

A Model of Care for Delivering Supports to Childcare Providers during the COVID-19 Pandemic

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Abstract

Objectives: The COVID-19 pandemic is a life-changing crisis that has pervasive effects on our society, but perhaps the forgotten are the childcare programs serving the youngest children who are in out-of-home care while their parents are on the frontlines. The purpose of the Jump Start initiative was to develop a model of care to support childcare providers during the pandemic.

Method: The Inter-Agency Standing Committee reference group for Mental Health and Psychosocial Support (MHPSS) in Emergency Settings was used as a guideline to implement a 3-phase comprehensive tiered system of care.

Results: In Phase 1, Workforce Development, 26 Mental Health Consultants were trained in trauma-informed care. 91 childcare providers completed Phase 2, Assessment of Needs through the Risk and Resiliency COVID-19 survey. Anxiety (72.6%), sleep disturbance (52.7%), and sadness/depression (39.6%) were reported impacts of the pandemic on providers. Accessing on-line services was the number one need identified. Phase 3, Resource Provision, established a 6-tiered model of care. There was a range of participation with 75% of providers participating in Tier 1 on-line supports to 40% receiving Tier 6 intensive mental health consultation.

Conclusions: There is a distinct need to provide support for childcare providers especially given their role as a protective factor for children. Implementing a tiered mental health support system can potentially mitigate negative outcomes to improve the functioning of childcare settings. Understanding and addressing mental health and psychosocial considerations is the key to preventing the risk of long-term repercussion on the population's wellbeing.

Program Highlights

- The COVID-19 pandemic altered society, including childcare programs, immeasurably.
- Jump Start created a tiered system of mental health supports for childcare providers.
- Mental Health and Psychosocial Support (MHPSS) framework was utilized.
- Applying this MHPSS framework may mitigate the derailing effects of the pandemic.
- Addressing mental health and psychosocial factors is key to coping and prevention.

Introduction

On March 11th of 2020, the World Health Organization (WHO) declared the coronavirus disease (COVID-19) to be a pandemic after 114 countries reported cases (World Health Organization, 2020). Sudden public health emergencies, such as the COVID-19 pandemic, pose huge challenges to the behavioral health system (World Health Organization, 2020) especially when little is known about community needs. A lack of psychosocial support systems and access to well-trained behavioral health providers increases risks of distress (World Health Organization, 2020). It is essential to tailor resources to local community needs to mitigate psychological sequelae and promote psychosocial well-being (World Health Organization, 2020).

Studies detailing the psychological sequela of COVID–19 are yet emerging. International researchers documented negative mental health effects in frontline health workers, including anxiety, depression, and insomnia (Liu et al., 2020; Kang et al., 2020). Similar mental health distress was noted among frontline workers during the 2003 SARS and 2009 H1N1 pandemics (Brooks et al., 2018; Matsuishi et al., 2012). While little is known about the effects of the current pandemic on young children, there is literature demonstrating caregiver distress (i.e., anxiety, stress, depression) increases risks for negative outcomes on the child (National Institute for Children’s Health Quality, 2020). Short term effects of children exposed to prolonged home confinement during pandemic can include being less physically active, more screen time, changes in sleep patterns and overall routines, fewer outdoor activities and exercise, food insecurity or lack of healthy food options, and less contact with friends and family. Children are also at risk for increased psychological impact with anxiety related to being infected, lack of privacy at home, frustration, boredom, and financial loss (Wang et al., 2020). Long term effects have been found in longitudinal studies following children conceived during previous pandemics, national disasters and famines. These studies identified higher risk of lower academic achievement and lifelong earnings, obesity, mental health problems, and non-communicable diseases (Yoshikawa et al., 2020). Conversely, the presence of a supportive, caring adult in a child’s life is a protective factor (Bartlett, Griffin, & Thomson, 2020), when faced with a traumatic event. In fact, the single most important factor that assists a child in overcoming an adverse childhood experience (ACE) is the support of a stable adult relationship in their life (National Scientific Council on the Developing Child, 2015). Especially when a parent is not available, children can benefit greatly from childcare providers (National Scientific Council on the Developing Child, 2015) who offer consistent, sensitive care that helps protect them from lasting psychological harm caused by uncertainty and anxiety during a pandemic.

To keep childcare centers open, the state mandated that every center keeps children 6 feet apart from each other, allows only nine children per caretaker, and frequently sanitizes work stations (Center for Disease Control and Prevention, 2020). Florida is also trying to entice childcare centers with a \$500 stipend for every child of a first responder they enroll, and up to a total \$12,000 over a three-month period (COVID–19 Resources, n.d.). Nevertheless, it is speculated that many centers closed because they decided it was not worth the financial and health risk to keep their business running with lack of funds to pay teachers and loan programs aimed at small businesses running out of funds.

In addition to the financial burden that centers are facing, essential workers across industries are reporting high levels of stress (Asmundson & Taylor, 2020). Given that provider stress impacts child stress, this is a compounding issue. Thus, there is an immediate research priority to understand how to support childcare providers to optimize coping strategies that can mitigate symptoms of stress so that young children can receive the best care possible (Homes et al., 2020). Developing preventive interventions now can serve as a model should future events occur (Homes et al., 2020). Thus, the purpose of this Jump Start initiative was to: 1) determine the impact of the COVID–19 pandemic on the psychosocial functioning of the childcare providers and assess the needs of the children in their care, 2) engage a workforce that is able to address their needs, and 3) implement a tiered system to provide virtual support services.

Method

Participants

There are approximately 1343 licensed and operational childcare centers and family child care homes in the county. Over a 4 week period of time (March 24-April 21), all operating centers were eligible to receive services. Given the widespread impact of the pandemic, the number of operating centers went from 1343 to 266 during the 4 week time frame. Of these, 95 providers completed the Risk and Resiliency survey. See Table 1 for sample demographic information.

Procedures

This program was funded by a local agency, The Children’s Trust, in a large metropolitan community. The Jump Start program (in existence prior to COVID–19) provides in-person mental health consultation services to childcare centers to improve their capacity to work with challenging behaviors and reduce rates of expulsion in children ages birth to five. Services targeted center directors and teachers using an Infant/Early Childhood Mental Health Consultation (I/ECMHC) model (Hunter et al., 2016)). On March 16th, all in-person consultation services provided via the Jump Start program switched to a complete virtual model. Recognizing that childcare providers were overwhelmed with the current demands related to the pandemic, the program received funder approval to shift focus to provide COVID–19-related support.

Theoretical Framework

To guide implementation of these supports, Jump Start utilized the Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support (MHPSS) in Emergency Settings (Inter-Agency Standing Committee, 2020). This provided a list of 14 globally recommended activities that should be implemented as a response to the COVID–19 pandemic. Those activities have been outlined in the document “Briefing note on addressing mental health and psychosocial aspects of COVID–19 Outbreak-Version 1.0” (Inter-Agency Standing Committee, 2020). Recommendations included integrating multiple levels of interventions within outbreak response activities. Jump Start adapted these MHPSS activities in response to COVID–19 (see Table 1).

To quickly and efficiently implement all 14 MHPSS recommendations, the Jump Start program rolled out three phases. Phase 1 consisted of workforce development corresponding to MPHSS recommendations 1, 3, and 5–9. By March 20th, Phase 2, a needs assessment survey, was developed as suggested by MPHSS recommendations 1, 3, and 14. Shortly thereafter, Phase 3, a tiered response system, was in place to address childcare center concerns regarding COVID–19, in accordance with MPHSS recommendations 2, 4, and 10–13. Given the urgency for providing these services, phases overlapped. For example, workforce training occurred in conjunction survey development and toolkit assembly.

Phase 1: Workforce Development (MHPSS #1, 3, 5–9)

Twenty-six existing Infant/Early Childhood Mental Health Consultants shifted their roles from providing mental health consultation focused on challenging behaviors in children to consultation focused on COVID-related issues. The consultants completed a 6-item survey that assessed their comfort and skills in providing COVID-19 support services in a virtual format. The survey was reviewed with their supervisors to develop an individualized training plan to ensure competent care. Two overall training needs (i.e., supporting young children during the pandemic and grief and loss) were identified by most consultants in the team. Therefore, a 3-hour seminar titled “COVID-19: Supporting Young Children in Uncertain Times” aimed at using a trauma-informed approach was developed to provide additional training. Topics included working with caregivers who had adverse childhood experiences, identifying child abuse, and the potential traumatic impact of this pandemic on young children and families. Through a trauma-informed lens, this presentation also provided tips for parents, educators and health professionals to speak to children about this pandemic. Additionally, the training addressed strategies to best support and build resiliency in both caregivers and children. This training helped shape the role of childhood professionals in mitigating children’s psychological harm from the COVID-19 pandemic.

A second seminar provided to the Jump Start staff was titled, “Supporting Grieving Children and Families: COVID-19 Factors.” This training provided an overview and comparison of grief responses in young children and adults, COVID-19-specific stressors that must be considered when individuals are grieving, and guidelines for consultants to both help themselves and their clients. This training also addressed multiple losses that individuals may experience which may complicate the grieving process. A recent study suggests that clinicians who had some training in grief reported greater self-efficacy for working with bereaved children (Waver, 2019). This training aimed to empower the Jump Start consultants with the tools they need to address grief reactions in the children, parents, teachers and other school personnel with whom they work.

In addition to these two scheduled trainings, consultants took advantage of web-based training opportunities provided by the University on delivery of virtual services via telehealth. Zoom was the identified virtual platform to utilize. In addition, all consultants completed the 8-hour online course “Psychological First Aid,” (NCTSN Learning Center, n.d.) about the essential psychosocial care principles and making necessary referrals. Consultants also participated in weekly mindfulness exercises with a trained professional to manage their own stress and incorporate individual resiliency planning. Other online seminars were completed on an individual basis, based on each consultant’s training needs. Clinical supervisors were mindful of each consultant’s personal circumstances and were flexible and supportive, taking time in weekly supervision sessions to check in individually and discuss effective coping strategies. Finally, the University kept the staff informed daily about COVID-19 current events, evidence-based practices for preventing transmission, seeking healthcare support, and tips regarding psychosocial wellbeing.

Phase 2: Assessment of Needs (MHPSS # 1, 3, 14)

The Risk and Resiliency Survey was distributed to all childcare facilities that were operating between March 24 and April 21. All 1343 childcare centers were called two-three times over the 4 week period. Two hundred and sixty six providers were open at some point during the 4 week period. The survey was administered via phone and entered into Qualtrics or the Qualtrics link was emailed to the provider to complete at their leisure. Given the time of crisis, and the fact that this was not designed to be a research project but rather a service program, services were not withheld if the survey was not completed.

Phase 3: Resource Provision (MPHSS 2, 4, 10–13)

Survey responses from the Qualtrics database were compiled twice weekly by the program manager and triaged to a consultant who served the zip code of the center or had a previous relationship with the provider. Once the consultant received the survey, she developed an individualized Risk and Resiliency Action Plan that highlighted the identified needs based on the scores from the survey. The Action Plan provided the caregivers with a tiered level of support services with six levels ranging from an online toolkit to weekly individual virtual consultation (see Table 4). The providers that were contacted but did not complete a survey also had a consultant assigned to them so that an Action Plan could be developed. The Action Plan determined which of the six tiers of service (from least to most support) the participant could benefit from and the tiers were not mutually exclusive. That is, some participants needed multiple levels of support. These tiers aligned with the intervention pyramid for mental health and psychosocial support as defined by the Inter-Agency Standing Committee (Inter-Agency Standing Committee, 2020), ranging from addressing basic services to providing specialized services for individuals with more severe conditions.

Tier 1. Multi-modal/media/lingual COVID–19 Online Toolkit & Resource Hub. A website was developed to house the on-line tool kit, videos, and calendar of workshops. Content was organized around six pillars chosen based on the WHO COVID–19 Healthy Parenting Guidelines (World Health Organization, 2020): Helping manage worries about COVID–19; Responding to early learning program needs due to COVID–19; Managing the behavior of the children in class that may be related to fear/anxiety related to COVID–19; Accessing resources in the community in response to COVID–19; Access to balanced meals during COVID–19; and Upholding the recommendations of handwashing, social distancing, and creating a routine/schedule. An online toolkit, which was a compilation of resources, was curated based on these pillars. The Jumpstart website was modified to include an area with COVID–19 resources for both childcare providers and caregivers. The web page for childcare providers included tips for early learning programs based on CDC guidelines. This page also contained a video developed by the Jumpstart team to assist childcare providers with implementing CDC safety guidelines. The Jumpstart COVID–19 resources page contained information geared towards caregivers as well, including information on explaining COVID–19 in a developmentally appropriate manner, supporting social and emotional health, physical health, and activities for kids. Animated videos were developed and housed on the website in English, Spanish, and Creole, including one to help young children understand social distancing. All video content created was also made available on the Jumpstart YouTube channel.

Tier 2. Referrals for Supportive Services in the Community: Food, Unemployment benefits, Free/low-cost Wi-Fi, Telebehavioral health services, Trauma services, External online resources.

Tier 3. One-Time Phone Call for Support (e.g. stress management). This included the establishment of a warm line. Select consultants were trained in stress management and community referrals. These consultants provided available blocks of time during which an interested participant could call in or schedule an appointment at a later date.

Tier 4. Virtual Workshops/Webinars related to Parenting Skills, Child Development, and COVID-19 for Teachers, Directors, and Parents. The Jump Start team gathered and vetted workshops/webinars that were available online. A calendar of events was created and posted on the Jump Start website.

Tier 5. Virtual Peer Support Groups for Directors, Teachers, and Parents. Jump Start Mental Health Consultants facilitated weekly peer support groups via Zoom in English and Spanish. A fourth type of peer support group, for family child care homes, was created based on the needs of the community. Mental health consultants tailored the group to their needs, as many of these family child care homes remained open during the pandemic, and had expressed different demands and challenges than larger centers. All groups provided an opportunity for the members to support each other and express their concerns in a safe environment.

Tier 6. Virtual Individual Consultations with a Mental Health Consultant. Consultations were tailored to needs that participants identified when they completed the survey and through the creation of a COVID-19 Action Plan. Some topics of consultations included reopening procedures, CDC guidelines, preparing caregivers and children for the “new normal”, managing challenging behavior due to fear/anxiety, providing resources for distance learning, facilitating use of new technology in the center, community referrals, and managing their own stress.

Measures

Demographics

Demographic information was compiled via review of records for participants previously enrolled in Jump Start. For new participants, demographic information was collected via phone interview.

Risk and Resiliency Survey

A Risk and Resiliency Survey based partially on previously validated measures was developed to assess the impact of the viral epidemic on mental health in childcare providers. We adapted 12 items from the Everyday Stressors Index (Hall, 1983) to assess the degree of caregiver distress regarding finances, employment, health of family members, transportation, housing, and relationships. Two novel items were added to assess concerns related to childcare and schooling from home. Each item was adapted to specify

concerns “as a result of COVID–19,” and was rated on a Likert scale ranging from (1) not at all bothered, (2) a little bothered, (3) somewhat bothered, (4) bothered a great deal, or (0) don’t know.

We used nine selected items from the Experiences Related to COVID–19 Questionnaire (Skinner & Lansford, 2020). Items assessed sleep, anxiety, sadness/depression, anger, eating, arguments, and hopefulness regarding the future along a four-point Likert ranging from “strongly disagree” to “strongly agree.” Participants also provided a global rating of how personally disruptive the COVID–19 pandemic has been to daily routines, work, and family life ranging from 0 (not at all) to 10 (extremely).

We assessed providers’ use of ten coping strategies, including mindfulness and relaxation, eating well-balanced meals with family, connecting with others virtually, physical activity, protective health behaviors (e.g., handwashing, social distancing), enjoying activities, engaging in fun activities for children, engaging in fun activities for children with special needs, resources to talk with children and families regarding COVID–19, and resources to manage challenging child behavior. Participants endorsed current use of each strategy (yes or no), and indicated whether they were interested in learning more about each.

Eight items based on the WHO COVID–19 Healthy Parenting Guidelines (World Health Organization, 2020) assessed provider self-efficacy along a four-point Likert scale ranging from “not at all confident” to “very confident.” Providers rated confidence in managing their own and their children and families’ worries related to COVID–19, responding to early learning program needs, managing child behaviors, accessing community resources in response to COVID–19, accessing well-balanced meals (based on U.S. Household Food Security Survey), remaining positive, and upholding CDC recommendations of handwashing, social distancing, and maintaining a schedule.

Eight additional items assessed telehealth readiness and acceptability. We assessed the urgency of providers’ need for telehealth services (i.e., I don’t want services at all, I can wait, or I want services right now). We used a checklist to evaluate provider preferences for one or more remote/online service according to the six tiers of support (see Table 4).

Results

Phase 1: Training

Twenty-six Mental Health Consultants with Master’s degrees in mental health counseling were trained. Twenty were licensed, and six were non-licensed. 70% Hispanic, 20% Non-Hispanic Black, 7% Haitian. Survey results showed that 37% of consultants reported being “comfortable in providing COVID–19 related supports”. 15% were comfortable in delivering telehealth or virtual supports. 100% indicated having a reliable device and internet connection to provide services. All consultants received 8 hours of psychological first aid, 3 hours of grief, 3 hours of trauma-informed care training, and 2 hour on-line telehealth.

Phase 2: Survey

All 1343 childcare centers were called two to three times over the 4 week period. We contacted 266 providers at some point during the 4 week period via phone, but we were unable to reach 1,077 centers via phone, indicating that they were closed. Of those contacted, 91 completed the survey. By the end of the 4 weeks, only 181 centers were open, indicating approximately 50% of program directors who were open completed the survey. The main barrier to completing the survey was reduced staffing which made it impossible to complete a phone survey while caring for the children.

Regarding how personally disruptive the COVID-19 pandemic has been, 23.2% of providers rated a 10 of 10 (extremely disruptive), $M = 7.09$, $SD = 2.59$. Additional results regarding the impact of the pandemic on psychosocial wellbeing are shown in Table 2. Nearly three out of every four childcare providers reported anxiety. Over half of providers reported sleep disturbance, and roughly 40% reported sadness/depression. Regarding stressors related to the COVID-19 pandemic, approximately three out of every four participants reported not having enough money for basic necessities, including clothing, housing, food, and/or healthcare. About 32% reported housing instability, with nearly three out of every four participants indicating concerns regarding employment. Approximately 40% reported child behavior problems, and more than half reported concerns about their own children's schooling from home and not having enough time to do things they want to do.

Regarding provider self-efficacy (shown in Table 2), providers were least confident regarding accessing resources in the community in response to COVID-19 (46%) and managing behaviors of children in their class that may be related to fear/anxiety regarding COVID-19 (31%). One in four providers lacked confidence in responding to their early learning program needs due to COVID-19, and nearly one in four providers did not feel confident to help families manage their worries about COVID-19. Over 90% of providers were confident in remaining positive, and nearly all providers were confident in upholding CDC safety recommendations.

Providers endorsed using a variety of coping strategies, including protective health behaviors (e.g., handwashing, social distancing; 93.4%), connecting with others virtually (78.0%), engaging in activities they enjoy (75.8%), eating well-balanced meals with household members (71.4%), engaging in fun activities for children (71.4%), doing physical activity/exercise (65.9%), using resources to talk with children and families about COVID-19 (64.8%), using resources for managing children's challenging behaviors (59.3%), meditating/relaxing/practicing mindfulness (57.1%), and engaging in fun activities for children with special needs (27.5%). When asked whether they would like to learn more about any of these coping strategies, 12.2% were interested in resources to talk to children and families about COVID-19 and resources to manage children's challenging behavior. Several providers (6.6%) expressed interest in learning more about meditation/relaxation/mindfulness, eating well-balanced meals with household members, and fun activities for children (with and without special needs). Fewer providers were interested in learning about enjoyable activities (4.4%), physical activity/exercise (3.3%), connecting with others virtually (2.2%), and protective health behaviors (1.1%).

Approximately 53% of providers indicated an immediate need for COVID-19-related services, 40.2% said they needed services but could wait, and only 6.5% did not request additional services. Table 3 shows types

of requested services along tiers. Participants were able to request more than one service. The highest demand (75%) was for an online COVID–19 toolkit with child activities (Tier 1). More than half of providers requested referrals for supportive services in the community (Tier 2). Demand for online support groups, workshops, and webinars ranged from 30% to 46% of providers (Tiers 4 and 5). Fewest requests (16.8%) were made for one-time support phone calls (Tier 3).

Regarding *accessibility* of telehealth, 96% had a reliable internet connection, 93% had a reliable device, and 95% had a private location at home for telehealth services. Only 25% had prior experience receiving telehealth services, but 60% had used an application like Zoom or Skype. Regarding *acceptability* of telehealth, 76.4% of providers agreed that using telehealth is a good way to learn new things, while 22.5% were neutral and one participant disagreed. Additionally, 69.7% agreed that using telehealth can help them with their concerns related to COVID–19, while 27.0% were neutral and 3.37% disagreed.

Phase 3: Resource Provision

Of those contacted, 190 requested services. An Action Plan was developed which consisted of their service plan based on needs identified. A tiered system of supports was available, which were not mutually exclusive. Table 4 indicates the percentage of participants that accessed each tier of support. Tier 1 was the most requested service.

Discussion

Early childhood programs are a critical outlet for fostering the mental and physical development of young children (Office of Disease Prevention and Health Promotion, 2020). The COVID–19 pandemic has increased stress levels and impacted childcare programs. Given that childcare providers were caring for children of essential workers, during the COVID–19 pandemic, it is important that these childcare workers are supported to stay at work. These essential workers were at higher risk for emotional strain and physical exhaustion, due to concerns of their own health, having available protective equipment, and managing expanded workloads (Ayanian, 2020; Greenberg et al., 2020). Thus, there was a need to mitigate the negative effects of working under these stressful conditions and develop a model of care that could quickly combat the pandemic’s negative effects. However, given the rapid rate with which the pandemic swept through the nation, there were limited viable supports in place to assist childcare providers and many were struggling to stay open. The Jump Start initiative developed a comprehensive system of virtual supports, based on The Inter-Agency Standing Committee’s recommendations for MHPSS (Inter-Agency Standing Committee, 2020), to not only meet the demands caused by this pandemic but to support providers and children into the future. The MPHSS recommendations were divided into three phases: Phase 1, Workforce Development, Phase 2, Assessment of Needs, and Phase 3, Resource Provision.

Results of Phase 1, Workforce Development, showed the need for developing workers to handle this crisis. Approximately one third of these mental health consultants felt comfortable providing telehealth services and much less felt comfortable delivering services related to the topic of COVID. This indicates that although mental health workers are well skilled, they may still need additional training before providing

these types of emergency services. Assessing training needs and building a matrix of what trainings should occur to fit each community are important to consider. There are many available resources, such as Psychological First Aid training, which are specifically designed to train frontline staff during times of crises (Jacobs et al., 2016; McCabe et al., 2014). In addition, there was a need to provide training around trauma-informed care and abuse. Domestic violence and child abuse increased around the world since social isolation and quarantine measures were put in place to contain the COVID-19 pandemic (Campbell, 2020; Peterman et al., 2020; van Gelder et al., 2020). It is well known that isolation places children at greater risk of neglect as well as emotional, physical and sexual abuse (National Society for the Prevention of Cruelty to Children [NSPCC], 2020). Thus, it was important to train mental health consultants on trauma-informed care and the warning signs of abuse that could be identified by center staff.

The other identified need was for training on grief and loss. According to the Centers for Disease Control and Prevention (CDC), as of May 20th, 2020 the number of COVID-19-related deaths in the United States was 91,664 and a total of 1,528,235 cases were reported. Given the large numbers impacted by this pandemic, it is recognized that many families and childcare workers, as well as our own consultants, may experience loss of loved ones during this pandemic. Thus, training was provided to help them feel equipped in handling this. Lastly, when asked about comfort levels providing services via telehealth, 85% were not completely comfortable. This indicates that telehealth training is an important step to ensure providers are adequately capacitated before they are expected to deliver services. It is not a natural step to transition from in-person services to virtual services without training and support.

Phase 2, Assessment of Needs, focused on assessing caregiver needs and experiences at all operating centers, services being received, and access and acceptability for various virtual supports/services. Phase 2 elucidated the grave impact of the pandemic on childcare providers during this first wave and thus the need to intervene and ensure providers are equipped should a second wave arise. The majority indicated anxiety, depression and poor sleep. All of these factors can impact the care that is being provided to the children. Although childcare providers are considered essential workers rather than frontline workers, it is important to note that our results indicate a similar level of psychosocial impact of the COVID-19 pandemic as those reported for frontline workers in the literature (Brooks et al., 2018; Kang et al., 2020; Liu et al., 2020; Matsuishi et al., 2012). The newest COVID-19 research shows that understanding and addressing these psychosocial considerations will be key to preventing the risk of long-term repercussion of COVID-19 (Legido-Quigley et al., 2020). In addition, the majority of providers indicated not knowing where to access COVID-19 related supports and 75% had never used telehealth support services. This indicates the importance of developing ways to connect providers to the community and provide access to care.

Phase 3 consisted of implementing a tiered support system ranging from Tier 1- On-line toolkit to Tier 6- Individual Consultation. Phase 3 showed that the most utilized service was the Tier 1. We expected that with fewer in-person services, providers needed access to virtual information and activities they could share with children. Approximately 35% needed Tier 6 supports. Other research has found that personalized consultative approaches are likely to be a key component to address their mental health conditions and assist with coping mechanisms so they can continue their vital role in this pandemic (Holmes et al., 2020).

Utilizing a tiered system has been suggested in previous responses to disasters and has proven effective (ISAC, 2007; ISAC, 2008).

Implications and Limitations

Future research should examine the trajectory of the pandemic over time. We intend to survey childcare providers again in one-month and three-months to investigate the impact on needs and progress; however, no post-assessment data are currently available. It is important to determine factors related to whether centers stay open or close and adherence to CDC protocols for those that reopen. While not a focus of the current survey, specific questions about the impact on families and children with disabilities should be asked so that special considerations and supports could be implemented. Lastly, the intersection of minority and disability status should be more closely examined so that potential disparities are more adequately elucidated and addressed.

Conclusions

There is a distinct need to enhance the capacity of childcare facilities to support children in their care. Childcare providers are experiencing large amounts of stress and other symptoms as a result of COVID-19. Given the uncertainty surrounding future waves or outbreak, a plan should be developed now to protect mental wellbeing and promotes their resilience in the face of stress. Utilizing that MPHSS framework that enhances workforce development, assesses the needs of the population, and provides a tiered response system, is one approach to consider. MHPSS approaches should adapt to the needs of each population and country affected by COVID-19 and continue to evolve during different phases of the outbreak (i.e., new waves, closures and reopenings). It is also important to consider policy and advocacy initiatives as childcare providers face new challenges upon reopening. Future research is needed to determine the effectiveness of these preventative interventions over time.

Declarations

Compliance with Ethical Standards

Ethics Approval This was not a research study but a program evaluation and thus was exempt from IRB approval.

Informed Consent Informed consent was obtained from all individuals who participated in the program.

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Tables

Table 1

Globally Recommended Activities for Mental Health and Psychosocial Support (MHPSS) in Emergency Settings

Globally Recommended Activity for MHPSS	Jump Start ECC Content Adaptation
<p>1. Conduct a rapid assessment of the context and of culturally specific MHPSS issues, needs and available resources, including training needs and capacity gaps across the spectrum of care.</p>	<ul style="list-style-type: none"> · Administered assessment to all participating directors, teachers, and caregivers to assess needs in the context of COVID-19. · Administered assessment to Mental Health Consultants to assess readiness and comfort to address directors', teachers', and caregivers' needs in the context of COVID-19.
<p>2. Strengthen MHPSS coordination by facilitating collaboration between MHPSS agencies, government and other partners. Coordinating MHPSS should be a cross-sectoral initiative, including health, protection and other relevant actors.</p>	<ul style="list-style-type: none"> · Intra- and inter-agency collaboration initiatives were started to disseminate supportive services in response to COVID-19. · The Mailman Center for Child Development at the University of Miami provided information and training relevant to the dissemination of services via the telehealth care model. · The Children's Trust of Miami-Dade County has supported expansion of consultation services to centers that typically do not qualify for the Jump Start ECC program. · Community collaborated with the Jump Start ECC program to become first responders and shared internal agency resources. · Efforts continued to create cross-sectoral collaborations that would most benefit program participants.
<p>3. Use information from assessments, including identified needs, gaps and existing resources, to set up/contribute to a system for the identification and provision of care to people with common and severe mental health</p>	<ul style="list-style-type: none"> · All assessment results were reviewed and analyzed to assess risk

<p>conditions and substance abuse disorders. As part of ongoing health system strengthening, every health facility should have at least one person trained and a system in place to identify and provide care for people with common and severe mental health conditions. This requires the allocation of longer-term resources and the development of an MHPSS advocacy strategy to influence funding, quality coordination and sustainable, long-term initiatives.</p>	<p>to determine prioritization of care.</p> <ul style="list-style-type: none"> · All first responders were trained to help participants navigate community resources.
<p>4. Establish a MHPSS strategy for COVID-19 cases, survivors, contacts (particularly those in isolation), family members, frontline workers and the broader community, with special attention to the needs of vulnerable groups (e.g. children, older adults and people with disabilities). Ensure that the strategy addresses: fear, stigma, negative coping strategies (e.g. substance abuse) and the other needs identified through assessment and is building on positive, community-proposed coping strategies and promotes close collaboration between communities and health, education and social welfare services.</p>	<ul style="list-style-type: none"> · Created a “Resource for Caregivers” within the Jump Start ECC program’s COVID-19 Infant and Early Childhood Emergency Toolkit. · Developed information and activities that address concerns related to vulnerable groups (e.g. cases, survivors, contacts, etc.). · Eligible participants were offered group and/or individual consultations with a mental health professional. · Participants who required higher level of care were eligible for referral for more specialized services.
<p>5. Integrate mental health and psychosocial considerations into all response activities.</p>	<ul style="list-style-type: none"> · Provided mental health consultations via a consultant with emphasis on psychosocial considerations.
<p>6. Ensure that accurate information about COVID-19 is readily available and accessible to frontline workers, patients infected with COVID-19, as well as community members. Information should include evidence-based practice for preventing transmission, how to seek out healthcare support, as well as messages to promote psychosocial wellbeing.</p>	<ul style="list-style-type: none"> · All team members and participants were informed about COVID-19 virtual events, evidence-based practices for preventing transmission, seeking healthcare support, and maintaining psychosocial wellbeing.
<p>7. Train all frontline workers (including nurses, ambulance drivers, volunteers, case identifiers, teachers and other community leaders), including non-health workers in quarantine sites, on essential psychosocial care principles, psychological first aid and how to make referrals when needed. COVID-19 treatment and isolation/quarantine sites should include</p>	<ul style="list-style-type: none"> · Team members completed Psychological First Aid Online Course.

<p>trained MHPSS staff. Online trainings might be used if it is not possible to bring staff together due to infection risks.</p>	<ul style="list-style-type: none"> · Learned about essential psychosocial care principles, psychological first aid and making referrals when needed.
<p>8. Ensure that a functioning referral pathway for persons with mental health conditions is activated between all sectors involved, (including health, protection and gender-based violence), and that all actors operating in the response are aware and use such a system.</p>	<ul style="list-style-type: none"> · The Jump Start ECC Program Services Protocol was developed to ensure referral process fidelity among all collaborating agencies.
<p>9. Provide all workers responding to the COVID-19 outbreak with access to sources of psychosocial support. This must be of equal priority with ensuring their physical safety through adequate knowledge and equipment. Where possible, ensure regular review of frontline workers' psychosocial status to identify risks, emerging issues and shape the response to their needs.</p>	<ul style="list-style-type: none"> · Team members received trainings to best equip them to address community needs during crisis, group and/or individual supervision, and participated in online peer support groups and workshops related to mindfulness and self-care.
<p>10. Develop activity toolkits that parents, teachers and families can use with their children in isolation, including messages on preventing the spread of the disease such as hand washing games & rhymes. Children should not be separated from their families unless for treatment and the prevention of infection. If separation must occur, then a safe and reliable alternative should be found and with regular family contact provided while maintaining child protection measures.</p>	<ul style="list-style-type: none"> · Developed the Jump Start ECC program's COVID-19 Infant and Early Childhood Emergency Toolkit to address the needs of early learning professionals, caregivers, and children. · For additional support, a visual version of the COVID-19 Infant and Early Childhood Emergency Toolkit was created and uploaded to the Jump Start Early Childhood Consultation website.
<p>11. Establish opportunities for the bereaved to mourn in a way that does not compromise public health strategies to reduce the spread of COVID-19 but reflects the traditions and rituals of the community.</p>	<ul style="list-style-type: none"> · The "Resource for Caregivers" section of the COVID-19 Infant and Early Childhood Emergency Toolkit addressed concerns related to grief and mourning.

	<ul style="list-style-type: none"> · Eligible participants were offered group and/or individual consultations with a mental health professional to address these topics. Participants who required higher level of care were eligible for referral for more specialized services.
<p>12. Establish measures to reduce the negative impact of social isolation in quarantine sites. Communication with family and friends outside of the site, as well as measures that promote autonomy (e.g. choice in daily activities) should be facilitated and promoted.</p>	<ul style="list-style-type: none"> · The “Resource for Caregivers” section of the COVID-19 Infant and Early Childhood Emergency Toolkit addressed concerns related to social isolation. · Eligible participants were offered group and/or individual consultations with a mental health professional to address these topics. · Participants who required higher level of care were eligible for referral for more specialized services.
<p>13. In the early recovery phase, support health authorities to establish sustainable and community-based mental health and psychosocial services</p>	<ul style="list-style-type: none"> · Developed the COVID-19 Jump Start ECC Program Services Protocol to ensure the sustainability of such services.
<p>14. Establish monitoring, evaluation, accountability and learning mechanisms to measure effective MHPSS activities.</p>	<ul style="list-style-type: none"> · All assessments were administered prior to services and will be administered following conclusion of service provision.

Table 2

Childcare Provider Demographic Characteristics (N=95)

Variable	Number (Percent)
Role	
Administrator	86 (90.5)
Teacher	9 (9.5)
Gender	
Female	91 (95.8)
Male	2 (2.1)
Other	1 (1.1)
Race	
White	62 (65.3)
Black	15 (15.8)
Unknown	18 (18.9)
Ethnicity	
Hispanic	63 (66.3)
Non-Hispanic Black	8 (8.4)
Non-Hispanic White	3 (3.2)
Haitian	2 (2.1)
Jewish	1 (1.1)
Unknown	17 (17.9)
Primary Language	
Spanish	58 (61.1)
English	20 (21.1)
Haitian Creole	1 (1.1)
Unknown	16 (16.8)
Education	
High School/GED	14 (14.7)
Technical Training	2 (2.1)
Some College/Associate's Degree	21 (22.1)
Bachelor's Degree	30 (31.6)
Graduate Degree	8 (8.4)

Unknown	1 (1.1)
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Table 3

COVID-19 Risk & Resiliency Survey Results

Item	Percent of participants who endorsed		
	A little or somewhat bothered	Bothered a great deal	Total
Stressors as a result of COVID-19 (N=91)			
Not enough money for basic necessities (i.e., clothing, housing, food, and health care) ^a	45.1	30.8	75.9
Problems with your job or not having a job ^a	36.3	36.3	72.6
Concerns about childcare or children being out of school	41.8	29.7	71.5
Taking care of family members other than your child(ren) ^a	31.9	31.9	63.8
Concerns about the health of a family member [not including your child(ren)] ^a	20.9	39.6	60.5
Concerns about your child(ren)'s health ^a	25.3	35.2	60.5
Not enough time to do the things you want to do ^a	35.2	24.2	59.4
Concerns about home-schooling	34.1	22.0	56.1
Problems with child(ren)'s behavior ^a	25.3	15.4	40.7
Problems with housing ^a	16.5	15.4	31.9
Problems getting along with your family ^a	17.6	6.6	24.2
Disagreements with others over discipline of your child(ren) ^a	16.5	6.6	23.1
Problems with transportation ^a	15.4	3.3	18.7
Problems with being married/single ^a	8.8	2.2	11.0
Impact of COVID-19 on physical and mental wellness	Endorsed somewhat	Endorsed strongly	Total
I feel hopeful about the future and that things will improve. (reversed)	22.0	69.2	91.2
I feel more anxious now than I did before the outbreak.	33.0	39.6	72.6
I eat more now than I did before the outbreak.	29.7	19.8	49.5
I sleep about as well now as I did before the outbreak. (reversed)	22.0	25.3	47.3
I feel more sad/depressed now than I did before the outbreak.	26.4	13.2	39.6
I sleep more now at unusual times than I did before the outbreak.	20.9	6.6	27.5
I feel angrier now than I did before the outbreak.	12.1	4.4	16.5

I get in more arguments now than I did before the outbreak.	5.5	2.2	7.7
Self-efficacy in managing impact of COVID-19	Not at all confident	A little confident	Total
How confident are you accessing resources in the community in response to COVID-19?	4.4	41.8	46.2
How confident are you in managing the behaviors of the children in your class that may be related to fear/anxiety related to COVID-19?	1.1	29.7	30.8
How confident are you responding to your early learning program needs due to COVID-19?	5.5	20.9	26.5
How confident are you helping children and caregivers manage their worries about COVID-19?	2.2	19.8	22.0
How confident are you in managing your own worries about COVID-19?	1.1	13.2	14.3
How confident do you feel that you can access to eat balanced meals during the COVID-19?	3.3	13.2	16.5
How confident are you in remaining positive during the COVID-19 pandemic?	0.0	9.9	9.9
How confident are you upholding the recommendations of hand washing, social distancing, and creating a routine/schedule?	0.0	2.2	2.2

Table 4

Services Requested and Provided via COVID-19 Resiliency & Needs Survey

Service Type	Number Requested (Percent ^a)	Number Provided (Percent ^b)
Tier 1. Multi-modal/media/lingual COVID-19 online toolkit & resource hub based on WHO standards	57 (77.0)	80 ^c (N/A)
Tier 2. Referrals for supportive services in the community	39 (52.7)	58 ^c (N/A)
Tier 3. One-time phone call for support (e.g. stress management)	8 (10.8)	12 ^d (N/A)
Tier 4. Virtual workshops/webinars related to parenting skills, child development, and COVID-19 for teachers, directors, and parents	29 (39.2)	21 (72.4)
Tier 5. Virtual peer support groups for directors/teachers	23 (31.1)	4 (17.4)
Tier 6. Virtual individual consultations with a Mental Health Consultant	26 (35.1)	19 (73.1)

^a percent of individuals who requested the service relative to individuals who completed the COVID-19 Resiliency & Needs Survey. ^b percent provided relative to individuals who requested specific service. ^c Number provided is greater than recorded number requested. Individuals were able to request the online toolkit and/or community referrals without completing the COVID-19 Resiliency & Needs Survey. ^d Number provided is greater than recorded number requested. Individuals were able initiate separate phone call to a designated support line staffed by an on-call Mental Health Consultant.