Symposium 5 - EIE2023

#42- Making practices more relevant: Examples of adaptations of the SafeCare parenting program by population, setting, and problem

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Introduction to your symposium

Evidence-based practices must often be adapted to enhance their relevance for a population, setting, or problem context. We will present examples of how the SafeCare parenting model was adapted to a population, context, and problem. One presentation will focus on the adaptation of SafeCare for refugees in the US from Afghanistan, Burma, and Democratic Republic of Congo (population). A second presentation will discuss SafeCare delivery during COVID shutdowns (setting) and how fidelity was maintained. A third presentation will discuss how SafeCare was adapted to address issue of smoking in the home (problem), and how effectiveness and fidelity are being tested.

Symposium abstract Nr. 1: Adaptation and delivery of the SafeCare parenting model for refugees in a U.S. resettlement zone

Migrants and refuges families often suffer from poor mental health with high rates of depression, anxiety, and behavioral issues. Through a CDC-funded Prevention Research Center, we adapted and implemented the evidence-based parenting program, SafeCare, for delivery to Afghan, Burmese, and Congolese migrants in a U.S. resettlement zone.

The adaptation process for SafeCare was structured and involved SafeCare experts, implementing agencies, and community members from the targeted populations. An adapted curriculum was developed over a year long process and that curriculum is being implemented by both community-based agencies (delivery as usual) and by independent community members (task-shifting framework) with no special training in service delivery.

To date, 42 families completed a baseline survey (9 Afghan, 19 Burmese, and 14 Congolese), and 28 have completed SafeCare services. Participants were all female, has been in the US on average 5.5 years, had an average 3.4 children (range 1-8), and 52% had less than 8 years of education. Parents who completed the six session PCI module (n = 28) demonstrated substantial behavior change, with skills improving by 81% (53% at baseline to 96% of the end of training), $p < .01$. Satisfaction with SafeCare was high at 4.0 on a 5-point scale.

Many challenges emerged in this implementation and are being documented via qualitative interviews with implementing staff. Key challenges documented to date include COVID-related effects, economic challenges for families, staff turnover, coordination of translation services for program delivery.

Symposium abstract Nr. 2: SafeCare Delivery and Implementation Adaptations Recommendations based on the impact of COVID-19

SafeCare, an evidence-based parenting program serves families at high risk for child maltreatment. In March 2020, most SafeCare agencies transitioned from in-person to virtual delivery due to COVID-19 restrictions. This study examined two research questions: 1) What are the impacts of virtual delivery of SafeCare on family and implementation outcomes? Data Source: NSTRC portal data collected from U.S. and international implementations of SafeCare; 2) What are SafeCare Providers perspectives on virtual delivery compared to traditional in person delivery? Data Sources: June 2020 survey and Fall 2021 focus groups of SafeCare providers

Quantitative results from the portal data indicate that virtual delivery is a promising direction for home visiting programs as it reduced SafeCare program completion time, and families exhibited similar outcomes and satisfaction with virtual delivery compared to in-person delivery. Qualitative results from the survey and focus groups suggest that virtual delivery increases scheduling flexibility, and leads to reduced cancellations and travel time. Virtual delivery also increases program access for some populations. Service providers used creative adaptations for rapport building and family connection to deliver the program virtually, while still maintaining program fidelity. Recommendations for future delivery include a call for virtual delivery resource development (e.g., modeling videos for parents and activities for children) and tools to support for virtual delivery (e.g., internet hotspots for rural families).

Study findings inform program delivery efforts for evidence-based home visiting programs to improve effectiveness, reach, and accessibility for families at risk.

Symposium abstract Nr. 3: Adaptation of SafeCare parenting model to address Secondhand Smoke Exposure for young children

Exposure to secondhand tobacco smoke (SHS) and child maltreatment (CM) are both major threats to child health. Few programs jointly target these co-occurring risks. The purpose of this project is to use a systematic braiding approach to integrate two prevention programs: Smoke-Free Homes: Some Things are Better Outside (SHS) and SafeCare® (CM).

The first 4 steps of the Systematic Braiding process were completed, including: 1) the identification of core elements of the curriculum and implementation process for both programs, 2) the development of an initial draft of the braided curriculum (Smoke-Free Home SafeCare - SFH-SC), 3) a feasibility pilot of SFH-SC with caregivers of young children who reported a smoker living in the home (N=8), and 4) feedback on braided curriculum from SafeCare Providers (N=9).

Results of the feasibility pilot indicated that caregivers were engaged in the SFH-SC program and felt supported discussing SHS with their provider. Caregivers reported an increase in smoke-free home rules from baseline to follow-up, and a reduction in parent stress. SafeCare Provider feedback following intensive review of the curriculum indicated high feasibility for the braided program delivery and implementation fidelity.

Parent and Provider findings suggest SFH-SC is a viable intervention that has potential to reduce SHS and CM. Study findings will inform the procedures for a large NCI-funded Hybrid Trial Type 1 of SFH-SC (Step 5 of Systematic Braiding) to guide future implementation and provide a roadmap for systematically braiding additional interventions.

Key highlights of your symposium

1. Evidence-based practices are typically narrowly focused on specific problems, but successful implementation of those practices must take into account the context in which those EBPs are delivered.
2. Adaptations may be done in a planful, systematic way, or may require on-the-fly, ad-hoc adaptation for emerging problems, such as COVID-19.

Implications for research and practice

There is a critical need to understand the adaptation process, and how adapted interventions are received by providers and consumers. There is also a strong need to understand how providers make adaptation on an ad-hoc basis. This symposium will discuss these issues and show effects on fidelity and acceptability.

Overall discussion

1. What are the key elements of an adaptation process that ensures acceptability and fidelity to the original model?
2. How can we train providers to create ad-hoc adaptations while maintaining model fidelity?