POLICY AND PRACTICE

Practical guidelines and case examples for adapting an evidence-based intervention in a complex community setting

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ABSTRACT:

The Problem: Evidence-based interventions (EBIs) are often tested in specific, structured settings, but may need modification to meet the complex needs of vulnerable youth in real-world settings. Nonetheless, past research has not provided practical guidelines to help community partners make decisions about how to adapt EBIs to their settings.

Purpose of Article: We identify barriers in implementing a mental health promotion and violence prevention intervention with youth in a complex community setting to provide practice examples of how the program was adapted to address different challenges. These adaptation decisions are framed within guidelines that are grounded in a wider evidence base.

Key Points: The guidelines underscore the importance of trauma-informed practice, emphasizing confidentiality, tailoring content to meet individual youth's clinical risk and responsivity factors, adjusting dosage and content to meet the group's needs, aligning programming with case planning, being flexible with format, and attending to contextual factors.

Conclusions: EBIs need to be adapted to meet the needs of both individual participants and groups. The guidelines and case examples presented here demonstrate how this adaptation was undertaken in an intentional and evidence-driven way in one agency in the context of a community-based research partnership.

KEYWORDS:

Adolescent Health Services, Community health partnerships, Community Health Services, Mental Health Services, Vulnerable Populations

Introduction

Social and emotional competence deficits are significant risk factors for adverse mental health and negative outcomes in the behavioural, educational, psychosocial, and vocational domains (see [1] for review). There has been increasing attention paid to preventive measures to address social and emotional competence since the early 2000s[2]. Many preventive interventions have taken the form of Social-Emotional Learning (SEL) programs that are delivered in schools as a tier-1 universal prevention initiative[3]; however, there are also considerable efforts to develop and provide targeted and intensive SEL programs to more vulnerable and at-risk youth. These targeted and intensive programs tend to be delivered in small groups and are modified to ameliorate specific deficits and to prevent the development or worsening of areas of concern[3].

Justice-involved and dually-involved youth (i.e., youth involved in both child protection and justice services) are more likely to have lower social-emotional competence than their peers[4] while also facing more adverse childhood and life experiences[5].Targeted and intensive SEL programs are an important component of prevention and recovery for these youth[6]. Most evidence-based programs for justice- and dually-involved youth need to be adapted to the different contexts and settings in which these youths are served[7] because these populations have unique programming challenges and requirements[8].

The Centre for School Mental Health (CSMH) is a research centre at the University of Western Ontario in Ontario, Canada. Researchers at the CSMH have worked with partners across Canada to develop an evidence base for an SEL program targeting relationship skills, substance abuse, intimate partner violence, and mental health promotion called the Healthy Relationships Program (HRP). Community agencies throughout Canada began using the HRP with vulnerable youth like LGBT2Q+ youth, newcomer youth, and child welfare, justice-involved, or dually

involved youth. As such, an enhanced trauma-informed program was developed (HRP Enhanced; HRP-E) to meet the unique needs of these contexts. The HRP-E program involves 16 hours of programming and was designed to be facilitated with groups of youth. The HRP-E is currently being evaluated in a multi-site multi-year study involving multiple partner agencies. At this initial phase of research, we are working with different partnering agencies to scope *how* they are adapting the program to meet their clients' needs. This paper highlights and contextualizes the necessary adaptations made by one agency in program delivery.

One of the key features of the HRP-E is a trauma-informed practice lens, which necessitates flexibility at the levels of the community agency, group, and individual. The core components of the HRP-E are: (1) relationships skills like resisting peer pressure, ending relationships, and assertiveness training, (2) harm reduction practices for substance use, (3) safety practices related to interpersonal violence and sex trafficking, and (4) mental health promotion (See Table 1 for a more detailed description of the program). CSMH sought suitable partners for piloting the HRP-E, including agencies that had expertise in working with justice-involved youth and those at risk of justice involvement to facilitate two-way integrated knowledge translation.

This paper uses case examples from work with one of our community partners (the John Howard Society of Waterloo-Wellington; JHSWW) to illustrate how they adapted the HRP-E to meet the needs of justice- and dually-involved youth.

History of Partnership between the CSMH and JHSWW

JHSWW has expertise in working with vulnerable populations including youth who are multiply-barriered (e.g., gang-involved, experiencing housing instability, child welfare system

involved). They provide services across a wide geographical catchment and through different avenues (e.g., alternative education, court diversion, probation). JHSWW sought to augment its existing menu of services through a partnership with CSMH. CSMH and JHSWW leadership began to discuss a partnership in 2017.

From the outset, the CSMH-JHSWW partnership has been grounded in principles of community-based scholarship and collaboration[9,] with the JHSWW acting as a research partner and not just a service delivery provider. Because JHSWW's priority is service delivery for youth with complex needs and because the delivery of groups was logistically complicated, the CSMH collaborated with the JHSWW to adapt the program to meet youth needs without compromising the integrity of the program. Provider agencies can sometimes be engaged in partnerships wherein strict adherence to fidelity to a program model has meant research goals have trumped client needs and the service provider's obligations to their clients. In contrast, a fundamental cornerstone of the CSMH-JHSWW partnership is mutual learning; our focus is knowledge *exchange,* not knowledge *transfer*.

The CSMH-JHSWW partnership sought funding for a dedicated JHSWW staff to implement the HRP-E program and participate in research activities. With more than 20 JHSWW staff trained to implement HRP-E, JHSWW has served over 200 clients with this program since 2018. JHSWW and CSMH continue to develop their partnership through regular communication, partnering in research activities and ongoing evaluation, and co-creating knowledge mobilization resources (such as this paper). The CMSH-JHSWW partnership is ongoing and is expected to continue throughout the length of the wider evaluation of the HRP-E. There is frequent informal contact between the two agencies with respect to program decision making as well as research

planning, as well as, a bi-annual Partner's Day meeting where more formal research plans are developed and where learnings are shared.

Evidence-Based Programs and Adaptation Science

Evidence-based interventions (EBIs) are an extension of a concept from the medical literature called evidence-based medicine, which was first introduced to increase the rigor and effectiveness of intervention[10]. The "evidence-base" of EBIs initially referred to clinical judgment, patient preferences, and research evidence, but over time, EBIs came to be misinterpreted as research evidence alone[11]. This interpretation of what constitutes an "evidence-base" has been challenged because it does not account for contextual variables in specific settings[12], nor does it account for varying levels of rigor in specific studies and classes of studies[11]. Unlike physical medicine, the mechanisms of action in psychosocial interventions are intrinsically linked with the world views, lived histories, and current contexts of the participants[12, 13], making these critiques especially salient.

To address these shortcomings, a new model for EBIs was developed with a focus on adapting programs to the practice context[12]. These adaptations are crucial for uptake and maintenance of EBPs in community settings[14] and for culturally sensitive programs[15]. Unfortunately, however, the scientific community has primarily focused on processes of adaptation (e.g.,[16,15,17]) rather than providing clear instructive guidelines to community agencies on *how* to adapt programs to specific contexts. Furthermore, there is insufficient literature describing how practitioners' real-world decision making can inform science.

Purpose

This paper seeks to provide insights into how to adapt programs to specific contexts by providing case examples illustrating seven barriers or practice challenges to delivering the HRP-

E through the CSMH-JHSWW partnership. More specifically, we review the different challenges that required adaptation and the program modifications made to address that barrier (See table 2 for description of the barriers and solutions).

These adaptation decisions are framed within guidelines that are grounded in a wider evidence base, with the intention of illustrating the decision-making process involved in adapting evidence-based programming. In line with the goal of establishing a "two-way street" between community-based implementation and academic program development[18], the guidelines in this paper were established through practice-based work with the JHSWW. Between June 2018 and August 2020, JHSWW has offered the HRP-E to 218 youth in diverse settings, including closed custody, alternative education, support homes for pregnant and parenting young mothers, and as an alternative to punitive punishment measures. This paper's guidelines emerge from adaptation decision-making from administering 17 groups to 104 clients and 25 individual programs. Together, our research partnership examined the program adaptations made at the JHSWW and situated them within the existing literature to ensure rigor. Because this policy and practice is grounded in learnings from the project including the JHSWW's ongoing program and service delivery evaluation/quality improvement commitment, IRB approval was not sought.

Case Examples

Guideline 1: Use trauma-informed procedures, respond to trauma reactions, and collaborate with out-of-session supports

Being trauma-informed is a central component of effective programming[19, 20, 21]. Although a fulsome description of trauma-informed practice is outside the scope of this paper, there are some key components of trauma-informed practice which we found helpful in adapting the HRP-E to the JHSWW. Given that approximately 90% of youth in conflict with the law have

a trauma history[22], trauma-informed programming is essential[23]. Three important trauma-informed principles are: avoid re-traumatization by approaching this content in a way that engenders autonomy, safety, empowerment, and within a context of caring[24], respond to trauma reactions in a safe and supportive manner[25], and facilitate out-of-session support to mitigate adverse health and mental health outcomes associated with discussing potentially re-traumatizing content[19].

These three trauma-informed procedures are evidenced in the case example below:

The program was offered to a group of three female youth between the ages of 16 and 18. The youth were on probation for various reasons and had each experienced multiple traumatic events. One youth approached the facilitator to explain that she had experienced multiple sexual assaults and was triggered by discussions related to her experiences. In an effort to avoid re-traumatization, the facilitator offered to provide session 10 of the HRP-E (which focuses on sexual consent) as a 1:1 session to give privacy and space to discuss the topic according to her own needs. During the session, the youth was triggered twice. She was aware of her coping mechanisms and utilized them when she felt triggered. With permission from the youth, the facilitator also informed the youth's probation officer about the topic to ensure wraparound supports, as well as, the youth's support worker and mother to let them know that she may be distressed and in need of support. By offering to have the session in a 1:1 meeting, the youth was empowered by having control over the pace of the session and the depth at which some topics are discussed. The youth was thus able to discuss pertinent information about consent and associated processes in an emotionally and psychologically safe manner, both during and after the session.

Guideline 2: Discuss rules related to confidentiality and group procedures

Many Tier 1 interventions are delivered in the classroom or other larger-scale platforms. When adapting Tier 1 interventions to at-risk groups, program facilitators will need to attend to processes usually reserved for group psychotherapy more carefully. Discussing rules and confidentiality with the group is particularly important in residential care settings and other closed-communities where youth-driven privacy breaches can cause significant interpersonal harm, even if the group is delivered as a psycho-educational group rather than a therapy group. Having clear rules and guidelines also provides stability and predictability for youth and prevents feelings of betrayal from adults which are important aspects of trauma-informed care[19]. The following case example highlights the importance of discussing limits of confidentiality, which is standard practice for all JHSWW programming.

When working with vulnerable populations, it is necessary to inform them of the limits of confidentiality to ensure that they are aware of the potential for interpersonal consequences for them and their living situations if they disclose suspected child abuse, risk of self-harm, or plans to harm others. Engendering autonomy and predictability around expectations for sharing created a trusting and safe context to seek resources or support from the facilitator. This was important because during one group there were two occasions where the JHSWW facilitator was required to call Family & Children's Services (F&CS) in response to child-protection concerns. Each of the youth had histories of trauma, including child abuse by their biological parents. Nonetheless, both youth chose to discuss their situation despite knowing it would trigger a call to F&CS. They were both active participants in calling F&CS and agreed to allow the investigator to follow up with them. Explaining the limits of confidentiality provided a safe space for the youth to raise concerns about others' safety and act to prevent further abuses. As noted below (Guidelines 3 and

6), when trauma disclosures occur facilitators sometimes need to slow the pace of content or skip certain content to focus on immediate needs.

Guideline 3: Be aware of the risks and needs specific to your client(s) and emphasize or de-emphasize content to meet those needs.

When adapting programs to a specific community agency and target population, program facilitators have the benefit of adapting the program to meet the specific needs of their population. Some groups may require additional content such as more examples, and/or supplementary information in order to use the program safely while others may need additional content to use the program at all[26]. Facilitators at the JHSWW found that they had to adapt the HRP-E in many ways to meet the needs of their clients, as illustrated by the following example:

The HRP-E was offered to a class at an alternative education school. Numerous youth in the group of 10 youth were substance users and had personal experience with loss related to substance use. The facilitator collaborated with other care providers (e.g. class social worker, teacher) when deciding if and how to deliver programming related to substance use given that many youth had lost loved ones to substance use and didactic instruction related to substance use could be experienced as re-traumatizing. In collaboration with other care providers, the facilitator decided that the session would be offered with additional supports and would focus only on harm reduction strategies, omitting the "impact of substance use" activities. The school social worker joined, and on the day of the program there were six youth and four adults. Implementing the revised session, with additional supports and awareness, allowed the youth to benefit from an engaging discussion about harm reduction approaches, how they can help keep their friends safe, and to learn about relevant community resources.

Guideline 4: Adjust the dosage and content of specific modules to meet the needs of the group

Adapting the HRP-E to meet the needs of the JHSWW youth required that the program facilitator adjust the amount of time, repetition, and practice to meet the needs of the group in question. This is in-line with previous research which has argued that psychotherapy dosage ought to be adjusted in relation to client factors[27,28].

In once case, a youth was referred to the program who had difficulty with information processing. While working through the program, facilitators recognized that the youth was not building an understanding of the program content. Session to session, there was limited recall of any information presented and the skills were not practiced or generalized outside of session. Rather than offer the program in a structurally traditional manner, the facilitators opted to change the dosage and content to improve his ability to understand. The program was delivered in a 1:1 format, broken down into smaller sessions and offered in an open-ended delivery format, with no end date to provide flexibility in delivery. By breaking down the content into smaller sessions, the youth was able to improve information uptake with use of repetition and allowing for conversational asides.

This youth also had difficulty with certain activity formats when processing information. This was particularly evidenced in session 9 after discussing the Power and Control Wheel. The youth was unable to make connections between conceptual definitions of abuse and behavioural examples. Facilitators provided a "homework" assignment that asked him to verbally discuss morally acceptable and unacceptable behaviours in emotional expression. Adapting the content to a new information processing model was effective. The youth was able to make connections between his own behaviour and experiences and the concepts of problematic behaviour.

Adjusting both the dosage and information processing models improved the youth's understanding of program material.

Guideline 5: Align the program with the client's overall care plan

Facilitators at the JHSWW found that some of the program content was contraindicated by other plans of care. Justice-involved and dually-involved youth require multiple avenues of intervention[29,8] and the JHW determined that some program content needed to be omitted or adapted to fit into larger plans of care.

For example, when HRP-E was offered in a residential setting, many members of the group had previously experienced substance abuse and/or dependence. Many of the participants were concurrently participating in Alcoholics Anonymous and Narcotics Anonymous. Both AA and NA are based on the practice of abstinence and the participants expressed success with these strategies and programs. While a core component of the HRP-E is harm reduction strategies for substance use, in this instance, this content was de-emphasized to fit with the other plans of care. By asking about other plans of care, program facilitators were able to omit and adapt content to meet the other clinical needs and strategies of the participants while still addressing a core component of HRP-E programming (substance use).

Guideline 6: Be flexible with the format and timing of the group

The JHSWW found that the delivery of the HRP-E was sometimes most effective when completed in a 1:1 setting. This was especially true if there was a high risk of peer deviance training (a process whereby youth observe higher levels of deviance and begin to act in more deviant ways) or victimization[30] or if a group member lacked sufficient emotion regulation to participate in the group safely.

In one case a young man (age 13) came to the program with severe antisocial behaviour including forced sexual acts and strong anti-social attitudes. The JHSWW chose to offer the program in a 1:1 context to prevent peer-deviance of other participants. In other cases, the JHSWW found that they had to alter the timing of how the program was delivered. Because many youth were involved in the program through a custody order or had unstable living arrangements the sessions were administered more frequently than what the program manual recommends, (e.g. multiple times per week), especially with persons who were receiving the program in a 1:1 format. The adaptation research identifies that alterations to program timing and delivery are commonly made in community organizations[31].

Guideline 7: Adjust programming to the social and contextual factors of the group to maximize impact

Consistent with trends in adaptation of EBIs[31,32,17], the JHSWW adapted the content to make examples culturally-relevant to the participants. An extension of this adaptation is that facilitators ought to be fluent and knowledgeable about the culture in question to promote cultural safety[33,15,34] and increase trust in the program by participants[34]. Taking a client-centred approach and asking clients how the relationship skills look in their cultural context are important ways of adapting the content to promote uptake and skill use. Culture can extend beyond ethnic identity and might also pertain to sexual, gender, and romantic cultures (adaptation of which is well-documented in past literature) as well as sub-cultures and micro-cultures. Micro-cultures are norms, values, patterns of communication, rituals, and other in-group processes shared by a small group of individuals who form community through a shared experience but which may not have a label or name and may not have wider cultural recognition

as a "group" by outsiders. An example of adapting the program for a micro-culture is provided here:

The HRP-E was offered at a shelter for pregnant and parenting young women, many of whom had been victimized in human trafficking, dating violence, and at home, by men. Because there was a micro-culture among the participants that was (understandably) distrustful and resentful towards men, JHSWW staff initially chose to offer the program with female facilitators. Nonetheless, facilitators also thought that the presence of a male facilitator that is assertive, calm, kind and respectful might be a more helpful learning context for the group. JHSWW ran the first session with a male co-facilitator and after the first session, the female facilitator checked in and asked whether the group felt comfortable and safe expressing themselves, and whether they desired for him to continue. The group chose to continue with the male facilitator. By attending to social and cultural context and collaborating with the group members, program's impact was augmented while still attending to social and emotional safety.

Discussion

This paper identifies real-world barriers of implementing EBIs in a community setting and provides examples of solutions to those barriers grounded in a wider evidence base. The guidelines discussed above were derived from collaboration between the CSMH and a chapter of the youth justice division at the JHSWW. The goal of the paper is not to provide an exhaustive how-to manual on adaptation. Rather, we endeavoured to describe common real-world implementation challenges and adaptations and modifications to address those program delivery realities with the intention of supporting practitioners in their work with vulnerable populations. While this research is limited by the lack of outcome data and arguably the absence of session-by-session fidelity measures, it provides useful service delivery adaptation guidelines and

examples emerging from a case study occurring within the context of an ongoing multi-site iterative research program to understand how people are using the HRP-E and the effects that these modifications have on program efficacy. Future research will require empirical study of these guidelines in a variety of contexts with different populations.

We hope that other CBPR partnerships share their real-world experiences in an evidence-based framework to continue to provide guidance on *how to adapt* EBIs to various contexts, and to further promote the two-way street of knowledge creation and translation.

References

Kupersmidt J, Coie J, Dodge K. The role of peer relationships in the development of disorder. In: Asher S, Coie J, editors. Peer rejection in childhood. New York: Cambridge University Press; 1990. P. 274-308.

Gresham FM. Social skills assessment and intervention for children and youth. Cambridge Journal of Education. 2015 Aug;46(3):319-32.

Eklund K, Kilpatrick KD, Kilgus SP, Haider A. A systematic review of state-level social–emotional learning standards: Implications for practice and research. School Psych Rev. 2018 Sep 1;47(3):316-26.

Claro A, Boulanger MM, Shaw SR. Targeting vulnerabilities to risky behavior: An intervention for promoting adaptive emotion regulation in adolescents. Contemp Sch Psychol. 2015 Dec;19(4): 330-9.

Baglivio MT, Epps N, Swartz K, Huq MS, Sheer A, Hardt NS. The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. J Juv Justice. 2014 Sep 15;3(2).

Farrington DP, Gaffney H, Lösel F, Ttofi MM. Systematic reviews of the effectiveness of developmental prevention programs in reducing delinquency, aggression, and bullying. Aggress Violent Behav. 2017 Mar;33:91-106.

Kerry AJ. Pilot and adaptation of a social-emotional learning program in youth justice settings. Electronic Thesis and Dissertation Repository. 2019 Aug 16.

Hirsch RA, Dierkhising CB, Herz DC. Educational risk, recidivism, and service access among youth involved in both the child welfare and juvenile justice systems. Child Youth Serv Rev Jan; 85:72-80.

Jull J, Giles A, Graham ID. Community-based participatory research and integrated knowledge translation: advancing the co-creation of knowledge. Implementation Sci, 2017 Dec 19;12(1):150.

Sur RL, Dahm P. History of evidence-based medicine. Indian J Urol. 2011;27(4):487–489.

Murad MH, Asi N, Alsawas M, Alahdab F. New evidence pyramid. Evid Based Med. 2016 Aug;21(4):125-7.

Satterfield JM, Spring B, Brownson RC, Mullen EJ, Newhouse RP, Walker BB, Whitlock EP. Toward a transdisciplinary model of evidence-based practice. Milbank Q, 2009 Jun;87(2):368-90.

Hofmann SG, & Hayes SC. The future of intervention science: Process-based therapy. Clin Psychol Sci. 2019 May 29; *7*(1), 37-50.

Southam-Gerow MA, Hourigan SE, Allin RB Jr. Adapting evidence-based mental health treatments in community settings: preliminary results from a partnership approach. Behav Modif. 2009 Jan;33(1):82-103.

Ivanich JD, Mousseau AC, Walls M, Whitbeck L, Whitesell NR. Pathways of adaptation: Two case studies with one evidence-based substance use prevention program tailored for indigenous youth. Prev Sci. 2020 Jun 6;21:43-53.

Chambers DS, Norton WE. The Adaptome:Advancing the science of intervention adaptation. Am J Prev Med. 2016 Oct;51(4):S124-31.

Movisisyan A, Arnold L, Evans R, Hallingberg B, Moore G, O-Cathain A, Pfadenhauer LM, Segrott J, Rehfuess E. Implement Sci. 2019 Dec 17;14(105).

Cabassa LJ, Baumann AA. A two-way street: bridging implementation science and cultural adaptations of mental health treatments. Implement Sci. 2013 Aug 19;8:90.

Tebes JK, Champine RB, Matlin SL, Strambler MJ. Population health and trauma-informed practice: Implications for programs, systems, and policies. Am J Community Psychol. 2019 Aug 24;64(3-4):494-508.

Zettler, HR. Much to do about trauma: A systematic review of existing trauma-informed treatments on youth violence and recidivism. *Youth Violence Juv Justice*. 2021Jul13;*19*(1): 113-134.

Bryson SA, Gauvin E, Jamieson A, Rathgeber M, Faulkner-Gibso, L, Bell S, et al. What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. Int J Ment Health Syst. 2017 May11; 11(1), 1-16.

Abram K, Teplin L, King D, Longworth S, Emanuel K, Romero E, McClelland G, Dulcan M, Washburn J, Welty L, Olson N. PTSD, trauma, and comorbid psychiatric disorders in detained youth. Washington: OJJDP Juvenile Justice Bulletin; 2013.

Knight C. Trauma informed practice and care: implications for field instruction. Clin Soc Work J. 2019 Jun 21;47(1):79-89.

Steele W, Malchiodi CA. Trauma-informed practices with children and adolescents. New York: Routledge; 2012.

Donisch K, Bray C, Gewirtz A. Child welfare, juvenile justice, mental health, and education providers' conceptualizations of trauma-informed practice. Child maltreat. 2016 Mar 8;21(2): 125-134.

Gibbs DA, Krieger KE, Cutbush SL, Clinton-Sherrod AM, Miller S. Implementer-initiated adaptation of evidence-based interventions: Kids remember the blue wig. Health Educ Res. 2016 Apr 23;31(3):405-15.

Owen JJ, Adelson J, Budge S, Kopta SM, Reese RJ. Good-enough level and dose-effect models: Variation among outcomes and therapists. Psychother Res. 2016 Oct 27;26(1):22-30.

Rubel JA, Lutz W. How, when, and why do people change through psychological interventions? Patient-focused psychotherapy research. Routine Outcome Monitoring in Couple and Family Therapy. 2017 Jan 20:227-43.

Greene CA, Ford JD, Ward-Zimmerman B, Honigfeld L, Pidano AE. Strengthening the coordination of pediatric mental health and medical care: piloting a collaborative model for freestanding practices. Child Youth Care Forum. 2016 Oct;45(5):729-44.

Zhu J, Yu C, Zhang W, Bao Z, Jiang Y, Chen Y, Zhen S. Peer victimization, deviant peer affiliation and impulsivity: Predicting adolescent problem behaviors. Child Abuse Negl. 2016 Aug;58:39-50.

Barnett ML, Brookman-Frazee L, Gonzalez JC, Zhan C, Rodriguez A, Stadnick NA, Lau AS. Qualitative reports of how and when therapists adapt children's evidence-based practices during community implementation. J Clin Child Adolesc Psychol. 2019 Nov-Dec;48(6):894-905.

Lau AS. Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. Clin Psychol. 2006 Nov 3;13(4):295-310.

Craig SL, Austin A, Alessi E. Gay affirmative cognitive behavioral therapy for sexual minority youth: A clinical adaptation. Clin Soc Work J. 2013 Sep;41(3):258-66.

Thomson MS, Chaze F, George U, Guruge S. Improving immigrant populations' access to mental health services in Canada: a review of barriers and recommendations. J Immigr Minor Health, 2015 Mar 6;17(6):1895-905.

Bendall S, Eastwood O, Cox G, Farrelly-Rosch A, Nicoll H, Peters W, Bailey AP, McGorry PD, Scanlan F. A systematic review and synthesis of trauma-informed care within outpatient and counseling health settings for young people. Child maltreat. 2020 Jun 15:1077559520927468.

Blease C, Kelley JM, Trachsel M.. Informed consent in psychotherapy: Implications of evidence-based practice. J Contemp Psychother. 2018 Nov15; *48*(2), 69–78.

Collyer H, Eisler I, Woolgar M. Systematic literature review and meta-analysis of the relationship between adherence, competence and outcome in psychotherapy for children and adolescents.

Eur Child Adolesc Psychiatry. 2020 Apr;29(4):417-31.

Webb CA, DeRubeis RJ, Barber JP. Therapist adherence/competence and treatment outcome: A meta-analytic review. J Consult Clin Psychol. 2010 Apr;78(2):200.

Klatte R, Strauss B, Flückiger C, Rosendahl J. Adverse effects of psychotherapy: protocol for a systematic review and meta-analysis. Syst Rev. 2018 Dec;7(1):1-7.

40-Schneibel R, Wilbertz G, Scholz C, Becker M, Brakemeier EL, Bschor T, Zobel I, Schmoll D. Adverse events of group psychotherapy in the in-patient setting–results of a naturalistic trial. Acta Psychiatr Scand. 2017 Sep;136(3):247-58.

Castro Batic B, Hayes D. Exploring harm in psychotherapy: Perspectives of clinicians working with children and young people. Couns Psychother Res. 2020 Dec;20(4):647-56.

Sanchez AL, Cornacchio D, Poznanski B, Golik AM, Chou T, Comer JS. The effectiveness of school-based mental health services for elementary-aged children: A meta-analysis. J Am Acad Child Adolesc Psychiatry. 2018 Mar 1;57(3):153-65.

Arias-Pujol E, Anguera MT. Observation of interactions in adolescent group therapy: a mixed methods study. Front Psychol. 2017 Jul 24;8:1188.

Burlingame GM, Jensen JL. Small group process and outcome research highlights: A 25-year perspective. Int J Group Psychother. 2017 Jan 27;67(sup1):194-218.

Table 1. Overview of the Healthy Relationships Program – Enhanced Program

Session #	Title	Key Content
1	Getting to Know You	• Begin to develop group cohesion • Socialize youth to the group tasks, expectations, and goals • Identify life stressors the youth experience • Identify existing resiliency and coping factors
2	It is your choice: Friendships and Relationships	• Facilitate discussion on qualities youth look for in different relationships • Discuss gender-based stereotypes • Discuss the impact of stereotypes on the individual and their relationships
3	Shaping our Views	• Identify influences (e.g. religion, parents, culture, media, peer norms) that shape our relationships with others • Discuss how these influence impact our expectations, decisions, and behaviours in relationships
4	Influences in Relationships	• Identify unhelpful media messages and gender-based stereotypes • Facilitate a deeper critical discussion to dismantle media messages about relationships and gender-based stereotypes • Discuss power in relationships and when power can be misused
5	Impact of Substance Use and Abuse	• Develop an understanding of different degrees and forms of substance use (e.g. occasional drinking, frequent drinking, binge drinking) • Discuss the impact of substance use on themselves and others • Discuss harm reduction strategies • Discuss and develop an understanding of ways of helping a friend who is struggling with substance use
6	Healthy Relationships	• Discuss the differences and signs differentiating healthy from unhealthy relationships • Teach and practice active listening skills
7	Early Warning Signs of Dating Violence	• Develop an understanding of myths related to dating violence • Identify reasons why someone might be abusive • Identify early warning signs of dating violence • Discuss ways of helping a friend who is in an abusive relationship • Gain awareness of resources and supports related to dating violence in their community
8	Safety and Unhealthy Relationships	• Discuss reasons why people stay in unhealthy relationships • Develop awareness about how to keep oneself safe and develop a safety plan / exit strategy for abusive relationships • Gain awareness about sexual exploitation

9	Rights and Responsibilities	• Develop an understanding of power and control in relationships • Develop an understanding of equality and respect in relationships • Discuss rights in relationships
10	Boundaries and Assertive Communication	• Discuss personal values related to boundaries • Develop an understanding of consent and the importance of respecting the boundaries of others • Teach and practice assertive communication skills
11	Taking Responsibility for Emotions	• Discuss aversive emotions and the ways in which they manifest in the youth's lives and relationships • Practice coping strategies to manage aversive emotions • Identify support systems for themselves and ways of seeking help • Teach and practice skills related to apologizing
12	Standing Up for What is Right	• Teach and practice skills for resisting peer pressure (delay, negotiate, and refusal skills) • Discuss barriers and solutions to using these skills in their everyday lives
13	When Friendships and Relationships End	• Discuss reasons why a relationship should end • Discuss strategies for coping with the end of relationships, being rejected, and break-ups • Teach and practice skills for ending a relationship in a health way
14	Mental Health and Wellbeing	• Develop an understanding of mental health and issues that affect mental health including signs and symptoms of mental health difficulties and their current stressors • Assess their own level of wellness and setting goals to improve wellness • Discuss the relation between mental health and relationships
15	Helping our Friends	• Teach and practice active listening skills to support friends with mental health difficulties • Teach and practice skills for setting boundaries and referring friends to supportive adults • Identify mental health supports in their community
16	Sharing and Celebrating	• Discuss learnings and take-aways from the program • Celebrate the completion of the program and say goodbye

* NB: Although the sessions are designed to last 60-90 minutes and are expected to be delivered in a group format, this paper identifies considerations for modifying the program to meet he unique needs of the youth being served.

Table 2. Barriers, solutions, and adaptation guidelines used when implementing the HRP-E with vulnerable youth.

Barriers / Problem of Practice	Solution	Guideline[a]
The HRP-E addresses several content areas that could elicit adverse trauma-related responses in youth, such as discussion about consent, dating violence, sexual exploitation, and substance use, among others. Facilitators were concerned that the content of the program would adversely impact trauma-related processes in one participant who disclosed a history of being sexually assaulted.	The facilitators were faced with the choices of: (1) run the program without modification and run the risk of adversely impacting the youth's trauma-related mental health, (2) omit that session from their programming, (3) exclude the youth from that session, or (4) adapt the mode of delivery and amount of support so that the content can be delivered safely In this case the facilitators chose to ask the youth how they wanted to proceed given the risks and benefits of the different choices (providing autonomy in a caring relationship). The youth expressed that they wanted to learn the material but that they were worried about how it might affect them. The facilitators chose to respond by offering the program 1:1 and with follow-up support from the youth's social worker. This adaptation balanced the client's needs with the program goals in a way that preserves fidelity (core psychoeducation was delivered) while placing clinical concerns at the forefront of the decision making.	**Guideline 1: Use trauma-informed procedures, respond to trauma reactions, and collaborate with out-of-session supports. This includes:** • avoid re-traumatization by approaching this content in a way that engenders autonomy, safety, empowerment, and within a context of caring • respond to trauma reactions in a safe and supportive manner • facilitate out-of-session support to mitigate adverse health and mental health outcomes associated with discussing potentially re-traumatizing content This guideline reflects core elements of trauma informed programming[19, 20, 21, 35].
The HRP-E was initially designed as a Tier 1 Universal prevention program where discussions around consent and limits of confidentiality are often omitted. Nonetheless, many community agencies have begun using the program with vulnerable youth.	Consistent with the standard practices of the partnering agency, the facilitators identified that the omission of discussing consent and confidentiality at start of the group would place their youth at risk. They decided to add a component to the HRP-E where they discussed the limits of confidentiality, procedures when those limits were breached, and group rules on how to use the space safely and effectively with one another.	**Guideline 2: Discuss rules related to confidentiality and group procedures** Regardless of how a program is written, in the opinion of these authors it is important to establish group rules and consent when doing mental health or behavioural programming with vulnerable youth. See [36] for a recent discussion on the implications of consent and confidentiality for effective and ethical treatment.

The HRP-E was delivered in a variety of settings and with different client populations. Program facilitators identified that depending on the population, additional content or support was required for safe and effective delivery of the program. The in-text problem of practice reviews a situation where an area of high youth need was also a domain where there was a high level of risk related to discussing the content (substance use and lived histories of losing loved ones to overdose and substance related violence). This allowed the facilitators to increase the emphasis on substance use while also mitigating the risk of adverse reactions to the content.	The in-text example discusses one solution where additional supports were provided to facilitate a discussion of potentially harmful material in a safe way. Depending on available resources and goals, this specific solution may not be feasible or advisable. Thus, we provide a more global recommendation which is to be aware and responsive to client risks and needs and to respond to those flexibly.	**Guideline 3: Be aware of the risks and needs specific to your client(s) and emphasize or de-emphasize content to meet those needs** Much like the principle of avoiding re-traumatization, it is important to note that vulnerable youth often have several co-occurring clinical needs and that it is important to avoid exacerbating other needs that might be indirectly evoked as a result of programming. Recent meta-analyses have found that fidelity does not significantly predict treatment outcome and adherence to treatment only has a small effect on outcome[37, 38]. While robust evidence on adverse outcomes in youth psychotherapy is replete with methodological difficulties[39] it is well established that adverse outcomes from psychosocial interventions do occur[39, 40]. Youth in conflict with the law, in child custody settings, or both have exceptionally high rates of trauma and adverse life experiences, as well as, higher rates of co-occurring social and emotional difficulties, and as such, are vulnerable to the mechanisms that lead to adverse outcomes or harm[41]. This guideline encourages program implementers to consider the many domains in which a youth might be struggling and to emphasize or de-emphasize elements of the program to avoid causing harm while still adhering to the core components of the program when safe to do so.
The program is developed so that each skill and content area takes between 60-90 minutes to learn and practice. The program facilitators recognized that some clients required more repetition and practice than what was described in the manual, especially those youth with information processing deficits.	The facilitators had the resources and flexibility to increase the amount of time on relevant sessions to ensure that the youth understood the material and some fluency in applying the material in both hypothetical scenarios and in real life. While it is recognized that there may be many implementation barriers that make this difficult, wherever possible the authors argue that it is beneficial to adjust the dosage to ensure that clients understand the material and can use the skills rather than simply following the instructions in the manual.	**Guideline 4: Adjust the dosage and content of specific modules to meet the needs of the group** Recent meta-analysis confirms previous reviews and meta-analyses which have found that there is no consistent dose-response relationship for psychosocial interventions with youth and that outcomes depend more on client factors and needs[42]. This guideline reflects the need to adapt the dose and delivery of content to meet the needs of different populations with respect to their ability to uptake and apply different skills and psychoeducation modules.
The program facilitators were delivering the program in to a group who was also involved with AA and NA. Whereas the HRP-E typically takes a harm-reduction approach to substance use rather than an abstinence approach, the facilitators were aware that this would be contraindicated for youth who were already engaged in an abstinence oriented substance use program.	The in-text example describes how the emphasis of the substance use module was changed to align with the messaging in NA and AA.	**Guideline 5: Align the program with the client's overall care plan** When possible and within reason, it is recommended that facilitators scope the other services in which the participant is involved to evaluate if any program content is contraindicated, and if so, work flexibly to align the program with other avenues of intervention.

The program facilitators were concerned that a particularly aggressive and anti-social youth might result in either peer deviance training and/or re-victimization of less deviant peers.	The facilitators had the resources and flexibility to offer the group in a 1:1 format for the anti-social peer. This allowed the youth to receive the programming without risk to the other youth in the program.	**Guideline 6: Be flexible with the format and timing of the group** Altering the timing and format are common adaptations made by community organizations[28]. Changes in format and timing can mean changing from in-person to virtual, changing the frequency or duration of sessions, or changing the number of people in the group. It is important to note that psychosocial interventions differ between group and individual formats[40, 43, 44]. There are also different operational costs associated with 1:1 programming. If individuals are changing the format or timing of the group it is important to consider whether there might be different costs of benefits related to the number of peers in a group, and the latency time between sessions for skills to be practiced or consolidated.
The in-text example discuses a group that comprised of women who had previous experiences of being victimized in romantic relationships by men. The facilitators identified that the women may be less able to engage if an imposing or brash male was facilitating the group. They also identified a potential benefit of talking about relationships and relationship violence with a supportive male.	The facilitators had the flexibility to invite a co-facilitator from another program to help run this group. The male co-facilitator was described as kind, gentle, and supportive. In so doing the facilitators considered the micro-culture and expectations of the group and were able to use facilitator characteristics (in this case gender and personality) to leverage possible gains within the group.	**Guideline 7: Adjust programming to the social and contextual factors of the group to maximize impact** The need to adapt programming to for cultural, sexual, gender, and romantic identity contexts is well established. This guideline goes further by suggesting that facilitators can also think about the micro-cultures of their client group and further adapt the program to leverage possible gains. In so doing the program can reflect the clients' naturalistic context in a way that promotes skill acquisition and use.

a. These guidelines emerged from reviews of the literature rather than original data. These guidelines are not intended to function as Must Do instructions, but rather, as a framework to help decision makers adapt programs to meet the needs of vulnerable youth when delivering EBIs.