Foundations
What Works Centre for Children & Families

Last reviewed: February 2023

Intervention website: https://www.fosteringhealthyfutures.org/programs/preteen

GUIDEBOOK INTERVENTION INFORMATION SHEET

Fostering Healthy Futures for Preteens

Please note that in the 'Intervention Summary' table below 'child age', 'level of need', and 'race and ethnicities information is **as evaluated in studies**. Information in other fields describes the intervention as **offered/supported by the intervention provider**.

Intervention summary	
Description	Fostering Healthy Futures for Preteens (FHF-P) is a preventative intervention for pre-adolescent children placed in out-of-home care due to child maltreatment. The intervention is delivered by a team consisting of group supervisors, group co-leaders and mentors. Two group facilitators deliver 90-minute weekly sessions to groups of 8 to 10 children for 30 weeks throughout the academic year. Each group session includes one hour of group skills-building activities and a 30-minute dinner. Children also receive individual mentoring for 2 to 4 hours on a weekly basis.
Evidence rating	3
Cost rating	5
Child outcomes	• Preventing crime, violence and antisocial behaviour - Reduced antisocial behaviour. • Supporting children's mental health and wellbeing - Improved mental health. • Preventing child maltreatment. - Reduced care placements.
Child age (population characteristic)	9 to 11 years old

Intervention summary	
Level of need (population characteristic)	Targeted Selected
Race and ethnicities (population characteristic)	• Black • Hispanic • White.
Type (model characteristic)	• Group • Individual.
Setting (model characteristic)	• Home • Secondary school • Community centre.
Workforce (model characteristic)	• Group supervisor (typically a master's qualified psychologist or social worker) • Skills Group Co-Leader (typically a qualification in a helping profession) • Mentor (typically a graduate intern pursuing a qualification in psychology, medicine, nursing, social work, or counselling).
UK available?	No
UK tested?	No

Model description

Fostering Healthy Futures for Preteens (FHF-P) is a preventative intervention for pre-adolescent children placed in out-of-home care due to child maltreatment. Young people eligible for the intervention typically have a history of two or more adverse childhood experiences, including a substantiated experiences of abuse and neglect, homelessness, and a parental history of substance misuse, mental illness, or incarceration.

FHF-P is delivered by a team consisting of a group supervisor, skills group co-leader, and mentor. The group supervisor and group co-leader deliver 30 weekly sessions to groups of between 8 and 10 children, while each child received 2 to 4 hours a week of individual mentoring in parallel.

The skills group content follows a manualised curriculum that combines cognitive-behavioural strategies with activities designed to help children process experiences relating to their adverse childhood experiences. Topics covered include emotion recognition, problem-solving, anger

management, cultural identity, change and loss, and resisting deviant peer pressure. Multicultural stories and activities are also integrated throughout. Each session includes one hour of skills-building and a 30-minute dinner. The group sessions can be delivered in a variety of venues, including schools and community centres.

Over the same time period, mentors work individually with children to reinforce the concepts covered in the group sessions, as well as provide more tailored support for specific challenges. A key aim is to use each young person's strengths and interests to solve problems and identify opportunities for further growth in the school and community. The mentor and the young person also work together to develop goals for improvement and practise skills for achieving these goals. Recreational activities are used to facilitate a strong mentor–mentee relationship which is considered critical for the intervention's effectiveness. Mentoring often takes place in the child's home or convenient community venue.

Target population

Age of child	9 to 11 years old
Target population	Pre-adolescent children placed in court-ordered social care due to maltreatment.

Please note that the information in this section on target population is as **offered/supported by the intervention provider**.

Theory of change

Why		Who	How	What		
Science-based assumption	**Science-based assumption**	**Science-based assumption**	**Intervention**	**Short-term outcomes**	**Medium-term outcomes**	**Long-term outcomes**
Experiences of abuse and neglect and exposure to trauma substantially increase the risk of children having emotional and behavioural difficulties as they develop.	Social, cognitive, and behavioural skills can help young people manage the impact of a history of child maltreatment and reduce the risk of future behavioural and emotional difficulties.	Young people in out-of-home placement due to child maltreatment can benefit from skills aimed at building resilience and reducing the risk of emotional and behavioural problems.	Young people learn how to: • Manage difficult emotions • Make responsible choices • Identify personal strengths and interests • Problem-solve to overcome personal challenges.	• The young person develops positive relationships with others • The young person is better able to manage difficult emotions • The young person is better able to problem-solve and make responsible choices.	• The young person is at reduced risk of behavioural problems • The young person successfully attends school.	• The young persons is less likely to engage in antisocial or criminal activities • The young person is less likely to misuse substances • The young person is less likely to engage in risky or self-destructive behaviour.

Implementation requirements

Who is eligible?	Pre-adolescent children placed in court-ordered social care due to maltreatment.
How is it delivered?	FHF-P is delivered using skill groups and mentoring. Skill groups are delivered across 30 weeks for 1.5 hours per week during the academic year each by two group facilitators (clinicians and graduate student trainees) to eight to 10 children. Mentoring is delivered across 30 weeks on a one-to-one basis, lasting for two to four hours, between a graduate intern and each child.
What happens during the intervention?	Skills Groups. The groups follow a manualized curriculum that combines cognitive-behavioural strategies with activities designed to help children process experiences relating to ACEs. Topics covered include emotion recognition, problem solving, anger management, cultural identity, change and loss, and resisting deviant peer pressure. Mentors work individually with children to 1) create positive relationships, 2) advocate for needed services, 3) help children generalize and practice skills learned in group, 4) engage children in educational, social, cultural, and recreational activities, and 5) promote positive future outlooks.
Who can deliver it?	The intervention is delivered by three practitioners: • Group supervisor – typically a master's qualified psychologist, or social worker • Skills Group Co-Leader – typically a practitioner with qualifications in a relevant field such as psychology, medicine, nursing, social work, or counselling • Mentor – typically a practitioner with qualifications in a relevant field such as psychology, medicine, nursing, social work, or counselling.
What are the training requirements?	Practitioners receive eight to nine days of training and attend a yearly eight-hour booster training.
How are practitioners supervised?	Practitioners are supervised by two clinical supervisors as well as a skills supervisor.

Implementation requirements (cont.)

What are the systems for maintaining fidelity?	Intervention fidelity is maintained through the following processes: • Training manual • Other printed material • Other online material • Video or DVD training • Face-to-face training • Fidelity monitoring • External supervisor watches video of intervention implementation.
Is there a licensing requirement?	Yes
***Contact details**	Contact person: Heather Taussig Organisation: Fostering Healthy Futures Email address: heather.taussig@du.edu Website: https://www.fosteringhealthyfutures.org/programs/preteen *Please note that this information may not be up to date. In this case, please visit the listed intervention website for up to date contact details.

Evidence summary

Fostering Healthy Futures for Preteens (FHF-P) most rigorous evidence comes from a single RCT conducted in the United States consistent with Foundations' Level 3 evidence strength criteria.

This study identified statistically significant reductions in FHF-P participants' reports of problematic mental health symptoms immediately post-intervention compared to young people not receiving the intervention.

Ten years post-intervention, FHF-P young people were significantly less likely to report involvement in criminal behaviour in comparison to young people not receiving the intervention. These reports were corroborated by criminal records showing 15 to 30% fewer court charges for total and violent crimes for FHF-P youths at mid-adolescence in comparison to young people not receiving the intervention.

FHF-P can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

Search and review

	Number of studies
Identified in search	8
Studies reviewed	5
Meeting the L2 threshold	0
Meeting the L3 threshold	1
Contributing to the L4 threshold	0
Ineligible	3

Individual study summary: Study 1

Study 1	
Study design	RCT
Country	United States
Sample characteristics	426 children between 9 and 11 years old who had been placed in out-of-home care due to maltreatment
Race, ethnicities, and nationalities	• Hispanic 51.3% • White 50.6% • Black 26.6%.
Population risk factors	• 66% of mothers had substance use • 61% of mothers had criminal history • 43% of mothers had mental illness • 19% of mothers were maltreated as a child • 87% of children were exposed to at least one Adverse Childhood Experience (physical abuse, sexual abuse, removal from a single parent household, violence exposure, caregiver and school transitions) • 27% of children experienced physical abuse • 11% of children experienced sexual abuse • 63% of children experienced emotional abuse

Study 1	
	• 48% of children experienced physical neglect • 83% of children experienced supervisory neglect • 26% of children experienced educational neglect • 28% of children experienced moral-legal maltreatment. Children were being referred to social services on average 4.7 times. • 42% of children were in foster care • 54% of children were in kinship care • 5% of children were in congregate/residential care.
Timing	• Baseline • 6 to 10 months post-intervention (study 1b) • 1-year post-intervention (study 1c) • Long-term follow-up: when participants were between the ages of 18 and 22, around 10 years after the intervention (this includes three timepoints: six months, 1.5 to 2.5 years post-intervention, and 10-year follow-up) (study 1a)
Child outcomes	*Six–10 months post intervention* • Improved mental health functioning (child and teacher report) • Reduced posttraumatic stress (child report) • Reduced dissociation (child report). *One-year post-intervention* • Reduced new placement in a residential treatment centre. *Long-term follow-up: when participants were between the ages of 18 and 22, around 10 years after the intervention* • Reduced total delinquency (child report) • Reduced non-violent delinquency (child report) • Reduced total charges (Administrative measure) • Reduced violent charges (Administrative measure).
Other outcomes	None
Study Rating	3
Citations	**Study 1a:** Taussig, H. N., Dmitrieva, J., Garrido, E. F., Cooley, J. L. & Crites, E. (2021) Fostering Healthy Futures preventive intervention for children in foster care: Long-term delinquency outcomes from a randomized controlled trial. *Prevention Science*. 22 (8), 1120–1133. **Study 1b:** Taussig, H. N., Weiler, L. M., Garrido, E. F., Rhodes, T., Boat, A. & Fadell, M. (2019) A positive youth development approach to improving mental health outcomes for maltreated children in foster care: Replication

Study 1	
	and extension of an RCT of the Fostering Healthy Futures Program. *American Journal of Community Psychology*. 64 (3–4), 405–417. **Study 1c:** Taussig, H. N., Culhane, S. E., Garrido, E. & Knudtson, M. D. (2012) RCT of a mentoring and skills group program: Placement and permanency outcomes for foster youth. *Pediatrics*. 130 (1), e33–e39.

Brief summary

Population characteristics

This study was conducted in the United States with a sample of children aged 9 to 11 years old at baseline, half of whom were male. Children were eligible for the study if they had been placed in any type of out-of-home care (i.e. foster care, congregate care, kinship care) by court order due to maltreatment within the preceding year; had lived in their current placement setting for at least three weeks; resided within a 35-minute drive to the intervention group sites at the time of recruitment; did not have a developmental disability that would preclude them from participating in groups; and demonstrated adequate proficiency in English (caregivers, however, could be monolingual Spanish speaking). Participants were recruited in 10 cohorts over the course of 10 consecutive summers.

87% children were exposed to at least one Adverse Childhood Experience (physical abuse, sexual abuse, removal from a single parent household, violence exposure, caregiver and school transitions).

In terms of child welfare characteristics, 27% experienced physical abuse, 11% sexual abuse, 63.1% emotional abuse, 48.4% physical neglect, 83.3% supervisory neglect, 26.3% educational neglect and 28.2% moral-legal maltreatment. Children has been referred to social services on average 4.7 times. 42% was in foster care, 53.8% in kinship care and 5.2 in congregate care.

66% mothers had substance use; 61% had a criminal history; 43% had mental illness, and 19% were maltreated as a child.

Study design

This study is an RCT, and involved random assignment of 233 children to an FHF-P intervention group and 193 to an assessment-only control group.

In the first five cohorts, when multiple siblings were eligible in the pilot trial, one sibling was randomly selected to participate in the RCT. In the second five half cohorts, eligible siblings were paired for randomization, and both were included in the trial. Overall, 22 sibling pairs were included in the RCT.

Study 1c focused specifically on part of the study sample (156 children) who were recruited in the first five cohorts (79 in intervention group, 77 in control group). It analysed placement and

permanency for participants over an 18-month period, from 3 months after the intervention began to 1-year post-intervention.

Measurement

The study used the following measures:

- **Child report** measures included the Adolescent Risk Behaviour Survey (ARBS), Trauma Symptom Checklist for Children (TSCC), the internalising scales of the Child Behaviour Checklist, the Life Satisfaction Scale, and a report of use of mental health services (at 6 months post-intervention)
- **Teacher report** measures included the Teacher Report Form (at 10 months post-intervention)
- **Administrative data** included court records, interviews and social histories to measure:
- Number of placement changes
- Whether a child had experienced a new placement in a residential treatment center
- Whether a child had attained permanency by 1-year post-intervention

Study retention

Study participants were recruited in 10 cohorts over the course of 10 consecutive summers. The first five cohorts comprised the 'pilot trial' and the second five cohorts comprised the 'efficacy trial'.

At time 3, long-term follow-up (study 1a), 92% (391) of the sample were retained, representing 93% (217) of the intervention group and 90% (174) of the control group. For court records, retention was higher at 99.7%.

At time 2, 1.5 year follow-up (study 1b), 89% (380) of the sample were retained, representing 91% (213) of the intervention group and 89% (167) of the control group for mental health outcomes.

Study 1c included only the first 5 cohorts. 71% (110) participants were retained in the analytic sample, including 70% (56) in the intervention group and 71% (56) in the control group, with data collected on placement changes and permanency.

Results

Data-analytic plan

At post-intervention (Study 1b), linear regression models were used to analyse continuous outcome variables, and logistic regression for dichotomous outcomes.

At 1 year post-intervention (study 1c), generalised linear regression models with negative binomial error assumptions were used to analyse count outcome variables, and logistic linear models were used for dichotomous outcomes.

At long-term follow-up (study 1a), multilevel modelling was used to analyse changes in delinquency outcomes over age while accounting for the nested structure of the data, in an intent-to-treat approach. Maximum likelihood estimation was used for missing data in an intent-to-treat analysis.

Findings

The study observed consistent, statistically significant benefits favouring the FHF-P intervention group.

6-10 months post-intervention, the study observed that the intervention had a significant impact in improving children's mental health functioning and reducing posttraumatic stress and dissociation. Children in the FHF-P group also reported higher life satisfaction and less use of mental health services than control group children.

1-year post-intervention, the study observed that intervention youth were 71% less likely to be placed in residential treatment, after controlling for baseline functioning and preintervention placement history.

In the long-term follow-up, the intervention group self-reported 30–82% less total and non-violent delinquency than the control group. Court charges for total and violent delinquency were also 15–30% lower for the intervention group.

Study 1: Outcomes table

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Child outcomes					
Mental health functioning	Mental Health Index*	d = -0.25	Yes	346	6-10 months post-intervention
Posttraumatic stress	Trauma Symptom Checklist for Children (TSCC) – Posttraumatic Stress (child report)	d = -0.2	Yes	375	6 months post-intervention
Dissociation	Trauma Symptom Checklist for Children (TSCC) – Dissociation (child report)	d = -0.29	Yes	375	6 months post-intervention

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Quality of Life	Life Satisfaction Scale	d = 0.16	No	375	6 months post-intervention
Use of mental health service	Child and caregiver report of service use	d = 0.62	Yes	377	6 months post-intervention
Use of psychotropic medication	Child and caregiver report of medication use	d = 1.01	No	378	6 months post-intervention
Placement change	Administrative data, interviews and social histories	Odds ratio = 0.68	No	110	1-year post-intervention
New placement in a residential treatment centre	Administrative data, interviews and social histories	Odds ratio = 0.29	Yes	110	One-year post-intervention
Permanency	Administrative data, interviews and social histories	Odds ratio = 1.81	No	110	One-year post-intervention
Total delinquency	The Adolescent Risk Behaviour Survey (ARBS) (child report)	Not reported	Yes	391	10 years follow-up**
Non-violent delinquency	The Adolescent Risk Behaviour Survey (ARBS) (child report)	Not reported	Yes	391	10 years follow-up

Outcome	Measure	Effect size	Statistical significance	Number of participants	Measurement time point
Violent delinquency	The Adolescent Risk Behaviour Survey (ARBS) (child report)	Not reported	No	391	10 years follow-up
Total charges	Court records, Administrative measure	Not reported	Yes	425	10 years follow-up
Non-violent charges	Court records, Administrative measure	Not reported	No	425	10 years follow-up
Violent charges	Court records, Administrative measure	Not reported	Yes	425	10 years follow-up

* The Mental Health Index is a composite created by principal component factor analysis of TSCC, CBCL, and Teacher Report Form scores.

** 10 years follow-up includes analysis of multiple timepoints between post-intervention and 10 years post-intervention (at six-month post-intervention, 1.5 to 2.5-year follow-up, and 10-year follow-up).

Other studies

No other studies were identified for FHF-P.

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Note on provider involvement: This provider has agreed to Foundations' terms of reference (or the Early Intervention Foundation's terms of reference), and the assessment has been conducted and published with the full cooperation of the intervention provider.