UNIVERSITY OF TORONTO
MISSISSAUGA
Centre for Child Development, Mental Health, and Policy

SPRINT

SUPPORTING PROSOCIALITY AND RESILIENCE IN NEWCOMER TRANSITIONS

AN EVALUATION OF THE SPRINT PILOT TRAINING

TRAINING REPORT
JULY 2022

Centre for Child Development, Mental Health, and Policy
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Report Summary

Service Providers

SAMPLE

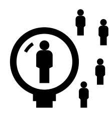
- **24** service providers from the Greater Toronto and Hamilton area (GTHA), Ontario and Calgary, Alberta.

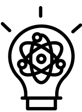
SATISFACTION WITH TRAINING

- **96%** of service providers reported being *somewhat satisfied* to *very satisfied* with the training.

TRAINING STRATEGY USE

- **89%** of service providers reported using the strategies *often* to *very often*.





Refugee Caregivers

SAMPLE

- **26** Middle-Eastern refugee caregivers of children ages 2-12, from GTHA.

SATISFACTION WITH TRAINING

- **96%** of caregivers reported being *somewhat satisfied* to *very satisfied* with the training.

TRAINING STRATEGY USE

- **89%** of caregivers reported using the training strategies *often* to *very often*.

Research Questions for SPRINT Training

1. Did refugee caregivers and service providers increase in their knowledge of core social-emotional concepts? (see pg. 19)

2. Were increases in refugee caregiver knowledge and greater use of training-based strategies associated with improvements in child social-emotional capacities, mental health, and well-being challenges? (see pg. 20)

3. Were increases in refugee caregiver and service provider knowledge and greater use of training-based strategies associated with improvements in their own mental health? (see pg. 21)

Background

As a result of pre- and post-migratory traumas and adversities, Middle Eastern refugee families experience disproportionately high social-emotional and mental health challenges, and these traumas and challenges have been rehashed and exacerbated by the COVID-19 pandemic (Hayward et al., 2021; Orcutt et al., 2020; Sieffien et al., 2020). In response to these compounding needs, the current training was implemented in fall 2021 to support the social-emotional development and mental health of Middle Eastern refugee families, and those who support them. Specifically, our aim was to promote refugee caregivers' and service providers' capacities to support protective factors in refugee children and themselves, including emotion regulation, empathy, positive early relationships, and stress coping.

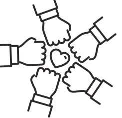
The training was developed and culturally adapted based on a needs assessment in 2020. The needs assessment included in-depth, comprehensive interviews with refugee caregivers and service providers about the most prominent strengths and needs of the refugee population during and beyond COVID-19. We used this knowledge to culturally adapt the core content of our training, which is rooted in leading developmental theory and 20-years of research on social-emotional development and adversity (Malti & Noam, 2016; Malti, 2020).

Aim

The goal of the SPRINT project is to use clinical-developmental research to create a training that will help caregivers and service providers understand the social-emotional development of refugee children, the effects of child and caregiver stress in the refugee context, and the roles caregivers and service providers play in fostering refugee children's development during their resettlement in Canada.

The Current Report

This report provides an evaluation of a pilot implementation of the SPRINT project's virtual social-emotional training initiative with 26 Middle-Eastern refugee caregivers and 24 service providers (N = 50) from the Greater Toronto and Hamilton area (GTHA), Ontario and Calgary, Alberta.



SPRINT Team

SPRINT is a community-based collaborative project between the Centre for Child Development, Mental Health, and Policy (**CCDMP**) at the University of Toronto Mississauga and several community organizations from the GTHA, Ontario and Calgary, Alberta. The SPRINT project's community partners played an essential role in the recruitment process for the implementation of the training.

Principle Investigator	Tina Malti, *CCDMP*
Project Lead	Redab Al-Janaideh, *CCDMP*
Project Supervisor	Tyler Colasante, *CCDMP*
Community Partners	Fariborz Birjandian *Calgary Catholic Immigration Society (CCIS)* Sarah Wayland *Hamilton Immigration Partnership Council (HIPC)* Ali T. Ghouse *Muslim Council of Greater Hamilton (MCGH)* Mona Aboumrad *University of Calgary*
Research Assistants	Danah Elsayed Maarya Abdulkarim Layla Akel Dima Taian Ghazal Jessani Shahd Fulath Khan Salwa Yaghi Nirma Jbara Hagar Saleh

Agence de la santé publique du Canada   Public Health Agency of Canada

Training Pedagogy

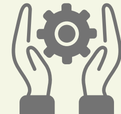
The CCDMP's training framework was developed based on 20+ years of our research spanning over 200 publications in the areas of social-emotional development and adversity. The training takes a clinical-developmental and strengths-based approach to address needs by building upon existing competencies. Additionally, the training is steeped in an understanding of the importance of early relationships and surrounding environments for facilitating healthy social-emotional development.

The pedagogical approach for SPRINT training is rooted in the following three aspects: knowledge, practice, and routine.

KNOWLEDGE

Reality: Service providers and caregivers have existing skills and knowledge that can be enhanced by research-based knowledge.

Training Added Strength: The knowledge component is integrated into each and every aspect of the training. Its purpose is to provide caregivers and service providers with the most up-to-date clinical and developmental knowledge of social and emotional development.



PRACTICE

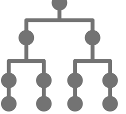
Reality: Learning is an active, collaborative process that is enhanced when combined with practice.

Training Added Strength: The practice component is supported by virtual live group sessions and at-home practice in which caregivers and service providers are given hands-on opportunities to apply concepts and share lived experiences in an interactive setting.

ROUTINE

Reality: Learning is a continuous process that is more effective when incorporated into our daily lives.

Training Added Strength: The routine component is maintained through strategy-based handouts, reading resources, and two virtual feedback sessions to provide ongoing support and to understand the strengths and challenges to create lasting change as a result of the training.



Training Structure

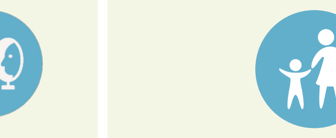
Three core components of social-emotional development — "the 3 Es" — are emphasized:

1. Emotion Regulation

2. Empathy for Others

3. Empathy for Self

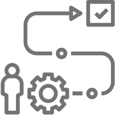
Three online modules were delivered weekly over the course of 3 weeks in fall 2021.

MODULE 1	MODULE 2	MODULE 3
Social-Emotional Development	Early Relationships	Growth, Well-Being, and Stress
		
• 1 asynchronous video session • 1 synchronous virtual session	• 1 asynchronous video session • 1 synchronous virtual session	• 1 asynchronous video session • 1 synchronous virtual session

*Module 3 for service providers also included a component on Social-Emotional Assessment

Each module included a one-hour asynchronous (i.e., self-paced) video session and a one-hour synchronous virtual (i.e., live group) session.

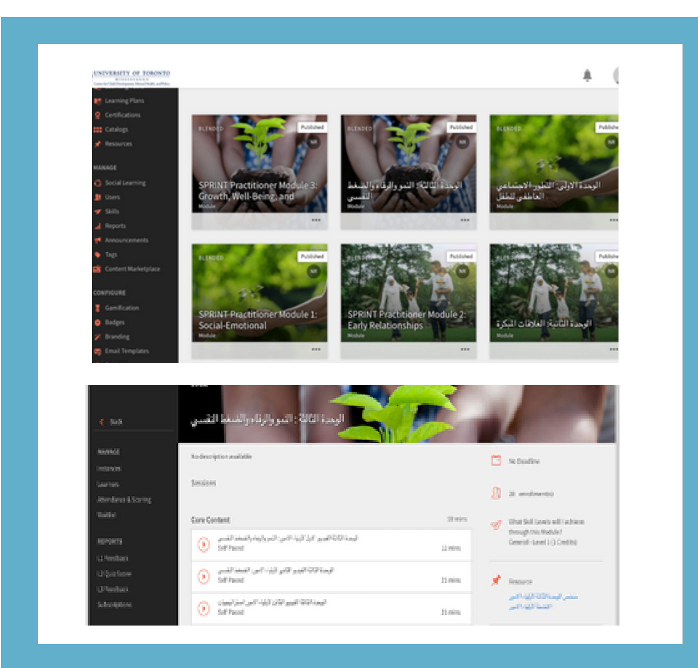
Participants were invited back for two follow-up sessions (one week after the final module in November 2021 and two months after the training in January 2021, respectively) to share successes and barriers related to continued application of the training strategies.



Methodology

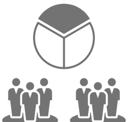
Fifty participants, including refugee caregivers (*n* = 26) and service providers (*n* = 24), participated in the pilot training. Eligibility criteria for caregivers required being a Middle Eastern refugee caregiver of a child aged 2-12 years, and having been resettled in Canada. Service providers must have worked with refugee families. Participants were recruited from two sites in Canada, GTHA and Calgary, using social media flyers and word of mouth in collaboration with our community partners at the Calgary Catholic Immigration Society (CCIS) and Muslim Council of Greater Hamilton (MCGH).

The training was delivered entirely online in November 2021 using a Learning Management System (LMS; Adobe Captivate Prime). The content of the refugee caregiver and service provider trainings were tailored to the different audience groups, but their formats were consistent. The training was facilitated by a developmental psychology PhD and undergraduate research assistant from the CCDMP team.



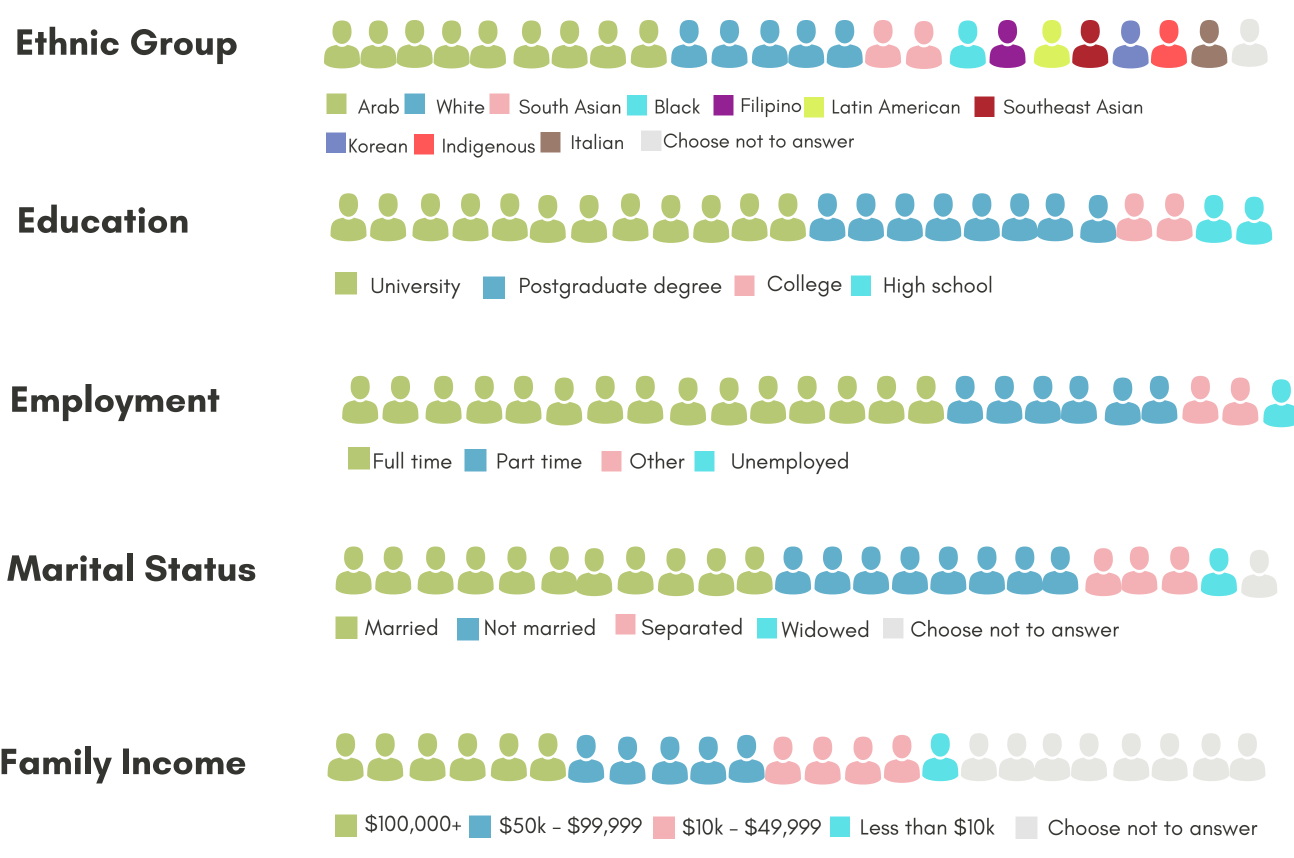
Note. Image of the SPRINT training materials on the Learning Management System (LMS). Each user had access to a similar screen on the LMS where they could access content and track their progress.

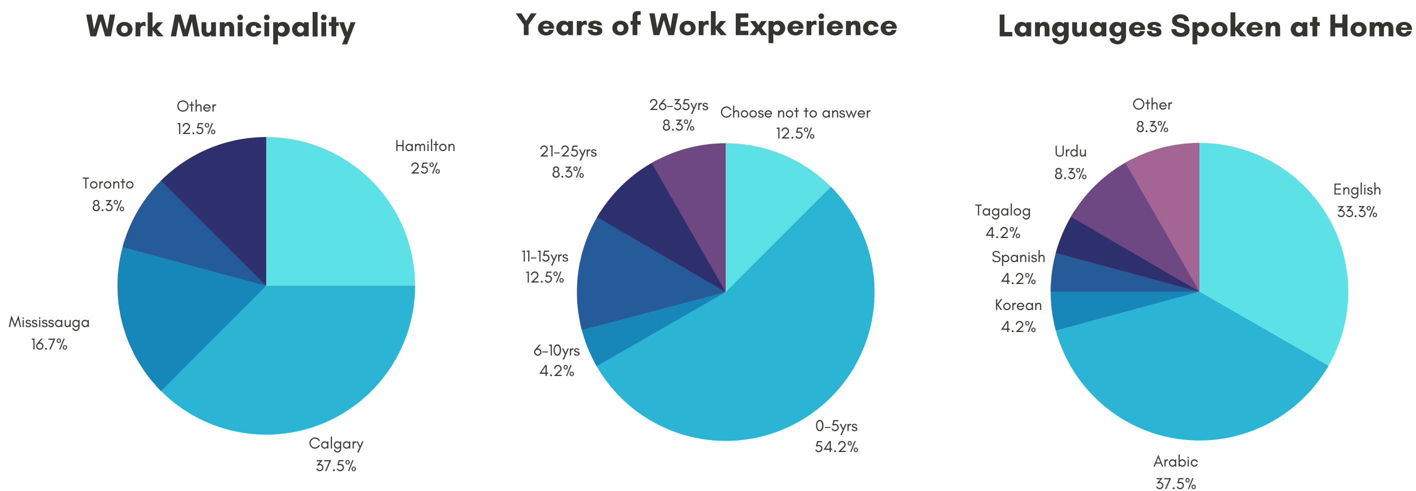
The core knowledge-based training content was delivered during the weekly asynchronous sessions using audio-narrated self-paced videos. This knowledge was further supported through weekly synchronous group sessions that included 3 components: 1) a mindfulness exercise, 2) structured group discussion and reflection based on the self-paced session content, and 3) activities to practice applying training concepts and strategies. To evaluate the training, service providers and caregivers completed a pre-survey and a series of post-surveys (after each module's session, a 1-week follow-up, and a 2-month follow-up).



Service Provider Demographics

A diverse group of 24 service providers working with refugee families and children in the GTHA and Calgary participated in the training.





Refugee Caregiver Demographics

A total of 26 Middle-Eastern refugee caregivers from the GTHA participated in the training.

Ethnic Group

Arab | Kurd | Choose not to answer

Education

High school | University | College | Secondary | Postgraduate | Choose not to answer

Employment

Unemployed | Full-time | Part-time | Choose not to answer

Marital Status

Married | Divorced | Widowed | Single | Choose not to answer

Family Income

$10k - $49,999 | Less than $10k | $50k - $99,999 | Choose not to answer

Municipality

Country of Origin

Family Size

Living in Refugee Camp

15% lived in a refugee camp

Religion

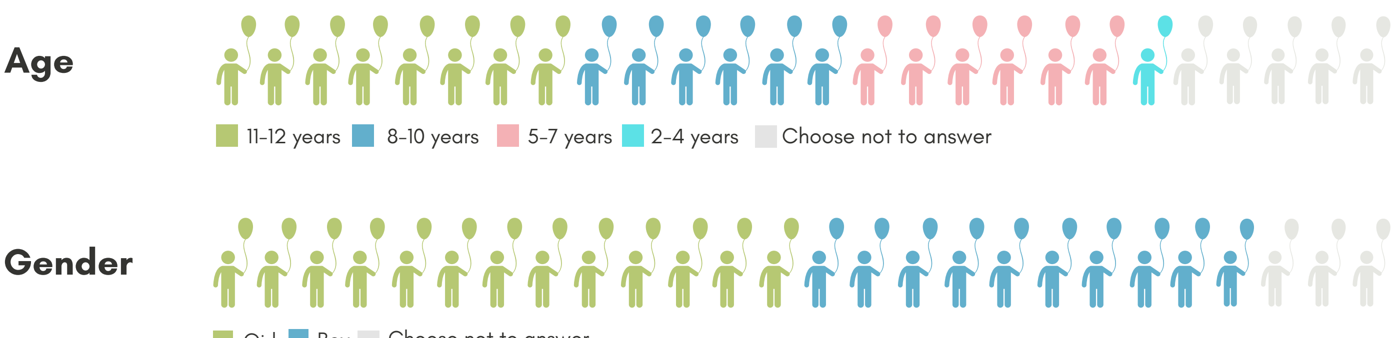
85% reported Islam as their religion

Support Services

76% reported not participating in support services (e.g., parenting workshops, family therapy)

Refugee Child Demographics

Age

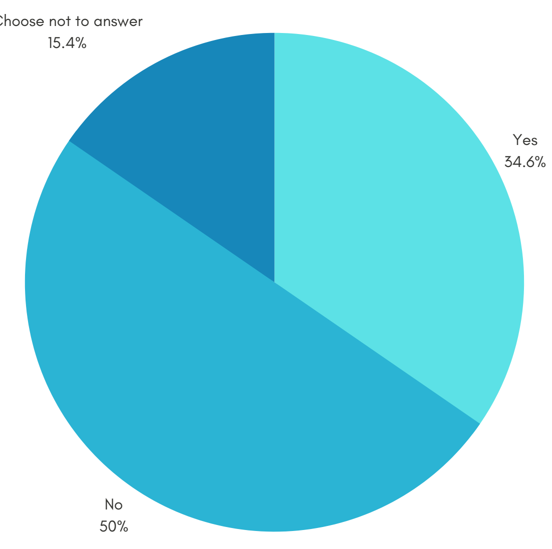


Gender

Canada Born

19% of children were born in Canada

Schooling before Resettlement



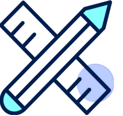
50% of children did not go to school before resettlement in Canada

Arabic Books at Home

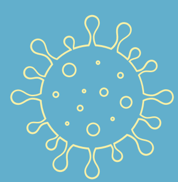
27% reported having more than 10 Arabic books at home

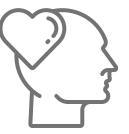
English Books at Home

62% reported having more than 10 English books at home



Training Measures

IMPACTS OF COVID-19 	At pre-training, service providers and refugee caregivers reported negative COVID-19 impacts across various areas of their lives using five items rated on a 4-point scale (1: no change, 2: mild change, 3: moderate change, 4: severe change) adapted from the Coronavirus Impact Scale (Kaufman & Stoddard, 2020), including changes in access to social supports, emotional health and well-being service access, medical health care access, food security, and income/employment.
SATISFACTION WITH THE TRAINING	After each asynchronous and synchronous session, service providers and refugee caregivers reported their satisfaction with the session on a 10-point scale (1: very dissatisfied, 4: somewhat dissatisfied, 7: somewhat satisfied, 10: very satisfied). Participants also reported their overall satisfaction with the training one week after it was completed.
KNOWLEDGE OF CORE SOCIAL-EMOTIONAL CONCEPTS	At pre-training, after each asynchronous and synchronous training session, and at the 2-month follow-up, caregivers and service providers rated their understanding of core social-emotional concepts targeted in the training using 18 items. The items were designed as part of the training material to assess knowledge of core social-emotional concepts (e.g., "I understand what emotion regulation is and how it develops") and knowledge of how to apply these concepts (e.g., "I know how to build and support a warm connection with children"). Items were rated on a 10-point scale (1: entirely disagree, 4: somewhat disagree, 7: somewhat agree, 10: entirely agree). Individual scores across the 18 items were averaged to form pre-training, post-training, and 2-month follow-up scores. The scales reliably measured what they were intended to measure (α = .93 on average).
USE OF TRAINING STRATEGIES	At post-training and the 2-month follow-up, service providers and refugee caregivers reported their use of strategies from the training (e.g., mindfulness, emotion coaching exercises) using a single item: "To what extent do you use any of the strategies from the training?" rated on a 10-point scale (1: not at all, 4: sometimes, 7: often, 10: very often).



Social-Emotional & Mental Health Measures

CHILD SOCIAL-EMOTIONAL CAPACITIES

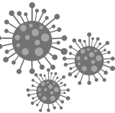
At pre-training and the 2-month follow-up, caregivers reported their child's emotion regulation, empathy for others, and sadness over wrongdoing using the Social-Emotional Responding Task (SERT; Malti et al. 2021). These capacities were assessed because they map onto the three core components of social-emotional development highlighted in the training: emotion regulation, other-oriented social-emotional capacities, and self-oriented social-emotional capacities, respectively. Caregivers completed 12 items assessing emotion regulation (e.g., "My child calmly deals with what is making them mad", α = .93 and .93), 4 items assessing empathy (e.g., "My child feels bad for other children who are sad", α = .81 and .71), and 4 items assessing sadness over wrongdoing (e.g., "When my child does something that makes another child feel sad, they feel sad", α = .62 and .63). Items were rated on a 4-point scale (0: not at all, 1: sometimes true, 2: often true, 3: almost always true) and were averaged to form emotion regulation, empathy, and sadness over wrongdoing scores.

CHILD EXTERNALIZING AND INTERNALIZING PROBLEMS

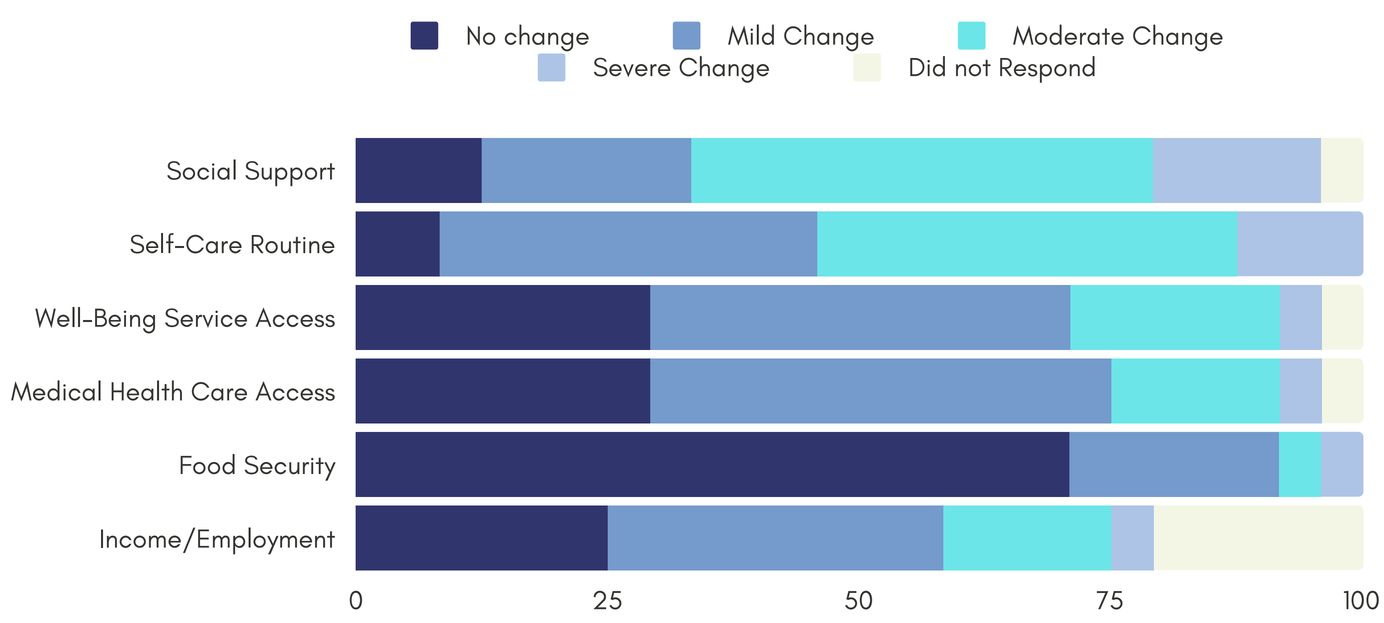
Externalizing and internalizing problems (e.g., overactivity and social withdrawal, respectively) were evaluated by caregivers at pre-training and the 2-month follow-up using the Arabic version of the Strengths and Difficulties Questionnaire (SDQ; Alyahiri & Goodman, 2006). Each item was scored (0: not true, 1: somewhat true, and 2: certainly true). Reliability calculated for pre-training and the 2-months follow-up were αs =.62 and .82 for internalizing problems and αs =.62 and .77 for externalizing problems, respectively.

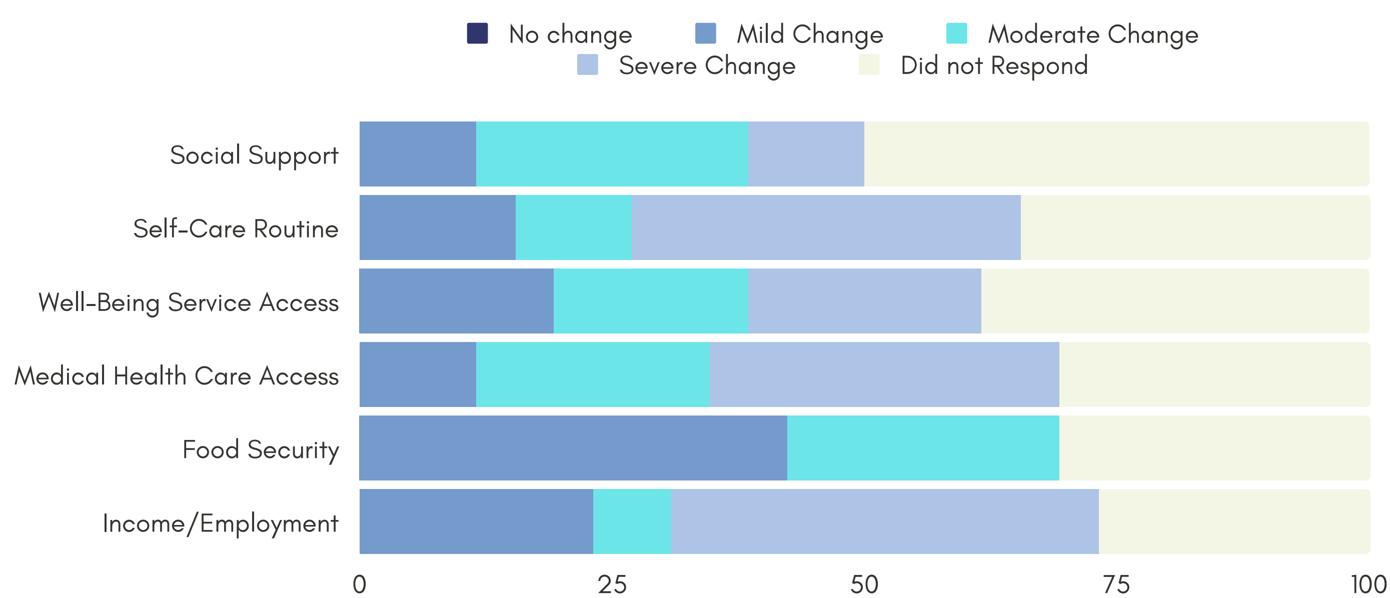
SERVICE PROVIDER AND CAREGIVER MENTAL HEALTH

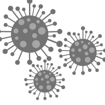
At pre-training and the 2-month follow-up, service providers and caregivers reported on their own depressive symptoms (Patient Health Questionnaire-2; PHQ-2; Kroenke et al., 2003; e.g., "Little interest or pleasure in doing things"; αs = .65 - .81) and anxiety symptoms (Generalized Anxiety Disorder-2; GAD-2; Kronenke et al., 2007; e.g., "Not being able to stop or control worrying"; αs = .77) over the previous 2 weeks. Items were rated on a 4-point scale (0: not at all, 1: several days, 2: over half the days, 3: nearly every day) and averaged into separate depressive and anxiety symptoms scores.



COVID-19 Impacts







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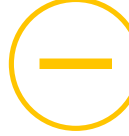
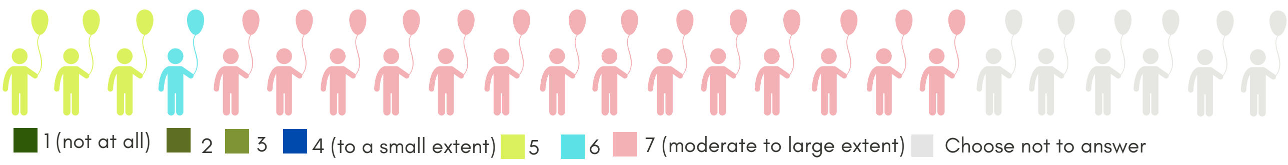


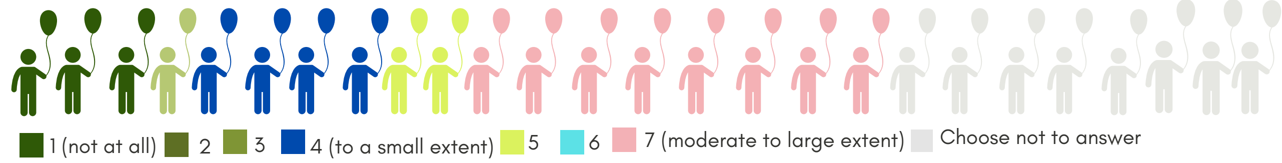
Negative Changes in Child Behaviour or Development Since the Start of COVID-19

Service provider report



58% of service providers reported noticing moderate to large negative changes in children's behaviour or development since the start of COVID-19.

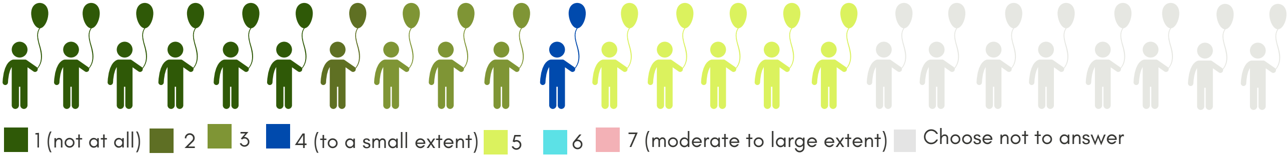
Refugee caregiver report



31% of refugee caregivers reported noticing moderate to large negative changes in children's behaviour or development since the start of COVID-19.

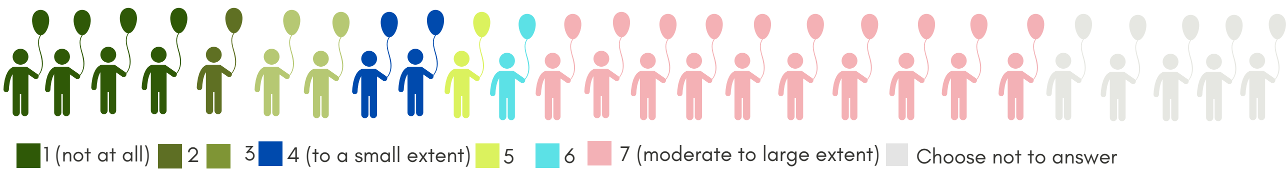
Positive Changes in Child Behaviour or Development Since the Start of COVID-19

Service provider report



25% of service providers reported noticing moderate to large positive changes in children's behaviour or development since the start of COVID-19.

Refugee caregiver report



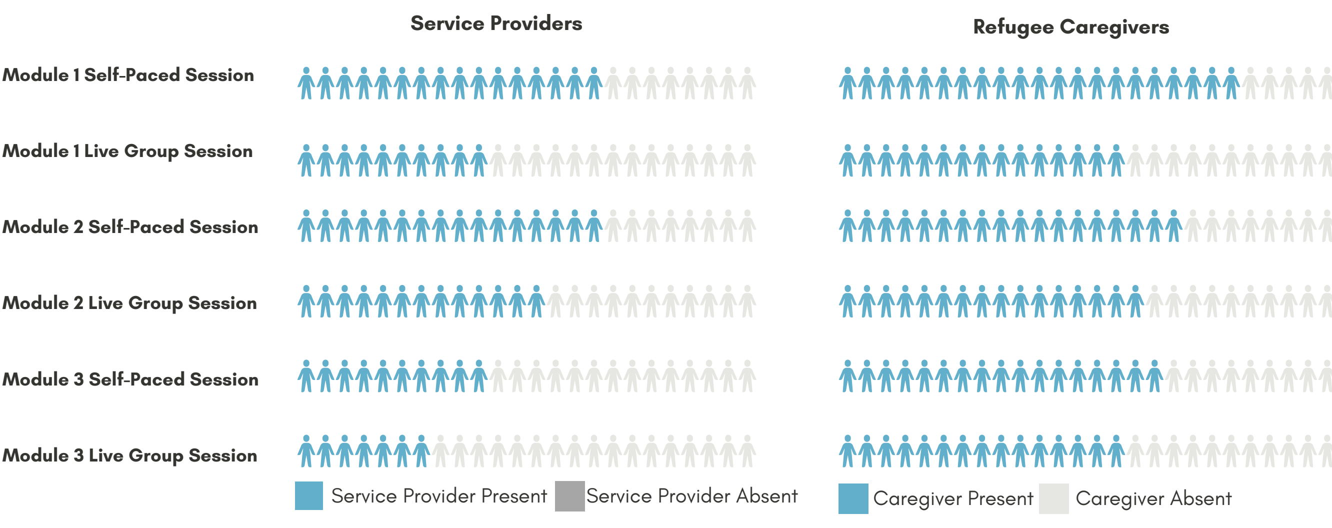
38% of refugee caregivers reported noticing moderate to large positive changes in children's behaviour or development since the start of COVID-19.

Training Evaluation

Training Attendance

On average, **50%** of service providers completed the self-paced sessions and live group sessions, and **65%** of refugee caregivers completed the self-paced sessions and live group sessions.

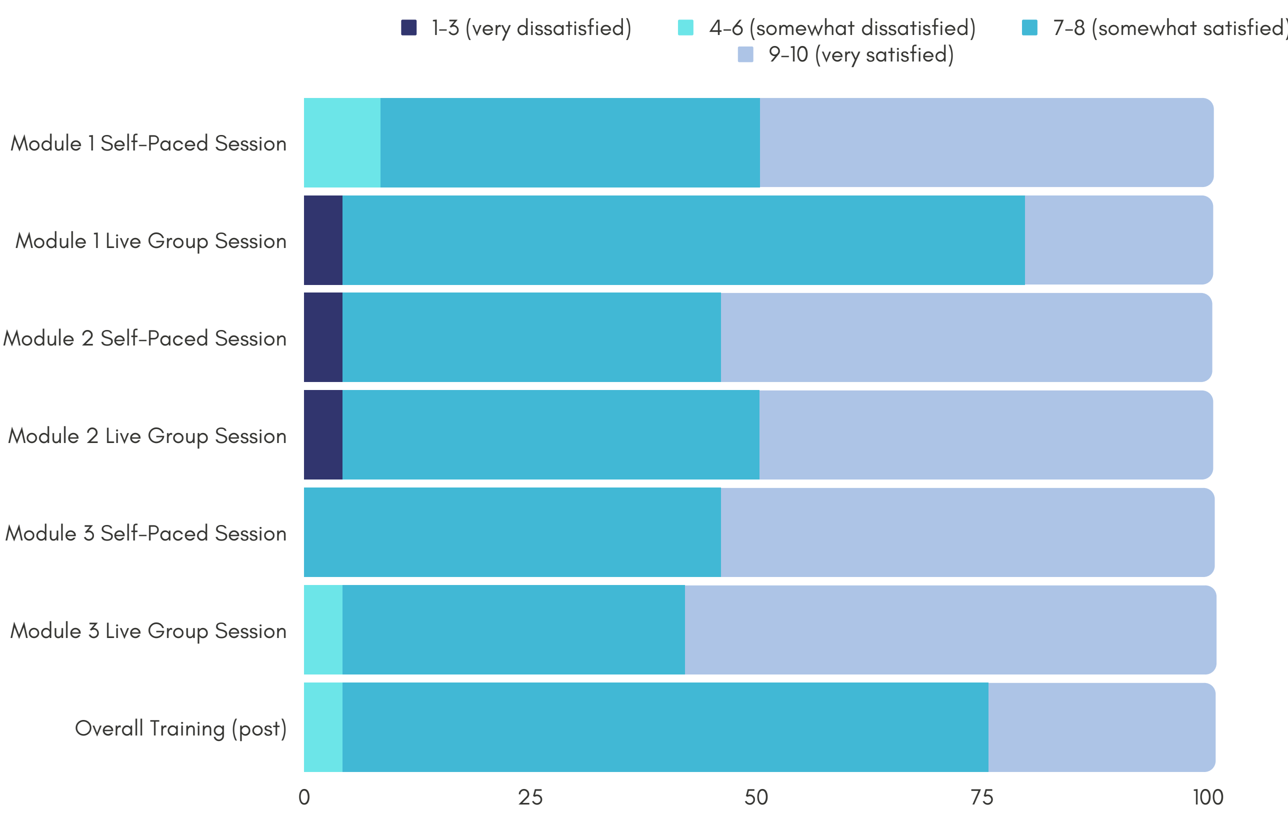
Attendance of service providers and caregivers across the self-paced and live group sessions



Conclusion: Given the context of COVID-19 and that the current training was coordinated across two different sites in Canada, attendance throughout the training was relatively low. Efforts to support attendance included the use of online, self-paced sessions to allow for flexible engagement that could be based around participants' schedules, as well as regular reminder emails and follow-ups.

Satisfaction with the Training

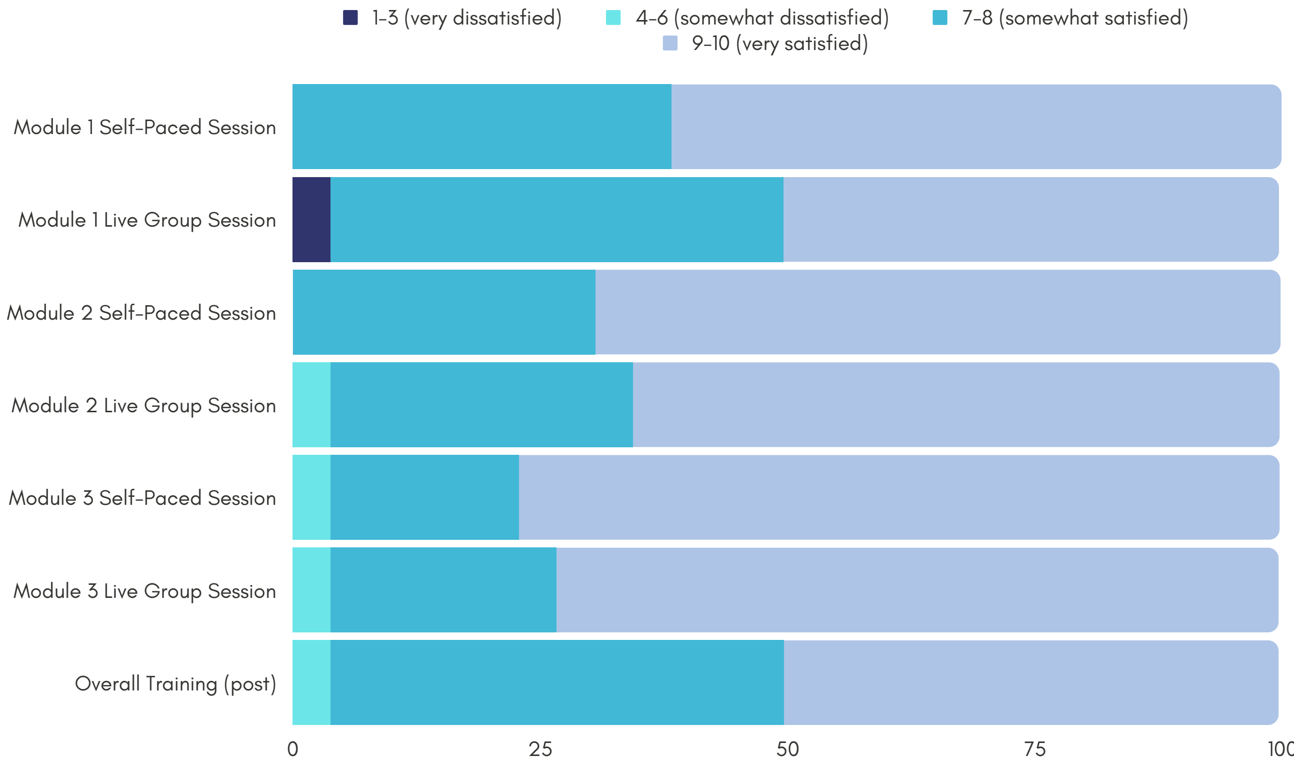
Service Provider Satisfaction



Conclusion: Service providers reported moderate to high levels of satisfaction throughout the training. Specifically, 96% of service providers reported being somewhat satisfied to very satisfied after each session and with the training overall. Levels of satisfaction were consistently high for the self-paced and live group sessions of the training, and remained largely consistent throughout the course of the training.

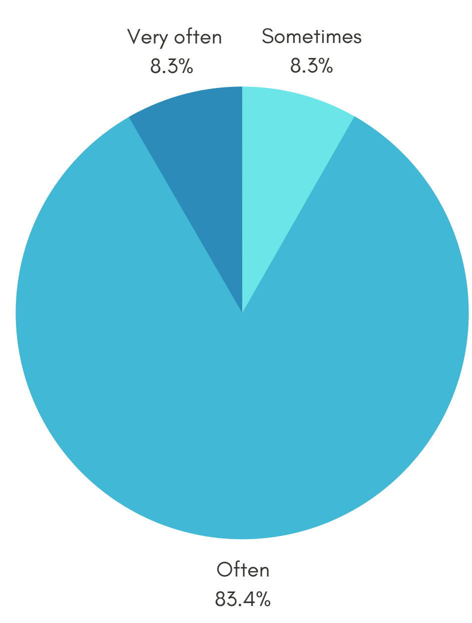
Satisfaction with the Training

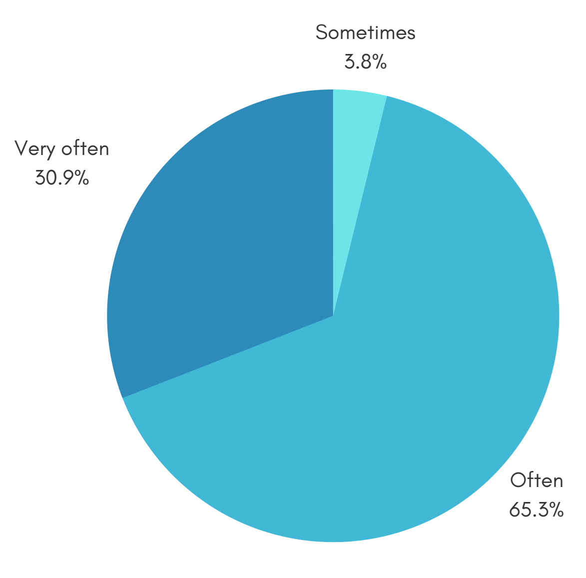
Refugee Caregiver Satisfaction



Conclusion: Refugee caregivers reported moderate to high levels of satisfaction throughout the training. Specifically, 96% of refugee caregivers reported being somewhat satisfied to very satisfied after each session and with the training overall. Levels of satisfaction were consistently high for the self-paced and live group sessions of the training, and remained largely consistent throughout the course of the training.

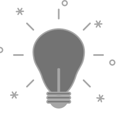
Use of Training Strategies





Conclusion: At post-training, service providers and refugee caregivers reported regularly engaging in strategies that were taught during the training. Specifically, 74% of participants reported using strategies often at post-training (94% of service providers and refugee caregivers reported using strategies “often” to “very often”).

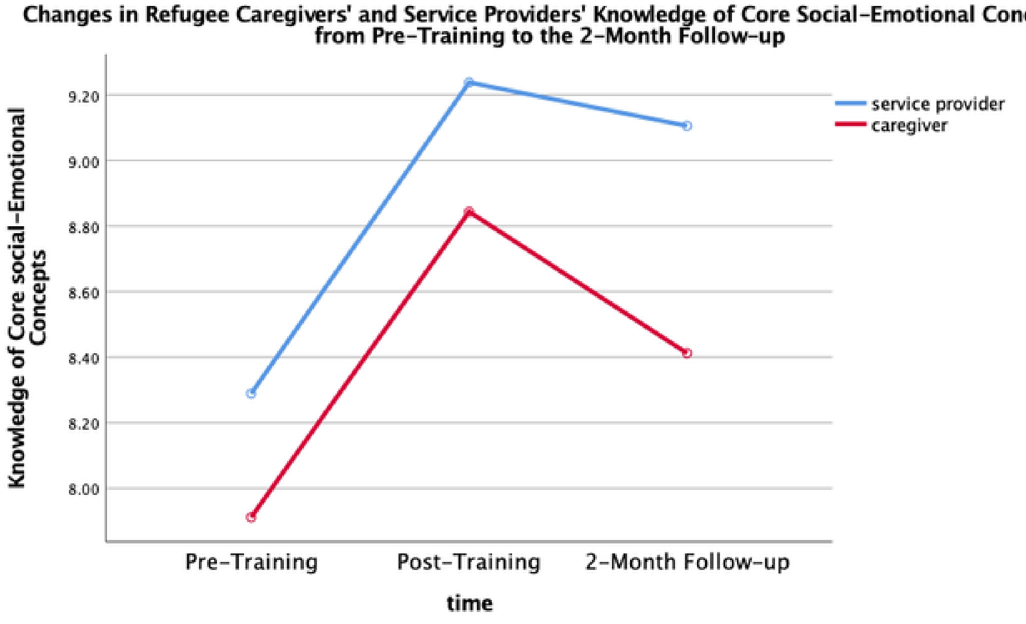
Service providers’ and refugee caregivers’ use of training strategies was also assessed at the 2-month follow-up. Statistical analyses revealed that service providers’ and refugee caregivers’ use of training strategies did not change from post-training to the 2-month follow-up, and service providers and refugee caregivers were similar to each other in their reported strategy use at each time point. This suggests consistent and continued application of the training content 2 months after service providers and refugee caregivers completed the training.



Research Question 1

Did service providers and refugee caregivers increase in their knowledge of core social-emotional concepts?

Summary: We examined changes in service providers' and refugee caregivers' knowledge across the pre-training, post-training, and 2-month follow-up time points using statistical analysis[1]. Results revealed that service providers and refugee caregivers both showed statistically significant increases in knowledge of core social-emotional concepts from pre-training to post-training. These changes plateaued but were maintained at the 2-month follow-up. Service providers remained statistically significantly higher in knowledge across time relative to refugee caregivers.



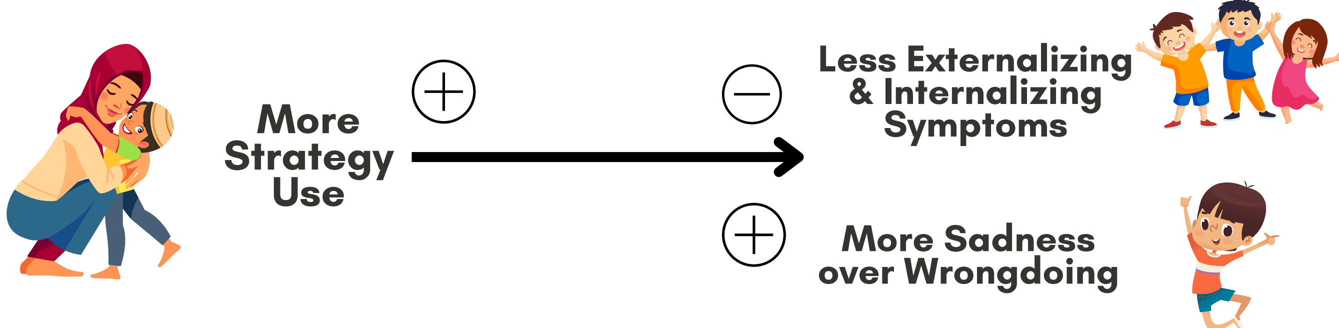
Conclusion: The training was successful in increasing both service providers' and refugee caregivers' knowledge of core social-emotional concepts, and these increases in knowledge were largely maintained 2 months after the training.

[1] Repeated-measures ANOVA was used as our statistical analysis to examine this research question.

Research Question 2

Were increases in caregiver knowledge and greater use of training-based strategies associated with improvements in child social-emotional capacities and emotional/behavioural challenges?

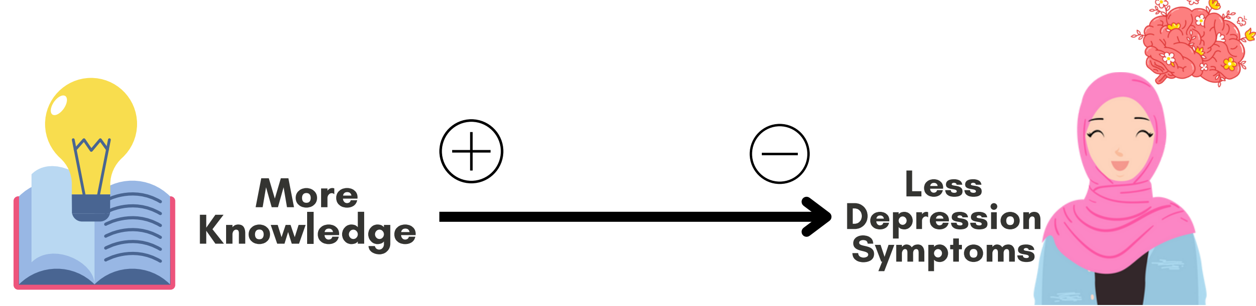
CHILD SOCIAL-EMOTIONAL CAPACITIES	Greater refugee caregiver use of training strategies was associated with increases in children's sadness over wrongdoing.
EMOTIONAL AND BEHAVIOURAL CHALLENGES	Greater refugee caregiver use of training strategies was associated with lower externalizing and internalizing symptoms among their children.

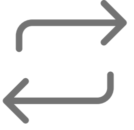


Research Question 3

Were increases in service provider and refugee caregiver knowledge and greater use of training-based strategies associated with improvements in their own mental health?

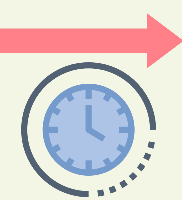
SERVICE PROVIDER AND REFUGEE CAREGIVER DEPRESSION	Increases in service provider and refugee caregiver knowledge were associated with decreases in their own depression symptoms.
SERVICE PROVIDER AND REFUGEE CAREGIVER ANXIETY	Neither changes in service provider or refugee caregiver knowledge nor use of training strategies were associated with changes in their own anxiety symptoms.





Training Changes in Light of the Evaluation Results

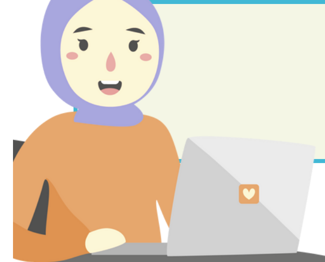
The findings revealed that the training had some positive impacts on service provider and refugee caregiver knowledge, mental health, as well as on select social-emotional capacities and emotional and behavioural challenges in children. More follow-ups may be beneficial in revealing long-term effects of training and confirming the persistence of the detected effects.



In general, participants expressed high levels of satisfaction with the self-paced and live group sessions of the training. Future trainings will continue to incorporate this hybrid approach and will offer flexible opportunities for in-person and virtual learning where possible to accommodate different preferred learning environments.

Future steps and considerations for the training:

- Incorporating short animated videos throughout the self-paced sessions to support visual learners.
- Integrating additional scenarios and examples throughout the training to support application and translation of new knowledge into practice.
- Developing videos and visuals that explain concepts and provide examples which caregivers can watch or read along with their children.
- Considering necessary steps for supporting refugee families from other communities who have been recently resettled in Canada (e.g., Rohingya, Afghan, and Ukrainian refugees), and for engaging different caregivers (e.g., fathers, grandparents) in the training.
- Implementing and evaluating a train-the-trainer model.



Our team is in the process of making the training materials permanently accessible to past participants on a virtual platform. This will enable participants to have continued access to the videos and handout resources.

Policy Implications

1

Incorporating social-emotional content into service provider and refugee caregiver training may improve its effectiveness.
High levels of satisfaction and use of social-emotional training strategies were reported by both service providers and refugee caregivers. In addition, the training was associated with improved results for service providers, refugee caregivers, and their children. Thus, service organizations may benefit from incorporating social and emotional content supported by empirical evidence into their existing programming for service providers and refugee caregivers.

2

Training programs should target knowledge and application of strategies.
Knowledge of social-emotional concepts and the use of strategies aided in the positive outcomes of service providers, refugee caregivers, and children. There was a clear increase in knowledge among service providers and refugee caregivers, their use of strategies increased their children's sadness over wrongdoing and reduced children's emotional and behavioural challenges. Finally, knowledge reduced depressive symptoms among service providers and refugee caregivers over time. These findings highlight the importance of incorporating research-based knowledge and strategy application into service provider and refugee caregiver training initiatives in order to facilitate the well-being of refugee families and service providers.

3

Social-emotional training may support child outcomes.
The training had a positive impact on children's social-emotional capacities and emotional and behavioural challenges. This contributes to a growing body of promising evidence for research-based trainings that translate research into accessible and effective community engagement initiatives. As a result, it speaks to the viability of focusing on change at the caregiver level to support children's social-emotional capacities and emotional and behavioural challenges.

4

Social-emotional training may support service provider and refugee caregiver outcomes.
The training also had a positive impact on the mental health of service providers and refugee caregivers. The mental health of service providers and refugee caregivers provides a foundation for positive child development, particularly in stressful refugee service settings and during the resettlement journey. The findings emphasize the significance of including refugee providers' own mental health in training objectives when the ultimate goal is to foster refugee child development and mental health.

5

Community-based research should be a focus to support community needs.
This community-based training was the result of a collaboration between the CCDMP and community organization partners. Collaboration with community partners for the recruitment and delivery of the training was crucial to its success. Future research and practice initiatives should use multi-sectoral, community-first collaborations to incorporate evidence-based and practice-based expertise into the design of training programs that are tailored to the specific needs of the target community.

THANK YOU!

Thank you to our partners and funders.

Please reach out for any questions or inquiries: **maltilab.sprint@utoronto.ca**

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