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BEYOND TRANSLATION

Evaluating a Culturally Relevant Mental Health Training for Spanish-Speaking ECE Providers

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Milwaukee Succeeds

Executive Summary

Grant funding allowed for the development of a mental health curriculum designed for early childhood education (ECE) providers to not only be translated into Spanish, but to be culturally relevant to Spanish-speaking ECE providers. Given that this curriculum was being adapted and with an eye on potentially expanding it beyond Milwaukee, a formative and impact evaluation was proposed. The formative evaluation allowed for adjustments to be made to the program curriculum and design as it was happening, while the impact evaluation measured the goals and outcomes of the program.

Overall, the Spanish-language ECE mental health curriculum demonstrated success. Almost 100% of participants indicated that the trainings increased their knowledge and that they could take what they learned and use it in their child care. Participants also indicated that the content was aligned with their beliefs and values. While there were some barriers that challenged the success of the trainings, such as logistical issues related to handouts and ability to see the projected materials, adjustments were made over the course of the trainings to account for these issues and concerns.

More detailed information regarding the background of the curriculum, results from the evaluation, and recommended changes to any future versions of the trainings are in the full report that follows.

Background

Milwaukee's early educators, who are almost all women and predominantly Black and Brown women[1], report high levels of stress, compassion fatigue, and secondary trauma. This is reinforced by national data showing that throughout the pandemic, early educators have reported higher levels of stress and depression than the adult population as a whole.[2] These mental health challenges impact the educators themselves, their families, and their communities, and they strain educators' ability to co-regulate, meaning their ability to be attuned to, empathetic to, and responsive to the needs of children in their care. Given the clear, well-documented evidence that adult-child interactions in the first years of life set the foundation for all future growth and development, diminished co-regulation in today's early childhood education settings could have lasting negative impacts on a generation of Milwaukee children.

Mental health challenges are also contributing to the urgent staffing crisis in early childhood education (ECE) that is leading to less access to ECE for Milwaukee's families and children. Almost 80% of Wisconsin early educators report that burnout and exhaustion are contributing to staffing challenges among early education professionals.[3]

In response, the Milwaukee-Succeeds led MKE Early Childhood Education (ECE) Coalition has prioritized building the mental health capacity of early educators through professional development and resource events funded by Milwaukee County, the MKE Responds Fund, and the Greater Milwaukee Foundation. These trainings and events, which have reached 350 early educators since 2020, have been well-received. Spanish translation and interpretation were provided during these trainings which was appreciated by the participants. However, feedback also led us to the understanding that training given in a participant's native language would have an even greater impact.

This provided the direction on needed next steps toward the goal of building the mental health and wellbeing of Milwaukee's early educators, including reflecting the linguistic and cultural diversity of Milwaukee by building trainings, resources, and activities in educators' native languages and ensuring that they reflect cultural values, norms, and practices. Using funds from the Wisconsin Early Childhood Association (WECA) and the Wisconsin Early Education Shared Services Network (WEESSN), a series of early educator mental health and wellbeing trainings, resources, and activities were developed and implemented for Latina early educators in collaboration with members of Proveedoras Unidas, a professional network of Spanish-speaking family child care providers based largely in Milwaukee. All

[1] Milwaukee Succeeds. (n.d.) *A Snapshot of Early Care and Education Teachers in Milwaukee*. Retrieved December 2023 from https://www.milwaukeesucceeds.org/ecedata.

[2] Elharake, J., et al. (September 2022). *Prevalence of Chronic Diseases, Depression, and Stress Among US Childcare Professionals During the COVID-19 Pandemic*. Retrieved January 2024 from https://www.cdc.gov/pcd/issues/2022/22_0132.htm.

[3] National Association for the Education of Young Children. (December 2022). *Uncertainty Ahead Means Instability Now: Why Families, Children, Educators, Businesses, and States Need Congress to Fund Child Care: Wisconsin.* Retrieved December 2023 from https://www.naeyc.org/sites/default/files/globally-shared/downloads/PDFs/our-work/public-policy-advocacy/wisconsin_naeyc_2022_fall_survey.pdf.

trainings, resources, and activities were developed and delivered in Spanish. Trainings were conducted from October 2023 to December 2023 and featured a range of topics listed in the table below.

Date	Topic (English)	Topic (Spanish)
October 16, 2023	Well-being for Early Childhood Education	Bienestar para la educación infantil
October 30, 2023	Framework	Marco de Trabajo
November 6, 2023	Co-regulation	Co-regulación
November 20, 2023	Joined	Unidos
December 4, 2023	Positive Identity and Demonstration	Identidad Positiva y Demostración
December 11, 2023	Help and Responsibility	Ayudar y Responsabilidad

Given that this was the first iteration of the culturally-responsive mental health trainings, a two-pronged mixed methods evaluation was designed, including a formative (process) evaluation and an impact evaluation. The formative evaluation, similar to a continuous improvement model, allowed for changes to be made as the trainings progressed, while the impact evaluation allowed for a summary analysis of the program as a whole.

A summary of both follows.

Formative Evaluation

Formative evaluation ensures that a program or program activity is feasible, appropriate, and acceptable before it is fully implemented. It is usually conducted when a new program or activity is being developed or when an existing one is being adapted or modified. The main purpose of a formative evaluation is to catch any deficiencies as quickly as possible so that changes can be made immediately to correct any issues that arise. The focus of a formative evaluation includes the components and activities of the program, with an appreciation as to how this work can be generalized to a broader audience.

Data for the formative evaluation were gathered via brief surveys or focus groups completed by participants after the sessions, observations of the training sessions, and discussions and interviews with the training team. Questions designed for the formative evaluation are listed below.

What barriers, if any, are occurring throughout the program that can potentially hinder implementation? What adjustments to the initial training curriculum, materials, and facilitation style are made to account for any barriers?

Participants mentioned a few things throughout the training program that could be improved.

- Logistical issues, such as participants struggling to see the screen projecting the slides at the front of the room or not having access to printed copies of the slides for reviewing or note-taking purposes.
    - Upon receiving this feedback after Week 1, the training team began printing hard copies of the slides for every participant and handing them out at the beginning of each session.
    - The site location of the trainings was undergoing renovations during this time period, but the room setup was modified around Week 3 to better accommodate the trainings, including the installation of a new and larger screen to project the presentations and the removal of excess items being stored in the learning space.
- Content concerns, including a desire from participants to have additional activities or movement throughout the trainings, access to resources, and having time to practice techniques learned during the trainings.
    - The Week 1 training featured an opportunity for participants to engage with each other while trying to keep a series of small balls in the air, to realistically portray what it is like to juggle many items in a given day like ECE providers often do. Providers spoke positively about this activity ("It (the activity) made me forget I was in a training.") and asked for additional activities like this. While a similar activity wasn't incorporated in additional trainings, the training team began incorporating mindfulness and breathing breaks, yoga, pair or table share time, and other group activities to incorporate movement or opportunity to thought partner with other participants.
    - Handouts were also created by the training team as items for providers to take home with them, including sensory checklists, how to create routines handout, and others.
    - Participants were also encouraged to bring in their own materials that they use in their child care facilities, including sensory toys and other items to support young children.

These items were passed amongst the providers as examples of things that their peers had used successfully.

- During the first training, it was observed that some of the conversations steered away from the topic at hand and took time away from the content and training.
    - A "parking lot", basically a large sheet of flip chart paper posted in the room, was utilized for participants to write any thoughts, ideas, or suggestions that did not align with that day's training topic. This was created to give participants a place to share things that were not necessarily on topic, but may still be useful at some point in time. Also, the entire group created group agreements or norms to help set the tone for the trainings.

The training team expressed concern with the number of participants (22) being a bit too large for a training of this type. The overall level of participation was high for a group of this size, but not every participant was fully committed to the trainings. Given adult learning theory, the length of time participants were expected to learn may not have been as tolerable given that these sessions were conducted in the evenings after a work day.

Even with these barriers, 76% of participants indicated that they were extremely clear and 24% were somewhat clear on takeaways from the trainings. This indicates that even with these slight problems, participants continued to grasp and understand the content on a regular basis.

What activities led to successful trainings and implementation of the program?

Participants were asked what they found most valuable from the training[4], and responses included:

- Learning specific techniques (23 responses), like self-regulation, breathing, and mindfulness. One trainer noted that participants often shared examples of what they had incorporated into their practice and that the participants often encouraged each other to "take care of yourself."
- Receiving information/resources (20 responses), like videos, websites, and slides. One participant stated, "I learned about topics I didn't know about, for example, the structure of children's brains, how it develops best with interaction."
- Being part of a community, spending time together, learning from other providers, and seeing that they were not alone (12 responses). One provider highlighted that the training was conducted entirely in Spanish, while another shared that "It was important to be among the same racial group and culture." The training team also noted the sense of community and that Spanish-speaking ECE providers typically do not have access to resources and tools that are needed for their role. On trainer stated, "The providers found a space where they could be themselves and support each other."
- Participating in activities (10 responses), especially those that involved movement and exchanging ideas in groups. One provider offered, "The participation of everyone writing on the posters."

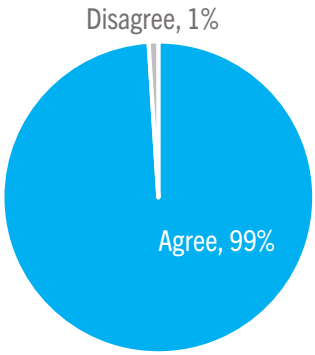
[4] These responses were gathered via surveys conducted at the end of the training sessions for Weeks 1, 2, 4, and 6.

- Learning about well-being/mental health (8 responses), including the importance of taking care of oneself and the children in their care. One participant shared: "After these trainings, I will prioritize myself and taking care of myself."
- Everything (6 responses). One provider expressed, "It was all very important and valuable."

Participants found learning specific techniques and information/resources to be most valuable.

Participants also indicated that the content was aligned with their beliefs and values, which was a critical component as the training was being modified to be culturally-relevant.[5] Participants stated that "Attendee's beliefs and cultures are respected" and "It (the trainings) relates to my values".

Almost 100% of participants agreed that the content was aligned with their beliefs and values.



[5] Based on additional comments and responses, it is possible that the 1% that disagreed read the question response scales incorrectly. However, the surveys were anonymous and with no way to tell who the respondent was, the answers will remain as originally recorded.

Impact Evaluation

An impact evaluation is an assessment of how an intervention has affected outcomes and to determine merit, worth, or value of a program in relation to specified and expected results. The purpose of an impact evaluation is to determine if and how well a program ultimately worked. A series of questions, outlined below, guide the impact evaluation.

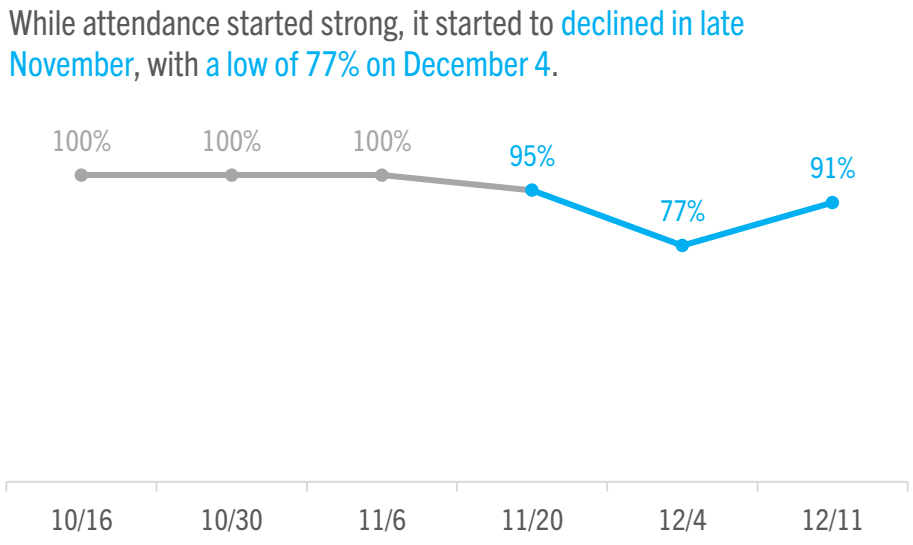
Data for the impact evaluation were gathered via brief surveys or focus groups completed by participants after the sessions, observations of the training sessions, discussions and interviews with the training team, and participant completion of the Professional Quality of Life (ProQol) assessment. Questions designed for the impact evaluation are listed below.

How many providers started and eventually completed the training program?

Completion of the program required attendance at every training session. A total of 22 providers started the training program in October, and of these, 15 providers (68%) attended every session.

What was the attendance rate for each training?

Trainings were conducted over the course of six dates from October to December[6]. Attendance rates for individual providers ranged from 77% to 100%, with an average attendance rate of 94% across all 22 participants.[7] The first three sessions were attended by all providers, and then a decline in attendance was experienced, with the lowest attendance occurring on December 4th with 77%. November 30th had an attendance rate of 95% and December 11th had an attendance rate of 91%.



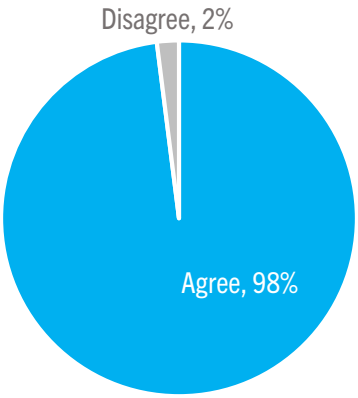
[6] Training sessions were conducted on October 16, November 6, November 20, November 30, December 4, and December 11.

[7] For those participants that did not attend sessions and chose to disclose why, reasons included illness, lack of transportation, and a death in the family.

Did providers increase their skill set and abilities related to self- and co-regulation, and if so, in what ways?

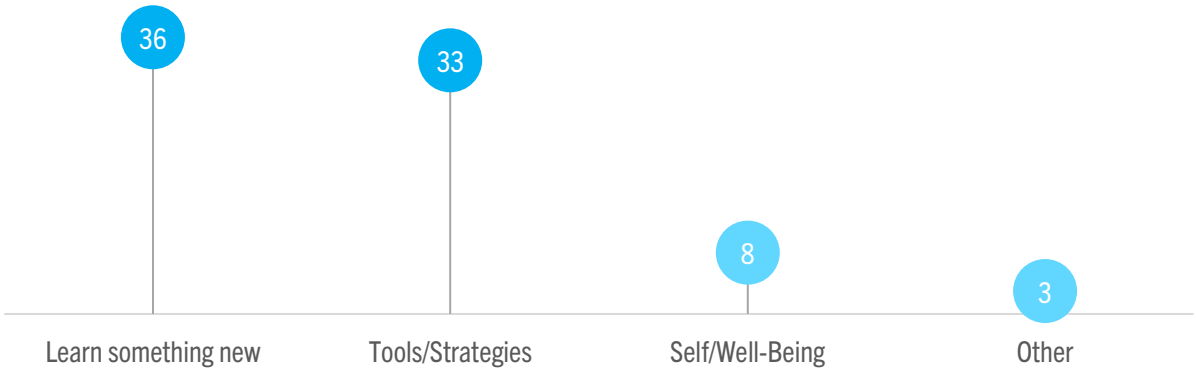
When asked on the survey if the training had increased their knowledge about the topic, almost 100% of the respondents agreed or strongly agreed that it had.[8]

Almost 100% of participants agreed that the training increased their knowledge.



When asked why their knowledge had increased, participants indicated that learning specific techniques (36 responses) and receiving information/resources (33 responses) as being most beneficial. One respondent shared that "It (the training) help(ed) me learn other skills to perform at work." Another shared that "I've watched videos I've never watched before and they're very helpful."

Participants found learning specific techniques and information/resources to be most valuable.



[8] Based on additional comments and responses, it is possible that the 2% that disagreed read the question response scales incorrectly. However, the surveys were anonymous and with no way to tell who the respondent was, the answers will remain as originally recorded.

During the last training session in December, participants were asked how they were implementing the trainings at their child care. Responses included:

- Creating a space where children can relax with appropriate sensory toys
- Sharing techniques learned in the trainings with parents/families
- Practicing breathing and making time for self, including creating a space for adults to relax
- Talking about feelings to normalize the practice
- Incorporating music and dance into activities with children

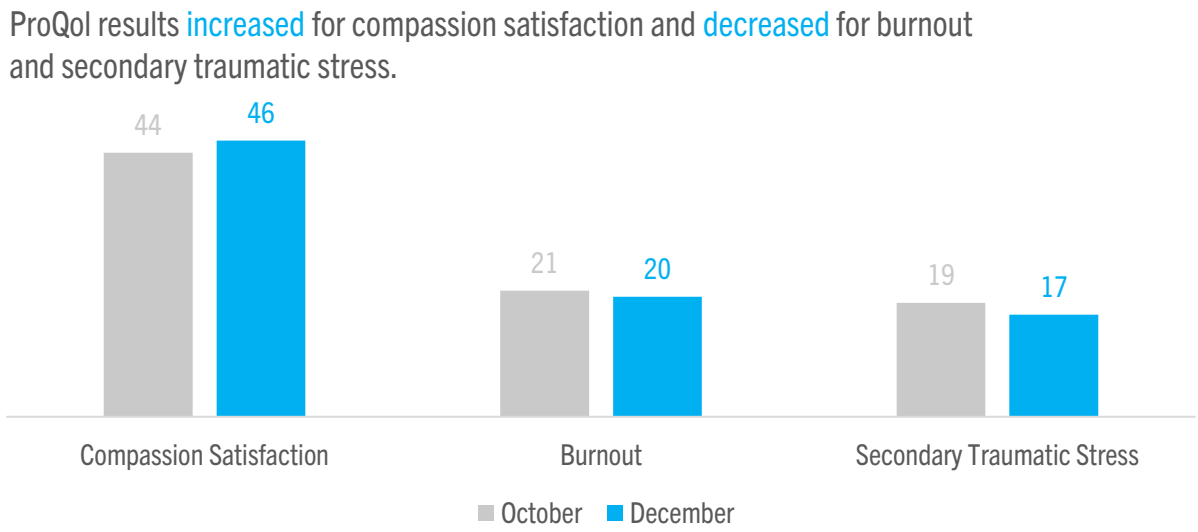
Did providers notice a change in behavioral incidents with the children in their care?

Providers were asked how many behavioral incidents they experienced with children in their care in an average week during weeks 2 and 5, in an attempt to see if the participants were utilizing the curriculum to support children in their care. For those providers that provided a numeric response, 9 providers indicated that behavioral incidents declined from the start to the end of training. At the beginning, just over 4 behavioral incidents per week were reported, which declined to 3 incidents at the end of the training period. Three providers shared that zero behavioral incidents occurred at their child care facility.

Did providers notice a change in their own behaviors?

Participants completed the Professional Quality of Life (ProQol) assessment, a measure of both the negative and positive effects of working with those who have experienced traumatic stress, at the start of the week 2 training and at the end of the week 5 training, as pre- and post-assessments.[9] The ProQOL has sub-scales for compassion satisfaction, burnout, and secondary traumatic stress. Ideally, between the pre- and post-assessments, compassion satisfaction would increase, while burnout and secondary traumatic stress would decrease.

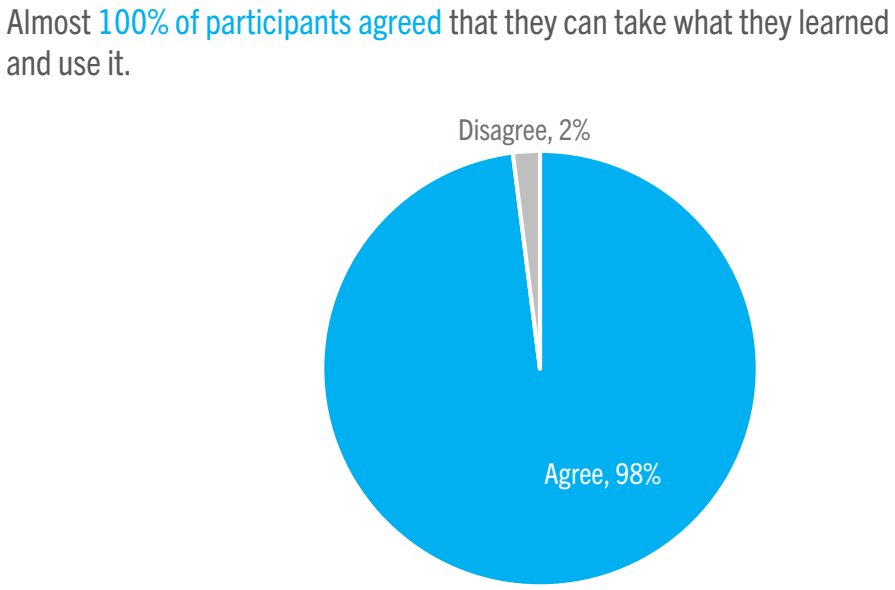
Results show a slight increase in compassion satisfaction between weeks 2 and 5, from an initial score of 44 to 46. Burnout declined by 1, from 21 to 20, and secondary traumatic stress declined by 2, from 19 to 17. While it cannot be said that the changes in the ProQol results were directly related to the six weeks of training, it is still a positive sign of the training's impact on the participants.



Participants were also asked if they could take what they learned and use it in their child care. Again, almost 100% of participants agreed or strongly agreed that they could use their knowledge in their child care.[10]

[9] The ProQol was assessed during week 2 to help build trust between the training team and participants in week 1 prior to completing the assessment. Week 5 was chosen so that results could be presented during the last training, Week 6.

[10] Based on additional comments and responses, it is possible that the 2% that disagreed read the question response scales incorrectly. However, the surveys were anonymous and with no way to tell who the respondent was, the answers will remain as originally recorded.



Were there any unintended consequences of the program (for example, an increase in belongingness, self-awareness, confidence)?

Phase 2 of the project is to train a subset of participants in this curriculum as they become trainers in an effort to bring this training to more providers in the area. At the time of this report, almost half of participants (10 participants, 45%) had applied to become trainers for Phase 2 of the project, indicating continued interest in the trainings and a desire to share the curriculum with more child care providers. As noted by one of the trainers: "You can see a difference in how the participants looked at the training and themselves. They can see themselves doing something different and now they have the confidence to lead and present."

Participants also mentioned have a greater sense of community, especially having a training conducted entirely in Spanish. One trainer commented, "There is no replacement for receiving content in native language by people like you and being accepted for who you are." As child care providers that juggle multiple responsibilities (like budgeting, cooking, cleaning, etc., on top of caring for children), they also appreciated being able to take time to themselves and either learn something new or relearn things that were forgotten. As stated by one provider when asked what was going well with the trainings: "Being here together, learning from each other, and continuing to learn."

Recommendations

The following are a list of recommended changes to the next iteration of the training, based on the evaluation results described previously.

- Given the heaviness of the topic (mental health), it is important to provide breaks to allow participants the opportunity to reflect or take time for their self-care. Participants requested additional activities and movement to allow them more freedom and flexibility, while also building relationships with other participants. This feedback was provided to the curriculum team as the training progressed, and as more movement and activities were incorporated, participants noticed this and mentioned it in their feedback. Continuing to build movement and activities, like yoga, mindfulness, and group projects, is important to the ongoing success of the trainings.
- Developing group agreements or norms is also a practice that should continue into Phase 2. As noted above, the first training had moments where participants went off-topic or shared some incredibly personal stories. In order to facilitate this process in the future, continuing to utilize the group agreements/norms and parking lot option should help alleviate some of these issues.
- To be a true pre-/post-assessment, the ProQol, or similar tool, should be given prior to the start of the training and at the end of the last session. It was reasonable to make accommodations for the timing due to needing to develop respect/rapport with the participants and wanting to give participants their results in-person to allow for questions.
- Providers consistently asked for resources, from where they could potentially buy items demonstrated by the training team or other participants, to access to handouts and additional information. Potentially creating a dedicated online folder that houses links, handouts, and other documents would be useful moving forward. They also requested additional time to learn from each other and share techniques that worked in their child care, so continuing to build that time into the curriculum is key.
- Lastly, this group of providers shared how much it meant to them that the training was conducted in Spanish and how important that sense of community was for them. One provider expressed how valued they felt being part of something that was created just for them for the first time. Continuing to offer this curriculum in Spanish, and other native languages, will be critical for its success.