Cultural adaptation of an evidence-based home visitation programme: Latino clients’ experiences of service delivery during implementation

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Abstract
Purpose – The purpose of this paper is to examine the experiences of Latino clients following a naturalistic cultural adaptation made to SafeCare, an evidence-based home visiting intervention designed to address specific linguistic and cultural issues affecting the Latino community during implementation in San Diego County, California.

Design/methodology/approach – Hierarchical linear models examined whether Latino clients experienced differences in perceptions of SafeCare delivery, working relationship with the home visitor and satisfaction with services when compared with non-Latino clients and whether language of service delivery and provider-client ethnic match were related to Latino clients’ experiences of the intervention.

Findings – Overall, across several different dimensions, there was no decrement in experience with SafeCare for Latino clients compared to non-Latino ones, implying that adaptations made locally adequately engaged Latino and Spanish-speaking clients in services without compromising perceived adherence to the programme model.

Research limitations/implications – Because this was a non-experimental study, conclusions could not be drawn as to whether the locally adapted SafeCare would fare better in Latino client ratings than SafeCare unadapted. However, the findings are important because they contradict concerns that EBPs may not be relevant to diverse client groups, and support the idea that when adaptations are made, it is possible to maintain adherence at the same level of adherence as when the programme is delivered in its non-adapted form.

Originality/value – The study explicitly documents and generates knowledge around an organic adaptation made in a community to an evidence-based intervention for a client group about whom there has been documented concern regarding the relevance of and engagement in services.

Keywords Implementation, Latino, Adaptation, Cultural, EBP, SafeCare

Paper type Research paper

Introduction
The development of high-quality services that meet the needs of culturally diverse clients and better understanding the relationship between culture – that is beliefs, attitudes, values and practices of families from diverse origins – and maltreatment are ongoing priorities for child welfare research (Institute of Medicine & National Research Council, 2013). Increasingly, child welfare organisations turn to practices having established foundations of empirical support, that is evidence-based practices (EBPs), to enhance the quality and effectiveness of their services (Barth et al., 2005). In some cases, such practices have been found to be culturally appropriate with different ethnic and cultural groups with little, if any, adaptation.
(Damashek et al., 2012; Kataoka et al., 2010). However, others have questioned whether the relatively defined internal structures of many EBPs may reduce their relevance for diverse cultural groups (Bernal et al., 2009; Bernal and Scharron del Rio, 2001). Questions about the cultural relevance of EBPs present something of a conundrum because, for many practices, research has not been carried out with clients from a range of ethnic and cultural backgrounds (Bernal et al., 2009; Bernal and Scharron del Rio, 2001; Weisz et al., 1998), even though the target population for such interventions in public child welfare systems tends to be socio-economically and culturally diverse.

This dilemma has generated increased research interest in the cultural responsiveness of evidence-based models and a desire to examine their application to child welfare service delivery in diverse community settings (Bridge et al., 2008; Sheets et al., 2009; Wells et al., 2009; Self-Brown et al., 2011). This paper uses data from a child welfare practice change initiative in a culturally diverse community to examine the experiences of Latino clients receiving child welfare services during implementation of a standardised parent training EBP. The term Latino, or Hispanic, in this context refers to families who identify as having origins in a Latin American country. Latinos in this study are mostly of Mexican origin, from impoverished socio-economic backgrounds, and are of varying immigration and citizenship statuses.

There is reason to believe that the cultural fit of practices adopted in child welfare has the potential to influence the experience of clients receiving services and the effectiveness of those services (Bernal and Saez-Santiago, 2006; Castro et al., 2004). Beyond the practice itself, other factors related to culture that are believed to influence Latino client experiences with services may include language of service delivery and ethnicity of the provider (or ethnic match between the client and provider). These are in addition to the cultural competence of an agency, achieved through policies and training in culturally responsive practices that improve communication, reduce value conflicts and enhance client engagement and satisfaction (Bernal and Scharron del Rio, 2001; Barona and Santos de Barona, 2003; McCabe, 2002; Kumpfer et al., 2002; Sue et al., 1994). Clients of Latino ethnicity in particular may face unique linguistic, cultural, attitudinal and socio-political barriers to establishing relationships with providers and engaging in services during the delivery of standardised practices (Bernal et al., 1995; McCabe, 2002; Lau, 2006; Barona and Santos de Barona, 2003).

Some researchers have directly addressed such concerns by rigorously testing adaptations that emphasise the reframing of clinical practices in ways that make them more acceptable or relevant to Latino groups (Bernal et al., 2009; Lau, 2006; Matos et al., 2006; McCabe et al., 2005; McCabe and Yeh, 2009). However, not all EBP adaptations are conducted in the context of gold standard research trials, nor is it likely to be realistic for adaptations of each standardised practice model to be thoroughly tested with all cultural groups, potentially defined by characteristics such as race/ethnicity, geography, country of origin and language dialect (Wells et al., 2009). Instead, cultural adaptations are sometimes made to EBPs by providers on a case-by-case basis depending on the individual family situation (Self-Brown et al., 2011). Adaptations that address specific cultural issues, facilitate engagement of a unique group of clients or fit within a particular service system or organisational context may also occur during the process of EBP implementation in local community settings (Aarons et al., 2012; Lee et al., 2008).

One of the primary concerns, however, around adapting an EBP for work with specific cultural groups is in the ability to retain fidelity to the core components of a practice model while at the same time improving engagement and receptivity among a wide range of clients (Aarons et al., 2011, 2012; Aarons and Palinkas, 2007; Honda et al., 2008; Palinkas and Aarons, 2009; Durlak and Dupre, 2008; Kendall et al., 2008). Some authors have suggested that it is possible to maintain flexibility in the delivery of a practice while preserving the core therapeutic components of the service model (Bernal et al., 2009; Backer, 2001; Kendall and Beidas, 2007; Kendall et al., 2008; Larsen and Samdal, 2007). Although some randomised trials of EBP adaptations have looked at these issues in a rigorously controlled fashion, this paper utilises a different approach to understanding diverse client experiences with an EBP.

Specifically, we take advantage of an opportunity to examine the experiences of clients of diverse ethnic and cultural backgrounds who are receiving SafeCare®, an evidence-based
home visiting intervention, as it is implemented in a particular geographical setting, in which adaptation of the EBP occurred systematically during the implementation process. SafeCare has demonstrated effectiveness in several randomised studies (Edwards and Lutzker, 2008; Gershater-Molko et al., 2002, 2003; Lutzker and Rice, 1984) and has been found particularly effective in preventing maltreatment and in families with issues of child neglect (Gershater-Molko et al., 2002, 2003). A large statewide SafeCare trial in Oklahoma recently demonstrated its advantages in improving positive parenting skills, reducing neglect and ultimately reducing recidivism as compared to home-based services as usual for that population (Hecht et al., 2007; Chaffin et al., 2012). SafeCare is being implemented in several other states as well, such as Georgia, Oklahoma, Kansas, Michigan and California (Edwards and Lutzker, 2008) all of which include diverse population bases. In one specific case conducted in Oklahoma, SafeCare was well received among the American-Indian population there (Chaffin et al., 2012).

The aim of this study is to examine the experiences of Latino clients following a naturalistic cultural adaptation made to SafeCare to address specific linguistic and cultural issues relevant to the Latino community during implementation in San Diego County, California. Although the design did not permit us to directly compare client experiences with the adapted version of SafeCare to a non-adapted version of the intervention, the study is valuable because it explicitly documents and generates knowledge around an organic adaptation made in a community to an evidence-based intervention for a client group about whom there has been documented concern regarding the relevance of and engagement in services. Specifically, analyses examine whether Latino clients experience differences in perceptions of SafeCare delivery (i.e. what occurs during SafeCare visits), working relationship with the home visitor and satisfaction with services, compared to non-Latino clients. We also examine whether the language of service delivery and provider-client ethnic match are related to Latino clients’ experiences of the intervention.

Overview of SafeCare

SafeCare is designed to improve parent communication and problem solving, improve parent-child and parent-infant bond and enhance home safety (HS) and health care skills, with the ultimate goal of preventing child maltreatment (Lutzker and Bigelow, 2002). The model grew out of the behaviour analysis field, is manualised, highly structured and uses classic behavioural intervention techniques (e.g. ongoing measurement of observable behaviours, skill modelling, direct skill practice with feedback, training skills to criterion).

Communication and problem-solving skills are pillars of the programme and are utilised throughout all modules. There are three topical SafeCare modules: Parent-Infant Interaction (PII) or Parent-Child Interaction (PCI) (depending on the age of the child), HS and Health (Hlth). Participants ideally complete all three of the SafeCare modules. Each module is divided into six sessions, one orientation session and five skill-building ones. Service is delivered in the home via weekly visits from a home visitor certified by SafeCare trainers. There is no dedicated time allotment for each session; some may require more than one visit for completion, while others may not take a full visit. Most sessions, however, do occur during one home visit. Parents must successfully demonstrate completion of all module components before moving to the subsequent module. There is no required order of module delivery, thus allowing for flexibility. Successful completion of each session and module is determined via a structured home visitor evaluation.

SafeCare San Diego cultural adaptations

A large implementation trial of SafeCare is currently underway in San Diego County, California. San Diego County is the fifth largest county in the USA, with a population of 3.14 million people comprised of approximately 32.5 per cent individuals of Latino ethnicity. In 2008, a “seed team” of local community providers in San Diego was trained by the National SafeCare Research and Training Center (NSTRC) from Georgia State University. The seed team members from two community-based organisations were selected for their excellence in direct service delivery and ability or potential to teach, engage and coach trainees. In the first year of implementation, the seed team’s goal was to train and support direct service providers in SafeCare. In San Diego
County, a majority of clients (73.8 per cent) were Latino and many were Spanish-speaking immigrants from Mexico, including some clients concentrated in the northern part of the county and employed as migrant farm workers.

One of the primary tasks undertaken by the seed team in the first year of implementation was to tailor aspects of the SafeCare model to the needs of Latino clients, many of whom were Spanish speaking, in the local area. Despite an existing Spanish translation of the SafeCare manual developed by the NSTRC, the adaptation involved revising that translation to enhance relevance to the Spanish-speaking population in San Diego. Through weekly feedback sessions with home visitors implementing the programme in the field, the team also identified content areas of SafeCare to be adapted to improve cultural relevance for the Latino (primarily Mexican-American) population in the county. Adaptations to the content and structure of the programme were designed to be delivered on an individual basis depending on the needs of the family. Although some principles of the adaptation have potential relevance for enhancing practice with other racial/ethnic groups, the changes made to the programme were intentionally utilised to meet the needs of Latino families in this community, and specifically directed towards them. Adaptations for Latino families were made in consultation with interventions developers at Georgia State and documented through interviews with seed team members.

Adaptations made to SafeCare for Latino families in San Diego fell into four categories, described as follows:

1. Manualised Spanish language material:
   - revised materials to reflect the local dialect; and
   - tailored materials to a lower literacy level.

2. Health module content:
   - added material about culturally relevant home remedies utilised in Latin American countries; and
   - added material regarding when it might be appropriate to seek outside medical assistance rather than rely on home remedies.

3. Home visitor training goals:
   - added material to sensitise home visitors to Latino client barriers to accessing health care; and
   - added material to encourage home visitors to adapt their expectations based on individual and cultural circumstances of many Latino families and to support adaptive values from the culture of origin.

4. Home visiting programme structure:
   - allotted more time for an expanded introduction session for Spanish-speaking immigrant families to educate on the concepts behind the programme; and
   - added trust-building activities and additional education on acceptable forms of child-rearing in the United States as compared to other Latin American countries

In San Diego, seed team members were certified by the NSTRC in delivery of SafeCare and had responsibility for training other home visitors to deliver the intervention with fidelity, so they had a strong understanding of the programme model and commitment to training others to deliver it with fidelity to its core treatment components. In practice, it is likely that local adjustments made to EBPs to improve their cultural relevance, such as those described above, are common, and viewed as necessary to improve service fit with regional populations (Self-Brown et al., 2011).

The present study

We examined Latino clients’ experiences of delivery of the SafeCare model adapted according to their cultural needs in San Diego, including their perceptions of adherence to core components of SafeCare, as well as indicators of the quality of their experience with services,
compared to non-Latino clients who, in the vast majority of cases, received standard SafeCare without such adaptations. We also examined factors that could influence experiences with service delivery among Latinos, such as receipt of the adapted intervention in Spanish and having an ethnic match with the provider. We were particularly interested in whether Latino clients would report experiences with SafeCare services that were less positive to those of non-Latino clients, which would be reflected in lower levels of adherence, working alliance and satisfaction with service. Given concerns about the development of EBPs and their relevance to diverse cultural groups, one might expect that Latino clients would report poorer experiences with services. However, under conditions in which trained personnel make adaptations based on local knowledge of a cultural group, we hypothesised that Latino clients would not report reductions in their experiences of service delivery, as reflected in reports on aspects of client perceived programme fidelity, working alliance and satisfaction.

Methods

Data

Participants. Participants were 760 SafeCare clients who received services between 2008 and 2010 from one of several agencies in San Diego delivering home visitation services. Participants had a child protective services investigation that did not rise to the level of risk required for child removal from the home, but that was of enough concern to warrant referral to SafeCare by the San Diego child welfare services agency. About one-third of these cases (222) were participants who had completed only one or two surveys before discontinuing participation in SafeCare services (see Procedures). These cases were excluded because of concern that they could not provide an accurate measure of aspects of SafeCare delivery based on a small number of home visits and early drop out. No differences were found in ethnicity between those who had completed fewer than three surveys and those who had completed three or more. Furthermore, including those clients who completed only one or two surveys in multivariate analyses did not significantly alter results of study analyses. Therefore, final analyses included 538 participants. Of the 538 participants, 413 were female (77 per cent), 397 were of Latino ethnicity (74 per cent) and 166 (31 per cent) received services in Spanish.

Procedures. At the end of each home visit, SafeCare participants were asked to complete a brief questionnaire measuring characteristics of the client-provider relationship and various components of adherence to the SafeCare module delivered that day. The questionnaire was completed in private at the end of the visit, and handed back to the home visitor in a sealed, preaddressed envelope to be mailed directly to the research team. Questionnaires required about five minutes to complete. Clients were provided with a small incentive (two dollars cash) as compensation for completing the questionnaire. The average client received between $20 and $40 in compensation over the course of their involvement in services. All study procedures were approved by the University of California, San Diego Institutional Review Board.

Dependent variables

Client perceived adherence. Perceived adherence to SafeCare in this study was measured by adapting existing client satisfaction and client report of provider behaviour measures to SafeCare content (Schoenwald et al., 2000). The adherence instrument was designed to measure the critical therapeutic components of adherence to the SafeCare model based on client responses to questions on each topical module. The core thematic domains identified in SafeCare, which are described further in Table I, are: psycho-education, teaching/modelling/observation, feedback/praise and homework. Total adherence scores for each therapeutic domain ranged from 0 to 2. Scores were obtained by summing and averaging responses to items within each domain across visits based on the degree to which a client agreed with each item, where "not at all" = 0, "some" = 1 and "a lot" = 2. Cronbach’s αs for each domain are reported in Table I. Pilot testing of the measure was not conducted specifically with Latinos as the questions were relatively straightforward and concrete in nature, having high face validity. However, we did compare results for adherence components measured in Spanish and English.
No differences were found in perceptions of adherence between Latinos who took the survey in Spanish and English. In separate working analyses, we have observed that adherence measures are sensitive to change over time as home visitors receive additional coaching, adding to confidence about their validity.

**Working alliance and satisfaction.** Ten items were used to examine the concept of working alliance, derived from a general set of questions that were asked of clients about each session. Items were adapted from the Working Alliance Inventory (Horvath and Greenberg, 1989), an empirically validated measure (Hatcher and Gillaspy, 2006; Horvath and Greenberg, 1989) and from the Client Cultural Competence Inventory (Switzer et al., 1998) which has been used extensively to measure client perceptions of cultural competence of services (Damashek et al., 2012). The items used in this study in total did not form an established standardised scale. Items pertained to two established aspects of working alliance, the client-home visitor bond and goal-oriented activity (Horvath and Greenberg, 1989). Examples of items that referred to bond included “My home visitor understands my world, my community and my family”; “My home visitor understood what is good about my family”; and “My home visitor was negative and critical with me” (reverse coded). Items related to the goal-oriented aspects of working alliance included “My home visitor and I work well together as a team”; “My home visitor told me exactly what I would be working on today”; and “My home visitor had a clear plan for what we would work on today”. Other research has found working alliance between client and clinician to be a

### Table I SafeCare™ adherence questionnaire

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<tr>
<th>Adherence domain*</th>
<th>SafeCare description</th>
<th>Example items</th>
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<tbody>
<tr>
<td>Psychoeducation (2 items; ( \alpha = 0.34 ))</td>
<td>The degree to which the home visitor provided psycho-education or explained the rationale behind the content of the intervention</td>
<td>“My home visitor told me why it’s important to have lots of positive interactions with my children” “My home visitor explained why it’s important to childproof my home and keep it clean” “My home visitor explained why it’s important to know how to care for my child’s health”</td>
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<td>Teaching/modelling/observation (13 items; ( \alpha = 0.86 ))</td>
<td>The degree to which the home visitor used teaching, modelling and observation to support client mastery of material</td>
<td>“My home visitor gave me activity cards listing different things to do with my infant” “My home visitor picked an activity and showed me how to do it” “My home visitor watched me practice the activity with my children” “My home visitor gave me a quiz about how to handle different kinds of health problems”</td>
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<tr>
<td>Feedback/Praise (6 items; ( \alpha = 0.72 ))</td>
<td>The extent to which the home visitor provided feedback relevant to client’s progress and praised client for positive change when appropriate</td>
<td>“My home visitor gave me feedback on how to improve my skills” “My home visitor noticed positive changes I made in my home” “My home visitor complimented me for showing what I had learned”</td>
</tr>
<tr>
<td>Homework (1 item)</td>
<td>The extent to which the home visitor provided client with tasks to complete on their own before the following session</td>
<td>“My home visitor gave me homework to do before the next visit”</td>
</tr>
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</table>

**Notes:** *Cronbach’s \( \alpha \)*s provide a measure of the intercorrelation among items in each adherence domain. Although some domains have lower Cronbach’s \( \alpha \) (e.g., psycho-education), it is not necessarily expected that internal consistency will be high in each domain. Adherence is defined by responses to the items in each domain, and is therefore important and meaningful even in domains where traditional metrics of internal consistency are lower. The teaching/modeling/observation domain had one extra item than was included in the calculation of the Cronbach’s \( \alpha \) because it applied only to parent-child interaction sessions involving infants.
crucial element of service quality associated with engagement in services and positive client outcomes (Horvath and Symonds, 1991). Internal consistency reliability for this set of items was good ($\alpha = 0.79$).

Three items that pertained to client satisfaction with home visits were also included in the questionnaire. They were “The home visit today was lively and interesting to me”; “My home visitor is helping my family”; and “I would recommend my home visitor to other parents like me”. Internal consistency reliability for this set of items was acceptable ($\alpha = 0.68$). Composite scores for all dependent variables were obtained by summing and averaging responses to items within each domain across visits, where “not at all” = 0, “some” = 1 and “a lot” = 2.

**Independent variables**

Independent variables were drawn from two sources, the individual client and the home visitor. At the client level, gender and Latino ethnicity were the two characteristics available and included in analyses. Gender was a dichotomous variable. Ethnicity was dichotomised as Latino and non-Latino. Other client-level variables included a dichotomous item for Spanish language, indicating whether the client received the intervention in Spanish or English. A dichotomised ethnic match variable was also created, indicating whether Latino clients had an ethnic match with their home visitor.

At the home visitor level, dichotomised variables were created for home visitor ethnicity and gender. Home visitor education was also dichotomised into two groups: those who had a master’s degree, and those who had a bachelor’s or lower degree. Home visitor age was represented in years.

**Statistical analyses**

In order to examine associations of client and home visitor characteristics with adherence, working alliance and satisfaction, data were analysed using hierarchical linear modelling procedures in HLM software (Luke, 2004; Raudenbush and Bryk, 2002). In our analyses, clients were nested within home visitors, and random effects were included for home visitors to account for the nested data structure. All predictor variables were dichotomous, with the exception of home visitor age. Home visitor age was grand-mean centred.

The entire client sample was included in a set of models that examined the association between client ethnicity and perceptions of service delivery. At level 1, client characteristics, including ethnicity and gender, were included as predictors of variation in adherence, working alliance and satisfaction. At level 2, home visitor ethnicity, gender, education and age were included as predictors.

Another set of hierarchical linear models was run with a subsample of Latino clients only, to examine whether receipt of the intervention in Spanish or the Latino client-provider ethnic match were related to client perceptions of service delivery. For these models, level 1 predictors included client language, ethnic match and gender. Level 2 predictors included home visitor education and age. Home visitor gender was not included in these models as there was not enough variability in home visitor gender among Latino clients.

**Results**

**Descriptive statistics**

Characteristics of the sample are presented in Table AI. The sample was predominantly Latino (73.8 per cent) and female (76.8 per cent). About 40 per cent of Latino clients participated in SafeCare in Spanish, as compared to only 3 per cent of non-Latino clients ($\chi^2 = 70.31; p < 0.001$). Average adherence scores across domains ranged from 1.54 to 1.90 for Latino clients, and from 1.35 to 1.93 for non-Latino clients. Average working alliance and satisfaction scores were between 1.86 and 1.89 for Latinos and non-Latinos. Latinos rated home visitors higher than non-Latinos in the areas of teaching/modelling/observation ($t = 2.66; p = 0.008$) and homework ($t = 2.43; p = 0.015$).
SafeCare services were delivered by 40 home visitors (see Table AII). Home visitors were predominantly Latino (75.0 per cent) and female (90.0 per cent). The majority of home visitors had a bachelor’s degree (70 per cent); one quarter had a master’s degree and two home visitors (5 per cent) had a high school diploma. Average home visitor age was approximately 36-years old.

Hierarchical linear regression analyses

Two models were estimated for each dependent variable, sequentially including client-level predictors and then adding home visitor-level predictors. The introduction of home visitor-level variables had little effect on estimates related to client-level variables from the first to second models. Therefore, results are presented only for the second models that included both client-level and home visitor-level variables.

Table AIII presents intercepts and coefficients from regressions for each dependent variable based on the entire sample. Results indicate that Latino clients rated home visitors as more adherent to the teaching, modelling and observation domain of SafeCare than non-Latino clients, with the Latino client reports averaging 0.11 higher. Female clients also reported having home visitors assigning homework somewhat more consistently than male clients. Latino home visitors were rated marginally higher on adherence to the teaching, modelling and observation domain of SafeCare than non-Latino home visitors. However, female home visitors were perceived to have lower adherence to the psycho-education component of the model. Table AII also indicates that Latino home visitors were given lower ratings on working alliance than their non-Latino counterparts. We identified three significant random effects, in the adherence models for teaching, modelling and observation, feedback and praise and homework. These variance components show that average ratings of home visitors’ adherence to different dimensions of SafeCare had significant variability, identified through client reports, suggesting that clients do perceive differences in how home visitors deliver core aspects of SafeCare.

Table AIV depicts analyses that include only Latino clients and incorporate the language of intervention and ethnic match as level 1 predictors of service delivery outcomes among Latinos. As these analyses contain a large subset of the total sample, we expected that many results would be similar to those that include the entire sample, but these analyses offer the opportunity to examine the association of language and ethnic match with client perception of services. Results revealed that Latinos with an ethnic match with their home visitor rated them somewhat higher on adherence to the psycho-education domain and the teaching, modelling and observation domain of the programme model. Again, female Latino clients perceived higher adherence to the homework domain. Of those home visitors with Latino clients, home visitor age was associated with lower adherence to the requirements for providing feedback and praise to clients. Home visitor age was also associated with working alliance with Latino clients, with older age related to weaker alliance. Among Latino clients, those who were delivered the intervention in Spanish had higher satisfaction scores than those who received it in English. Utilising Cohen’s $d$, effect sizes for all significant parameters in Tables AIII and AIV ranged from 0.25 to 0.38, suggesting that differences were significant but effects were small.

Discussion

This study aimed to shed light on the experiences of Latino clients during the implementation of an evidence-based home visiting intervention adapted with the purpose of enhancing cultural relevance in the context of a local community. Overall, across several different dimensions, we identified no decrement in experience with SafeCare for Latino clients compared to non-Latino clients, consistent with previous SafeCare research (Damashek et al., 2012). The potential for lower working alliance, satisfaction and/or reduced adherence was a primary concern given the vast literature on disparate service access and use for Latinos in other settings (e.g. Garland et al., 2003; Hines et al., 2004; Lopez et al., 2008; Snowden and Yamada, 2005; Waters and Eschbach, 1995). These findings are more consistent with other studies involving cultural adaptations of EBPs that have found adaptations to be necessary to enhance engagement (Self-Brown et al., 2011) and positively influence retention, satisfaction and outcomes of Latino
Perceptions of delivery of SafeCare during implementation in San Diego appear to be relatively consistent for Latino and non-Latino clients, implying that adaptations made locally are engaging Latino and Spanish-speaking clients in services, as well as other racial/ethnic groups, without compromising adherence to the programme model. This is important to note in light of other research that has cautioned against cultural adaptations occurring at the cost of reducing critical therapeutic content of a standardised behavioural model (Castro et al., 2004; Kumpfer et al., 2002). In some cases, Latino clients reported receiving services that were slightly more consistent with the SafeCare model than non-Latino clients, especially in how home visitors taught and modelled practices and behaviours.

Among Latino clients, having a home visitor of the same ethnicity was associated with marginally higher adherence ratings for the home visitor, although the effect size was small. Clients who received the intervention in Spanish reported higher levels of satisfaction with services. This could indicate that clients who received the adapted intervention in Spanish were more satisfied with services than those who received a version in English. However, because language use in the Latino population can also represent a crude proxy for level of acculturation, this finding could be reflective of differing interpretations of measures among Latinos with different levels of acculturation or, alternatively, higher satisfaction among less acculturated Latinos. Regardless of interpretation, these findings signal that the client-provider ethnic match and the language of intervention are important factors to consider in successfully implementing an EBP with culturally diverse groups. Consistent with other research citing language and provider-client ethnic match as key to engagement in services among Latinos (Bernal and Scharron del rio, 2001; Barona and Santos de Barona, 2003; McCabe, 2002; Sue et al., 1991, 1994), the findings indicate that these aspects of cultural responsiveness may potentially influence perceptions of fidelity to an evidence-based model during implementation.

Other characteristics at the home visitor level were associated with client experiences of service delivery, implying a need to look more closely at the provider role in EBP implementation, as suggested in previous findings (Aarons, 2004). Older home visitors and female home visitors had reports of slightly reduced adherence to the programme model in this intervention. Besides being rated lower on having completed requirements for providing feedback and praise, older home visitors were reported to have weaker working alliance with clients, possibly reflecting a less positive connection overall. It is also possible that these findings could be indicative of resistance to change and innovation in services, or a preference to continue with existing service patterns, among those more experienced workers. If nothing else, it serves as a cue to a deeper examination of provider characteristics and processes during the implementation of innovative EBPs (Aarons, 2004; Aarons et al., 2010).

There are some limitations of this study that merit discussion. The most obvious is that, because this is a non-experimental study, we have no way of knowing how Latino clients would have rated service delivery without the cultural adaptation. In one comparative study of a culturally adapted evidence-based parenting intervention, there were no differences found in retention and satisfaction among Mexican-Americans who participated in the original standardised programme and those who participated in the culturally adapted one (McCabe and Yeh, 2009). We cannot draw conclusions as to whether the locally adapted SafeCare would fare better in Latino client ratings than SafeCare unadapted. Although we are able to make a general comparison between Latino families who received a culturally adapted version of SafeCare and non-Latino families who received the standardised version, because this was an observational study, it is possible that some non-Latino families might also have benefited from discussions that occurred locally about adapting SafeCare to the needs of Latino families. However, our findings are important particularly because they contradict the notion that EBPs may not be relevant to diverse client groups. Just as valuable, these findings support the idea that when adaptations are made carefully at the local level, it is possible to maintain adherence at a level as high as when the programme is delivered in its non-adapted form.

Another limitation is that underlying our rationale for this study is the assumption that client reports are one reasonable indication of fidelity of programme delivery. While client report is valued enough to be used to guide supervision in other interventions, such as Multisystemic...
It has not received the same research attention with SafeCare. However, the existence of variability in clients’ perceptions of home visitors’ service delivery gives us some confidence that clients are able to and do attend to differences in the services that they receive.

These data were collected during the initial phase of SafeCare implementation in San Diego, at a time when we possessed a limited subset of client information. We would have benefitted from having more detailed demographic information such as client race, immigration status and socio-economic status. Because the only racial/ethnic information available for clients was Latino ethnicity, we were unable in these analyses to go beyond comparisons focused on client-provider ethnic match for Latino clients. Therefore, conclusions cannot be drawn as to the effects of factors such as immigration status or socio-economic status on client experiences with services.

Additionally, an important aspect of client experiences with service delivery is participation. We did not include client participation rates in our study as we had an imperfect measure of number of sessions attended, which was estimated from the number of surveys completed after attending a session. We estimate that surveys were completed after approximately 75 per cent of sessions. Although not reported in this manuscript, analyses involving the number of modules completed also did not reveal differences in participation rates between Latinos and non-Latinos.

Conclusion

This study has demonstrated that EBPs implemented in real-world settings can have relevance for clients of diverse cultures and that systematic local cultural adaptations made in the process of implementation may enhance client experience without compromising adherence to the standardised programme model. These results are largely consistent with a growing body of literature demonstrating positive impacts of EBPs with diverse cultural groups when such adaptations occur systematically (during research or implementation) with careful attention given to core components of model fidelity. However, other studies also support the notion that a number of EBPs are robust and may require little adaptation to be effective (Damashek et al., 2012; Ho et al., 2010; Kataoka et al., 2010; Morales and Norcross, 2010). Indeed, the US Surgeon General’s report suggests that existing EBPs may be the most effective treatments available for diverse populations lacking specific tailored approaches (United States Department of Health and Human Services, 2001). Although fundamentally not as rigorous a test of these issues as can occur in randomised trials, we propose that further research that pays explicit attention to and documents the process of implementation of EBPs with diverse cultural groups can make important and needed contributions to understanding the cultural relevance of service system changes as they are influenced by ongoing EBP-centered quality improvement efforts.

Summary of implications for policy and practice

- This study demonstrate that EBPs implemented in real-world settings can have relevance for clients of diverse cultures.
- Systematic local cultural adaptations made in the process of implementation may enhance client experience without compromising adherence to the standardised programme model.

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## Appendix

### Table A1  Client characteristics by ethnicity

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<tr>
<th></th>
<th>Latino</th>
<th>Non-Latino</th>
<th>$\chi^2$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$n$ (Column %)</td>
<td>397 (73.8)</td>
<td>141 (26.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>309 (77.8)</td>
<td>104 (73.8)</td>
<td>0.97</td>
<td>0.33</td>
</tr>
<tr>
<td>Male</td>
<td>88 (22.2)</td>
<td>37 (26.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language of intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>235 (59.2)</td>
<td>137 (97.2)</td>
<td>70.31</td>
<td>0.000</td>
</tr>
<tr>
<td>Spanish</td>
<td>162 (40.8)</td>
<td>4 (2.8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table AII  Home visitor characteristics

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino</td>
<td>30 (75.0)</td>
</tr>
<tr>
<td>Non-Latino White</td>
<td>5 (12.5)</td>
</tr>
<tr>
<td>Non-Latino Black</td>
<td>5 (12.5)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>36 (90.0)</td>
</tr>
<tr>
<td>Male</td>
<td>6 (10.0)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>HS diploma</td>
<td>2 (5)</td>
</tr>
<tr>
<td>Bachelors degree</td>
<td>28 (70.0)</td>
</tr>
<tr>
<td>Masters degree</td>
<td>10 (25.0)</td>
</tr>
<tr>
<td>Age</td>
<td>35.6 (8.80)</td>
</tr>
</tbody>
</table>

### Table AIII  Hierarchical linear models with all clients and home visitors

<table>
<thead>
<tr>
<th></th>
<th>Delivery of service: adherence domains</th>
<th>Reception to service</th>
<th>Working alliance</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psycho-education</td>
<td>Teach/model/observe</td>
<td>Feedback/praise</td>
<td>Homework</td>
</tr>
<tr>
<td>Level 1: client</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino</td>
<td>−0.03</td>
<td>0.11***</td>
<td>−0.02</td>
<td>0.17</td>
</tr>
<tr>
<td>Female</td>
<td>−0.02</td>
<td>−0.04</td>
<td>−0.01</td>
<td>0.20**</td>
</tr>
<tr>
<td>Level 2: home visitor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino</td>
<td>0.02</td>
<td>0.11*</td>
<td>0.04</td>
<td>0.12</td>
</tr>
<tr>
<td>Female</td>
<td>−0.08*</td>
<td>−0.12</td>
<td>0.04</td>
<td>−0.25</td>
</tr>
<tr>
<td>Education$^a$</td>
<td>−0.00</td>
<td>−0.00</td>
<td>−0.06</td>
<td>−0.03</td>
</tr>
<tr>
<td>Age$^b$</td>
<td>−0.00</td>
<td>−0.00</td>
<td>−0.00</td>
<td>−0.00</td>
</tr>
<tr>
<td>Intercept</td>
<td>2.00</td>
<td>1.59</td>
<td>1.76</td>
<td>1.37</td>
</tr>
<tr>
<td>Random effect (variance component)</td>
<td>0.000</td>
<td>0.005*</td>
<td>0.007*</td>
<td>0.051***</td>
</tr>
</tbody>
</table>

**Notes:** $n = 538$. All other variables are uncentered. $^a$Master’s degree compared to bachelors’ or lower degree; $^b$age is grand mean centered. $^*p < 0.05$; $^**p < 0.01$; $^***p < 0.001$
### Table AIV
Hierarchical linear models with latino clients and home visitors

<table>
<thead>
<tr>
<th></th>
<th>Delivery of service: adherence domains</th>
<th>Reception to service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psycho-education</td>
<td>Teach/model/observe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feedback/praise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working alliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Satisfaction</td>
</tr>
<tr>
<td><strong>Level 1: client</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnic match</td>
<td>0.07*</td>
<td>0.15**</td>
</tr>
<tr>
<td>Language</td>
<td>-0.03</td>
<td>0.01</td>
</tr>
<tr>
<td>Female</td>
<td>-0.02</td>
<td>-0.06</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Level 2: Home visitor</strong></td>
<td>0.02</td>
<td>0.04</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>-0.02</td>
</tr>
<tr>
<td>Age</td>
<td>-0.00</td>
<td>-0.01</td>
</tr>
<tr>
<td>Intercept</td>
<td>1.87</td>
<td>1.64</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.79</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.87</td>
</tr>
<tr>
<td>Random effect (variance component)</td>
<td>0.001</td>
<td>0.004</td>
</tr>
</tbody>
</table>

**Notes:** n = 397. All other variables are uncentered. *Master's degree compared to bachelors' or lower degree; ^age is grand mean centered. *p < 0.05; **p < 0.01; ***p < 0.001

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**About the authors**

Megan Finno-Velasquez, MSW, is a PhD Candidate at the University of Southern California School of Social Work. Her research interests focus on enhancing the cultural relevance of services and systems that serve Latino immigrant children at risk of maltreatment. Megan Finno-Velasquez is the corresponding author and can be contacted at: finno@usc.edu

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