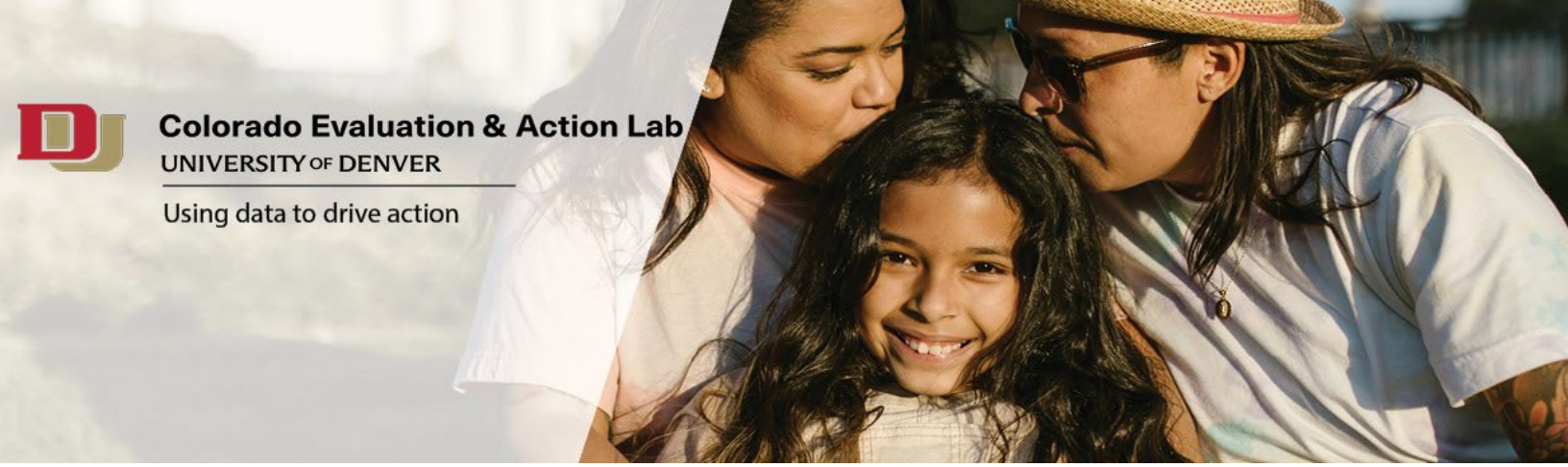

Child First Evaluation: Preliminary Findings

An Evaluation Conducted Through the Family First Evidence-Building Hub

REPORT HIGHLIGHTS:

- **This document provides preliminary findings from conducting the ongoing Child First impact evaluation.**
- **Enrollment into the study has concluded.** The study enrolled 526 families at sites located in three states.
- **The study team researched the implementation of the Child First model**. The team found that the implementation following the return to in-person services remained largely the same as the pre-pandemic model.
- **Follow-up data collection for the first planned follow-up, including the acquisition of administrative data, is ongoing.** Direct data collection with families is proceeding as anticipated.

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BUILDING KNOWLEDGE TO IMPROVE SOCIAL POLICY

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Abstract

This document provides preliminary findings to date about conducting the ongoing Child First impact evaluation, focusing on the process of conducting the evaluation, implementation research findings, and the characteristics of families at study entry. Child First is a comprehensive, home-based, therapeutic intervention targeting multi-risk young children and families, embedded in a coordinated system of care. The study aims to estimate the impacts of the Child First treatment on outcomes for children, parents, and families.

The study will assess the impact of Child First on child safety (i.e., involvement with child welfare system) 12 and 30 months after randomization, as well as child well-being (i.e., behavioral and emotional functioning), and adult well-being (e.g., mental or emotional health, substance use or misuse, economic security, and housing stability) 12 months after randomization. Enrollment into the study has concluded, as of December 2024. The study enrolled 526 families. Follow-up data collection for the first planned follow-up on child well-being and adult well-being 12 months after randomization is underway and expected to conclude in early 2026.

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Acknowledgements

This research was supported by the Colorado Department of Human Services. The opinions expressed are those of the authors and do not represent the views of the State of Colorado, or the University of Denver. Policy and budget recommendations do not represent the budget or legislative agendas of state agencies, the Governor's Office, or other partners. Any requests for funding or statutory changes will be developed in collaboration with the Governor's Office and communicated to the legislature through the regular budget and legislative processes.

Suggested Citation

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Note on Gender-Inclusive Language

The Colorado Evaluation and Action Lab affirms our commitment to the use of gender-inclusive language. We are committed to honoring the unique gender identity of each study participant. Throughout this report, we follow the guidance of the Associated Press Stylebook and the Chicago Manual of Style and use the gender-neutral, singular "they" when appropriate.

Introduction

The Colorado Evaluation and Action Lab (Colorado Lab) serves as the Family First Evidence-Building Hub to coordinate rigorous evaluation efforts on behalf of the Colorado Department of Human Services (CDHS). In this role, the Colorado Lab coordinates the pipeline of evidence building for Family First programs/services positioned to meet the needs of children, youth, and families in Colorado. Together with cross-system prevention partners, the Colorado Lab co-creates a strategic vision for evidence building, communicated annually in the annual strategy report.

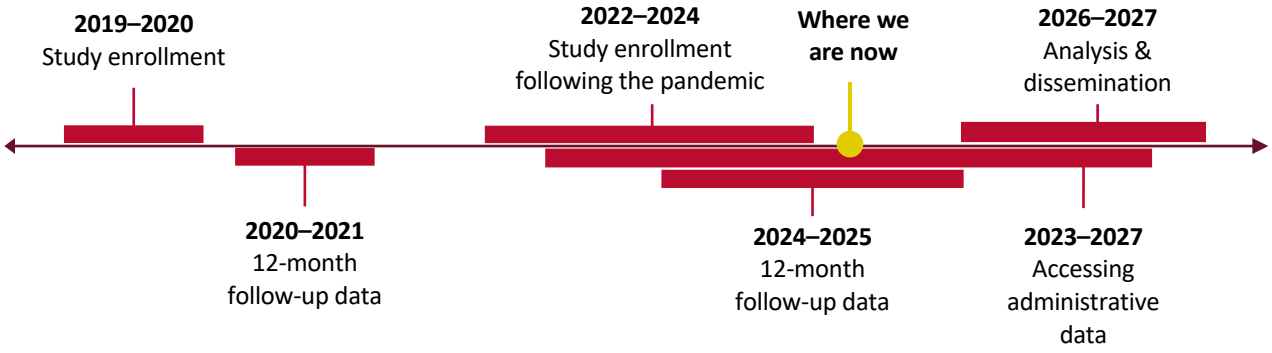
The Colorado Lab subcontracted with MDRC to build evidence for Child First. Child First is designated as a "supported" practice by the Title IV-E Prevention Services Clearinghouse (Clearinghouse). MDRC is conducting a multi-state randomized controlled trial (RCT) with the goal of building evidence toward a "well-supported" designation.

This report includes preliminary findings related to:

- Enrolling families into this study;
- Baseline characteristics of enrolled families, including a preliminary look at baseline equivalence and the intended random assignment ratio;
- Strategies for supporting enrollment following the pandemic;
- The implementation of the Child First model following the pandemic (see December 2023 brief);
- The value of blending funding for a multi-state RCT; and
- Conducting primary follow-up data collection.

These preliminary findings reflect the learnings following the conclusion of study enrollment and during the 12-month follow-up data collection period. See Figure 1 below for a timeline of study activities. Between June 2019 through March 2020, the study team carried out study enrollment but paused at the start of the pandemic. Between summer 2020 and early 2021, the study team collected 12-month follow-up surveys with the families that were enrolled pre-pandemic. The study team resumed enrollment in October 2022 through December 2024. During that time, the study team also began the 12-month follow-up data collection, which is slated to end in 2025. The study team also began the process of accessing administrative data, which is expected to continue through 2027. The study team is currently in the midst of follow-up data collection with families and accessing administrative data records. Analysis for the first follow-up will begin in 2026 and dissemination of findings will follow.

Figure 1. Study Timeline



Child First Program

Child First is a comprehensive, home-based, therapeutic intervention targeting multi-risk young children and families, embedded in a coordinated system of care. The study aims to estimate the impacts of the Child First treatment on outcomes for children, parents, and families.

The Child First program has two components that act synergistically:

1. A system of care approach to provide comprehensive, integrated services and supports; and
2. A relationship-based approach, rooted in parent-child psychotherapy, to promote nurturing, responsive parent-child interactions as well as positive social-emotional and cognitive development.

The program is implemented in the field by teams of staff made up of mental health clinicians and care coordinators, supervised by clinical directors.

Families with children ages 6 months to 6 years old are identified as being eligible for Child First services if the target child has shown evidence of developmental delays, or a parent or caregiver in the family has screened high for psycho-social risk. Therapeutic services are delivered predominantly in the home, which provides an opportunity to respond to identified problems as they arise in their natural setting and eliminates barriers of transportation, child care, and stigma. The clinician and care coordinator partner with the parent(s) in a comprehensive assessment of the child and family, identifying and involving all other service providers. The result is a family-driven plan of broad, integrated supports and services for all family members, which reflect family priorities, strengths, culture, and needs.

Study Description

Evaluation Purpose

The study design is a family-level RCT in which 526 families split across Connecticut, North Carolina, and Colorado were randomly assigned to either the Child First program or to a Usual Care control group. Child First is designated as a "supported" practice by the Clearinghouse. MDRC is conducting this RCT with the goal of building evidence toward a "well-supported" designation. The study will assess for sustained impacts of Child First on child safety (i.e., involvement with child welfare system), child well-being (e.g., behavioral and emotional functioning), and adult well-being (e.g., mental or emotional health, substance use or misuse, economic security, and housing stability).

Research Questions

This study will address the following research questions:

1. What is the impact of Child First on parental psychological functioning 12 months post-random assignment?
2. What is the impact of Child First on family involvement in the child welfare system 12 months post-random assignment?
3. What is the impact of Child First on family involvement in the child welfare system 30 months post-random assignment?

We will also ask a series of secondary research questions to capture additional outcomes that are of interest to the Child First program developer and are also relevant to policymakers. These analyses will consider impacts of Child First on children's social-emotional outcomes 12 months post-random assignment, family and child emergency room visits and hospitalizations, parental education and employment, parental income, parenting stress, and children's emotional regulation.

In another set of secondary analyses, we will test whether effects of Child First vary by 1) caregiver baseline depression; 2) child behavior problems at baseline; 3) evidence of child welfare involvement at baseline; 4) caregivers' evidence of baseline substance abuse; 5) caregivers' race and ethnicity; and 6) state.

Learning Goals

Learning goals refer to specific priority areas that have been identified with partners to inform program improvement, reach, and scale, above and beyond Clearinghouse requirements. Learning goals for this study include:

1. How has implementation of the Child First model changed following the pandemic?
2. How and when did Child First staff members utilize telehealth pre-pandemic, early in the pandemic, and after Child First's return to in-person services? How did Child First staff and

caregivers perceive the use of telehealth during these same time periods? How, if at all, did Child First teams incorporate telehealth in their regular practice during the return to in-person services?

3. How does Child First fit into Colorado's prevention service continuum? How does the effectiveness of the program differ based on caregiver or child characteristics or needs?

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Methods

Methods

Random Assignment

The study design is a family-level RCT in which families split across Connecticut, North Carolina, and Colorado were randomly assigned to either the Child First program or to a Usual Care control group. Following the collection of baseline data, families were randomized individually, with a 60% chance of receiving the Child First treatment and a 40% chance of assignment to the control group. Families randomly assigned to the control group received a list of alternative services available to them in their community. The target sample size was approximately 600 families. Enrollment was extended following the pandemic and concluded on December 31, 2024.

Analysis

The team will use an intent-to-treat approach to estimate the impact of Child First on identified outcomes. As such, all families enrolled in the study will be retained in the analysis and included in their original random assignment group regardless of service receipt. This approach is considered the gold standard in evaluation research and, assuming random assignment succeeded in producing equivalent groups, allows us to estimate causal impacts of Child First compared to business-as-usual services in the community.

Data Sources

The study uses data from three sources:

1. A baseline survey conducted prior to random assignment is providing demographic information on enrolled families and baseline measures of outcomes, where applicable.
2. A follow-up survey conducted approximately 12 months after study enrollment will ask parents to report on their own psychological well-being, depression, parenting stress, economic well-being, involvement in child welfare services, and their child's behaviors and emotional regulation.
3. Child welfare records will provide information on families' involvement with the child welfare system. Data on families' involvement will be accessed through requests to state and county agencies. We will access the data retrospectively and then estimate impacts on involvement in child welfare services at two time-points—one shorter-term and one longer-term.

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Preliminary Findings

Preliminary Findings

Because our study is ongoing, we report here on study enrollment including the baseline characteristics of study families, preliminary investigations into baseline equivalence and the integrity of random assignment, findings from the implementation study, follow-up data collection efforts, and blended funding for an RCT.

Study Enrollment

The study began in 2019, prior to the start of the COVID-19 pandemic in March 2020. The research team worked with sites to enroll 224 families into the study between June 2019 and March 2020. The study restarted random assignment in October 2022.

We concluded study enrollment on December 31, 2024. Between October 2022 and the end of enrollment, we enrolled 302 families into the study across all participating sites and states. The two Colorado-based Child First sites, Aurora Mental Health & Recovery and San Luis Valley Behavioral Health, enrolled 85 of those families.

Enrollment was drawn from nine sites in three states, and 526 families were enrolled in the study. About 59% of families (n = 312) were assigned to the program (treatment) group and about 40% of families (n = 214) were assigned to the control group. In Colorado, two sites contributed about 16% of the study sample (n = 85 families).

Table 1 shows sociodemographic characteristics for families enrolled in the study. As expected, the majority of study families reported having lower incomes and are receiving public assistance. The sociodemographic characteristics of families in the program group and the control group were similar. A two-tailed t test indicated there were no statistically significant differences between the groups on these characteristics.

Table 1. Sociodemographic Characteristics of the Sample at Study Enrollment

Characteristics	Overall (n = 526)	Control Group (n = 214)	Program Group (n = 312)
Child			
Age in years	3.86	3.84	3.87
Female (%)	35.55	36.92	34.62
Caregiver			
Age in years	34.84	34.15	35.31
Birth mother (%)	75.29	77.10	74.04
Race/ethnicity (%)			

Characteristics	Overall (n = 526)	Control Group (n = 214)	Program Group (n = 312)
Hispanic	37.24	39.81	35.48
Non-Hispanic White	40.88	36.49	43.87
Non-Hispanic Black	15.74	16.59	15.16
Non-Hispanic Other	6.14	7.11	5.48
Marital status (%)			
Married or living with partner	46.74	46.01	47.25
Divorced or separated	14.37	11.74	16.18
Single, never married	38.12	42.25	35.28
Work status (%)			
Unemployed	39.03	37.20	40.26
Part-time employment	26.64	28.85	25.16
Full-time employment	34.56	34.13	34.84
Highest level of education (%)			
Less than high school degree	14.72	15.09	14.47
High school degree or GED	27.72	29.72	26.37
Some college	39.58	39.15	39.87
Bachelor's degree or higher	16.83	15.09	18.01
Household (%)			
Has low income	74.19	72.77	75.17
Receives public assistance	69.35	67.45	70.65
Ever experienced homelessness	14.04	14.29	13.86
Any reported substance abuse	23.35	23.67	23.13
Any prior or current CPS involvement	53.41	52.38	54.13

NOTE: Sample has limited missing data. GED = General Education Development test and CPS = Child Protective Services. *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$.

When we re-started the RCT in October 2022, enrollment was much slower than it had been prior to the pandemic. This was due in part because sites did not receive sufficient referrals for families from external referral partners to maintain waitlists. As such, we took several measures to increase referrals and enrollment, including:

1. **Extending the enrollment period for the study**. To allow sites more time for enrollment, we extended enrollment to the end of 2024. All participating sites agreed to extend their participation so that they could enroll more families, including Aurora Mental Health & Recovery. By extending the study by an additional 6 months, sites were able to enroll an additional 97 families into the study.
2. **Site recruitment and training.** In 2024, we brought on two additional sites: one from Connecticut and one from Colorado (San Luis Valley Behavioral Health). The additional site from Connecticut had several teams and, as such, was able to enroll a large number of families into the study. This site also subcontracted a smaller site, increasing the total number of teams available to support enrollment into the study. The additional site from Colorado, although much smaller, enrolled more families than some of the other participating sites during the same time period.
3. **Supporting sites to find new referral sources.** Since Child First sites (in all three states) were not receiving as many referrals as they had previously, we encouraged sites to build relationships with community partners so that they could serve as a potential referral source and strengthen relationships with existing partners. We discussed potential referral partners and worked with sites to create outreach plans for contacting new partners and regularly reaching out to them to build and maintain the relationship.
4. **Incentivizing enrollment.** Additionally, we provided incentives to sites that successfully enrolled participants in the study or maintained a large enough waitlist to be able to conduct random assignment. Every month that sites met this benchmark, we provided a gift card to each Child First team member that enrolled families. Because the sites were all facing different issues, it was challenging to find a one-fits-all solution. Instead, in partnership with the Child First National Service Office (which provided the incentive funds), we decided to incentivize sites to increase referrals into their program, hoping that the incentive would encourage them to continue working toward a site-specific solution that would allow them to do so.

Baseline Equivalence

The Clearinghouse Handbook of Standards and Procedures 2.0. (Handbook 2.0) recommends that even when a direct pre-test measure is available, that baseline data is also assessed to compare race/ethnicity, socioeconomic status, and child age for the program and control groups when available. Preliminary results from investigations into baseline equivalence are shown in Table 1, which includes measures related to child age at enrollment, child gender, caregiver race/ethnicity, caregiver marital status, caregiver work status, caregiver education, household income, family's receipt of public assistance, caregiver substance abuse, families' involvement in child welfare services, and history of homelessness. As shown in Table 1, there are no statistically

significant differences on these characteristics between the program and control groups, indicating that random assignment resulted, as expected, in substantively similar groups.

Final analysis of baseline equivalence, which will occur when the impact analysis is conducted, will include measures of caregiver psychological well-being, child behavior problems, and parenting stress, and will also include an examination of whether there are systematic differences between the treatment and control groups when all baseline characteristics are taken together. The Clearinghouse no longer requires analysis of baseline equivalence for low-attrition RCTs that maintain integrity of random assignment, because, as they note, "Random assignment and low attrition result in contrasts that have no expected outcome differences between the intervention and comparison conditions except those caused by the program or service."[1]

Integrity of Random Assignment

The intended random assignment ratio was maintained, meaning that about 40% of families were randomized into the control group and about 60% had access to the program (see Table 1).

Implementation Study

Around the time that study enrollment resumed in late 2022, the study team set out to understand how implementation of the Child First model may have changed following the pandemic. The team knew that several Child First teams shifted to offering services via telehealth at the start of the pandemic—an approach that was rare pre-pandemic. Thus, the team sought to learn more about any changes that started during the pandemic and continued in the years following its onset, including:

- The receipt of referrals and the number of families on waitlists;
- The delivery and receipt of Child First services;
- The number of families assigned to teams' caseloads; and
- The format and content of training and supervision for Child First teams.

For this implementation study, the team collected data from Child First staff (n = 64) and families (n = 9) from Colorado, Connecticut, and North Carolina between September 2022 and April 2023. Our team conducted surveys and interviews with Child First care coordinators, clinicians, and supervisors to learn more about their experiences delivering the Child First model before the pandemic (prior to March 2020), during the height of the pandemic (March 2020 through June 2021), and following the return to in-person services for most Child First teams (summer 2022 through April 2023). The study team also interviewed caregivers who participated in Child First services during these same time periods. The study's implementation brief includes more details about the sample and methodology.[2]

Overall, the study team found that the implementation of the Child First model following the return to in-person services remained largely the same as the pre-pandemic model. Child First staff reported similar levels of referrals and caseloads, as well as similar levels of dosage and frequency when delivering services during these two time periods.

However, some changes that began during the pandemic remained, such as the use of telehealth and virtual professional development. For instance, during the height of the pandemic, many teams offered hybrid services—a combination of in-person and telehealth—to families. Although teams returned to providing services primarily in-person in 2022, telehealth became an option that teams offered to families when needed (e.g., if a child was sick, Child First staff could still work with the family remotely). Additionally, training and supervision for Child First staff transitioned from in-person to virtual at the start of the pandemic. While supervisors were making an effort to bring their teams back for in-person supervision, training and supervision remained largely virtual since the return to in-person services.

Despite these changes, Child First teams continued to deliver the core model following the return to in-person services as they had pre-pandemic.

Follow-up Data Collection to Date

MDRC is completing the survey follow-up activities in collaboration with our survey partner RTI. RTI began fielding the follow-up survey for post-pandemic families in January 2024. One hundred forty-six study families have been invited to complete the survey to date, and 111 families have completed surveys. For the 143 families who have had at least one full month to complete the survey, the response rate is about 76%.

Our target for follow-up response rate is 80%. This target exceeds What Works Clearinghouse standards for attrition, which consider the overall rate of attrition, or how many families did not complete follow-up surveys, and differential attrition, or the percentage point difference between rate of survey completion among the program and control groups. Study participants can complete the survey on the web or over the phone, and in-person outreach may be used.

Blended Funding for a Randomized Controlled Trial

This study draws on funding from Arnold Ventures, the Duke Endowment, and the Colorado Lab. Blended funding from these sources has allowed the study to include sites from three states, conduct study enrollment over a longer period to increase the number of families included in the study, and engage with a survey firm to conduct primary data collection with families in three states, using web, phone, and in-person outreach.

Making Data Actionable

This Hub model advances Colorado's 5-year vision for Evidence-Based Decision Making (EBDM). EBDM recognizes that research evidence is not the only contributing factor to policy and budget decisions. It is the intersection of the best available research evidence, community needs and implementation context, and decision makers' expertise. Recommendations and lessons learned below capture actionable insights primarily based on the best available research evidence. Consider pairing this report with community needs and implementation context as well as decision makers' expertise to make these findings more actionable for Colorado's children, youth, and families.

Lessons Learned

When study enrollment is slower than anticipated and programs need support to recruit families, we recommend supporting programs so that they can implement solutions that work within their unique context. As noted above, our team implemented multiple strategies to support sites through enrollment, such as:

- Helping sites find new referral sources, and
- Incentivizing sites to increase enrollment.

In addition to the strategies above, the evaluation team learned the **importance of keeping in touch with potential sites for recruitment purposes**. Following the pandemic, study enrollment was slower than anticipated across the participating Child First sites. Recruiting additional sites was the most effective way to increase enrollment, but it was not easy. Many Child First sites, even those that did not participate in the study, faced issues that made it challenging for them to participate in an RCT (e.g., funding cuts or a slowdown in referrals). Yet, the study team remained in contact with these sites for months—in some cases, a year—to regularly check in on them and determine their readiness for participation. While several of these sites did not participate, others did eventually come onboard. And those that came on at the end made a notable difference in our enrollment. Thus, keeping those sites engaged, even in light-touch ways, allowed the study team to recruit them later on.

The study team also found it **helpful to stay in regular communication with the child welfare agencies during the course of enrollment**. In Connecticut, in particular, the county-level agencies were a big source of referrals to Child First. As such, it was important to ensure that they had the information they needed (e.g., eligibility criteria) and received ongoing updates about the project. To do this, the study team joined monthly virtual meetings to present to staff from these agencies and sent out quarterly bulletins with updates on study enrollment and reminders of different aspects of the study. The study team found that maintaining this regular communication with the agency reminded them of the importance of this work and how they could support enrollment efforts.

Conclusion

Enrollment into the Child First study has concluded, and preliminary analysis of baseline data indicated that the intended random assignment ratio was maintained and that the program and control groups were similar on sociodemographic characteristics measured at study entry. Direct data collection with families for the study's first planned follow-up is ongoing and is proceeding as anticipated.

Preliminary results are expected to be disseminated through peer-reviewed publications in late 2026 or early 2027. If the results demonstrate positive effects on child well-being, adult well-being, or child safety, Child First will be well positioned for a Clearinghouse re-review of evidence and a potential *well-supported* designation.

Endnotes

[1] Title IV-E Prevention Services Clearinghouse. Handbook of standards and procedures 2.0. (p. 64) https://preventionservices.acf.hhs.gov/sites/default/files/attachments/psc_handbook_v2_508c.pdf

[2] Hefyan, M., Goldberg, M., & Swinth, E. (2023, December). *Changes in home visiting since the start of the pandemic: Lessons from the Child First Program*. https://www.mdrc.org/work/publications/changes-home-visiting-start-pandemic/file-full