



Implementation of Blueprints Model/Model Plus and Promising interventions during the COVID-19 pandemic

Follow-up Survey Results July 2021

This survey covers multiple topics, all relevant to the changing prevention environment, as programs respond to the COVID-19 pandemic ("COVID"). **Blueprints for Healthy Youth Development surveyed contacts listed for all Model/Model Plus and Promising programs in our database.** The self-funded survey was administered in collaboration with Evidence Based Associates (<https://evidencebasedassociates.com/>). The original survey was conducted between May and June 2020 (for a response rate of 62%); a one-year follow-up was assessed between May and June 2021 (58% response rate). Some open-ended responses have been redacted to preserve anonymity.

Thank you to our colleagues for sharing your feedback with us!

As of May 2021 to June 2021.....
to what extent has dissemination or implementation of your Blueprints-certified intervention been affected by the Covid-19 pandemic?

- Great impact, leading to discontinuation or serious difficulties in sustaining dissemination of the intervention (12%)
- Small impact, some difficulties in maintaining dissemination, but overall stability (49%)
- No significant impact (7%)
- Positive impact, providing new opportunities for development (28%)
- Do not know (4%)

Status of dissemination or implementation

Which of the following describes the status of the dissemination and/or implementation of your intervention because of Covid-19?

Check all that apply.

We have...	2020	2021
had requests for changes to the delivery modality.	78%	81%
had requests for changes to training and/or support.	76%	71%
suspended implementation.	10%	7%
discontinued/cancelled implementation.	0%	2%
experienced new requests for the adoption of our intervention model.	48%	58%
None of the above.	0%	4%

Other (please describe): (14%)

- If not for a partially forgivable loan from the government, I am not sure that the non-profit that disseminates our program would have survived. We had to cancel all of our trainings in 2020. So far, we have also had to cancel our spring and summer trainings in 2021. Trainings are our primary source of revenue.
- Many of our school partners have taken core elements of the program for use in online settings (e.g., setting clear behavioral expectations, using positive reinforcement) but have not continued to implement the program as a whole in virtual classrooms.
- The pandemic expanded our reach to more states and countries, as we developed a virtual training for our level 1 workshop. This has increased demand dramatically. We also offered online support to providers to help them learn how to deliver the program via zoom to their clients.
- This is a classroom-based intervention delivered by teachers. This year, many schools were closed for periods of time or had to manage significant reductions in class size. We do not know how many of the established sites were able to sustain the program over this time period. We had no new requests for implementation, although we now have put substantial training materials online.
- We added customized technical assistance and support to our implementing agencies.
- We have continued to train new group leaders. Some agencies have continued to offer the program remotely to teachers, but since schools were not in session, the way that classrooms were run was very different than our program model. A lot of the intervention support offered was just to support teachers, rather than delivering the core of the program with respect to behavior management and positive behavior support.

Modifications to service delivery

Which, if any, of the following modifications have been made to your intervention or its delivery to ensure the safe continuity of programming in the context of the Covid-19 outbreak?

Check all that apply.

We have....	2020	2021
not modified the intervention or its delivery due to COVID.	22%	11%
provided online resources to support implementation.	55%	65%
turned to tele-sessions and/or video conferencing to support service delivery.	60%	67%
offered online training workshops or lessons.	72%	88%
started a blog page to provide a forum for conversation.	12%	5%

In the last year (May 2020 to May 2021), we have implemented changes to...

- The delivery modality (70%)
- Training and/or support (83%)

Other (please describe): (21%)

- I consider virtual and online 2 different things. We have provided virtual supplementary and recertification trainings but not virtual 3-day new facilitator trainings. We have also provided virtual implementation of the program with families. Some sites continued to implement in person with minor adaptations to ensure safety throughout COVID. We only paused in-person new facilitator trainings for 4 months in 2020. We provided online resources for all professionals and families that covered topics not specifically related to our program.
- We provided nation-wide networking sessions for implementation sites to share challenges & adaptation practices.
- Online resources included adjustments made to our curriculum to support virtual lesson delivery.
- We are in the process of adapting our program for online delivery, which we began prior to COVID. However, this is a complex intervention so adapting for online delivery is complicated and time-consuming. Further, the resulting online version will have to be tested in a randomized controlled trial before we feel comfortable disseminating it.
- We developed tools that provided micro-coaching to parents through the phone and text messages and training to teachers on how to use these tools. Parents could upload videos of children doing key activities and teachers and parents could text back and forth about the developmental level and discuss ideas for scaffolding, which was simultaneously translated into 100 different languages allowing seamless communication. More than 300,000 messages were exchanged.
- We did not initiate any new locations this year. We put training materials online, but we did not

have any new requests for training this year.

- We have developed multiple guidelines related to use of virtual sessions, virtual collaboration with stakeholders, and virtual Q/A activities.
- We have launched an entire intranet site for virtual supports to staff, participants, and partners. We distributed tech hardware (computers and Wi-Fi hotspots) to thousands of students and interns so they can participate virtually.
- We have worked with partners to identify how core elements can be adapted for the virtual setting.
- We increased the frequency of our reflective, clinical consultation for our clinical supervisors from monthly to weekly or biweekly. All direct clinical supervision of staff was by conducted via videoconferencing. We made deliveries of gift cards, tablets and internet service, food, cleaning supplies, diapers, formula, and other essentials to homes of families. We did fundraising (\$140,000) dedicated to purchase of essentials for our families.

Impact of modifications on service delivery

Are you collecting data to examine the relationship between modifications made due to Covid-19 and intervention outcomes?

	2020	2021
These data are not necessary as we have not modified our intervention or its delivery due to COVID.	5%	4%
We are presently collecting these data.	24%	23%
We are planning to collect these data soon.	14%	11%
We do not have the resources to collect these data.	28%	35%
Do not know.	0%	2%

Other (please describe): (26%)

- Data has been collected on the modifications made to our training, comparing the traditional in-person delivery of training with delivery via Zoom. Analysis showed no substantial differences in outcomes for practitioners. This study has been submitted for publication.
- Implementing organizations have collected qualitative and quantitative data.
- We are considering doing an analysis on differences in outcomes by type of attendance.
- The program was not implemented, and we do not have plans to collect data on the core elements as modifications are too significant to expect intervention outcomes.
- There were several existing publications demonstrating the effectiveness of our intervention delivered via telemedicine prior to the pandemic. I believe several labs are collecting data.
- We are preparing a proposal to NIH to collect evaluation data on our virtual implementation.
- We are collecting user satisfaction data from people who attend training. We are interested in collecting outcome data but do not have the resources to do this.
- We are in the process of collecting qualitative data through conversations with our implementing agencies. Though some quantitative data was collected (e.g., youth surveys, implementation data), we are not able to examine the relationship between program modifications and outcomes.
- We compared implementation parameters and therapist reported outcomes in the first six months of the pandemic to the same time period of the prior year and we published the paper in an academic journal. We are planning to look at the next six months as well.
- We conducted a focus group and will be submitting results to an NIH RO1 controlled trial to fully test the intervention conducted via telehealth.
- We have collected these data repeatedly and analyzed them in ongoing fashion to keep informing the program since March 2020 when the pandemic inspired social distancing and virtual work/learn policies.
- We have continuously implemented feedback surveys for our trainings. Some of our initial implementation training went from in-person to synchronous online training.

What have you learned this past year (May 2020 to May 2021) in implementing your evidence-based intervention in the context of COVID?

- This is an evidence-based program delivery model, and not an actual program, so the following are in that context: 1. Local Teams, when not meeting in person, have a tendency start to fade. People get Zoom fatigue, and it becomes more difficult to get people to attend; 2. We have learned what can and should be adapted, and what should not. That is, we have learned what is affected by training online vs training in person.
- Although not ideal, training facilitators virtually is possible. We will consider continuing virtual training for current sites that are seeking to train new facilitators. We will resume in-person trainings for all new sites. We found creative ways to support sites that wanted to implement a modified version of our program virtually. There is value in developing and testing a model for implementing our program virtually.
- Although not measured, we have been able to continue offering trainings, site visits, implementation reviews, and consultation support to sites via technology.
- An online delivery and support model for staff training has worked extremely well during Covid, enabling us to reach 20,000 teachers and teaching assistants with high-quality, self-paced training to deliver the intervention to their children, and ensuring schools are supported by an online mentor group of speech and language professionals throughout delivery.
- Both our training of clinicians and the delivery of the program to parents was surprisingly smooth after working out technical issues (due to the varied experience with technology of both parents and clinicians). We will be adopting both modalities in the future to offer agencies more options.
- Changes related to offering training and sessions electronically will likely continue to some degree after the pandemic.
- Confirmed the importance of: *Proportionate universalism: providing support for all families, but increased support for vulnerable families/those with the greatest level of need. *Rapid engagement and responsiveness to need (from parents, practitioners and organizations and governments). *Taking an approach that is grounded in implementation science, focused attention on listening and responding to the needs of stakeholders and different contexts, and on continually responding to feedback and available data sources. Being sheltered in place often meant that paradoxically parents had even less time to devote to focusing improving their parenting skills. Thus, some providers found it necessary to offer briefer forms of our intervention and also ad hoc sessions focused around the COVID-19 parenting guides, which were positively received. We also learned that providers continued to deliver services when they felt supported and when technical assistance around remote delivery was made available, just as the pandemic was worsening. We also found that supporting advocacy at the local, state, and federal level helped to keep spirits high and help prevent practitioner burn out. Practitioners were able to voice their front-line experience in COVID relief efforts with local elected officials and in letters to legislators. We received confirmation of the continued need for different modalities that parents can engage with parenting support (e.g., online, virtual, in-person outside, in-person in-home). While many families and practitioners have utilized virtual delivery methods, which has been extraordinarily beneficial (and many times leading to more engagement from families like in seminars delivered virtually), not all families are able to use technology to engage, so having options that span different modalities is crucial. Demand for digital services increased.
- Delivering a national program virtually is hard, but it is possible. There are both challenges and opportunities in virtual delivery. Some elements of our program are still done best in person (e.g., tight-knit community building among students), but virtual connectivity allows us to include

- students and partners in new ways (e.g., connecting students in Boston with students in Arizona and Chicago for skill development sessions with expert panelists on guest webinars). We will maintain a variety of hybrid offerings, where we were majority in-person before COVID.
- For some parents, participation in parenting workshops virtually has removed transportation and childcare barriers. For others, it has highlighted disparities in access to technology and high bandwidth internet. As the pandemic continues to impact families, it has become harder to recruit parents to get on to virtual meeting platforms. We suspect virtual meeting fatigue is partly to blame.
 - Hard copy curriculum must take advantage of the modern classroom and technology. Teachers have learned to use the technology more effectively since COVID, and we believe that they will continue to use it going forward. If access to the curriculum is limited to hard copy only, schools will not select the curriculum, regardless of effectiveness. Technology can significantly impact training and make it more affordable for schools to ensure that all their staff is trained more easily and efficiently. Since offering online training, we have increased teacher training from 20% of curriculum purchases and teachers trained to 100% of curriculum purchases and teachers trained.
 - We have made accommodations for fully online training of therapists in our model. We plan to move forward using in-person/online hybrid formats - some advantages to online training include less loss of productivity for trainees and opportunity to "learn in place." Disadvantages include difficulties related to role-plays and direct practice. It is possible but less fluid to do online vs in person. Same with clinical services. Loss of control in moving from clinic to online session, but greater validity and generalization from delivering services in the home environment, as well as reduced barriers like transportation costs, childcare, time off work (etc.).
 - In the context of COVID, some of our implementation communities are experiencing a decrease in referrals, likely due to children not being in school. This led to delays in training progress and increased time to reach certification. Additionally, we have seen a surprising increase in parenting group attendance. This is largely attributed to parents having an easier time getting to the groups with transportation and childcare concerns eliminated. It is possible parental access to the internet and technology increased when school districts helped make the internet available to school-age children attending online school. All of our 19 workshops (each lasting 2-5 days) have been conducted online this past year. We learned flexibility in scheduling these is key. Some staff need to pack the Zoom workshops in to full days in order to create dedicated time for training and not have other responsibilities. Others appreciate half-day workshops over a longer period of time in order to avoid Zoom-fatigue. We learned to schedule and arrange our training workshops based on the needs of each training group.
 - In the spring of 2020, it was apparent that a brief shutdown and suspension of services were not sufficient to keep COVID-19 at bay. We worked with our partners to revise the service delivery of our program. Adaptations included: methods for recording child-parent interaction using teleconferencing recording features; methods for sharing handouts (mailing/emailing/shared screen); changes in activities not feasible online; training on building a connection with caregivers online and managing boundaries and confidentiality. Most adaptations were around managing a new format for delivery. The core features of the intervention did not change. To preliminarily assess the feasibility of an online format, we conducted two focus groups with eight community providers who had delivered the program via telehealth to 125 families in the summer and fall of 2020. The focus group participants noted the strengths/benefits and challenges/barriers. Strengths/Benefits: All eight providers felt that the online format was equally as "effective" when delivered by home visiting or telehealth. When asked what type of devices families used, providers estimated that 90% of caregivers used their smartphone to participate in the session. Providers felt that parents were just as engaged in the online activities via smartphone as in-person, and that

smartphone use was not a barrier. We asked if parents had difficulty accessing the Zoom teleconferencing application, downloading the app, and getting into the appointment. Providers unanimously agreed that this was not a problem. Parents appeared quite technologically skilled and were able to learn how to use Zoom. However, the providers did recommend taking 10 minutes at the first session to explain how the sessions would progress with the online format because five of the sessions require the caregiver to set their phone/tablet up so that the provider could see them and record. The providers also shared some Zoom “tricks of the trade.”

- It has been hard to initiate our model via a virtual platform, but existing coalitions have been able to sustain their efforts by meeting and training virtually.
- It is a lot of work to take a program virtual while keeping the core components intact. Fidelity to the curriculum was most important to us. I worked personally with 14 states on their virtual implementation of our program to ensure they were implementing with fidelity. I observed the families in sessions in those 14 states from the beginning in April 2020 to the present time. I am working currently with 2 countries in Europe as we take the program virtual in those countries. I have also worked with another evidence based program over this past year to help them as they considered the steps to going virtual. The payoff of this hard work has been immense. Families needed us more than any other time, so we did what was necessary to be there for families. COVID stretched us to be creative.
- It was easier to convert the training from in-person to virtual than it has been for some schools to convert their program implementation to virtual. We have seen both ends of the continuum. Some schools are starting the program due to new training options and other schools have put program implementation on hold as they felt they had too much else to deal with.
- Many teachers feel that teaching in virtual classrooms alleviates many of the behavioral concerns they deal with on a day-to-day basis. While it introduces significant other concerns around student engagement, attendance, and academic progress, classroom management was not a pressing concern for most teachers over the past year, due to virtual classrooms and/or smaller class sizes.
- There is a need for strong partnership between secondary and postsecondary institutions to ensure clarity around policies.
- Online implementation and training seem feasible. The program content did not change, but the option for delivery did change to the online setting. Training in the online format may be something that we keep in the future if we can collect data on that training modality.
- Over the past year, we have learned: 1) The importance of the existence of programs like ours that fill a critical need for adolescents, a need that was heightened during the pandemic; 2) That our program is flexible and with the right supports can still be implemented well virtually. This leads us to wanting to learn more about effective virtual programming; 3) The value of our network of implementing agencies – they were available for each other to talk and collaborate during this challenging time which was extremely helpful; and 4) how to effectively deliver virtual technical assistance and training to our implementing agencies.
- Schools are willing to adopt online professional development and coaching support. May help increase scale of our program.
- Our program has been delivered virtually by many schools since the onset of COVID. It appears to achieve results that are similar to in-person delivery, although we are not collecting data to measure these effects (due to lack of resources). Delivery of the program virtually requires that the group leader take a more proactive role in generating group discussion. In addition, some of the in-session exercises needed to be modified for delivery via videoconferencing.
- Our program can be delivered virtually using videoconferencing (e.g., Zoom). We are collecting data on effect sizes when the group is conducted virtually, and initial results indicate that change

effects for risk factors and symptoms associated with our program are comparable to in-person delivery. Virtual delivery of the program requires that group leaders be more proactive in generating discussion. Also, the session may take a bit more time because of technical difficulties with group member's video connections.

- The intervention seems to work well through telehealth, but we are collecting data to confirm this.
- The two largest lessons that implementation sites have shared is it revealed significant gaps in site capacity around technology and holistic support services for participants. Around technology, there was a significant need to build capacity (both in hard/soft technology resources, but also tech savvy skills among staff). Relating to participant services, staff realized that many participants needed basic needs met (food insecurity, housing, mental health resources, health resources). Programs recognized the need to be even more engaged and aware of securing resources to meet participants' basic needs so that they can fully engage in the full program model.
- There has been a very positive response from providers and participants during the transition from face-to-face delivery to online delivery. There has been a slight increase in session completion rates, but this has not been formally analyzed.
- This was an extremely difficult year for providers of early childhood education. Many of the smaller programs struggled to stay open due to the pandemic restrictions and requirements. We had no new requests this year for program expansion or training. Hopefully, interest will increase in the coming year(s) as centers recover from the challenges associated with the pandemic.
- Virtual sessions will continue to be used as a valuable alternative for connecting with key participants who aren't available to meet in person, such as parents or extended family who live too far away to meet in person. Stakeholders have greatly appreciated the flexibility and continued availability of our program as a treatment service. In some communities, this has led to relationships with stakeholders being stronger than they were pre-COVID.
- We already had substantial training workshops and supports online. We developed a video coaching program for teachers leading to an online dashboard that helps teachers track their development toward fidelity of the model and understanding of the child development theory behind it. We created a classroom model that allowed teachers to have a hybrid model of classroom implementation so if some of the children were at home and others were at school, all children were kept on the same page as far as play themes and key executive function and literacy and math activities. The training and response of parents to the online resource materials and the micro coaching changed the parent-teacher relationship and we have preliminary data indicating that this had a positive effect on child experience and teacher/parent satisfaction.
- We developed a "lessons learned" document to assist therapists in providing services to families using "tele-formats". We learned creative ways to implement family therapy work at all stages of the treatment process. We also identified areas of training and consultation in which webinar-based training might be particularly efficient. We also identified difficulties in building team cohesion and a working relationship with the consultant using on tele-platforms.
- We have been able to modify training and oversight to continue to meet the needs of the providers with whom we are working.
- We have had questions about implementing the program virtually and have developed PowerPoint slides to help facilitate that. Our training department has adapted the Training of Educators to a virtual format, and that is the only training we are offering right now.
- We have learned many rich lessons this past year in implementing our program in the context of COVID: that group-based programs delivered online (rather than in-person) can lower barriers to participation for some parents and certain school leaders; that online sessions for parents and teachers had to be shorter; that relationship-building and experiential learning can occur virtually

to an extent; that close partnership with a dedicated mental health workforce can enable quick pivots and large-scale implementation even during a public health crisis. While we have long recognized that adult caregiver social-emotional well-being is critical to any effort to support young children's social-emotional well-being, implementation experiences during COVID crystalized this truth and deepened our commitment to advocating for professional learning for teachers, school leaders, and school-based mental health professionals to include robust support for adults' own well-being.

- We have learned that the ideal implementation of our program model is in person, but we are grateful that we could make adaptations to a virtual platform for trainings. We also provided modifications that agencies could use to continue implementing virtually. While an online platform is not the same as being in person, we do feel that there is still a lot of value to the programming in a virtual context.
- We learned that we will continue to do a hybrid approach once we are able to get back into the schools that previously housed our program. Our program meets 2 x/wk. We will do one evening of exercise only online and the second evening, which is an exercise & nutrition/behavior module, in person if we are let back into schools (as of today, we do not know).