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Exploring Adaptation and Fidelity in Parenting Program Implementation: Implications for Practice With Families

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Acknowledgements

The national structure of child welfare services is changing to include contracting with community-based organizations to deliver evidence-based programs (EBPs) aimed at preventing or reducing child maltreatment. Common services include parenting education classes (to improve parenting skills) or parenting support groups (to reduce isolation and increase social support) in order to prevent child abuse or neglect. Several models of parenting education based on behavioral family interventions have strong empirical support, including Triple P, Incredible Years, and Strengthening Families (see Kumpfer & Alvarado, 2003; Menting, Oroibio de Castro, & Matthys, 2013; Sanders, Kirby, Tellegen, & Day, 2014). Parenting support strategies, also often used by community-based organizations (CBOs) to address child maltreatment, have been found to be helpful but have a more limited evidence base (Andrews, 2014).

One ongoing area of concern is the changes that CBOs make to such programs as they are implemented in real-world settings. Research has documented the wide array of factors that influence implementation, or use of programs, in real world settings. The wide array of influences on implementation has led to multiple models of implementation. Recent efforts focus on creating a comprehensive typology for these constructs (e.g., the Consolidated Framework for Implementation Research, Damschroder & Hagedorn, 2011).

An important conceptual distinction to be made is the difference between factors that influence implementation and implementation outcomes (Proctor et al., 2011). Implementation outcomes include program acceptability, feasibility, adoption, fidelity, cost, penetration, and sustainability (Proctor et al., 2011). For example, when providers make adaptations to evidence based programs, they are impacting the fidelity implementation outcome.

Adaptations to EBPs occur frequently in real-world delivery settings. Moore, Bumbarger, and Cooper (2013) examined adaptations made to EBPs in natural settings; a significant number of providers reported making adaptations to address program delivery problems. Asgary-Eden and Lee (2011) reported the results of a study examining program use and adherence to intervention in a sample of 64 community agencies delivering a behavioral parenting program (Triple P-Positive Parenting Program). Adherence was assessed using the content checklists in service provider Triple P manuals; providers rated the most recent Triple P session they had completed. In this sample, providers had been trained in Triple P about two years prior to completing the survey and reported average session adherence of 85.89% (SD 16.67) (Asgary-Eden & Lee, 2011). Reasons for variation in adherence were not examined.

Providers make adaptations to parent skills education interventions to address a variety of professional and client needs. As noted by Shapiro, Prinz, and Sanders (2014), adaptation can increase providers' confidence in program delivery; although, the adaptation may not reflect adherence to intervention protocols. Rigid adherence to manuals that guide intervention delivery is not necessarily desirable (Mazzucchelli &

Sanders, 2010); some flexibility is necessary to meet the needs of families. In recognition of this, Mazzucchelli and Sanders (2010) have conceptualized the adaptations that providers make as being either high or low risk, depending on the relative advantage that the adaptation provides. Low risk adaptations involve the service delivery setting (home or clinic) or changing the length of sessions to meet parent needs; neither involve changing the intervention content in substantial ways. Higher risk adaptations involve changes made to either intervention process or content in ways that threaten the integrity of the intervention or stray significantly from the manner in which interventions were successfully delivered (leading to improved outcomes) for the population of interest. Finally, adaptation may be heavily influenced by differences between the populations served in real-world community settings and the populations with which evidence-based interventions were evaluated.

Motivation and Research Question

The present study explored the types of adaptation CBOs make to evidence-based parenting programs and the reasons for adaptations. Moore et al. (2013) proposed a taxonomy for categorizing adaptations based on fit (philosophical or logistical), timing (reactive or proactive), and valence (alignment with programs' goals and theory). Here we explore the kinds of adaptations that CBOs make when delivering parenting and family support program. Using the taxonomy as guide, we also explore the reasons for these adaptations.

Method

We conducted a qualitative study with family practitioners and program participants in multicultural settings to better understand the adaptation choices and motivations facing practitioners. Semi-structured phone interviews were conducted with program coordinators from three community providers in a Southeastern state. Interviews were followed by an in-person focus group with program coordinators and participants. We adapted questions from Moore et al. (2013) to explore fit, timing, and valence, and we developed questions to probe for autonomy. Qualitative responses were coded by two members of the research team across the four domains. Internal validity was assessed by a third team member coding a sample of the team's coding for comparison.

Participants

We used purposive sampling of CBOs to utilize the trust and rapport that we developed with the organizations over the course of building the impact evaluation of parenting education with mutual support. The interview participants are trained in mutual support as well as parenting education models; they draw from support group facilitation in family life skills delivery. A unique aspect of this dataset is the emphasis on community-based professional and parent leader perspectives as providers of services, rather than

researcher or developers of particular program models. Here we start with the setting and its providers.

Our study focuses on overarching themes or concerns related to implementing evidence-based parenting programs in the real world, not to evaluate or critique specific programs. We looked at the experiences of CBOs delivering different models of group-based parenting education programs. Since we did not carry out impact or process evaluations, we took their word for their delivery of programs that they named or said were EBPs. Nonetheless, throughout our discussion of findings we can summarize the broad expectations for delivering the programs as the CBO interviewees described them.

We selected three stable, independent nonprofit CBOs that have each provided services to families at-risk of child maltreatment for over twenty years. Each has a history of providing a range of services that have included parent mutual support groups and group-based parenting education. The first CBO provides parent support services in multiple counties across the state, with central offices and primary activities located in a mid-sized urban area with a county population of 372,803 (U.S. Census, 2014). The parenting mutual support group is the organization's central program focus. Additionally, during the past two years the organization has begun delivering two parenting education classes (Triple P and Strengthening Families). In 2012 this CBO served 963 adults in parent support groups along with 25 adults in one parent education class (prior to adding a second parenting education program). The second CBO serves seven predominantly rural counties with activities that include crisis shelters and therapeutic services, centered in a county with a population of 138,326. This CBO provides a parenting support group and a parenting education class of its own design with class facilitators trained in several evidence-based family life education models. In the past two years the organization has also begun delivering Strengthening Families. In 2012 the second CBO served 333 adults in parent education and support classes (prior to adding Strengthening Families). The third CBO serves a two-county rural and suburban area with services that include home visiting, through a central office in a county of 119,829 population. In 2012 the organization served 145 adults in parenting education classes out of approximately 1,200 adults that the organization assisted through other services including home visitation, counseling, and employment assistance. The percentage of families with children under age 18 with incomes federal poverty level in the prior year was high in each of the three CBO's regions, at 20.0%, 23.95%, and 17.0%, respectively (U.S. Census, 2014).

Each CBO provides services funded by state government contracts, foundation grants and independent fundraising. Two of the three CBOs provide a large array of family services, including home visitation, domestic violence and sexual assault victim care, mentoring, and fatherhood skills, in addition to the parenting education and mutual support programs. The majority of the CBO's parents in the parenting support or

education groups attend because of court or state child welfare service agency requirements. For consistency in service perspective, we asked each CBO to send a representative who had training and experience in providing parent mutual support using the Parents Anonymous® model and parent education using the Triple-P group (level 4) model. Some of representatives also reported having training in Strengthening Families.

Analysis

We composed focus group and interview questions based on Moore et al. (2013) as well as other sources to explore the dimensions of fit, timing, valence, and autonomy. The codes and definitions we used are as follows.

Type of Variation. Moore et al. (2013, p. 149) describe categories for different types of adaptations, which we used to code our interview responses. The different types are:

- Procedure – the way the program is delivered (e. g., timing, location, recruitment/referral);
- Dosage – the number of or length of sessions; and
- Participants – targeting different populations by cultural appropriateness or risk characteristics.

Dimension of Adaptation. We use the taxonomy of adaptations as proposed by Moore et al. (2013, p. 150), which are:

- Fit (philosophical) – conceptual models of the evidence-based parenting program do not align with practitioner's or organization's views about the causes of problem behaviors or how to address them.
- Fit (logistical) – incompatibility between the way the parenting program was designed and the context in which it is being delivered, including match to target population, resources, time, location, facilitator skills, schedules, and transportation/accessibility.
- Timing (proactive or reactive) – adaptation before implementation (proactive) in anticipation of potential problems with the fit of the program or after implementation (reactive) from unanticipated obstacles.
- Valence (positive, negative, neutral) – how the adaptation may alter the program's logic model and thus its effectiveness. Adaptations may be aligned with (positive), deviate from (negative) the program goals and theory or logic model, or neither (neutral).

Additionally, we added our own category to those proposed by Moore et al. (2013): Autonomy – the degree to which the organization can freely make changes to the program or is constrained by external influences.

A team of three researchers coded qualitative responses, dividing the interview and focus group transcripts among members. Each transcript was coded by one researcher and reviewed by a second. Internal validity was assessed by a third team member coding a sample of the team's coding for comparison. The three coders convened to discuss convergence and themes. Our original plan was to test the utility of the Moore et al.'s (2013) framework. Accordingly, we were going to organize findings by the four major dimensions. We changed our plan, however, after our use of a grounded approach generated additional patterns and themes that the research team determined were crucial to highlight.

Results & Discussion

In this section we present our results along with discussion of their implications for implementing evidence-based parenting interventions. We have combined the results and discussion sections to accommodate the complexity of qualitative findings and the practice-related concepts to which they relate. We first present the types of variation and adaptations described in our interviews. Next we explore the reasons for adaptations and their timing using the modified taxonomy by Moore et al. (2013).

Types of Variation and Adaptations

The CBOs we interviewed made numerous adaptations to the parenting programs they described as evidence-based. We coded several adaptations that CBOs discussed and we grouped these into four categories, following those mentioned in Moore et al. (2013), described above: procedure, dosage, and participants. Changes seem to relate largely to CBO's varying levels of commitment to the EBP designs and attempts to meet needs of large numbers of clients with complex issues. One of the CBOs used a specific program model while two described using eclectic approaches. The CBO committed to a specific program model appeared to make fewer adaptations.

Procedure. Model cross-over or adding content from other parenting program models was an overarching theme among the CBOs. A major way the CBOs in our study did this was to add a parenting support component, which two of the three CBOs described doing. (The third described delivering a distinct parenting support group separate from a curriculum-based parent education class.) Interviewees from two of the three CBOs reported excluding or not covering specific content or lessons in the parenting classes. Similarly, the same two CBOs described adding activities within parenting class sessions or parenting support groups, thereby going beyond the prescribed content of some of the evidence-based programs. The additional content included "praise reports"

(acknowledging behavior change or using appropriate parenting skills), social events such as baby showers or group dinners, and adding separate one-on-one training sessions with group participants. Practitioners from two CBOs described providing their parenting education through a blend of elements of various curriculum-based programs and mutual support. One representative described their CBO's approach as eclectic, but intended to follow medical practice, wherein the aim is to develop protocols for delivering appropriate intervention based on the needs "presented" by each client. They serve each client through a "system of care" involving a team caseworker/coordinator approach with clients who may be in multiple programs. More of the details of these adaptations will be described later in the section on reasons.

Dosage. Interviewees described two adaptations relating to dosage. One adaptation extended the length of sessions beyond the prescribed time for group parenting education classes. The other varied the number of prescribed sessions each participant was allowed to attend to be considered for successful completion of the training. The CBO representatives described how individual parent attendance was irregular, but allowed.

Participants. According to the interviewees, none of the CBOs screened or assessed clients for selective placement to parenting programs, but included all child protection service-mandated or voluntarily referred parents. (They do assess for selective placement in other types of services.) One of the CBOs that delivers distinct parenting support and education classes said they rely entirely on the state child welfare system agency to make the assessment of program needs for parents in the child welfare system. "We don't make a determination that the program is needed. State caseworkers make that determination. We're telling caseworkers that regardless of the group they decide, they should ask clients to go to a mutual support group. We're not qualified to assess what parents need." However, other representatives of the CBOs we interviewed reported that the state agencies referring clients do not assess parents for placement in specific models of parenting programs. All three CBOs' representatives said they do not send anyone away and they will find some service for everyone. The CBO representatives described their clients as having all kinds of needs, including employment, secondary education, parenting skills, prenatal care education, and even assistance as a victim of abuse. All three CBOs discussed including parents or guardians that were abusive, had drug or alcohol problems, were involved in the criminal justice system, or whose children had mental health or serious emotional challenges. The CBOs included these high risk parents with parents who had less serious issues, even those who voluntarily enrolled in parenting education.

Having described the major adaptations that the CBO representatives reported in interviews and focus group, we turn below to discussing the reasons for these

adaptations as we coded them according to the dimensions developed by Moore at al. (2013).

Reasons For and Dimensions of Adaptation

This section describes the reasons for and dimensions of adaptations to EBPs discussed in the previous section. We coded adaptations following Moore et al.'s (2013) typology: fit, timing, and valence. Additionally, we added a dimension called autonomy. We defined these dimensions earlier in the methods section.

Fit (Philosophical). We coded adaptation reasons under the Fit (philosophical) dimension where the adaptations and their reasons appeared to relate to a misalignment of the EBP's conceptual values and those of the CBO. We detected differences in the ways the CBOs follow a philosophy of change and willingness to commit to delivery of a particular model with fidelity or just take whatever as long as the parts seem to fit. One interviewee alluded to the feeling of urgency to stabilize the crises that parenting class participants experience before advancing with a theoretically-grounded curriculum:

> Everybody's situation is not conducive to maybe that line of thinking. You know maybe sometimes we do need to kinda step away from this for a moment, because…maybe we need to focus on this right now, because this is where your attention is at, not so much on the dynamics of what this program is supposed to do, but we need to address your immediate need so that maybe you can focus a little bit more on what we're trying to accomplish overall.

The three CBOs articulated aspects of a vision of aiming to help parents and guardians become self-reliant. As one interviewee put it, "there is a difference between giving someone information and having an impact on someone's life." Accordingly, they use mutual support groups to address what they see as a shortcoming in the evidence-based parenting education models. Interviewees criticized these models as being narrowly focused on education and attitude change. From the CBOs' point of view, parenting classes are too general. Augmenting with mutual support is a way to develop parents' foundational skills such as self-awareness, communication, trust, self-reliance, and figuring out how to meet concrete family needs.

CBOs see both mutual support and parenting education classes as necessary to meeting complex needs particularly of mandated participants who tended to have serious problems and who are often resistant. CBOs who offered separate parenting skills classes from the mutual support groups found that these participants tended to be less resistant to skills content if they had previously been in a parent support group. Similarly CBOs who did not have separate groups for these type of evidence-based

parenting models felt, based on experience, that integrating peer support into skills classes was imperative to get resistant, angry, or traumatized (i.e., having had their children removed) parents to focus on skills content.

Two of the CBOs did not seem to commit to a particular theory or evidence based approach, but rely on accumulated knowledge of various practices that they understand to be effective. While two of the CBOs appear to mix elements of different evidence-based programs, one seemed to provide distinct programs of support groups and education classes. This seems to be related to the organizational philosophy in which this CBO follows a specific philosophy and model of influencing parenting behavior change (mutual support). Accordingly, the agency prioritizes providing a particular model while adding other models as they have the capacity to do so. Commitment to a specific model seems to coincide with an organizational structure that accommodates delivering other parenting education programs with commitment to fidelity.

Fit (Logistical). We coded reasons for adaptations under the Fit (logistical) dimension where the adaptations and their reasons appeared practical in nature. We identified four prevailing themes that seemed to be related to logistical adaptations that our interviewees described. These four themes include: the client characteristics/group dynamics, organizational characteristics, group facilitator, and social ecological context.

Client Characteristics and Group Dynamics. Bearing in mind the description of adaptations relating to the participant characteristics that we discussed earlier, it appears that most of the adaptations were based on accommodating the various needs of these clients. The CBOs explained that the clients are in need of different approaches to parenting education than those available in a single parenting program. However, the CBOs are located in regions where the child welfare system does not support a wide market or array of program for the variety of client needs and risk levels. According to the interviews, more than half of the clients of the CBOs are mandated and subject to time-limited service plans required by a state authority such as the courts and the child welfare services agency. Some EBPs have been developed for parents who voluntarily refer themselves for parenting education or who are referred by the state system as needing basic parenting skills, rather than serious intervention for abusive behavior. As one practitioner put it: "Some of 'em are having a hard time being first time separated from their children. They've never had this happen to them and some of their cases in the parenting classes are from the fact that a lot of their situations aren't warranted." By contrast, other clients could be considered to be a higher risk. The interviewees described mandated clients as experiencing crisis or trauma reflecting instability in their life circumstances. They described challenging conditions that need to be addressed in addition to the parenting skills, such as: psychiatric disorder, substance abuse,

intellectual disability, victimization from family violence, trauma, unemployment, and even criminal charges.

Further, according to the interviewees, the client mix varies on a weekly basis as clients come and go and the intensity of their needs changes. Again, we see incongruence between the severity of the clients' risk and needs and the evidence-based programs that CBOs described delivering to all the clients that come to them alongside inconsistency in matching clients with the appropriate intervention. These multiple needs should be addressed in order for parents to engage in intervention content aimed at addressing the parenting concerns that led to investigation by the state child protective services and/or removal of their children. Without prior assessment of needs before participation in parenting skills class and the availability of local resources to address other multiple and serious needs providers find it difficult to maintain fidelity as they make largely reactive adaptations in response to these needs.

The reaction of parents to the mandated referral also involves resisting engagement in the group education sessions. Interviewees described mandated parents as feeling punished by the system. As one practitioner said, "It goes back to that stigma I was talking about. Nobody's gonna volunteer to come to a group, because the stigma is that you're bad." Representatives from all three CBOs described needing to dismantle such resistance in order to proceed with parenting education content. Accordingly, three CBOs include mutual support groups as a method to address the resistance and reduce the feeling of being stigmatized. While one of the CBOs maintains a separate support group from the parenting skills classes, the other two CBOs integrate the support group into the parenting classes. Interviewees from the two CBOs with such an arrangement described using their tools from training in different parenting education models along with the support group setting to tailor the class content to the needs of their clients. They eclectically draw from various models as they do so. As a representative put it, "We have multiple tools in the toolbox because different things work."

Without "positive parenting" training, parents tend to see behavior as either good or bad. They do this to their kids, and they feel it done to them. In order to help parents change the way they see their children, parents need help in how they see themselves and how they perceive how others see them. Promoting a child's self-regulated behavior begins with the parent feeling capable, self-determining, and empowered (Andrews, 2014; Boehm & Staples, 2004). Accordingly, the practitioners we interviewed tend to focus on the parents, rather than the parent-child relationship *per se*.

Organizational Resources. The interviewees portrayed their CBOs' philosophy as promoting respect, dignity, and empowerment of clients. This reflects the experience that the interviewees described as serving all who come to them, including fitting all types of clients within the parenting class or support group, despite important risk and

need differences. The organizations explained that they prefer to adopt programs or interventions based on professional expertise, *ad hoc* assessment, and accumulated understanding of their client needs, rather than adding programs in order to receive state child welfare agency funding.

Interviewees described a number of logistical variables that influence their adaptations to evidence-based parenting programs. We coded these under Fit (logistical) as they appear to be related to the resource constraints of the organizations themselves. Some adaptations stemmed from the CBO's resource limitations and insufficient capacity to deliver with fidelity. These pertained to staffing and assessment and planning assistance systems, and funding. These variations related to logistic fit resonate with similar findings from other research on adaptations of EBPs (Beidas and Kendall, 2010).

Schedule. Parents' employment circumstances may not allow for taking time off to attend mandatory classes when they are scheduled or parents have trouble finding childcare to allow for attending classes. CBOs reported not having adequate resources to offer additional classes that can fit the schedule of some working parents or for child care.

Client flow. The composition of groups and/or classes is mixed with new and continuing participants coming and going throughout. Parents enter when referred and leave as needs arise, resulting in continuous fluctuation of group sizes. One interviewee described the situation:

> There are other people that are coming in within those twelve weeks as well, so it's ongoing. You have some rotating out and someone new is coming in. [They're] all different levels. So that makes it hard for the particular curriculum because, those coming in, that's where we'll start with them, okay. And sometimes I'll get back around to the very beginning, you know, and sometimes I don't. That kind of a thing. And I may be all over this book of curriculum and various areas based on what is needed from that particular individual or individuals.

This example suggests that the practitioner is working in an organizational structure that does not regulate its delivery of programs to ensure adherence to the model. They are concerned about including the parent as soon as possible, while the parents' needs are acute and motivation to participate is high. They avoid placing parents on a waiting list. The practitioner's philosophy of including all participants wherever they are in the process is the operational model.

Place. The location of classes can affect the program delivery. Interviewees described the ideal settings as places where participants felt familiar or that they could relate to and be more likely to take ownership of their parenting group, but which they

struggled to actually provide. Providers felt that this sense of ownership was important for retention of participants. As one parenting support group practitioner remarked: "They have to own the group. To come back, they have to own the group!" Accordingly, some of the program changes we noted earlier were related to situating the group session in a setting conducive to building trust.

Group Facilitator Characteristics. The interviewees emphasized that facilitator skills and characteristics are very important to the quality of delivery, parent engagement, and influencing change in behaviors and attitudes. In the group setting, especially when trainings involve mutual support components, facilitators need training on how to build relationships and how to manage group sessions, not just on to follow the manual or curriculum. Perhaps a major distinction between mutual support groups and curriculum-based parenting education program is the follow-up/review discussions that mutual support groups provide. The practitioners we interviewed stressed the importance of those skills and characteristics as critical for mutual support groups and parenting education classes alike. "The quality of the facilitator has everything to do with everything," as one practitioner put it.

It appears from our interviews that the facilitator in two of the CBOs also has considerable autonomy, rather than being required to stick to a program manual/design. One interviewee said:

> Well, you know the training or the [EBP] models gives us the instinct or the information that we could absorb. And, because I pull from all sorts of things, even just classroom activity or books that I have at home, or you know, that I'm reading. And I say, oh this is a good thought process, let me try that this week because so and so was going through a situation and I'm gonna work with that person next week on this subject matter. Just like I have hand-outs, we have fun with some of the things…And so, and it's just where they are for that week.

The practitioners' autonomy to adopt on the fly was a characteristic consistent with the organizational structures and philosophies of two of the CBOs, as discussed in the previous section. Those two CBOs have their own "home-grown" parenting education classes that combine with mutual support groups, in addition to delivering externally designed parenting education curriculums.

Group facilitators must develop the trust of the participants to be effective instructors. Facilitators said they face resistance from participants, as most of the parents in the parenting education classes are mandatory participants referred by the court or child welfare services. Interviewees said their clients see the CBO providers as an extension of the authorities. The practitioners said that parenting class participants express frustration from having to take time off from work to attend parenting classes.

The practitioners see this as limiting trust in the beginning. The practitioners described that it usually takes at least two meetings for parents to vent their frustration and show some willingness to engage in the course content. Additionally, practitioners described how adopting mutual support groups for parents helps to build trust and capacity to engage in the formal training material as peer-to-peer communication seems to elicit honesty. The practitioners we interviewed said that EBP models do not allow for such "start-up" time for preparing participants to engage in the program. Accordingly, two of the CBOs combine the mutual support group with the parenting education class and the third primarily provides the mutual support group, to which they also supplement their curriculum-based parenting education classes.

Systemic and Social-Ecological Context. The incongruence between the appropriate participants and the evidence-based parenting education models appears to be partly related to the structural circumstances in which the CBO is embedded. Parents' behavior is affected by their neighborhoods and social networks, but evidence-based parenting education class models do not always take that into consideration. For example, Bernal and Sáez-Santiago (2006) and Castro, Barrera and Martinez (2004) highlight the importance of cultural adaptations for evidence-based programs to be effective.

The practitioners described adapting to the resistance of parents to participating in the classes and even the support groups. The CBO representatives related that their clients are treated harshly by the child welfare and criminal justice systems. The practitioners explained that this was, in part, cultural and class-based. According to CBO representatives, most of their parenting class clients are from low-income and often ethnic minority neighborhoods with high proportions of families with members involved in the criminal justice system and public welfare services. One practitioner described the predominant view:

> It's almost as though parents in [our] area, they look at parenting classes and groups as punishment, instead of viewing it as a source of help. And everybody that they're involved with they view as being the one who's issuing punishment...It's hard to get a parent to understand that I'm not punishing [them], I'm here to try to help.

Clients are described as seeing the parenting class as yet another punishment that must be survived in order for parents to reunite with their children, as most parents have been separated from them. The parents seem to have a narrow view of their participation as an exchange, "If I do this, I get my kid back, just need to do it and get it over with."

The availability of programs by these CBOs is largely a function of the CBOs' funding, which mostly comes from philanthropic grants and state reimbursements. For the most part, the CBOs provide one model of parenting class along with a support group or they mix the support group with the class. Their choice of EBPs is often a function of available funding, whether the sponsored program is best for client or not. Whether the state or philanthropic grantor, the funders often dictate the decision of, and terms for, the type of program to be delivered. A CBO representative described this dynamic:

> If we provide the state's selected evidence-based parenting program, then the child welfare service agency is saying this [funding] is what they'll come to the table with. But if we don't provide that program, then they're not bringing anything to the table.

The interviewee's comments suggest that the state child welfare agency had chosen one model of evidence-based parenting education that the agency required CBOs to use to qualify for contract fees. Accordingly, the CBOs arranged their staff to be trained in the EBP model.

The interviewees raised other problems that appear systematic or engrained in the structure of the child welfare system. First, due to large caseloads and inadequate resources, neither the CBO nor the state agency conduct formal assessments of the parents and the children to determine the specific and appropriate intervention. Thus, parents and children are likely to be mismatched to the interventions, undermining the effectiveness of treatment. The state, through the different channels of official referrals to parenting classes, including the courts, the child welfare services agency, and the juvenile justice agency, expects parents or guardians (and sometimes the children) to comply with orders to complete the classes. Yet, from the interviews, it appears that authorities refer more persons than the CBOs have a capacity to serve effectively. Consequently, facilitators crowd the parenting class and support groups even though the practitioners said that many parents have complex needs that require individualized care or different skills-based curriculums.

Second, there are immediate family or sustenance issues that families have to take care of their immediate needs before they can address parenting skills. The CBOs are embedded in a regional market or network of social services. The practitioners stressed the importance of meeting each parents' crisis needs to be able to engage them effectively in parenting education. Yet, many communities in remote and rural areas are resource-poor. It may be that evidence-based parenting education and parenting support groups can be delivered with fidelity only with logistical support for such services as transportation, child care, food, employment assistance, and health

care. Adaptation appears to occur where there is no or inadequate services parents to services to address other needs (e.g. mental health). As noted by a CBO director,

> Families have intense, multiple needs but in this area we are able to refer to other services; [however] local facilitators must have linkages to other providers and to mutual support groups…If the facilitator can navigate parent to other resources, it is easier to stick to the model.

Our interviews with practitioners suggest that the decision to implement a specific model-based parenting intervention must weigh in on the context of other services that may be needed to ensure that parents can participate fully in the program and facilitators may maintain boundaries for appropriate delivery.

Third, the court or state agencies sometimes determine treatment dosage for mandated clients. The CBOs providing parenting education may have different visions and priorities for parents compared to the state child welfare policy. This makes it difficult for CBOs to maintain fidelity to dosage requirements even when they have capacity to do so, as one provider noted:

> You make realistic plans and then you have the family court judges who order all this and they're not even understanding what we do, how we do it or anything. And even though ours are eight weeks, they'll say, 'Oh you have to go to six weeks.' And then you have somebody arguing with you, 'The judge says I only have to go to six weeks. But that's all I have to do and I get my kids back.'

Providers feel that they are focused on longer-term approach to achieving changes in parental behavior and attitudes while the courts or state policy seems to be guided by disposing of cases in a short-time without consideration of what is the adequate time is needed for parents to accomplish durable change.

Fourth, the practitioners claimed that the state child welfare agency has limited capacity to monitor or evaluate the implementation of the programs for which they pay. Interviewees complained that the requirements of reporting on outputs (i.e., numbers served and amount of activities) for funders can be distracting when the data are not applied to measuring outcomes or informing the quality of program delivery. A discussion in our focus group illustrates the practitioners' concerns:

> Interviewee A: We get so tuned on making this number.
> Interviewee B: How many did you serve? Regardless of what I served or – how many did you serve? Did they set any goals? Not what the goals were. Did you accomplish this? That's all they want to know, and then send that number in. Okay, you've met that. We met that grant.

> Interviewee A: But we're not McDonald's because this family might need you all day (Multiple interviewees: Yes.) because we have to advocate at the child welfare agency office, all this.

More clarity is needed in some instances on what are funders or government agencies' expected outcomes and also instruments/measures for evaluation. Some providers are concerned that evaluation data requested by external sources, funders does not focus on actual behavioral and attitudinal change and also struggle with finding valid measures that capture these outcomes and in obtaining information that would answer whether this impacts post program incidents of actual or investigation for child maltreatment

Based on these observations, research on EBP implementation and adaptation needs to analyze the structure of services in which the program is embedded. Fidelity to the EBP model may be more likely or easier if the CBO has resources or is located among appropriate resources to deliver the model as intended and meet parents' complex needs without adjusting the program model inappropriately. Further, implementation of evidence-based parenting programs needs to be supported by the agencies that fund CBOs or pay for mandated participants.

Timing (Proactive vs. Reactive). The interviewees described making some program changes prior to delivery and most changes during the course of the program. Proactive adaptations were mainly associated with parent support groups where CBOs added activities to help encourage participation and build trust, such as "praise reports" and preparing a positive setting (e.g., party or dinner). We noted another instance of change that was proactive, though this seemed less an adaptation and more an informed decision about selecting an EBP. One agency said they refused to adopt the EBP that the state child welfare service agency was funding for parenting education because the CBO believed they could not deliver it with fidelity and they believed the program was not the appropriate match to their clients. The interviewee declared:

> I didn't go after the money for [a specific EBP curriculum] because it doesn't fit. I didn't believe in [taking] three hours for my families. I could see it in an after school setting, or a Sunday. But looking at my agency, yeah, I could have gotten the money. But it didn't fit well. And I also have to believe in [that model], because three hours is a heck of a long time to have families engaged.

Despite the one CBO's concern for program fit and fidelity, most of the adaptations that were discussed appeared to be reactive. Some of the changes the facilitators described making were to actively to respond to the immediate needs of their clients. The CBO

interviewees expressed the need to "meet parents where they are," thereby letting group dynamics dictate content. One interviewee said:

> When you're talking about catering to individuals, you have to meet them right where they are. Some of that structure or that paperwork, or that curriculum that you have planned for that particular session or class…you have to go with the flow. They may come in there with a different idea of – 'I need to talk about this, I have an issue.' And you need to let them be to speak and have that freedom to be able to do that…And they're there to say or to let loose whatever they need to work on. So that curriculum may go out the window for that day. It's about focusing on what they need at that moment.

It appeared that neither were the facilitators required to maintain fidelity to program models nor concerned about doing so out of trying to meet their clients' needs. Consequently, it is hard to tell if divergence from program design was inadvert or intentional.

Valence (Positive, Negative, Neutral)
Following Moore et al.'s (2013) typology, valence refers to how adaptation is aligned with the program goals and theory or logic model, which could be positive, neutral or negative. The interviewees expressed no clear statement of valence about the changes described above. It seemed that the prevailing perspective of the CBO interviewees was that the changes were positive; done for the benefit of families. As we discussed in previous sections, much of the adaptation these CBOs discussed was adding mutual support to curriculum-based programs, as well as changing the content *ad hoc* to accommodate the urgent needs that arise in the moment. These adaptations are, according to the practitioners, necessary to engage highly resistant parents and caregivers with complex needs. Additionally, these adaptations appear to be an attempt to fit the program material to the cultural and social backgrounds of the client populations in largely rural, ethnic minority, and economically disadvantaged regions.

Yet, when comparing the description of the adaptations to the EBP model designs, we see the possibility for negative valence. The interviewees of all three CBOs expressed that their organizations prioritize delivering services relevant to parents, but within the limits of their capacity and resources they take on all parents referred to them regardless of appropriate fit to the class. Evidence-based parenting programs usually have specific criteria for the intended characteristics (in terms of risk and need) of participants. Most evaluations of evidence-based curriculums assume appropriate risk and need characteristics of participants that must be determined by screening or assessment at referral or intake. Expanding the range of participants could generally be

seen as straying from the treatment model and possibly eroding the effectiveness of the program.

Intended outcomes may also be lost when facilitators allow the group dynamics or individual participant needs to direct the group's content rather than sticking to the content that has been shown to be effective for the intended group; but the facilitators are not serving the intended group. The limited organizational capacity creates a dilemma for the CBOs where they feel compelled to take in clients unselectively to try to meet the need rather than exclude certain people in order to maximally serve a few with services that fit their needs. The result could be seen as a negative valence—a drift away from the program design of evidence-based programs—that would have a negative impact on outcomes. The interviewees described how their parenting classes included parents who were court-ordered (most frequently) and voluntary participants seeking help in exasperation. Further, interviewees commented that their parenting class and support group clients often included individuals with serious mental health problems or substance abuse problems, or whose children had these issues. The parenting education classes and support groups described the practitioners described were not the appropriate interventions for individuals with higher risk to harming their children and greater needs for additional treatment.

Autonomy

We coded adaptation reasons under the Autonomy dimension where the adaptations and their reasons appeared to relate to the degree to which the organization can freely make changes to the program consistent with the program design or, by contrast, is constrained by external influences. We identified a couple themes from our analysis.

We have highlighted the struggle of the CBO to meet all the needs of their clients within the locus of the parenting education or support group which they facilitated. As discussed above, practitioners described their clients as having multiple problems that needed to be addressed in order for those clients to successfully improve their relationship with their children. Further, CBOs expressed that their agency is the coordinating case manager and primary provider for all the services to the client. CBOs serving populations in the thoroughly rural areas of the state recognized that there are few, if any, alternative providers to which the CBOs might direct clients. Yet, a major assumption for the effective delivery of evidence-based programs is that there are discrete services for clients provided through service plan, of which the EBP intervention is a separate intervention component. It seems from our data that in the real world, CBOs that are isolated from robust social service networks attempt to be everything to everyone, which results in variation in the delivery of discrete evidence-based programs.

The structure of a CBO's funding enables the organization to provide services with flexibility or severe constraint. The latter was the case among the CBOs we

interviewed. Sometimes the EBP is adapted out of necessity to fulfill obligations to provide services dictated by the funder. For example, one CBO described implementing a program that was intended to include a training group for children, along with parents, but the CBO could not provide the child group given limited resources. Similarly, two of the CBOs described having group sizes larger than what the program model would advise in order to accommodate the disproportional demand to group facilitator ratio. Such reactive adaptations were related to insufficient remuneration for facilitators. But other situations involved inadequate or absent oversight or guidance from the funding agency to ensure implementation with fidelity or to validate appropriateness of adaptations. The CBOs said their staff or contracted facilitators had been to the official trainings for facilitating the state's preferred EBPs. Yet, the interviewees also were critical that they were neither funded for quality assurance efforts nor had state officials or independent evaluators assessed the program delivery to verify adherence to program design.

State authorities, as funders of contracted CBO services, expect high client participation, yet they appear to provide insufficient information to clearly articulate expectations for program delivery. CBO interviewees indicated that it was unclear why the state preferred a certain model that was selected for parents with children involved in protective services. An iterative process is needed that allows for state and private funders to interact with CBO providers to assess EBP selection and implementation and guide CBOs to assure delivery of the EBPs with fidelity or appropriate adaptations.

Yet, without the specific guidance or monitoring from the state to ensure program fidelity, the CBOs appear to have autonomy to adapt for better or worse. Given the context of limited resources to other social services, the CBOs serve people from different cultures and socio-economic backgrounds; the facilitators described adaptations aimed to "meet parents where they are." Given the organization's concern about the long term self-reliance of families, their perspective suggests that, as structured, they cannot treat their clients' needs separately in compartmentalized services, as the CBOs perceive the delivery models of many evidence based programs.

Implications for evaluating EBPs

Our analysis revealed several considerations for designing studies of parenting EBPs set in the real world, involving CBOs that serve families at risk for child maltreatment. Broadly, these issues are around feasibility, practicality, and costs.

Feasibility. Random assignment design may be very challenging to achieve. Evaluation of programs involving comparison group design often face constraints at the level of organizations as well as the policy environment in which CBOs operate. Official requirements for mandated parenting education classes might limit a randomized trial research design. Parents may refuse to participate in a study that might involve a

waiting list if the parents are concerned with complying with official requirements to complete classes in order to be reunited with their children. Similarly, state officials may oppose delaying interventions. Such a situation may require control or comparison group conditions to include treatment as usual rather than no treatment at all.

A related problem will be distinguishing between participants who are mandated and voluntary. Each participant condition may present issues of bias related to self-motivation or resistance; inclusion of both voluntary and mandated families in the same intervention group may also impact research design and outcome assessment measures. A comparison of voluntary and mandated participants would be desirable, especially to examine the differences in outcomes given the different personal conditions. The value of combining parents with critical needs (e.g., mandated) and those whose needs are less urgent (e.g., voluntary) has not been examined; the mixture may prove beneficial for both groups. But, such a comparison may not be practical in rural locations or where multiple locations may not be possible.

Practicality. Implementation with fidelity to the program model is a crucial concern for evaluating the impact of evidence-based interventions. Yet, as we have shown, the program providers may not deliver the program with fidelity for a variety of reasons. Using a systems-contextual perspective, Beidas and Kendall (2010) describe the wide array of therapist, client, and organizational level influences on implementation of EBP's. Provider training experiences and beliefs, client needs, and organizational support all play a role in whether or not a program is delivered with fidelity. Our findings from interviews with parenting education providers adds further support. Because of these factors, additional resources may need to be provided in collaboration with researchers to ensure that the program can be delivered with fidelity.

Where parenting education program participants are mandated, many families may be experiencing crisis or instability, which impedes behavioral change, according to the CBO representatives we interviewed. Integrating case management to address the continuum of needs for parents in crisis would be a step to ensure parents' full participation and effective program delivery. Accordingly, researchers should consider the additional funding to provide for such support, including: transportation, employment assistance, housing, and meals or the like. Such services should be seen as investments equal to training and quality assurance monitoring intended to ensure program fidelity.

The different service mix that each participant receives should also be controlled. We saw from our analysis that mandated parents tend to enter the system during a crisis and may need an array of services. The relative stability of participants and the related services they are receiving may influence the program outcomes. The geographical or regional setting of programs may have an impact on evaluation—one CBO remarked that model programs seem to be evaluated in urban or suburban

settings, not rural, where client and implementation constraints may be different. Context of services might be related to outcome. Areas that have a strong network of social services may show better program treatment outcomes than in areas that have a weak or limited network of services.

The skill of the program instructor or group facilitator is another component related to quality program implementation. Several characteristics of an effective group facilitator or instructor were recommended in our interviews:

- Experience with and understanding of the clientele, including cultural sensitivity (e.g., by social class, ethnicity, gender, age, parenting status, and other complex needs);
- Skill in service delivery (*e.g.*, empathy, group facilitation, interpersonal communication, flexibility, critical thinking in novel situations);
- Interest in outcomes and research, understanding of assessment and program evaluation;
- Diligence in following protocol and willingness to record activities and/or be recorded, and willingness to champion research at the setting;
- Time management and assertiveness to ensure the curriculum components and group interaction are allowed sufficient time during meetings; and
- Trauma-informed counseling skills to respond to parents in crisis or dealing with residual trauma (e.g., from the experience of being separated from their children or from being abused by partner or children).

The facilitators' skills are important above and beyond the specific training and familiarity of the evidence-based parenting program that the facilitators have received. It is also likely that facilitator skills are influenced by their beliefs and attitudes. A number of studies have found that provider attitudes toward evidence-based practice can influence implementation and specific measures have been developed to assess these attitudes (e.g., EBPAS, Aarons, Cafri, Lugo, & Sawitzky, 2012). Provider self-efficacy has also been demonstrated to impact program implementation (Shapiro, Prinz, & Sanders, 2012). Thus, researchers must consider methods to assess these important provider-level characteristics which may mediate outcomes.

Researchers must partner with the providers to build a build an environment that encourages clients to participate in research. Researchers should consider the questionnaires and research instruments, which may be seen as burdensome by participants and the CBOs who must administer them. A parenting program instructor complained about the participant assessment questionnaire from a family-life skills curriculum, "The evaluation tool consists of 200 questions. What parent in a right mind, after sitting through 12 weeks of group, is gonna sit at the end of that and complete a 200 question survey?" To address this issue we gave sample questionnaires to the three CBOs to ask some of their clients and parent group facilitators to read through. The CBO coordinators provided summaries of the responses that allowed us to get a sense of how long it took to complete the questions and how comfortable participants

felt taking the surveys. As a result, we had to substitute two of our preferred measurement instruments with others that had a smaller battery of questions.

Fidelity means complying with the design of delivering group sessions of often two hours or more. The practitioners we interviewed said parents will have concerns about finding childcare in order to attend the parenting classes. The longer the sessions, the greater the difficulty on children, especially younger children under the age of six. Accordingly, it may be a good practice for researchers to plan to find resources to support childcare for providers participating in program evaluations. Similarly, the program design may benefit from including children in the sessions. Some of the CBO representatives we interviewed criticized the manner that the state required for delivering a specific evidence-based program as not allowing for the instructors/facilitators to assess interaction between parents and kids during the parenting classes. Such involvement would allow researchers or facilitators to gauge parents' interaction with their children.

Collaborative research with CBOs should entail providing the CBO with feedback from findings of the study. The representatives of CBOs said they would benefit from having more clearly stated guidance form the funding agency about expectations of program outcomes. Given the challenges we found with seeking guidance from state officials on intended outcomes and performance goals for the programs that CBOs deliver, researchers may want to work with CBOs to design a feedback questionnaire that the CBO can use for soliciting feedback from the state child welfare services agency.

Costs. Costs of delivering programs will vary if done with fidelity. Evaluating costs of programs cannot take the program as is, but as should be delivered, including appropriate adaptations. Adopting evidence-based interventions may mean adding quality assurance and evaluation to supplement the program delivery. Researchers seeking funding for evaluations of evidence based parenting education and support models should factor the fidelity oversight training and monitoring into the proposal budget. Similarly, CBOs should involve funders in planning discussions to request support for fidelity monitoring.

Conclusion

The present study sought to add to our understanding of what types of adaptation CBOs make to evidence-based parenting programs and the reasons for adaptations. We explored the kinds of adaptations that CBOs make when delivering parenting and family support program, focusing on fit, timing, valence, and autonomy.

Our study emerged from the process of studying two group interventions for parents in natural CBO settings: behavioral parenting education and mutual support. Our goal was to examine the separate and combined effects of two group interventions.

No large scale rigorous, randomized, controlled studies have examined the degree and nature of mutual support effects or the conditions leading to the largest benefits for families at risk. Exploratory evidence points to the potential of mutual support programs to prevent child maltreatment (Andrews, 2014). We needed a well-grounded understanding of the social ecology of CBOs serving at-risk families and the degree to which these CBOs adhere to the program models of the evidence-based programs they deliver.

The results described above share limitations in common with any community-based qualitative inquiry. Our sample is limited to providers who we know provide mutual support in addition to parenting education classes in the study locale. Other CBOs in the region provide parenting programs, and we do not claim to have a representative sample for purposes of generalizing findings. The purpose of our study was exploratory with an aim to understand adaptations by practitioners with experience in parent education or mutual support. We cannot comment on EBP adaptations by parenting education facilitators who are trained in other methods.

Recent research in this area includes attempts at systematic adaptation (e.g., Method for Program Adaptation through Community Engagement; Chen, Reid, Paker, & Pillemer, 2012). However, use of such systematic adaptation frameworks rarely occurs in community practice settings such as child welfare. For example, a number of evidence-based parenting programs incorporate direct observation of parent-child interactions or involve assignments requiring parents to implement strategies with their children either in session or between sessions or separate but concurrent sessions for parents and children (e.g., Nurturing Parents).

For families in the child welfare system, neither of these activities are feasible or practical if families have had their children removed from their care or custody. Thus, if use of an evidence-based interventions involving direct observation are mandated of community providers, adaptations are highly likely to occur.

Lack of resources is another reason that adaptations are made. Child welfare and family service agencies often experience high caseloads, frequent staff turnover, and client crises that place excessive demands on staff, thus reducing capacity to provide parenting education or support (Budd, 2005).

Overall, we demonstrated the application of a typology of adaptation developed by Moore et al. (2013). Our findings confirm the approach for investigating variations in implementing evidence-based parenting programs in natural settings. The model may be also useful to practitioners for monitoring program delivery.

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