Findings from the First 5 California Home Visiting Workforce Study | *Executive Summary*

The First 5 California (F5CA) Home Visiting Workforce Study collected data to help the state understand the landscape of California's home visiting workforce, including characteristics of home visitors and supervisors, implementation supports for staff, and program needs for workforce recruitment, development, and retention. The following summary presents key findings from a survey of more than 900 home visiting staff representing 171 home visiting programs across the state.

Key findings about California's home visiting workforce

Key findings from this workforce survey include a description of the California home visiting workforce, the ways they are meeting the needs of families, changes in their work due to the COVID-19 pandemic, and how home visitor well-being and program supports affect workforce retention.

- **The majority of California's home visiting workforce identifies as Hispanic or Latinx and can speak Spanish fluently.** These demographics mirror the families comprising home visitor caseloads, with the majority of families also being Hispanic or Latinx, and Spanish being their second most commonly spoken language after English.
- **Although the workforce is experienced working with parents and families, they are new to the field of home visiting.** More than 40 percent of home visitors have worked in the field for less than three years and the majority have been in their current position for less than three years.
- **While almost three-quarters of California's home visiting workforce hold at least a bachelor's degree,** staff come from a diverse range of disciplines, representing degrees in child development, early childhood education, psychology, social work, nursing, and education.
- **The well-being of the home visiting workforce is a concern.** One quarter of the workforce is experiencing depressive symptoms, which is a higher rate of depressive symptoms than those found in recent national studies of home visiting staff.
- **The COVID-19 pandemic continues to affect families and home visitors.** Almost all home visitors are conducting virtual home visits during the pandemic, and almost all reported that their work is more challenging now compared to before COVID-19. In addition, both home visitors and supervisors are now working almost twice as much during the evenings and weekends compared to before the pandemic.
- **While high levels of stress and depressive symptoms are being reported during the pandemic,** most home visitors have not experienced a change in their level of satisfaction with work now compared to before COVID-19, and plan to stay in their current position for at least the next year. Home visitors also reported that they appreciate support from their supervisors as well as employment benefits such as paid vacation or sick leave and health insurance. At the same time, about half of home visitors would like additional mental health supports.
- **Predictors of whether home visitors in California intended to remain in their current position include** having a say in decisions that affect them, receiving training on implementing virtual home visiting, having three or more years of home visiting experience, being satisfied with the amount of on-the-job stress they experienced, and having higher salaries. However, reporting more depressive symptoms and experiencing discrimination in the workplace decreased the likelihood of expecting to remain in their current position.

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Supporting the home visiting workforce

Additional analyses were conducted to understand what workforce supports are necessary to ensure home visiting staff are well prepared to meet the needs of families and ultimately support retention. Several key variables related to workforce retention were examined, including: 1) the extent to which home visitor demographics mirror those of the families on their caseloads, 2) whether training, supervision, and other program supports are preparing home visitors to meet a wide range of family needs, 3) characteristics that influence the association of stress and depressive symptoms, and 4) factors that predict the likelihood that staff will stay in their current position.

To some extent, the home visiting workforce is representative of the families it serves.

Almost all home visitors (90%) reported that they share racial, ethnic, or cultural traits with *at least some* of the clients that their program serves, with the majority of these home visitors (67%) reporting that they share these traits with *most* of the clients they serve.

One way to further understand how representative the workforce is of the families they serve is to examine the extent to which home visitors can provide services in the same languages their families speak. Most home visitors reported that they have at least some families on their caseload who speak English, and almost all home visitors were able to speak and provide services in English. However, for all other languages, significant gaps between family and home visitor language existed (Table 1). These results indicate that there were families served by home visitors who did not speak the same language, which likely resulted in communication challenges. These same challenges might affect rapport-building and provision of services, including referrals and health education.

Table 1. Language concordance between families and home visitors (n = 802)

Language spoken	Number of home visitors with families on their caseload who speak this language	Home visitor speaks the same language
English	712	98%
Spanish	612	74%
Arabic	63	3%
Vietnamese	40	15%
Tagalog	35	3%
Cantonese	32	6%
Hmong	18	17%

Source: Home visiting workforce survey, 2020, Child Trends
Note (1): Supervisors with a caseload were classified as home visitors in these analyses
Note (2): Data include the following responses: "very few families," "about half of families," "more than half of families," and "all families"

The home visiting workforce generally feels well-supported and prepared to meet the needs of its families but may require more mental health support.

To identify how home visitors are supported and prepared to meet their families' needs, caseload data were grouped into four categories reflecting different family experiences: 1) poverty, 2) involvement with the child welfare system, 3) prenatal or postpartum depression or mental illness, and 4) high risk.[1]

Overall, most home visitors who have families in any of the four categories received training to address the family needs reflected in their caseload. For instance, almost all home visitors (>90%) who had parents identified as high risk on their caseload received training in child maltreatment or mandated reporting as well as training in family stress and mental health. However, supervision and mental health supports were not always provided to home visitors who served families in the four categories. For example, home visitors who had caseloads with parents experiencing poverty tended to receive less supervision than those who did

[1] Includes caseloads with parents experiencing homelessness or unstable housing, intimate partner violence, prenatal or postpartum depression or mental illness, substance use, involvement with child welfare system, or incarceration.

not have these families on their caseloads. Home visitors serving the most vulnerable families, particularly parents involved in the child welfare system and parents identified as high risk, were less likely to report that their program provided mental health supports for their well-being compared to home visitors who do not serve these families. It may be that home visitors have the training and resources needed to address families' needs, but they could develop and improve skills through high-quality supervision and benefit from mental health supports to address stress and feelings of burnout.

Home visiting staff well-being is a concern: Staff are experiencing high levels of depressive symptoms and COVID-related stress; supporting staff mindfulness may reduce these experiences.

More than one quarter of home visitors reported experiencing high levels of depressive symptoms. This high rate of depressive symptoms is likely strongly influenced by the impact of COVID-19, as the study found that COVID-related stress was strongly associated with depressive symptoms. Using a composite total score of the COVID-related stress items, for every 1 unit increase in the score, there is about a 16 percent increase in the odds of having high levels of depressive symptoms. In addition, results indicated that mindfulness is strongly associated with depressive symptoms; as mindfulness increases, the likelihood of experiencing high levels of depressive symptoms decreases.

The study also sought to identify whether characteristics such as home visitors' mindfulness changed this strong relationship between COVID-related stress and depressive symptoms. Results indicated that for all levels of mindfulness, there is an association between COVID-related stress and depressive symptoms. However, follow-up analyses suggest that when mindfulness is low, COVID-related stress and depressive symptoms are more strongly associated compared to when mindfulness is high.

Programmatic supports and home visitor characteristics predict the likelihood that home visitors may remain in current positions.

Bivariate and multivariate statistical models were tested to identify the strongest predictors of remaining in one's position, including community-level factors, programmatic supports, and home visitor characteristics.[2]

- For programmatic supports, home visitors who felt they have a say in decisions that affect them were more likely to indicate they intend to remain in their current position. In addition, those home visitors who reported receiving training on implementing virtual home visiting were nearly two times more likely to remain in their position compared to home visitors who did not receive training.
- Some of the strongest predictors of home visitors remaining in their current position included: 1) having three or more years of home visiting experience, 2) satisfaction with the amount of on-the-job stress, and 3) higher salaries. Reporting more depressive symptoms was associated with less likelihood of expecting to remain in their current position for at least the next year.
- Although only 6 percent of home visitors reported experiencing discrimination in the workplace, this was a negative predictor of intent to remain in current position. Additionally, although it was not a statistically significant finding at the bivariate or multivariate level, home visitors who identified as non-Hispanic White were more than two times more likely to remain in their current position compared to home visitors who identified as Hispanic or Latinx (p=.13).

Discussion

The home visiting workforce in California includes a much greater proportion of staff who identify as Hispanic or Latinx and speak Spanish fluently compared to national studies. Staff also represent a diverse set of disciplines and come into the field of home visiting through various channels. This diversity of staff makes supporting the workforce complex, particularly for building a coordinated system to support a stable and competent workforce that can meet the needs of California's families.

In addition, much of the home visiting workforce in California is new to the field of home visiting and, at least during the COVID-19 pandemic, they are experiencing high rates of depressive symptoms and stress. Likewise, about 40 percent of home visitors and 30 percent of supervisors report that they are likely to

[2] Reported variables showed statistically significant differences at the p<.10 level.

leave the home visiting field in the next year. Analyses conducted to understand factors that support workforce retention reveal the need for various programmatic supports, including supportive supervisors and ongoing feedback, and additional training on implementing virtual home visits, family stress and mental health, and available community services for families. These analyses also indicate the need for a supportive workplace environment in which an effort is made to reduce staff stress, include home visitors in decision making, and understand and address discrimination.

Additional resources that specifically target staff's mental health are also needed if this workforce is going to remain in the home visiting field long-term. Having three or more years of experience in home visiting predicted the likelihood that staff would remain in their current positions, even during this turbulent time. Long-term retention has additional benefits such as increased salaries, which also predicted the likelihood that staff would continue to remain in their jobs. Conversely, home visitors with less than three years of experience were not only more likely to anticipate leaving their job in the next year, they were also more likely to report high rates of depressive symptoms and struggle with family engagement, particularly during the pandemic. Further, well-being supports and efforts to reduce staff stress, including addressing discrimination in the workplace, are needed to support retention. Whether staff have experienced discrimination also predicted if they anticipate leaving their current position.

Data collected though this survey are intended to provide a broad landscape of the home visiting workforce in California, including the number of programs and staff providing home visiting services across the state, and the characteristics of these staff. These data revealed key findings about the workforce, particularly in regard to its well-being and factors for retention. These findings need further investigation to inform future phases of this workforce study—including understanding California's home visiting workforce pipeline and preparation—and to develop final policy recommendations for ensuring California's home visiting workforce has a cohesive infrastructure for recruiting, training, and retaining staff across the state.

Methods

Data were collected through 20 interviews with home visitors and a survey of home visiting staff, which received responses from 918 home visitors and supervisors across the state, representing 48 counties and 54 home visiting models.[3] Data collection tools and study design considerations were developed in collaboration with F5CA, and with additional support from members of the study's Core Advisory Group, which included representatives from local First 5 commissions, the California Departments of Public Health (CDPH) and Social Services (CDSS), and state policy leaders.

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[3] Home visiting programs administered in California include evidence-based and home-grown models; this study addresses a range of home visiting models, not just those funded by MIECHV.