Examining the need for cultural adaptations to an evidence-based parent training program targeting the prevention of child maltreatment

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**ABSTRACT**

Evidence-based behavioral parent training programs (BPTs) have been recommended as a primary prevention strategy for child maltreatment, and use of BPTs is increasing. As these programs are implemented in new contexts and among new populations, the cultural relevance of these programs and need for adaptations or modifications must be considered. The purpose of this study was to assess the types of cultural adaptations that are being made to a widely implemented BPT, SafeCare, by providers working with families involved in the child welfare system, and to explore the need for more systematic adaptations. Eleven SafeCare providers, from six states, participated in individual, semi-structured interviews. Overall, the providers did not recommend systematic adaptations of the model for specific ethnic groups. However, they provided general and specific information regarding SafeCare components that require adaptation on a case-by-case basis, which is likely to be applicable to many BPTs. More research is needed to develop clear guidance about when and how to assess the need for cultural adaptations and how to institute adaptations that improve rather than weaken evidence-based programs. By sharing data and experiences, purveyors can contribute to the body of knowledge about adaptation.

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1. Introduction

Child maltreatment is a significant public health problem in the United States. In 2008, there were approximately 772,000 substantiated cases of child maltreatment. Although child maltreatment can occur in any sector of the population, racial disparities are evident, with rates of maltreatment per 1000 children highest among African American (16.6), Alaskan native or American Indian (13.9), and multi-race (13.8) children, in comparison with rates among Caucasian children (8.6) (U.S. Department of Health and Human Services, 2010). These data may represent true differences in maltreatment levels based on income, culture or ethnicity, or they may be due to biases in the reporting, substantiating, and handling of suspected child abuse (Ardis, Chung, & Myers, 1998; Coulton, Korbin, & Su, 1999; Westby, 2007). Regardless, it is clear that the children and families in the child welfare system are very diverse and that minorities are overrepresented.

In recent years, there has been a significant push for child welfare agencies to implement evidence-based programs and models with parents at high risk for or who have perpetrated maltreatment (Bridge, Massie, & Mills, 2008). Behavioral parent training programs (BPTs) have increasingly been recognized by experts as a type of evidence-based model that may benefit families in the child welfare system (Barth et al., 2005; Chaffin & Friedrich, 2004; Whitaker, Lutzker, & Shelley, 2005). BPTs are based on the assumption that parenting skill deficits can be improved by providing parents with a repertoire of skills, using a specific instructional format that includes: provider instruction and behavioral modeling of targeted skills, parent practice of skills through role plays and live practice with the child, and homework assignments for the parent, for example, to practice targeted interaction skills with the child outside (Shaffer, Kotchick, Dorsey, & Forehand, 2001).

There is mounting evidence that BPTs, including Parent–Child Interaction Therapy (PCIT), The Incredible Years, Triple P, and SafeCare®, can be effective in reducing maltreatment risk and substantiated reports for high-risk families when implemented with fidelity (Chaffin et al., 2004; Gershater-Molko, Lutzker, & Wesch, 2002; Prinz, Sanders, Shapiro, Whitaker, & Lutzker 2009; Webster-Stratton & Reid, 2010). For instance, Chaffin et al. (2004), in a randomized clinical trial, demonstrated PCIT to be effective for reducing the likelihood of child physical abuse allegations one year posttreatment, among families who had formally been involved with child protective services. While such findings are encouraging, the implementation of such practices are complex and challenging, and very little is understood about how to implement effectively within existing state systems (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009; Binder et al., in press; Lee, Alteschul, & Mowbray, 2008).

One of the most difficult implementation challenges is how to balance the need to modify the program to address cultural and other
differences among families against the need to retain fidelity to the details of a proven intervention (Saul et al., 2008). Ensuring that programs are implemented with fidelity is critical to their effectiveness (e.g., Blakely et al., 1987; Mowbray, Holter, Teague, & Bybee, 2003), with high fidelity implementation resulting in greater program effectiveness than lower fidelity implementation (Durlak & DuPre, 2008; Elliott & Mihalic, 2004; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Schinke, Brounstein, & Gardner, 2002). However, some research suggests that cultural adaptations can affect both the providers delivering the intervention and the family being served in ways that could impact effectiveness. For instance, research indicates that offering providers the flexibility to modify interventions can increase their sense of independence and ownership in program implementation (Backer, 2001), as well as increase their feelings of competence, because they believe they are providing the best practices to families (e.g., Bernal & Saez-Santiago, 2006; Castro, Barrera, & Martinez, 2004; Ringwalt, Vincus, Ennett, Johnson, & Rohrbach, 2004). For families, carefully designed cultural adaptations can increase participant retention, improve provider–client communication, reduce value conflicts, enhance client comfort and engagement, and reduce treatment failure (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Ultimately, the impact of adaptation appears to be complex, and may depend on the type of intervention and the extent to which a program is adapted.

Recent research specifically examining structured, programmatic cultural adaptations of BPTs for specific cultural/ethnic groups (Latino, African American) has found that the adapted BPTs are no more effective with diverse families than the original versions (Coad, Foy-Watson, Zimmer, & Wallace, 2007; McCabe & Yeh, 2009). For instance, McCabe and Yeh (2009) studied the effectiveness of a culturally modified version of PCIT, Guiando a Niños Activos (GANA), as compared to standard PCIT and Treatment as Usual (TAU) for Mexican American parents with children with behavior problems. Both GANA and standard PCIT produced results that were significantly superior to TAU across a wide variety of both parent report and observational indices. Interestingly, GANA and PCIT did not differ significantly from one another for parent or child outcomes, and there were no significant differences between the three groups on treatment dropout. Research has also indicated that program adaptations can reduce positive family outcomes if the adaptation involves reduced dosage or the elimination of critical program content (Castro et al., 2004; Durlak & DuPre, 2008; Kumpfer et al., 2002). Thus, although many providers indicate clear need for some level of cultural adaptations, to date, there is no compelling evidence that structured, programmatic cultural adaptations promote better outcomes for ethnic minority families (Lau, 2006). Currently, there is very limited research on adaptation of BPTs for families in the child welfare system.

1.1. Purpose of current study

The purpose of this exploratory study was to collect data that would inform further adaptation or modifications of SafeCare. In particular, semi-structured interviews were used to determine what adaptation providers are already making to better serve diverse families in the child welfare system and what additional adaptations they believe are needed.

SafeCare is an evidence-based, BPT that targets risk factors for child physical abuse and neglect (Lutzecker & Bigelow, 2002; Whitaker, Lutzecker, Self-Brown, & Edwards, 2008). SafeCare includes three modules: Health, Safety, and Parent–Child Interaction. In the Health Module, parents learn to identify symptoms of common child illnesses and injuries, as well as determine and seek the most appropriate health treatment for their children. In the Safety Module, parents learn to identify and eliminate safety and health hazards by making them inaccessible to children. In the Parent–Child Interaction Module, parents are taught to provide engaging and stimulating activities, increase positive interactions, and prevent troublesome child behavior. As is true in other BPTs, families participating in SafeCare receive instruction and structured behavioral modeling of the targeted skills, participate in role plays and practice activities for targeted skills, and complete related homework. Although SafeCare has been implemented successfully with diverse populations (Gershater-Molk et al., 2002), no systematically collected data exist on cultural or other adaptations that have been made or are needed for this intervention. Therefore, providers who are delivering SafeCare to families involved in the child protection system were queried about the populations they were serving and whether they were implementing or desired guidance for implementing cultural adaptations or augmentations for specific cultural groups.

2. Methods

2.1. Participants

SafeCare Trainers from four states assisted the National SafeCare Training and Research Center (NSTRC) to identify study participants. Specifically, the SafeCare Trainers provided names and contact information for SafeCare providers who had experience implementing SafeCare with diverse families and whose clients were always or often referred by child welfare agencies. Of the 17 providers suggested, 12 agreed to participate. Interviews were completed with 11 of these 12. Participation was voluntary and the study was approved by the Georgia State University Institutional Review Board. Participants work for organizations across six states (Oklahoma, California, Colorado, Washington, Kansas, and Indiana). Their field experience with the SafeCare model ranged from six months to seven years. The participants identified themselves as Caucasian (n = 5), Latino (n = 5), or African American (n = 1). Nine of the organizations only receive referrals from child protective services, and two receive referrals from child protective services and other sources, such as clinics and hospitals.

2.2. Interview procedure

Qualitative data were collected through the use of semi-structured interviews (see Table 1). Interview questions were developed by four SafeCare experts from NSTRC at Georgia State University, with input from an expert consultant in the field of cultural competency. Questions addressed engagement strategies, adaptations and modifications made to SafeCare delivery and session structure, and recommendations. Interviews were conducted via telephone by NSTRC faculty and graduate research assistants, and were audio-recorded. At the start of the interview, participants were asked to acknowledge their receipt of and familiarity with the consent agreement, which was previously sent via email. Next, the participant was asked the interview questions. The interviews ranged from 21 to 77 min in duration. Although participants discussed their work with African American, Caucasian, and Native American families, the majority of participants focused on Latino families. Each participant was compensated $50 for their time.

2.3. Analysis

Interview data collected via the recorded telephone interviews were transcribed verbatim and analyzed using thematic analysis (Arsonson, 1994). The transcribed interviews were independently read and coded by each of the three team members. Following initial coding, the research team met to discuss their reviews of the transcripts, and themes were identified by aggregating related information across the three reviewers into classifiable patterns. When coding discrepancies arose, transcripts were reexamined until
3.1. Approaches to family engagement

Participants stressed the importance of engaging families and gaining trust during the initial visit with families. Participant 11 talked about promoting engagement by demonstrating respect and openness. She indicated, "...the main thing is just really get to know your clients and just let them be the expert and let them teach you... if you build a good relationship with your client that will be the key to how the implementation goes." Participants noted that in some cases more than one visit was needed before starting training on SafeCare modules. For instance, Participant 9 noted that with the Latino families she works with, "you have to show up and come in without the curriculum in front of you... spend one or more sessions in the engagement where you talk with [the families] about their concerns, engage the rest of the family, really talk about where they are, and look at their acculturation process and where they are in that... if you spend the time up front, it pays off drastically towards the rest of treatment."

Some participants suggested that matching providers and families based on race or ethnicity could increase acceptability by families, especially their initial willingness to engage and share with the home visitor. Matching based on language was also reported to be critical. Participant 4 stated, "It doesn’t matter where you come from, or your culture, just if you’re respectful and you’re empathetic with families, and you really care about them as a person, as a family... But there are times, in reality, that the families [who have a shared culture with the home visitor] find a connection, number one. Number two, they can speak in their own language and... when it came to talking about their feelings, their families, and their home situations, they felt more comfortable talking it in their language." However, participants generally reported that when it is not possible to match home visitors to families on ethnic or other characteristics, it was not usually a major obstacle to engagement.

Participants noted that families who have an extensive history with child protective services are often more difficult to engage in services. They indicated that these parents are often more cautious due to fear of getting re-reported to the state, and suggested that this fear often increases for families who are of diverse backgrounds, especially those who are undocumented. For instance, Participant 1 stated, "...there’s a lot of hostility because of child welfare. I think that once the families understand what the service is, and that [the home visitor] is really there to help the family, I think in most cases its fine." Participants reported that families who had been reported to child welfare services as a result of practices that were acceptable in their cultures were particularly resistant to trusting and engaging with home visitors. Participant 1 said, "we hear lots of stories of the kids [of parents who immigrate to the United States] being removed when it was really just an unfortunate translation issue." For example, she said, "[with] Native American [families]...some of the home remedies, they'll want to sweat a fever out, or something like that, or you hear a lot about cupping...they will heat a cup and put it on the back of people to suck out the bad stuff in the body... Things where in their cultures, it is not necessarily good...they do it as a last resort, but it’s not a reportable offense where kids can be taken away." Participants indicated that it is critical to spend significant time explaining mandated reporting requirements to build open communication and trust with these particular families.

3.2. The importance of flexibility in service delivery

Several participants identified flexibility about session logistics as being important for retaining families. Participants 9 and 10 commented that being open to "offering sessions in different training environments, such as McDonalds, foster home/relative home, at the department... various locations as they try to find permanent housing," can improve family engagement and retention and overall intervention acceptability. Participants 9 and 10 also noted the importance of being flexible with agency policy when cultural or ethnic celebrations or traditions are disruptive to continuity of care. For example, Participant 10 described how his agency altered policy for Native American families, stating, "Even though we put in a policy on the consent around needing to maintain appointments, there are certain times where the parents are going to have Powwows or if there’s a death, or things like that [resulting in many sessions being missed]...to be sensitive [about these events], which engages the parent a little bit more in the service, to the point that we can even
double up on some sessions, if we know when those things might be happening.”

3.3. Perspectives on the SafeCare model

3.3.1. Subtheme: SafeCare delivered through home visitation

The fact that SafeCare is a home visitation-based program is important to recipients. As Participant 1 explained, families appreciate home services; “there are transportation issues, especially in rural areas; there’s just not a lot there and so they love having somebody come to their home… I think they’re very appreciative they don’t have to worry about babysitting and everything else. They really view the workers as family friends and so I think it’s been a very good approach.”

Because SafeCare is delivered in the home, it affords an opportunity to include other family members, which can be advantageous for providing a structured, consistent environment for the child. Participant 7 stated, “…family members and grandparents [can] play a huge part—sometimes even neighbors and friends—in terms of child-rearing for these families. So, it’s not just you’re working with the parents, but you do have to include all those other people as well. And they have so much of a larger voice than even us. I mean, we’re coming out and we’re saying one thing, and then they may have Auntie or next door neighbor saying something else.” Similarly, Participant 2 reported, “…with the different cultures, just being aware of the culture, and knowing that, like with the African-American families, if there’s a grandmother in the home, then they’re going to refer to the grandmother a lot for information on health and parenting—and to be respectful and include grandmother.” Thus, as noted by several participants, a home visiting approach which allows for the inclusion of these important caretakers in the intervention can be very beneficial to family engagement and buy-in, as well as overall child outcomes.

3.3.2. Subtheme: The focus on parenting skills

The majority of participants reported that families enjoy the SafeCare content and, especially, the skill-based focus. Participant 3 stated, “We’ve had really good feedback about [the content of SafeCare], actually—that there have been, especially with the health, a lot of ‘a-ha’ moments. Like, ‘Oh, I didn’t know I could do that,’ or, ‘Oh, I would have just taken them to the emergency room.’” Similarly, Participant 7 noted that the families she works with appear to enjoy the Parent–Child Interaction module, indicating “…they get so much out of it. They just enjoy the feedback. Some of our parents who just feel a little insecure and really don’t know if they’re doing the right thing, it’s important for them to have somebody that’s there, that’s observing…saying their doing well.”

3.3.3. Subtheme: Including children in sessions

Most participants perceived that the inclusion of children in SafeCare sessions often increases parent engagement and acceptability of the program. Participant 8 said that the families she serves, which are primarily Latino, “have a tendency to be a little bit more invested because it’s more interactive, it’s not somebody coming out and just lecturing them, or providing them with information, but they have an opportunity to show us what they’re getting out of it…they’re very receptive to that and they’re always excited to show us what they’ve used with their child, and how they’ve used it, and how it’s helped make a difference in their situation.” Similarly, Participant 6, who also primarily serves Latino families, indicated, “Parents like the idea of working with their children [during a] session. They often state that they are too busy to interact with their children, so this gives them an opportunity to make the time and actually interact in a positive way with their children.”

Our sample was too small for generalizations; however, Participant 4, who mainly works with African American families, noted more resistance from the parents she works with related to playing and interacting with children during sessions. She stated, “I think sometimes they feel a little bit intimidated just because they don’t—a lot of them weren’t played with as a child so they don’t really know how to play with their kids, and I think it is intimidating to have somebody watching you while you’re doing something—to critique you, but I try my hardest to tell them that I’m there to help and I’m not there to judge them and that they don’t need to be nervous about it so most of them are okay with it. And I usually do the parenting [activity training] after I’ve build a lot of the positive rapport so that they trust me. I don’t just jump into it.”

3.4. Need for modifications or adaptations of structure or content of SafeCare sessions

All participants stated that developing adapted versions of SafeCare for particular ethnic groups or cultures would be of limited use or perhaps detrimental. For instance, Participant 10 noted, “Every family is definitely different and [you cannot] just stereotype the family based on what [you] know about that culture, or assume that the family is the same as another family that was from the same culture.” For these reasons, the participants uniformly recommended a more individualized approach to adaptation for specific local populations or specific families. For example, Participant 4 stated, “I find the material of the content of the model is very usable, in any culture, really. It’s more of how you present it…”

However, many individualized or case-by-case adaptations were described by participants. For instance, Participants 1 and 11 both use motivational interviewing techniques to engage families. Participants also reported extending the amount of time during sessions spent on important cultural social exchanges and including additional family members or caretakers in the home. Participant 5 indicated that with Latino families she typically, “spends more time being social with families because that’s the nature of the culture—for most of them, not everyone, but for most of them… I think that it shows that we’re respectful to them. It gives them more trust in us, and I think they accept the intervention once they see that it does work. And that’s pretty immediate when they do see it.”

Several participants had experiences that required learning about specific aspects of the cultures and beliefs of the populations they served to make needed modifications. For example, cultural beliefs may impact attitudes towards treating medical conditions, preferred ways of interacting with children, or home hazards requiring attention. These impacted their delivery of the Health, Parent–Child Interaction, and Home Safety Modules, respectively. For instance, Participant 1 provided this example: “With the health module, being open to discussing and working with home remedies, superstitions, and spiritual beliefs with families who consider these as a component of dealing with health issues is important…be respectful, if you are hearing about another approach, find out as much as you can to assess if it’s harmful and if it’s not harmful really your job is to say, ‘If that doesn’t work, how do you know it’s not working?’ Here’s something else you can try. Are you willing to try this?’” Regarding the Parent–Child Interaction module, Participant 7 and 8 discussed how the term “active ignoring,” which is discussed in this module, is often not well received by African-American parents. Participant 7 explained, “…ignoring minor misbehavior, [often with] the African American community, that’s a big problem. Because, for them, especially single African-American mothers, you know, no behavior is worth being ignored. And sometimes to try and explain that to them can be real challenging… For them, being able to have control over their kids and keep their kids in line is so much more important than, you know, this thought of ignoring those minor misbehaviors… So, I think you just have to get kind of creative with how you word stuff.”

Several participants had developed materials to augment those provided by SafeCare. For instance, participants reported that they have added picture aides and or revised the SafeCare handouts for parents to make the more easily comprehended for parents with
language barriers or low literacy. Additionally, one participant reported that some adaptations were made to the SafeCare health manual to include health scenarios that are important to the Latino population being served in her area. Specifically, an additional health scenario was developed for the SafeCare health module to teach families that depressed fontanels in infants can indicate severe dehydration. A need for this was identified when many of the SafeCare providers in that area reported that Latino parents were “…taking the baby by the ankles and hanging them upside down and shaking them real hard to try to get it [the fallen fontanel] to pop out, or they’ll stick their fingers in the baby’s mouth and try to pop it out. Instead of recognizing its dehydration, they’re doing all these other things. By adding a health scenario about a fallen fontanel we could kind of address that.”

3.5. Participant recommendations

The most common recommendation for improving the SafeCare program for diverse families was to adapt the materials to be more user-friendly. This includes lowering literacy levels of some materials and incorporating more pictures. In addition, participants noted that the Spanish translations were too literal and/or formal to make sense to the families they serve and should reflect typical spoken language. For example, Participant 6 stated, “I think there are a lot of questions that just do not translate in Spanish, and I’ll give you one. In there is the word time-out. The word time-out, [tiempo aufera], for us means you take the baby outside… I think what’s happening is every word is being translated from English into Spanish and there’re just some words that cannot be translated, but the whole sentence can just be put in a different way.”

Several providers indicated the importance of considering level of acculturation of families participating in SafeCare. In fact, a few providers suggested that adding a structured acculturation measure to be given in the first session with families may help to establish a dialog between families and home visitors and help home visitors frame parenting information and training in the most acceptable way. In contrast, two providers cautioned that it is “disrespectful” to ask clients specific questions about this topic, and that it is better to be sensitive during the intake process and learn about the families through other means.

Other recommendations included adding more information about cultural competency and cultural sensitivity to SafeCare home visitor training, including examples taken from practitioner experiences. Participants were eager to share with other SafeCare colleagues the information and examples they have collected about how to present health, safety, and parent–child interaction to different ethnic groups. Two participants suggested a need for bringing SafeCare sites together annually to share information and experiences, especially related to delivering SafeCare to diverse families.

4. Discussion

One of the most difficult challenges in the implementation of BPTs is balancing the need to modify the program to address cultural and other differences among families against the need to retain fidelity to the details of a proven intervention. This project examined ways in which providers for diverse families in the child welfare system adapted SafeCare, a BPT targeting prevention of child neglect and physical abuse, and their perceptions about the need for systemic adaptations for particular populations. Although some insights are SafeCare-specific, most of what was reported is generally applicable to the dissemination of BPTs, especially within the child welfare system.

4.1. Provider opinions and reported behaviors related to adaptation

Overall, the findings from this exploratory study suggest that providers who have experience implementing SafeCare with diverse populations perceive the model to work well and do not recommend making systematic, cultural adaptations for specific populations. These findings are consistent with recent research on culturally-specific adaptations to BPTs which offers little support that adapted interventions are more effective with diverse families than the original versions (Coard et al., 2007; McCabe & Yeh, 2009). Further, BPTs without systematic cultural adaptations have been successfully utilized for preventing maltreatment with diverse samples in child welfare, with no significant moderation of intervention condition effects emerging by parent race (Chaffin et al., 2004). Study participants noted concerns similar to those of some researchers (Miranda et al., 2005; Sue & Zane 1987), that cultural adaptations for specific populations could inappropriately stereotype individuals or families based on their membership in a large sociocultural group. As the child maltreatment field moves towards implementation of BPTs on a broader scale, making extensive culture-based adaptations of BPTs could also limit the potential reach of a program, as there would need to be more extensive, costly training of providers in the various versions of the program, as well as on the assessment approaches to determine which families are appropriate for the adapted program versus the standard intervention. Given the current preliminary data and that, to date, there is little compelling evidence that structured, programmatic cultural adaptations promote better outcomes for ethnic minority families (Lau, 2006), as well as the potential for such adaptations to decrease public health impact of BPTs due to training costs, systematic adaptations of SafeCare do not seem warranted.

However, participants reported using various types of engagement techniques, adaptations, and modifications. Given the particular concerns related to engagement and resistance to intervention for families in the child welfare system (Webster-Stratton & Reid, 2010), incorporating more time for cultural exchanges and rapport building, and including training on motivational interviewing techniques are possible approaches that could be incorporated into SafeCare and other BPTs. Further, spending time discussing mandated reporting policies, and the approach that will be used if a provider is considering making a report (i.e. telling parent he/she would be informed before a child protection call would be made), may be critical to building trust with these families. Participants also discussed the importance of adaptations and modification related to session delivery, both in terms of flexible scheduling and the inclusion of extended family members or others who serve a caretaking role.

Some of the suggested adaptations of materials would likely be valuable for many SafeCare recipients, and possibly recipients of other BPTs, from all backgrounds. These include using more pictures and simpler language to explain SafeCare targeted skills. Ensuring appropriate translations, which use informal, common language, could provide widespread benefits, although specific sites may still need to modify the language for different Spanish-speaking subgroups. Other adaptations, such as adding specific content on cultural factors that impact health, hazards, or parent–child interaction important to SafeCare modules for smaller sub-populations, may also be better made on a case-by-case basis.

Importantly, participants did not report reductions in dosage or elimination of critical content from SafeCare when making modifications or adaptations—changes that have been associated with reducing positive outcomes for other evidence based practices (Castro et al., 2004; Kumpfer et al., 2002). The adaptations reported suggest that participants are retaining fidelity to SafeCare while making appropriate adaptations in ways that are complementary and necessary for best practice (Webster-Stratton & Reid, 2010). Interestingly, there was one participant that reported not making modifications, and this provider had the least experience of the participants in delivering SafeCare to families. While this finding should be interpreted with caution, perhaps newer, less experienced SafeCare providers focus more on fidelity to the model and less on adapting it to better fit with families. Then as home visitors gain more experience, they feel more comfortable making adaptations. If this is true, this is consistent with recommendations by
Fixsen et al. (2005) that adaptation should not occur until after high fidelity implementation has been well established. It would be interesting to track providers over time to understand the typical trajectory of home visitors comfort with adaptations based on their experience with the model and what this means for family outcomes.

4.2. Provider perspectives on SafeCare

Providers reported on several aspects of the SafeCare model that reportedly increase family acceptance of the intervention. First, providers indicated that the delivery of SafeCare through home visitation is appreciated by most families they serve. SafeCare is different from most other BPTs in that it was designed to be delivered in the home setting, where most others were designed to be clinic-based. Masse and McNeil (2008) discuss how in-home delivery of BPTs can reduce logistical barriers that are often responsible for client no-shows and late arrivals, enhancing client engagement, retention, and satisfaction. Additionally, the CDC Task Force on Community Preventive Services has recommended home visitation as the major intervention delivery approach for working with families at risk for child maltreatment (Briss et al., 2000).

Providers reported that many parents like the focus of SafeCare on parenting skills versus education only, and they enjoy practicing the skills with their children in session. Parent skills training and having parenting skills versus education only, and they enjoy practicing the skill changes that are often responsible for client no-shows and late arrivals, enhancing client engagement, retention, and satisfaction. Additionally, the CDC Task Force on Community Preventive Services has recommended home visitation as the major intervention delivery approach for working with families at risk for child maltreatment (Briss et al., 2000).

SafeCare among families referred from child welfare systems, to evaluate Project SafeCare: Teaching bonding, safety, and health care skills to parents/participants also expressed interest in having a forum for providers to share their experiences with the model and what this means for family outcomes.

4.3. Limitations

The present study had several limitations. The sample was small, with only one African American participant, and the participants who responded to recruitment methods for the study may have been a biased sample. Further, only one BPT was studied and no observational data were included. Importantly, no measures were included of the impacts of the changes made on the effectiveness of the intervention.

4.4. Conclusions and future directions

This evaluation was conducted because of the increasing use of SafeCare among families referred from child welfare systems, to determine whether changes to SafeCare were needed to optimally serve this population. As BPTs become integrated practices with more diverse populations, purveyors of BPTs need to be attentive to how their interventions are performing. It is unclear when to assess whether adaptations are needed to a BPT, and whether results from small evaluations such as the one conducted here can be aggregated and generalized. Ideally, future research will utilize multiple methodologies to explore adaptation and implementation issues in ways that will provide results that are generalizable to a range of BPTs. Study designs could include collecting information from providers through key informant interviews with larger sample sizes; surveys, which could be anonymous to encourage full disclosure; focus groups; and observations of practitioners during sessions. It would also be helpful to gather data from families about how they experience BPTs and their perceptions about the need for adaptation. Such research would not only answer the question of when adaptation needed, but also how to institute adaptations in ways that improve rather than weaken the existing program. Optimal implementation of SafeCare specifically, and BPTs in general, in child welfare systems and with diverse families will likely be contingent on a further understanding of these critical factors.

Just as providers in our study who work with diverse families proposed the need for sharing of experiences, purveyors should be encouraged to share their data and experiences and, thereby, contribute to the body of knowledge about adaptation.

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