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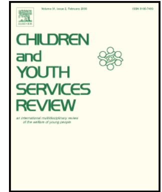

Cultural adaptation and implementation of evidence-based parent-training: A systematic review and critique of guiding evidence

Ana A. Baumann [a,*], Byron J. Powell [b,1], Patricia L. Kohl [b], Rachel G. Tabak [c], Valentina Penalba [d], Enola K. Proctor [b], Melanie M. Domenech-Rodriguez [e], Leopoldo J. Cabassa [f]

[a] *Brown School, Washington University in St. Louis. 600 S. Euclid, CB 8217, St. Louis, MO 63110, USA*
[b] *Brown School, Washington University in St. Louis. One Brookings Drive, Campus Box 1196, St. Louis, MO 63130, USA*
[c] *Prevention Research Center, Washington University in St. Louis. 621 Skinker Boulevard, St. Louis, MO 63130, USA*
[d] *Department of Counseling & Family Therapy, Saint Louis University. 3500 Lindell Blvd., St. Louis, MO 63103, USA*
[e] *Utah State University. E. Eccles Jones, Education Building, Logan, UT 84322, USA*
[f] *School of Social Work, Columbia University. 1255 Amsterdam Avenue, Mail Code 4600, New York, NY 10027, USA*

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ABSTRACT

With advances in knowledge regarding efficacious evidence-based interventions, there have been significant attempts to culturally adapt, implement, and disseminate parent training interventions broadly, especially across ethnic and cultural groups. We sought to examine the extent to which researchers and developers of evidence-based parent training programs have used cultural adaptation models, tested implementation strategies, and evaluated implementation outcomes when integrating the interventions into routine care by conducting a systematic review of the literature for four evidence-based parent training interventions: Parent-Child Interaction Therapy (PCIT), The Incredible Years (IY), Parent Management Training-Oregon Model (PMTO[TM]), and the Positive Parenting Program (Triple P). A total of 610 articles across the four programs were identified. Of those, only eight documented a rigorous cultural adaptation process, and only two sought to test the effectiveness of implementation strategies by using rigorous research designs. Our findings suggest that there is much work to be done to move parent-training intervention research towards a more rigorous examination of cultural adaptation and implementation practices.

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1. Introduction

Child disruptive behavior is a public health concern and costly issue in the U.S. (Honeycutt, Khavjou, Jones, Cuellar, & Forehand, 2013) and, if left untreated, can lead to delinquency later in life (Fergusson, Horwood, & Ridder, 2004). With the assumption that parents' behaviors mediate child behavior, parent training programs have been created to prevent and/or intervene on child disruptive behavior (e.g., Hagen, Ogden, & Bjørnebekk, 2011; Honeycutt et al., 2013; Presnall, Webster-Stratton, & Constantino, 2014). Considering that there are now a number of evidence-based parent training programs that could be readily implemented in community settings (Substance Abuse and Mental Health Services Administration, 2012; The California Evidence-Based Clearinghouse for Child Welfare, 2014), it should follow that parent training programs are disseminated and implemented in usual care[2] to prevent and intervene on child disruptive behavior. However, evidence-based care is still the exception rather than the rule in usual care settings serving children, youth, and families (Kohl, Schurer, & Bellamy, 2009; Raghavan, Inoue, Ettner, & Hamilton, 2010). Indeed, an evaluation of parent-training programs in one midsized Midwestern city revealed that only about 11% of agencies had adopted evidence-based programs (Kohl et al., 2009). The low rates at which evidence-based parenting interventions are delivered suggests that simply publishing reports on their

* Corresponding author. Tel.: +1 314 747-9109.
E-mail addresses: abaumann@gwbmail.wustl.edu (A.A. Baumann), bjpowell@wustl.edu, byronp@upenn.edu (B.J. Powell), pkohl@wustl.edu (P.L. Kohl), rtabak@wustl.edu (R.G. Tabak), vpenalba@gmail.com (V. Penalba), ekp@wustl.edu (E.K. Proctor), Melanie.domenech@usu.edu (M.M. Domenech-Rodriguez), ljc2139@columbia.edu (L.J. Cabassa).
[1] BP is currently at Center for Mental Health Policy and Services Research, Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania. 3535 Market Street, 3rd Floor, # 3131, Philadelphia, PA 19104.

[2] We use the term "usual care" to describe the care given by practitioners in a community without the judgment or normative implications of the term "standard of care" (Dawson et al., 2009).

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availability and effectiveness, while necessary, is not sufficient given the myriad of barriers at the client, clinician, team, organizational, policy, and funding-levels (e.g., Flottorp et al., 2013; Powell, Hausmann-Stablile, & McMillen, 2013). This signals a need to study the implementation of evidence-based parenting interventions, and to evaluate strategies that can facilitate the uptake of such interventions in usual care.

The research-to-practice gap is even larger for racial and minority groups. Compared to non-Hispanic Whites, racial and ethnic minority groups in the U.S. tend to underutilize mental health services, to discontinue treatment prematurely, and to receive poor care (Institute of Medicine, 2003, 2009; United States Department of Health and Human Services, 2001). Even with comparable insurance, needs, attitudes toward treatment, and beliefs about treatments, African Americans and Latinos are less likely than their European counterparts to use mental health services (Alegría et al., 2008; Chow, Jaffee, & Snowden, 2003). As Kazdin and Blase (2013) articulate, the lack of services for most people in need has direct implications for models of treatment delivery. The current methodology to provide mental health services has not been successful in improving mental health in the U.S.; a shift and expansion in intervention research and practice is needed to be able to prevent and treat mental illness and decrease health and mental health disparities (Kazdin & Blase, 2013). A powerful solution may be found in bringing together the fields of cultural adaptation research and implementation research. In the cultural adaptation, program modifications are intended to increase the fit of the intervention to the target population while protecting scientific integrity (Castro, Barrera, & Martinez, 2004; Kumpfer, Alvarado, Smith, & Bellamy, 2002). In implementation research, methods aim to promote the systematic uptake of research findings and evidence-based practices into routine practice (Eccles & Mittman, 2006). In combination, these can be sources for thinking about designs and methodologies that can accelerate the spreading of evidence-based prevention and intervention for those in need. In fact, the Healthy People 2020 report challenges researchers and practitioners to eliminate disparities and improve the health of all groups (United States Department of Health and Human Services, & Office of Disease Prevention and Health Promotion, 2012). To achieve such a goal, scholars tend to focus on adapting evidence-based interventions to clients' culture with the premise that, to be effective, an intervention should be responsive to the cultural practices and worldview of the target population (Domenech Rodríguez & Bernal, 2012). Similarly, implementation researchers aim to promote the systematic uptake of evidence-based interventions to improve the quality and effectiveness of health services (Eccles & Mittman, 2006).

1.1. The interventions

This review focuses on four parent training interventions that have been given the highest possible rating as "well supported by research evidence" by the California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org): Parent-Child Interaction Therapy (PCIT), The Incredible Years (IY), Parent Management Training-Oregon Model (PMTO[R]), and the Positive Parenting Program (Triple P). Our sample was selected from the list of 22 interventions indicated by SAMSHA's National Registry of Evidence-based Programs and Practices (NREPP) to have focused on mental health promotion and treatment in early childhood, to have been funded by the National Institutes of Health, and have been evaluated in comparative effectiveness research studies. From there, we selected our sample based on the ratings from the California Evidence-Based Clearinghouse, as programs that have (a) no case data suggesting a risk of harm; (b) a well-defined treatment manual and strong empirical evidence demonstrating their ability to change parenting behaviors and reduce child behavior problems; and (c) demonstrated efficacy across a variety of populations and in multiple settings. Triple P is a continuum of parent support and training (Sanders, Markie-Dadds, & Turner, 2003), so we focus here on Level 4 Triple P, which is most comparable to the other interventions under consideration.

1.2. Cultural adaptation of evidence-based parenting interventions

There are several types of intervention adaptation (e.g., adapting the training, the agency; Stirman, Miller, Toder, & Calloway, 2013). We focus here on cultural adaptation, defined as "the systematic modification of an evidence-based treatment (EBT) to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns meanings and values" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Cultural adaptation is an important part of the implementation process (Cabassa & Baumann, 2013), and considering the current diversity of the U.S. population, attention to how cultural factors affect the implementation of parent trainings in usual care is crucial.

Meta-analyses in the cultural adaptation field have indicated that adapting interventions to clients' cultural backgrounds by explicitly integrating cultural factors such as language, cultural beliefs, and explanatory models into the intervention improves the relevance, acceptability, effectiveness, and sustainability of the intervention by the providers and target populations (e.g., Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Huey & Polo, 2008; Smith, Domenech Rodríguez, & Bernal, 2011). Care should be taken, however, as these meta-analyses reflect great variability in effect sizes, study designs, populations, and interventions sampled (Cabassa & Baumann, 2013).

There is no single, correct way to culturally adapt interventions and there is no rule that states that every EBT should be adapted (Domenech Rodríguez & Bernal, 2012). When considering whether to culturally adapt an intervention, one should carefully consider what evidence about the intervention is available (e.g., what information does the literature provide about the EBT?), the target population (e.g., who was the original target population? To whom will the intervention be delivered?), and what is the target domain of the intervention (e.g., changing parenting practices). Domenech Rodríguez and Bernal (2012) provide guidelines to support the decision of whether to adapt an intervention, which involve assessing whether (a) the EBT is accessible to the providers who will be delivering the intervention, (b) the underlying mechanism of change of the intervention is a good fit for the target population, and (c) the EBT is acceptable for the target population. If the decision is to culturally adapt an intervention, the next step is to decide which framework will guide the process.

There are two sets of cultural adaptation frameworks: those that inform modification to the content of the intervention and those that inform the process of adaptation (Ferrer-Wreder, Snudell, & Mansoory, 2012). One model that informs *what* to adapt in the delivery and content of the intervention is the Ecological Validity Model (EVM) by Bernal, Bonilla, and Bellido (1995). The EVM specifies eight domains: language, persons, metaphors, content, concepts, goals, methods, and context. Another content model is the cultural sensitivity model, which distinguishes deep versus surface adaptations (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000).

The second set of frameworks focus on the *process* of adaptation, where decisions about when to adapt, how to adapt, and which stakeholders should be involved in the process are outlined. A number of frameworks fall into this category and vary in how prescriptive (i.e., have a set of a priori steps that guide the process) or specific (i.e., focused on the adaptation of one specific EBT) they are (Ferrer-Wreder et al., 2012). Several of them have been described elsewhere (Bernal & Domenech Rodríguez, 2012). Generally, these models recommend adaptations to be informed by the expertise of stakeholders, use formative research methods, and conduct formal evaluations of the adapted intervention (Cabassa & Baumann, 2013; Domenech Rodríguez & Bernal, 2012). It is important to assess the extent to which adaptations to parent training interventions have been guided by cultural adaptation frameworks in order to document the types of

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