Effective strategies and interventions for adolescents in a child protection context

Literature review

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Literature review

Effective strategies and interventions for adolescents in a child protection context

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Executive summary

Adolescence is a time of significant developmental transition that is considered to be second only to infancy in the magnitude of changes that occur (Lerner and Villarruel, 1994). Adolescents experience numerous developmental challenges at varying pace, including: increasing need for independence; evolving sexuality; transitioning through education and commencing employment; consolidating advanced cognitive abilities; and negotiating changing relationships with family, peers and broader social connections (Cameron and Kanabarrow, 2003). The adolescent period is also marked by increased involvement in risk behaviours that may predispose young people to poor long-term outcomes. Many of these risk behaviours are relatively transitory in nature and are resolved by the beginning of adulthood. However, there is increasing evidence of the significant level of emotional and behavioural difficulties such as depression, anxiety, conduct disorder, substance misuse and suicidal thoughts that are experienced by some Australian adolescents (Sawyer, 2001).

Purpose of the paper

The purpose of this paper is to review the literature on effective strategies and interventions for young people 12 to 18 years of age within the child protection system. Implementing effective strategies and interventions is necessary to prevent the intensification of the involvement of young people within the child protection system. The paper has three specific purposes:

- to provide an overview of the nature and characteristics of adolescence and the risk and protective factors as well as risk behaviours that influence outcomes for young people who are referred to a child protection agency

- to describe strategies that are effective in casework practice with young people, particularly strategies to establish relationships and facilitate engagement

- to review the evidence for effective interventions and therapeutic approaches that can support young people and their families.

Risk and protective factors related to adolescent development

Risk factors for maladaptive outcomes in adolescents are found across all domains including individual characteristics, family, peers, school and community. For example, current research indicates the following:

- depressive symptoms in adolescents are strongly related to family factors such as poor family functioning (Bond, Toumbourou, Thomas, Catalano and Patton, 2005)

- self harming behaviours in young people are predicted by family discord including poor communication styles, parental mental health problems, family stress, abuse and neglect (Miller and Glinski, 2000)

- conduct disorder is strongly related to previous anti-social behaviour; involvement with anti-social peers; poor social connectedness such as low popularity and peer rejection; early substance use; and having anti-social parents (Bassarath, 2001).

The work of Ungar (2004) and the International Resiliency Project indicate that families are central to the lives of adolescents. Young people want guidance and support from caring adults and need a balance between autonomy and setting limits. Furthermore, even when young people have experienced physical abuse, several protective factors may buffer such youth 'at risk' from anti-social behaviour. These protective factors include a positive peer group, positive school climate, religiosity, other adult support, family support, positive view of the future and involvement in extra-curricular activities (Perkins and Jones, 2004). These findings point to the important place of peers, school and community as well as family in the lives of adolescents and the need for interventions to address these domains.

Effective interventions and programs for working with adolescents and their families

The paper reviews the evidence for effective interventions that can support young people and their families. Interventions reviewed are divided into adolescent, parent and family focused programs.

Adolescent focused interventions

Individual therapeutic approaches

- Cognitive Behavioural Therapy (CBT) has been found to be the most 'efficacious' intervention for anxiety in adolescents (Butler, Chaman and Beck, 2006; Barrett, et al., 2004) and is considered to be 'probably efficacious' or promising for depression in adolescents (Ollendick and King, 2004; Butler, et al., 2006).

- Interpersonal Psychotherapy (IPT) has also been found to be effective in reducing symptoms of depression in adolescents (Mufson et al., 2004; Hazell, 2003) and is possibly more effective than CBT. However, to date IPT does not appear to be effective for young people with anxiety.

- Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a model of psychotherapy that focuses on the unique needs of children 4 to 18 years of age who are experiencing post traumatic stress disorder (PTSD) or other problems related to traumatic life experiences, particularly sexual abuse. There is strong evidence that TF-CBT is the most appropriate intervention for PTSD, anxiety and depression in sexually abused children and likely to be effective for children exposed to other traumas as well (Saunders, et al., 2003; Chorpita, 2002; Cohen, et al., 2000; Berliner, 2005).

Group interventions

Group interventions, using approaches such as CBT, have also been developed and tested with adolescents. Most commonly, group therapy has been used for adolescents who have experienced sexual abuse. For these young people, research demonstrates improvements in levels of anxiety, fear, depression, self-esteem, and feelings of competence after attending group interventions (Gagliano, 1987; Kitchur, 1989; Rice-Smith, 1993; Reeker et al., 1997; Stevenson, 1999; Nurcombe, Wooding, Marrington, Bickman and Roberts, 2000; Dufour and Chamberland, 2004). There are several reasons that group work is considered to be successful with adolescents, for example:

- adolescents accept comments more readily from peers than from adults

- groups offer the advantage of peer interactions and emphasise importance of relationships

- members can benefit vicariously from the work done by others; and

- groups give opportunities for listening without demands.

Parent focused interventions/programs

Parenting programs for parents of adolescents have two broad aims:

- to modify the risk factors of coercive family interaction and poor parenting which play a role in causing and/or maintaining externalising behaviour problems and delinquency (Dishion and Andrews, 1995; Dishion and Patterson, 1992); and

- to enhance parent-child communication and connectedness and improve parental supervision and monitoring.

Parental supervision, in particular, appears to be of crucial importance in preventing a range of adolescent risk behaviours (Coleman, 1997; DeVore and Ginsburg, 2005).

Research on the effectiveness of parenting programs as an *intervention* for children and young people 12 to 18 years who are already experiencing difficulties is scarce, and no parenting programs have been evaluated in the child protection context. There is some evidence to suggest that Parent Management Training (PMT) may be effective in improving parenting skills and reducing adolescent conduct problems particularly if delivered as an intensive or multi-modal intervention that includes the young person and targets a number of risk and protective factors.

Family focused interventions

Family focused interventions are based on social-ecological models and hold that family functioning and interactions may cause, maintain or worsen adolescent conduct disorder or problem behaviour such as substance misuse.

Each of the interventions discussed in this review, including Functional Family Therapy (FFT; Barrett Waldron et al., 2001), Brief Strategic Family Therapy (BSFT; Santistiban et al., 2003), Multidimensional Family Therapy (MDFT) and Multi-systemic Therapy (MST), are all significantly better at reducing adolescent substance abuse than 'treatment as usual', and most are promising or effective in reducing conduct problems. While components of these forms of family therapy differ, the underlying principles are the same and include:

- enhancing positive family relationships by improving communication and conflict resolution

- tackling problems within the family which are maintaining the adolescent's problem behaviour

- increasing the level of support provided from parent to child

- shifting the focus of the problem from something within the adolescent to something within the family system.

This paper also identifies a number of key issues to be considered in the development, implementation and evaluation of interventions for adolescents including the need to:

- develop interventions that shift the focus from individual young people and their families to incorporate community and neighbourhood approaches

- offer long-term, multi-component interventions to children and young people within the child protection system

- implement strategies to actively engage families in interventions and programs that support adolescents

- conduct further research to evaluate both casework practice and therapeutic approaches and interventions for adolescents to identify what works, what does not work, with whom and in what situations.

Effective casework strategies with adolescents

There are a diverse range of strategies and practices that are considered to be effective in working with adolescents. To date, little research has focused on the nature and characteristics of effective casework practice with children, adolescents and their families.

The literature reviewed in this paper indicates that establishing a relationship with a young person to facilitate their engagement in services is the core element of practice. To build and maintain a relationship with a young person, a worker should display characteristics or attributes such as empathy, honesty, humility, care, flexibility and practicality, together with the skills of a professional helper such as being a good listener, being non-judgemental and being able to be straightforward and accountable towards a young person (Davis, Day and Bidmead, 2002; Elliot and Williams, 2003; Maidment, 2006; Schmied & Walsh, 2007).

Of equal importance are practical strategies to assist young people in achieving their goals. Several strategies that utilise a strengths-based approach are described in the review, for example:

- getting to know and understand the young person

- getting the young person's perspective and gaining their participation

- 'looking forward' with the young person to describe the situation and identify solutions

- setting achievable goals and reviewing progress

- being practical and active such as providing information, access to resources, encouraging the young person to brainstorm options, write letters or diaries

- facilitating social and academic supports in the school environment.

Effective interagency work is important in working with the families of young people. To build and maintain effective interagency relationships it is important for caseworkers to establish positive relationships with staff from other services and agencies, have good local knowledge of services and agencies, share information, provide feedback and follow up, and have clear expectations of roles.

1.   Introduction

Adolescence is a period of intense and rapid development and is characterised by numerous developmental tasks including gaining new and more mature relationships with others, achieving a masculine or feminine social role and achieving emotional independence from parents and other adults. When adolescent development is successful, the result is a biologically mature individual equipped with the capacity to form close relationships and the cognitive and psychological resources to face the challenges of adult life (Hazen, Schlozman & Beresin, 2008). For some young people this period is particularly difficult because of the presence of family and community risk factors such as parental mental illness, substance abuse, domestic violence, and child abuse or neglect that predispose them to poor developmental outcomes.

In Australia, almost one in seven children and young people experience significant emotional and behavioural problems, such as anxiety, depression, conduct disorder and attention deficit hyperactivity disorder, and adolescents with mental health problems report a higher rate of suicidal thoughts and other health-risk behaviours than their peers (Sawyer et al., 2001).

The number of child protection notifications in Australia has more than doubled over the past 6 years (Australian Institute of Health and Welfare [AIWS], 2006). Of the children and young people involved in child protection reports in NSW in the period July 2004 to June 2005, 28% were aged 12 to 17, and it appears that girls aged 13 to 15 are more likely to be involved in reports than boys (NSW Department of Community Services, 2006).

1.1   Purpose of the paper

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- to provide an overview of the nature and characteristics of adolescence and the risk and protective factors and risk behaviours that influence outcomes for young people who are referred to a child protection agency

- to describe the strategies that are effective in casework practice with young people, particularly strategies to establish relationships and facilitate engagement

- to review the evidence for effective interventions and therapeutic approaches that can support young people and their families.

1.2   Definition of adolescence

Adolescence is the period of transition from childhood to adulthood, a stage of major growth and development in which significant physiological, cognitive, psychological and behavioural changes take place and important developmental tasks, such as developing an identity and becoming independent, need to be accomplished.

The concept of adolescence is socially constructed rather than being biologically determined and definitions vary widely among cultures and over time. Current literature also varies in the age ranges used to define adolescence. According to some definitions, adolescence may begin as early as seven years and extend to18 through 22 years of age (Santrock, 1996). Other definitions describe it as lasting from age 12 to 18 years, or from completion of primary school to graduation from high school (Peterson, 2004). There is also a distinction between early adolescence, which includes most pubertal changes, and late adolescence. Current opinion suggests adolescent issues should be considered for girls from age 10 and boys from age 11 (Goldenring and Rosen, 2004). However, the period of dependence appears to be getting longer with a variety of adult behaviours such as leaving home, marriage and economic independence occurring at later ages (Shuman & Ben-Artzi, 2003).

For the purposes of this paper, adolescence is defined as the period between 12 and 18 years of age inclusive. The term 'young person' is used to refer to adolescents but these terms are also used interchangeably for ease of reading.

1.3 Scope of review

This paper reviews the strategies and interventions that are effective in working with children and young people aged 12 to 18 years who enter the child protection system. The next section of the paper provides background on adolescent development, an overview of risk and protective factors in adolescence and a summary of key theories informing practice with young people. Section 3 of the paper examines the therapies, interventions and programs that are effective or 'promising' in addressing the behaviours and emotional and mental health problems that are common in adolescents referred to DoCS, such as depression, anxiety, conduct problems, substance misuse, and suicide or self harm. Section 4 of the paper focuses specifically on the strategies that caseworkers use with adolescents in the child protection system.

This paper complements other recent research papers produced by the Centre for Parenting and Research:

- Models of service delivery and interventions for children and young people with high needs' (Schmied, Brownhill and Walsh, 2006)

  This paper reviews effective services and interventions for children and young people with high needs, including Therapeutic Foster Care, Residential Care, Multi-systemic Therapy, and approaches to service co-ordination such as Case Management, Wraparound and Systems of Care. This paper reviews in detail a number of programs such as Multi-systemic Therapy. Multi-systemic Therapy is therefore only discussed in briefly in the current paper.

- Early intervention strategies for children and young people 8 to 14 years old. (Tully, 2007)

  This paper describes the strategies and programs that are effective in early intervention with children and young people and their families and identifies factors that influence the effectiveness of the interventions. It is important to note that there may be a number of these universal and targeted early intervention strategies for this age group that would be of value for young people who enter the child protection system. However, early interventions, such as school-based anti-bullying programs and neighbourhood development programs are not reviewed in this current paper.

Interventions for young people who sexually offend have also been recently reviewed in a separate paper (Nisbet, Rombouts and Smalbone, 2005)[1].

1.4 Review methodology

Search Strategy

This review is based on journals accessed through a number of databases including *Psychology and Behavioural Sciences*, *PsycARTICLES*, *SocINDEX*, *MEDLINE*, *PsycINFO*, *PsycBOOKS*, *PsycEXTRA*, and *Family and Society and Cochrane Controlled Trials Register*. In addition, a more general Google and Google scholar search was conducted, to access unpublished literature from various national and international government and non government organisations.

A search of the relevant databases was undertaken using search terms that were relevant for the different section of the paper. For Section 3, the terms 'adolescents', 'maltreatment', 'child abuse', 'cognitive behaviour therapy', 'family therapy', 'parenting programs', 'parent training', 'efficacious', 'effectiveness'

[1] Literature review: Impacts of programs for adolescents who sexually offend. Available on the DoCS website.

'effective interventions', 'mental health' and 'treatments' were used as well as more problem-specific keywords (for example, 'anxiety', 'depression', 'substance misuse', 'conduct disorders'). For Section 4, the general terms 'adolescent', 'social worker', 'child protection', 'casework', 'best practice', and 'evaluation' were used.

Initially the search covered the period 1995 to 2006, however, this was extended to 1985 to 2006 to obtain literature relevant to Section 4. In revising this paper, some more recent key papers were also included.

Studies included in the review

Section 3 of the paper examined effective interventions, programs, therapies and treatments for adolescents and included the findings of meta-analyses, systematic reviews and narrative reviews of these interventions. The review also draws on single studies, particularly randomised control trials and other comparative studies, where available and appropriate.

While randomised control trials (RCTs) are considered to be the 'gold standard' in demonstrating efficacious interventions[2], and have been included in this review, the conduct of RCTs in 'real life' settings may not always be valid or reliable (Chaffin and Friedrich, 2004). Furthermore, interventions that have been validated in a controlled environment may not translate to or perform well in community settings (Kazdin, 2004; Schoenwald and Hoagwood, 2001). For this reason, quasi-experimental (non-randomised) studies such as pre-post test, longitudinal cohort and cross-sectional studies are also included in Section 3 of this paper.

The review of effective casework practice for working with adolescents presented in Section 4 draws on three main sources:

(1) literature published in peer-reviewed journals

(2) unpublished literature, such as practice guidelines and policy papers

(3) findings of a recent study undertaken with DoCS caseworkers (referred to in this paper as the 'Caseworkers Study').

The aim of the Caseworkers Study was to explore and describe the nature of effective casework practice with adolescents from the perspective of staff working in DoCS. For details of the study methods and findings see Schmied and Walsh (2007).

1.5   Methodological limitations

In determining what works for adolescents and their families it is important to highlight the methodological limitations that exist in the research reviewed in this paper. Firstly, many approaches used with young people have been rigorously tested with adults or young children and there is limited research with adolescent samples (Ollendick and Vasey, 1999). It is also rare that research is undertaken on young people presenting with more than one problem or diagnosis. Research assessing treatments for a particular problem, such as depression, will typically recruit participants who have symptoms of depression, or meet the diagnostic criteria for depression but will exclude those who have co-morbid presentations (for example, anxiety and depression). While it makes sense for the purposes of research

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2   The term 'efficacious' refers to treatments which have been studied by means of randomised controlled trials. What this means is that if a study is researching the effect of treatment 'A' when compared to a control treatment (eg, wait list/no treatment), subjects within the study need to be allocated to either of the treatment conditions (treatment 'A' or wait list) randomly, so that if any significant effects are found they can be attributed solely to the different treatments rather than any pre-existing differences within the individuals which were not accounted or controlled for (Cook and Campbell, 1979). In studies where the outcome variables are experimenter ratings of participants' symptoms, these raters should be 'blind' to the experimental condition participants were allocated to, again so the results can be solely attributed to the treatments under scrutiny. Finally, results demonstrating the efficacy of a particular treatment need to be replicated to ensure they can be demonstrated repeatedly, and are not therefore the product of one particular aspect of a study which is not replicable outside that specific experimental setting.

to limit the potential for confounding results, it does not reflect what happens in reality as co-morbid presentations are extremely common, so excluding these participants may reduce the 'generalisability' of the findings (Seligman, Goza and Ollendick, 2004).

Dufour and Chamberland (2004) reported that overall there are only a small number of studies that have evaluated interventions for children or young people who have been maltreated. Many of these studies have methodological limitations including a lack of longitudinal and replication studies, small sample sizes, lack of comparison groups, inappropriate randomisation techniques, and reliance on self-report measures (Dufour and Chamberland, 2004; Cameron and Karabanow, 2003). Further, Dufour and Chamberland (2004) raise concerns about program fidelity, that is, how rigorously the principles and guidelines for specific programs and interventions are adhered to during implementation. Lack of program fidelity can make it difficult to draw sound conclusions about the effectiveness of interventions.

In undertaking this review it has also been difficult to isolate studies that have focused on young people 12 to 18 years of age. Studies frequently address a broad age range, for example, children under the age of 18, and rarely differentiate outcomes for children and young people in different age groups.

Most of the studies reviewed in this paper have been conducted in the United States, some in Canada and the UK and very few in Australia. In addition, data collected for these studies is mainly from programs for inner-city American young people (Cameron and Karabanow, 2003). Thus, the findings may not be generalisable to Australian samples.

Finally, it is also important to note that most of the 'well established' or 'probably efficacious' interventions reviewed in this paper are based on behavioural and cognitive-behavioural principles. As Ollendick and King (2004, p.8) note

> … *we do not really know whether frequently practiced treatments from other orientations work or not, (for example, play therapy, interpersonal psychotherapy) in many instances they have simply not been evaluated sufficiently.*

As Cognitive Behaviour Therapy is most frequently used in practice, it is also more likely than other approaches to be evaluated in research.

2.   Background

2.1   Nature and characteristics of adolescence

Adolescence is a time of significant developmental transition that is considered to be second only to infancy in the magnitude of changes that occur (Lerner and Villarruel, 1994). Adolescents experience numerous developmental challenges at varying pace, including: increasing need for independence; evolving sexuality; transitioning through education and beginning employment; consolidating advanced cognitive abilities; negotiating changing relationships with family, peers and broader social connections; assuming legal responsibilities; and developing personal ethics and a healthy identity (Cameron and Karabanow, 2003). Appendix 1 provides a brief summary of adolescent developmental stages in terms of early, middle and late adolescence and the developmental issues, concerns, cognitive development levels and practice strategies associated with each stage. For young people in Australia, the transition to adulthood is made more complex by the social, economic, environmental and technological changes in Australian society over recent decades (AIHW, 2007), which are shaping the experiences of young people in new and unpredictable ways (Burns et al., 2008).

The adolescent period is marked by increased involvement in risk behaviours. While these risk behaviours can predispose young people to poor long-term outcomes, they are also seen as a normal part of adolescent development and are usually resolved by the beginning of adulthood (Steinberg and Morris, 2001). However, as Kazdin (1993) has noted, it is incorrect to assume that young people will simply 'grow out of their problems' with time. For example, there is an increasing distinction between 'adolescence-limited' conduct problems, which only emerge during adolescence and do not persist into adulthood, and those that are 'life-course persistent'. Life-course persistent conduct problems emerge in early childhood, persist into adulthood and are associated with significant mental health problems, substance use and violence (Moffitt, 1993; Moffitt, Caspi, Harrington and Milne, 2002). While adolescence is a period of increased risk for problems, it also represents an important window of opportunity for change through intervention (Wekerle, Waechter, Leung and Leonard, 2007).

As well as increases in risk-taking and exploration, the adolescent period also involves other behavioural changes such as increase in time spent with peers, increase in conflicts with authority, changes in sleep patterns and decreased satisfaction with daily life (White, 2005). The behavioural changes that occur in the transition to adolescence may be explained by the significant hormonal and physical changes (puberty) during adolescence as well as changes in brain function. Some of the changes in brain function that occur during adolescence appear to explain common adolescent behaviours such as difficulty controlling impulses and risk taking (White, 2005).

There are particular characteristics of adolescent development, such as individuation from one's parents and the development of cognitive reasoning abilities that can influence the choice of interventions and mode of service delivery for a young person. Some young people may not be ready to face their difficulties alone yet may also be in the process of 'separating' from their parents and uncovering their own thoughts, beliefs and values, and discovering that their beliefs differ from those of their parents. It can be challenging for both caregivers and caseworkers to support a young person's path to independence. Knowing when to intervene in decision-making and exercise control versus when to allow the young person to make their own decision and experience the consequences creates challenges. Young people can give mixed messages regarding wishes for their own autonomy versus wanting limits set for them (Ungar, 2004).

2.2 Prevalence and significance of behavioural and emotional problems and risk behaviours in adolescence

In Australia, the prevalence of mental health problems has been assessed in a national survey of a sample of 4500 children and young people (Sawyer et al., 2001). In this survey, the prevalence of mental health problems among children and adolescents aged 4 to 17 years was 14% (Sawyer et al., 2001), a rate that is almost comparable to the adult rate of 18% (Australian Bureau of Statistics, 1998). Depression is one of the most common mental health problems affecting young people in Australia today. Up to one in four young people in the general population experience an episode of major depression by the time they are 18 years old (NSW Health, 1999; NHMRC Clinical Practice Guidelines, 1997). In Australia, the prevalence of internalising problems (depression and anxiety), according to adolescent reports, was 16.5% for young people aged 13 to 17 years (Sawyer et al., 2001). A recent study of a representative sample of 8984 secondary school students in Victoria (Bond et al., 2005), found the prevalence of depressive symptoms was 10.5% for males and 21.7% for females.

Internalising problems such as anxiety often begin during adolescence. Anxiety is characterised by fear but manifests itself in many different ways (for example, social anxiety, generalised anxiety, post-traumatic stress, obsessive-compulsive disorder, separation anxiety). Boyd et al. (2000) found that 13.2% of adolescents in their Australian sample were anxious, with significantly more girls than boys reporting symptoms.

Externalising disorders such as conduct disorder and attention deficit hyperactivity disorder (ADHD) can also become manifest in adolescence. Conduct disorder is a pattern of behaviour which violates the basic rights of others as well as age-appropriate norms and rules and includes aggressive behaviour, deceitfulness, theft, truancy or damage to property such as fire setting or vandalism (American Psychiatric Association, 1994). The behaviours that characterise conduct disorder are often referred to as 'delinquency' and 'anti-social behaviour'. ADHD is characterised by persistent overactivity, impulsivity and difficulties in sustaining attention (American Psychiatric Association, 1994). Within young people aged 13 to 17 years, the prevalence of ADHD is 10% in boys and 3.8% in girls, and conduct disorder is 3.8% in boys and 1.0% in girls (Sawyer et al., 2001). The majority of males with conduct disorder also meet the criteria for ADHD or depressive disorder (Sawyer et al., 2001).

Adolescence is characterised by an increase in risk taking behaviours such as risky sexual behaviour, self-harm, risky driving behaviour and substance use. A risk taking behaviour that is particularly prevalent in adolescence is substance misuse. A survey of secondary school students in Australia found that 10% of 12 year olds and 49% of 17 year olds were current drinkers (drank in the week prior to the survey) and of current drinkers, 30% of 15 year olds and 44% of 17 year olds had consumed alcohol in harmful amounts (White & Hayman, 2006a). About 18% of all secondary school students aged between 12 and 17 years reported the use of cannabis at some time in their life (White & Hayman, 2006b). Experience with smoking becomes more common as adolescents progress through secondary school. Around 16% of 12-year-olds have had experience with smoking and this proportion increased to 55% among 17-year-olds (White & Hayman, 2006c). Substance use is related to behavioural and emotional problems. For example, Sawyer et al. (2001) found that more than half of adolescents with very high levels of behaviour problems reporting smoking during the previous month compared with 11% of adolescents with low problems.

There is also mounting concern about the level of self-harm among young people in Australia. The act of suicide or self-harm is usually thought to be symptomatic of significant mental health difficulties, such as depression, anxiety or stress (Miller and Glinski, 2000), as well as certain underlying maladaptive thought processes. A lack of self-efficacy in one's ability to cope with difficulties may lead to a sense of hopelessness (Townsend et al., 2001). In the Australian National Mental Health survey, 12% of adolescents reported suicidal thoughts in the past year and an additional 9% reported a suicide plan (Sawyer et al., 2001). Of the adolescents with high levels of behaviour problems, 42% reported that they had seriously considered suicide in the last 12 months compared with 2% of adolescents with a low level of behaviour problems (Sawyer et al., 2001).

2.3   Risk factors

Risk factors, factors that increase the likelihood of future maladaptive outcomes, can be broadly grouped into five domains:

- individual (eg, personality variables, developmental delays)

- family (eg, low socioeconomic status, mental illness, family conflict, coercive parenting)

- peer (eg, peer rejection, deviant peer-group membership)

- school (eg, academic failure, low commitment to school)

- community (eg, neighbourhood, poverty).

Within the literature, research has largely examined the risk factors that are associated with specific outcomes or behaviours such as depression, substance misuse and suicide/self harm. The study by Bond et al. (2005) of Victorian secondary school students found that depressive symptoms were associated with increased risk factors in all domains including individual, family, peer, school, and community with the strongest associations in the family domain. In a literature review of the risk factors for conduct disorder, Bassarath (2001) identified a number of factors that were strongly related to future conduct problems. These included prior anti-social behaviour; involvement with anti-social peers; poor social connectedness such as low popularity and peer rejection; early substance use; male gender; and having anti-social parents. Family factors such as poor supervision, low warmth and a negative attitude toward the child or young person were found to be moderately predictive of later conduct problems.

Miller and Glinski (2000) examined the risk factors for youth at risk of suicide and/or self-harm. Risk factors include drug and alcohol misuse, mood disorders, conduct disorders, and personality disorders such as borderline personality disorder.

Family discord, including maladaptive communication styles, parental mental health problems, family stress, and abuse and neglect, is also thought to be a significant predictor of youth self-harming behaviours (Miller and Glinski, 2000). As well as these 'distal' influences, more proximal precipitating events are also relevant to self-harm. Such influences include stressful events, such as the breakdown of a romantic or family relationship or leaving home. Miller and Glinski (2000) suggest that these precipitating events in conjunction with distal influences increase the likelihood of the young person attempting to harm themselves.

In relation to individual risk factors, the early onset of puberty is a risk factor for a range of emotional and behavioural problems and risk behaviours. There is increasing evidence that earlier pubertal timing is associated with anxiety, conduct disorder and substance use (Burt et al., 2006; Costello et al., 2007; Reardon, Leen-Feldner & Hayward, 2009). However, it is not yet clear what the nature of relationship is between these variables. For example, in relation to conduct disorder, early puberty may lead young people to associate with older more deviant peers but it is also possible that biological and/or genetic factors that lead to early puberty also influence conduct problems.

What is less well researched is the impact of community and neighbourhood on adolescent development. For example, Weatherburn and Lind (2001) have shown that concentrated disadvantage acts to increase the rate of juvenile offending. The economic and social stress associated with living in disadvantaged neighbourhoods disrupts the parenting process in ways that render children and young people prone to later involvement in crime through association with delinquent peers. Low socio-economic neighbourhoods will generally have larger populations of delinquents and will therefore produce higher rates of interaction between young people already involved in crime and young people susceptible to such involvement.

Young people who have experienced abuse or neglect in childhood face additional pressures as they transition through adolescence and deal with the emotional and psychological impact of their past. Recently, Wekerle et al. (2007) have documented the special challenges faced by adolescents with a history of maltreatment. These difficulties relate to problems in forming an attachment to others; problems managing emotions, especially maltreatment-related avoidant emotions such as anxiety and panic; information processing biases such as self-blame and hostile appraisals of the intentions and actions of others; and symptoms of hyper-arousal often associated with Posttraumatic Stress Disorder such as anxiety, impulsivity, intrusive thoughts and sleep problems.

While childhood abuse or neglect is known to be a risk factor for a range of later problems, much less is known about the effects of maltreatment experienced during adolescence. Smith, Ireland and Thornberry (2005) have suggested that adolescent maltreatment may be largely overlooked in the literature due to a perception that young people are better protected against maltreatment and are less harmed by it. However, recent studies have found that substantiated abuse and neglect during adolescence is associated with increased likelihood of arrest, general and violent offending and illicit drug use in young adulthood (Ireland, Smith and Thornberry, 2002; Smith, Ireland and Thornberry, 2005).

2.4   Protective factors and resilience

Protective factors are not simply the absence of risk factors, although this is sometimes the case. Protective factors are those variables that offset, or buffer against, the effects of risk factors. A related concept is that of resilience, which refers to the ability to bounce back from tough times, or the capacity to overcome challenge or adversity. In a study by Ungar (2004) resilience was shown to be the result of negotiations between individuals and their environments to maintain a self-definition as 'healthy'.

The growing interest in resilience has arisen from researchers finding that approximately one-third of children living with risks and adversities were well adjusted, happy and successful (Grotberg, 1997). Researchers began to explore factors accounting for their success, and identified specific protective factors enabling young people to overcome the adversities they faced and make the most of their opportunities (International Resilience Project, 1997)[3]. Wise et al. (2003) state that the available evidence overwhelmingly supports boosting protective factors, and note the most commonly cited protective factors as:

- a strong sense of connectedness to parents, family, school, community institutions, adults outside the family

- the development and enhancement of academic and social competence

- involvement in extracurricular activities that create multiple friendship networks.

Resnick et al. (1997) found that family connectedness and school connectedness were protective against a range of health risk behaviours in adolescence. Ungar (2004) studied the importance of parents and other caregivers in building the resilience of high-risk adolescents. The findings affirm that adolescents remain attached to their parents through the developmental stage of increasing independence and want their support and guidance. To promote resilience, Ungar's study identifies the need for caregivers to provide a balance between encouraging autonomy and setting limits. Adolescents seek a form of 'benign control' where they have enough structure provided by adults to enable them to accomplish and achieve the developmental tasks necessary for them to develop a positive and widely accepted identity.

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[3] The International Resilience Project (IRP) is a multi-year international research study funded by the government of Canada through Dalhousie University in Halifax, Nova Scotia Canada. The purpose of the IRP is to develop a better, more culturally sensitive understanding of how youth around the world effectively cope with the adversities that they face in life. (http://www.resilienceproject.org/cmp_text/)

Perkins and Jones (2004) explored the protective factors that led to resiliency in physically abused adolescents. Several protective factors were found to be significant for increasing the likelihood that physically abused adolescents would not engage in risk behaviours such as alcohol use and anti-social behaviour. These protective factors included positive peer group, positive school climate, religiosity, other adult support, family support, positive view of the future and involvement in extra-curricular activities.

2.5 Theories informing practice with adolescents

There are a number of traditional and developing theoretical frameworks used to explain the relationship between childhood experiences, risk and protective factors and outcomes for young people. These theoretical frameworks are also used to inform appropriate interventions. However, the link between theory and practice is often overlooked. Practitioners can focus so intently on the content of the intervention that the underlying principles and the theoretical rationale can be disregarded. For example, it is important to give consideration as to why a particular technique might be helpful with one young person and a different approach or therapy more useful for another young person and/or their family.

For many years psychological theories of learning and attachment have predominantly guided therapeutic interventions with young people. However, within child protection casework practice the social ecological framework, strengths-based approaches and resilience theory predominate and appear to be used more frequently in practice (Schofield and Brown, 1999; Trotter, 2004; Schmied, 2007).

This section provides a brief overview of the main theories which guide therapeutic interventions and practice strategies with adolescents.

Social Learning Theory

Social Learning Theory is based on the premise that "environmental contingencies play an important role in guiding behaviour" (Durkin, 1995 p.21). The theory balances understanding of the individual as a social being, as well as one who is cognitively aware of their surroundings. The primary difference between Bandura's Social Learning Theory (1989) and previous learning theories is the idea of observational learning, that is, that individuals learn not only by experience but also by observing others. Basic reinforcement principles highlight that individuals learn about the world and their behaviour through the process of reinforcement. Maladaptive behaviours, which may be inadvertently reinforced by parents, will continue because they provide some reward. Likewise adaptive behaviours, which are not acknowledged, may in fact be extinguished because of the lack of reward available.

Parents who utilise reinforcement principles effectively in their everyday interactions with their children will rarely find the need for harsh discipline. However, particularly with 'at risk' families, the use of such techniques can be undermined by high levels of conflict or stress, and families can become embroiled in a 'coercion cycle' (Patterson, 1982; cited by Kazdin, 2003), whereby the family is caught in a cycle of negative interactions (eg, misbehaviour, punishment, increased misbehaviour, harsher punishment etc.), which are unhelpful for family cohesiveness. Knowledge of these principles can assist parents to deal with problem behaviours within their child, and Social Learning Theory is the basis for many parenting interventions (eg, Parent Management Training and Multi-systemic Therapy for problem behaviours and conduct disorders).

Attachment Theory

Attachment Theory is based on the fundamental principle that humans are social beings, and therefore have an innate drive to connect with those around us (Bowlby, 1980). Attachment refers to the close emotional ties that develop in the very early years between young children and their primary caregivers (usually the mother and father) which form the basis for future relationships throughout the individual's life.

Attachment theory is linked with social learning principles in that an individual learns from their early caregiving experience whether the world is 'safe' and whether they are able to explore this world from a safe, secure and constant base (the parents). If parents are inconsistent in their affection or availability, the infant learns that this security cannot be taken for granted, and they form anxious early attachments which tend to replicate in later relationships (Bowlby, 1980).

Thus, effective parenting is based on the balance between social learning and attachment principles, whereby the parents' affection and availability towards the child are constant, such that when misbehaviour is not being rewarded (in line with social learning principles), the child remains secure in their attachment to their caregiver. These principles remain pertinent to relationships throughout the lifespan. Therefore, for adolescents, particularly those within the child protection system, the primary aim of any therapeutic intervention is to provide families with skills to enable them to assist the young person to increase adaptive and decrease maladaptive behaviours, while maintaining a secure, loving and consistent bond with them.

Social ecological model

Over the past thirty years there has been a shift in the explanation for child developmental psychopathology from being centred on the child, or mother and child (as in attachment theory or Social Learning Theory), to an explanation based on systems theory. In his seminal work, Bronfenbrenner (1979) proposed a socio-ecological model. He argued that the child's development was influenced not only by the more proximal, and relatively stronger influences, of family, peers, school and neighbourhood, but also by the distal factors of the broader social context such as the media, parental work arrangements and government policies.

This system is portrayed in a series of concentric circles to which Bronfenbrenner later added a chronosystem to reflect the non-static nature of influences as the child develops (Bronfenbrenner and Ceci, 1994). For instance, over time parents may divorce, the family membership may change, the child may change schools and neighbourhoods. This approach led to the search for risk factors in a child's environment, which would predispose a child to poorer outcomes, and protective factors which might buffer them.

Resilience theory

Resilience theory is a more recent theoretical approach that guides work with children, young people and families. Resilience is broadly understood as positive adaptation in circumstances where difficulties – personal, familial or environmental – are so extreme that we would expect a person's cognitive or functional abilities to be impaired (Rutter 1985; Garmezy 1985; 1983; 1991; Masten and Coatsworth 1998). The International Resilience Project which collected data from 30 countries, described resilience as "a universal capacity which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity" (Grotberg, 1997, p.7).

Cross-culturally, the concept appears to be understood as the capacity to resist or 'bounce back' from adversity. The International Resilience Project, which surveyed almost 600 children aged 11 years, described the most commonly mentioned adversities reported by children. In order of frequency, these were death of parents and grandparents, divorce, parental separation, illness of parents or siblings, poverty, moving home, accidents, abuse, abandonment, suicide, remarriage and homelessness (Grotberg 1997).

Ungar (2005a) argues that resilience is much more than the internal capacities or behaviours that one has to counter adversity. He states that "there is growing evidence that resilience is as much dependent on the structural conditions, relationships and access to social justice that children experience than to any individual capacities" (Ungar, 2005a, p.446).

While definitions of resilience are clearly helpful, we also need to know what qualities we might expect to find in a child who has been described as 'resilient'. In an effort to determine this, the Search Institute in the US designed the developmental assets framework (Scales and Leffert, 1999; Benson, Leffert, Scales, and Blyth, 1998). This framework identifies 40 factors (or assets) that are demonstrated to be associated with positive youth development. Twenty of these assets are internal psychological attributes, grouped into four categories (commitment to learning, positive values, social competencies, and positive identity) while the remaining 20 are external features of the environment, also in four categories (support, empowerment, boundaries and expectations, and constructive use of time).

Resilience research has the potential to provide a theoretical understanding of how caseworkers can assist young people in overcoming the cycles of abuse, poverty and failure that may have characterised their families lives (Wise et al., 2003). However, commentators emphasise that resiliency is contextual. It is not a discrete quality that people either possess or do not possess, people may be more or less resilient at different points in their lives depending on a range of factors. Resilience cannot be seen as a fixed attribute of the individual, if circumstances change, the risk alters.

At present the evidence about risk and protective factors, outcomes for children and young people, and what constitutes resilience remains limited. Loeber and Farrington (2000, p.746) note that "even after years of research on childhood development we have few tools to distinguish between those children who will continue with their problem behaviours and those who will not".

Strengths-based approaches

Utilising a strengths-based approach is consistently favoured in the literature as an approach to working with children, young people and families. While resilience theory has advanced insights into the relationship between risk and protective factors, strengths-based approaches provide a way of identifying and fostering resilience in young people, focusing on what is important and not what is urgent (Hammond, 2005).

Strengths-based perspectives developed as a way to value children and young people as 'experts' in their own lives and experience, able to find solutions to life challenges (Hammond, 2005). As Trotter (2004, p.25) notes "people learn more and progress better if workers resist focusing on pathology instead focusing on what clients do well and on their achievements". Strengths-based practice is based on the belief that even people with the most entrenched problems and adversities have inner resources that can help them develop (Saleebey, 2001). In essence, strengths-based approach offers a different language to describe children's and families' difficulties and struggles.

There are a number of therapeutic approaches that are based on a strengths-based approach. For example, Solution Focused Therapy or counselling offers a structure for negotiating the problem according to the clients' perspective (Cade and O'Hanlon, 1993; Saleebey, 1997; Anderson-Klontz et al., 1999; Lethem, 2002), Narrative Therapy and problem solving approaches are similarly strengths-based approaches drawn on in casework practice. Both involve eliciting and examining client's 'real' stories or perspectives and involve helping a client to see alternative possibilities (Trotter, 2004). The application of Solution Focused Therapy to casework practice is discussed in more detail in Section 4.

3. Effective interventions and programs for working with adolescents and their families

This section of the paper describes interventions that have demonstrated efficacy or are promising in addressing some of the problems facing adolescents, particularly depression, anxiety, post traumatic stress disorder (PTSD) and conduct disorder, and risk behaviours such as drug and alcohol misuse, suicidal thoughts or behaviours or self-harm. These interventions are divided into those which target the adolescent, those which target the parent(s), and those which involve the family system as a whole. The interventions discussed are:

- Adolescent focused interventions and therapies, which include:
    - Cognitive Behavioural Therapy (CBT)
    - Interpersonal Psychotherapy (IPT)
    - Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT)
    - Group work with adolescents
- Parent focused interventions/programs
- Family focused interventions, which include:
    - Functional Family Therapy
    - Brief Strategic Family Therapy
    - Multidimensional Family Therapy
    - Multi-systemic Therapy

For many of the interventions discussed in this section, the literature emphasises the importance of the participation of both the young person and their parent/s. The involvement of parents in many of the interventions is based on social-ecological theory (Bronfenbrenner, 1979) and the purpose is to address the broader spectrum of risk and protective factors. However, there is an assumption that the parents are appropriate and supportive role models for the adolescent and this may not always be the case. As the focus of this review is on adolescents who are within the child protection system, it is, important to determine whether it is appropriate for the young person's parents to be involved in the interventions. Huey, Henggeler, Brondino and Pickrel (2000) noted that family members involved in treatment need to be fully engaged, otherwise their involvement may have a detrimental effect on the outcome of the intervention. In the case where parental engagement is not thought to be possible, clinicians may seek the involvement of an appropriate significant other adult in the adolescent's life.

The interventions which follow focus on working with the young person in their current environment together with those adults who are significant in their lives. The type of intervention and the mode of delivery is dependent on a variety of factors, such as the quality of relationships within the adolescent's primary support group and the nature of the difficulties they are experiencing.

What is noteworthy about the interventions, services and therapies that have developed an evidence base and are reviewed in this section of the paper is that they draw heavily on social learning theories and attachment theory, and to a lesser extent are based in socio-ecological theories such as in multi-systemic approaches. This means that despite developments in resilience theory and strengths-based approaches, there continues to a focus on individual and family problems and treatments to address the problem and deficits, rather than identifying strengths and drawing on family, school and community/neighbourhood resources.

3.1   Adolescent focused interventions

This section of the paper discusses therapeutic interventions that focus on the young person. It examines Cognitive Behavioural Therapy (CBT), Trauma Focused Cognitive Behavioural Therapy (TF-CBT) and Interpersonal Psychotherapy (IPT) as interventions for depression, anxiety, PTSD, and self-harm in young people. The effectiveness of group work with adolescents is also examined.

Cognitive Behavioural Therapy

Cognitive-Behavioural Therapy (CBT) can be broadly defined as a combination of cognitive and behavioural therapeutic approaches used to modify maladaptive thoughts and behaviours (Beck, Rush, Shaw, and Emery, 1979). CBT is often considered a 'short-term' therapy, which generally consists of approximately 8 to 12 sessions where the client and therapist work collaboratively to identify problem thoughts and behaviours, in order to enable the therapist to provide the client with tools and techniques to alter the way in which they think, feel and behave in a given situation. There are a variety of CBT-based techniques used for different populations and different presenting issues; however, the underlying principle of therapy remains the same.

Beck et al. (1979) described the A-B-C model, which identifies that situations (A) per se do not create feelings/emotions (C) in a person; rather, they are mediated by cognitive appraisals (B) of the meaning and value of the situation to the individual. These appraisals are often based on faulty thinking or distortions of reality (also known as 'cognitive distortions', 'core beliefs' or 'schemas') which often arise from previous experiences(either one's own, or those of others that have been modeled). For example, if a socially anxious adolescent is invited to a party (the situation, 'A') and they are thinking "Everyone will think I'm stupid" (the cognitive appraisal/thought, 'B') they may then feel a heightened sense of anxiety (the emotion/feeling, 'C'), and may consequently, avoid such social situations. This unhelpful thought, which is unlikely to be a true reflection of reality, maintains the anxiety and the avoidance of social situations. The primary aim of CBT, therefore, is to address these mediating unhelpful thoughts and replace them with more helpful and realistic thoughts in an attempt to alter how the individual feels and behaves in a given situation.

CBT is the most studied and practiced form of therapy in Australia today, and has been for many years. Therefore, the majority of studies have examined the efficacy of CBT and very few studies have examined other approaches. It may be that CBT really is the most effective intervention and therefore the 'treatment of choice' for practitioners and clients alike, or alternatively, it may simply be that CBT is the intervention with the most research to support its effectiveness (Brosnan and Carr, 2000).

When is CBT used?

To date CBT has been found to be the most 'efficacious' intervention for anxiety in adolescents (for example social anxiety, generalised anxiety, post-traumatic stress, obsessive-compulsive, separation anxiety) (Butler, Champan, Forman and Beck, 2006; Barrett, Healy-Farrell, Piacentini and March, 2004; Ishikawa, Okajima, Matsuoka and Sakano, 2007). Kazdin, 2003; Mattis and Pincus, 2004; Ollendick, Davis and Muris, 2004).

CBT is considered to be 'probably efficacious' or promising for depression in adolescents (Ollendick and King, 2004; Butler et al., 2006). A number of studies have compared forms of CBT to 'treatment as usual' such as supportive counseling or a wait list control group (no treatment) and have found CBT to result in significantly greater reductions in depression (eg, Clarke, Hornbrook and Lynch, 2001; Hazell, 2003). The two most recent meta-analyses examining CBT in comparison to no treatment or to other forms of psychotherapy demonstrate small to moderate significant effects of CBT on reducing depression in adolescents (Klein, Jacobs and Reinecke, 2007; Weisz, McCarty and Valeri, 2006). These effects appear to last for a few months after the intervention but disappear a year or so later (Weisz et al., 2006).

CBT has also been found to be useful for young people who hold suicidal thoughts or engage in self-harm. Townsend et al. (2001) conducted a meta-analysis examining effective interventions for suicide and self-harm and found that a problem-solving approach within a CBT framework[4] is more effective at reducing repeated self-harm than control interventions. Furthermore, this study highlighted that a problem-solving approach was also more effective at reducing suicidal thoughts and behaviours, and improving various aspects of functioning than control interventions (Townsend et al., 2001).

Problem-solving therapy is a brief, focused form of cognitive therapy commonly used with people who experience depression or who engage in self-harm. In this approach self-harming behaviours are viewed as "dysfunctional coping strategies" (Muehlenkamp, 2006, p.168). It focuses on the problems a person is currently facing and on helping to find solutions to those problems and teaching coping and problem-solving skills (Muehlenkamp, 2006). Importantly, problem-solving therapy shifts the focus of therapy from the client to the framework of the family unit. This approach differs from other therapies by emphasising the social context, or social situation, of human problems. In a review of the literature, Muehlenkamp (2006) reports mixed support for the efficacy of problem-solving therapy. However some studies in this review found that problem-solving therapy reduces depressive symptoms and feelings of hopelessness and may therefore decrease self-harming behaviours.

In CBT and other problem-solving approaches, parental involvement is considered to be a key factor in influencing outcomes, especially given the very strong correlation between parental and child anxiety (Cobham, Dadds, and Spence, 1999) and parental and child depression (Bond et al., 2005).

In summary, while there is a growing body of research to support CBT as an intervention for behavioural and emotional problems in young people, CBT is currently considered to have a 'promising' but not well-established, evidence base as an intervention for anxiety or depression in young people (Ollendick and King, 2004; Weisz et al., 2006) and further research is needed.

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) is described as a time-limited therapy which focuses on the individual's current difficulties in functioning (Mufson et al., 2004). The aim of IPT is to reduce depressive symptoms by improving the individual's interpersonal functioning and is based on the premise that a deficit in interpersonal functioning is the cause of the depression (Gallagher, 2005).

Interpersonal Psychotherapy has its roots in attachment theory (Bowlby, 1980), where the focus is on interpersonal relationships. As noted in Section 2.5, attachment theory states that infants' early attachments with their caregivers form the basis for future relationships. These attachment styles can be modified throughout the lifespan, meaning that an individual who has poor attachments early in life is still able to form secure attachments later in life. Secure attachments (a balance between exploring the world and attachment to one's caregiver) are thought to lead to improved mental health; insecure attachments make the individual less adaptable to stress and can lead to unsatisfactory relationships (Durkin, 1995). Based on this notion, IPT focuses its attention on relationships that are either secure or insecure for the individual.

When working with adults, a therapist using IPT focuses on four main areas where interpersonal difficulties may be leading to depressive symptoms: grief, interpersonal disputes, role transitions, and interpersonal sensitivities (Mufson and Pollack Dorta, 2003). The aim is to identify the specific interpersonal relationship difficulties within one of these four key areas in order to effectively treat the symptoms of ensuing depression.

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[4] Effective programs involve defining the specific current problems and then systematically identifying appropriate goals, whilst also using various cognitive strategies to identify and challenge dysfunctional beliefs.

In order to be more developmentally appropriate, IPT has also been adapted for adolescents (Interpersonal Psychotherapy for Depressed Adolescents; IPT-A) (Mufson and Pollack Dorta, 2003). IPT-A works by building the competence level of the adolescent and this is particularly important given the requirement in IPT-A that the young person leads the therapeutic process (Mufson and Pollack Dorta, 2003). The structure of IPT-A is very similar to that of IPT; however a fifth area of potential difficulty has been added to address the fact that so many young people come from single-parent families.

There is also a parent component to IPT-A, and their involvement ranges from being present for simple psycho-education to engaging in numerous sessions. Given the underlying theoretical basis for IPT, engaging an individual's significant caregivers in the therapeutic process can be beneficial (Mufson and Pollack Dorta, 2003), although care should be taken when there is conflict within the relationship.

Studies comparing the efficacy of IPT to 'treatment as usual' have found that IPT is significantly better at reducing symptoms of depression (Mufson et al., 2004; Hazell, 2003). Research on the impact of IPT as an intervention for anxiety in adolescents is sparse. Of the few studies conducted, it appears that IPT is not effective in reducing anxiety (Feske, Frank, Kupfer, Shear and Weaver, 1998).

Depression in adolescents: IPT compared to CBT

Given the positive findings of both IPT and CBT for depression, it is important to consider their comparative efficacy. One of the first reviews comparing CBT and IPT (Asarnow, Jaycox and Thompson, 2001) identified one study that showed greater benefit from treatment with IPT than from CBT. In the other studies reviewed there was no difference between the two approaches (Asarnow et al., 2001). Two further reviews, one a meta-analysis by Feijo de mello, de Jesus Mari, Bacaltchuck, Verdeli, and Neugebauer (2005) and a review by Seligman et al. (2004) have found IPT to be more efficacious at treating adolescent depressive symptoms than CBT. Some studies have also found stronger effects for IPT in older adolescents with depression (Mufson et al., 2004). This may be because of an increased focus on interpersonal relationships in late adolescence, or perhaps because of more advanced cognitive capacities which allow the adolescent to better comprehend and engage in therapy. IPT has also been compared with Solution Focused Therapy for depression, and the study found no significant differences between the approaches.

In their review of the literature, Asarnow et al. (2001) found that increased family stress was associated with a longer and more intense initial episode of depression in the adolescent and factors such as high parental criticism and over-involvement were associated with adolescent depression. These findings provide a framework within which to understand why IPT shows more promising results than CBT in treating depression. That is, if interpersonal factors within the family are associated with adolescent distress and contribute to increased levels of depression, then it follows that interventions aiming at improving these factors will likely have a better effect than those which focus more on the individual's thought processes, such as CBT (Gallagher, 2005).

Trauma-Focused Cognitive-Behavioural Therapy

The goal of Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) is to help address the unique biopsychosocial needs of children 4 to 18 years of age who are experiencing Post Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, particularly sexual abuse. TF-CBT is a model of psychotherapy based on social learning and cognitive theories and combines trauma-based interventions with CBT. Non-offending parents are included in the treatment process to enhance support for the child, reduce parental distress, and teach appropriate strategies to manage child behavioural reactions. In the latter stages of therapy, family sessions that include siblings may also be conducted to enhance communication (Cohen and Deblinger, 2004).

TF-CBT is a clinic-based, individual short-term intervention that involves separate sessions with the child and parent as well as joint parent-child sessions. Children and parents are provided with knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviours; emotional regulation skills; stress management skills; enhancing safety; re-education about healthy interpersonal relationships; parenting skills; and family communication (Cohen and Deblinger, 2004; National Child Traumatic Stress Network). TF-CBT also places sexual abuse and other traumatic experiences into a broader context of children's and young people's lives so that their primary identity is not that of a victim (Cohen and Deblinger, 2004).

Recent evidence suggests that TF-CBT is effective in alleviating symptoms of children who have experienced sexual abuse and other traumatic events (Berliner, 2005; Cohen, Mannarino, and Knudsen, 2005). TF-CBT has been compared to nondirective supportive therapy in a randomised, control trial 82 children and young adolescents (7 to 14 years old) (Cohen et al., 2000; Cohen, 1998; Cohen and Mannarino,1998; 1996a, 1996b; Cohen, Mannarino and Knudsen, 2005). The nondirective supportive therapy consisted of child- or parent-directed supportive therapy. Among those young adolescents who completed the intervention, TF-CBT was superior to nondirective supportive therapy in improving anxiety, depression, sexual concerns and social competence at the end of the intervention, and in improving PTSD symptoms at one-year follow-up (Cohen and Mannarino, 1998; Cohen et al., 2005).

In this study, both the type of treatment (ie. TF-CBT) and parental emotional distress mediated the positive outcomes of the study. At one-year follow-up, the strongest predictor of positive response in the TF-CBT group was parental support of the child (Cohen and Mannarino, 1998, 1996b).

In a multi-site randomised control trial conducted by Cohen, Deblinger, Mannarino and Steer (2004), TF-CBT was found to be effective in reducing symptoms of post traumatic stress in children exposed to a variety of different and multiple traumas. Two hundred and twenty nine 8 to 14 years olds were assessed and those children who had experienced sexual abuse were found to have high rates of other traumas including sudden loss of a loved one, exposure to domestic violence, physical abuse, accidents and other traumatic events. The results showed that the intervention was superior to the non-directive supportive therapy even for these children with multiple trauma histories. A very similar intervention delivered in schools to children exposed to community violence was also shown in a randomised trial to produce positive results (Stein et al., 2003) when compared with a group of children exposed to community violence who did not receive the intervention.

Berliner (2005) suggests there is now ample evidence that TF-CBT should be the first-line approach for PTSD, anxiety and depression in sexually abused children and likely to be effective for children exposed to other traumas as well. (Saunders, Berliner and Hanson, 2003; Chorpita, 2002; Cohen et al., 2000).

Group work with adolescents

Various group interventions have been developed and tested with adolescents, including groups for social skills, cognitive-behavioural groups, psychoanalytic and psycho-educational groups, and other specialised groups, for example, groups for chronically ill and disabled young people, those with a mental illness and those who have been sexually and physically abused (Corder, Haizlip, Whiteside and Vogel, 1980; Kymissis, 1993; Reeker, Ensing and Elliot, 1997; Stevenson, 1999; Nurcombe et al., 2000; MacMillan, 2000; Berliner and Kolco, 2000; Dufour and Chamberland, 2004). Glodich and Allen (1998) note that an extensive literature endorses group therapy as an appropriate mode for the delivery of interventions for adolescents and some of the therapeutic approaches described above have also been used and tested in group situations.

According to Chaffin, Bonner, Worley, and Lawson (1996), there are a number of reasons why group work is considered to be successful with adolescents, for example:

- adolescents accept comments more readily from peers than from adults

- groups offer the advantage of peer interactions and emphasise the importance of relationships

- group norms can be a powerfully socialising influence

- members can benefit vicariously from the work done by others

- groups provide opportunities for listening without demands.

It is believed that group work is more successful in gaining the immediate participation of young people and alleviating the early resistance that can characterise individual therapy with adolescents (Glodich and Allen, 1998). Furthermore, peer relationships are viewed as central in helping adolescents with the process of separation-individuation and identity development. Groups can support a positive connection between young people and interpersonal styles and social skills can be observed (Chaffin et al., 1996). Importantly, participation in groups can reduce a young person's isolation and feelings of 'differentness' by engaging with others who have similar experiences (Chaffin et al., 1996; Gagliano, 1987; Kymissis, 1993; MacLennan,1991; Schamess, 1993; Grayston and De Luca, 1995). In addition to the value of connecting with peers, Eder (2006) draws attention to the important role of the group facilitator or therapist who forms a therapeutic relationship or alliance with individual young people. This relationship is important in facilitating positive outcomes for adolescents (Eder, 2006).

Most commonly group therapy has been used for adolescents who have experienced sexual abuse. Research indicates improvements in levels of anxiety, fear, depression, self esteem, feelings of competence for one to two years after attending group interventions in young people who have been sexually abused (Gagliano, 1987; Kitchur, 1989; Rice-Smith, 1993; Reeker et al., 1997; Stevenson, 1999; Nurcombe et al., 2000; Dufour and Chamberland, 2004). For children and young people who have experienced other forms of abuse there is less evidence of the value of group interventions (Dufour and Chamberland, 2004).

Group interventions with young people have been effective in managing social phobia in female adolescents (Hayward, Varady, Albano, Thienemann, Henderson and Schatzberg, 2000) and anger in adolescents (Snyder, Kymissis & Kessler 1999). Adolescent depression has also been shown to be responsive to cognitive-behavioural group therapy, especially when combined with booster sessions when full recovery was not attained at the end of the initial therapy (Clarke, Rohde, Lewinsohn, Hops and Seeley, 1999). This finding is important as it highlights the value of booster sessions with adolescents,

While group interventions are effective for a range of problems, it is unclear as to whether individual or group CBT is more effective (Eder, 2006). Some meta-analyses have shown a slightly increased effect size for individual therapy in comparison to group therapy (Weisz et al. 1995) but the differences in outcomes have not reached significance. Prout and DeMartino (1986) found that in schools, group treatments were more effective than individual interventions but the small number of studies that involved a combination of group and individual interventions produced better outcomes (Prout and DeMartino, 1986).

3.2   Parent focused interventions/programs

Overview of Parenting Programs

The term 'parenting programs' is an umbrella term used to describe all forms of parenting interventions, including parent education, parent training, and parenting support. Parenting programs can be implemented as an early intervention to prevent the onset of problems or to ameliorate the severity of existing problems in high risk children and youth. Research examining the efficacy of parenting programs for child, parent and family outcomes has overwhelmingly focused on the preschool and early school-age years, and there is a lack of studies that have focused on parenting interventions for adolescents. One of the reasons for the lack of research on parenting programs for youth is the assumption that parental influence becomes less important as children enter adolescence, due the increasing influence of peers, and due to young people spending less time in the home and therefore being less amenable to change through typical parenting strategies (Kazdin, 2005). However, research confirms the strong and enduring influence of parenting practices during the adolescent period (DeVore and Ginsburg, 2005) and it is clear that parents have an important role to play in supporting their adolescent in the transition to adulthood.

Parenting programs for parents of adolescents largely aim to modify the risk factors of coercive family interaction and poor parenting which have a role in causing and/or maintaining externalising behaviour problems and delinquency (Dishion and Andrews, 1995; Dishion and Patterson, 1992). Parenting programs also aim to enhance parent-child communication and connectedness and improve parental supervision and monitoring. Parental supervision, in particular, appears to be of crucial importance in preventing a range of adolescent risk behaviours (Coleman, 1997; DeVore and Ginsburg, 2005). Parenting programs may also address additional family risk factors such as parental stress and depression and marital conflict.

There are a number of parenting programs that have been evaluated in the prevention of maladaptive outcomes in young people, such as conduct problems, smoking, and alcohol and substance use. However, there is a paucity of research examining the effectiveness of parenting programs as an *intervention* for young people who are already experiencing difficulties, and no parenting programs have been evaluated in the child protection context. For example, Australian parenting programs such as *Teen Triple P* (Ralph and Sanders, 2006) and *Parenting Adolescents: A Creative Experience* (PACE; Toumbourou and Gregg, 2002) have only been evaluated as preventive interventions and have not been investigated with high risk populations. Of the studies that have been conducted with high risk populations, the majority have evaluated the effectiveness of Parent Management Training.

Parent Management Training

Parent Management Training (PMT) is based on social learning principles and involves intervention procedures in which parents are trained to alter their child's anti-social behaviour at home (Kazdin, 1997). PMT is also known as behavioural parent training, parent training, parent behaviour management training and contingency management (Kazdin, 2005). PMT aims to modify coercive parent-child interactions that foster aggressive and anti-social child behaviour. Patterson's (1982) coercion hypothesis states that parents and children establish a pattern of interaction in which parents escalate their discipline over time to keep up with the children's similarly escalating aversive responses. Within PMT, parents are taught how to change this coercive interaction by promoting desirable, pro-social behaviours in their child or adolescent and applying discipline to minimise undesirable behaviours. PMT can be delivered in individual or group settings, and parents are taught specific behaviour modification skills via active skills training involving practice, role play, feedback and modelling by the therapist (Kazdin, 2005).

PMT has been predominantly utilised in the management of externalising problem behaviours, including oppositional defiant disorder and conduct disorder. A meta-analysis of behavioural parenting interventions found evidence to support the short-term effectiveness of parent training in modifying anti-social behaviour at home and at school and in improving parental adjustment (Serketich and Dumas, 1996).

However, most of the studies in this meta-analysis were conducted with children aged 3 to 10 and there have only been a few studies with parents of adolescents. Some authors have suggested that adolescents may respond less well to PMT than younger children, although this effect appears to be accounted for by the severity of behaviour problems rather than the age of the child (Dishion and Patterson, 1992; Ruma et al., 1996).

Despite the lack of research, there is some evidence to suggest that PMT may be effective in improving parenting skills and reducing adolescent conduct problems. PMT ('contingency management') was found to be superior to communication skills training in reducing clinically significant problem behaviour in youth with conduct disorder (Hughes and Wilson, 1988). Bank, Reid, Patterson and Weinrott, (1991) examined the effectiveness of PMT for families of chronically offending delinquents by comparing it to a community intervention based on a family systems approach. PMT resulted in a faster reduction in arrest rates over the three-year follow-up and fewer days spent in institutional settings. Those in the PMT condition spent a total of 1287 fewer days in institutional confinement from the onset of intervention through to 2-year follow-up.

Studies have also sought to combine PMT with other empirically supported interventions in an effort to enhance effectiveness. An intervention targeting adolescent-focused problem-solving plus PMT had a more significant impact on child behaviour and parental dysfunction than PMT alone (Kazdin, Siegal and Bass, 1992). Similarly, an intervention that offered an adjunctive intervention targeting parental stress in addition to PMT and adolescent-focused problem-solving showed less severe youth anti-social behaviour, and greater reduction in parental depression and stress than PMT and problem-solving alone (Kazdin and Whitley, 2003). These finding are not surprising, and suggest that more intensive or multi-modal interventions that include the young person and target a greater number of risk and protective factors may result in more significant and durable treatment effects.

However, not all intensive interventions have resulted in enhanced outcomes for children and young people. Dishion and Andrews (1995) developed the *Adolescent Transitions Program* (ATP) as a preventive intervention for high-risk families to promote adaptation in the adolescent years. Families were randomly allocated to one of four ATP programs: parent-focused group (PMT), teen-focused group, parent-plus-teen focused group, or a self-directed program. Of concern, the two interventions that aggregated teens into groups (teen-focused and parent-plus-teen focused) showed escalations in tobacco use and teacher-rated problem behaviour at one-year follow-up, suggesting that aggregating high-risk youths into groups may serve to increase risk behaviour via increasing contact with deviant peers.

PMT has also been evaluated as an intervention for family conflict in families with young people with ADHD. PMT was found to be equivalent to communication skills training and structural family therapy in reducing negative communication and improving child behaviour (Barkley, Guevremont, Anastopoulos and Fletcher et al., 1992). Similarly, PMT plus family problem-solving was equivalent to family problem-solving training alone in changing parent and adolescent behaviour (Barkley, Edwards, Laneri, Fletcher and Metevia et al., 2001).

It should be noted that parenting programs for young people can also be delivered as part of multi-component program, with interventions that also target the young person directly, often within the school setting. While there is a lack of research that has compared single component and multi-component programs, there is some evidence that multi-component programs that target a range of risk and protective factors are more effective than single component programs (Tully, 2007).

While there is clearly a lack of research on parenting programs for parents of adolescents, it not known the extent to which such parenting programs are commonplace in clinical practice. Shaffer (1997), for example, reported that within California, it is common practice for the courts to refer parents of offending adolescents to parenting programs. These are typically 10-week group programs completed within three months of sentencing. However, there does not appear to be a clear theoretical basis for these programs, nor is there any evidence to support their efficacy. Thus, it may be that mandated and court-referred parenting programs are commonplace in clinical practice, yet largely unsupported by research evidence.

3.3   Family focused approaches

Based on the social-ecological theory proposed by Bronfenbrenner (1979) many theorists and practitioners have recognised the need to tailor interventions towards not only the individual adolescent but also towards the significant others in the adolescents' lives Including school and peers, the local community.

Family based interventions hold that family functioning may cause, maintain or worsen adolescent conduct disorder or risk behaviours such as substance misuse. If family relationships are appropriately modified, these approaches can be effective in reducing the problem behaviours (Woolfenden, Williams and Peat, 2001). For example, research into adolescent substance misuse has found that family factors (such as poor communication, parental criticism, ineffective discipline, emotional disengagement) can negatively impact on the adolescent and increase their risk of substance abuse (Curry, Wells, Lochman, Craighead and Nagy, 2003; Liddle, Rowe, Dakof, Ungaro and Henderson, 2004). Consequently, family focused interventions that target negative patterns of interaction have been found to be the most effective approaches to adolescent substance abuse when compared with individual supportive interventions or skills training (Carr, 2003). Other research, such as that by Ogden and Halliday-Boykins (2004) found, with a sample of young people presenting with anti-social behaviours, that improving family functioning by working with them within their own social context decreased anti-social behaviours.

It has also been proposed that family therapies may be effective in managing the symptoms of ADHD. A recent Cochrane review (2005) reported two studies examining family therapy for ADHD. One study found no difference between family therapy and treatment with medication (Bjornstad and Montgomery, 2005) and in a second study family therapy was found to be more effective than a medication placebo (Bjornstad and Montgomery, 2005). Further research is required in this area.

By involving family members in the intervention there is a shift in the focus of problem from within the adolescent to within the family; this may have particular therapeutic benefits for the adolescent. As noted previously, however, the inclusion of the family in the interventions for young people may not be appropriate for all families. It is important to consider factors such as the young person's age and level of maturity, as well as the current level of parental/familial involvement. In addition, and probably the most important factor, is the nature and supportiveness of the relationship between adolescent and their family.

In this section of the paper a number of approaches to family therapy are briefly described, for example, Functional Family Therapy, Brief Strategic Family Therapy, Multidimensional Family Therapy (MDFT) and Multi-systemic Therapy (MST). Overall, family based approaches have been found to be most effective for adolescents with conduct disorder and substance misuse.

Functional Family Therapy

Functional Family Therapy (FFT) has been described as a behavioural model which works within the family system in an attempt to alter maladaptive family interactional patterns which might contribute to adolescent behavioural difficulties, such as substance misuse and conduct problems (Barrett Waldron, Slesnick, Brody, Turner, and Peterson, 2001; Sexton and Alexander, 2000). FFT is an intervention specifically oriented towards 'at risk' youth and their families. Barrett-Waldron and Kern-Jones (2004, p.335) noted that FFT works with the assumption that "family members and their behaviours are mutually interdependent and that the meaning of behaviour resides in the context of relationships".

The program is aimed towards adolescents between the ages of 11 and 18 from various cultural backgrounds. It is a short-term, structured therapeutic intervention for the adolescent, their parents (or significant adult figures), as well as any younger siblings (Sexton and Alexander, 2000). All family members attend sessions conjointly.

Barrett Waldron et al. (2001) have identified two stages of treatment within FFT. During the first stage, the primary goal is to engage the family, conduct a thorough assessment, and uncover patterns of communication, beliefs about problems and potential solutions, identify current contingencies used to manage the young person's behaviour, and enhance any motivation for change. The emphasis is moved from blame for a particular problem behaviour allocated to the young person, to discussing the relational difficulties within the family which have led to the problem behaviour.

The second phase of treatment focuses on exacting behavioural change within the family system, using predominantly practical behavioural techniques (for example, communication skills, problem solving, contingency management). The use of these techniques is guided by the assessment of the particular problem areas, and the aim is to assist the family to find more adaptive ways of interacting, while still having their needs met.

Numerous studies have demonstrated the efficacy of FFT for dealing with delinquent behaviours, drug use, and other externalising problems within the family context (see Sexton and Alexander, 2002, for review). Brosnan and Carr (2000) in their review of studies of FFT and other family therapies conclude that eight to 36 sessions of family therapy is effective in improving family communication, reducing conduct problems and reducing recidivism rates in delinquent adolescents with severe conduct problems from a range of socio-economic backgrounds. Improvements were maintained up to three and half years after the intervention.

Sexton and Alexander (2002) have also noted that FFT has a significant positive impact not only on the 'target' young person, but also on other members of their family, including younger siblings who may look up to their older sibling. In this way, FFT works not only to intervene with the family currently, but also to potentially prevent future difficulties with other family members.

Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) is an approach that requires the therapist to be pragmatic, problem focused, and goal directed in their interventions (Szapocznik and Kurtines, 1989). BSFT is based on social learning theory and attachment and the underlying premise is that adolescents' problem behaviours are the product of maladaptive family interactions and poor boundaries. Therapy aims to alter these interactions to improve the family system as a whole, as well as changing the adolescent's specific maladaptive behaviour(s) (Santisteban et al., 2003). In contrast to socio-ecological approaches such as MDFT and MST, it maintains a consistent focus on 'within family' work (Santisteban, Suarez-Morales, Robbins and Szapocznik, 2006). BSFT has been found to be effective with culturally diverse adolescents (Santisteban et al., 2003).

The unique aspect of BSFT is the development of research based strategies for engaging reluctant family members to participate in the intervention. In addition, the researchers have developed strategies for 'joining' with family members (Sexton and Robbins, 2005), for diagnosing and assessing family interactions (Szapocznik et al., 1991), and for restructuring family interactions that have been linked to severe adolescent behaviour problems and substance abuse (Santisteban et al., 2003). Such dimensions of family functioning include family conflict, lack of support, poor communication, poor limit-setting, inadequate parental monitoring, inconsistent parenting, and parental drug use, which have been shown to impact the emergence and maintenance of adolescent behaviour problems and drug use (Ary, Duncan, Duncan and Hops, 1999; Gorman-Smith, Tolan, and Henry, 2000; Lindahl and Malik, 1999; Loeber, Farrington, Stouthamer-Loeber, and Van Kammen, 1998). Finally, the researchers have applied findings from basic research on the cultural factors prominent among the Hispanic population to their studies of this intervention (Szapocznik, Scopetta, Aranalde, and Kurtines, 1978).

A study of 122 African American and Hispanic young people demonstrated that BSFT impacted on risk factors for substance use, which suggests that BSFT showed promise as a prevention intervention (Santisteban et al., 1997). Although the results of this study should be interpreted with caution due to the lack of a control group, the findings suggest that child behaviour problems and poor family functioning were predictors of substance use initiation nine months later, and that BSFT could effectively impact on these risk factors.

In a more recent study (Santisteban et al., 2003), 126 Hispanic adolescents with challenging behaviour and substance misuse problems were randomly assigned to either BSFT or group counselling. In this study, two findings were worthy of consideration. The first was that BSFT was significantly more effective than group counselling in reducing conduct problems, associations with anti-social peers, marijuana use, and in improving observer-rated family functioning. The second finding was that family changes were found to be associated with changes in behaviour problems only for those families who entered treatment with poor family functioning (Santisteban et al., 2006). The researchers identify that there is much to learn about tailoring family interventions to the profile of the family at service entry (Santisteban et al., 2006).

Multidimensional Family Therapy and Multi-systemic Therapy

Multidimensional Family Therapy (MDFT) and Multi-systemic Therapy (MST) are based on Bronfenbrenner's ecological approach and emphasise the importance of working within a young person's and family's 'systems', (Barrett-Waldron and Kern-Jones, 2004). Both approaches recognise that risk factors associated with anti-social behaviour and emotional problems arise from many levels of influence (Henggeler, Pickrel et al., 1999; Burns, Schoenwald, Brown and Henggeler, 2000)[5]. Such influence extends beyond the young person to multiple factors within their social or natural environments (for example, the family, peer group, school environment, and the community or neighbourhood) contributing to the development and maintenance of the problems (Bronfenbrenner, 1979; Schoenwald et al., 2000; Cox, 2005).

Both MST and MDFT target multiple risk and protective factors, within a variety of domains of the adolescent's functioning (Liddle et al., 2004) and have been described as 'flexible' interventions in terms of the intensity and number of sessions, as well as the mode of therapeutic delivery (Barrett-Waldron and Kern-Jones, 2004; Liddle, 2004). For example, some interventions may need to occur in the school with the young person's peers. The primary difference between these two interventions is the mode of delivery; MDFT works with adolescents and their families on an outpatient basis, while MST is home-based with therapists available 24 hours a day, 7 days a week for troubled families (Austin, Macgowan and Wagner, 2005).

In essence, MST aims to 'correct' behaviour by improving family emotional bonding and parental discipline strategies, increasing parent-teacher communication and academic performance, promoting involvement in extracurricular activities, structured sports, or volunteer organisations (Kashani, 1999)[6].

To maximise the likelihood of affecting change, the entire family is usually involved in the program: parents, as well as young people receive treatment to address any barriers to effective parenting such as substance abuse or stress (Henggeler, 1982; Burns et al., 2000; Lyons and Rawal, 2005). Problem areas are identified, together with formal and informal sources of support. Based upon initial assessments, therapists develop an individualised strategy for the young person, and then implement an intensive treatment 'package' using a variety of therapeutic techniques including structural family therapy, strategic family therapy, behavioural parent training, cognitive behaviour therapy and social skills training.

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[5] Multi-systemic Therapy is reviewed in detail in the paper 'Models of service delivery and interventions for children and young people with high needs' prepared by the Centre for Parenting and Research.

[6] MST is based on theories of behaviour including systems theory (Bertalanffy, 1968), social ecology, and human development (Bronfenbrenner, 1979), cognitive development, childhood psychopathology, family therapy models and community mental health (Henggeler, 1982; Lyons and Rawal, 2005). It uses the family preservation model of service delivery as an alternative to more restrictive settings (Sheidow et al., 2004).

MDFT appears to have gained the most consistent support as an effective approach to drug misuse (Austin et al., 2005; Centre for Treatment Research on Adolescent Drug Abuse, 2002; Liddle, 2004; Liddle et al., 2004).

Several reviews have classified MST as a 'promising treatment model', and an empirically established 'evidence-based' treatment for young people with serious emotional disturbance and anti-social behavioural problems (Lyons and Rawal, 2005; Burns et al., 2000; Rosenblatt and Woodbridge, 2003) and those who are at imminent risk of out-of-home placement (Rowland et al., 2004; Rowland et al., 2005; Dirks-Linhorst, 2004; Henggeler, Melton and Smith, 1992). In general, positive outcomes for young people, their parents and families, involved in MST, have included extensive improvement in family and peer relations, particularly higher family cohesion and lower peer aggression (Henggeler et al., 1992), effective restructuring of problematic parent-child relations with abusive and neglectful families (Brunk, 1987).

Results from these studies support the short- and long-term clinical effectiveness of MST as well as its potential to produce significant cost savings and capacity to retain families in treatment. In comparison with control groups, MST has consistently demonstrated improved family relations and family functioning, improved school attendance, decreased adolescent drug use, 25% to 70% decreases in long-term rates of rearrest, and 47% to 64% decreases in long-term rates of days in out-of-home placements. Given that a large body of literature supports a multi-determined aetiology of child maltreatment, comprehensively addressing the factors that may influence maltreatment seems logical. To date, one randomised trial has taken on this challenge by evaluating the effectiveness of MST versus parent training with abusive and neglectful families (Brunk, Henggeler, and Whelan, 1987). MST was more effective than parent training for improving parent-child interactions associated with maltreatment. Abusive parents showed greater progress in controlling their child's behaviour, maltreated children exhibited less passive non-compliance, and neglecting parents became more responsive to their child's behaviour.

Other studies of MST have reported decreased behavioural problems at home and school (Henggeler et al., 1986), reduction in anti-social behaviour including lower recidivism rates for arrests, sexual offences and criminal offences (Borduin, Henggeler, Blaske and Stein, 1990), reduction in incidence and severity of criminal acts, fewer arrests for violent crimes (Borduin et al., 1995, Schoenwald and Borduin, 1998), and lower rates of out-of-home placements (Kashani, 1999). Similar to MDFT, MST has also proven effective in reducing drug use (Borduin et al., 1995; Henggeler et al., 1992; Henggeler, Pickrel and Brondino, 1999). A recent Cochrane systematic review has identified family and parenting interventions in particular MST as effective in reducing conduct disorder and delinquency (Woolfenden, Williams and Peat, 2001).

In sum, each of the family based interventions discussed here, are all significantly better at reducing adolescent substance abuse than 'treatment as usual'. While components of these forms of family therapy differ, the underlying principles are the same and include:

- enhancing positive family relationships by improving communication and conflict resolution

- tackling problems within the family which are maintaining the adolescent's substance abuse

- increasing the level of support provided from parent to adolescent

- shifting the focus of the problem from something within the adolescent to something within the family system.

Summary

This section has reviewed the interventions and therapies that are effective for range of problems that adolescents may face including depression, anxiety, PTSD, conduct disorder and substance misuse.

Both CBT and IPT are promising interventions for young people with depression and CBT has been found to be the most 'efficacious' intervention for anxiety in adolescents. For young people who have been sexually abused and who experience PTSD, anxiety and depression, there is strong evidence that TF-CBT is the most appropriate intervention (Saunders et al., 2003; Chorpita, 2002; Cohen et al., 2000; Berliner, 2005). Group interventions using approaches such as CBT have also been developed and evaluated with adolescents. Most commonly, group therapy has been used for adolescents who have experienced sexual abuse. For these young people, research demonstrates improvements in levels of anxiety, fear, depression, self-esteem and feelings of competence after attending group interventions (Gagliano, 1987; Kitchur, 1989; Rice-Smith, 1993; Reeker et al., 1997; Stevenson, 1999; Nurcombe et al., 2000; Dufour and Chamberland, 2004).

Families within the child protection system are frequently referred to parenting programs. However, there is a lack of research that has examined the effectiveness of parenting programs as an *intervention* for young people who are already experiencing difficulties, and no parenting programs for young people in this age range have been evaluated in the child protection context. PMT may be effective in improving parenting skills and reducing adolescent conduct problems particularly if delivered in as an intensive or multi-modal intervention that include the young person and target a greater number of risk and protective factors.

Family focused interventions (particularly MDFT and MST) that target negative patterns of interaction have been found to be the most effective approaches to adolescent substance abuse (Henggeler and Pickrel, 1999; Carr, 2003; Liddle, 2004) and anti-social behaviour (Lyons and Rawal, 2005; Ogden and Halliday-Boykins, 2004; Burns, et al., 2000), and are promising in relation to young people with ADHD.

4. Effective strategies for casework practice with adolescents

This section of the paper focuses on effective strategies for casework practice with adolescents and their families that lead to positive outcomes for the young person.

To date, little research has focused on the nature and characteristics of effective casework practice with children, adolescents and their families. In their review of effective interventions for maltreated children, Dufour and Chamberland (2004, p.44) comment that: 'casework interventions are one of the least evaluated types of interventions aimed at maltreating parents … despite the fact that this best reflects the day-to-day child welfare work'.

Due to the paucity of research about effective casework practice, this section of the paper draws on a broad range of research and other literature to provide practical information about 'what works' in casework practice with adolescents. This section is also informed by the findings of the Caseworkers Study, a study of Department of Community Services staff perceptions of effective strategies for working with adolescents and their families (see Schmied & Walsh, 2007).

The following issues are examined in this section:

- the nature of child protection casework with adolescents, including building a relationship and facilitating engagement with the young person and strategies and activities used to support adolescents

- working successfully with the young person's family

- the characteristics of successful interagency work

- the organisational factors that influence casework practice and outcomes for young people.

Hammond (2005) notes that research over the past 40 years indicates that the two best predictors of successful change in young people are engagement in meaningful relationships and engagement in meaningful activities. These two issues are used to focus the discussion in this section.

4.1 The nature of casework practice with adolescents

Building relationships and facilitating engagement with young people

Establishing a positive relationship is the basis of practice in all aspects of casework with children, young people and families (Trotter, 2004; Davis et al., 2002). In the Caseworkers Study, participants described casework practice with adolescents as a collaborative process of "walking it together" with the young person. In this process, the caseworker is the "common denominator", linking the adolescent, their family and other services or agencies. The caseworker's key role is to build and maintain a relationship with the young person and, as appropriate, their family in order to facilitate engagement in services (Schmied & Walsh, 2007). For each adolescent the dynamics of this relationship may differ.

The importance of, and challenges to, forming a therapeutic relationship with an adolescent are demonstrated by studies within the field of psychotherapy. However, the relationship between caseworkers and adolescents in the child protection context is rarely studied or described in the literature (for exceptions see Jones, 1987; Hill, 1999; Malekoff, 2005; Maidment, 2006).

Oetzel and Scherer (2003) found that the therapeutic relationship between the psychotherapist and child or adolescent is critical to positive change. It can be particularly difficult to establish a therapeutic or helping relationship with adolescents due to the fact that they rarely refer themselves for support or treatment (Hill, 1999) and will typically have limited insight into the strength and nature of their difficulties (Shirk and Karver 2003; Oetzel and Scherer 2003). Professionals such as social workers and

psychologists are frequently regarded with considerable caution due to their roles and functions being unclear or poorly understood (Hill, 1999). In addition, the young person is striving for autonomy from the family unit and this may mean that they do not necessarily have the desire to build new relationships with adults.

Within the context of child protection it may be even more difficult for workers to establish a positive relationship with an adolescent. Their caregivers may have either been reported for child protection concerns or they may have reported the young person to child protection authorities. The young person may disagree that there is a problem, and feel as though they have lost their power and control in the situation. Further, as reported in the Caseworkers Study, adolescents are suspicious of caseworkers who they may perceive to be breaking up their family unit (Schmied & Walsh, 2007).

Key elements of the relationship

Participants in the Caseworkers Study described three key elements of the relationship between caseworkers and young people that will facilitate the engagement of the young person in services. These elements are:

- commitment to the young person

- connection with, and an interest in the young person

- providing continuity of caseworker.

In the helping relationship, notions of commitment and 'going the extra distance' are important to effective relationships (Leigh and Miller, 2004). Commitment to a young person was described by caseworkers as "hanging in there", "sticking with them". The key message they want to give to the adolescent is "I am here if you need me" (Schmied & Walsh, 2007). Caseworkers identified the need to spend time with young people if they are to succeed in developing a relationship. Time is required to build trust (Hill, 1999). Spending time conveys respect and gives the message to the adolescent that they are worthwhile. However, in practice this may only be possible in longer-term casework

Being 'available' and 'reliable' are also key factors (Hill, 1999; Schofield and Brown; 1999) and involve caseworkers maintaining regular contact, having the flexibility to be contacted as needed, being punctual when meeting and encouraging the young person to initiate contact as required.

Massinga and Pecora (2004) and Hammond (2005) describe the importance of maintaining a positive regard for the young person, showing an interest and 'connecting with' them. Connection may be facilitated by, learning about the young person for example, their interests or hobbies, and 'doing the little things' (Schmied & Walsh, 2007).

The importance of commitment and connection is supported by Schofield and Brown (1999) who described how this made a difference to the lives of adolescent girls through the demonstration of clear-cut support: "…making sure to remember to make a phone call, turning up at the hospital at the right time, travelling to see a girl in difficulty in a residential unit. These were ordinary things but in a reliable pattern and within a theoretical framework" (Schofield and Brown, 1999, p.31).

Continuity of caseworker is identified by both caseworkers (Worrall-Davies, 2004; Schmied & Walsh, 2007), and young people (Jones, 1987; Hill, 1999) as an important factor in effective casework.

Caseworker attributes and skill

The child and family literature indicates that a caseworker's personal attributes and skill are crucial to the formation of an effective relationship (Davis et al., 2002; Elliot and Williams, 2003; Maidment, 2006). Caseworkers need to demonstrate attributes such as empathy, honesty, humility, being caring,

flexible, and practical. Caseworkers also require the skills of a professional helper such as being a good listener, being non-judgemental, able to be straight and be accountable to a young person. Through these personal attributes and skills, a caseworker will convey respect and gain the trust of an adolescent.

Malekoff (2005) recommends losing your self-importance – "credentials don't impress kids". It is important to be genuine. This includes admitting ignorance or mistakes, valuing the truth, reliability, honesty and sincerity, and maintaining a sense of humour (Malekoff, 2005). It is also important to accept that you don't have to be the 'expert' (Malekoff, 2005).

Others highlight the importance of workers being optimistic, holding an expectation that things will change for the better (Massinga & Pecora, 2004). Davis et al. (2002) refer to this as a 'quiet enthusiasm', a belief that the work is rewarding and can make a difference. This helps to prevent burn out, enhances the helping relationship by providing motivation and can be infectious to a young person.

At the same time, it is important to be accepting of adolescents and to have realistic expectations. Chown and Kang (2004) reinforce the need to be non-judgmental in working with adolescents. This helps the young person to be open and honest without fearing they will be lectured to. It is important to adopt a straightforward and honest approach, use plain language and avoid jargon (Chown & Kang, 2004).

It is also important to avoid the use of labels. Young people are frequently labelled by the community as well as by professionals. While diagnostic labels may be helpful to inform appropriate interventions, Ungar (2006, p.62) cautions against their use with young people because labels "are not benign…(they) define a young person's life by one single aspect of his or her life story". Instead Ungar (2006, p.62) stresses the value of finding out what makes a young person "unique, powerful and confident".

Establishing clear roles, expectations and boundaries

Establishing a relationship with a young person and their family and facilitating their engagement in services is not easy or straightforward and has to be balanced with the need to establish clear roles and boundaries. Clear communication is required during all stages of service provision including; definition of roles, developing a case plan, describing the purpose of any intervention, discussing referral options and establishing boundaries by informing clients of what is negotiable and what is not (Trotter, 2004). Young people need to know 'where everyone fits in' and what they can offer (Hill, 1999; Massinga and Pecora, 2004; Trotter, 2004; ACT Office for Children and Family Support 2002).

Boundaries are described as a limit or edge that defines an individual as separate from others (Okamoto, 2003). Boundaries are the framework within which the client/worker relationship occurs, making the relationship professional and safe for the young person and family (Okamoto, 2003), as well as setting the parameters within which services are delivered. The primary concern in establishing and managing boundaries with each individual must be the best interests of the young person and their family. Typically boundary setting will include outlining what will occur in an appointment or interview, the length of a session, time of session, the role of the caseworker, and the expectations of the young person (Hill, 1999; Massinga and Pecora, 2004).

There is a notable lack of literature or research to guide the development of professional boundaries in the caseworker/client relationship, particularly regarding boundary setting with young people. Trotter (2004) identified role clarity as a core component of child protection casework practice, but in a study of child protection casework with families in Victoria, he found that caseworkers tended to talk little about their role with families or attempt to clarify their dual role of investigators and helpers.

More recently however, authors have offered a critique of the construction of rigid professional boundaries within the helping relationship (see for example, Leigh and Miller, 2004; Ribner and Knei-Paz, 2002; Maidment, 2006). They argue, for example, that the traditional interpretations of what is considered appropriate in client/worker relationships (such as the little or no self-disclosure and not

accepting gifts or other tokens of appreciation) contrast with the views of those from Aboriginal and Torres Strait Islander populations, where self-disclosure and 'storytelling' is a necessary building block in the helping relationship (Maidment, 2006).

Discussing confidentiality

The need to respect confidentiality is identified consistently in the child and family literature (Hill, 1999; Poertner, 2000; Davis et al., 2002). Explaining the terms of confidentiality to the young person is very important in the initial stages of building a relationship, and may need to be discussed again later if sensitive issues arise. It is helpful to establish a format for discussing this with the young person in a way that feels natural and reflects the caseworker's style.

However, there are some circumstances where it may be necessary to break confidentiality, and it is important that the caseworker outline in advance the limitations to a confidentiality agreement. There are three main circumstances where it may be necessary to break confidentiality in order to protect the young person's safety:

- if the adolescent is threatening to harm or kill themselves

- if someone else is threatening or harming the young person, such as physical or sexual abuse

- if the young person is at risk of harming someone else.

Practice Strategies

While the relationship is central to work with children and families, it is a means to an end and not an end in itself (Jones, 1987; Hill, 1999; Trotter, 2004). The practice strategies caseworkers use with adolescents are crucial to facilitating positive outcomes. Dawson and Berry (2002), suggest that while caseworker attributes and skills are important, caseworker behaviours or practices are even more important than qualities. Qualities, they argue are best communicated through clear and concrete behaviours (Dawson and Berry, 2002). This is supported by participants in the Caseworkers Study who emphasised, young people need to be supported by practical strategies to assist them in achieving their goals, 'they need to be doing things, not just feeling better about it' (Schmied & Walsh, 2007).

The strategies identified in this section reflect a strengths-based approach to practice. It is important to emphasise that being strength-based does not mean simply focusing on positives and ignoring concerns or making up strengths that do not exist (Malekoff, 2005). Rather, it means recognising and utilising genuine strengths in the young person, parents and family in order to build competencies and effectively address concerns. A strengths-based approach means believing that young people have the resources to learn new skills and solve problems and therefore involve them and their family in the process of discovery, learning, and coping with the challenges they may face (Trotter, 2004; Hammond, 2005; Ungar, 2006).

Getting to know and understand the young person

In the Caseworkers Study, emphasis was placed on "seeing the person behind the behaviour". In practice, some of the behaviours displayed by 'at risk' young people can be confronting, offensive and/or dangerous. For many workers such interactions or experiences may be frightening and it is difficult to see beyond the behaviour. In order to get to know the adolescent as a person it is important to 'look back', to identify the experiences of abuse and neglect or deprivation, to understand where this person has come from (Schmied & Walsh, 2007). However, they cautioned that in their efforts to 'look back', caseworkers may inadvertently use the young person's past history to make excuses for their behaviour. This has the potential to limit the opportunities for the young person to learn to take responsibility.

Getting the young person's perspective and gaining their participation

Young people want to actively participate in decisions that affect their lives. Hill (1999), in reviewing research regarding young people's expectations in seeking help, found that caseworkers and parents often have different views to the young person regarding what the problem is and what needs to change. Hill stresses the need to clarify these differences so that common goals can be established and the young person is not labelled or 'pathologised'. The caseworker needs to avoid quick assumptions and focus instead on how the young person views their situation (Hill, 1999; ACT Office for Children and Family Support, 2002).

Ungar (2006, pp.42-43, 59) identifies some questions or prompts that may be useful in gaining the young person's perspective of the situation, for example:

- *I am curious about what you think is going on, what's making it difficult for you to stay at home?*

- *You said a couple of things have changed. You don't see some of your friends, you aren't playing football. Can you tell me more about these things?*

- *What are your friends like? What's special about them that has made you choose them as your friends?*

There are also important techniques for facilitating participation in decision making such as ensuring that the adolescent is well prepared for what is likely to happen at a case conference and being conscious of their support needs both during and after the meeting. Taking Participation Seriously is a resource that provides practical advice regarding how to involve children and young people in activities, events and decision-making about issues that affect their lives[7].

'Looking Forward' with the young person and their family and solution focused therapy

'Looking Forward' is a key strategy that was outlined in the Caseworkers Study as a strengths-based approach to assist a young person to look to the future. As described by a participant in the Caseworkers Study the focus is not on the problem:

> *You don't look at what is going wrong, you look at what is going right. Because you come in (when) 90% is going wrong, (instead) you try to look at the 10% that is going right and broaden it out to 12%-15%. So we might say "you're pretty good at this and we'll work on it"* (Schmied & Walsh, 2007).

'Looking Forward' is related to goal setting and case planning. Solution Focused Therapy is one approach that caseworkers find is effective in 'Looking Forward' and supporting young people to identify practical solutions.

Solution Focused Therapy (SFT) has been described as an intervention which facilitates change by focusing on the positive, the solution and the future (Anderson-Klontz, Dayton & Anderson-Klontz, 1999). Solution-focused therapy is developing an evidence base as an effective strength-based approach to providing individual and family support[8].

One of the key principles of SFT is that the client already possesses the necessary resources for effectively dealing with any difficulties and the role of the caseworker in this interaction is to facilitate their use of these pre-existing skills (Lethem, 2002). This is achieved through specific questioning about the interactions and relationships of the young person, and thus relates the difficulties being experienced to

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7 The NSW Commission for Children and Young People has developed resource materials to assist organisations and individual workers to promote the active participation of children and young people. The resource can be ordered online through the NSW Commission for Children and Young People (http://www.kids.nsw.gov.au/publications/tps_sections.html

8 Cochrane Review of Solution-focused therapy (Gingerich and Eisengart, 2000) found it to be significantly better than no treatment or standard institutional services. Paylo (2005) notes that solution-based therapies, (including brief, solution-focused and narrative therapies) are still in the initial stages of research with promising current results, however further research is required to address the effectiveness of these therapies with specific populations and presenting problems.

a relational context. The key message of SFT is to maintain focus on the solution, preferred futures and goals, not the problem. As Sharry and Owens, (2000, p.55) state 'such a positive, optimistic view of clients in itself can create the conditions for a good therapeutic alliance and engagement". Helpful strategies and questions from SFT include:

- **The "miracle question"** is a questioning technique that allows a formation of what a solution may look like (Paylo, 2005, p.456).

  When you go home tonight and fall asleep, a miracle happens. The reason you need to see me is no longer there. Because the miracle happened in the night, how would you know that it happened? What would be different? What would you be doing that is different?

- **Scaling questions** are useful to ascertain where the young person is now in relation to the problem and where they would like to be. For example,

  On a scale of 0 to 10, where 0 is the worst the problem can get and 10 is like the miracle has happened and there's no problem, where are you on the scale now? Where would you like to be on the scale in 3 months? What do you think needs to happen to help you move from 3 to 5 on the scale?

- **There are always exceptions to the problems**. It is important to explore with the young person when the problem occurs less often or is not there. Sharry and Owens (2000, p.55) suggest exploring and amplifying these times, for example,

  Are there times when the problem does not occur? What is happening then? What are you doing? If I was there what would I notice about you?

  Highlighting exceptional times can be very motivating to clients who feel helpless in the face of the problem. It allows them to begin to see the possibility that they can create change in their own lives.

- **Work with the young person's definition of the problem**. Using the young person's metaphors and language helps the solution to make sense to the young person and their life. "Working within clients' own descriptions can be more motivational and provides a better long-term fit for any solution generated" (Sharry and Owens, 2000, p.56).

The caseworker aims to provide opportunities for the young person to move from contemplating change to engaging in a change process. If the intervention is not working, the young person is not merely viewed as unmotivated. Instead, other factors are considered such as whether the caseworker needs to take a different approach.

Setting achievable goals and reviewing progress

Hammond (2005) and Chown and Kang (2004) argue that exploring and agreeing on goals that the young person is interested in, as well as agreeing on ways to reach those goals, are crucial steps to engaging a young person in meaningful activities. Participants in the Caseworkers Study talked about setting action oriented and practical goals as a component of 'Looking Forward':

> *It is important to set short term, realistic goals that are going to be achievable, for example something they might achieve on a weekly or fortnightly basis, just so you can see that they have got some direction for themselves with what they are doing. And not so caught up in the chaos of everyday things and not nebulous goals that they can't achieve* (Schmied, 2007).

It is also important to recognise when the young person needs more direction or assistance in making choices. A caseworker may need to take some control over the setting of goals and strategies to achieve those goals as well as raising concerns about risky behaviours. Appropriate 'control' refers to the caseworker balancing how much control they need to take in the casework relationship, for example, talking too much versus talking too little, being soft versus being firm/hard, and being strict versus not strict (Jones, 1987).

Similarly Trotter (2004) argues that collaborative problem solving and partnership approaches need to be balanced by skills focusing on a young person's positive and pro-social actions and the use of appropriate confrontation. In casework practice with children and families, Trotter (2004) suggests that effective workers identify and reward pro-social comments and actions. For example, a young person who keeps an appointment, contributes positively to a case conference or who has been making an effort to attend school more regularly, should receive praise and reinforcement for his/her efforts. As Trotter (2004, p.114) comments in the pro-social model, caseworkers need to model the desired actions. For example, it is important that a caseworker is on time for an appointment or rings a client as arranged.

In practice, case plans and goals are routinely set but the progress of casework interventions should be reviewed on a regular basis (Dawson and Berry, 2002). Hammond (2005) identifies the need for workers to regularly ask for feedback and adapt strategies and practices based on the young person's responses. It is important to assist the young person to notice the positive outcomes they are making and what may have contributed to achieving these. Laufer (1992) notes that an important factor in an adolescent's decision to continue with an intervention depends on how positively they evaluate the help being received: Is the help meeting their expectations? What are they finding most helpful?

Being practical and active

In one study that examined young people's perspectives of social workers, Jones (1987) found that adolescents have a desire for action during their social workers' visits, and activity (not just sitting and talking) is important, especially for boys, in enabling them to engage with their social worker. However this needs to be planned with purposeful contact, not merely unstructured visiting on the pretence of establishing and sustaining a relationship. Hill (1999, p.142) found that most young people "…want tangible results, both because they often have urgent wants or needs and because this symbolises that they are valued".

Caseworkers need to provide information and access to resources that assist a young person with daily life (Cameron and Karabanow, 2003). Often what the young person needs most is accurate information. This may be about their health, education or where to access services. Practical support can also be provided through regular phone calls and home visits (Schofield and Brown, 1999).

There are a number of activities that caseworkers can use during discussions with young people that can assist them to express their thoughts and feelings, such as, brainstorming, preparing lists, and writing diaries or letters.

Caseworkers also need to be aware of services and interventions that are effective in supporting young people such as school and community based programs. The review by Cameron and Karabanow (2003) of the nature and effectiveness of program models for adolescents at risk of entering the formal child protection system support the benefits of family and community interventions particularly multi-systemic strategies rather than family therapy alone. Their review highlights the need to support pro-social relations with peers, adults and the community through community connection programs such as mentoring programs, providing information, coping skills and resources for daily living, and parenting support for challenging adolescents (Cameron and Karabanow, 2003). Family and multi-systemic interventions are discussed in Section 4.

Facilitating social and academic supports in the school environment

Education of young people is crucial to improving their life opportunities, health and well being and there is a clear link between a young person's level of connection to school and their overall resilience and ability to make the most of opportunities (Wise et al., 2003; Mancini and Heubner, 2004; Ungar, 2006).

Caseworkers need to remain cognisant of the importance of young people being at school and need knowledge of the supports available to link a young person with education (Cameron and Karabanow, 2003). Worrall-Davies et al. (2004) and Hill (1999) identify the need for a high level of collaboration between health, education and social services to improve outcomes for young people with complex needs.

Several strategies have been identified for supporting young people at school, these include:

- limiting the number of schools attended by a young person at risk due to the impact this can have on an adolescent's opportunities to be involved and form strong attachments at school (Malmgren and Meisel, 2004)

- the importance of intervening early before disruptive behaviours become entrenched (Malmgren and Meisel, 2004)

- developing social and academic supports in the school environment for adolescents at risk of entering the child protection system. School-based skill development programs which demonstrate modest to moderate effects reducing risk factors for general student populations (Cameron and Karabanow, 2003)

- organisational change to facilitate improved collaboration between schools and welfare services through a commitment to activities such as joint planning and goal setting (Altshuler, 2003; Worrall-Davies et al., 2004)

- individual workers to commit to working collaboratively, building trust, and speaking a common language (Altshuler, 2003).

Further research is required on interventions which support a stable connection to school, career development and study skills (Massinga and Pecora, 2004).

4.2   Working with the families of adolescents

Despite family factors often contributing to the young person's difficulties, families frequently remain significant in the young person's support network (Hill, 1999; Ungar 2004). Ungar (2004) studied the impact of parents and other caregivers on the resilience of high-risk adolescents who had extensive involvement with social workers while they maintained contact or continued to live with their parents. This study found that young people maintained a preference to live with their families despite the adversities unless the out-of-home placements provided stability and engaged caregivers. Ungar (2004) and others (Malekoff, 2005; Mancini and Huebner, 2004; Rishel et al., 2005; Cameron and Karabanow, 2003) emphasise that adolescents are best supported by their family and community and that caregivers need to be included in interventions.

Participants in the Caseworkers Study acknowledged the importance of working with families, but felt at times they had to 'walk a fine line' as they determined where best to place their focus, with the young person, the parent or to work with both (Schmied, 2007).

Actively maintaining the connection between a young person and their family and community

Facilitating connection with family and community involves identifying, strengthening and utilising the young person's natural support network including parents and family members, peers, school and community. This may be done by explicitly identifying a team to support the young person which includes the young person, family members, natural supports, departmental agencies and service providers (Hill, 1999; ACT Office for Children and Family Support, 2002; Cunningham, Henggeler, Brondino and Pickrel, 1999).

If a young person is placed in out-of-home care, placements that are within or close to their family and community can facilitate continuity with friends and school. Participants in the Caseworkers Study also described how they facilitated regular phone contact between a parent and young person or acted as a conduit, conveying messages from parent to child (Schmied, 2007).

It is important that caseworkers recognise that they do not need to control or manage everything for a young person. It is also important to encourage families to take responsibility and Malekoff (2005) talks of being partners with parents and other relevant people in the young person's life.

Providing support for parents

Parents of adolescents often struggle with the developmental changes that this period brings. Caseworkers can provide support for parents by acknowledging these difficulties and, as described by participants in the Caseworkers Study, 'normalising' some of the risky behaviours or activities that young people engage in (Schmied, 2007). Knowing that you are not the only parent experiencing difficulties and learning about the developmental changes that are occurring can help parents to reflect on and modify their responses.

Participants in the Caseworkers Study also believed that they had a role to bring clarity and provide a different perspective on a situation. For example, explaining to parents the impact that past events, such as sexual abuse, may have on a young person that can account for the current behaviours and emotional distress.

Based on the evidence suggesting a strong link between parent's supervisory practices and behavioural outcomes in young people (Petit, Baird, Didge, Bates and Criss, 2001), caseworkers can also assist parents to understand the benefits of proactively monitoring their adolescent's activities and whereabouts.

Chown and Kang (2004) outline strategies for supporting parents who are struggling with the changes in their child as they move into adolescence including:

- providing information about the young person's issues, and guidance as to how they can best respond

- providing parents with reassurance and support

- being sensitive to the concerns of parents from diverse cultural backgrounds

- balancing responses to the parents' concerns while respecting the adolescent's right to confidentiality.

The adolescent period may be even more challenging for parents who have limited parenting skills and who may have misunderstood and/or neglected the needs of their children for many years. When working with parents to assist them in managing difficult adolescent behaviour, it is important to discuss with them (or assess) the factors which may impede their ability to be present and engaging. Such factors include parental emotional and mental health problems (Marmorstein and Iacono, 2004), stress

(Abidin, 1986), parental substance misuse (VanDeMark, Russell, O'Keefe, Finkelstein, Noether, and Gampel, 2005), and their attributions about their child's behaviour (Bugental, Johnston, New, and Silvester, 1998). Some of these factors may make it difficult or even impossible for the parents to be engaged in services and interventions aimed at addressing the needs of their child. It may be advisable for the parents themselves to receive individual psychological support. While this issue is beyond the scope of this paper, caseworkers dealing with families in the child protection system should remain vigilant regarding not only of the adolescents' need for referral, but also of the need for therapeutic referral for the parent(s).

Many parents may benefit from participation in a structured parenting program. In section 3 of this paper, effective parenting programs for 'at risk' populations are reviewed.

4.3   Effective interagency work

The benefits of interagency collaboration are widely cited in the literature (Altshuler, 2003; Cameron and Karabanow, 2003; Dufour and Chamberland, 2004; Worrall-Davies et al., 2004). Interagency work can be described as a parallel process between the worker with their client, service management and interagency partners. In the study by Worrall-Davies et al. (2004), practitioners from health, education and social services identified interagency collaboration as a key to working successfully with young people with high and complex needs.

Defined service protocols, role definition, clear assessment and case management guidelines form the basis of interagency work. Interagency work is strengthened by:

- identifying the different ways the agencies involved prioritise cases

- working together from assessment stage onwards and joint case management planning

- valuing other workers and respecting their different work practices and styles (Worrall-Davies et al., 2004, p.181).

Participants in the Caseworkers Study identified characteristics of effective interagency collaboration such as:

- working in partnership

- building and maintaining an effective relationship

- having good local knowledge of services and agencies

- having clear expectations

- being up front and honest

- sharing information, and providing feedback and follow up

- staying connected.

Several additional suggestions are made in the literature for enhancing collaboration including joint training and regular forums with agencies working together. Worrall-Davies et al. (2004) also noted that workers should not be defensive about their own work. Practitioners who took part in the study by Worrell-Davies et al. (2004) also reported that some of the facilitators of interagency work could act as barriers to practice. For example, procedures and policy guidelines, although necessary could simultaneously limit more creative options being pursued or the ability to respond quickly to an individual child's need.

Worrall-Davies et al. (2004) also reported that the failure to share responsibility between practitioners can lead to tension, "…some practitioners said that when a crisis happened they felt that one person was left to deal with it, rather than all the professionals involved joining together to produce a coherent management plan." (Worrall-Davies et al., 2004, p.182).

4.4 Organisational factors that facilitate effective work with adolescents

Organisational characteristics and context influence the relationship between theory and practice (Smith and Donovan, 2003) and the outcomes for young people (Worrall-Davies et al., 2004). These factors include worker skills and training, support from supervisor and co-workers, worker satisfaction with the job, caseloads and perception of leadership (Yoo, 2002), as well as the broader service structure and availability of specialised services (Worrell-Davies et al., 2004).

Factors that hinder effective service delivery include: workers and managers being unclear about their available budget, gaps in appropriate services affecting referral options, poor communication and support between managers and caseworkers, and a lack of long-term planning and shared responsibility across agencies. Further research into the effects of program and organisational characteristics (such as program structures, supervisory supports and organisational climate) will assist in understanding the variable factors influencing outcomes of casework practice with adolescents (Littell and Tajima, 2000).

Participants in the Caseworkers' Study also identified a number of organisational characteristics that influence their practice with adolescents. For example, they stressed that allocating adequate time for assessment, case planning and case management was key to successful work with adolescents. This is supported by the literature on casework with children and families where it is suggested that manageable caseloads seem to foster client compliance and cooperation with the caseworker (Littell and Tajima, 2000; Poertner, 2000; Watson, 2005).

It is important to note that working with adolescents as well as with their family can be equivalent to working with two clients or cases. Counting work with both parents and the young person needs to be considered in caseload allocation. Otherwise work with parents can be compromised as it is time consuming and may not be considered a core activity (Smith and Donovan, 2003).

Casework managers need to recognise the intense and challenging nature of work with adolescents and provide adequate supervision and support. Caseworkers need recognition and respect for the work they are doing from their team and agency. This is viewed as crucial in enabling the caseworker to deal with the inherent stresses of work with at risk adolescents over a period of time (Schofield and Brown, 1999).

The complex nature of work with adolescents needs to be supported by flexible and appropriate services and interventions that are available along a continuum of need (ACT Office for Children and Family Support, 2002; Walton, 2001; Worrall-Davies et al., 2004). Maintaining individual service plans rather than standard or routine plans is considered essential (Smith and Donovan, 2003).

The importance of intervening early before disruptive behaviours become entrenched in young people is emphasised (Malmgren and Meisel, 2004; Worrall-Davies et al., 2004). Interventions and supports for young people need to be mobilised in a planned way and not just at the point of crisis (ACT Office for Children and Family Support, 2002). Worrall-Davies et al. (2004) found that practitioners' frustration can arise when other services do not respond as quickly as community services require, for example counselling services with long waiting lists. They also state the need not to give up on young people once they reach a certain age such as 16 years, for example.

Culturally sensitive practice

The need for caseworkers to respect and acknowledge a young person's cultural context within their practice is discussed in the literature (Massinga and Pecora, 2004; ACT Office for Children and Family Support, 2002; Chown and Kang, 2004). Cultural sensitivity in casework is supported by the child and family literature. Staff require training in culturally appropriate programs (Watson, 2005) and they need to develop an understanding of the client's social and cultural ties within the family (Poertner, 2000).

Chown and Kang (2004) identify issues to consider when working with young people and their families from Cultural and Linguistically Diverse Backgrounds (CALD):

- avoid cultural stereotyping by not assuming people from a particular cultural background share the same set of cultural attributes, beliefs and practices

- adopt a respectful and non-judgemental approach in dealing with differing cultural norms and practices

- consider the impact of experiences such as migration, refugee experience, exposure to war and trauma, language difficulties, discrimination, racism, conflict of expectations between 'new' and 'old' cultures

- consider how life experience, ethnicity or religious beliefs are relevant to the current issues

- the most important source of cultural information is from the young person themselves – ask about their cultural beliefs, family history, how they wish to identify themselves, if they identify with their parents culture

- in the case of language difficulties, check understanding of what has been discussed and where necessary use a professional interpreter

- consult with relevant CALD services and workers if unsure about cultural issues.

Summary

This section of the paper has described the diverse range of strategies and practices that are considered to be effective in working with adolescents. For example, spending time with the young person; understanding their past; looking forward and taking a strengths-based approach to finding solutions; facilitating participation; being practical and action-oriented; being a skilled helper; as well as working effectively with parents and other agencies are examples of key casework strategies. Further research into the effects of program and organisational characteristics will assist in understanding the factors influencing outcomes of casework practice with adolescents (Littell and Tajima, 2000).

5. Key issues and conclusion

This paper has reviewed the literature on effective strategies and interventions for children and young people 12 to 18 years of age within the child protection system. In Section 2 of the paper, the nature and characteristics of adolescence and the risk and protective factors that influence outcomes for young people were discussed. The review identified the significant level of emotional and behavioural difficulties that are experienced by Australian adolescents such as, depression, anxiety, conduct disorder, substance misuse and suicidal thoughts.

Section 3 of the review examined the evidence for effective interventions and therapeutic approaches that can support young people and their families. CBT and IPT appear to be most effective for adolescents with depression and anxiety, and TF-CBT for adolescents with PTSD, particularly those who have been sexually abused. This section also examined the effectiveness of parenting programs and family based interventions in managing conduct disorder and risk behaviours such as drug and alcohol misuse, suicidal thoughts or behaviours or self-harm. Involving family members in the intervention means there is a shift in the focus of the problem from within the adolescent to within the family.

In Section 4 of the paper, a broad range of literature was used to describe 'what works' in casework practice with adolescents. A key message from the literature is that adolescents benefit from engaging in meaningful relationships and activities. The literature reviewed, including the findings from the Caseworkers Study, suggests that establishing a relationship with a young person is the core element of practice and this relationship is characterised by 'being there' and 'spending time', continuity of worker, and commitment to and connection with the young person. Of equal importance, because young people are action oriented, they are best supported by practical strategies to assist them in achieving their goals. Several strategies using strengths-based approach were described, for example, 'looking forward' with the young person to describe the situation and identify solutions, getting the young person's perspective and gaining their participation, setting achievable goals and reviewing progress, and providing information and access to resources. The review also emphasised the importance of working with the families of young people and effective interagency work.

5.1 Key issues and challenges identified in the review

Theoretical frameworks informing interventions with adolescents

The interventions, services and therapies that have developed an evidence base and are reviewed in this paper draw extensively on social learning theories and attachment theory. Socio-ecological theories are increasingly informing family focused and multi-systemic approaches, particularly for substance misuse and conduct disorder in adolescents. In practice this means that despite developments in resilience theory and strengths-based approaches, there continues to be a focus on individual and family problems and interventions or treatments to address deficits, rather than identifying strengths and drawing on family, school and community or neighbourhood resources (Hammond, 2005; Ungar, 2005).

Hammond (2005) notes that such deficit or 'at risk' models tend to be program driven rather than driven by young people; it is rare that young people are asked what works for them. Within these interventions or programs young people tend to be labelled or diagnosed, determining the therapeutic approach. Such interventions or treatments tend to be linear in approach and task oriented rather than process oriented (Hammond, 2005). This critique is supported by Ungar (2006, p.3) who notes, "In our haste to change children's behaviours we overlook how these behaviours make sense to children themselves". Ungar (2006) argues that it is important to understand the way that marginalised young people may use deviant behaviours to gain a sense of identity, self-esteem and access to resources such as recreational facilities, social support and meaningful attachments.

This critique highlights that interventions need to focus on social skill development, integration and community development programs particularly for young people 'at risk' and those within the child protection system. Cameron and Karabanow, (2003) suggest that it is insufficient to focus only on the young person within their home environment.

Multi-component interventions

Importantly, in addition to strengthening and evaluating programs that draw on family, school and community resources, it is evident that children and young people who are 'at risk' of entering or enter the child protection system may benefit most from multi-component programs.

It appears that PMT may be effective for some families, particularly parents of children and young people experiencing conduct problems. However, for families with multiple problems, PMT alone is unlikely to modify risk and protective factors, and more intensive, multi-component programs which involve the young person and/or target parental risk factors should be provided.

Cameron and Karabanow (2003, p.460) note that for this group of children and young people "one shot, uni-dimensional interventions will not suffice". Not only do these adolescents and their families require multi-component strategies but they require it over a period of years.

In order to support adolescents at risk, Cameron and Karabanow (2003, p.463) suggest programs need to facilitate the following:

- pro-social relations with peers, adults and community institutions

- information, coping skills and tangible resources for everyday living

- special support for academic progress and social relations at school

- direct support for parents coping with the challenges of adolescent difficulties.

Multi-systemic Therapy provides an example of a rigorously designed program that has multiple components. MST works directly with the family to improving family emotional bonding and parental discipline strategies, together with opportunities for increasing parent-teacher communication and support for academic performance, as well as promoting involvement in extracurricular activities, structured sports or volunteer organisations.

However, successful outcomes from programs such as MST rely on the training and commitment of staff, adherence to principles underlying the program/s, commitment to the strategy by young people and their families, co-operation within and between school staff, positive involvement with peers and community or neighbourhood and effective interagency work.

Engaging and working families of young people

One of the most consistent findings in this review is that parents and family members are keys to the success of most interventions with adolescents. Brosnan and Carr (2000) note in their review of Functional Family Therapy that while the skills base of interventions is important to their success, the capacity of workers to make and maintain collaborative relationships with family members is a particularly important determinant of positive outcomes. Similarly Carr and Semel (2004) note that positive outcomes of interventions for adolescent substance misuse are associated with parental involvement. When parents are involved, young people are more likely to reduce their drug use.

Involving parents in an intervention can be challenging in the context of child protection and the tension working with families was highlighted by participants in the Caseworkers Study (Schmied & Walsh, 2007). This review highlighted that parental and family involvement may not always be appropriate nor possible, particularly in the context of child protection investigations and needs to be considered on a case by case basis. Participants in the Caseworkers Study were aware of these tensions.

It is also important to consider the feasibility and likelihood of family participation. A family's capacity to enter and remain connected to a program or treatment over time may be limited (Carr and Semel, 2004). Rarely are all family members enthusiastic about attending programs when only one family member may

appear to them to be experiencing the problem (Santisteban 2006). For example, a number of authors note that most families where children require mental health outpatient services do not use these services for very long (Santisteban and Szapocznik, 1994; Hoagwood, Burns, Kiser, Ringelsen and Schoenwald, 2001; Stanton and Heath, 2004). In particular, vulnerable populations such as children of single mothers, children living in poverty, children with serious problems and those from minority groups are less likely to stay in a program beyond one session and are more likely to discontinue therapy prematurely (Hoagwood et al., 2001).

To achieve family participation it is important to identify and address the barriers to participation. For many families, attendance may be limited by practical reasons such as needing to care for other children (Brody, McBride Murry, Chen, Kegan and Brown, 2006). Santisteban et al. (2006) also indicate that the presence of marital conflict or parental substance misuse may influence parent's decision to participate, and alternatively the young person who is misusing substances may have a powerful role within the family which is limiting their involvement in programs, or other family members may be trying to maintain the status quo.

Santisteban et al. (1996) and Szapocznik et al. (1988) report on successful efforts at increasing engagement and ongoing participation in services. Using a randomised control design they found that a systematic approach to engagement of adolescents and their families in interventions was more successful than the routine approach. The routine approach generally consisted of polite and empathic conversation while scheduling appointments. The specialised engagement strategies to reach reluctant family members consisted of well-planned telephone interventions that sought to identify and address the reasons for their reluctance but sometimes included going out to meet family members in person. Results of both studies showed that specialised interventions were very effective in increasing the percentage of families engaged into treatment (93% versus 42%) and in retaining them in treatment.

What is noteworthy about the study findings was that the vast majority of effective interventions were conducted by phone rather than requiring out-of-office visits (Santisteban et al.,1996) which means that this engagement strategy can be implemented in a cost-effective way.

New directions in meeting the needs of marginalised young people

Ungar (2005) highlights the need to consider the role of systems in providing care and support for children and young people that offer a seamless transition across agencies and services. Ungar (2005) has identified a number of specific principles that have the potential to make systems (such as child welfare, mental health, corrections and education) more responsive to the needs of young people. These include:

- Community reach – systems and resources that meet the needs of young people must be readily available and accessible. This principle emphasises rethinking the access that young people have to services. For example, can the young person identify and access the service without a professional having to refer or direct them to the service?

- One stop shop – children and young people find it much easier to navigate their way to services when those services are clustered or co-exist.

- In order to facilitate successful reintegration into the family and community, children and young people require access to services that form a link or 'stop gap' service to provide support to a young person moving from an in-patient facility, correctional placement or out-of-home care, and their subsequent reintegration into the family home and community.

- Continuity of carer and care – if young people are to be well supported and successfully move around in the system they are best served by a few workers who get to know them and their needs well.

- Emphasis needs to be placed on staff training and skill development particularly in relation to cultural sensitivity and an openness to appreciate differences in other world views.

Ungar (2005: 458) concludes:

> *Case planning and service integration that allows children to convince providers in multiple systems, their communities and families of their uniqueness and competence, as well as be provided with opportunities to show their talents will be those that survive best.*

5.2 The need for further research

There is a need for future research to evaluate both casework practice and therapeutic approaches and interventions for adolescents to identify what works, what does not work, with whom and in what situations (Evans and Seligman, 2005; Kazdin, 2003; Dufour and Chamberland, 2004). As Ollendick and King (2004) note, currently there are only a limited number of empirically-supported interventions for children and young people. Many approaches used with adolescents have been tested only with adults or young children and there is limited research conducted with adolescents. Further, most of the 'well established' or 'probably efficacious' interventions reviewed in this paper are based on behavioural and cognitive-behavioural principles. As Ollendick and King (2004) note, the most frequently used interventions such as CBT tend to be the ones that are evaluated and other approaches used in practice are not sufficiently evaluated.

Dufour and Chamberland (2004) have identified there are virtually no studies that evaluate the effectiveness of social work or casework interventions for children, young people and families that enter the child protection system. For example, further research is needed to evaluate the quality of casework relationships within the field of child protection. The Trusting Relationship Questionnaire (TRQ) is a tool which may be considered for such research. The TRQ assesses the quality of relationship from both the young person's and the adult's perspectives and is consistent with a strengths-based approach. The TRQ has been used for research with young people residing in foster care and group homes (Mustillo, Dorsey and Farmer, 2005).

Participants in the Caseworkers Study have spoken positively about the value of Solution Focused approaches in their work. Yet there are limited efficacy studies of SFT that demonstrate promising qualities which may be useful in therapeutic interactions with young people, Well designed comparative studies are required to establish Solution Focused Therapy as an effective intervention within casework practice.

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Appendix 1:
Adolescent development stages (Chown & Kang, 2004)

Early (10 – 14 years)	Middle (15 – 17 years)	Late (>17 years)
CENTRAL QUESTION		
"Am I normal?"	"Who am I?" Where do I belong?"	"Where am I going?"
MAJOR DEVELOPMENTAL ISSUES		
☐ Coming to terms with puberty ☐ Struggle for autonomy commences ☐ Same sex peer relationships all important ☐ Mood swings	☐ New intellectual powers ☐ New sexual drives ☐ Experimentation and risk-taking ☐ Relationships have self-centred quality ☐ Need for peer group acceptance ☐ Emergence of sexual identity	☐ Independence from parents ☐ Realistic body image ☐ Acceptance of sexual identity ☐ Clear, educational and vocational goals, own value system ☐ Developing mutually caring and responsible relationships
MAIN CONCERNS		
☐ Anxieties about body shape and changes ☐ Comparison with peers	☐ Influence of peers ☐ Tensions between family and individual over assertions of autonomy ☐ Balancing demands of family and peers ☐ Prone to fad behaviour and risk taking ☐ Strong need for privacy ☐ Maintaining ethnic identity whole striving to fit in with dominant culture	☐ Self-responsibility ☐ Achieving economic independence ☐ Developing intimate relationships
COGNITIVE DEVELOPMENT		
☐ Still fairly concrete thinkers ☐ Less able to understand subtlety ☐ Daydreaming common ☐ Difficulty identifying how their immediate behaviour impacts on the future	☐ Able to think more rationally ☐ Concerned about individual freedom and rights ☐ Able to accept more responsibility for consequences of own behaviour ☐ Begins to take on greater responsibility within family as part of cultural identity	☐ Longer attention span ☐ Ability to think more abstractly ☐ More able to synthesise information and supply it to themselves ☐ Able to think into the future and anticipate consequences of their actions

Early (10 – 14 years)	Middle (15 – 17 years)	Late (>17 years)
PRACTICE POINTS		
☐ Reassure about normality ☐ Ask more direct than open-ended questions ☐ Make explanations short and simple ☐ Base interventions needed on immediate or short-term outcomes ☐ Help identify possible adverse outcomes if they continue the undesirable behaviour	☐ Address confidentiality concerns ☐ Always assess for health risk behaviour ☐ Focus interventions on short to medium term outcomes ☐ Relate behaviour to immediate physical and social concerns – eg, effects on appearance; relationships	☐ Ask more open-ended questions ☐ Focus interventions on short and long term goals ☐ Address prevention more broadly