

What works with adolescents?

Family connections and involvement in interventions for adolescent problem behaviours

Elly Robinson, Lyndal Power and David Allan

Adolescence is an important period of growth in which healthy transition from dependence on family ideally occurs, particularly in Western societies. This may be perceived, however, as meaning that young people are increasingly less likely to need family involvement and support in their lives. As a consequence of this, there is no consistent approach to the involvement of family members in treatment and intervention options for young people in need of support. This paper examines the literature regarding adolescent–parent relationships, and explores the evidence for family involvement in interventions, such as family therapy, to address adolescent problems. Examples of practice are provided.

There is little doubt that the relationship between children and parents changes during adolescence. A shift from dependence on parents to increased involvement with peers and others occurs in adolescence, with the timing of change dependent on the cultural expectations of the environment (Christie & Viner, 2005). In this sense, adolescent relationships with parents move to inter-dependence, resulting in reciprocally supportive and connected networks not just with family members, but also friends, partners, colleagues and others (Daniel, Wassell, & Gilligan, 1999).

The role of parents in an adolescent's life, however, remains important. For example, a growing body of literature indicates that many family-related protective factors—such as providing a secure base (which is discussed further below), caring, connectedness, support and belonging—are linked to positive outcomes (e.g. Luthar, 2006, Rayner & Montague, 2000). The benefits of parental monitoring and limit setting are also emphasised within the literature (Luthar, 2006), with poor parental monitoring clearly linked to negative outcomes in adolescence, such as antisocial behaviour, substance use and sexual risk taking (Hayes, Smart, Toumbourou, & Sanson, 2004). The limits set by parental monitoring, however, may provoke tension as the adolescent negotiates the struggle between developing autonomy and continuing close bonds with parents (Luthar, 2006).



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The authors

Elly Robinson is the Manager, Australian Family Relationships Clearinghouse and a Research Fellow at the Australian Institute of Family Studies.

Lyndal Power is a Clinical Supervisor at RAPS Adolescent Family Therapy and Mediation Service (NSW), a program of Relationships Australia (NSW); and President of the New South Wales Family Therapy Association

David Allan is a Clinical Supervisor at the Sydney City office of Relationships Australia (NSW).

Editor: Elly Robinson, Manager, Australian Family Relationships Clearinghouse

Edited and typeset by: Lauren Di Salvia

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Australian Institute of Family Studies

Level 20, 485 La Trobe Street, Melbourne VIC 3000 Australia

Phone: (03) 9214 7888 Fax: (03) 9214 7839

Email: afrc@aifs.gov.au

Internet: www.aifs.gov.au

ISSN 1834-2434 (Online)

ISBN 978-1-921414-20-6

This tension may also be evident in service provision to young people. The balance between parental rights and the rights of minors regarding issues such as protection, competence and a desire to make personal decisions affecting health and wellbeing on their own is important (Larcher, 2005). Decisions such as these are further complicated by the fact that adolescents have developing, yet often immature, cognitive capacities. Brain growth research in recent years has provided new insight into a biological basis for adolescent behaviours (see Patton & Viner, 2007), which is important to consider in developing therapeutic interventions for young people.

Family risk and protective factors

There has been an increased understanding of the role of family-based risk and protective factors for adolescent risk behaviours. For example, there is extensive research that highlights the link between family environment and adolescent depression (Micucci, 2009), including physical and sexual abuse, neglect, attachment problems, parental mental illness and family conflict, stress and breakdown (Larner, 2009). Research on youth homelessness also indicates that characteristics of family environments can lead to homelessness, such as family breakdown, conflict, poor communication, lack of emotional warmth, abuse and neglect (Hyde, 2005; Suk-Ching Liu, 2005; Thompson & Pillai, 2006). Chamberlain and McKenzie (2004) talked about “critical junctures”, which are defining moments such as bitter family disputes or violence, on the “career path” of youth homelessness.

In contrast, close relationships with parents can be a protective factor against poor outcomes. Part of this protective relationship is the “secure base” function that parents continue to play in the adolescent years (Daniel et al., 1999; particularly mothers—see Markiewicz et al., 2006). Five elements of a secure parent– or caregiver–adolescent attachment have been described in the literature (Schofield & Beek, 2009):

- *availability*—helping young people to trust;
- *sensitivity*—helping young people to manage feelings and behaviours;
- *acceptance*—building the self-esteem of the young person;

- *co-operation*—helping young people to feel effective; and
- *family membership*—helping young people belong.

While the secure base serves a physical and psychological role in early childhood, the emotional and psychological support offered via a warm and communicative child–parent relationship plays an even more important role in adolescence (Allen et al., 2003; Schofield & Beek, 2009). Gilligan (2006) termed this a “scaffolding” role, that is, support is provided when needed and withheld when not. While parents are ideal to play this role, other significant adults can also play a part (Rayner & Montague, 2000).

Positive relationships between parents and young people continue into early adulthood. Vassallo, Smart, and Price-Robertson (2009) found that parents continued to play the role of adviser and supporter to young adult children, while moving away from the more tangible and practical support offered in childhood. Interestingly, parents often underestimated the level of support they actually provided to young adult children, which is highly valued by the young people themselves. As such, contrary to popular beliefs around the diminishing role of parents in late adolescence/early adulthood, a view that many parents held themselves in this study, parents continue to be a vital presence in young people’s lives.

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Family also remains important for young people who are removed from the family home. Being an adolescent doesn’t necessarily diminish a desire for young people in care to be adopted or to have a permanent family connection (Charles & Nelson, 2000). These young people need the same family connections as other young people. This is supported by research on young people who leave care, which shows that contact with non-abusive family members can assist successful transition out of care (Mauders, Liddell, Liddell, & Green, 1999). Dwyer and Miller (2006) likewise suggested that family relationships remain an enormous source of pain for young people who have run away or been removed from family, and the desire for connection remains deeply held. Physical separation over many years, they suggested, rarely equates to emotional separation.

Family involvement in interventions for adolescents

If there are risk factors within the family that influence outcomes for adolescents, it makes sense that family should be seen as part of any intervention addressing adolescent problems. While parents and families are seen as vital to successful early childhood interventions, far fewer programs focus on families when late childhood and beyond is reached (Ryan, 2003). For example, Dwyer and Miller (2006) argued that while fewer and fewer services are mandated to work with young people and families together, family work is essential to assisting recovery from trauma.

Youth services are often focused on young people’s rights to individuation, autonomy and confidentiality to the extent that family factors known to be important in healthy development are overlooked (Robinson & Pryor, 2006). Garfat (2003) suggested that youth work has traditionally cast the family as irrelevant, then relevant in a negative sense, such as the cause of the problem or the “enemy”. This may be potentially detrimental where workers are only involved in young people’s lives for a limited time without working on more enduring connections. As such, including or at the very least working with an awareness of family and/or other significant adults,

would seem essential (Robinson & Pryor, 2006). In the case of psychiatric treatment, it has been suggested that as a minimum, good clinical practice would include the involvement of family, especially to contain suicide risk (Bickerton, Hense, Benstock, Ward, & Wallace, 2007).

What works?

If we adopt the view that working jointly with families and adolescents is a logical response to the outcomes of recent research, what do we know about what works? As a starting point, evidence presented in Cochrane Reviews¹ are mixed in their endorsement of family therapy/interventions, with most areas examined needing further research. The strongest evidence exists for the effectiveness of family and parenting interventions in reducing time spent by juvenile delinquents in institutions (Woolfenden, Williams, & Peat, 2001). Family therapy for depression in general also shows promise (Henken, Huibers, Churchill, Restifo, & Roelofs, 2007), although young people are not specified in the review. It would appear that the effectiveness of family-based interventions

for problems in adolescence is an area of research that is comparatively in its infancy, and caution needs to be adopted in embracing any particular approach. It is worth considering, however, that most of the Cochrane Reviews in the area of family interventions for adolescent problems were written in 2006 or earlier. Subsequent research has added to the evidence base for family-based interventions, as outlined below.

A decade of randomised clinical trials that included parents in the treatment of child and adolescent psychiatric disorders, reviewed in 2005, concluded that family interventions are effective (Diamond & Josephson, 2005). Carr (2009) argued that family-based therapies are as effective as individual cognitive-behavioural therapy and psychodynamic therapy in the specific treatment of major adolescent depression. Lerner (2009) similarly calls for the integration of family therapy into treatment for adolescent depression, due to “limited, but encouraging” support for a family therapy approach (see also David-Ferdon & Kaslow, 2008). Some of the suggested features of family interventions for depression include:

ment for adolescent depression, due to “limited, but encouraging” support for a family therapy approach (see also David-Ferdon & Kaslow, 2008). Some of the suggested features of family interventions for depression include:

- improving communication skills;
- promotion of systemic family-based problem solving;
- promotion of attachment and disruption of negative and critical interactions between parents and adolescents; and
- building family resilience and hope and helping families manage depression and contain suicidal risk. (Carr, 2009; Lerner, 2009)

Evidence supports the use of family-based therapies to address other adolescent problem behaviours. For example, family-based therapies are considered among the most effective current treatments for adolescent substance abuse (Carr, 2009; Carey & Oxman, 2007; Cottrell & Boston, 2002; Diamond & Josephson, 2005; Hogue & Liddle, 2009). In Australia, evaluations of the BEST-Plus program (a whole-of-family therapy option for families of adolescent drug abusers) indicate that the program is effective in helping families to redevelop positive family environments that

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¹ Based on the best available information about healthcare interventions, Cochrane Reviews explore the evidence for and against the effectiveness and appropriateness of treatments (medications, surgery, education, etc.) in specific circumstances. For more information, see: <www.cochrane.org/reviews/clibintro.htm>

encourage recovery from drug abuse. The program has also been shown to have a similar positive impact on other adolescent behaviours, indicating that the behaviours are symptoms, rather than causes, of difficult family relationships (Bamberg, Findley, & Toumbourou, 2006).

Support has also been found for family-based treatment for co-morbid behaviours (e.g., delinquency and drug abuse) and for externalising (e.g., aggression) and internalising (e.g., anxiety) behaviours, although the evidence base is limited (Hogue & Liddle, 2009). Good evidence also exists for the effectiveness of family-based therapies for eating disorders (Cottrell & Boston, 2002) and conduct disorders (Carr, 2009; Cottrell & Boston, 2002). Carr (2009) highlighted family-based interventions as effective for anxiety, school refusal, obsessive-compulsive disorder, grief, bipolar disorder, attempted suicide and somatic problems (e.g., recurrent abdominal pain).

Types of therapies

Of all the therapies that include family elements, multi-systemic therapy has a particularly supportive evidence base for certain behaviours in adolescence. Multisystemic therapy has the most extensive evidence base for its effectiveness in dealing with conduct disorder, and it is also described as a promising intervention for the treatment of adolescent substance abuse (Carey & Oxman, 2007). It has also been effectively used to address delinquency, with outcomes such as improved family relations, decreased behavioural problems and decreased out-of-home placements (Utting, Monteiro, & Ghate, 2006). In a 4-year follow up of a randomised clinical trial of multisystemic therapy with juvenile offenders who met a formal diagnosis of substance abuse/dependence, there were significant long-term reductions in aggressive criminal behaviour (but not property crimes) (Henggeler, Clingempeel, Brondino, & Pickrel, 2002). The impact on long-term drug use was mixed. The authors also highlighted that even though outcomes were significant, many of the participants still engaged in significant problem behaviours, supporting the view of the chronicity of problems and the likely need for long-term, intensive intervention.

It has been suggested that work in this area is at the point where “implementation science” is needed (Hogue & Liddle, 2009). In other words, there is a growing urgency to work out how to implement favourable findings, given that family-based therapies are not used widely in working with adolescents. There

Types of therapies involving family members

Functional family therapy

A variant of family therapy that incorporates elements of behavioural and cognitive theories and practice, but also focuses on the functional nature of problems within a family, for example, the problems of an adolescent that regulate distance to or from other family members (Cottrell & Boston, 2002).

Multisystemic therapy

A strengths-based family intervention that considers problems as having multiple determinants (Carey & Oxman, 2007). Comprises detailed assessment of the factors involved in behaviours followed by a combination of therapeutic interventions drawn from strategic and structural family therapy, parental training, marital therapy, social skills training. As such, is bigger than family therapy, but family therapy remains a key element. Families and other societal systems are at the core of multisystemic therapy (Cottrell & Boston, 2002).

Structural family therapy

A form of family therapy that aims to change the structure and interactional patterns in families so that problems are not maintained. The goals of therapy include correcting dysfunctional hierarchies and boundaries so as to put parents in charge of their children. The therapist works with issues in the here and now and coaches family members around different ways of behaving. A typical goal might be to dismantle unhelpful coalitions between family members in order to strengthen the parenting team.

is also a need to determine how to export validated treatments to “real world” clinical settings (Diamond & Josephson, 2005). This includes considering the best methods of delivering empirically supported family therapy in a range of settings, to address a range of problems, and creating clinical/policy guidelines to support this work. Hogue and Liddle (2009) suggested a “core elements” approach, using a small number of overlapping practice elements that clinicians can mix and match to suit client presentation. Similarly, interventions that are delivered using standardised manuals to maintain treatment integrity are supported by the literature (Cottrell & Boston, 2002).

When parents seek to regain authority, the outside environment can react either positively or negatively and the worker’s job is to try to enhance the wider system’s cooperation and collaboration.

Larner (2009) claimed that no particular school of family therapy has a monopoly on effectiveness. He argued that the way the therapies are delivered is important, including the establishment of therapeutic alliance. In contrast, Sells (2004) suggested that in the case of behaviour-based problems a good therapeutic alliance is necessary but not sufficient. In addition, Sells argued for the use of structural and strategic approaches to restructure family hierarchy. Parents need to regain authority by intervening strategically, but at the same time the nurturing side of parenting needs to be maintained. Consideration must also be given to the larger environmental system: when parents seek to regain authority, the outside environment can react either positively or negatively and the worker’s job is to try to enhance the wider system’s cooperation and collaboration.

Engaging families of adolescents in treatment

With the focus on individual treatment for adolescent problems (Brown, 2008; Robinson & Pryor, 2006), parents may be difficult to engage in a therapeutic process, not least if they fail to recognise or are threatened by suggestions of their possible role in the problem. This is, however, an under-researched area. Brown (2008), in an article on child and adolescent mental health services, highlighted the dilemma for therapists in these situations. The request to “fix” the child lays the blame and onus for change on the child. If therapists otherwise choose to expand the family’s view to include their part in the child’s symptoms, the risk is that the family will drop out of therapy. Unfortunately, as Brown (2008) noted, there has been little written on how parents can be helped to see their own role in how child problems have emerged. A therapeutic alliance with both adolescents and parents is the key to successful treatment, yet this may be a difficult balance in practice.

Examples of practice

This section describes three Australian programs chosen as examples of interventions with families and adolescents. The first program, Adolescent Mediation and Family Therapy, is supplemented with a detailed example of a service funded by the program (RAPS Adolescent Family Therapy and Mediation Service). This will provide readers with a sense of how a service is structured to address the needs of adolescents within a family intervention.

Adolescent Mediation and Family Therapy

Adolescent Mediation and Family Therapy (AMFT) is an early intervention program that aims to promote child, adolescent and family safety as a means of fostering positive family and community relationships. The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) established AMFT in 1990 in response to *Our Homeless Children*, the Report of the National Inquiry into Homeless Children by the Human Rights and Equal Opportunity Commission (Burdekin, 1989). In 1993, the AMFT was approved as a sub-program under the Family Relationship Services Program to receive recurrent funding.

AMFT programs are situated across Australia and run by 12 different organisations. Mediation and/or family therapy services are offered via the programs to adolescents (aged 10–21 years) and their families who are experiencing varying levels of conflict and complex issues that could potentially lead to family breakdown and/or youth homelessness. AMFT programs aim to improve relationships and deal with conflict between adolescents and other family members.

The RAPS Adolescent Family Therapy and Mediation Service (RAPS) is an AMFT program of Relationships Australia (NSW). RAPS is located in Parramatta and services the Sydney Metropolitan Area. Details of the program are provided below as an example of the way in which an AMFT program operates.

RAPS Adolescent Family Therapy and Mediation Service (RAPS)

Established in 1991, RAPS is a preventative service working with both adolescents and their parents on issues that may lead to youth homelessness, including violence, substance abuse, truancy, running away, self-harm and family conflict.

The seven principles behind RAPS' work are:

1. Adolescents are in a unique developmental stage between childhood and adulthood that takes over a decade to complete. It is a common misconception that this is a time of separation when, in fact, the role of parents in supporting, empathising, guiding and setting boundaries for adolescents is crucial.
2. It follows that workers can assist parents to maintain the balance between a connected relationship with their adolescent and the importance of parents being in a position of hierarchy.
3. Effective work with adolescents involves working with parents and other family members, as relationships are interconnected and impact on each other.

RAPS staff members give a rationale to parents for their involvement, explaining that change can occur more quickly if the whole household can attend the first session. Staff members also explain that individual counselling works best if the client is motivated for change. Sending the adolescent to individual counselling may not address the parents' concerns if the adolescent does not articulate them. RAPS staff may also use explanations of adolescent development to point out to parents that adolescents need their parents' help to change.

When RAPS is first contacted by the family, a comprehensive intake is undertaken. This intake includes who has referred, parents' concerns, a genogram,² a history of past relationships and events, and an assessment of family safety.

A single session appointment is offered within 1–2 weeks of the initial phone call. This means that families are seen when their motivation is high and it ensures that urgent cases can be picked up quickly. The whole family is encouraged to attend, so that:

- the therapist is able to gain a deeper understanding of the adolescent's relationship with each parent/caregiver, the patterns of interaction between family members, and the quality of relationships, including the parents' couple relationship; and
- new information heard from other family members can help to change one's own thinking and behaviour, leading to more helpful responses. Younger family members can voice their experiences, which are often overlooked in the heat of conflict where young children are frequently frightened or worried.

4. As well as family, a broader "systems perspective" locates an adolescent's problem behaviours within other systems, such as school and community.

RAPS assessments include the wider system surrounding the young person by identifying risks and strengths, critical parts of the system that influence behaviour and strategies for intervening with these parts of the wider system. An assessment of the wider system involves identifying key domains that offer risk or protective factors and developing intervention strategies where needed.

Systems assessment involves consideration of the agendas of the various systems in which the young person operates, how the problem is defined by these systems, the history of previous interventions by other parts of the system, and any cross-system alliances or antagonisms.

5. Early intervention in problem behaviours is preferable. This will help to avoid an escalation into more serious problems from which recovery becomes more difficult, such as homelessness and its associated poor health and wellbeing outcomes.
6. Experienced workers with training in family therapy are needed, who are competent in handling the challenges of engaging and managing both parents and adolescents in the same space.

RAPS employs social workers and psychologists with postgraduate training in family therapy. These employees have the skills to engage both parents and adolescents, contain conflict that arises, maintain engagement and impartiality and work with family members of different ages. Family therapists also have the skills to work with the parents' couple relationship, the dynamics of which may be the driver of adolescent behaviours.

RAPS staff frequently work in teams where a therapist behind a one-way screen can phone in questions and observations to the therapist conducting the interview with the family in front of the one-way screen. Benefits of this approach are that team members share expertise and responsibility for the work.

² For more information on the use of genograms with young people and their families, see: <www.strongbonds.jss.org.au/workers/families/genograms.htm>

7. Workers need access to good consultation and supervision.

The stakes are high in work with at-risk young people, and this places enormous demands on staff members' knowledge, skills and emotional and mental wellbeing. Regular and consistent supervision is needed, as well as back-up supervision in between formal sessions if required. At RAPS the team meet fortnightly with an external consultant to receive "live" supervision of their work with families and develop best practice. Supervisors also have regular access to this external consultant.

Other methods of service delivery

In addition to family therapy, group work has a role at RAPS. A joint parent–teenager group, Keeping it Together, was developed to assist parents and teenagers to strengthen their relationship and assist parents with skills such as setting boundaries. A variation of Keeping It Together has been developed for culturally and linguistically diverse families.

RAPS also runs three seminars for parents that cover understanding adolescence, the importance of parent–adolescent connectedness and the importance of boundary setting. The seminars also serve as a "soft entry" point for the family therapy services offered by RAPS—parents will often approach the RAPS facilitator for further help either on the night or afterwards.

Evaluation

RAPS routinely evaluates work with every family. At the end of counselling an evaluation form is sent to every family member aged 12 and over with a reply paid envelope. The results are collated and fed back into the program every 6 months.

In 1999, FaHCSIA commissioned an independent evaluation of all 12 existing AMFT programs, and RAPS was cited as a model of best practice. In 2008 RAPS was included in an independent evaluation of all Relationships Australia's (NSW) counselling programs in which clients reported there was "high counselling service benefit" across all these programs.

Family Reconciliation and Mediation Program

The Family Reconciliation and Mediation Program (FRMP) is a statewide initiative in Victoria that is administered by Melbourne City Mission. The program was one of five key initiatives within the Youth Homelessness Action Plan, which arose in 2003–04 from the Victorian Homelessness Strategy and was developed by the Department of Human Services.

There are three main components of the program:

- brokerage grants—that enable Supported Accommodation Assistance Program (SAAP)³-funded agencies to apply for grants to purchase family reconciliation and mediation services, group work and other discretionary supports from private practitioners in the local area;
- family mediation services—provided directly by FRMP staff; and
- capacity building—aimed at strengthening homelessness support services' understanding of and commitment to family reconciliation as an important early intervention strategy to prevent homelessness.

3 The Supported Accommodation Assistance Program (SAAP) was established in 1985 to consolidate a number of Commonwealth, state and territory government programs assisting homeless people and women and children escaping domestic violence. SAAP provides recurrent funding for salaries and other operational costs associated with the provision of housing and support for people who are experiencing homelessness or are at risk of homelessness. Source: AIHW <www.aihw.gov.au/housing/sacs/saap/index.cfm>

During 2006, 337 individual young people accessed interventions that were purchased by SAAP caseworkers with FRMP brokerage grants (Baxter, 2007). Young people accessing FRMP tend to be younger (15–17 years) than SAAP services more generally (20–24 years) (Thomson Goodall Associates, 2008).

Good practice elements of the FRMP, as outlined in the 2008 evaluation report by Thomson Goodall Associates (2008), included:

- the implementation and/or strengthening of a “service model” context for FRMP in each Homelessness Support Service agency, including articulation of a clear rationale and potential benefits of family reconciliation (including individual counselling) and mediation in the context of early intervention, a family-sensitive case management approach, and a framework for ways in which FRMP options can complement a young person’s case plan;
- an agency-wide commitment to providing an early intervention response, with access to family reconciliation and counselling and/or mediation facilitated by protocols and other arrangements;
- assessing the needs of each young person holistically, which includes consideration of relationships with family members and connections with significant others;
- valuing the relationship of young people with counsellors, which may extend beyond the SAAP support period;
- using appropriate techniques (including group work) to engage young people in aspects of family reconciliation;
- encouraging young people at the appropriate time to participate in FRMP where this is expected to increase housing stability and facilitate pathways out of homelessness;
- exploring opportunities for reconciliation and mediation when recognised as appropriate;
- developing a greater range of accommodation options which provide a suitable basis for early intervention, and which incorporate family reconciliation (e.g., respite options); and
- supporting the use of FRMP through appropriate training for staff, compliance with relevant standards, and contract management.

The external evaluation indicated a wide range of benefits for young people who used FRMP, with strong indications that FRMP interventions were associated with immediate and improved quality of life outcomes. Young people receiving grants were assisted to increase their awareness and understanding of family problems, relationship dynamics and childhood experiences, and to enhance skills such as coping, communication and anger management.

The flexible arrangement of providing brokered services, when and where needed, and accessing specialist skills not currently part of homeless support services, was considered an “excellent approach” in the evaluation.

The flexible arrangement of providing brokered services, when and where needed, and accessing specialist skills not currently part of homeless support services, was considered an “excellent approach” in the evaluation. However, while evidence existed for good immediate outcomes, there was no quantitative data on increased housing stability, or the number of young people returning home, directly as a result of FRMP. The report concludes:

For many SAAP youth services, a focus on “family reconciliation” requires a change in culture and practice. This can be characterised as a shift from a partisan youth-centred focus (which may exclude family) to a commitment by workers to incorporate consideration of family issues and opportunities for reconciliation or mediation. (p. 17)

Baxter (2007) concurred with this conclusion, proposing a shift towards a more inclusive way of homelessness workers optimising outcomes for young people by recognising, legitimising and facilitating ongoing family connections. This in turn often leads young people to return or remain at home. She called for the development of a broad-based, coherent model that repositions safe and appropriate families and family relationships as a central feature of assessment and service delivery intervention within the youth homelessness sector.

Reconnect

Funded by the Department of Families, Housing, Community Services and Indigenous Affairs, Reconnect is an early intervention program for young people aged 12–18 years who are homeless or at risk of homelessness that seeks to repair their connections to their families, education, employment and the community.

Reconnect works with young people and their families in flexible and holistic ways by employing a delivery model that focuses on a quick response to referrals and the use of a “toolbox” of approaches that includes counselling, mediation, practical support and collaboration with other service providers.

Reconnect was evaluated in 2003, with an overall evaluation finding that the program had resulted in significant positive outcomes for young people and their families (Ryan, 2003). The program had a major effect in achieving family reconciliation, improving the stability of young people’s living situations, developing their ability to manage conflict and improving their communication with families. Three quarters of young people and parents reported overall improvement in the situation that led them to Reconnect.

Factors that have contributed to the success of the Reconnect model include: innovative service design; good practice forums and the principles that emerged from the forums; an emphasis on action research at the service level; and a national approach to evaluation. The flexible and client-driven approach that characterises Reconnect is consistent with the evidence base for promoting resilience in vulnerable young people. The program is still operational, but no formal external evaluation has occurred since 2003.

Summary and conclusion

Evidence regarding risk and protective factors that exist in the family domain for adolescent risk behaviours is now well established. While one of the primary goals of adolescence is to individuate from family, this has often been construed as a dwindling need for parental involvement in adolescents’ lives. Research suggests the contrary, with parents continuing to play an important role for adolescents to rely on as they move through a period of intense and prolonged growth (e.g., Vassallo, Smart, & Price-Robertson, 2009).

Alongside this, there is an emerging body of evidence that suggests that family therapy is an effective intervention in a range of adolescent risk behaviours, including depression, conduct disorder and substance abuse. Carr’s (2009) summary suggested that family-based interventions are effective and may be offered by a range of professionals for a range of problems. Therefore, the time appears right for increasing the number of programs that utilise family-based treatment for adolescent risk behaviours, accompanied by appropriate training for workers.

Upon saying this, there are a small number of programs that show promise, three of which are outlined in this paper. RAPS Adolescent Family Therapy and Mediation Service, Family Mediation and Reconciliation Program and Reconnect are all examples of well-established programs that successfully work with parents and adolescents, particularly as early intervention programs in homelessness. Key principles that guide the programs' work are outlined in this paper to illuminate processes that can successfully support parent-adolescent interventions. Further rigorous evaluations of these and similar programs, including the implementation and evaluation of international evidence-based models, will help to build a strong evidence base for family-based interventions in adolescent problem behaviours within the Australian context.

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