A Clinical Model for Parenting Juvenile Offenders: A Comparison of Group Care versus Family Care

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ABSTRACT

Treatment foster care, an intervention model that offers an alternative to group residential care for serious chronic juvenile offenders is described along with results of a study comparing outcomes for boys who participated in treatment foster care (TFC) and group care (GC) placements. The TFC approach is an extension of the parent-mediated treatments that have previously been shown to be effective in working with children with aggression and antisocial behavior problems. In TFC, community families were recruited and trained to provide placements for study boys. One boy was placed per home. GC boys were placed with 6–15 others with similar delinquency problems. For boys in both conditions, they and their adult caretakers participated in an assessment 3 months after initial placement. The assessment was designed to evaluate key treatment process variables thought to predict later outcomes: the extent to which the boy was well supervised, the level of consistent discipline he received, the extent to which he associated with delinquent peers, and the quality of the boy's relationship with his adult caretaker. Results on these variables are presented, as are results on outcomes: subsequent arrests, program completion rates, rates of running away from placement and number of days incarcerated in follow-up. A brief case study is included to illustrate the TFC treatment approach.

KEYWORDS

adolescent treatment, antisocial behavior, delinquency, deviant peer group, treatment foster care

IN MOST US communities there is substantial concern about how to deal with juvenile crime. In particular, solutions seem elusive for dealing with serious and chronic offenders

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who commit the majority of juvenile criminal acts. In response to the increased rate of serious crime by adolescent males during the past decade (Greenwood, Model, Rydell, & Chiesa, 1996), public attitudes about crime and punishment have become more punitive (Di Julio, 1995; Mayer, 1992; US Bureau of Justice Statistics, 1993).

Longitudinal studies examining the life course development of antisocial behavior and delinquency have documented a number of antecedents to the development of serious delinquency. Although some of these are not likely to be affected by psychosocial interventions (e.g. poverty), others, such as parenting practices or parental functions, are potentially malleable and could be considered as targets for such interventions. Parenting practices such as supervision and discipline have been strongly implicated in the development and maintenance of delinquent behavior (Laub, & Sampson, 1988; Patterson, 1982), as have peer variables such as association with friends who engage in criminal activities and drug use (Elliott, Huizinga, & Ageton, 1985).

In addition, from the last decade of research findings on risk factors contributing to the development of antisocial behavior, it has become increasingly clear that chronic and severe patterns of delinquency are multiply determined; that is, parent, peer, school and community factors all contribute to the development of each individual's pattern of criminal behavior. Researchers have asserted that to have sufficient power to change what have been shown to be stable patterns of antisocial behavior, interventions must focus on multiple targets present in the settings in which the adolescent operates (Chamberlain, & Rosicky, 1995; Henggeler, Smith, & Schoenwald, 1994).

At the same time, mental health researchers have called for the development of interventions with high external validity. Controlled clinical trails with treatments that offer services in laboratory or university settings, with subjects having narrowly defined disorders and with therapists hired and trained specifically to conduct the research trial, may not reflect how services are typically provided in the community (Henggeler et al., 1994). As noted by Clarke (1995), the participants in such controlled clinical trials typically have been subjected to a number of inclusion and exclusion criteria and may have little resemblance to cases treated in the community. These factors may contribute to differences in effect size that have been observed in studies conducted in laboratory vs community settings (Weisz, Donenberg, Weiss, & Han, 1995).

This paper describes a community-based intervention for chronic juvenile offenders that focuses on delivery of the intervention in a family setting, has good ecological validity, and focuses on multiple targets that have been implicated as risk factors for the development of antisocial behavior. The intervention relies on placing young offenders in community families selected for their strong parenting skills and willingness to work

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with teenagers in trouble with the law. The participants were adolescents referred by a multi-agency community team that assigned youngsters to out-of-home care because of their ongoing criminal involvement. The study described here evaluated the effectiveness of a parent-mediated intervention (treatment foster care; TFC) that had been part of a state-funded juvenile corrections program in Oregon since 1983. The program had been operating for 7 years prior to the beginning of the research. The study compared the effectiveness of TFC, where boys were placed and treated in a family setting, with group care (GC), the traditional alternative placement commonly used for this population. In addition to local families, the TFC program was staffed by community clinicians, some without formal degrees and others who were bachelor's and master's level personnel. In many ways, the clinical practices described here correspond closely to those used in real-world mental health and juvenile justice settings, and the findings are therefore applicable and generalizable to those settings.

Summary of research methods

Sample and design

Participants were boys, aged 12–17, referred from the local juvenile court. They had an average of 13 previous arrests and 4.6 felonies at the time of referral to the study. Eligible boys were those for whom an out-of-home placement was ordered by the juvenile court judge. During the 5-year period of the study, all boys who were mandated to participate in a residential care program by the Department of Youth Services were in the pool of eligible cases. Boys in the pool were randomly assigned to participation in TFC (n = 39, experimental condition) or in GC (n = 40, control condition). Boys' parents or guardians were sent a description of the study which was described as an attempt '. . . to learn more about the effectiveness of juvenile services for boys going into out-of-home care.' The letter was followed by a telephone call from the principal investigator who further explained the study and answered questions. For families without telephones, we included a number they could call reversing the charges, and in some instances we visited families in their homes to obtain consent. Families and boys were paid $10 per hour for their participation in the assessment with bonuses for completing the assessments in a timely manner.

At the time we applied for funding for the study, we held several meetings with the director of the juvenile department and the juvenile court judge. Our purpose was to obtain their permission to conduct a randomized study with the boys they were referring to out-of-home placements. To provide them with an incentive to accept this inconvenience and loss of control over who would use what resources, we included in the study budget the cost of treatment for 15 boys funded in the state budget. In addition, we agreed to let the judge violate the random assignment up to three times a year over the 5-year study period if he felt strongly that a certain boy should be placed in either TFC or GC. Given these two conditions (the extra funded slots for treatment and the possibility of being able to violate random assignment), the judge and court director agreed to let us use the randomization procedure. The judge only used the exception to randomization twice during the entire course of the study by placing the boys initially assigned to GC into the TFC condition.

Boys and their parents were assessed at baseline, and treatment outcomes were assessed at 6-month intervals for 2 years post-baseline. In addition, after boys had been placed in either TFC or GC for 3 months, they and their primary caretakers participated in an assessment designed to examine key components of treatment that were hypothesized to predict outcomes at the subsequent assessments. These key components were

the extent to which the boys were supervised by adults, the extent to which they were consistently disciplined for rule violations and other problems and the amount of time they spent associating with peers who also had problems with delinquency. These variables were assessed from both the boys' and the caretakers' points of view and multiple methods of assessment were used [e.g. three telephone interviews, questionnaires, in-person interviews; see Chamberlain, Ray, & Moore (1996) for a full description of these and other measures used].

Participating boys were an average of 14.4 years old at the time of referral, had spent an average of 76 days during the previous year in lock-up, and had been arrested for the first time when they were an average of 12.3 years old. In addition, boys had an average of 1.3 previous out-of-home placements, and 75% of the boys had a history of running away. For a full description of the sample, see P. Chamberlain and J.B. Reid (in press). There were no significant differences in any of the demographic or risk factors assessed or in the rate or seriousness of previous criminal behavior at baseline.

To study the effect of TFC and GC treatments on criminal behavior, we examined official arrest records for each boy at baseline and at 6- and 12-month assessments. At these time intervals, to evaluate boys' use of substances, we asked them how often they used alcohol, tobacco, marijuana, and a variety of hard drugs. In addition, we examined their program completion rates and the number of days they spent incarcerated in follow-up.

Treatments

Both the TFC and GC treatments were designed for use with 12- to 17-year-old males who were placed in residential care because of severe and chronic delinquency. Both types of treatment were funded by the Oregon Youth Authority and had been in place in the local community since the 1980s.

Treatment foster care (TFC)

The TFC model used in this study was a parent-mediated treatment model specifically developed to address problem behaviors occurring in multiple settings, including family, educational and peer settings (Chamberlain, 1994; Moore, & Chamberlain, 1994). There are several components to this model, including: (a) foster parent recruitment and screening; (b) intensive preservice training for TFC parents; (c) use of a structured behavioral management system in the home; (d) ongoing consultation between TFC parents and professional staff; (e) ongoing school consultation and monitoring of behavioral and academic progress; (f) individualized youth treatment including weekly therapy or skills training sessions; (g) family therapy with biological, adoptive, or other aftercare resources; and (h) aftercare services using flexible or 'wraparound' services that were customized to fit the individual needs of youths and their families. The aim of this treatment model is to teach, reinforce, and support parents (TFC foster, biological, adoptive, relatives) to focus on changing targeted youth behaviors through the use of effective discipline, supervision, and reinforcement practices. These key parenting practices have been shown in previous research to be associated with the development (and desistance) of child and adolescent delinquency and antisocial behavior (Forgatch, 1991; Patterson, & Bank, 1989; Vuchinich, Bank, & Patterson, 1992).

Common targeted youth behaviors included compliance, emotional modulation (i.e. coping with anger, depression or anxiety), decreased unsupervised wandering, increased productive use of free time, educational achievement, close monitoring of behavior and attendance in school, association with prosocial vs antisocial peers and engagement in

recreational activities. On the microsocial level, these targets were defined on daily individualized behavioral management plans that used point systems and levels. The point and level systems allowed TFC parents to clearly specify to youths what the minimal daily expectations were (e.g. getting up on time, doing morning chores, attending, participating in and behaving at school, completing homework, following adult instructions). Moreover, training youths in the use of the point and level system helped TFC parents reinforce acceptable behavior and provide minor consequences for transgressions. An important aspect of this treatment model is its built-in flexibility that allows TFC parents and supervising professionals to individualize each youth's program and behavioral targets. To fully actualize the potential of the treatment model, only one youth was placed in each home.

TFC parents were recruited from the community using newspaper advertisements and word of mouth. A four-step screening process was used: telephone screening, written application, home visit, and participation in preservice training. The preservice training involved instruction in the use of the structured behavior-management point and level system that the TFC parents implemented in their homes. Other areas covered in preservice training included how TFC parents would work as part of the treatment team, staff roles, how to support the adolescent's biological (or adoptive/relative) parents, and program policies and procedures.

To control treatment fidelity, TFC parents were thoroughly trained prior to placing a youth with them, then were supervised weekly. In addition, TFC parents were telephoned daily (M-F) to collect data on boys' progress/problems during the past 24 h and to troubleshoot potential problems.

Group care (GC)

The treatment model most commonly used in GC settings in this study was peer mediated. Programs typically had between 6 and 15 youths in residence. Most GC programs used a variation of the positive peer culture (PPC) treatment model (Vorrath, & Brendtro, 1985) that attempts to use peer influence to help youth develop prosocial skills. In PPC, the assumption is that 'the peer group has the strongest influence over the values, attitudes and behavior of most youth' (Vorrath, & Brendtro, 1985, p. 2). Staff attempt to develop a peer culture where peers watch out and care for each other by giving feedback on and reporting inappropriate behavior and thoughts. In addition, youth in this model are encouraged to help each other to adopt prosocial attitudes and behaviors across settings. This peer influence is exerted by getting members to acknowledge their problem behaviors and commit to improve in the future. Most PPC programs have a specific language through which they label youth problem behaviors. For example, many programs attempt to help youths identify 'thinking errors' and other problems such as 'fronting' that are thought to be associated with delinquent behavior and resistance to positive change. This 'therapeutic' peer culture is ongoing throughout the day and evening, but is most concentrated and intense during daily group therapy sessions that typically occur at least several times a week, sometimes daily. These groups consist of a check-in with all members, then concentrate on one member's problems or issues through group problem solving.

Previous researchers working in treatment and institutional settings using PPC have reported significant variation in the structure and delivery of this model (Gold, & Osgood, 1992), and we believe that this was the case in the GC settings in this study. However, as discussed in the next section, staff and youth in the GC programs reported program practices that were consistent with the PPC theory of peer-mediated change described earlier.

Measures of theoretical assumptions and program practices in the two models

In a previous report (Chamberlain et al., 1996), we found that adults and adolescents in the two program models reported beliefs, perceptions of adult and youth behavior, and actual program practices that were consistent with each program's respective theories of change. To more fully describe the two treatment programs, highlights from that report are presented.

Theoretical assumptions In preplacement interviews conducted with program staff in each type of setting (TFC parents and GC staff members), we asked whether peers or parents/adult staff were expected to be the most influential on boys' success in the programs. Although staff in both program models believed that as adults they had the most influence on youths' success, TFC parents thought they had a more powerful influence relative to peers than GC staff did. In GC, the influence of adults and peers was nearly equal, with adults being only slightly more influential.

When adults in each treatment model were asked who youths were likely to spend their time with, there were significant differences between the GC and TFC programs. TFC youths were thought to be likely to spend significantly more time with adults alone and significantly less time with peers alone (i.e. no adult present) than GC youths.

Differences were also found in program philosophies of discipline. For example, TFC parents reported that they exercised significantly more control over the particulars of discipline than GC staff (i.e. who decides when discipline is needed, who decides what the discipline will be and who administers the discipline).

Program practices After youths had been in their respective programs for 3 months, the adult caretakers and the youths were interviewed in person and on five separate occasions over a 2-week period using parallel versions of the Parent Daily Report (PDR) Checklist (Chamberlain, & Reid, 1987). This is a telephone interview during which adult caretakers and youths respond to questions separately and out of ear shot of each other. Adults and youths were asked about the occurrence of problem behaviors, the amount and kind of discipline and supervision youths received, and about their peer and adult contacts during this time.

Adults in both TFC and GC settings reported that the boys in their respective treatment programs had very similar numbers of problem behaviors per day (3.7 and 3.6, respectively). However, there was a significant difference between TFC and GC boys in the number of problem behaviors they reported engaging in each day. GC boys reported that they engaged in 6.6 problem behaviors per day, whereas TFC boys reported they engaged in only 3 problem behaviors per day. In terms of treatment process, what was more interesting than the magnitude of the difference between youths' reports in the two groups was the fact that GC youths reported more behaviors than their adult caretakers, and TFC youths reported fewer problem behaviors than their adult caretakers. Moreover, there was a significant discrepancy between the number of behaviors reported by GC youths and their caretakers, whereas there were no significant differences between youths' and parents' reports of problem behaviors in the TFC program.

In terms of discipline, when caretakers and youths were asked what, if any, consequences were given for the problem behaviors reported, both parents and youths in TFC reported almost twice as many consequences as reported by GC caretakers and youths.

Caretakers' and youths' reports of supervision practices revealed that in GC, youths spent an average of 3 h per day in the presence of their caretakers. TFC parents and youths reported spending an average of 5 h per day together. In addition, there were

differences between the groups in terms of how much time youths spent unsupervised. GC boys reported spending an average of 78 min per day unsupervised, and TFC youths reported spending an average of 35 min per day unsupervised.

When asked about how much time was spent with delinquent peers who were from outside their programs, there were significant discrepancies between boy and caretaker reports in both GC and TFC, but in opposite directions. GC youths reported more time spent with delinquent peers than their caretakers reported; but in TFC, parents reported that boys in their care spent more time with delinquent peers than the boys reported they spent. Moreover, on a 10-point scale (1 = no influence), TFC boys and parents reported less influence by negative peers than both GC youths and caretakers.

Summary of treatment program assumptions and practices

In the data presented earlier, we found a great deal of consistency between the theoretical assumptions of the two program models and their practices. In the peer-mediated GC model, peers were thought to have more influence on the success of the boys in their programs, and GC youths spent more time with peers than youths in the TFC parent-mediated model. In contrast, TFC adults were thought to be more influential on boys' success and boys spent more time with their adult caretakers. There were also differences between the two models in discipline and supervision with TFC youths receiving more consequences from adults, having higher levels of supervision, and spending less time with peers. Although adults in both programs reported that boys had the same level of problem behaviors per day, boys in the peer-mediated model reported twice as many problem behaviors as did boys in TFC. With regard to the occurrence of problem behaviors, TFC boys and caretakers were more in agreement about what was happening than their GC counterparts.

Study outcomes and implications

At 1 year following referral to the study, boys in TFC had significantly fewer arrests than those in GC. On the average, boys in GC had two fewer arrests in the year after treatment than in the year before, and boys in TFC had an average of six fewer arrests after than before treatment. A two-by-two mixed ANOVA (group by time) was conducted and the interaction was significant at the $p = .003$ level. Fewer boys in TFC ran away from their placement settings than in GC (31 vs 58% respectively; $\chi^2 = .02$). A greater proportion of TFC boys completed their programs (i.e. graduated) than GC boys (73 vs 36% respectively, $\chi^2 p < .001$). Additionally, TFC boys spent 60% fewer days (mean = 21 days) in lock-up settings (e.g. detention, training schools) than GC boys (mean = 69 days) during the 12 months after referral to the study. This difference was statistically significant ($p < .001$). Finally, boys in TFC spent nearly twice the number of days living with their parents or other relatives during the year after enrollment in the study, also a significant difference between the two conditions. A more detailed description of study outcomes can be found in P. Chamberlain and J.B. Reid (in press).

In general, outcomes favored those boys who participated in the adult-mediated TFC program model. We were interested in which factors directly contributed to the greater reduction in arrests in TFC than in GC. We hypothesized that regardless of treatment group (TFC or GC), boys receiving the closest supervision, the most contact with caretaking adults, the most consistent discipline, and having the least association with delinquent peers would have fewer crimes post-treatment. Initial analyses indicate that all four of these conditions predict fewer crimes in follow-up. An essential set of questions for programs attempting to treat juvenile offenders is how to 'provide effective

supervision, foster close relationships with caretaking adults, provide consistent discipline, and limit contact with and negative influence of delinquent peers.

In our study, boys were placed in family settings where the TFC parents were selected for their high-quality parenting skills. In addition, TFC parents were given a great deal of support and backup for systematically implementing effective supervision and discipline practices. As a result, TFC boys associated less than GC boys with delinquent peers and reported that they were less influenced by them. This finding held even when we excluded peers that the GC boys were living with; boys in GC spent significantly more hours with nonprogram delinquent peers. Our findings strongly imply that it is more feasible to closely supervise and consistently discipline boys when they are living in a family setting than when they are living in group care.

It is often thought that by the time youngsters reach their teen years, adults have little impact on them; that peers are the only powerful influencing force. Our results disputed this notion. On a score constructed to measure the quality of the relationship between boys and adult caretakers, we found that to the extent that the boys felt liked and understood by the adults they lived with during their placements, they were less likely to commit crimes in follow-up. On the flip side, the more boys connected with delinquent peers, the more likely it was that their offending behavior would continue.

Brief case description using the TFC approach

Presenting problems

When Dale, age 16, was referred to the study he had been arrested for three burglaries in the first degree, unlawful possession of a short-barreled shotgun, and two separate counts of unauthorized use of a vehicle. At the time of referral, his probation officer was pessimistic about Dale's ability to change his criminal behavior and peer associations. The P.O. gave the program a list of Dale's co-offenders that included 12 other males, two of whom were adults, and all of whom had extensive criminal records. Dale had previously participated unsuccessfully in a group home placement and in an intensive probation supervision program.

Individualized behavior management plan in the TFC home

Areas targeted by the TFC parents and program staff for inclusion in Dale's point and level system included daily living skills (including hygiene), compliance with adult directives and attending and doing well academically and behaviorally in school. The TFC parents emphasized giving Dale points for acceptable behavior. Dale was highly responsive to the daily feedback and worked hard to improve in areas where he lost points. The TFC parents did a good job of orienting the point system to Dale's positive behavior and they gave him feedback on problem behaviors with little negative emotion. Consequences were designed to be immediate. When Dale had a bad day, it did not affect him for more than one day if his behavior improved quickly. Moreover, his motives were never guessed at, targeted for intervention, or talked about during discipline. Dale reported that he particularly liked this aspect of the program because in the past he had been involved in programs when even if he did well, his motivation for improvement was questioned. He also complained that in previous interventions he would be confronted about his 'dysfunctional family,' and he did not view his family as dysfunctional or responsible for his actions. The point and level system developed for Dale that was used in the TFC home was also used with his biological family during home visits and when he returned to their care.

Dale was closely supervised and not allowed to associate with people with whom he

had formerly committed crimes; in fact, all of Dale's peer associations were closely monitored by the TFC parents. He was able to earn free time by earning the required number of points, but his whereabouts and associations were prearranged, and the TFC parents checked to see that he complied with the planned activities. The point program was eventually titrated so that the level of supervision was less intensive.

Individual treatment

Dale willingly participated in individual therapy and never missed a session. He rarely complained about his foster placement or daily treatment in the foster home. Throughout individual treatment, Dale's constant theme was that he wanted to complete the program and return home as soon as possible. Moreover, he stated he was no longer interested in getting into trouble. He indicated a willingness to find which behaviors he needed to change and to work on these. He wanted to do whatever it took to complete the program, stay out of trouble and return home. He said that he did not want to become like his older brother who had a prison record and was not successful maintaining in the community.

Dale was well-defended about any aspect of his family life that would indicate there may have been 'something wrong' with his parents. However, over time he was able to tolerate talking about challenges that his parents experienced raising a family and surviving economically, and about family events and conditions that may have disrupted his own social and emotional development. For example, he indicated that his mother had always bailed him out of difficult situations, and although it made him feel good that she joined with him, it may not have been helpful for him in the long run. He also indicated that his father often reacted harshly when he got into trouble, and then would withdraw, which Dale acknowledged was not helpful either.

Dale was encouraged to make better use of his parents' different strengths rather than focus on their weaknesses. He reported that his relationship with his father improved, and they began to do things together again (e.g. hunt, work on cars). He was also able to take more responsibility for his actions and not let his mother defend him when he faced failure. Moreover, Dale acknowledged that an earlier separation between his parents (when he was 8–11 years old) had been difficult for him. During that time, his father had a child with another woman and his mother began drinking. Dale relied increasingly on older delinquent friends for support.

Although Dale presented with a tough, gang-like physical presence, he was a highly anxious youth whose anxiety had been interpreted in the past as denial and resistance. We found that he could accept negative feedback and consequences in *small* doses when there was reinforcement of his positive behaviors and acceptance. He indicated that he felt he had matured since age 15, and that the behaviors he displayed during those years were 'dumb' and not helpful. He was able to discuss his disappointment with his selection of a peer group and indicated that he did not want to become reinvolved with most of these peers when he returned home.

An issue that Dale eventually worked on in individual therapy was his tendency to respond to stress with antisocial behavior. He focused on learning more prosocial ways to cope with interpersonal and family pressures, disappointment and stress. He was also able to talk about and come to some understanding that his tough demeanor may have created more stress by provoking adults and peers to treat him harshly.

In summary, the program implemented in the TFC home that focused on using an overt, consistent point and level system and on behavior rather than motives set the stage for Dale to be a delight to work with in individual therapy. He made significant progress in his ability to talk about interpersonal and family issues that had previously blocked his prosocial development. Once Dale acknowledged he was highly sensitive to any

implication that there was something wrong with him or his family and that he very much wanted to be seen as a capable and accomplished young adult, his behavior began to change in a prosocial direction.

Family therapy

After Dale had been in the program for 3 weeks, his mother, Alison, began coming to weekly family therapy sessions. In the beginning, sessions were focused on teaching her to use the point system and encouraging her to contact the program manager to find out about Dale's progress and arrange for home visits. Alison clearly wanted Dale to do well in the program and stay out of trouble. She was adamant that she and her husband were supportive of Dale, but that it was up to him to do what he needed to do. Dale's father did not attend weekly sessions and was unwilling to meet with program staff.

Alison used the point system during home visits and taught her husband how to use the program, as well. They sent point cards back with Dale when he returned to the TFC home from 1-day and eventually weekend visits with his family. As family therapy continued, we discussed strategies for Alison to supervise Dale's activities and progress after he returned home. These sessions were centered on what activities Alison wanted Dale to be involved in and what her and her husband's expectations for him were. We then began planning ways for these goals to be met.

A main concern was that Dale be employed and pay off the restitution that he owed. The parents were being sued privately for the restitution, and they were very upset about this. During joint sessions with Alison and Dale, it became apparent that Alison had a tendency to minimize Dale's involvement in criminal behavior. Treatment focused on ways that Alison could support and encourage Dale and, at the same time, send him a clear message about the things he needed to do at home and in the community. Specifically, she expected him to pay his restitution, stay out of trouble, go to school and work toward not being involved in the juvenile justice system.

Dale was able to get a job during weekend home visits working at the same metal recycling plant as his father. By the end of his treatment, he had obtained another job as a laborer in a pellet manufacturing plant. Given the isolated style of Dale's family, it was significant that Alison agreed to continue her involvement by attending weekly aftercare parent support meetings.

Reunification and follow-up, including offenses in follow-up

One-year follow-up data showed that Dale had one post-treatment criminal offense; taking items from an unlocked car. He reported that he was disappointed in himself and that the experience of again getting into trouble with the law reminded him that delinquent peers and an antisocial lifestyle was not for him. After that incident, he re-invested in a prosocial lifestyle. By age 18, Dale was working in construction, living independently, and had not been re-arrested.

Summary and conclusions

Clinical studies that are conducted in the context of real-world programs have the potential to bridge the well-documented gap between research and practice (Weisz et al., 1995). This study demonstrated that severely delinquent youngsters, even those with over 10 previous arrests, can be served in family settings where they are closely supervised, consistently and fairly disciplined, and isolated from delinquent peers. Moreover, placement in a family setting appears to have some strong advantages over congregate care. Youngsters have the opportunity to establish close relationships with mentoring

adults, their treatment can be individualized to fit their unique needs and they are not exposed to delinquent peers who have the potential to reinforce criminal behavior and thinking patterns.

The treatment foster care approach highlights the great potential of families for socialization of even the most troubled youths. Furthermore, participants in such a treatment approach are living in relatively nonrestrictive community settings. In the study described here, boys attended public schools and participated in community activities. The level of supervision and discipline they received was very intensive at first, but was titrated over the course of their placements, given appropriate progress.

Family therapy was an important part of the treatment. Typically, parents of the boys who participated in this study were discouraged and had been unable to make any progress in changing their teenagers' serious conduct problems. Often they were overwhelmed by the severity of the problems, felt angry at their children and at the system, and felt thoroughly defeated in their attempts to parent their boys. Placement in TFC allowed a fresh start. They were given a pretested and debugged program to implement with their sons. They had the on-call backup support of the program staff during their sons' visits. Although the families were asked to implement new ways of parenting that were often difficult for them to accomplish, the program structure and level of support set the stage for helping them make major changes. Demonstrations such as this of the positive influence families can have on troubled adolescents give credence to the notion that parents are their child's most powerful teachers.

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