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Fostering Healthy Futures for Teens: Adaptation of an Evidence-Based Program

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Abstract

Objective—This article describes the process of adapting and implementing a complex, multicomponent intervention for a new population. Specifically, the article delineates the development and implementation of the Fostering Healthy Futures for Teens (FHF-T) program, which is an adaptation and extension of the Fostering Healthy Futures® (FHF) preventive intervention. FHF is a 9-month mentoring and skills group program for 9 to 11 year olds recently placed in foster care. Following the designation of FHF as an evidence-based intervention, there was increasing demand for the program. However, the narrow population for which FHF had demonstrated efficacy limited broader implementation of the existing intervention. FHF-T was designed to extend the reach of the program by adapting the FHF intervention for adolescents in the early years of high school who have a history of out-of-home care. Specifically, this adaptation recognizes key developmental differences between preadolescent and adolescent populations.

Method—After designing a program model and adapting the program components, the FHF-T mentoring program was implemented with 42 youth over 2 program years.

Results—Of the teens who were offered the program, 75% chose to enroll, and 88% of those graduated 9 months later. Although the program evidenced high rates of uptake and participant satisfaction, some unexpected challenges were encountered that will need to be addressed in future iterations of the program.

Conclusions—Too often program adaptations are made without careful consideration of important contextual issues, and too infrequently, these adapted programs are studied. Our process of program adaptation with rigorous measurement of program implementation provides a useful model for other evidence-based programs seeking thoughtful adaptation.

Keywords

evidence-based intervention; implementation; adaptation; foster care; youth mentoring

The development of a novel, evidence-based psychosocial preventive intervention typically takes multiple randomized controlled trials (RCTs), millions of dollars, and many years. Over the past few decades, many interventions for youth have been rigorously tested and deemed *evidence-based interventions* (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). Characteristics of participants eligible for study enrollment in such trials are often well defined and the population from which the sample is recruited is usually restricted to reduce the impact of confounding factors when examining outcomes (Westen, Novotny, & Thompson-Brenner, 2004). These rigorous designs typically struggle with tension between sample size, inclusion and exclusion criteria, and generalizability of findings (Godwin et al., 2003). This ongoing tension makes it difficult for providers to know which interventions can be used in real-world settings with the culturally heterogeneous youth with whom they work, many of whom have severe, comorbid mental health concerns (Weisz et al., 2013). Regardless of the caution taken by developers of evidence-based programs (EBPs) to not overstate the reach and benefits of their programs, there is often pressure to have such programs implemented for a wider array of individuals who might benefit from the program (Mason, Fleming, Thompson, Haggerty, & Snyder, 2013). A topic of great interest to providers is whether adaptations can be made to existing EBPs and remain efficacious (Goldman et al., 2001). Although research supports the idea that flexibly implemented EBPs lead to equivalent if not superior outcomes than rigidly implemented programs (e.g., Chu & Kendall, 2009), more research is needed to determine whether substantial adaptations—such as using EBPs with populations not included in the efficacy trials—can be successful (Substance Abuse and Mental Health Services Administration, 2012).

Current Study

The goal of this paper is to discuss an adaptation of an EBP, namely Fostering Healthy Futures (FHF), for a new population and to report on program uptake and acceptability data following these adaptations in a pilot trial. FHF is an EBP in the fields of child welfare and mental health that consists of 9 months of mentoring and skills groups for preadolescent

children who have been placed in foster care due to maltreatment. Mentoring is provided by graduate students in social work and related fields. We have tested the FHF program in a rigorous RCT that demonstrated positive effects on mental health and associated outcomes (Taussig & Culhane, 2010; Taussig, Culhane, Garrido, & Knudtson, 2012). FHF was recently named a research- and evidence-based program by the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org), the Washington State Institute for Public Policy (2013), and the Administration for Children, Youth and Families (Samuels, 2012). FHF was designed for children between the ages of 9 and 11 years who were maltreated and placed in foster care within the prior year. As soon as the program was given a “gold stamp” by agencies that review such programs, we began receiving inquiries about program adoption and adaption, including whether agencies could use non-graduate students as mentors and whether they could use the intervention with new populations that had not been involved in the efficacy testing. For example, we were asked whether the FHF program could be implemented with older or younger children, children who had lengthier histories in foster care, children who were maltreated but never placed in foster care, and children who were truant. We had watched other EBPs demonstrate diminished efficacy when similar modifications were made, such as when the Nurse Family Partnership was tested with paraprofessionals (Olds et al., 2002) or when another home visiting program was tested with maltreating families (MacMillan et al., 2005); therefore, we were concerned about achieving attenuated or iatrogenic effects in such adaptations to FHF. However, after reviewing efficacious programs for the foster care population (Taussig & Raviv, 2014), we understood the demand for such interventions, as few available EBPs have demonstrated efficacy with this vulnerable population.

In addition to wanting to expand the reach of FHF, we were also concerned that our 9-month mentoring and skills-group program designed for delivery in preadolescence might not be potent enough for youth to navigate the bumpy road of adolescence experienced by many children involved with the child welfare system. We knew that many of the children with whom we worked in preadolescence would likely have achieved permanency by adolescence, but we also knew that permanence did not equate with well-being and that these young people would continue to be at risk for adverse outcomes (Taussig & Clyman, 2011; Taussig, Clyman, & Landsverk, 2001). To expand the reach of the program, as well as examine whether a program in adolescence could “boost” the effects of the preadolescent program, we developed and pilot tested the Fostering Healthy Futures for Teens program (FHF-T), an adaptation of the FHF program. In the adaptation described below, the FHF-T program was piloted both as a booster program for teens who had received the FHF program during preadolescence as well as implemented as a primary intervention for teens who had never participated in the FHF program. In designing the adaptation, we followed key steps that included developing a FHF-T program model, identifying mismatches between the original FHF program components and the new FHF-T model, and designing changes to the program to address these mismatches (Card, Solomon, & Cunningham, 2011).

Theoretical Framework

Both the FHF and FHF-T programs are theoretically grounded in the positive youth development (PYD) approach, which reframes longstanding perceptions of adolescents.

PYD approaches reject deficit models that focus on reducing undesirable behaviors, and instead focus on promotion of health in multiple domains (physical, intellectual, social, and emotional; Lerner, 2005). PYD programs are designed to foster the development of skills and competencies within multiple contexts (individual, family, school, and community) to help youth chart a future that will make them healthy, productive citizens (Lerner, 2005). The PYD approach is based on the assumption that an inverse relationship exists between indicators of PYD and problem behaviors. It is hypothesized that the promotion of positive development will naturally lead not only to reductions in problem behaviors but will also buffer high-risk youth from the impact of prior adverse experiences, such as exposure to violence (Bernat & Resnick, 2006; Lerner, 2005). A synthesis of the literature has suggested that PYD programs were more likely to be efficacious when based on well-specified models, manualized, and of sufficient duration to realize the intended positive outcomes (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Durlak, Weissberg, & Pachan, 2010).

In an effort to promote positive youth development, both FHF and FHF-T use mentoring and skills training to deliver many of the prevention strategies that are critical for increasing protective factors among youth. These prevention strategies include teaching youth skills to problem solve, resolve conflicts, resist negative peer pressure, identify the consequences of problem behavior, maintain self-control, communicate effectively, manage stress, and make good decisions. Finally, mentors support students in setting realistic short- and long-term goals, and help them identify and complete the steps necessary to achieve these goals. In all of these endeavors, FHF and FHF-T employ SAFE (i.e., sequenced, active, focused, and explicit) practices, an approach that has been found to enhance the treatment effects of positive youth development programs (Durlak et al., 2010). Despite the shared conceptual framework and intervention components of both FHF and FHF-T, we identified several adaptations that were necessary to make the program appropriate for teens.

Adaptation Process

To understand the context for the adaptation of the FHF program for teens, a brief description of the preadolescent FHF intervention is provided.

Fostering Healthy Futures (FHF) Program Design

FHF recruitment—Each summer between 2002 and 2011, all 9 to 11 year old children from participating counties in a large U.S. metropolitan area who met the following eligibility criteria were recruited: (a) placement in foster care by court order due to maltreatment within the preceding year; (b) current residence within a 35-minute drive to intervention sites; (c) placement with current care-giver for at least 3 weeks; and (d) adequate proficiency in English. In all, 91% of eligible children and their caregivers agreed to participate in the RCT. Following the baseline interview, and after stratifying on gender and county, eligible children were randomized manually, by cohort, in a single block to intervention and control groups. The sample was 50.7% female, with a mean age of 10.51 years ($SD = .87$).

FHF study procedures—The study protocol received IRB approval, and informed consent and assent were obtained from all participants. Participation was voluntary, and

could not be court ordered. All children who participated in the baseline interview were screened for cognitive, educational, and mental health problems, using standardized tests of intellectual ability and academic achievement, as well as normed caregiver- and child-report measures of psychological functioning. The findings and accompanying recommendations were summarized in reports provided to children's caseworkers, who were encouraged to use the reports to advocate for educational and mental health evaluations and services (Taussig & Culhane, 2010). Participants randomized to the intervention group received the screening assessment and participated in the FHF mentoring and skills groups program, whereas participants randomized to the control group received the screening assessment only.

FHF preventive intervention—The FHF program is a 30-week preventive intervention comprised of time-limited one-on-one mentoring and weekly manualized skills groups (FHF is described in detail in Taussig, Culhane, & Hettelman, 2007). Mentors are graduate students in social work or related disciplines who receive course credit for their work on the project. Mentors spend 2 to 4 hours per week with their mentees on individual mentoring visits. They also transport children to and from skills groups. Mentors receive weekly individual and group supervision and attend a weekly didactic seminar, all of which are designed to support mentors as they aim to create empowering relationships, ensure that children receive appropriate services, help children generalize skills learned in the group, engage children in extracurricular activities, and foster a positive future orientation. Table 2 lists the seminar topics for mentors. The FHF skills groups meet for 30 weeks for 1.5 hours per week during the academic year; each group includes eight children and two group facilitators (i.e., licensed clinicians and graduate student trainees). The FHF skills groups follow a manualized curriculum that combines traditional cognitive-behavioral skills group activities with process-oriented material to address topics such as emotion recognition, anger management, healthy relationships, and future outlook. Children graduate from the program after 9 months, and both mentoring and skills groups end.

Program Adaptation: Fostering Healthy Futures for Teens (FHF-T)

The key similarities and differences between FHF and FHF-T are summarized in Table 1.

Key considerations in the design of FHF-T—In developing the original, preadolescent FHF program, we sought to intervene to prevent mental health and behavior problems in adolescence. We hypothesized that children would feel vulnerable following recent placement into foster care, and therefore, might be receptive to intervention activities. As such, the FHF program focused on children recently removed from their homes. Although in intervening with teens with a *history* of out-of-home care placement the same vulnerability is unlikely to be present, it was hypothesized that teens with a history of foster care might feel especially vulnerable and in need of support during the transition to high school. Such feelings and needs might arise from having changed schools and homes many times, not knowing other teens at the high school, having experienced academic failure, not having the skills to navigate the increased workload, or lacking organizational skills necessary to succeed in high school. Thus, the initial idea was to recruit incoming ninth graders who might demonstrate greater vulnerability and more potential for prevention of adverse outcomes. However, from an adaptation standpoint, we were interested in whether

the program might work for a broader group of youth, and therefore, the targeted enrollment group was expanded to include tenth graders.

A major difference between the FHF and FHF-T programs was the lack of a weekly skills group for the teen participants. Although we felt that teaching the teens skills should be a core component of our program, we wanted to be sure that our approach was developmentally sensitive. During the process of adapting and extending FHF, we decided against having weekly skills groups for teens in the FHF-T program for the following reasons: (a) concerns about deviancy training (i.e., when youth spend time in groups and their interactions reinforce rule breaking, leading to more problem behaviors; Dishion, McCord, & Poulin, 1999) being more problematic for older youth; (b) concerns that teens would not enroll in the program if there was a mandatory group component; and (c) concerns about scheduling the groups at a time that would work for teens on a regular basis because many had competing demands. Instead of implementing a regular skills group, we chose to train mentors to deliver skills training during their weekly mentoring sessions. We hypothesized that this approach would provide a unique opportunity to individualize the teaching of specific, relevant skills that would build on each teen's strengths while addressing their challenges. Although individualized mentoring could address engagement, logistical, and deviancy training concerns, we also recognized the teens' developmental needs for relational and collective connections through group opportunities (Watkins, 2005). For this reason, well-supervised small group workshops were offered sporadically throughout the program year.

Additional developmental considerations also guided the structure of the program. From a developmental competency perspective (Kellam & Rebok, 1992; Masten, Burt, & Coatsworth, 2006), we wanted teens to take more ownership over their involvement in the program than what was asked of the preadolescents in FHF. This approach was reflected in differences between FHF and FHF-T, ranging from assessments and goal setting to communication strategies and program focus. In the preteen FHF program, we conducted assessments of children's functioning and summarized our findings in a report given to the child's caseworker. As described below, teens in FHF-T completed self-assessments of their functioning and used the information to set personal goals. Visioning and goal setting were explicit components of FHF-T program, which was not true of the FHF program. Goal setting for teens, even those at very high risk, has been shown to increase positive feelings about future plans (Galotti, Kozberg, & Gustafson, 2009). Another difference between the FHF and FHF-T programs was the method of communication between mentors and mentees. In the FHF program, mentors worked with caregivers to arrange activities, and therefore mentors and mentees rarely had any direct communication between mentoring visits or skills groups. In the FHF-T program, not only did mentors usually schedule mentoring visits directly with teens, but most mentors also used texting to maintain contact between visits. Finally, although the focus in the FHF program was largely on social-emotional domains of functioning (cf., model in Taussig et al., 2007), the FHF-T program emphasized educational functioning in addition to social-emotional functioning because academic achievement in high school is a strong predictor of young adult functioning (Chen & Kaplan, 2003; Freudenberg & Ruglis, 2007).

Beyond developmental considerations, adaptation of FHF for this new population also required careful thinking about how to engage teens and families with histories of involvement in the child welfare system involvement, but who were no longer system involved. The majority of teens enrolled in FHF-T (88%) had closed child welfare cases. Those with closed cases were heterogeneous in their living situations. Some were living with adoptive parents, others had reunified with their biological parents, and still others were living with kin. Many of these teens, however, were not living in the permanent placement noted in their child welfare records; after their cases were closed, several teens had unofficially changed homes and caregivers, gone to live with friends, or been homeless. A primary challenge for the FHF-T program was figuring out an engagement strategy for such diverse teens and families, many of whom were incredibly wary about any involvement with a program connected to social services. We know of no other programs that target youth with a *history* of foster care placement who are *no longer involved* with child welfare. In our experience, these young people are often forgotten until they come to the attention of school officials for chronic truancy, to the hospital for a psychiatric emergency, or to court for a delinquent offense.

FHF-T conceptual model—Based on the theoretical, developmental, structural, and pragmatic issues discussed above, we developed the Fostering Healthy Futures for Teens (FHF-T) conceptual model to guide our intervention. As Figure 1 shows, we hypothesized that the teen program would demonstrate proximal outcomes in five key domains, for which we developed the acronym *REACH*: relationships, education, activity involvement, career development, and health. These domains are identified in the positive youth development literature as being salient to achieve adaptive and healthy functioning during and after adolescence (Catalano et al, 2002; Eccles & Grootman, 2002). We believed these proximal outcomes would lead to a greater number of competencies and fewer adverse outcomes as teens continued through high school and into young adulthood. In addition, we hypothesized that several baseline factors would moderate the impact of the interventions on outcomes. Although the model was developed prior to pilot testing, it was refined based on input from program staff, both during and after the pilot phase, especially in regards to the moderating variables.

FHF-T Program Design and Implementation

In-home family visits—Similar to the FHF program, the FHF-T program included in-home visits with teen participants and their caregivers to introduce the program. Conducting in-home visits enabled the supervisor to get a sense of each teen's living situation and family dynamics, which enabled better supervision of the mentor. Family visits lasted approximately one hour, during which the supervisor explained the program structure and expectations in depth. The supervisor described the self-assessments and goal setting process as well as the time-limited nature of the program. To help with the matching process, supervisors also asked teens about their current interests, activities, and schedule. The supervisor reviewed policies regarding contact with mentors outside of visits, transportation during visits, use of money for activities, and confidentiality. FHF-T family visits differed from FHF family visits in that the visits with teens and caregivers included explicit discussion about teenage risk behaviors. Specifically, supervisors told families that

if teens spoke with mentors about drug use, sexual behaviors, or illegal activities, mentors would encourage them to talk with their caregivers about these issues but would not break confidentiality unless someone was in imminent danger or there was suspected child abuse. Most caregivers stated these parameters regarding confidentiality were acceptable because they wanted their teen to feel able to talk freely with their mentor. In rare cases when caregivers expressed concerns about this policy, we clarified that teens would be unlikely to share sensitive and important information with their mentor without a sense of privacy and trust, thereby precluding intervention. Following this explanation, all caregivers agreed to the confidentiality policy.

Mentor selection and orientation—Similar to the FHF program, the FHF-T program mentors were master's-level graduate students in social work or psychology. The mentors received internship credit for their work with the program. Prospective mentors were selected after interviewing with program staff. Successful applicants had experience with children or teens, were self-reflective and insightful, and demonstrated a positive attitude and a strong desire to learn about and commit to the needs of often-challenging youth and families. Mentors received 3 days of orientation, including training in how to engage high-risk teens and their families, maintain boundaries and confidentiality, facilitate self-assessments with teens, set goals with youth, practice cultural awareness, maintain basic safety skills, and access community resources.

Mentor/mentee matching considerations—Each mentor was matched with three adolescents for whom they were to provide one-on-one mentoring. As part of the matching process, program staff used their knowledge of the teens' and the mentors' interests, geographical location, gender, race/ethnicity, and other relevant information. Given the disproportionate number of female mentors, girls were always paired with a female mentor, although boys could be matched with either a male or a female mentor. These matching techniques replicated those that had been successfully used in the preadolescent FHF program.

Mentor supervision and training—All mentors received weekly individual and group supervision, each for an hour. Supervisors were licensed clinicians who helped mentors focus on goals and interventions as well as reflective practice. Supervisors emphasized teaching specific skills for intervening with teens and provided regular, systematic feedback. The model of supervision used was similar to that in the FHF program, which has been described elsewhere (see Petrila, Fireman, Schnoll-Fitzpatrick, Wertheimer Hodas, & Taussig, 2015).

As a complement to individual and group supervision, mentors attended a weekly one-hour didactic presentation on topics relevant to their work with mentees. FHF-T didactic and skills training topics were selected to be developmentally appropriate for adolescents. These topics, outlined in Tables 2 and 3, related to either (a) skills and knowledge to enable mentors to be more effective in their work with youth, or (b) training mentors how to teach adolescents to conduct self-assessments and skills to support their goal attainment.

Mentoring visits—Mentors were expected to conduct weekly 1- to 4-hour individualized mentoring visits with each teen over the 30 weeks of the program. The length of the visits depended on the activity scheduled and the needs of the adolescent. The first few visits typically consisted of activities designed to help the mentor–mentee matches get to know each other. Mentors then supported teens as they completed self-assessments in the five REACH domains. The self-assessment tools are listed in Table 3. The FHF-T assessments offered teen participants the opportunity to take stock of themselves in different domains, and to reflect on their strengths and areas for growth. One goal of this multi-week process was to establish the foundation for goal setting. Mentors guided youth in reflecting on their self-assessments and to use the information gleaned to identify goals they would work on with their mentors’ support. After this initial period, mentoring visits were focused on helping teens identify and execute action steps to move them toward their goals. The focus on goal setting and goal achievement occurred within the context of continuous relationship building as well as fostering teen engagement in age-appropriate social and recreational activities.

Mentors provided individualized educational support, including meeting with school counselors, supporting teens in advocating for appropriate in-school academic support or credit recovery, helping teens organize their backpacks, teaching good study habits and stress reduction techniques, and researching course-work options. Mentors also helped to facilitate teens’ attachment to their schools, and worked to connect the teens with positive youth groups and adult role models both within and outside the academic environment. In addition, mentors worked with teens during their out-of-school time to identify leadership and service opportunities that built on their strengths and interests. In all activities, mentors worked to find the “sparks” that motivated and empowered youth to set and achieve their goals. Research has demonstrated that it is difficult for children to achieve academically if they are not functioning well in other key domains (Duchesne, Vitaro, Larose, & Tremblay, 2008; Liew, 2012); therefore, FHF-T took a holistic, PYD approach to building skills and competencies in multiple domains.

Because technology is a mainstay of our culture and being computer literate is necessary for success in many classrooms and careers, mentors and teens used iPads during their mentoring visits to complete online assessments and find information (e.g., availability of community resources, check grades). Mentors also used texting to communicate with their mentees between visits. Growing evidence suggests hybrid programs, which combine face-to-face interventions with texting to enhance and reinforce key messages, are the most efficacious use of texting in the context of prevention program delivery (Bull, 2010; Heron & Smyth, 2010). Mentors’ texts were meant to support goal attainment, share important information, and provide support during a difficult time. In addition, mentors often used texting to schedule visits with teens.

Career shadows—As in the FHF program, FHF-T mentors were responsible for locating an adult working in their mentee’s field of interest and requesting a career shadow for their mentee (if possible, an adult who matched their mentee on race/ethnicity and gender). Career shadow individuals were asked to (a) spend approximately one hour with the teen and their mentor; (b) share important information about their profession; (c) discuss how

obstacles in their career path could be overcome; and (c) encourage appropriate goal-setting. The mentor accompanied the teen to meet with the individual so that information obtained could be discussed and reinforced during subsequent mentor visits. Prior to the meeting, mentors worked with teens to prepare questions, determine appropriate dress, and anticipate feelings they might have when meeting with an unknown adult.

Workshops—Workshops for youth (who attended with their mentors) were offered four to six times during the program. These workshops were designed to encourage youth interaction in a highly supervised environment as well as to enable teens to learn new knowledge and skills. Teens in the first pilot year completed surveys that guided the selection of topics, session length, and frequency of the workshops. The workshops, which were led by professionals in the field, included the following topics: How to Get a Job, Is College Right for Me?, How to Save and Manage Money, Improvisation to Build Self-Confidence, What is Grit and Do I Have It? Youth workshops consisted of approximately 90-minute presentations/interactive activities over dinner.

Contact with collateral adults—One of the main goals of the FHF and FHF-T programs was to expand and strengthen the adult supports in mentees' lives. Mentors were strongly encouraged to meet with caregivers, school personnel (especially academic counselors), and other important adults to assist their mentees in building a web of support both during and after the program. Through these contacts with collateral adults, mentors were able to model advocacy as well as provide opportunities for the teens to advocate for themselves. These experiences were intended to serve as the foundation for continued adult support post program. Different from FHF, teens in the FHF-T program were highly encouraged to be present and involved when mentors interacted with collateral adults so that they could learn and practice self-advocacy skills.

Mentor documentation—Mentors were required to document all their contacts with youth, caregivers, and other collateral adults in progress notes via a Web-based system. Mentors also reported on length of mentoring visits, content of visits, youth engagement during visits, texting between visits, and contact with collateral adults. Supervisors reviewed all documentation weekly and integrated feedback into their supervisory sessions with mentors.

Program ending—At the end of the 30-week period, when teens were coming to the completion of their academic year at school, mentors ended their work with the youth. In the preadolescent FHF program, the ending process was supported by a group graduation ceremony, which normalized program ending for the children. In the FHF-T program, there was no such group ending, which required more individualizing of the goodbye process on the part of the mentors to meet the needs of each teen. Mentors engaged in a variety of activities to help teens reflect on their accomplishments, plan for attaining their longer-term goals, and process feelings related to ending the relationship. The goal was to enable youth to experience a healthy goodbye through an intentional, tailored process, largely directed by the youth.

Program Uptake and Acceptability

Enrollment

Eligible participants for the FHF-T program were those teens entering ninth or tenth grade who had participated in the preadolescent FHF study (in either the intervention or the control group). Youth in the FHF study had been participating in several waves of interviews post-intervention, and the baseline FHF-T interview also served as a follow-up interview for the FHF study. This baseline FHF-T interview was conducted the summer before the intervention for both the 2012 and 2013 cohorts, following receipt of Institutional Review Board approval.

Over the 2 years of the pilot trial, there were 98 potentially eligible youth, and 84 (86%) participated in the baseline FHF-T interview. Of the 84 youth interviewed, two became ineligible due to moving too far ($n = 1$) or being on the run ($n = 1$). After the baseline interview, eligible teens were stratified on FHF status (i.e., intervention or control) and gender before being randomized into either the FHF-T intervention or control group. Of the 49 teens randomized to the FHF-T intervention condition, 13 (26.5%) declined to participate. Of the 36 teens who agreed to participate, 19 were FHF intervention participants and 17 were FHF controls. Because of the higher than anticipated number of program refusals, we added six teens to the FHF-T intervention who were not initially eligible but who had completed a baseline interview as part of our longitudinal follow-up: five teens who were too old (either 17 or 18 years and/or in the 11th grade) and one teen who was deemed too low functioning at the baseline assessment. Although ineligible participants' data will not be used in future intent-to-treat analyses, all 42 FHF-T intervention participants' data were used in reporting program uptake data below.

Participants

Of the 42 FHF-T intervention participants, 43% were girls. Participants' mean age was 15.3 years (range 14.0 to 16.7 years, $SD = .75$). At the time of the FHF-T baseline interview, more than a third of participants ($n = 18$; 42.8%) were entering ninth grade, half ($n = 21$; 50.0%) were entering 10th grade, and three (7.0%) were entering 11th grade. The racial ethnic distribution of the sample was 47.6% Caucasian, 33.3% Hispanic, 16.7% African American, 16.7% Native American, and 4.8% Native Hawaiian or Pacific Islander (nonexclusive categories). Based on maltreatment that was coded at the baseline FHF interview, 42.8% experienced physical neglect, 88.0% supervisory neglect, 21.4% physical abuse, and 9.5% sexual abuse, with 85.7% of youth experiencing more than one type of maltreatment. Of the 42 participants, 12 ($n = 5$) had open cases with child welfare at the time of the baseline interview; of these teens, three were living with a nonrelative foster family, one was living in kinship care, and one was living in a group home. Of the youth with closed child welfare cases ($n = 37$), 14 had reunified, 13 had been permanently been placed with kin, and 10 had been adopted. The 42 caregivers who completed the baseline assessment were 85.7% female; 54.8% were Caucasian, 21.4%, Hispanic, 7.1% African American, and 16.7% multiracial/ethnic.

Program Uptake

Of the 42 youth who began the program, 37 youth (88.1%) completed the 30-week program. Among the five (11.9%) teens who did not receive the full program, one teen actively withdrew, two teens passively withdrew by not responding to their mentors' attempts to schedule visits, one teen was on the run for the majority of the program and his mentor was unable to maintain contact with him, and one teen moved from the area. The engagement numbers reported below include these five teens in the total sample but not in the subsample data.

Of the 30 possible mentoring visits, the total sample averaged 74.4% of completed visits (range 16% to 100%; *median* = 76.7%; *SD* = 19.3%) and the subsample that received the full program averaged 79.6% (range 43%–100%; *median* = 79.3%; *SD* = 12.9%). Of the total sample, 88% received more than 50% of possible visits, almost two-thirds of teens (64.3%) received 75% or more visits, and one fifth (21.4%) received 90% or more possible visits. Of the subsample, 97.3% received more than 50% of possible visits, almost three-quarters of the sample (73.0%) received 75% or more visits, and one quarter (24.3%) received 90% or more possible visits. The length of mentoring visits averaged 2.1 hours (*SD* = .94). Mentors reported the percentage of time spent each visit on relationship building (*M* = 43.3%, *SD* = 30.5%), processing feelings (*M* = 19.1%, *SD* = 21.4%), conducting assessments or goal setting (*M* = 15.2%, *SD* = 21.8%), skill building (*M* = 12.1%, *SD* = 19.6%), and accessing resources (*M* = 10.0%, *SD* = 20.4%). The large standard deviations suggest that there was great variability in activities and focus of the mentoring visits, which is to be expected given the individualized nature of this intervention. Mentors' weekly reports also indicated that they spent an average of 8.86 (*SD* = 17.51) minutes using the iPad per visit. Mentors sent an average of 2.4 (*SD* = 2.5) texts per week and received an average of 1.8 (*SD* = 2.2) texts back from their mentees. More than half of the full sample of teens (57.1%) met with career shadows, and about two-thirds (64.3%) of the full sample attended one or more workshop. Almost half (45.9%) of the mentors had weekly contact with their mentees' caregivers, the majority met with their mentees' school counselors at least once (67.5%), and about half of mentors (46.0%) met with one or more of their mentees' teachers.

At the end of the program, mentors completed a survey summarizing their work with each teen. Table 3 shows the percentage of teens in the total sample who completed each self-assessment and the percentage of teens who worked on each skill mentors were trained to teach. As Table 3 shows, the majority of the mentees completed each assessment and received skill training in each area.

Program Satisfaction

Youth feedback—Quantitative and qualitative data were gathered from surveys administered to youth following program completion. Surveys were administered to 36 out of 42 (85.7%) youth. One participant declined to answer the questions and five participants could not be reached to conduct the follow-up interviews. Three-quarters (75.0%) of youth reported that they enjoyed setting goals *a lot* and the majority (77.7%) found goal setting *very helpful*. Three-quarters of the participants (75.0%) also rated the following statement as being *very true*: "Since beginning the program I find myself being more focused about my

future.” The majority (90.3%) of youth reported the frequency of mentor visits as *just right*, and the program length as *just right* (63.8%). All of those who did not endorse *just right* for program length felt the program should be longer. Teens rated their relationships with their mentors as extremely positive, with 100% of teens reporting that it was *often true* that their mentor “listened to me,” and “accepted me.” More than 85% of teens also reported it was *often true* that their mentor “helped me with my problems,” “cared about me” and “was proud of me.” However, teens provided a greater variety of responses on two items: “My mentor did not understand what I was going through” was rated by 58.3% as *not true*, 38.9% as *true*, and 2.8% as *often true*; and “I shared thoughts and feelings with my mentor” was rated by 2.8% as *not true*, 19.4% as *true*, and 77.8% as *often true*. Youth were asked to give an overall rating of the program using response options ranging from *poor* (=1) to *excellent* (=10). The average rating was 9.1 ($SD = 1.3$) and 88.8% of youth rated the program an 8 or higher. Finally, when teens were asked, “Knowing what you know now about this program, would you have signed up?” 100% reported *yes*.

Youths’ open-ended responses reflected the benefits of goal setting, as typified by comments such as, “It helped me figure out what I wanted in life instead of just waiting for things to come to me,” and “*I thought it was cool accomplishing my goals.*” Another teen shared that through goal setting, “I was able to get my life straight. I got enrolled in school, got connected with a program to find a place to live and filled out the job applications.” One of the teens who expressed dissatisfaction with program length stated, “It can be hard saying goodbye . . . I would like to have made the decision of when to say goodbye,” but this participant also stated, “I understand why the program ends the relationship and it wouldn’t stop me from doing it again.” Finally, youths’ open-ended responses to the question, “What did you enjoy most about the program?” reflected the support of their mentors. Youth reported that they liked “someone else cheering me on and being right there by my side,” and “having someone to turn to who had an unbiased opinion; my mentor was good at playing the devil’s advocate.”

Caregiver feedback—A majority (85%) of caregivers completed the post-intervention survey and reported that mentors engaged teens *well* (33.3%) to *very well* (66.7%). Similarly, caregivers evaluated their teen’s mentor as being *somewhat helpful* (35.1%) to *very helpful* (62.2%) to the teen. Several of the caregivers who rated the mentors as *helpful* commented that the mentor was unable to do more because of their teen’s “*own issues*” or because their child “*did not reciprocate.*” In the first year of the pilot, the frequency of mentor and caregiver communication was an identified concern, with only 69% of the caregivers reporting the mentors communicated well with them *very often*. Therefore, changes were made in the second year of the pilot to emphasize the importance of effective communication with the adults in the youths’ lives and to teach improved communication skills to the mentors. These changes were reflected in Year 2 caregivers’ ratings, with 85% of caregivers reporting that mentors communicated well with them *very often*. In addition to concerns about mentor communication, caregivers were also concerned about length of the program, with almost half (45.9%) of caregivers reporting the program was *too short*. In open-ended responses, caregivers reported wanting the program to “*taper off or allow ongoing communication*” or to “stretch the program longer to 12 months to get the youth

through the summer.” Despite this feedback, caregivers seemed satisfied overall with the program as evidenced by an average rating of 4.34 ($SD = .80$) on a 5-point scale ranging from *poor* (=1) to *excellent* (=5). Caregivers also gave highly positive feedback about the mentors, stating that the mentor was a “*role model to look up to*” and an “*outside resource and support*.” The mentor “let her know that she is worth it and that her input is relevant,” and the mentor “*cared about him genuinely*.”

Lessons Learned

This paper describes the adaptation of the evidence-based FHF program. Originally designed for, and tested with, preadolescent youth (9 to 11 years old) in foster care, the FHF program was adapted and piloted with high school freshmen and sophomores who had a history of out-of-home care placement. The new program for teens, FHF-T, was developed following key adaptation steps outlined by Card et al. (2011). Although the positive youth development framework remained unaltered, several developmentally sensitive changes were made in an attempt to ensure the program was appropriate and engaging for older youth.

Adolescents in foster care and those with a prior history of foster care are sorely in need of targeted services (Samuels, 2014). Although studies have found that two-thirds of teens involved in the child welfare system are in need of mental health services, only 25% of these youth receive appropriate services. For children with a history of child welfare involvement, the need is likely just as great, but these youth are even less likely to receive services (Burns et al., 2004). It was within this context that we implemented the FHF-T program. Although 91% of eligible participants enrolled in the FHF program, only three-quarters of those eligible enrolled in the FHF-T program. Even though this enrollment rate might be laudable for a high-risk adolescent population, we were surprised by the number of participants who declined the intervention. We did not conduct focus groups with stakeholders prior to piloting the FHF-T program, as we had done before launching the FHF program and as is commonly recommended for program adaptations (Chen, Reid, Parker, & Pillemer, 2013). Such feedback prior to recruiting and screening participants would likely have enabled us to identify better methods for engaging teens and their caregivers. Another challenge for enrollment was that, unlike traditional mentoring programs, none of the teens had signed up for this program; rather, they assented to be randomized at the time they were completing a follow-up interview as part of the FHF study. It is possible that those who declined to participate post randomization would not have benefited as much from the program as those who elected to participate. As we gear up for a full-scale trial, we will look carefully at the reasons youth declined the program and speak with stakeholders about ways to engage these youth. If we transition to a model of recruitment in which youth sign up for the program (as is commonplace in community-based mentoring programs), we are unlikely to reach those youth who do not have the social capital to sign up but who could benefit from the program. Therefore, we are committed to finding ways to enroll hard-to-reach and disadvantaged youth who otherwise might not have access to quality services.

Despite the enrollment rate being lower than anticipated, youth engagement among those enrolled was remarkably strong for such a high-risk group of young people. At program

initiation, we learned that many youth were experiencing or on the brink of homelessness, dropping out of school, or juvenile detention. Despite the challenging circumstances, FHF-T mentors were able to engage youth, teach them skills, and support them in setting and achieving their goals. We found higher than anticipated rates of mentoring visit attendance and implementation of core program components, and 88% of the teens graduated from the program. The pilot phase enabled us to gather important data on length of mentoring visits, workshop attendance, the use of iPads on visits, texting between visits, and amount of time mentors spent communicating with collateral adults. Stakeholder feedback was also quite positive, with the program receiving high overall ratings.

Although the adapted program was intended to meet the developmental needs of adolescents, empower these youth to set goals, and give them the tools to achieve their goals, we encountered several systems challenges that differed from those experienced in the FHF program. These challenges made it difficult for some mentors to deliver the program as envisioned. For example, in the course of our work with the teens, we observed that a number of the youth were already involved in the juvenile justice system when they started FHF-T. Some youth had outstanding warrants, others were on probation, and others were detained during the program. Because the youth were not referred to our program through the juvenile justice system, justice system staff was often unaware of the mentoring program and seemed less interested in collaboration. Mentors and program staff also encountered difficulties in getting child welfare and mental health systems engaged when youth were in need of their services. It appeared that this lack of system engagement stemmed from considerable “system shifting” in terms of who was responsible for supporting these youth in difficult times. In the pre-adolescent FHF program, all children had open child welfare cases at the time of enrollment and the younger children were receiving a higher level of systems coordination.

In terms of the school setting, mentors encountered great variability in school supports and school counselor engagement. Mentors attempted to meet with each mentee's school counselor to introduce the FHF-T program and discuss how best to support the student collaboratively. Although some school counselors worked with mentors and teens to access critical resources such as credit recovery and tutoring, other school counselors failed to respond to mentors' repeated efforts to connect. Finally, the family setting also posed challenges for program implementation. The preteen program included a policy that required an adult to be present during drop-off after mentoring visits. This requirement ensured regular contact between mentors and caregivers. In the FHF-T program, the mentoring visits were typically scheduled by the mentor and the youth, and caregivers were rarely present when mentors picked up or dropped off teens. Although these adapted procedures were developmentally appropriate, this approach provided fewer opportunities for the FHF-T mentors to share information with caregivers, and therefore, fewer opportunities to work collaboratively with caregivers. Although some caregivers reported wanting to give the youth “space” to be with the mentor on their own, the lack of involvement among other caregivers seemed to be the result of their being frustrated with parenting their teenager. Finally, mentors observed that several caregivers struggled with their own mental health and/or substance abuse issues, which affected their ability to work as part of a team with the mentor and the FHF-T program.

In addition to the family and service system challenges, characteristics of the teenagers also made intervention delivery more challenging than we had experienced in the FHF program. One of the goals of the mentoring program was to increase teens' extracurricular engagement both within and outside of school. For some teens, especially those who had not engaged in extracurricular activities before the FHF-T program, this type of encouragement to engage in high school activities came too late. These teens seemed to have developed a sense of themselves as non-participants and were uncomfortable taking the risk to get involved at that developmental stage.

Teens' mental health and substance-use challenges also hampered intervention efforts. Mentors struggled with how to best help teens move toward their goals when such issues dominated the teen's functioning and/or when a teen refused to consider getting outside support for the addiction or mental health problems that were greatly impairing their functioning. Several youth who refused outside support for these issues reported they had previously gone to therapy and that it was not helpful, made them feel worse, or was stigmatizing.

As described above, FHF-T mentors used texting as a primary method of communication between mentoring visits. Although generally perceived as a useful adjunct to the face-to-face mentoring visits, two unanticipated challenges arose. The first challenge became apparent when teens were on the run from home but maintained contact with their mentor. In several cases, the caregivers did not know the youth's whereabouts or well-being, which placed mentors in an uncomfortable position. After the first instance of this situation, the FHF-T program instituted a policy whereby mentors would not break confidentiality with the teens but would contact the family to serve as a resource and support while also encouraging the youth to reach out to their family and/or return home. A second challenge with texting was that mentors did not always know whether teens received the texts sent. As reported above, mentors sent a third more texts than were received from mentees, and mentors were sometimes worried that they were bothering teens when texting them repeatedly without a response. A case example supported our hypothesis that even though a mentee might not respond to texts, these messages might still have their intended impact. One mentor texted her mentee on a weekly basis without ever receiving a return text during the 9 months. After giving her mentee a goodbye letter on their last visit, she received her first and only text from him:

I really enjoyed your letter that you wrote to me. I was very touched and thankful to have someone that cared and had such a positive outlook on my future! Even if it was just talking about my week I always learned something different and learning how to deal with things differently. I am definitely upset that we won't be able to chat every week. But I will never forget the inspirational, fun-filled, and bright mentor I had in my crazy 9th grade year! One thing that I would never possibly forget would be your beautiful personality! Even though I was a mess all the time I always felt really good inside noticing that there was a text in my inbox reminding me to strive for something better in life . . . And never settling for less. I couldn't have asked for something better! Thank you for actually caring and making a change in my life.

Although this quote and other measures of program satisfaction and engagement suggest that the FHF-T program achieved some of the intended effects, only empirical research can demonstrate whether hypothesized proximal and distal effects were achieved. In the meantime, the pilot phase of this program enabled us to study many adapted program elements, providing the basis for the next phase of investigation.

Conclusion

Before the next study of FHF-T, our team will discuss the feedback received from stakeholders and the data collected during the pilot phase to determine what modifications to make in the next program iteration. Key questions include (a) What is the target population best suited for this intervention, and how do we successfully recruit participants who have not participated in our prior longitudinal studies? (b) How do we balance between activities being too prescriptive (e.g. teens must attend all workshops) versus activities being voluntary? (c) How do we address concerns about program ending after the academic year? (d) How do we plan for sustainability when no service system views these youth as “belonging” to them?

Too often, adaptations of effective programs are put in place without careful consideration of the resulting impact (Substance Abuse and Mental Health Services Administration, 2012). This article sought to outline a sensitive adaptation and extension of the FHF program to inform others of key adaptation processes that may be important to consider when expanding the population served. In particular, this study demonstrates the importance of clarifying which elements of the EBP need adaptation and which should be maintained, based on differences in developmental stage, cultural factors, and needs/strengths of the two populations. The article also highlights the importance of considering differences in participant motivation and collateral system involvement when adapting an existing EBP with the purpose of benefitting more youth. Although we cannot yet speak to that ultimate goal in the FHF-T program, this study of program acceptability and up-take yielded valuable data that will allow us to continue to refine a program with great promise for reaching youth heterogeneous on many characteristics (e.g., race/ethnicity, living situation, maltreatment history, cognitive and behavioral functioning). FHF-T was designed to meet teens where they are, and empower them to build on their diverse strengths to create their own healthy futures. We will continually strive to help all vulnerable young people reach that goal.

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Figure 1.
Conceptual Model

Table 1

FHF and FHF-T: Key Similarities and Differences

	Fostering Healthy Futures (FHF) Preadolescent Program	Fostering Healthy Futures for Teens (FHF-T) Program
Theoretical Framework	Positive youth development	
Target Ages/Grades	Preadolescent children, 9–11 years	9th and 10th graders, 14–16 years
Eligibility	Placed in out-of-home care during prior year; in care at intervention start	History of out-of-home care; cases could be open or closed at intervention start
Enrollment	In-home family visits with youth and caregivers	
Mentors	Graduate students in social work and related fields	
Matching Considerations	Interests, geography, demographic characteristics	
Mentor Supervision and Training	3-day orientation; weekly individual and group supervision; weekly seminar	
Key Components	1 : 1 mentoring, skills groups	1 : 1 mentoring, optional workshops
Assessments	Assessments conducted by licensed clinicians; reports given to children's caseworkers	Teens conducted self-assessments and reviewed the findings with support from their mentors
Major Intervention Foci	Social skills, behavioral/emotional regulation, future orientation	Social skills, educational engagement, future orientation
Mentoring Visit Content	Social activities aimed at strengthening social/emotional skills; career shadows	Social/emotional skill building, self-assessments, visioning and goal-setting in REACH domains; career shadows; workshops
Skills Training Format	Group and mentoring	Mentoring
Mentor/mentee contact between visits	Typically none	Texting, e-mail or phone calls
Program Dosage	30 weeks; 2–4 hours mentoring weekly; 1.5 hours skills groups weekly	30 weeks; 1–4 hours mentoring weekly; 2-hour workshops bimonthly
Mentor/Caregiver Contact	Weekly; mentoring visits scheduled with caregivers; interfaced with caregivers at pick-ups and drop-offs	Typically infrequent; mentors made plans with teens and rarely saw caregivers on visits
Mentor/Collateral Adult Contact	Mentors meet with teachers, caseworkers, school counselors and others to coordinate intervention strategies	
Documentation	Mentors and skills group leaders document interactions, behaviors and advocacy efforts	Mentors document interactions, behaviors, and advocacy efforts
Program Ending	Group-based graduation ceremony with all mentors and mentees	Mentors and mentees plan individualized goodbyes; meet with program staff to recount successes and future plans

Table 2**Seminar Topics for Mentors**

-
- Program documentation
 - Facilitating self-assessments with teens
 - Motivational interviewing
 - Using texting as an intervention to reinforce skills
 - Impact of trauma on adolescent functioning
 - Impact of early attachment on relationships
 - Suicide assessment
 - Advocating for student academic success
 - Child welfare policy and practice
 - Teen civic engagement
 - Intimate partner violence
 - Adolescent health and teen pregnancy
 - Talking with teens about media messages regarding body image
 - Substance use in adolescence
 - Facilitating a healthy goodbye with your mentee
-

Table 3Percentage of Youth Who Participated in Self-Assessments and Skills Trainings (N = 42)^a

Self-assessments	% of Mentees who Participated
Get to know you worksheets	85.7
Career interest online survey	69.0
Quality of life assessment	57.1
Educational/activity scavenger hunt	71.4
Genogram or personal timeline	76.2
Physical health discussion cards	76.2
Mental health assessment	47.6
Healthy relationship quizzes	61.9
Skills training	
Healthy coping Part I–Affect regulation/stress Management	78.6
Healthy coping Part II–Cognitive distortions/healthy self-talk	69.0
Teen dating violence prevention	45.2
Healthy communication and relationship skills	45.2
Refusal skills	66.7

Note.

^aThis sample includes five teens who did not receive the full program.