Community Alternatives for Chronic Juvenile Offenders and Emotionally Disturbed Youngsters: Implications for the Foster Care System

By Patricia Chamberlain

Treatment foster care has proven more effective in reducing criminal activity among serious juvenile offenders than traditional group care. For every $1 spent on treatment foster care, taxpayers save more than $17 in criminal justice and victim costs. The program has also been successful for youth with such severe mental illness that they would typically be placed in psychiatric hospitals. The linchpin of treatment foster care is the foster parent who is carefully selected, supported, and trained for 20 hours in parent management skills. Moreover, parent training and support, when combined with an extra $70 monthly stipend, reduced the foster parent drop-out rate by two-thirds.

Wisconsin's rate of juvenile arrests is the highest in the nation. Because of the unacceptable rates of repeat crimes by juveniles and the escalating costs of correctional institutions, interest has grown in alternatives to institutional care for troubled youth.

In this chapter, I focus on community treatments for older youth with severe criminal records. First, I address what we know from research about the factors that lead to antisocial behavior and delinquency during adolescence. Then I compare the traditional group-based facility for delinquent youth with a treatment foster care program in which carefully selected foster parents receive parent management training and support. Can treatment foster care reduce crime and delinquent behavior among chronic offenders and, if so, is it cost-effective? Will it work for older boys with more serious criminal records and with youngsters with severe mental illness? Finally, in a time when the demand for foster care is increasing faster than the number of foster families, we examine whether offering parent training, support, and a small extra stipend increases the willingness of foster parents to provide care.

What Do We Know About Delinquent Behavior Among Youth?

Key elements contributing to antisocial behavior and delinquency during adolescence include poor parental supervision, lack of consistent discipline, low parental involvement, friendships with delinquent peers, and school failure (Chamberlain, 1994, 1996; DeBaryshe, Patterson, & Capaldi, 1993; Reid, 1993; Reid & Eddy, 1997). Research has shown that antisocial behavior leads to increasingly serious delinquency, and also that the behavior itself wears down the social forces that could potentially guide the youth to more acceptable behavior. Their families are distressed, demoralized, defeated and cynical. As a result, the family becomes incapable of supervising, mentoring, setting limits, or negotiating with the teen. The youth's homework, attendance and school behavior deteriorate, while he be-

comes increasingly influenced by peers. Finally, the youth's behavior compromises community safety.

The courts intervene and the youth is taken out of the home. At this point, the challenge is to re-create the powerful socialization forces of functional family life for these teens, while protecting the community, the adults in charge of the youngsters, and the youth themselves.

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Teens who have been removed from their homes for chronic delinquency have traditionally been placed in secure or community-based group care facilities. However, in one of our studies, we found that keeping troubled teens in the community with carefully selected and trained foster families has had better short- and long-term impacts on changing antisocial behavior.

Results from this study found boys ran away less frequently, completed their programs more often, and were locked up in detention less while participating in treatment foster care, compared with group care. In addition, teens in foster care had fewer criminal referrals in official court records and fewer self-reported violent or serious crimes than teens in group care.

How Does Treatment Foster Care Work?

We compared treatment foster care and group care with 79 boys ages 12 to 17 (average age: 15 years) who had histories of serious, chronic delinquency. (See Table 1). Thirty-seven boys were assigned to foster care, and 42 to group care conditions. All had been required to be placed in out-of-home care. The boys averaged 14 previous criminal referrals, including more than four previous felonies. All had been detained in the year before the study, and the average number of days in detention was 76. All had been placed out of their homes at least once before. All lived in a medium-sized metropolitan region or surrounding rural neighborhoods in the Pacific Northwest. Eighty-five percent were white; 6 percent were black; 3 percent were Native American; and 6 percent were Hispanic.

Table 1. Risk Factors of Boys in Sample

Factor	Group Care (%)	TFC (%)
Single-parent family	54	59
Parent hospitalized	7	9
Parent convicted of crime	30	25
Siblings institutionalized	22	16
Perpetrator of sexual abuse	7	13
Drug or alcohol abuse	15	3
Chronic truancy	69	61
Fire setting	22	13
Had run away from placement	78	75
2 or more of the above	85	87
3 or more of the above	63	56

Note: TFC = treatment foster care.

Treatment Foster Care Program

The central component to the treatment foster care program was the foster parent. Families were recruited based on their experience with teens, their willingness to act as treatment agents, and their nurturing family environment. Selection included a telephone screening, an application form, a home visit, and a 20-hour preservice training. To provide the boys with a structured living environment, the training emphasized parent management skills such as monitoring whereabouts and setting clear rules. Foster parents were taught to track positive and negative behaviors and to respond appropriately and consistently. Youth were supervised closely, all free time was prearranged, and contact with peers with known histories of delinquency was prohibited. Foster parents also learned how to implement an individual plan for each teen.

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Foster parents received weekly supervision and daily phone calls where parents identified problems and discussed potential solutions. Case managers were on call 24 hours per day, 7 days per week.

Each boy participated in weekly individual therapy focused on problem solving and non-aggressive methods of communicating. Each boy's biological family or caregiver participated in weekly family therapy, including supervision, encouragement, discipline, and problem-solving. Frequent home visits occurred, beginning with 1- and 2-hour visits, increasing to overnights.

All teens were enrolled in public school, with 45 percent involved in at least some special education programming. School staff attended a conference with program staff before enrollment. Teens carried a card to each class for teachers to sign off on attendance, homework and attitude. Support was provided to the school if a teen had problems. Program staff were on call to remove a youth if he was disruptive.

Consequences for breaking rules were tailored for each teen, including loss of privileges, work chores, and demotion to a lower level. Consequences were consistent, even for minor rule violations (e.g., being 2 minutes late, not doing breakfast dishes). Boys were encouraged to accept consequences and start each new day with a clean slate. Foster parents were trained to offer consequences in a neutral way and to give boys credit for complying with the consequence.

Group Care

Teens assigned to group care went to one of 11 programs located in the state. Each had from 6 to 15 youths in residence, and all employed shift staff. The approach most often used was the positive peer culture approach, which assumes that the peer group can best influence and motivate youth to change. Teens participate in therapeutic group work to establish prosocial expectations, confront each other about negative behavior, and participate in discipline and decision-making. Teens usually attended in-house schools. Family contact was encouraged, and family therapy was provided if families could commute to program sites, most often once a month or less.

Differences Between Treatment Foster Care and Group Care

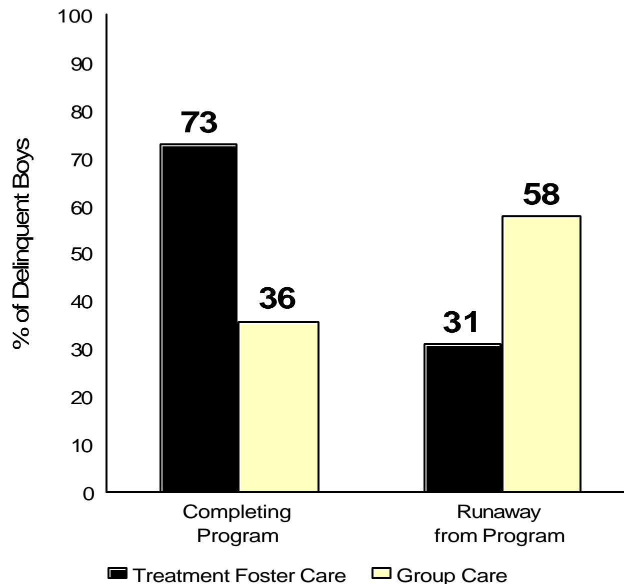
Differences between treatment foster care and group care include:

- ❖ Group therapy occurred at least weekly in more than three-quarters (77 percent) of the group care placements; it was not offered at all in treatment foster care.
- ❖ Adults in group care believed peers had the most influence on teens' success; foster parents felt adults had the most influence.
- ❖ Adults spent less one-on-one time with teens in group care than they did in foster care.
- ❖ Peers had more influence on house rules and discipline in group care than foster care.
- ❖ Teens in group care spent more time with peers than did their counterparts in foster care.

Is it Feasible and Safe to Place Serious Youth Offenders in Foster Families in the Community?

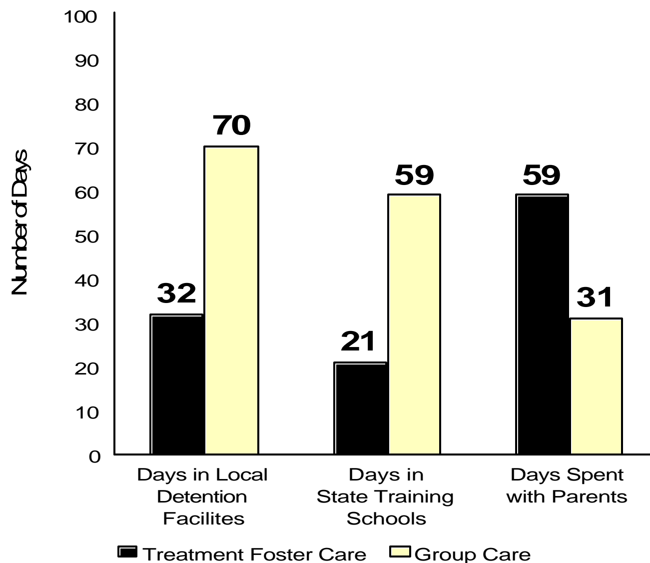
Results from this study found that teens placed in treatment foster care actually were much more likely to complete their programs successfully, and much less likely to run away while in foster care, compared with teens in group care. Nearly three-quarters, or 73 percent in foster care completed their programs, compared with 36 percent in group care. Clearly, traditional group care appears to provide the community with only modest protection from the criminal behavior of program participants. Likewise, 31 percent of teens in foster care ran away from their placements, compared with nearly 58 percent of teens in group care (See Figure 1).

Figure 1. Delinquent Youth Are More Likely to Complete Foster Care Than Group Care



During the year following referral, youth in foster care spent, on average, fewer than half as many days in detention as youth in group care and about a third less time locked up in state training schools (See Figure 2). Overall the treatment foster care boys spent 60 percent fewer days in jail during the year following referral. In addition, teens in foster care spent nearly twice as much time living with parents or relatives—a major goal of both types of treatment programs—during the year after their program than boys in group care (See Figure 2).

Figure 2. Foster Care Resulted in Less Time in Jail and More Time with Parents

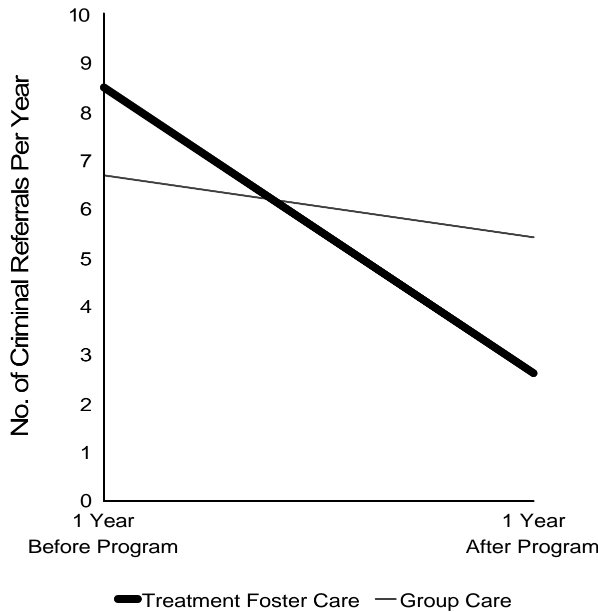


Can Foster Care Actually Reduce Crime and Delinquent Behavior in Chronic Offenders?

Foster care was more effective than group care in reducing recorded delinquent behavior.

The study looked at official juvenile court records of teens in both foster care and group care from one year before enrollment through one year after leaving the out-of-home placement. Clearly, foster care was more effective than group care in reducing recorded delinquent behavior. The study found that teens entering foster care had an average of 8.5 criminal referrals per year before treatment, and 2.6 referrals a year after treatment foster care. In contrast, the group of teens entering group care had an average of 6.7 criminal referrals per year before treatment, and 5.4 referrals a year after group care (See Figure 3). In self-reports, the boys also committed fewer delinquent acts and fewer violent or serious crimes. A year after out-of-home placement, 41 percent of teens in foster care had no criminal referrals, compared with only 7 percent of teens placed in group care. These results are over and beyond any effects of age at first criminal referral and number of prior offenses.

Figure 3. Foster Care Reduced Delinquent Acts in Official Juvenile Court Records



Is Treatment Foster Care Cost-Effective in the Long Run?

Our treatment foster care model was chosen as one of the ten National Blueprint Programs for violence prevention by the U.S. Department of Justice. The Washington State Public Policy group (Aos, Phipps, Barnoski & Lieb, 1999) calculated that for every $1 spent on this foster care program, taxpayers save more than $17 in criminal justice and victim costs by the time the participating youth is 25 years old.

For every $1 spent on treatment foster care, taxpayers save more than $17 in criminal justice and victim costs.

Does Treatment Foster Care Work as Well for Older as for Younger Boys?

Most of the participants in this study were early, chronic offenders. The age at which they committed their first official offense varied from under 6 years old to just over 16 years old. We were surprised to find that the foster care program had beneficial effects on this hard-to-reach group, and also that the program's impacts did not seem to vary by age. The older teens responded as well as the younger ones. The study seems to suggest that placing older, early-onset delinquents in strong, well-trained families has the potential to set them on a more positive life path.

Can Community Foster Care Work for Youth with Severe Mental Illnesses?

While recent research is finding that treatment foster care in community settings can be highly effective for teens with chronic delinquency, there is less information on the success of teens who have such severe mental illnesses that they would traditionally be placed in psychiatric hospitals.

Another of our studies (Chamberlain & Reid, 1991) with a sample of 8 boys and 12 girls ranging from age 9 to 18 found reason to be hopeful. The youths involved in the study had diagnoses including conduct disorder, schizophrenia, substance abuse and borderline personality. Other risk factors among the group included eight who had family histories of mental illness, eight who had been sexually abused, eight experiencing family violence, six who had attempted suicide, five living in poverty, and three who had been through failed adoptions.

The study placed 10 of the youth in treatment foster care with carefully screened and trained foster parents, and 10 of the youth in a control group. Of the control group, seven went into settings such as a group home, residential treatment center, or parent's or relative's home, while three remained in the hospital.

All 10 youth in the treatment foster care program were eventually placed in a family setting compared to only four of the 10 youth in the control group, a difference which was statistically significant. Youth in the foster care group were also placed outside the hospital more quickly than those in the control group.

Placement of emotionally disturbed youngsters in treatment foster care saved an average of $10,280 per child in hospital costs.

During the first three months of the study, the results regarding youth behavior were striking. The youth placed in foster care went from 22 reported problems per day down to 10, while the control group went from 24 to 22 reported problems per day. However, after seven months, the control group dropped, but still not as low as the treatment foster care group. The control group decreased to about 15 problems per day, while the foster care youth held steady at around 10 problems per day.

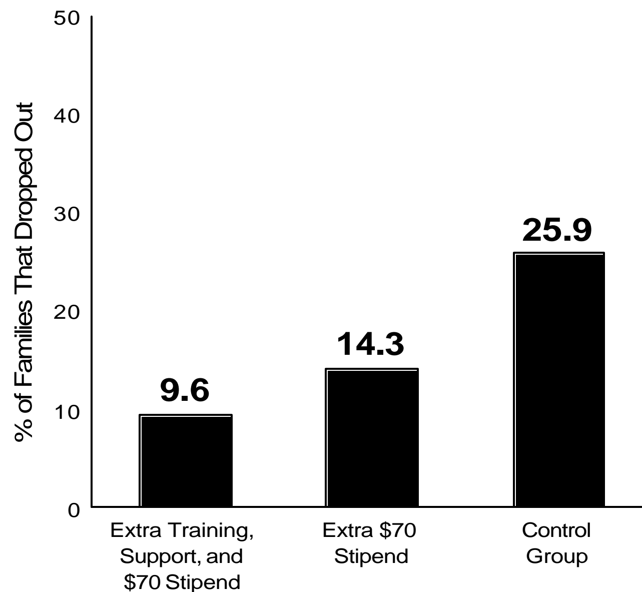
We are optimistic about the treatment foster care program, given that the young people in the study had severe, complex problems that have been very difficult to support in community settings. In practice, community placements for these children are difficult to find and are usually restricted to one or two "slots" in any given program. Moreover, hospital programs average about $6,000 per month per child, while treatment foster care averages $3,000 per month. Placement in treatment foster care saved an average of $10,280 per child in hospital costs.

Does Enhanced Parent Training, Support, and a Small Stipend Increase Parents' Willingness to Provide Foster Care?

In a 1992 study (Chamberlain, Moreland, & Reid, 1992), we found that increased parent training, support, and an extra $70 monthly stipend resulted in a foster parent drop-out rate two-thirds less than in the control group (See Figure 4). Also, children in the enhanced training and support and stipend group had fewer multiple placements then in either of the other two conditions.

The enhanced training and support included a weekly two-hour meeting with other foster parents and a trained facilitator. The trained facilitator also contacted each foster family three times per week. The staff costs of implementing the enhanced training and support for 15 to 20 foster families includes the cost of one experienced foster parent facilitator (salary equivalent of a case worker) and two hours of weekly supervision by clinical staff experienced in group process.

Figure 4. Training, Support, and Small Stipend Increased Foster Parents' Willingness to Provide Care



Summary

In summary, our studies show that treatment foster care can be more effective in reducing criminal activity among serious juvenile offenders than group care, regardless of how old the offender is, and can be at least as effective for treating young people with serious mental illness, at greatly reduced cost. The cornerstones of the treatment foster care approach include developmentally appropriate, intensive, and individualized family-focused treatment that address the antecedents to antisocial behavior, conditions such as poor parental supervision and involvement, friendships with delinquent peers, and school failure.

The linchpin of treatment foster care is the foster parent, who is carefully selected, trained, and supported. Not only were the boys taught to be responsible members of the family, but the treatment foster parents also used parent management strategies to encourage youth to attend school regularly, to improve their relationships with teachers and peers, and to do their homework. A key part of the program is isolating teens from contact with other delinquents and promoting activities that will bring them into relationships with less troubled youths.

Providing foster parents with training, support, and a small stipend enhances their willingness to provide care.

These findings are promising over the short run, yet long-term outcomes still need to be demonstrated. What remains to be seen is whether these results will extend to youth in large metropolitan areas and to minority or female delinquents.

Training and supporting foster parents as professionals appears to have the potential for providing young people who have criminal records or severe behavioral problems with a more normal lifestyle, while at the same time saving substantial amounts of money in the treatment system and in potential victim costs.

Providing foster parents with enhanced parent training, support, and a small additional stipend also enhances the willingness of foster families to continue to provide care.

During the 16 years we have been involved in the program, we have been pleased by the response from strong, tightly knit families that were willing to accept training and supervision so they could provide a positive family experience for delinquent or disturbed youth.

This article is based on the following three publications:

Chamberlain, P., Moreland, S., & 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., & 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. & Reid, J. B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. Journal of Consulting and Clinical Psychology, 66*(4),* 624-633.

References

Aos, S., Phipps, P., Barnoski, R., & Lieb, R.(1999). The comparative costs and benefits of programs to reduce crime: A review of national research findings with implications for Washington state. (Document No. 99-05-1202). Olympia, WA: Washington State Institute for Public Policy.

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