exciting ways to build a connection with children.

"The share screen, that was like my 'Aha,' I could write them messages and they were like oh 'she's writing to me,' and then they could write back and that was my connecting with them. We would practice writing letters or doing shapes and that's how they would do it. That was really fun for me, I love that we can share screens and write messages back and forth." – Staff/Provider

Some parents also reported that creative approaches during remote visits improved children's engagement in therapeutic

services. For example, one parent described how her provider incorporated personal aspects of her home life, such as her dogs, into the visits with her daughter. The parent stated that it enhanced her child's experience and made her more engaged.

"For instance, [provider] had dogs. With the sessions virtually, she incorporated the dogs into the sessions, which my daughter loves. That connection was easily translated, and she used these homey things that, of course, in an office you can't. I feel that she was good at incorporating that, not making it so that it was like an office session. It was different and my daughter loved it...Being able to normalize a situation which at the beginning was not normal, that's a huge strength. Being able to connect with the kid, no matter what. I think those are [the providers] strengths." – Parent/Caregiver

Some home visiting programs were creative in finding ways to support contact among families, including virtual parent-child playgroups, parent socialization groups, and virtual parenting groups. Several programs reported enhanced engagement of families in these virtual groups compared to in-person pre-pandemic efforts and they expressed a desire to continue to provide these opportunities post-pandemic so families would not have the barriers of transportation, travel time, and childcare.

As one home visitor described:

"We had these beautiful series of workshops...we'll put these group bags together and we'll drop them off at the doors...we also slip in the bag some information for the fathers, trying to engage them also...Then we'll all meet together on Zoom, on an early evening at six o'clock, and play a little game or do a little introduction and then do our group night, whether it's a paint night or a story and a cookie, or a story and a craft. And both engaging the parent and the child...We did a survey, we asked them what they would like, trying to meet service needs...I think it's successful." – Staff/Provider

More Focus on Parent-Child Interactions

Some providers reported that the shift from visits focused on provider-child interaction to parent-child interaction was a practice improvement and helped parents to build their confidence. Other providers noticed that changes in the home visits increased parents' involvement, especially in terms of the parent's ability to find new ways to help their child engage with the visit content. This created more of a partnership between the parent and the provider.

"I think the families are way more involved... Whenever it's on Zoom, they have no choice, like their child's going to need help, they're going to need to

follow that routine. So, providing them with the materials and then they can be creative and flex it however they need to, to make their child stay engaged. I had a mom who she just – she's really creative, she's great, I truly enjoy her and she really just can make a whole visit keeping her child completely engaged 100% of the time for the whole hour and a half, even on Zoom. So, it was really great, she's amazing. And they work a lot better, they want to sit there and they want to be engaged, so we take turns versus me leading and them trying to follow. I think they're a lot more confident." – Staff/Provider

Staff in therapeutic infant mental health programs also described how virtual sessions provided deeper insights into the home environment and the dynamics of the parent-child relationship. This gave them a deeper understanding of why parents and children might behave in certain ways as well as an opportunity to address behaviors in real time. One provider explained that it is the behaviors at home that are generally motivating parents to seek help.

"One thing about the remote services that is an advantage is you actually do see the environment that the family's in. For parents that aren't as verbally expressive or the way I was asking the questions, it was just difficult to picture, why is this such a challenge? When you see the environment, and then you see how the child is reacting and responding in the environment, now, you're just a lot more aware of what does this look like for a parent on a daily basis?" – Staff/Provider

Increased Focus on Family & Staff Mental Health

Another shift in services during the pandemic that was described by families was an increased level of support for their own emotional and mental well-being, and that the support offered through their relationship helped to *"catch things about our mental health that we don't catch."* Providers provided listening ears, advocacy, and support systems for these families during the pandemic:

"I feel like because I tend to stress a lot, so it is really very helpful for me, because, if he cries too much or something I can call [Provider], and she helps me. She's like 'have you tried doing this, or this or this' and in like half of the calls it'd be what would be wrong with him." – Parent/Caregiver

Differences Between Home-Based and Office-Based Early Childhood Supports

One key difference across the programs in this study was whether the original supports provided to families were primarily offered in-home (e.g., home visiting of various types) or in-office (e.g. Parent-Child Interaction Therapy). While parents across the board valued being able to continue to engage in these services during the pandemic, services offered primarily in-home were more likely to be described as "good enough" or "better than no services" while both parents and staff clearly found aspects of doing PCIT visits in-home to be important. Having regular opportunities to support parents and children in their natural home environment was clearly viewed as a positive change in the quality, and potentially, in the effectiveness, of these services.

"One thing about the remote services that is an advantage is you actually do see the environment that the family is in. For parents that aren't as verbally expressive or the way I was asking the questions, it was just difficult to picture, why is this such a challenge? When you see the environment, and then you see how the child is reacting and responding in the environment, you're just a lot more aware of 'what does this look like for a parent on a daily basis'?" – Staff/Provider

"Well I think that the benefit of doing PCIT from your living room is it teaches you skills to use in the home environment, rather than the settings that it was before. Not that it wasn't great and the toys were fantastic, but I mean to be able to learn how to do that stuff in the house is priceless because that's where the behaviors are, the behaviors are at home." – Parent/Caregiver

"She just always makes sure that I'm doing good and well mentally. I think that it's very important that she still wants to connect with me and make sure that I'm doing okay." – Parent/Caregiver

What Didn't Work and What Needs Improvement?

Across the sites, there were several recurring themes about the aspects of service delivery that were made more challenging with technology-enabled services. First, however, it is important to emphasize that like previous research teams, we heard a consistent theme about the difficulties that families and staff experienced in the digital divide that undermines connectivity in rural and urban areas and disproportionately impacts BIPOC and under-resourced communities. Whether it is access to reliable broadband, devices, or data plans, families and staff articulated concerns about when and how the technology itself was a barrier to high quality infant service delivery. These issues have been highlighted in other research, and have begun to draw policy attention to the need to improve national infrastructure for high-speed broadband. Other systemic challenges remain, however, in terms of how to finance access to these services and how to ensure equitable access for non-English speaking communities.

Below we describe the challenges identified in this study that go beyond the digital divide. The first several themes reflect the challenge of **navigating relationships** in a technology-enabled service mode:

The difficulty in engaging effectively with babies and toddlers, due to their developmental capacities

Challenges developing and maintaining relationships between parents and providers, especially during a time of great strain on everyone

Other key challenges that were identified were related to managing the complexity of providing virtual services in-home, in particular:

- Difficulty reducing external distractions during visits
- Confidentiality issues and concerns about safety with the unexpected or uncontrolled presence of others during conversations related to sensitive topics
- Difficulty doing developmental and other assessments

Challenges Engaging Directly with Infants and Toddlers

One Early Head Start home visitor stated the following, which underscores several aspects of the challenge in delivering technology-enabled services to babies and toddlers using evidence-based models.

> *"One of the hardest challenges is keeping the families and the children engaged in the 90 minutes. That's a long time for a two– year– old to sit and engage with me."- Staff/Provider*

SPOTLIGHT
Families Who Stopped Receiving Services During COVID

Although programs generally did not feel that a substantial number of families had had to drop out of services during the pandemic, one factor that did seem to contribute to family attrition was the presence of multiple older children in the home, and the burden on families to support these older children to meet expectations for engagement in virtual learning as well as to provide needed instructional and homework help at home. Staff shared with us - as did a few parents - that a number of parents felt they needed to opt out of early childhood services in order to attend to these other demands. This likely reflects several systemic issues. First, the expectation for, and demands on, families to support virtual learning for school-aged children was immense, and many had limited resources - either technologically or in terms of available time to successfully meet these needs. Second, this may reflect the ongoing larger societal value and prioritization of school-age learning over early childhood, despite the well-documented importance of the 0-5 age period for cognitive and other forms of development.

Developmentally, babies and toddlers are not able to (nor should they be expected to) engage with screens for 90 minutes. And yet, Early Head Start Performance Standards specify weekly visits for 90 minutes. Juggling concerns with fidelity to the model with the flexibility and creativity needed to engage parents with infants and toddlers through a cell phone or tablet was articulated across the sites as a challenge that was uniquely difficult for this age group. While many programs eventually changed the required duration of services, engaging these youngest children during visits remained a challenge that was mentioned repeatedly by families and providers.

Challenges Maintaining Positive Provider-Parent Relationships

Across the sites, parents and providers both expressed concerns about challenges to building rapport, cultivating trust and sustaining relationships between the adults engaged in the services. Single parents, especially those who were in remote areas, were especially apt to elevate the absence of an in-person visit as something that undermined the effectiveness of the technology-enabled services. Families who had been engaged in in-person services and

then transitioned to virtual had the prior experience to compare this new modality to, which gave them a point of comparison.

"It would be nice to actually have [home visitor] in person, I know we can't because of COVID, but it would actually be nice because I'm a single mom and just being a home doing everything over Zoom there

Prioritizing Family Choice - Leading with Values in Technology Decisions

Two programs shared examples of how they made decisions that prioritized family comfort and preference over other concerns in decisions related to technology. Specifically, while some programs disallowed the use of social media applications (namely, WhatsApp and Facebook Messenger) for providing remote services (due to concerns about lack of adequate security), two others elected to use these platforms in deference to family preference and existing comfort with using them. WhatsApp is widely used within the Latino/a/x community, and one program continued to offer it to families out of their belief that prioritizing family comfort and ease in accessing technology-enabled services was paramount. This program provided families with options for remote access, including Zoom and other more widely used platforms, and many families opted for something they were familiar with (WhatsApp, in this case). Providers shared that they felt this contributed to accessibility among the families they worked with.

"I choose whatever works best for the family, some families have access to different modes of technology so I'll use that one with the families and what they feel more comfortable with and so that's what I go with." – Staff/Provider

"It was definitely a learning experience on how to connect with them [families], because a lot of my families, they're monolingual in Spanish. The programs like Zoom and everything are in English. Having [families] follow this, at first was very difficult. Even now, I don't really see families through Zoom. The app that we use is WhatsApp. We're mainly using it for the families that agreed to do video calls. The ones that did not agree, or we're not comfortable doing them that way, we just do them through phone calls." – Staff/Provider

has been like a week when I haven't been outside at all." – Parent/Caregiver

This issue also may have explained why some programs described having difficulty enrolling and/or retaining new families in services. As described previously, a number of parents and providers felt that their ability to move into remote services was facilitated by the strength of their pre-existing relationship.

Distractions in the Home Environment

As was mentioned earlier, some of the providers we heard from embraced their new-found ability to see what was going on in the home environment and shared that it actually enhanced the therapeutic goals. But for many parents and providers alike, even those accustomed to home-based service delivery, the addition of technology made navigating the distractions in the home even more challenging.

"I'd get a phone call while I was meeting with my home visitor, or the baby's crying and screaming, and she's right there, and the dog was barking. So much going on in the home, which is if they're right there with you in person, that's a little bit easier to manage." – Parent/Caregiver

Providers and parents expressed that having visits in person were more conducive to balancing the kinds of distractions that inevitably emerge during a home visit with attention to the visit itself. For example, during a face-to-face visit, if a baby is crying and the dog is barking and the phone is ringing, the home visitor can step in and offer to soothe the baby while the parent lets the dog out; in remote sessions, parents juggled these competing demands themselves.

Concerns about Confidentiality & Safety

In several sites, the issues about how to navigate around having more people in the home than usual came up as a challenge to managing the complexities of confidentiality in this work. Some providers raised this issue in the context of conversations about interpersonal violence and safety planning—which were made more difficult by the presence of a potential abuser in the home during the visit. Others spoke about concerns of having adult conversations about topics that were not appropriate for children to hear, but having children in the room.

"Another adjustment is confidentiality. My impression is that most of the people I see virtually don't mind if their children or a parent are around. But I've had to redirect conversations if children are around to where we can't talk about certain things because it's not appropriate talking about those things in front of kids." – Staff/Provider

Some staff further discussed the challenge of identifying and addressing safety concerns virtually.

> "I think that safety is always a huge factor. I think safety really is so important, when we're providing and we're supporting relationship therapy, safety is number one. Oftentimes I don't have the control that I would have in face to face, so finding new ways to support families safely. I think sometimes with tele-health it's a little more challenging to track."
> – Staff/Provider

> "We weren't in the homes, so if there was domestic violence going on, or there was abuse going on, neglect going on, we did not have actual eyes in the home. Of course, they can hide that virtually. They're only going to show us the good parts. They're not going to show us the bad, or the stuff that we feel might be a safety issue for the children. Having both [virtual and in person] options available is good, but it needs to be a good balance of both. You have a visit one week on the phone, but the next week, you're in the house doing activities with the child and can see the home. That's very important." – Staff/Provider

Challenges Conducting Important Assessments

In a similar vein, providers and families raised concerns about the limited ability to do developmental and psychosocial screenings and assessments remotely.

> "I missed being able to get my daughter's weight and her measurements and stuff like that. I was pretty much in the dark for days until she went to her well child checks." – Parent/Caregiver

Providers expressed concern about the validity of depression screening when conducted over the phone or in a room full of people. Home visitors reported on the difficulties of not being able to model certain behaviors to promote parent-child interaction. As one provider said:

> "You can't see their living environment, because we would typically do visits in the home. ... Assessments are definitely more difficult, teaching breastfeeding is a little bit more difficult anything that's hands down that you would have to do as a nurse to do an assessment or treatment off of that assessment that is much more difficult to do over a telephone and even so to do it over a computer, even when you can see them it still can be hard." – Staff/Provider
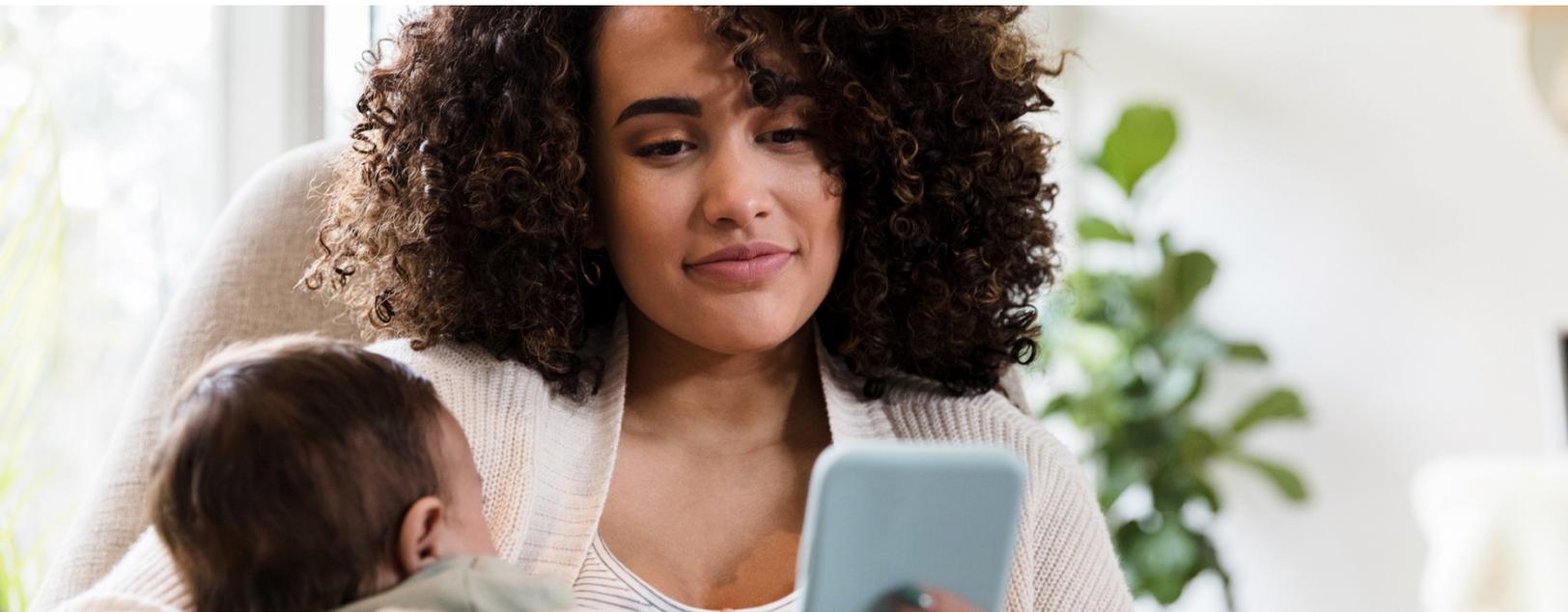
Conclusions & Recommendations

In the course of this study, we heard from 100 parent/caregivers and early childhood service providers from highly diverse geographic regions; racial, ethnic, and cultural backgrounds; and program models about the importance of relationship-based infant and early childhood services during an unprecedented period of social isolation, economic disruption, and continuing health crisis. As of this writing (September 2021), the COVID-19 pandemic has only begun to loosen its grip. Resurgences related to the Delta variant, rates of breakthrough infections among the fully vaccinated, and ongoing politicization and turmoil related to the need for safety protocols such as vaccination and mask requirements raise questions about when and to what extent any return to pre-pandemic, face-to-face service delivery strategies may be fully possible. It is increasingly clear that the COVID-19 pandemic has taken a toll on both parents and children across all age groups – and that how these impacts will be manifested in the longer term is as yet unknown. At the same time, findings such as those in this report suggest that by continuing to provide important supports to parents that both directly (e.g., by ensuring housing stability and adequate food) and indirectly (e.g., by decreasing parenting-related stress and supporting effective parenting) impact children, we may be able to ameliorate potential longer-term negative consequences. Given this, our recommendations relate both to how to improve the delivery of remote/technology-enabled early childhood and infant mental health services, as well as implications for improving the quality and effectiveness of these services delivered in-person.

Additionally, we offer ideas related to how programs might be improved through intentionally developing hybrid approaches that incorporate successful elements of remote practice offered in combination with in-person services. In thinking about the future of remote delivery of infant-toddler services, it is important to note that despite the challenges experienced by both parents and staff, these results suggest that the benefits greatly outweighed the difficulties. Most staff and families ultimately felt comfortable engaging in remote services, and were interested in continuing to provide and/or receive services this way. Thus, delivering these valuable infant and toddler services remotely, in full or in part, is likely to continue, and will be a critical area for additional model development and research. Developing ways to incorporate remote strategies may contribute to improving the overall quality and effectiveness of these programs.

We offer the following ten recommendations based on study findings below. While most of these recommendations have implications for multiple audiences, we have organized these to emphasize those who hold the key levers for decision making and power to implement changes.

Recommendations for Policy Makers & Funders

1. **Increase availability of, and connection to, adult mental health services through telehealth.** The need for adult mental health services for parents/caregivers in home visiting and other infant/toddler services has been well-documented. At the same time providers and families continually describe the difficulty of accessing these services, given the large-scale, systemic lack of available mental health services, especially for adults with young children. Further, this lack of access is even more pronounced for non-English speaking families and for families in rural communities. Telehealth is a promising approach to helping bridge this gap, as parents can access services without regard to physical location and distance, and barriers related to transportation and lack of child care are greatly reduced. Home visitors and infant/early childhood providers, who have strong trusting relationships with parents and caregivers, could play an important role in linking families with these resources. These service providers may also be in a position to talk with parents about cultural and social stigma, and to break down these barriers, especially if providers have a deep knowledge and lived experience of the families' culture and how that plays into reluctance to seek out mental health supports. In this study, programs that included adult mental health services as part of the larger organizational service array may have had the most success in expanding access to families (as well as staff) during the pandemic. While not all programs will be able to do this, it speaks to the importance of organizations developing close collaborative relationships with mental health service agencies, the need to advocate for these agencies to provide mental health services using remote technology, and the potential value of strong and integrated organizational partnerships to reduce barriers to access for families.

2. **Expand availability of Infant and Early Childhood Mental Health Consultation (IECMHC) to infant and toddler programs.** IECMHC is an evidence-informed model for expanding the types of mental health and social/emotional support available to children, families, and staff. While much more typically associated with and/or required for center-based and other forms of early childhood care, it may also provide significant benefits within the context of home visiting.[7,8] In the context of these programs, this service augmentation could be a powerful tool - potentially available through telehealth and/or supported through Medicaid billing, for both improving staff capacity and skills for support parent-infant dyads when the parent or the child has mental health concerns, as well as for supporting staff wellness directly.

SPOTLIGHT
Policy Lesson for Providing Virtual Services

One of the programs we worked with that provides primarily direct early childhood mental health supports, told us that a barrier to providing remote-enabled services was the lower level of reimbursement provided by Medicaid and private insurance for telehealth visits. Given the potential for providing some visits remotely to families, this is an area of policy inequity that warrants change. Some also worried that licensing restrictions might limit providing telehealth across county or other geographical boundaries.

> *"Right now mental health billing has been opened up for telehealth services. They made it very easy on us without all the standard restrictions, so I don't know what that might mean in our future when we're back to in person visits. I actually don't even know as far as our mental health services what our agency license [requires] - whether we can provide services in [a different county]" – Staff/Provider*

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[7] Goodson, B. D., Mackrain, M., Perry, D. F., O'Brien, K., & Gwaltney, M. K. (2013). Enhancing home visiting with mental health consultation. Pediatrics, 132(Supplement 2), S180-S190;

[8] Lambarth, C. H., & Green, B. L. (2019). Exploring a model for infant and early childhood mental health consultation in early childhood home visiting. Infant Mental Health Journal, 40(6), 874-888.

Recommendations for Program Model Developers

1. **Increase flexibility in evidence-based model requirements,** especially those related to frequency and duration of visits, and by allowing remote visit options, in order to improve family engagement and contribute to the quality of services. In particular, the following changes were described as particularly important:
   a. Allowing home visits to be delivered remotely and/or in other locations
   b. Reducing the required duration of visits
   c. Creating more flexibility in visit scheduling, including offering visit times that go beyond traditional work hours as well as allowing more flexibility in terms of the frequency of regular visits
   d. Increasing communication between providers and families between visits through more regular use of texts, phone calls, and other social media for brief check-ins, reminders, and updates
   e. Seeking more input from families about their preferences for frequency, duration, and service modality and using this to continually individualize service delivery so that it authentically puts families at the center of how services are delivered

2. **Create intentionally hybrid approaches** that incorporate effective aspects of remote/distance services while intentionally maintaining those aspects of services that may be best done face-to-face. It was clear that some activities did not translate as well into a telehealth/remote visit platform.
   While some of these could likely be improved with better technology and more time for strategic work to refine remote strategies, hybrid approaches offer a way to blend the best of both worlds. **For infant mental health services** typically provided at a clinic or office, benefits of a hybrid approach that includes some visits at home would likely be an important model improvement. Parents and staff both described considerable benefits of remote services due to allowing sessions to be held at more convenient, flexible times, and to the added value of having sessions provided in the home environment (as compared to only in-office). This suggests that maintaining remote services even when face-to-face visits are possible could improve the overall quality of services. Offering a hybrid model moving forward that includes a remote service component could help to increase parent engagement, as well as provide clinicians with opportunities to gain deeper understanding of the family home environment and of the child's behavior across different settings.
   Model developers should therefore intentionally create hybrid model options, considering:

   a. Having initial visits be face-to-face, in order to support relationship building prior to moving to remote or video visits
   b. Retaining specific tasks such as developmental and other assessments that are better conducted face-to-face
   c. Offering multiple options for families to individualize how they receive services, and revisiting these preferences on a regular basis
   d. Considering ways to provide support for basic needs and resources that rely more strongly on remote technologies, such as through website request links and connections to community-wide information and referral resources. Moreover, this may be a piece of the home visitors' work that can be effectively dealt with remotely, through check ins and support in between regular visit times; this would allow visit times to be more focused on early childhood development and parenting-related supports.

3. **Prioritize and rethink strategies for meeting families' basic resource needs.** Family needs during COVID-19 expanded dramatically, and with the increased likely of climate-related events and crises, as well as other unexpected community events, the field of early childhood may want to both prioritize how to best meet these needs, recognizing that family instability and lack of basic food, shelter, and safety harms children and parents, and reduces parents' capacity to work on longer-term goals. Given the extensiveness of these needs, home visiting and infant mental health models may need to consider how to expand supports in this area without taking away from staff time and energy to support families' other goals. (e.g., partnerships with other programs, creating separate access mechanisms for meeting these needs), That said, helping families meet these basic needs helps create family stability needed for healthy child development, and serves as an important point of entry for some families.

4. **Create openness to change in model delivery by actively listening to parents and responding to their needs.** A key lesson learned from the programs and families we spoke with was that what might have seemed impossible at the beginning of the COVID-19 pandemic (e.g., effectively providing services remotely) was, in fact, possible. Moreover, the level of flexibility and responsiveness to parents' needs pushed these evidence-based models to implement changes that in the past had not been considered feasible due to model fidelity requirements. This lesson in how to more actively listen and respond to parents' needs and voices is an important one for practice and policy – and is aligned with recent work across early childhood and

home visiting programs to more intentionally incorporate parent voices into leadership and decision making at the policy and practice levels[9]. Program leaders and model developers would do well to adopt a listening stance and be open to small and large practice shifts that reflect parents' stated needs.

Recommendations for Programs & Practitioners

1. **Incorporate what was learned about planning and advance preparation for visit success.** Parents appreciated and valued pre-visit support that was offered in advance of remote visits. This included reminders about materials and activities, gathering input on planning for upcoming visits, and preparing families logistically to be ready to participate in remote/distance visits. This work in between visits may have helped parents to remember to practice or work on ideas shared from visit to visit, reduce no-shows at visit time (giving parents more opportunities to reschedule in advance), and to build a sense of shared planning and commitment to future visits. As such, this kind of planning interactions may contribute to service quality, regardless of whether those services are delivered in-person or remotely.

2. **Build on approaches used by providers to more intentionally focus on and support caregiver-child interactions.** Most, although not all, home visiting and infant mental health services implicitly or explicitly see the parent as the primary agent of change for improving child outcomes. Thus, these models focus on helping parents build their skills and knowledge in order to more successfully promote their children's development. That said, home visiting research suggests that providers spend much of the time during their visits interacting directly with children, rather than working with parents. Thus, for these providers, providing services remotely required a shift in practice, with many describing an approach more like parent coaching - providing verbal support and guidance for parents as they engaged with their children than had previously been the case. While this was not unilaterally successful (and some parents voiced their experience of loss of support in response to this shift), many providers felt it represented an important practice change that may improve service effectiveness overall. While the idea of working with home visitors to more explicitly focus on guiding parents and parent coaching is not new, the pandemic forced the hand of providers, and may offer an opportunity to build on this to continue to support this practice change even as face-to-face visits are resumed. Such a shift also has

implications for ongoing training and workforce development to increase providers' skill in effective coaching methods. Additional research to identify successful practices and strategies used for this purpose during remote service delivery would be helpful in creating professional development resources.

3. **Continue to expand organizational support for staff.** Programs' ability to provide support for staff was a key factor in successful service delivery; most notably, providing mental health services for staff as well as clearly attending to staff emotional needs and personal stressors through supervisory support. Continuing these strong organizational supports moving forward could have a long-term beneficial effect on staff retention. Improvements in staff support included:
   a. More flexible work schedules.
   b. More frequent check ins between staff and supervisors.
   c. More planned opportunities for professional shared learning (e.g., virtual meetings to share lessons learned, brainstorm ideas, etc.).
   d. More frequent regular supervision opportunities, with expanded supervisory support for holistic staff well-being (in contrast to more administrative supervision).
   e. More use of virtual/remote technologies for doing supervisory observations of visits.

4. **Explore parents' continued interest in remote parent education and support groups.** Several programs were highly successful implementing remote (typically, via Zoom) parent-child playgroups during the pandemic. Keys to making these successful include offering them in multiple languages, providing frequent reminders, and providing materials needed for families and children to use during the sessions. Some families reported preferring these remote groups because they were much easier logistically (e.g., no travel time, no need for child care for other children) and welcoming opportunities to connect with other parents. However, as more face-to-face contact reduces overall social isolation, and families (and staff) face increasing levels of Zoom fatigue, the interest in these groups should be continually re-assessed.

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[9] https://hv-coiin.edc.org/content/parent-leadership-toolkit. Downloaded 9/13/2021.

Workforce Implications

The input from families and staff, and the related recommendations for how infant and early childhood home visiting and mental health services could be improved have implications for how this workforce is trained and supported. In particular, a key recommendation coming from this study is the need to increase the flexibility and responsiveness of these services. How to incorporate intentional training and ongoing support for staff to both have more ongoing, frequent communication and more flexible, informal contact while also supporting home visitors to have appropriate boundaries and maintain their own balance for attending to personal and family wellness is important. That said, it may also be important to examine traditional, white-dominant models of practice and the implications of these for maintaining professional distance. Staff and families both shared how their ability to have more informal contact, to see each other in more formal settings (e.g., staff homes), and their sense of going through a shared traumatic experience was beneficial for the therapeutic relationship.

A Final Note: Finding the Willingness to Change - Reflections on the Impact of COVID-19

A final reflection on the experiences of these parents and staff during the COVID-19 pandemic is the importance of recognizing what it took for these early childhood services to more fully actualize a truly family-centered and family-driven approach - namely, a global pandemic that led to broad societal shifts in personal, social, and work-related behavior. While previously, these evidence-based models required adherence to a relatively strict set of implementation guidelines thought to enhance program effectiveness, suddenly there was a need - and willingness - to change practices and to "do what it took" to respond to families' needs. To be effective in this context, programs and staff were called upon to make changes in how, how often, and in what ways they provided services. Thus, the pandemic created an opportunity to change long-standing assumptions rooted in White-positivistic ways of knowing about what it takes to provide effective services. During the pandemic, programs changed these standards and challenged these assumptions in ways that perhaps more fully realized core values of relationships, responsiveness, and family-centered, in ways that may actually promote broader program effectiveness. As society moves on from the pandemic, keeping this lesson in the forefront - and moving forward in a way that advances a truly equity-oriented approach without falling back on standard, white dominant models and requirements will require collective will to continue to make changes and question assumptions about what is important to families.

Appendix A: Family Survey Data

Parent/Caregiver Characteristics.

Race/Ethnicity (N=53)						
White 43% (23)	Black/AA 9% (5)	Latinx 28% (15)	Pacific Islander 2% (1)	American Indian 8% (4)	Multiracial 8% (4)	Self-Identify 2% (1)

Education (N=53)					
Some High School 17% (9)	High School Diploma/GED 40% (21)	Some College 19% (10)	Associate's Degree 6% (3)	Bachelor's Degree (BA/BS) 11% (6)	> Bachelor's Degree (BA/BS) 8% (4)

Gender (N=53)			
Female 92% (49)	Male 6% (3)	Transgender -	Non-Binary 2% (1)

Age (N=53)					
<18 2% (1)	18-24 30% (16)	25-29 21% (11)	30-39 34% (18)	40-49 9% (5)	49+ 4% (2)

Employment Status (N=53)		
Not Employed 53% (28)	Employed <20 hrs/week 23% (12)	Employed Full-Time 25% (13)

Language Spoken Most at Home (N=53)			
English 62% (33)	Spanish 26% (14)	English & Spanish 6% (3)	Other 6% (3)

Relationship to Children in the home (N=56) %Yes				
Mother 93% (52)	Father 5% (3)	Stepparent 4% (2)	Grandparent 4% (2)	Foster Parent 4% (2)

Number of Children in the Home (N=56)			
1-2 71% (40)	3-4 27% (15)	5+ 2% (1)	7+ (0)

Ages of Children in the home (total =) % yes?				
0-3 86% (48)	4-5 39% (22)	6-10 32% (18)	11-15 13% (7)	15-under 18 7% (4)

Parent/Caregiver Report of Effectiveness of Different Remote/Distance Strategies

N= 53	Do not use	Not Very Effective	Mostly Effective	Very Effective
Telephone Calls	6% (3)	2% (1)	45% (24)	47% (25)
Video Conferencing (Skype, Zoom, FaceTime)	13% (7)	13% (7)	36% (19)	38% (20)
Text Messages	6% (3)	6% (3)	30% (16)	58% (31)
Social Media	51% (27)	15% (8)	26% (14)	8% (4)
Email	23% (12)	21% (11)	25% (13)	32% (17)

Parent/Caregiver Perspectives on Receiving Remote Services

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
It has been easy for me to engage in the services provided by the program since face-to-face visits were stopped. (N=54)	-	7% (4)	9% (5)	41% (22)	43% (23)
I like receiving services from the program remotely (through phone, video, etc.) (N=54)	4% (2)	15% (8)	26% (14)	28% (15)	28% (15)
I would like to continue to get at least some supports remotely even after face-to-face visits can start again. (N=54)	5% (3)	11% (6)	17% (9)	43% (23)	24% (13)
I hear from my provider more often now than before COVID. (N=53)	17% (9)	28% (15)	36% (19)	11% (6)	8% (4)

Parent/Caregiver Perspectives on Important Remote Supports

Food (N=54)		
No 46% (25)	**Yes** 54% (29)	
	Not Very Important -	Somewhat Important 14% (4)	Very Important 86% (25)

Activities for my children (N=53)		
No 19% (10)	**Yes** 81% (44)	
	Not Very Important -	Somewhat Important 19% (8)	Very Important 81% (35)

Emotional Support (N=53)		
No 9% (5)	**Yes** 91% (48)	
	Not Very Important -	Somewhat Important 6% (3)	Very Important 94% (45)

Emergency financial resources (N=53)		
No 62% (33)	**Yes** 38% (20)	
	Not Very Important -	Somewhat Important 20% (4)	Very Important 80% (16)

Information about COVID-19 and health/safety (N=53)		
No 17% (9)	**Yes** 83% (44)	
	Not Very Important -	Somewhat Important 27% (12)	Very Important 73% (32)

Parenting information and support (N=53)		
No 8% (4)	**Yes** 92% (49)	
	Not Very Important -	Somewhat Important 16% (8)	Very Important 84% (41)

Access to community resources (N=52)		
No 29% (15)	**Yes** 71% (37)	
	Not Very Important -	Somewhat Important 32% (12)	Very Important 68% (25)

Appendix B: Staff Survey Data

Program Staff Characteristics

Race/Ethnicity (N=32)						
White	Black/AA	Latinx	Pacific Islander	Native American/ Alaska Native	Asian	Multiracial
59% (19)	13% (4)	19% (6)	-	-	-	9% (3)

Education (N= 32)					
Some High School	High School Diploma/GED	Some College	Associate's Degree (AA)	Bachelor's Degree (BA/BS)	> Bachelor's Degree
-	-	13% (4)	19% (6)	34% (11)	34% (11)

Gender (N= 32)			
Female	Male	Transgender	Non-Binary
97% (31)	3% (1)	-	-

Age (N= 32)				
18-24	25-29	30-39	40-49	49+
9% (3)	9% (3)	41% (13)	22% (7)	19% (6)

Language (N=32)		
English	Spanish	Both English and Spanish
84% (27)	6% (2)	9% (3)

Experience with Organization (N=32)			Experience in the Field (N=32)		
0-2 yrs w/ org	3-6 yrs w/ org	6+ yrs w/ org	0-2 yrs in field	3-6 yrs in field	6+ yrs in field
34% (11)	41% (13)	25% (8)	13% (4)	31% (11)	56% (17)

Remote Technologies Used by Staff

N=32	% Yes
Telephone Calls	100% (32)
Video Conferencing (Zoom, Skype, FaceTime)	100% (3)
Text Messages	91% (29)
Social Media (Facebook, etc.)	35% (11)
Email	84% (27)
Other (YouTube, Google Duo)	23% (6)

Staff Experiences Providing Remote Services

N=32	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am comfortable providing services over the phone and/or online.	-	3% (1)	19% (6)	40% (13)	38% (12)
Providing services remotely is as effective as face-to-face.	13% (4)	47% (15)	16% (5)	9% (3)	16% (5)
I have received the necessary support from my program/agency to shift to remote/distance services.	-	3% (1)	9% (3)	53% (17)	34% (11)
I would like to continue providing remote supports in some way even after face-to-face visits can be resumed.	-	9% (3)	22% (7)	34% (11)	34% (11)
I have more frequent contact with families now than I did before COVID.	3% (1)	34% (11)	38% (12)	16% (5)	9% (3)

Appendix C: Family Interview Questions

Active Parents (Parent Still Engaged in Services)

- To begin, can you tell me a little about your family? How many children do you have, how old are they?
- Tell me a little about how has COVID-19 impacted you, your family, and your child(ren)?
- How long have you been participating in the [PROGRAM NAME]? Were you enrolled before COVID-19?
- How are you connecting with your [home visitor/staff name _____] now?
- What do you like about getting remote/distance supports and services?
- What's not working well for you now? What has been difficult? What would you like to do differently?
- What has been the most valuable service or support you, your family or your child have gotten from [PROGRAM] since the COVID-19 shut down?
- Tell me about your experience with getting a typical "distance" visit.
- In what ways are these remote visits different than when you received services in person?
- How have you felt about these changes? Are there things that you like better about the supports you are getting now, and if so what and why?
- How, if at all, has COVID-19 impacted your relationship with your home visitor?
- What, if anything, has the program or your [home visitor/staff] done to make these remote visits work better for you?
- Is there anything else you think it's important to tell us about your experience with [program] during COVID-19?

Inactive Parents (Parent No Longer Engaged in Services)

- How long have you been participating in the program? Were you enrolled before COVID-19?
- How are you connecting with your home visitor/clinician now, if at all?
- Did you participate in any remote home visits at all, and if so, what were these like?
- What about remote services has made it difficult for you to participate in services?
- What can the program do, if anything, to help you to be able to participate?
- Are there things that you need right now that you're not getting because you haven't been getting face-to-face home visits?
- How would you describe your relationship with your home visitor before COVID-19? How would you describe it now? Why do you think it's changed?
- Do you think you would participate again if face to face visits were brought back?
- Is there anything else that you would like to share with me or with the program that might improve remote services for yourself or other families?

Appendix D: Staff Interview Questions

- To begin, can you tell me a little about your role– what is your current position, how long have you worked here, how long have you been working in this field?
- Tell me about how you are providing services right now. What kinds of technology are you using? About what percent of your contacts involve each remote option? Does this vary for different families? If so, why?
- What strengths do you have that you think are helping you to connect with families right now?
- Do you see any benefits to providing services remotely, compared to providing face-to-face visits, and if so what are they?
- What are the biggest challenges for you in providing services this way?
- In what ways are these remote visits different than when you provided services in person?
- Do you think these changes are consistent across your families or does it vary? If so, why do you think that is?
- What do you see as the most important part of your program to provide to families during the pandemic?
- Thinking about the families you work with, are there families you feel have "fallen through the cracks"?
- How has your program or organization supported you to do your job more effectively since the shift to remote services?
- What keeps you doing this work right now? How are you handling this situation and managing other challenges and stressors?

Appendix E: Director Interview Questions

- Can you tell me about the services that your program provides, and what your role is within this program?
- Tell me about how your program is delivering technology-supported services right now.
  - What kinds of technology are your staff using to connect with families?
  - Do staff have any face-to-face contact with families, and if so, what does that look like?
  - What resources have you provided to staff or families to help facilitate remote visits?
  - In addition to home visiting and direct one-on-one services, is your program providing other kinds of supports for parents, such as parent groups or parent education?
- What is important for us to know about how COVID-19 has impacted your community and your program?
- In what ways, if any, do think that families or staff in your community have been disproportionately impacted by the COVID19 pandemic because of institutionalized racism, poverty, or other factors?
- Tell me about the staff you work with who have had an easier time shifting to remote services, or who you think are more effective working with families remotely?
- What about staff who've struggled more, or had a more difficult time making this shift?
- Has your program continued to enroll families during the COVID-19 pandemic? How open to services are families, knowing they are remote?
- Are the families you are recruiting different than those you used to recruit pre-Covid-19?
- Have you lost families who did not transition to the virtual format? If so, who did you tend to lose?
- What, if anything, do you think staff have been able to do more effectively – or at least as effectively using remote technology, compared to face-to-face?
- Have you had staff leave their positions since the shut-down? Why do you think this happened?
- Is there anything else you'd like to share with me today about how things are going with your program or what recommendations you would have to improve the nature or quality of technology-supported services?