Toolkit for Adapting Evidence-Based Interventions for Children and Families Impacted by Crisis and Conflict

Introduction

Adapting evidence-based mental health interventions for forcibly displaced populations is essential because most established treatments were developed and validated within Western contexts and may not account for differing understandings of mental health, distress, and healing. Forcibly displaced children, youth and families may also carry unique stressors that standard interventions may fail to adequately address, including trauma from conflict or displacement, acculturative stress, and language barriers. By adapting existing interventions with communities, providers can provide impactful services while also building trust in the care provided. This toolkit provides practical guidance for practitioners and community-based organizations navigating this adaptation process. It outlines key steps to support the selection, adaptation, and implementation of interventions to ensure they are responsive, accessible, and relevant to the communities they serve.

A range of frameworks exist to guide the adaptation of mental health interventions[1]. This toolkit draws primarily on the Cultural Treatment Adaptation Framework (CTAF)[2] and the Framework for Reporting Adaptations and Modifications – Enhanced (FRAME)[3]. CTAF is used to guide the adaptation process, while FRAME supports the systematic documentation of modifications during adaptation and implementation. Both frameworks are referenced throughout this toolkit.

The CTAF model provides a framework for understanding how to adapt interventions to align with the contexts, languages, and values of diverse populations. It ensures that interventions remain clinically effective while becoming more accessible and relatable to the target population. The framework operates by separating adaptations into two distinct levels: core and peripheral components. **Core components** are the essential parts of the intervention that make it work, while **peripheral components** are how the treatment is delivered.

1. Identify Intervention & Assess Fit

Before any adaptation work begins, practitioners must first determine whether a given intervention is the right fit for their context. This involves evaluating the strength of the intervention's evidence base, understanding the population it was originally designed to serve, and assessing whether it can realistically be delivered within your organization's capacity and resources. The steps below outline how to conduct this assessment systematically.

Assess Impact

The first step in the adaptation process is to identify an intervention with strong potential for impact — meaning there is credible evidence that it produces meaningful improvements in the mental health outcome areas you seek to target. Practitioners should look for interventions that have been evaluated through rigorous research, such as randomized controlled trials or well-documented implementation studies. For example, an intervention shown to reduce symptoms of depression may not be the right fit if your primary goal is to address trauma or build parenting skills.

Assess Feasibility

Even a highly effective intervention may not be appropriate if it cannot realistically be delivered within your organizational context. Feasibility encompasses a range of practical considerations, including the staffing and qualifications required to implement the intervention, the availability of training and certification pathways, associated costs, and the time and materials needed for delivery. Practitioners should also consider whether the intervention's format — such as its length, setting, and session structure — is compatible with the schedules, mobility, and circumstances of the population you serve. An honest feasibility assessment early in the process can prevent significant challenges down the line and help ensure that the intervention you select is one your organization can sustain over time.

Assess Fit for the Target Population

Even when an intervention has a strong evidence base and appears feasible to deliver, it is essential to evaluate whether it is a genuine fit for the specific population you serve. This requires developing a clear understanding of the intervention's background and history — including where it was developed, the theoretical framework it draws from, and the communities in which it has previously been implemented. Practitioners should examine prior studies and implementation reports with the following questions in mind:

- **Who was the intervention designed for?** Review the demographics of populations included in prior research, including presenting challenges such as symptoms, diagnoses, and comorbidities, as well as broader individual, family, and community characteristics such as cultural background, migration experience, and socioeconomic context. Consider how closely these characteristics align with those of the community you serve.
- **Where and how was it delivered?** Assess the settings in which the intervention has been implemented — for example, whether it was delivered in clinical or community-based environments, urban or rural areas, and through professionals or paraprofessionals. Understanding the implementation context helps clarify whether the intervention can be adapted to your own setting without compromising its effectiveness.

- **What does implementation require?** Examine the practical demands of the intervention, including the qualifications and training required of practitioners, certification processes, associated costs, and the materials and resources needed for delivery. This overlaps with feasibility but is viewed here through the lens of fit — asking not just whether you can deliver it, but whether the intervention's requirements are appropriate and sustainable for your organization and community.

Engage Developers

Once a suitable intervention is identified, practitioners should establish communication with the intervention developers. Collaborating with developers is essential to ensure a clear understanding of training requirements, implementation costs, permissions for using or modifying materials, and expectations for maintaining fidelity — that is, delivering the intervention in a way that preserves its core components and intended effects. This collaboration should be initiated early, as it may take time to establish relationships and align adaptation guidelines before work begins.

Engage Content Validators

Before the adaptation process starts, practitioners should also engage content validators. These are individuals who share the language, background, experiences of forced displacement, country or region of origin, and community ties of the target population. Their involvement is critical to ensuring that the intervention is not only linguistically accurate but also meaningful and acceptable to the people it is meant to serve.

Content validation often occurs with a group of two to six people ideally of mixed sex and different ages to capture the full range of language expression and experience. Content validators provide feedback on semantic meaning, common understanding, and level of acceptability in target communities. Be prepared to coordinate input across content validators, implementing staff, intervention developers, and assessment tool developers both before and after implementation, as this process requires ongoing communication and time. For more information about validation processes, CARRE has developed a Validation and Translation Review Toolkit that is available for use.

CARRE sought to implement a mental health intervention for newly arrived Afghan and Ukrainian families experiencing the compounding effects of forced displacement. A core priority was identifying an intervention that could be delivered by trained community members — enabling greater language and identity matching, integration into agencies that already held high levels of trust with these families, and delivery at a cost that community-based organizations could sustain over time. Research indicated that Parent-Child Care or PC-CARE, developed by the CAARE Center at UC Davis, was a strong fit for several reasons. The intervention had already been successfully implemented with Spanish-speaking families demonstrating its adaptability across contexts, though it had not yet been used with families affected by forced displacement specifically. PC-CARE can also be delivered by practitioners with mental health training but without formal degrees, licenses, or certifications, making it well suited for community-based delivery by trained paraprofessionals. Its brief format — seven sessions, deliverable in the family's home or in an office — offered the flexibility and shorter timeframe likely to support higher retention among forcibly displaced families.

2. Prepare for Adaptation Documentation

Before initiating adaptation, practitioners should establish a structured documentation process to track all modifications as this ensures that changes are made intentionally, can be clearly communicated to intervention developers and funders, and creates a record that supports replication by other practitioners working with similar communities.

CARRE used the FRAME documentation model as the basis for tracking adaptations, as it provides a codebook and tracking system for documenting the nature, purpose, and rationale for each modification. We then slightly modified the model using the CTAF so that it could capture specific dimensions relevant to forcibly displaced children and families within the U.S. The result is a combined CTAF/FRAME Excel Tracking Spreadsheet.

Structure of the Tracking System

The modified CTAF/FRAME Excel Tracking Spreadsheet organizes documentation into five color coded categories and includes a primary tab for recording adaptations and additional tabs with definitions and guidance. Practitioners should document the following:

- **Process tracking** – when the modification took place, whether if it was planned, who decided, and the modification outcome.
- **Modification type** – which intervention component was modified (content, context, training and evaluation or implementation and scale-up) and the level of delivery.
- **Peripheral modifications** – modifications to format, setting, personnel, population, or contextual (for more information on peripheral components, see section 4).
- **Core modifications** – how the change relates to core components and the nature of the modification (for more information on core components, see section 3).
- **Reasons for modifications** – the rationale and goal, including whether the modification was driven by sociopolitical, organizational/setting, provider or participant factors.

All adaptations should be recorded consistently to support transparency, replication, and evaluation.

3. Identify, Assess & Adapt Core Treatment Components

After identifying the intervention that you will adapt and implement and preparing your tracking sheet, the next step is to identify the “core treatment components”, or the specific techniques, activities, or therapeutic principles that drive the intervention’s effectiveness and must be preserved for it to work as intended [4].

Practitioners should follow these steps:

Identify Core Components

- Engage with intervention developers to identify core treatment components. If the developers have an existing log frame or theory of change, these can be helpful in this process.
- Practitioner manuals, training materials, or published evidence may also be helpful in determining which components are essential to achieving the intervention's intended outcomes.
- Identify key terms and concepts related to the core components. These will need to be translated and validated for appropriate semantic meaning during the adaptation process.

Assess Fit

- Schedule time to collaborate with content validators to evaluate the relevance of core components for the target population assessing how each component may be received by participants.
    - Review should consider language, background, experiences of forced displacement, country or region of origin, and sex, family and community dynamics, as relevant.
    - This can also include intervention-specific topics such as the parent-child relationship, parenting and family norms, and perspectives regarding mental health, healing from adversity and trauma and coping.
- Determine whether each component should be maintained, adapted, or supplemented.
- Identify which intervention components need to be prioritized for translation. For example, many manualized interventions are hundreds of pages long and translation of the entire package is often time and cost prohibitive. It is often helpful to prioritize translation of client-facing materials and key concepts and terms used in the intervention.
- If the intervention requires substantial changes, consider selecting an alternative intervention as the changes may compromise the intervention's evidence base and effectiveness.

Document Adaptation Decisions

For each core component, document the level of adaptation required and the rationale:

- **No Change:** The component is fully relevant and requires no modification.
- **Core Addition:** Additional components are needed to enhance or support the impact of existing core elements.
- **Core Modification:** One or more components require adjustment to improve relevance or appropriateness.
- **Complete Change:** The intervention is not a suitable fit for the target population; an alternative intervention is recommended.

All decisions should be clearly recorded in the adaptation tracking system to ensure transparency, consistency, and alignment with implementation goals.

4. Identify, Assess & Adapt Peripheral Treatment Components

Peripheral treatment components increase how accessible, understandable, and acceptable an intervention is to a specific community. This is often the area in which the most adaptation occurs to facilitate a greater resonance and acceptance of the intervention[5].

Identify and Adapt Peripheral Components

In collaboration with validators and key stakeholders, practitioners should adapt peripheral aspects of the intervention:

- **Provider–client relationship:** Determine whether practitioners should have an existing relationship with clients (e.g., caseworker, educator) or operate in a distinct therapeutic role. It can be helpful to incorporate community views on the role of practitioners. For example, when delivering an intervention about navigating challenging child behaviors with Afghan families, participants preferred to call the provider a "teacher" rather than a counselor or therapist.
- **Session structure:** Review pacing, timing, and session duration. Adjust as needed to support comprehension and participation. For example, if interpretation is used, you will need to have longer sessions or increase the number of sessions to have enough time to cover all of the content.
- **Intervention sequencing:** Assess whether the order of modules supports engagement, while maintaining caution to avoid altering core components.
- **Population composition:** Evaluate whether the intervention is appropriate based on client stability, time since arrival, and relevant linguistic, spiritual, or contextual factors.
- **Delivery setting:** Determine whether in-person, virtual, or hybrid delivery is feasible and appropriate. Assess barriers such as transportation or digital literacy.

Adapt Contextual Components

Practitioners should also adjust contextual elements to improve relevance:

- Replace or modify examples and activities to reflect the shared characteristics of the target population.
- Simplify technical language to improve comprehension.
- Identify and modify language that could be stigmatizing in target population.
- Identify and replace idioms or metaphors to support accurate translation (e.g., "trauma trigger" replaced with "trauma reminder").
- Throughout the intervention, incorporate prompts that invite participants to reflect and share examples, resources and practices from their family and community.

One of CARRE's partnerships included working with the Institute for Adolescent Trauma Treatment and Training at Adelphi University on Structured Psychotherapy for Adolescents Responding to Chronic Stress, or SPARCS. SPARCS is a 16-session support group for adolescents exposed to chronic interpersonal trauma. One of the core components of this intervention is learning and practicing effective communication skills, utilizing a variety of examples, many of which include short stories about dating. Due to diverse religious and familial expectations surrounding adolescents dating, CARRE worked with the developers to create alternative short stories that did not include dating. This peripheral addition allowed for greater acceptance in targeted communities.

One intervention included a common description of how a caregiver comforts a child with a minor injury like a bruise or scrape. Instead of using a set example, the adapted intervention prompted participant reflection asking them about a common comforting practice in their family or community. This prompt helped ensure the example was best aligned with the participants.

5. Training and Evaluation Components

Training and evaluation components ensure that practitioners are prepared to deliver the intervention effectively and that outcomes are measured appropriately. If the intervention has been adapted to be delivered in a new setting or by a different type of practitioner, then the training and evaluation components need to be reviewed to make sure they remain aligned. This includes:

Assess and Adapt Training Components

Practitioners should review training requirements and assess whether existing assumptions apply to the new context:

- Evaluate prior training and experience of implementing practitioners, including familiarity with mental health systems and intervention approaches.
- Assess whether practitioners have protocols in place for responding to crisis situations, including suicidality and child protection concerns.
- Identify areas where additional training, modification, or simplification is required to support implementation.

Assess and Adapt Evaluation Components

Practitioners should review how intervention outcomes are measured and how this is communicated to clients:

- Identify standardized tools[6] used for assessment, intake, or outcome measurement.

- Evaluate whether these tools are appropriate for the target population, considering language, context, and experiences.
- Assess the community's literacy level and familiarity and comfort with standardized instruments.
- Try, whenever possible, to design and translate feedback forms, if these do not exist to understand acceptability of the intervention.

One intervention, Attachment Vitamins, aimed to improve parent and caregiver confidence in their parenting approaches. To measure this, the developers of the intervention recommended using the Tool to Measure Parenting Self-Efficacy (TOPSE). This measure needed to be translated into various languages, including Dari, Congolese Swahili and Ukrainian. The CARRE team was able to contact the TOPSE developers to work with them to adapt certain items for more accurate translation. One such adaptation included changing one item that originally stated: "I am able to put myself in my child's shoes" to "I am able to put myself in my child's place" as the idiom of putting one in someone else's shoes is not universal. By working with content validators, the intervention developers, and the standardized measure developer, the CARRE team was able to ensure that the intended change was still able to be measured using a validated tool that did not lose meaning across languages.

Ongoing monitoring during implementation helps practitioners identify what is working, catch problems early, and build a record that supports future replication. Practitioners should:

- **Track adaptations in real time** — record any changes made during delivery directly in the CTAF/FRAME Spreadsheet, including the reason for each change. Waiting until after implementation increases the risk of losing important details.
- **Use fidelity forms if available** — if the intervention includes a fidelity checklist, use it consistently across sessions to document whether the intervention is being delivered as intended and to flag any deviations.
- **Capture participant feedback** — note any feedback from participants during or after sessions, including what resonated, what felt confusing or misaligned, and any concerns raised. This helps assess acceptability and informs further refinement.

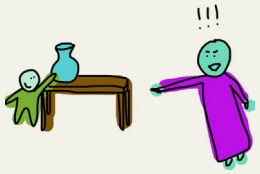
Together, these practices create a running record that strengthens both the current implementation and the ability of other practitioners to replicate or build on the work.

6. Conclusion and Lessons Learned

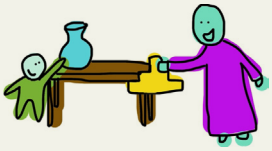
Through the adaptation process, the CARRE team identified key considerations for adapting mental health interventions for children and families affected by forced displacement. These lessons may serve as a starting point for practitioners undertaking similar work:

- Start collaborative conversations early – this process can take between six and twelve months when completed with all relevant stakeholders (intervention developers, validators, community advisors, standardized measure developers, etc.)
- Whenever possible, try to be as wide-reaching as possible in adapting interventions so the intervention can be piloted in multiple and various languages and community settings. This ensures the intervention is widely accessible and flexible to meet the needs of individuals and specific communities.
- Use clear, direct language and remove idioms to support understanding and translation.
- Ensure that concepts, examples, and phrases are written directly and simply.
- Establish clear consent, confidentiality and privacy communication practices. This should include where client information and data is going, who will see their data, and the level of anonymity of any information or data that might be shared.
- Ensure psychoeducational content includes relevant examples related to displacement, integration, and adjustment.
- Provide alternative examples for potentially sensitive topics (i.e. adolescent dating, drug use, specific religious practices, etc.).
- Reduce reliance on written materials and incorporate visual content to improve accessibility for low- and pre-literate participants.

For interventions that relied heavily on handouts with written information, CARRE worked with the developers and an art therapist to create abstract yet accessible visuals that conveyed the meaning of the content.



Don't/Stop Statements



Do Statements

Choices

Allows child to feel like they have some control. Teaches child to make appropriate choices.

EXAMPLE
"I have two shirts for you to choose from."

Illustrations by Maggie Simon, MSW

- Prioritize delivery in participants' primary language whenever possible. If interpretation is required, extend session time or reduce content per session and extend number of sessions.
- **Considerations for translation:** Full translation of an intervention is not always necessary or feasible. Practitioners may prioritize translating key materials, including participant handouts, standardized measures, and core concepts. Factor additional time for translation and validation and establish partnerships to conduct these processes early on.
- Develop a shared glossary of key terms defined clearly in English and translated into target languages. This will support consistent and accurate implementation while allowing practitioners flexibility in delivery.

Adapting evidence-based mental health interventions is a critical step toward ensuring equitable access to effective care for all children, individuals and families while expanding reach. This toolkit is intended to support practitioners, communities, and developers in working collaboratively to address and mitigate the impacts of childhood trauma for those most in need.

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[4] (Chu & Leino, 2017)

[5] (Chu & Leino, 2017)

[6] NCTSN list of standardized measures appropriate for forcibly displaced communities