



**Literature Review
For
Transition to Adulthood Project**

Therapeutic Interventions for 16-24 year olds

April 2009

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Introduction

The *Transition to Adulthood* work considers the problems faced by 16-24 year olds in making the transition between child and adult services. The *Revolving Doors* client group is people who have multiple needs, in particular substance use issues and mental health problems. Referral to psychological services for adolescents is overwhelmingly for behavioural or conduct disorders, which frequently result in criminal activity as individuals age, and which are also very frequently co-morbid with substance abuse disorders (Hill 2005; Tranah, Harnett, & Yule 1998; Weinberg et al. 1998). This literature review is looking at the types of intervention that address these issues and are best suited to the age group in question.

Particular Issues for the age group

Currently, people in this age group can fall between children and adult services. Some children's services have extended to cover 16-18 year old, although they are often reluctant to begin a new engagement with someone over 16 - and over 18 people are still considered unequivocally adult. Sociological changes mean that children are leaving home and attaining independence from their parents later than they ever have in the past (Arnett 2007; Furstenberg et al. 2003; Furstenberg, Rumbaut, & Settersten 2004). Furstenberg et al (2004) suggest this is akin to a longer and more drawn out adolescence. Others suggest a new life stage of 'emerging adulthood' between the ages of approximately eighteen and the mid-twenties, in which people's lives are at their least likely to be structured by social institutions and which can be an 'age of possibilities' (Arnett 2007). In combination with new psychological and biological research indicating that the brain does not reach full maturity until at least 25, particularly with regards to impulse control (Chater 2009), this suggests that this group's needs may not be properly served by adult services. There seems to be little research on the particular needs of the 19-25 age group with regards to the therapeutic interventions that work best for them, therefore the best approximation seems to be to extend, where possible, the recommendations for the adolescent age group – for which there is a large body of work.

Limitations

There are many problems that research has shown to have strong correlative relationships with each other. It is difficult to ascertain if, or to what extent, each of these factors are causally significant in explaining the presence of others, but we can say that poverty, homelessness, growing up in a single parent household and certain parenting styles are both antecedent to, and make it statistically more likely that, an individual will develop conduct disorders, substance abuse disorders, poor educational achievement, poor mental health, lower employment levels, and partake in criminal activity (Brooks-Gunn & Duncan 1997; Conduct Problems Prevention Research Group 2000; Harker 2006; Mendes & Moslehuddin 2006). Clearly, some of these problems are sociological, or of too wide a remit to fall under the scope of psychological interventions. In particular, poverty is an issue that can be addressed only by large changes in public policy. The concentration of poverty and crime in small geographical localities and communities has resulted from a combination of housing, social policy, economic policy, even bank policy (Chater 2009; Sherman 1996).

This review concentrates on psychosocial interventions that attempt to address not only the individual's problematic behaviour, but to get as close to the root cause of these behaviours as possible. Current literature indicates that network-type interventions such as Multi-Systemic Therapy and Wraparound are the most successful. These entail working not only with the individual but with their support networks such as their family, school, peers and neighbourhood. Although this approach certainly makes sense for the client group in question, who often suffer multiple, multi-determined problems (Burns et al. 2000), such a method may not always be possible. For example, those with the most severe issues may be in substitute care, already left the parental home, be excluded or finished school, or have a peer group who are not a positive influence. For this reason, a section has been included on individual-level interventions including Cognitive Behavioural Therapy and Motivational Enhancement Interviewing, which also function as good complements to other family-based interventions.

Furthermore, this review concentrates on secondary, rather than preventive, intervention. Although it has been shown that early, preventive interventions have the highest success rates, the *Transition to Adulthood* project is concerned with an age group for whom such interventions are simply not relevant in the vast majority of cases (Greenwood 2008; Sherman et al. 1996).

Due to time and space restrictions, not much discussion will be made of 'what does not work', but the common elements that give an intervention a higher likelihood of a positive outcome should become clear. The following interventions will be excluded from the review because research has shown them to be unsuccessful:

- Talking therapies alone
- Military style 'boot-camps' (Dodge, Dishion, & Lansford 2006; Sherman, Gottfredson, MacKenzie, Eck, Reuter, & Bushway 1996)
- Delinquent awareness programs eg. 'Scared straight' (Dodge, Dishion, & Lansford 2006; Petrosino, Turpin-Petrosino, & Buchler 2009)

The latter two of these are purely punitive, whilst the first does not address the behaviour of the person, and how they can change that. This is a key development in therapy in the last twenty years or so. Traditional therapies would take the person out of the environment in which they live and address the problems, but on return to their home environment they fall into the same patterns of behaviour as previously (Sherman, Gottfredson, MacKenzie, Eck, Reuter, & Bushway 1996).

The last section of the literature review regards the best approaches available for people leaving state care. This is felt to be particularly pertinent given that such a high proportion of children who have been in care have multiple needs, and concomitantly that the client group has a very high proportion of people who have been in out-of-home care as children. As outlined above, interventions can be

categorised by the level of intervention – individual only, family-based, or including wider networks around the person. The most successful interventions within each category shall be addressed in turn.

Other kinds of intervention

Although this review concentrates largely on psychosocial and therapeutic secondary interventions, this by no means exhausts the options for addressing problem behaviour. Poverty in early childhood has been shown to be very strongly related to mental health and substance abuse in particular and seems to be becoming more prevalent and entrenched (Brooks-Gunn & Duncan 1997; Institute of Medicine 2000; Taylor 2009). Government policy clearly has a role to play in alleviating poverty. More specifically, poor quality, overcrowded housing and/or homelessness has especially strong correlation with mental health problems and can best be addressed by government housing policies. There are also planning issues. There is a school of thought that much anti-social behaviour can be 'designed out' of public areas, both by thinking about the way buildings are used and constructed (Brantingham & Brantingham 1981) and by ensuring that neighbourhoods present a respectable appearance which makes people less likely to commit acts of vandalism etc. (Kelling & Wilson 1982; Wilson & Kelling 1989).

Another approach is legal intervention against the young person themselves, such as Anti-Social Behaviour Orders (ASBO's); Mental Health Treatment Orders; Drug Testing and Treatment Orders (DTTOs), Home Detention Curfew (HDC – colloquially known as tagging) as part of community sentencing, pharmacological interventions (such as methadone programmes and stimulant medications for ADHD) and so on (Frick 2000; Fromme et al. 1994). In some cases these make some attempt to address underlying causes of the person's problems behaviour, whether that is substance use or some other criminal activity. However, it is worth noting that these aspects of community sentencing (MHTOs, DTTOs for example) are amongst the least used by magistrates and courts (Roberts 2002; Roberts & Hough 1999). In recent years the government has passed legislation that holds parents responsible when, for example, their children do not attend school (Koffman 2008). It seems significant that this comes at the same time that therapeutic interventions concentrate more and more on the involvement of parents. Perhaps this is the punitive side of the same coin?

It should be borne in mind that much of the research in this area is very US-centric and there are difficulties with translation across settings. This is a difficulty that researchers run into when moving from a highly controlled experiment to the general public and is likely to be an even greater problem when there are deep-set differences of culture (Henggler, Pickrel, & Brondino 1999).

Interventions

The causes of conduct disorder – defined as ‘aggressive, destructive and disruptive behaviours in childhood that are serious and likely to impair a child’s development’ that continue for more than six months - are manifold, including: biologic vulnerability; inconsistent, overly permissive or harsh discipline; community deprivation; and exposure to violence (Harrington & Maskey 2008; Hill 2005; Rappaport & Thomas 2004). Girls are twice as likely as boys to suffer post traumatic stress disorder, whilst disorganised attachment patterns and lowered salivary cortisol levels have shown some connections with early onset aggression. However, there are many children who show both of these markers and yet do not develop conduct disorder (Rappaport & Thomas 2004). Girls are also more likely to exhibit internalising violence (self-harm, depression, suicide) rather than externalising behaviours (see below). There are several subsets of aggressive behaviour that Rappaport and Thomas (2004) identify:

- **Overt** : Bullying and annoying others, followed by assaultive behaviour and forced sex
- **Covert**: Acts such as stealing, lying, followed by property damage, vandalism and arson and finally culminating in fraud, burglary and serious theft
- **Authority Conflict**
- **Proactive**: Aggression is initially instigated in order to gain social dominance or particular rewards
- **Reactive**: Force is used against a perceived threat or provocation. Related to decreased levels of serotonin metabolites. Fear induced, leading to hyperarousability and irritability.

Individual-only Interventions

❖ *Cognitive Behavioural Therapy*

Cognitive Behavioural Therapy (CBT) aims to change the way people interpret social situations. It is therefore an intervention useful where people are exhibiting reactive aggression, because they are misinterpreting neutral or pro-social behaviour as negative or aggressive towards them. If they can learn to interpret social behaviour accurately, they would no longer behave aggressively. CBT is a popular treatment because it can be applied to a wide range of behaviours. In Conduct Disorders, the main target is aggression (eg. Anger Coping Program) but it can also be used to help the person deal with substance abuse (see below). Furthermore, CBT is proven to be effective in a range of settings, both community and clinical (Frick 2000).

Initially, CBT will require the patient and the clinician to identify the problem behaviour, anticipate likely consequences and generating alternative responses. The intervention usually involves:

- Role playing
- Homework assignments
- Practice
- Skill building exercises
- Problem-solving skills training

Patients are taught to recognise their own physiological signs of anger and then to initiate their problem-solving training to avoid externalising anger. This will usually involve explicit instructional thoughts such as “stop and think!” (Frick 2000). There will usually be approximately twenty sessions and the positive effects have been shown in follow-up assessments of up to one year later. However, due to the intensive nature of the intervention, the attrition rate is very high – up to 50-75% in some cases – and this may mean that the most hard to treat families are self-selecting out of the program, thus distorting results (Rappaport & Thomas 2004).

CBT-type approaches have been shown to be effective in tackling alcohol and substance abuse in young people, especially the skills-training modules (Baer et al. 1992). These interventions are shorter, for example the six session Alcohol Skills Training Program (ASTP) but only tackle a particular problem behaviour, rather than the underlying causes of it (Fromme, Marlatt, Baer, & Kivalahan 1994). It has been shown that aggressive youths report antisocial beliefs, and this suggests that there is a place for cognitive elements in all programs designed to tackle antisocial behaviour (Granic & Butler 1998).

❖ *Motivational Enhancement Interviewing*

Motivational Enhancement Interviewing (MEI) is a one-off, one-to-one interview with a therapist that is intended to give the interviewee some of the CBT-type skills to avoid partaking in substance (or alcohol) use. When combined with other interventions, it has been found to help reduce attrition rates. For medium risk young adults it has been found to have results comparable to those of a 6-week CBT skills classroom-based training course (Baer, Marlatt, Kivalahan, Fromme, Larimer, & Williams 1992). Although this sounds like a much more cost effective way of administering CBT skills training, the research quoted was not carried out on the very problematic client group that this research focuses on, and it seems unlikely that such impressive results would be replicated from such a short intervention with this group.

One factor that should be borne in mind is the effect of interventions on other people around the targeted individual (addressed with a different slant with regards to group interventions below). Researchers assessing Brief Strategic Family Therapy found that when the family was not involved in therapy (ie with traditional, individual-type interventions), family functioning actually worsened¹. This sort of finding, although in need of confirmation, accords with a network or systems-type view of delinquency that emphasises how the way a person lives their lives and the people they interact with play a large part in explaining their behaviour. These interventions are dealt with in the following three sections.

Family Interventions

❖ *Parenting Management Interventions*

Interventions that concentrate on the parents reaction to their child's behaviour are most suited to those types of aggression that are instigated in order to obtain a positive outcome ie. proactive aggression. Parent Management Training (PMT) has been shown by several trials to be very effective, especially with children aged between three and ten years of age (Briton 2009; Rappaport & Thomas 2004; Scott 2008). It aims to give the parent the tools to reinforce pro-social behaviour in their children. The key tenets of this are:

- Small consequences (not over lenient)
- Avoid punishing parent
- Never Abuse (not over harsh)
- Effective = consistent (Dishion, Poulin, & Burraston 2001)

It is worth bearing in mind that boys with an adolescent-onset pattern of Conduct Disorder tend to have:

“a more abrupt onset of severe conduct problems ... They also tend to have less dysfunctional family backgrounds, are less likely to have cognitive impairments, are less likely to have problems of impulsivity and overactivity, show a greater desire and ability to maintain social relationships, and show better adult adjustment than their childhood-onset counterparts” (Frick 2000)

¹ <http://www.preventionaction.org/what-works/you-take-therapy-be-sure-read-label>

This may in part explain why PMT is less effective for adolescents than children – their parents may not be doing as much wrong. According to Frick (2000), girls tend to show adolescent-onset with many of the development patterns associated with childhood onset in boys.

❖ *Multi-Systemic Therapy*

Multi-Systemic Therapy (MST) is a highly individualised and flexible intervention that is personalised to the particular family's needs. One of its principle devisers describes it as follows:

“MST is defined by principles that emphasize its individualized, positive, present-oriented, and action-oriented nature. In contrast to most treatment models, MST is multidimensional and comprehensive, and focuses on the family, school, and community systems that contribute to antisocial behaviour”(Henggler et al. 1998)

MST may involve the individual, their family and/or neighbourhood – the ‘social ecology’ that maintains the individual's behaviour. The initial assessment will determine the severity of the patient's problems and a treatment plan is developed. It may consist of one or several of the following and vary considerably in length:

- Individual therapy
 - Cognitive skills building
- Family Therapy
 - Marital Therapy for parents
 - Parent Management Training
- School intervention
 - Academic remediation
 - Classroom behaviour management
 - Parent-teacher communication
- Peer interventions
 - Direct
 - Coaching to join in pro-social peer groups
 - Emotional support to join in pro social groups eg. Athletics, scouts (Frick 2000)
- Neighbours
- Workers from any other agency mandated to help the youth (Burns, Schoenwald, Burchard, Faw, & Santos 2000)

MST has been shown to be effective with adolescents and takes a behaviourist view, in that, by changing the way a person acts in certain situations, this will alter the way they think, and hence the way they act in other comparable situations (Tolan 1990). The reason MST aims to involve wider networks is because its proponents recognise that a person's behaviour does not exist in a vacuum, but requires the people with whom the individual interacts to maintain that behaviour in some way, whether intentionally - as in the case of some peers - or unintentionally - as parents often do (Swenson et al. 2004; Swenson et al. 2005; Tolan 1990; Wells 2007).

MST has been found by the devisers to be very effective for adolescent substance abusers, possibly in part because of the very low attrition rate through the course of the intervention (Henggler et al. 1993; Henggler et al. 1996). This has led to this intervention being held up as the gold standard in therapy, demonstrating how personalization is one of the most important factors in a successful intervention. Indeed, the UK government is currently funding an MST project to the tune of £14m, with The Brandon Centre the first government-funded practitioners of the therapy in the UK (Institute of Medicine 2000; Prevention Action 2007)². However, there have been some problems with replication of these results. The developers trained other therapists in the technique but the results for adolescents enrolled in this programme were neither as long lasting as the original, nor in many cases statistically significant (Henggler, Pickrel, & Brondino 1999). It is unclear whether this is due to the poor transportability of the therapy from controlled conditions, or poor training of the

² <http://www.brandon-centre.org.uk/research.php>

therapists administering the intervention. There have also been questions raised about the effectiveness intervention by a meta-analysis, which found it to be no more effective than other therapies. In turn, the methods of the meta analysis itself have been called into question, and overall the results from MST seem promising (Henggler, Pickrel, & Brondino 1999; Institute of Medicine 2000; Littell, Popa, & Forsythe 2005; Prevention Action 2007). One evaluation by the US government found it to be the most cost-effective of the eleven they evaluated, reducing crimes by 44% and saving over \$21,000 per year (Burns, Schoenwald, Burchard, Faw, & Santos 2000).

❖ *Wraparound (Burns, Schoenwald, Burchard, Faw, & Santos 2000)*

This shares the MST approach in that it combines multiple interventions and is systems-based. The major difference is that Wraparound tries to utilise existing services in the most efficient way possible. An initial assessment identifies the most suitable interventions and what services are available in the area to address that person's needs. The service is intended to be long-term, with whatever interventions are considered appropriate continuing for as long as they are required, rather than for a pre-determined or therapist-set amount of time. In essence, Wraparound is a way of approaching existing services in order to use them in the most effective way possible. Both Wraparound and MST rely on many doses of varying interventions rather than one long intensive course of one type of intervention. This has shown to be the most effective way of reinforcing pro-social behaviour a factor which should be borne in mind when devising any intervention programme.

Wraparound has an advantage over MST in that it can be delivered without and new specialist training, using the service infrastructure that is already in place. This is an advantage as it means treatment can begin immediately, but if the infrastructure is lacking this is certainly problematic. Furthermore, for this approach to function effectively there would need to be a great deal of interagency working, information sharing and communication. This is something that Labour have emphasised a great deal since 1997, but it is unclear that there has been improvements to the extent that would allow this to work well (Masson 2008).

A further point to consider: it is highly likely that some of the client group in question will be parents themselves and so could receive the parent management aspects of the training alongside the CBT and MET elements. This could be highly desirable, due to the intergenerational aspects of antisocial behaviour (Blazer, Iacono, & Krueger 2006). Such an administration of MST (or even stand-alone PMT) would also serve as an early intervention for the child and as has been mentioned earlier, preventive interventions are the most successful.

School-Based Interventions

As with all interventions, interventions through the school can be tiered:

- Universal – every child receives them
- Selected – for children who seem to be at risk
- Targeted – the most intensive

These interventions, by their nature, are only suitable for the younger end of the 16 to 24 year old age group and so are only dealt with briefly here. However, there are some useful lessons regarding peer group influences that can be taken from these interventions and applied to older age groups. Where possible, school is an ideal forum for such interventions as there are quite natural introductions, for example a poor school report or problem behaviour in the classroom can be fairly natural in-routes to interventions which can involve the parents and peer networks.

❖ *Reconnecting Youth (Eggert et al. 2001)*

Reconnecting Youth (RY) is a targeted intervention for high risk individuals. The primary delivery of this intervention is through a daily class that counts towards the pupil's credits. The course lasts for

one school term. Each class has 10-12 pupils in it and is run by a specially trained teacher. The classes cover life and relationship skills. In addition to this, there is a heavy emphasis on parent involvement and on engaging the youth with prosocial activities both in the classroom, through achievements that are recognised by the whole community and through recreational activities

RY aims to increase personal control and decrease risk factors, and has been shown to be effective in: decreasing hard drug use; raising academic achievement levels and reducing drop-out; reducing depression and stress.

❖ *Adolescent Transitions Program (Dishion & Kavanagh 2000)*

In contrast with the findings of Eggert et al. as described above, Dishion et al. (2001) and Dodge et al. (2006) has repeatedly found that putting a group of high risk individuals into a group has a negative effect. One particular instance (Dishion, Poulin, & Burraston 2001) of a group intervention in which a therapist attempts to influence them towards prosocial goals found two major results:

- Neither therapist reinforcement nor engagement of the individual with the group had an effect on outcomes for individual
- Individuals rejected by the group tended to be less likely to have an increase in problem behaviour

These imply that the positive peer group interaction was outweighed by the unintended negative influences of aggregating high risk individuals. Indeed, the negative effects on smoking and delinquency lasted for three years. This demonstrates how important it is for adults to take a proactive role in structuring their children's peer groups. It makes intuitive sense that putting high-risk individuals together is likely to have a detrimental effect; parents talk of children 'getting in with a bad crowd' and prisons have been criticised as 'universities of crime' and this intuition that has been confirmed by criminologists (Moffitt 1993). However, groups are easier and, it would seem, cheaper to treat than one-to-one treatment. This cost-effectiveness is not borne out however if the result is worsening behaviour.

As an alternative to group-based therapies that aggregate high risk individuals Dishion and Kavanagh (2000) propose the Adolescent Transitions Program (ATP). This consists of three tiered services, from universal through to targeted interventions.

- **Family Resource Room (universal)** – the main aim of this is to open up lines of communication between parents and teachers, as. It serves three major purposes:
 - Infrastructure for school-parent collaboration: parent self-assessment tools (tick box and videotape); parent involvement has been shown to be a major factor in resolving problem behaviour, home visiting during school holidays
 - Supports norms for protective parenting
 - Dissemination of information – weekly emails about homework commitments, parent-child assignments, 'plan for success'
- **Family Check up (selected)** – consists of three sessions including a motivational interview and psychological assessments
- **Menu (indicated)** – variety of services available (as with MST and wraparound) such as
 - Brief family intervention
 - School monitoring system
 - Parent groups
 - Behavioural family therapy
 - Case management
 - Family Management Curriculum (parenting training)

This tiered programme has been reported as effective in reducing problem behaviour by teachers and parents, as well as youths themselves.

As has been alluded to earlier, many high risk adolescents may not attend school regularly. Nonetheless, there may be some networks that they are engaging with regularly that could be used as a delivery point for some of these interventions described above. For example, youth groups,

Youth Offending Teams, Probation teams, and any other services they go to. Participation in interventions is also often found to be much higher when there is some home-based delivery, including home visits, and this is one reason that the designers posit that MST is so successful. There is also the possibility of community-based interventions, as discussed in the following section.

Neighbourhood Interventions

Given the particular age group that this piece of work deals with, there will certainly be some who are not engaging with school or family networks in a way that makes the interventions discussed above altogether appropriate. Some researchers have therefore proposed ways of allowing communities to partake in interventions that deal with the problem behaviours they experience. This has proved controversial to some who suggest that the idea of neighbourhood empowerment is a farce, when the problems are as entrenched and wide-ranging as those of the most disadvantaged (Sherman 1996; Sherman, Gottfredson, MacKenzie, Eck, Reuter, & Bushway 1996). Sherman (1996) suggests that since the true causes of the problem behaviour is the extreme poverty and social exclusion that these communities suffer is caused in large part by government policies, to suggest that a neighbourhood-based intervention and empowerment can resolve them is akin to throwing these communities overboard without a life jacket. Nonetheless, these same researchers allow that within limited boundaries, these interventions can have a positive effect on the immediate neighbourhood and so are worth discussion here.

❖ MST (Swenson, Henggler, & Randall 1999)

MST has been administered on a neighbourhood basis through extensive consultation with community leaders. Key factors are promotion of pro-social educational (eg. IT training, homework club), vocational (eg. Job training programs, mentoring) and recreational activities (eg. Sports teams and clubs). They also agree early intervention plans with schools and attempt to open up communication between police and youth. MST therapists also train teachers in Classroom Behaviour Management and negotiate with schools to reverse policies (such as zero tolerance to violence or substance use) if they are felt to be unhelpful to the community overall. Neighbourhood leaders were responsible for identifying at-risk youths and referring them to the therapist groups for CBT and other individual level interventions. The same leaders also approach the youth and their family where possible to try and engage them in the scheme. Living in a disadvantaged neighbourhood is acknowledged to be a major risk factor for antisocial behaviour and makes parenting a more difficult job (Jarrett 1999). Given this, such a neighbourhood approach is certainly worth pursuing as a forum for intervention delivery.

Corporate Parenting

As it has been found that 25% of the money that a parent spends on their children is spent after the age of seventeen, it seems wholly appropriate that direct parental responsibility for children in care has now been extended to eighteen years of age by the Children (Leaving Care) Act 2000 (Arnett 2007;Reid 2007). After the age of eighteen, a local authority has to 'befriend and advise' a young person and financial support is given up to the age of twenty four provided the training is started before the young person is twenty one (Reid 2007) but this is a fairly vague definition that is open to variation in its interpretation. Despite this upper age limit, it is still widely acknowledged, both by researchers and by young people themselves, that the support offered by the state for children who have been in care is inadequate given the very difficult histories these young adults have, by definition (Bullock et al. 2006;Cocker & Scott 2009;Courtney & Heuring 2005;Stace & Lowe 2007). For example, among 11- to 15-year-olds, the prevalence of mental disorders for children looked after by local authorities compared with children from the private household survey were:

- Emotional disorders: 12% compared with 6%
- Conduct disorders: 40% compared with 6%
- Hyperkinetic disorders: 7 % compared with 1%
- Any childhood mental disorder: 49% compared with 11%.(Meltzer et al. 2003)

The extent of these disorders persisting into young adulthood is clear from the very high levels of mental health disorder, unemployment and homelessness in adults aging out of care(Arcelus, Bellerby, & Vostanis 1999;Courtney 2009;Courtney & Heuring 2005;Millar 2007;Osgood et al. 2005;Reid 2007;Tweddle 2008). The work of psychologists, especially Bowlby have further shown that children with chaotic contact with their primary carers suffer from attachment disorders (Adam, Sheldon Keller, & West 2009;Holmes 2000).

The trend in the UK, where there are now more attempts to support children in their own families, is for longer placement times and more court orders since only the most difficult cases resort to out-of-home care (Bullock, Courtney, Parker, Sinclair, & Thoburn 2006). This makes it more difficult for young people to maintain meaningful contact with their birth parents and other family, which can be extremely important in giving them a sense of permanency and stability. Such connections can be a crucial resource for older children as they transition to independence (Henggler, Schoenwald, Borduin, Cunningham, & Rowland 1998). Most young people placed in foster care will eventually return home or to a kin carer, and even those for whom adoption or a permanent foster placement is judged to be the best option will continue to have psychological connections to their birth families that "are critical to children's sense of self, ability to cope with and resolve loss, and ability to form new and more lasting attachments" (Fahlberg, 1991; Jewett, 1982). Given the importance of support networks, it makes sense for youths to be fostered within communities where they already have some supportive networks available, so that they can rely on these through the placement and upon leaving for independence. Considering this as part of fostering placements may need to take a more community-based concept of 'family', to allow the involvement of individuals who know and care about the child: members of the child's extended family, neighbours, friends, teachers, and others already involved in the family's life (Barbell & Freundlich 2001).

Research has shown that the seven key contributors to a successful transition to adulthood are:

- **Relationships** – networks of social support, healthy peer friendships and consistent, positive adults in their lives
- **Education** – study skills; qualifications; career development
- **Housing**
- **Life-skills** – Money management, self-care, social development
- **Identity**
- **Youth engagement**

- **Emotional healing** – may include mental health services (Massinga & Pecora 2004; Reid 2007)

For many young people these will come naturally from their parents, but in the case of adolescents leaving care they may need more structured programs to help them with such skills. These skills are of even greater importance for emerging adults who are leaving care than others, because they may not have the safety net of a parental home to return to if they do get into difficulties. Programmes often focus on clinical services to the exclusion of these kinds of essential skills and resources (Massinga & Pecora 2004). Independent Living Programmes attempt to address this aspect of transitioning to adulthood (Lemon, Hines, & Merdinger 2005).

Accessing appropriate and sustainable housing is another major problem for youths transitioning between out-of-home care and independent living. There are certain provisions in the Homelessness Act of 2002 for young people who have been in care. Someone who has been in care will always be considered vulnerable and so judged to be in priority need (Macklin 2007). Yet young people leaving care with nowhere to go are often placed in hostel accommodation, in order that they can make a homeless application for housing, without which it is very difficult to get permanent local authority housing³. These hostels are the same ones that the local authority houses all its homeless people in and as such may accommodate adults who, for example, have recently been released from prison. As such they are not appropriate housing for vulnerable young people. This remains a problem for young people even if they have been adequately prepared for independent living by their carers.

❖ *Independent Living Programmes (ILP) (Lemon, Hines, & Merdinger 2005)*

There are a wide variety of ILPs in place, with the most commonly offered services including:

- Budgeting
- Job readiness and retention
- Education preparation

For a limited number of youth, transitional living arrangements such as a supervised flat are available. There has been little research into which of these modules are the most effective, however it does seem clear that participation in such programmes improve outcomes in the areas in which they are instructional.

❖ *ILPs in Scotland (Millar 2007)*

There are also ways in which residential homes can help make the transition easier. Millar points to small things such as the young person getting a front door key and not being subject to curfews any longer, as well as the more practical skills discussed above (shopping, cooking, budgeting etc.). Millar's interpretation of best practice recommends allowing a young person to make the decision about the best time to move out, get a choice of accommodation and a say in the decor by means of a grant. He also recommends that once the young person moves into their first home, follow-up care should not be time-limited, but entirely lead by the needs of the young person. It is worth noting that although 77% of Scottish local authorities offered such a throughcare plan, only 39% of young people received this care. If this provision is replicated in the rest of the UK, it is no surprise that young people are not getting the support they need.

❖ *Lighthouse Project ILP (Kroner 2007)*

The Lighthouse Project provides the supervised transitional living recommended as best practice by Lemon et al. (2005). They rent, and furnish, flats from private landlords for youths aged between

³ Interview with Youth Offending Team workers in Norfolk

sixteen and nineteen and then give them a small weekly allowance. The flats can be anywhere as long as it is near a bus-line and the youth is familiar with the area. The Project tries to find flats that the young person might be realistically able to afford to stay in once the ILP has finished. If the young person has employment when the ILP ends, they are allowed to keep the furniture and security deposits as well. If they do not have employment, they are helped to find other, subsidised, accommodation.

The young people receive regular visits and calls from a social worker. This social worker should be contactable at anytime, with new participants asked to call daily. The worker will also link clients in with local resources, including medical ones. Over the course of the ILP, the young person will also receive life-skills training, topics include: budgeting, time-management, planning, use of community resources, apartment management, nutrition, food preparation, employment skills, problem-solving, self-care and building a support network. The training received will depend on the participants needs.

All youth leave the project with secure housing, ideally with secure employment as well. It is very flexible to allow for personalisation of the service and allows the young people to make mistakes they can learn from whilst being provided a safety net. Thus they are empowered at the same time as learning coping skills they will need in their adult life. The project works within the limits of state provision – care is cut off at a certain age, which may be too early for some and some youth are still unprepared for a lack of network of adult services comparable to the network of children’s services.

The Lighthouse Project has composed the list on the following page of key items that should be in place for young people before they are ready to live independently. Many of these measures are very simple and yet the lack of them can create insurmountable barriers to social inclusion for a young person.

❖ *Lighthouse list of priorities for 16-19 year olds*

1. Help them get an original copy of their birth certificate.
2. Help them get a social security card (and a wallet to put it in).
3. Enroll them in a school program in which they can succeed.
4. Help them get a picture identification card.
5. Find out if they are eligible for a Medicaid card.
6. Help them get copies of medical records.
7. Start a "life book" that will contain important papers, pictures of family, and other mementos.
8. Help them open up a bank account.
9. Teach them how to write and cash a check.
10. Line them up with a dentist whom they can continue to use.
11. Line them up with a doctor whom can use when they are on their own.
12. Help them put together a family scrapbook.
13. Help them renew contact with family members.
14. Help them develop at least one friendship.
15. Line them up with a good counsellor.
16. Take them to join a local recreation centre.
17. Teach them some new ways to have fun.
18. Connect them with a church group.
19. Help them find a better-paying job.
20. Make sure they really understand birth control.
21. Show them the best places to shop for food, clothing, and furniture.
22. Help them learn how to look up resources in the telephone book.
23. Help them work through an independent living skills workbook.
24. Teach them how to read a map.
25. Take them on a tour of the city.
26. Teach them how to use the bus system and read bus schedules.
27. Buy them an alarm clock, and teach them how to use it.
28. Show them how to use the library and get a library card.
29. Help them get a driver's license and price insurance.
30. Role-play contacts with police, bank tellers, doctors, and others.
31. Role-play several different styles of job interviews.
32. Help them put together a résumé and an application fact sheet.
33. Make a list of important telephone numbers.
34. Teach them how to cook five good meals.
35. Teach them how to store food.
36. Teach them how to use coupons and comparison-shop.
37. Teach them how to read a paycheck stub.
38. Teach them how to use an oven and microwave.
39. Teach them how to thoroughly clean a kitchen and bathroom.
40. Take them to a session of dult court: traffic and criminal.
41. Tell them how to get a lawyer and when to get one.
42. Help them understand a lease or rental agreement.
43. Teach them how to do their taxes.
44. Teach them how to write a letter and mail it.
45. Help them develop good telephone communication skills.
46. Go over tenant and landlord rights.
47. Help them find a safe, inexpensive place to live.
48. Teach them how to budget their money.
49. Help them find and get along with a potential roommate.
50. Talk to them often about feelings about going out on their own

❖ *Projet Qualification des Jeunes (PQJ) (Goyette 2007)*

This Canadian project is intended to promote young people's autonomy and reduce their risk factors. Analysis by the Ansell-Casey Life Skills Assessments (ACLSA) indicates that the programme is successful in doing this over a three to four year period. The PQJ can provide support up to nineteen and is provided on a ten to one ratio of staff to youth. Together with the PQJ worker, and guided by the ACLSA tool, the young person identifies particular competencies they need to work on in the following areas: daily tasks, community resources, financial management, capacity to take care of oneself, social relations and schooling. Intervention strategies to address these needs are identified. The PQJ staff member will provide many of the interventions and will also link the young person in with local services and resources within the community they live in. These services will help provide support once the PQJ programme is over.

The assessment of the programme shows that the PQJ programme is a significant help in guiding youth towards an adult lifestyle. It is also worth noting that the programme is not outcome driven – its success is not judged on whether a move to living on one's own has actually been made, and it is this soft-outcomes approach that is often ignored in the target-driven services of the UK, but which can be extremely useful to vulnerable people in the long-term.

❖ *Treatment Foster Care (Chamberlain 2009)*

This combines a series of individual interventions and birth-parent therapies as deemed appropriate for the youth. The foster child's behaviour is monitored fairly intensively, with a phone call to the case manager every day, where rule transgressions are reported and the day is graded. This phone call is used to enforce a reward-based point system, which is used to form the basis of consistent small consequences for various rule-breaks (in accordance with SANE principles of PMT, see above), whilst also ensuring that behaving in accordance with the rules is duly noted and rewarded. Points are removed for behaviour such as possession of unexplained items, having unsupervised time without permission, or lying. The case manager takes on the role of rule enforcer, in order to take on the focus of power struggles for the youth and so make it easier for the foster child and parent to form a good relationship.

TFC is effective in reducing the number of arrests following placements as well as during placements by increasing the youths' protective factors – less contact with delinquent peers and greater contact with prosocial peers; high levels of adult contact and supervision; fair and consistent discipline. Visits to birth families are also scheduled regularly throughout the treatment.

❖ *Special Youth Career Program (SYC) (Reid 2007)*

This is a program from South Australia. It places children with one caregiver in a house not owned by the caregiver. If there is breakdown in this relationship that is not resolvable, the carer is replaced, with the young person remaining *in situ*. Once the young person reaches eighteen they have the option to remain in the house and take over the tenancy. However, the program is not time-limited and the carer can remain for as long as is appropriate for the young person in question. This set-up allows the child to have somewhere that they can call home indefinitely without the risk of being moved on, which addresses the instability that so many of these children suffer throughout their lives.

Conclusion

The programmes mentioned above are only a sample of all the interventions that are being tested with a degree of success. Just a few that there is not time or space to discuss more fully include the *Fast Track Model* (Conduct Problems Prevention Research Group 2000), the *Triple-P Positive Parenting Programme* (Sanders 2000), the *Behaviour Resource Service* (Kelly et al. 2003). The sample of interventions that have been gone into in more detail all demonstrate key features which are repeated in a variety of forms and combinations across the more successful therapies. Current thinking promotes the following principles for adolescents – and by extension the 16 – 24 age group:

- It is preferable to engage the individual with several brief interventions than one single type
- Behavioural or situation management training are the most effective individual-level treatment (both stand-alone and in combination with other interventions)
- A social ecology approach, including key networks for the individual; be it family, school, peers, neighbourhood partnerships or a combination of several of these, improves outcomes.
- Parent Management Training consistently improves outcomes for adolescents
- Needs based determination of programme to allow personalisation

The key difference in treating adults and adolescents or children is the emphasis on parents and other networks. It would be useful to investigate further how network and family-type interventions can be translated into services for older people, given that they provide consistently better outcomes for participants. It is acknowledged to be particularly difficult to intervene other than on a individual level for emerging adults, because they often lack parental and educational structures in their life, and have not yet settled into new stable structures, with a life partner, own home or long-term career (Arnett 2007). Possible forums include neighbourhood partnerships, Youth Offending Teams and using a wider definition of family, to include non-relatives to whom the person may be very close.

Young people leaving care to live independently need to be given the opportunity to learn the skills they need to do this. Ideally this should include some kind of supervised first home with support for as long as the young person needs it. The stable placements of the Australian SYC programme are a very innovative approach to out-of-home care and truly address both the instability of many foster care placements and the problem of providing appropriate accommodation for young people making the transition to adulthood.

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