U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
Shay Bilchik, Administrator
December 1998
JUVENILE JUSTICE BULLETIN

Treatment Foster Care

Patricia Chamberlain, Ph.D

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) is dedicated to preventing and reversing trends of increased delinquency and violence among adolescents. These trends have alarmed the public during the past decade and challenged the juvenile justice system. It is widely accepted that increases in delinquency and violence over the past decade are rooted in a number of interrelated social problems—child abuse and neglect, alcohol and drug abuse, youth conflict and aggression, and early sexual involvement—that may originate within the family structure. The focus of OJJDP's Family Strengthening Series is to provide assistance to ongoing efforts across the country to strengthen the family unit by discussing the effectiveness of family intervention programs and providing resources to families and communities.

Most communities are concerned about developing effective strategies to deal with the problem of juvenile crime. A key issue is how to protect the public, particularly from repeat, serious offenders, and at the same time provide juvenile delinquents with rehabilitative services. Incarceration of juvenile offenders is an option that is being used at an increasing rate in many States. However, incarceration is costly and may have negative long-term effects on youth, eventually resulting in higher rates of adult incarceration.

Alternatives to incarceration have typically involved placing youth in group care settings along with other youngsters who have similar histories of juvenile delinquency. In most communities, placement in a group care setting is the last step before a youth is incarcerated in a closed-custody facility such as a State training school. Although this alternative is widely used, there is a scarcity of data on the effectiveness of nonsecure group residential treatment for juvenile offenders (Chamberlain and Friman, 1997). A substantial body of evidence in the developmental psychology and sociology literature suggests that group care treatment models might have some unintended negative consequences (Patterson, 1982).

Most adults would agree that during teenage years peers become more important and influential and adults' impact decreases. Therefore, it seems logical that treatment programs for adolescents should rely less on adults and more on peers to produce positive changes in a youth's behavior and attitude. Group treatment approaches, such as Positive Peer Culture (Vorrath and Brendtro, 1985), attempt to use a group process for therapeutic effect to motivate and influence youth to change positively. However, association with delinquent peers has been shown to be a strong predictor of youth involvement in aggressive and

From the Administrator

As the capacities of juvenile corrections facilities across America are sorely tested by the increase in juvenile crime over the past decade, the demand for effective alternatives to secure detention also grows. Many alternatives involve placing youth in group care facilities with other offenders. Often this is seen as the last stop before a State training school, but is it a stop or a way station?

Research has shown that association with delinquent peers is a strong predictor of future involvement in delinquent and violent behavior. Two studies funded by the Office of Juvenile Justice and Delinquency Prevention bear this out. The Seattle Social Development Project found that youth with delinquent peers reported more than three times the violent acts as those without delinquent peers. The Rochester Youth Development Study found that offense rates for general delinquency, violent delinquency, drug selling, and drug use were higher for youth with delinquent peers than for those without.

Treatment Foster Care describes an alternative to corrections—and group care—facilities. The program places juvenile offenders who require residential treatment with foster families who are trained to provide close supervision, fair limits, consistent consequences, and a supportive relationship, instead of with other delinquents. In short, it is an approach that promotes both rehabilitation of juvenile offenders and public safety.

Shay Bilchik
Administrator

delinquent behavior and the escalation of such behavior over time (Elliott, Huizinga, and Ageton, 1985). In addition, it has been demonstrated that peer support of substance use increases a youth's drug and alcohol use over time (Dishion and Andrews, 1995).

It is ironic that most treatment programs place juvenile delinquents with similar backgrounds in groups together, which can facilitate further bonding and social identification among group members. It seems unlikely that, just because youth are enrolled in a treatment program, they will suddenly establish prosocial norms and values and become positive influences on each other.

On the other hand, a number of studies have shown that parents or other adults can play a strong role in the development and socialization of at-risk adolescents (Dishion and Andrews, 1995; Borduin et al., 1995). Specific parental processes, such as providing good supervision (Sampson and Laub, 1993), consistent discipline (Capaldi, Chamberlain, and Patterson, 1997), and adult support and mentoring (Werner and Smith, 1982), have been shown to have a positive effect on adolescent adjustment and functioning. Some delinquency treatment programs underestimate the power and influence that adult-initiated norms can have on program outcomes.

Treatment Foster Care (TFC) is an adult-mediated treatment model in which community families are recruited and trained to provide placement and treatment to youth with a history of chronic and severe delinquency. In TFC, the youth's association with delinquent peers is minimized. TFC youth are closely supervised at home, in the community, and at school. They are provided with consistent discipline for rule violations and one-on-one mentoring by their TFC parent(s).

The Treatment Foster Care Program

I have my daughter back . . . Without this program, she'd probably be dead.

—Mother of TFC participant

The TFC program was developed by the Oregon Social Learning Center (OSLC) in 1983 as an alternative to residential and group care placement for serious and chronic juvenile offenders. Chamberlain (1994) describes the TFC model in detail. A brief overview is provided here.

The program was created to provide adolescents in need of out-of-home care with close supervision, fair and consistent limits and consequences, and a supportive relationship with at least one mentoring adult and to reduce adolescents' exposure to delinquent peers. The TFC program attempts to do the following:

- Reinforce youth's appropriate and positive behaviors.
- Closely supervise youth at all times.
- Carefully monitor peer associations.
- Specify clear, consistent rules and limits.
- Consistently follow through with consequences.
- Encourage youth to develop academic skills and positive work habits.
- Encourage family members to improve communication skills.
- Decrease conflict between family members.

Population

Throughout the life of the program, more than 300 youth have been served using this model. (Demographic and family characteristics for the most recent 79 subjects are summarized in table 1.) In 1986, the TFC model was adapted to youth with severe emotional and behavioral problems who were leaving the State hospital. These children were 9 to 18 years old and had been hospitalized for most of the year prior to treatment in TFC. Based on that work, OSLC began treating youth ages 4 to 18 who were referred from the mental health and child welfare systems, were eligible for Medicaid services, and had previously had a number of out-of-home placements. In 1996, OSLC began a TFC program for adolescents with developmental disabilities and a history of acting out sexually. This program is small (five cases) but appears to be working well for this population of adolescents. The most recent research focus for the TFC approach is on adolescent females (12 to 16 years old) with a history of criminal behavior and severe emotional problems. In February 1997, OSLC began a study funded by the National Institute of Mental Health to examine relevant treatment processes and outcomes for this high-risk group (Chamberlain, 1997).

Table 1: Demographic and Family Characteristics of Treatment Foster Care and Group Care Participants

Characteristics	Group Care	Treatment Foster Care
Youth Measures		
Mean age at referral	15.1	14.8
Mean age at first arrest	12.5	12.8
Mean number of previous charges	14.6	12.6
Mean number of lockup days (1 year before referral)	89.0	71.0
Target youth adopted (prior to foster care)	5%	9%
Perpetrator of sexual abuse	7%	13%
Drug or alcohol abuse	15%	3%
Chronic truancy	69%	61%
Firesetting	22%	13%
Ran away from placement	78%	75%
Committed two or more of above offenses	85%	87%
Committed three or more of above offenses	63%	56%
Family Measures		
Single-parent family	54%	59%
Parent hospitalized	7%	9%
Parent convicted of crime	30%	25%
Siblings institutionalized	22%	16%

In the TFC program, adolescents are placed individually or, at the most, in pairs in a family setting. Foster care families are recruited from the community and trained by TFC program staff. TFC parents are part of the treatment team along with program staff and provide well-supervised placements and treatment. They receive a monthly salary and a small stipend to cover extra expenses. TFC parents implement a structured, individualized program designed to build on the adolescent's strengths and to establish clear rules, expectations, and limits.

Program Content Features

TFC parents participate in a 20-hour preservice training that includes the following:

- An overview of the TFC model is presented.
- A four-step approach to analyzing behavior is taught.
- Procedures for implementing the individualized daily program are demonstrated and discussed.
- Methods for working with the adolescent's biological family are reviewed.
- TFC policies and procedures are explained.

The training methods are didactic and experiential. Following the preservice training, prospective TFC parents are matched with participating youth. The youth's individualized daily program is developed by a case manager with participation from the TFC parents. The daily program specifies the schedule of activities and behavioral expectations and assigns the number of points the youth can earn for satisfactory performance. The goal of this program is to give TFC parents a vehicle for providing the adolescent with frequent positive reinforcement for normative and prosocial behavior.

At the time of placement, the daily program is reviewed with the juvenile participant and the TFC parents. The case manager will have previously reviewed a prototype daily program with the youth while he or she was in detention. The case manager will also have held a preplacement meeting with the youth's parents to explain the program and obtain approval and consent. Although parents are not technically required to provide consent (because the child is under the jurisdiction of the juvenile authorities), parental cooperation is sought.

Three days after the placement, a meeting is held with the TFC parents and the youth to review how the placement is progressing. For this meeting, a specific protocol exists: The TFC parents speak about the youth's positive qualities, and the youth meets with his or her therapist individually and identifies what he or she thinks the biggest challenge will be. The therapist expresses confidence in the youth's ability to succeed. The case manager then assesses whether the TFC parents have taken away any points for minor misbehavior or rule violations. If so, the case manager asks how the point loss was accepted. If no point loss occurred, the case manager will instruct the TFC parents to take away at least one point within the next 24 hours, even if they have to create a reason for doing so. The purpose of this procedure is explained to the youth as allowing the youth to get used to receiving feedback prior to having to deal with a more serious problem. The goal of this meeting is to clarify the role of the case manager as the authority, clarify the roles of the TFC parents as the youth's support persons, and reinforce the youth's positive initial adjustment to the program.

Routine consultation with TFC parents is a cornerstone of the TFC model. Without this, adolescent behavioral problems, particularly extremely negative behaviors, quickly influence adults to behave in nontherapeutic ways. For example, given adolescent sulking or noncompliance, the natural adult reaction includes anger and irritability. These types of adult reactions set off a chain of interactions through which the misbehavior of the adolescent increases and the adult avoids teaching or relating positively to the teenager. Ultimately, the relationship and placement are in jeopardy.

Preservice training is not enough to maintain the motivation or competence TFC parents need or to address the range of intervention strategies necessary in treating the complex behavioral problems of the youth in the program. One way in which routine consultation is maintained is through daily telephone communication with TFC parents. TFC parents are contacted daily, Monday through Friday, by telephone for information on the youth's behavior during the past 24 hours. These calls are structured through the Parent Daily Report (PDR) Checklist (Chamberlain and Reid, 1987) and allow TFC parents to identify potential problems and review plans for the coming day. PDR data are used during weekly group meetings and help TFC case managers track case progress. Daily telephone communication can be performed by case managers but is often completed by a former TFC parent who serves as the PDR caller.

Another form of routine consultation is through the TFC case manager. The case manager provides consultation and on-call crisis intervention to TFC parents on a 24-hour basis. TFC parents are supported by a case manager who coordinates all aspects of the juvenile's treatment program and conducts weekly meetings with TFC parents and other TFC program staff. These group meetings focus on development and review of the youth's daily programs and allow for feedback to TFC parents on their strengths and weaknesses, feedback from TFC parents on how the program can increase its support, and coordination of any needed special services. The goals of

the meetings are to support and motivate TFC parents and to develop a team approach to youth care.

Each individualized program is structured to give the youth a clear picture of what is expected of him or her throughout the day and evening. During the placement period, individualized programs are adjusted to fit the youth's changing needs, reflect progress made, and target new problems. The individualized programs help guide TFC parents to be specific in the way they reinforce progress and to be consistent in setting limits and consequences. The individualized programs give participating youth a concrete way to measure their success. Further, the individualized programs are used by parents or relatives when youth make home visits and when they return home after their placement.

Because the youth involved in the program have committed several delinquent acts prior to enrollment (an average of 13 arrests), a high level of supervision is required. Participating youth are not permitted to have unsupervised free time in the community, and their peer relationships are closely monitored. Over the course of the placement, levels of supervision and discipline are assessed and reduced or increased, depending on the youth's level of progress or lack thereof. Close monitoring at home and at school is a hallmark of the TFC model. Heavy emphasis is placed on teaching interpersonal skills and on encouraging positive social activities, including sports, hobbies, and other forms of recreation.

Each youth in the TFC program is assigned an individual therapist. Unlike many treatment models that stress individual therapy as the focus of treatment, in the TFC model, individual therapy supplements the main treatment course. The therapist's responsibility is to provide support for the adolescent and help him or her acquire and practice the skills needed to relate successfully to adults and peers.

The TFC program also provides family therapy, which is aimed at teaching the biological parents (or legal guardians) to effectively supervise, encourage, support, and discipline their child. The primary mechanism for accomplishing this is to teach parents to use a daily behavior management ("point-and-level") system, which is part of the youth's daily program in the TFC home. The family therapist assesses the parents' strengths and areas that need improvement and the barriers that have prevented effective parenting in the past. The youth's parents are supported in their views of the evolution of the problem and are encouraged to have frequent and continual input in their child's TFC program. They are given 24-hour telephone numbers for the therapist and the case manager. The case manager schedules regular home visits for the youth. These visits are used to practice and refine the juvenile's daily program in preparation for aftercare. The case manager and the family therapist are on call during each visit. Other typical components of family therapy include focusing on problem-solving and communication skills, methods for deescalating family conflict, and instructions on how to advocate for school services for the adolescent. Individual and family therapists are supervised by the case manager.

Another function of the TFC staff is to serve as liaison between school staff and TFC parents. Prior to enrolling the youth in the program, TFC staff conduct an initial meeting with a school staff member, usually the counselor or vice principal. A tentative class schedule is created for the youth, and details of the program are discussed. Juveniles enrolled in the program carry a school card that lists each class and provides a space for each teacher to sign his or her name and rate the youth's behavior as acceptable or unacceptable. These cards are collected daily by the TFC parents, and the ratings are converted into points earned or lost on the daily program. TFC program staff are on call to schools to remove program participants if they become disruptive. In addition to these standard program features, TFC conducts school-based interventions on an as-needed basis. The most common problems are skipping class and demonstrating aggression during unstructured school activities (e.g., lunch, time between classes). School interventions are supervised by the case manager.

After the TFC juvenile completes his or her placement and returns home, the youth's biological parents or legal guardians participate in an aftercare group with other parents. This group serves as a support network and is led by a case manager or therapist. A TFC parent or biological parent serves as a coleader. Case managers remain on call to families, and PDR calls continue on a daily basis for 6 months, at which time they are reduced to weekly calls.

Additional components of the TFC program include frequent contact between participating youth and their biological family members or legal guardians, including home visits; close monitoring of the youth's progress in school; coordination with probation/parole officers; and psychiatric consultation/medication management.

The TFC program attempts to provide youth with many positive role models and mentors. Participants are restricted from associating with peers who might be a negative influence and are taught skills that foster social development. The TFC placement is an opportunity for youth and their families to experience a turning point and engage in positive and productive relationships and activities.

Planning and Implementation

One of the reasons group homes and juvenile jails don't work is they become finishing schools for delinquents.

—Presiding State trial court judge,
Lane County, Oregon

During the planning stage of the TFC program, contact was made with juvenile court directors, parole and probation officers, and juvenile court judges. At that time, some of them doubted that community families could provide effective treatment for tough juvenile offenders. Having come to realize that juvenile delinquents are markedly easier to deal with on an individual basis than in a group setting,

these critics have become the program's most ardent supporters.

During planning and implementation, OSLC stressed the importance of collaboration among the following groups:

- **Juvenile parole/probation.** Depending on how a local justice system is organized, the involvement of parole/probation officers can be important to the success of a treatment program. They can facilitate placements, serve as backup when youth violate program rules, and provide a law enforcement presence. TFC staff conducted initial meetings with parole/probation staff and maintained routine telephone contact with them during a youth's placement, providing case updates and sharing PDR data.
- **Juvenile court judges.** In OSLC's area, juvenile court judges rotate on a yearly basis, requiring TFC staff to regularly acquaint new judges with the goals and operating procedures of the program. To deal with this efficiently, TFC created a one-page description of the program that the judge receives prior to meeting with TFC staff.
- **Schools.** It is important to have good working relations with local schools. Once school personnel know that program staff can be relied on to provide backup, they are usually more than willing to cooperate with the program. The daily school card was designed to be easy for teachers to fill out. TFC staff have frequent telephone contact with teachers to monitor a youth's progress and to verify that school cards are not being forged.
- **Child protective services.** In some of the cases referred to the TFC program, parental abuse or neglect was an issue and the juvenile had an assigned child protective services (CPS) caseworker. In these cases, coordination of the family treatment with the goals of the CPS agent is critical.

Funding

OSLC obtains funding from several sources in order not to be dependent on one funding source. The State juvenile corrections division provides the primary contract for services for the juvenile offender population. The rate is $77 per day per youth. Out of those funds, TFC parents are initially paid $28 per day, or $868 per month. More experienced TFC parents earn up to $33 per day, or $1,023 per month. In addition, OSLC bills Medicaid for family therapy sessions, because payment for that component is not funded by corrections. OSLC bills approximately 1 hour per week at the rate of $76 per hour, making the total program cost $2,691 per month per youth. The average length of stay is 7 months, bringing the average total cost per youth to $18,837.

OSLC receives funding for its program for socially and emotionally disturbed children through a partnership with the local child welfare and mental health divisions. Child welfare provides funds to the TFC home using special-rate foster care funds. Special rates for TFC parents range from $500 to $1,200 per month, depending on CPS assessment of the difficulty of the case. For these special needs youth, Medicaid is billed at the rate of $76 per hour for family and individual therapy services and for case consultation. Those costs average $1,000 per month per child, and the average length of stay for these children is 9 months.

The State Division of Developmental Disabilities funds the TFC program for adolescents who are developmentally delayed and who have had problems with sexual acting out or sex offending. It contributes $130 per day per youth, for a total of $36,270 over 9 months.

Staffing and Training

I always tell parents to talk and explain less. Kids aren't supposed to be happy after they are punished.

—Therapist, Oregon Social Learning Center

TFC managers are familiar with adolescent development and developmental psychopathology and are trained in social learning principles. The levels of formal education vary from a bachelor's degree with extensive experience to a doctoral degree in psychology or a related field. Case managers are required to balance the agendas of all team members in order to provide participating youth with integrated treatment plans. Successful case managers are excellent problem solvers, practically oriented, and flexible thinkers. They also must possess outstanding interpersonal skills. Case managers are the key contact with the TFC parents, provide supervision and direction for the therapists, and are the liaison with individuals in the community (e.g., the juvenile court judge, teachers) who have contact with or influence on the child. Case managers have a maximum caseload of 10 and are supervised weekly by the program director. TFC therapists typically have master's degrees and have been trained in family and individual therapy with adolescents or in related fields. Therapists are supervised by case managers and the program director.

TFC parents are supervised by case managers during daily telephone contacts and weekly group meetings.

All TFC program staff are required to attend a 3-day orientation on the TFC approach. The orientation includes a combination of didactic instruction, role-playing, and case examples. New staff are expected to read available treatment manuals, program descriptions, and research publications. In addition, all clinical staff (case managers, therapists) must attend the most immediate TFC parent training session available.

Recruiting and Selecting Program Participants

The TFC program receives referrals from the juvenile court, child welfare, and mental health systems. TFC staff meet with the youth and his or her parents and screen the situation to determine whether another, less restrictive, environment would be more appropriate and whether the juvenile would compromise the TFC family's safety. Initial contact with the juvenile usually takes place in a detention facility. A protocol is available for this contact. Briefly, the case manager gives the youth an overview of the program, including how the daily point-and-level system works. The case manager asks the youth what the most difficult aspect of participating would be and obtains a history of the problems from the adolescent's perspective. The structure and rules of the program are stressed to the juvenile, who is instructed to think about the possibility of being placed in the program and is contacted again within a week of the meeting. Not surprisingly, most of the juveniles immediately say that they want to participate, as the program represents greater freedom.

The case manager also meets with the juvenile's parents to discuss the program's goals, policies, and procedures and to obtain a parental history of the child's problems. Case managers stress that the parents' work with program staff is a key aspect of the treatment plan and that the parents will be asked to participate in weekly sessions. The goal of this first

meeting is to reassure the parents that TFC staff will work with them to try to solve the problems their child has been presenting. It is made clear that TFC staff do not blame the parents for these problems and that the program sees them as key players in their child's treatment. The case manager acknowledges that this is a difficult situation for parents and that they are probably uncomfortable having their child placed with another family. Policies and procedures regarding visitation and contact are discussed. If parents agree that the program is appropriate for their child, arrangements are made for a placement. Throughout the child's placement, parents are encouraged to communicate frequently with the case manager and are given a telephone number where they can reach the case manager 24 hours a day.

Both two- and single-parent families have served as TFC parents. The core requirements for TFC parents are that the applicant must be interested in and comfortable with adolescents and must be willing to work as a member of a treatment team.

Overview of the Intervention

TFC is an intensive intervention. It takes place on a daily basis in the TFC home and in the juvenile's school and community. Participants are closely supervised by TFC parents and program staff. They are not allowed unsupervised free time in the community. As they progress through the program, levels of structure and supervision are reduced. It is important that this be a gradual process based on the juvenile's compliance with high levels of structure. Three levels of supervision are defined in the TFC program. On level 1, the youth are within adult supervision at all times; they are driven to and from school and are not allowed out of eyesight of supervising adults except when sleeping. Level 1 usually lasts for 3 weeks. On level 2, youth can earn limited free time in the community, given a high level of compliance with program rules. Free time is limited, in that settings are prescribed (sports activities and other supervised activities are sanctioned; "hanging out" is not). Youth are required to state exactly where they will be and with whom, and TFC parents and program staff legitimize their whereabouts. Level 2 typically lasts for 4 months. On level 3, the structure is lifted somewhat and peer activities that require less structure are encouraged. Participants are not allowed to associate with peers who have criminal histories or who are not well supervised by their own parents. At level 3, visits to home are more frequent and last longer. Level 3 usually lasts for 1.5 to 3 months.

Barriers to implementation and ways of addressing them. One of the most significant problems in implementing a TFC program is recruiting and maintaining a group of competent, well-trained TFC parents. OSLC has used a number of recruiting strategies and relies on two primary methods for recruitment—newspaper advertising and word of mouth from TFC parents. Recruitment and training are activities that need to be conducted continually. To address this concern, OSLC employs a full-time foster parent recruiter who recruits homes for the 90 children served per year.

Another implementation problem is that of developing effective methods of communication for treatment staff and TFC parents. People who are accustomed to working in outpatient settings tend to work in isolation. In the TFC program, the quality of the teamwork is crucial to the success of the cases. Formal and informal systems of communication that promote quality communication between team members have been established.

Program Evaluation and Effectiveness

> *I am here tonight to say "Thank you." First, I'd like to thank [my foster mother] Holly. You let me stay at your house. Sometimes I wasn't the easiest person to be around, but you didn't give up on me. Your doors were always open.*
>
> —TFC "graduate"

Four studies have been conducted on the effectiveness of the OSLC TFC approach (table 2). Overall, the results showed that TFC was not only feasible but, compared with alternative residential treatment models, was cost effective and led to better outcomes for children and families. In 1990, OSLC compared the rates of incarceration for TFC participants with those for adolescents who received treatment in other community-based programs (Chamberlain, 1990). All of the participants had been committed to the State training school but were placed in community-based programs as an alternative to incarceration. This first study used a matched comparison design in which youth were matched by age, sex, and date of commitment to the State training school. The number of days youth were incarcerated during the first 2 years after treatment and the program completion (versus expulsion or runaway) rates were examined. The results showed that juveniles who participated in the TFC program spent significantly fewer days in lockup, resulting in a savings of $122,000 for the program in incarceration costs alone (estimating costs at $100 per day). In addition, significantly fewer TFC youth were ever incarcerated following treatment (Chamberlain, 1990). Although, on the average, youth in both groups spent the same amount of time in treatment, more TFC participants completed their treatment programs, and there was a significant relationship between the number of days in treatment and the number of days of subsequent incarceration for youth in TFC, but not for youth in the comparison group.

In the second study, OSLC compared the effectiveness of TFC versus typical community treatment for children ages 9 to 18 leaving the State mental hospital (Chamberlain, 1990; Chamberlain and Reid, 1991). Participants had been hospitalized for an average of 245 days during the year prior to referral. In this study, a random assignment design was used. Cases were referred by the hospital community outreach team as they became ready for placement in the community. Measures included the PDR Checklist, which examined rates of problem behaviors; the Behavior Symptom Inventory, which examined the presence/absence of psychiatric symptoms; and the tracking of rehospitalizations. Results showed that juveniles in the TFC group were placed out of the hospital at a significantly higher rate. In fact, during the 7-month followup period, 33 percent of the control participants remained in the hospital the entire time because no appropriate aftercare resource could be identified. More TFC youth were placed in family settings, while control youth tended to be placed in institutional settings. There were no differences found in rehospitalization rates or in rates of child reports of psychiatric symptoms. Significant differences favoring TFC participants were found in adult reports of child problem behaviors.

In the third study of the TFC program, OSLC formed three groups of foster parents and placed conditions from the TFC program on the groups to evaluate how the conditions affected disruption rates for children in regular foster care (Chamberlain, Moreland, and Reid, 1992). The three groups were (1) assessment only—

Table 2: Four Studies Using the Oregon Social Learning Center Treatment Foster Care Model

Location	Subjects	Comparison/ Control Group	Assignment Procedure	Followup Period	Risk/ Protective Factors	Outcome	Reference
Comparison Study Eugene, OR	32 youth committed to State training school; ages 12–18	Two groups: TFC and other community-based treatments	Matched on age, sex, and date of commitment	2 years	Supervision, family processes	TFC participants spent fewer days incarcerated	Chamberlain, 1990
Transitions Study Eugene, OR	20 youth from Oregon State Hospital; ages 9–18	Two groups: TFC and typical community treatment	Random	7 months	Family support	TFC placed out of hospital at higher rate; more TFC youth were placed in family homes	Chamberlain and Reid, 1991
Team Treatment Study Eugene, OR	70 foster care families	Three groups: AO, IP, and ETS	Random	7 months	Behavior management training for foster parents	ETS group had fewer disruptions in placement than IP and AO; ETS had greater foster parent retention than IP and AO	Chamberlain, Moreland, and Reid, 1992
Mediations Study Eugene, OR	79 boys; mean offenses, 13; ages 12–18	Two groups: TFC and GC	Random	1 year (so far)	Delinquent peers, supervision, discipline, relationship with caretaking adult	TFC had half as many arrests in followup, fewer days incarcerated, and higher rates of program completion	Chamberlain, and Reid, 1998

Note: ETS = enhanced treatment services; IP = increased payment only; AO = assessment only.

in which the parents were neither paid for their participation nor given enhanced training and support; (2) payment only—in which the parents were paid for their participation but did not receive enhanced training or support; and (3) enhanced training and support—in which the parents did not receive payment but did receive enhanced training and support. All three groups were assessed prior to and after the study. Seventy foster families from three Oregon counties were randomly assigned to one of the three groups: assessment only, payment only, or enhanced training and support (ETS). In the ETS group, foster parents were taught to use a version of the TFC individualized daily program to help them deal with child behavior problems. OSLC used such measures as the PDR Checklist to assess rates of child behavior problems, track disruptions in foster care, and track the foster parent dropout rate. Fewer foster parents in ETS groups dropped out; that is, there was a significantly higher retention rate for foster parents in ETS. In terms of adolescent outcomes, youth whose foster parents participated in the ETS group had significantly fewer disruptions in their placements. In addition, 3 months after the study, children in the ETS group showed the largest drop in the rate of problem behaviors. However, the ETS group initially showed a significantly higher rate of problem behaviors at baseline.

The findings from these three initial studies encouraged OSLC to apply for Federal funding to conduct a full-scale clinical trial on the efficacy of TFC for juvenile delinquents. When designing the

study, OSLC was interested in understanding what factors or key treatment components led to success or failure for individual participants, in addition to looking at the relative effectiveness of each treatment model.

Researchers and policymakers agree that the development of effective interventions for juvenile delinquents should be based on research that addresses the development of aggression and antisocial behaviors. Further, expensive intervention trials should provide experimental tests of their theoretical model of change (Mrazek and Haggerty, 1994). Thus, an efficient intervention study should ideally serve two purposes: evaluate the effectiveness of the intervention and provide specific information that can guide the development of better interventions in the future. Therefore, the goals of the OSLC study were to systematically evaluate the immediate and long-term outcomes of the interventions and the contribution of the interventions' key variables to changes in outcomes.

The fourth study, conducted from 1990 to 1996, was the largest and most comprehensive test of the TFC model and included evaluations of treatment processes and outcomes. It compared the effectiveness of two treatment models for male adolescents who had histories of chronic delinquency. The two models used very different approaches to exposure to delinquent peers. One attempted to use peer group interactions, and the other attempted to maximize the influence of mentoring adults and prosocial peers and to isolate boys from their delinquent peers (Vorrath and Brendtro, 1985; Craft, Stevenson, and Granger, 1964).

Seventy-nine 12- to 17-year-old male juvenile offenders were randomly assigned to treatment in TFC or Group Care (GC) for an average of 7 months. The youth who participated had an average of 13 arrests, and half had committed at least one crime against a person. In GC, the boys lived with 6 to 15 others who had similar histories of delinquency. In TFC, boys were placed individually in homes with families that had been recruited from the community. The TFC parents were trained in the use of behavior management skills and were closely supervised throughout each boy's placement.

The measurement of study outcomes was fairly straightforward. OSLC collected data on official arrests, including each boy's arrest history prior to entering the study, and collected confidential reports of criminal activity from each boy. The number of days each boy was incarcerated and/or "on the run" was tracked, as was information on school attendance, academic advancement, and mental health.

To assess the contribution of key treatment components to the studies, OSLC first identified variables thought to influence a boy's success or failure in treatment from research literature on the development of aggression and delinquency. Patterson (1982) reviewed the literature and showed that problems with adult supervision and discipline practices and with attachment and involvement with the child are powerful predictors of child conduct problems. The influence of negative peers also plays a key role, especially in the escalation of an existing delinquency problem (Elliott, Huizinga, and Ageton, 1985).

To examine the relative contribution of these variables to individual outcomes, the youth were assessed at baseline, 3 months after placement, and then every 6 months for 2 years. At the 3-month assessment, four factors were examined that were assumed to predict treatment outcomes (specifically, subsequent arrests) regardless of the boys' placement settings (TFC or GC). To the extent that these four factors were operating well, it was predicted that the youth would do better in followup. The four factors examined were supervision, discipline, positive relationship with a caretaking adult, and nonassociation with deviant peers.

At the 3-month assessment, it was found that, on average, youth in the TFC group received better scores on being supervised and had more consistent discipline, better relations with adults, and fewer associations with delinquent peers than did those in GC. Other findings from the 3-month assessment showed that although caretakers in both TFC and GC settings reported that the youth engaged in approximately the same number of problem behaviors per day (an average of 3.6 and 3.7 per day, respectively), the number of problem behaviors reported by the youth was significantly different in the two groups. TFC participants reported 2.9 per day, while GC participants reported 6.6 per day. In TFC, participants and caretakers agreed much more about how many problem behaviors occurred than did those in GC. Agreement between participants and caretakers on the occurrence of problems is helpful, if not necessary, for providing the participants with consistent consequences for their misbehavior. Youth in the TFC group were faced with the consequences of their actions more often than those in GC, according to both participant and caretaker reports in both settings. Agreement between TFC participants and their caretakers regarding reports of the amount of unsupervised time the youth had each day was also higher than it was for GC participants and their caretakers.

One year after completing treatment, TFC participants had significantly fewer arrests than did GC participants. Significantly more TFC youth than GC youth had no further arrests after treatment. Also, TFC youth were incarcerated significantly less often and spent more time living at home or with relatives than did GC youth. Three times as many youth ran away or were expelled from GC than from TFC. Furthermore, regardless of placement set-

ting, the examined program variables (supervision, discipline, relationship with an adult, deviant peers) predicted arrests 1 year after the youth had completed treatment (Chamberlain and Reid, 1998).

OSLC is currently examining the role that supervision, discipline, and peer and adult relations played in predicting future arrests. It is clear from the data that association with delinquent peers was the single most powerful direct predictor of continued offending. Whether youth associate with delinquent peers appears to depend on the quality and quantity of supervision and discipline they receive from their adult caretakers. In addition, the relationship with adult caretakers is a protective factor that buffers youth from delinquent peers and, in turn, from subsequent arrests.

Program Replication

There are two replications of the OSLC TFC model in progress. The first is the Early Intervention Treatment Foster Care (EITFC) program, which applies the TFC model to severely abused and neglected 3- to 7-year-old boys and girls in State foster homes. They exhibit significant behavioral and emotional disturbances and developmental delays. The second replication is a TFC program that addresses the specific needs of adolescent females with criminal histories and severe emotional and behavioral difficulties.

Early Intervention Treatment Foster Care

The EITFC program was designed as an extension of the OSLC TFC model that involves children between the ages of 3 and 7 who have been removed from their parents' care by State child protective services. These children demonstrate extremely challenging behavior that has typically led to their being removed from one or more prior foster homes. The most common problems seen in this population include extreme and prolonged tantrums, poor social skills resulting in difficulty forming positive relationships with adults and peers, oppositional and defiant attitudes toward authority, hypervigilance, and bed wetting. In addition, many of these children experience developmental delays.

Many of the standard components of the OSLC model are used in the EITFC program. Foster parents receive extensive training and ongoing support, including daily phone contact from program staff, and they participate in a weekly support group.

Several changes have been made in this replication. First, the behavior management techniques have been modified to be more developmentally appropriate. The concept of using encouragement to teach positive behaviors and setting limits to decrease negative behaviors has been retained, but the immediacy of reinforcement and delivery of consequences was changed (Fisher and Fagot, 1993). With older children, the consequences can be delayed for anywhere from a few minutes to a few hours. In the EITFC program, consequences occur immediately or as quickly as possible. Foster parents use stickers, star charts, "kid bucks," and other tokens as positive reinforcers. Time out and withdrawal of privileges are used as the primary tools for limit setting. Second, much of the service delivery in EITFC occurs in the home of the foster family. This allows EITFC staff to work with the foster family and the child in a more natural surrounding, as opposed to a therapist's office. A third difference is that children are assessed for developmental delays when they are placed in the foster home. Those who are found to be at risk are administered a comprehensive programmatic assessment to determine specific areas that need remediation. Then, using a standardized curriculum, an early intervention specialist works with the child and the foster parents to focus on problem areas. Finally, all the children in the EITFC program participate in a weekly 2-hour play group in which they learn social skills designed to help them make the transition to primary school.

The EITFC program treats approximately 15 children per year. A 1-year pilot study was initiated in March 1997 to evaluate the effectiveness of the program. A variety of measures related to outcome are being collected, including physiological measures of emotion regulation through cortisol, a chemical contained in saliva (Stansbury and Gunnar, 1994).

TFC for Adolescent Girls

I'm better at accepting "no."

—TFC participant

In February 1997, OSLC began a program funded by the National Institute of Mental Health to evaluate the effectiveness of the TFC model on the treatment of female juvenile delinquents. The program will examine key treatment processes that contribute to successful or unsuccessful outcomes. During the next

5 years, 130 girls, ages 12 to 16, will participate in the program. They will undergo an intensive assessment at baseline, an assessment 2 months after they are placed, and followup assessments at 6-month intervals for 4 years. The program has been modified to address the specific needs of these adolescents. Compared with their male counterparts, female adolescents tend to participate in more self-destructive behaviors, run away more often, and engage in high-risk sexual behaviors. Treatment targets also include dealing with relational aggression, which is more common in girls than in boys (Crick and Grotpeter, 1995). In addition to participating in individual and family treatment, the girls in the TFC program will take part in a skill- and image-development group. TFC parents will be given specialized training for dealing with adolescent females. So far, implementation problems have been surprisingly few. OSLC has recruited TFC homes and has added staff who specialize in working with this population. No evaluation data are available at this time.

Training

During the past 10 years, OSLC has conducted a number of trainings for programs throughout the United States. Probably the most comprehensive approach was with the Youth Villages programs in Tennessee and Kentucky. Youth Villages sent a delegation of staff members to visit the OSLC program and to receive an over-

view of procedures. Two OSLC senior staff members conducted a week-long training for Youth Villages staff in Tennessee and a 3-day, onsite training workshop. Youth Villages began using the OSLC model in January 1997 and is currently collecting program evaluation data.

Conclusion

The Treatment Foster Care model has proven to be relatively effective when compared with other community-based treatment models. One advantage of TFC is that a youth's program can be individualized to fit his or her needs, problems, and strengths. Youth are not placed with others who have similar problems and may be a source of negative influence (Dishion and Andrews, 1995). Placement in TFC provides juvenile delinquents with a relatively nonrestrictive experience and promotes learning and adjustment in a family setting, increasing the possibility for future progress. While in TFC, a youth's biological or adoptive family (or other family resource) is very much involved in the program. Not only do they have continual input into their child's treatment and care, but they are also counseled on parenting skills that will support their child's progress after the program is completed.

Youngsters having severe problems with delinquency are typically alienated from adults who might have a positive influence on them (Fisher, Chamberlain, and Dishion, 1996). Yet this is the time when youth are in critical need of close adult supervision and guidance. The TFC model uses a system of intervention that benefits from the powerful influence skilled adults can have on such youth.

For Further Information

For more information contact:

Patricia Chamberlain
207 East Fifth Street, Suite 202
Eugene, OR 97401
541–485–2711
E-Mail: pattic@oslc.org

References

Borduin, C.M., Mann, B.J., Cone, L.T., Henggeler, S.W., Fucci, B.R., Blaske, D.M., and Williams, R.A. 1995. Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology* 63(4):569–578.

Capaldi, D.M., Chamberlain, P., and Patterson, G.R. 1997. Ineffective discipline and conduct problems in males: Association, late adolescent outcomes, and prevention. *Aggression and Violent Behavior* 2(4):343–353.

Chamberlain, P. 1990. Comparative evaluation of specialized foster care for seriously delinquent youths: A first step. *Community Alternatives: International Journal of Family Care* 2:21–36.

Chamberlain, P. 1994. *Family Connections: Treatment Foster Care for Adolescents with Delinquency.* Eugene, OR: Castalia Publishing.

Chamberlain, P. 1997. Female delinquency process and outcomes. Study conducted under grant number R01MH54257. Washington, DC: U.S. Department of Health and Human Services, National Institute of Mental Health, Violence and Traumatic Stress Branch.

Chamberlain, P., and Friman, P.C. 1997. Residential programs for antisocial children and adolescents. In *Handbook of Antisocial Behavior,* edited by D.M. Stoff, J. Breiling, and J.D. Maser. New York, NY: John Wiley & Sons, pp. 416–424.

Chamberlain, P., Moreland, S., and Reid, K. 1992. Enhanced services and stipends for foster parents: Effects on retention rates and outcomes for children. *Child Welfare* 71(5):387–401.

Chamberlain, P., and Reid, J.B. 1987. Parent observation and report of child symptoms. *Behavioral Assessment* 9:97–109.

Chamberlain, P., and Reid, J.B. 1991. Using a specialized foster care community treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology* 19:266–276.

Chamberlain, P., and Reid, J.B. 1998. Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology* 66:624–633.

Craft, M., Stevenson, G., and Granger, C. 1964. A controlled trial of authoritarian and self-governing regimes with adolescent psychopaths. *American Journal of Orthopsychiatry* 34:543–554.

Crick, N.R., and Grotpeter, J.K. 1995. Relational aggression, gender, and social-psychological adjustment. *Child Development* 66:710–722.

Dishion, T.J., and Andrews, D.W. 1995. Preventing escalation in problem behaviors with high-risk young adolescents. *Journal of Consulting and Clinical Psychology* 63(4):538–548.

Elliott, D.S., Huizinga, D., and Ageton, S.S. 1985. *Explaining Delinquency and Drug Use.* Beverly Hills, CA: Sage Publications, Inc.

TFC: A "Blueprint" Program

OJJDP is funding an initiative at the Center for the Study and Prevention of Violence (CSPV) at the University of Colorado to help communities replicate model "blueprint" programs. The Treatment Foster Care program is 1 of 10 blueprint programs. These programs have undergone rigorous evaluations that have demonstrated their effectiveness in preventing violence, substance abuse, and/or delinquency. CSPV is providing technical assistance to help 50 sites across the country replicate blueprint programs, including Treatment Foster Care. For information on how to apply to become a blueprint site, contact:

Center for the Study and Prevention of Violence (CSPV)
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309–0442
303–492–8465
303–443–3297 (Fax)
Web site: www.Colorado.EDU/cspv/blueprints/
E-Mail: cspv@colorado.edu

Fisher, P.A., Chamberlain, P., and Dishion, T.J. 1996. Working with troubled adolescents in a community setting: Approaches to intervention and prevention. Paper presented at the Pacific Northwest Conference on Youth Violence, Seattle, WA.

Fisher, P.A., and Fagot, B.I. 1993. A multi-dimensional risk model of negative discipline in traditional families. *Journal of Family Psychology* 7:250–254.

Mrazek, P.J., and Haggerty, R.J., eds. 1994. *Reducing Risks for Mental Disorders: Frontiers for Prevention Intervention Research.* Washington, DC: National Academy Press.

Patterson, G.R. 1982. *Coercive Family Process.* Eugene, OR: Castalia Press.

Sampson, R.J., and Laub, J.H. 1993. *Crime in the Making: Pathways and Turning Points through Life.* Cambridge, MA: Harvard University Press.

Stansbury, K., and Gunnar, M.R. 1994. Adrenocortical activity and emotion regulation. *Monographs of the Society for Research in Child Development* 59:108–134, 250–283.

Vorrath, H., and Brendtro, L.K. 1985. *Positive Peer Culture.* Chicago, IL: Aldene.

Werner, E.E., and Smith, R.S. 1982. *Vulnerable but Invincible: A Study of Resilient Children.* New York, NY: McGraw Hill.

Acknowledgments

This Bulletin was written by Patricia Chamberlain of the Oregon Social Learning Center. The work was supported by grant number R01MH47458 from the National Institute of Mental Health, Violence and Traumatic Stress Research Branch: James Breiling, Project Officer; titled Mediators of Male Delinquency—A Clinical Trial.

Share With Your Colleagues

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Washington, DC 20531

Official Business
Penalty for Private Use $300

PRESORTED STANDARD
POSTAGE AND FEES PAID
DOJ/OJJDP
PERMIT NO. G–91