Shared Family Care: Child Protection and Family Preservation

Richard P. Barth

Shared family care involves planned provision of out-of-home care to parents and children so that the parent and host caregivers simultaneously care for the child and work toward independent in-home care by the parents. Characteristics of five types of shared family care arrangements are described: (1) residential programs for children that also offer residence and treatment for their parents, (2) drug and alcohol treatment programs for adults that also offer treatment for children, (3) drug treatment programs for mothers and children, (4) residential programs for pregnant and parenting mothers, and (5) foster family homes that offer care of parent and child. Opportunities for development of more shared family care arrangements are presented.

Key Words: *children; drug treatment; family preservation; foster care; residential treatment*

This nation's explicit public policy objective for child welfare services is to avoid the separation of mother and child unless such separation is absolutely necessary for the protection of the child. Yet placement of children in out-of-home care has been a common practice for the past 50 years and has, at least until recently, been on the rise. This rise has occurred in good part because of increased homelessness and parental drug abuse. The risk of leaving a child at home in a dangerous situation with often minimal supervision from a child welfare worker is considered unacceptably high so often that more than 200,000 new out-of-home placements occur each year in the United States (Tatara, 1993). Programs to reunify children with their families after placements in foster care appear to return no more than 30 percent home quickly (Barth, Courtney, Berrick, & Albert, 1994). As many as 30 percent of children who are returned home experience failed placements and are re-placed in foster care (Goerge, 1990; Wulczyn, 1991). The children entering foster care are getting younger, and group home care for infants and children younger than five is an increasingly common and costly response.

The search for methods to protect children and preserve families continues. Given the anticipated shortage of foster parents and the more-intense demands for care of children who are drug affected, medically troubled, and infected with the human immunodeficiency virus (HIV), alternatives to foster care that maintain the mother–child connection and ensure adequate supervision are much needed.

Home-based, intensive family preservation programs that place a social worker in the home for a brief period are an emerging alternative to

separation of mother and child. Whereas these programs can effectively serve some drug-affected families, they have their limits (Rossi, 1992; Sudia, 1990). They may be least effective with families suffering mental illness (Berry, 1992), chronic neglect (Landsman, Nelson, Saunders, & Tyler, 1990), drug abuse (Spaid & Fraser, 1991), and problems with older children's behavior.

This article describes programs that fall under the rubric of "shared family care." Kufeldt and Allison (1990) used "shared care" to refer to a broad phenomenon in which "the principle of shared care reinforces the notion of support of the family to maintain the child at home. Where a child does have to be taken into care, this principle establishes the basis for an inclusive orientation to foster care" (p. 10). This article uses *shared family care* more narrowly to describe the planned provision of out-of-home care to parents and children so that the parent and host caregivers simultaneously share the care of the child and work toward independent in-home care by the parents. In shared care, the living arrangement crosses the traditional precipice between in-home and out-of-home child welfare services; shared family care arrangements provide both.

Rationale for Shared Family Care

The trend toward family-centered residential care goes back several decades (for example, Simmons, Gumpert, & Rothman, 1973; Whittaker, 1978). Yet work on the development of parent involvement strategies seems to have stalled. Kadushin and Martin (1988) argued that "Residential institutions must provide opportunities for parents to interact with institutional staff, to engage their children, and to serve the institution itself. Parents are to be included in the daily activities of the agency; their participation is not to be limited to occasional visiting" (p. 699). Yet they aptly reported that "many institutions continue to severely restrict the parents' role and to closely control the amount of contact they have with their own children" (p. 699).

Whereas efforts have been made by residential care providers to involve parents in their programs, in the United States few residential care institutions allow parents to reside with their children. Parents are generally allowed the right to daytime visits with the child in residential care, to attend family treatment, and occasionally to spend evenings (but not nights) with the child. Family-centered approaches to child care that involved parents in a variety of activities can certainly result in considerably more parent–child contact than traditional residential care or foster care (Oxley, 1977). Yet these approaches do not avoid the confusion and distress of parent–child separation or structure significant parent education experiences. Even five-day foster care, a version of family-centered care that assists parents by placing the children in professionally supervised foster homes during the week and returning them to their own parents during weekends, holidays, and vacations, does not meet these tests of protection and parent education without separation (Loewe & Hanrahan, 1975). The five-day program closed because few families were so troubled as to need foster care but still well enough to have their children at home over the weekend (T. Hanrahan, director, Children's Services of Cleveland, personal communication, February 28, 1991).

Shared family care goes beyond family-centered approaches. Littauer (1980) described strategies for working with families of children in residential treatment that demonstrated the great capacity for teaching effective parenting techniques. This opportunity for learning is more available to families in residential care than those operating in isolation from other children and caregivers. Krona (1980) argued for discussing all major disciplinary decisions about children in child care with the children's parents. Simmons et al. (1973) did the same in collaborative meetings between parents, social workers, and children. Although resonant of shared care arrangements, these approaches are too limited to help the most distressed families.

Shared living provides innumerable opportunities for observation and support of effective parenting. The most intensive in-home service programs may include 10 to 30 hours a week for six to 10 weeks, or about 140 hours per family. More typically, they include no more than 50 hours (Kinney, Haapala, & Booth, 1991). Shared family care arrangements can include 140 hours of direct contact with families in just the first two weeks. Families can observe other families and receive feedback about their parenting styles at all hours and across many and diverse parenting tasks.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) calls for providing services in the most family-like setting. Ideally,

services would be provided in the family's own home. Intensive in-home services intend to create the equivalent of a residential care bed at home. Shared family care, conversely, creates a home in residential care. In many cases, the residential setting is more homelike than the settings in which families had resided, especially in the United States, where housing shortages are a critical contributor to the need for out-of-home care: As the director of the Texas Baptist Children's Home (TBCH) program in Round Rock observed, "If they had a home, we would have provided the services there" (N. Nagle, director, TBCH, personal communication, May 23, 1991). Relief from the pressures of protecting themselves from homelessness and violence may allow for the development of alternatives to substance abuse and child abuse. The routines of the residence may help families who have long forgotten the rhythms and responsibilities of home life to recover an independent living situation.

Indeed, battered women's shelters have long provided shared care (Haffner, 1979). Programs for those women have evolved from having a nearly exclusive emphasis on women to providing some children's programming. Children's coordinators often ensure appropriate activities for the children in the shelter and often provide parent support services (Grusznski, Brink, & Edleson, 1988). Battered women's shelters have shown the potential for crisis-oriented services that address the issues of substance abuse, family violence, and child protection (Davis & Hagen, 1988). Children's services providers considering the transition into residential family care would do well to look for information and guidance from their experienced colleagues in the women's shelter movement.

The need to rapidly develop arrangements that prevent separation of parent and child and promote parental capacity to care is not just a matter of fairness to parents. Compelling evidence asserts that parental involvement—indeed, parental improvement—is central to the successful return of a child to the family (Fanshel & Shinn, 1978). When children are young and many, and when parents are chronically ill, have substance abuse problems, or have a history of neglect, improvements are hardest to achieve (Landsman et al., 1990). Increasingly the children of such parents enter foster care at a young age and stay the longest (Wulczyn & Goerge, 1992).

Models of Shared Family Care

At least five types of shared family care living arrangements have evolved to keep parent and child together: (1) drug and alcohol treatment programs for adults that also offer treatment for children, (2) drug treatment programs for mothers and children, (3) residential programs expressly developed to offer care to pregnant and parenting mothers, (4) foster homes that offer care of parent and child, and (5) child care homes (residential treatment programs for children) that also offer residence and treatment for their parents. These programs operate across the United States and in Europe, where the practice of opening one's home to unrelated adults and children goes back for centuries.

Residential Adult Programs with Provisions for Children

Residential drug treatment programs for adults are beginning to address the needs of families. In Sweden, roughly 10 percent of all children in out-of-home care are in treatment homes for adults with drug or alcohol dependency problems (Barth, 1992). Certainly, proportionately fewer children are in such programs in the United States. Almost all of the programs that exist are reserved for mothers and their children; few children are also in programs with their fathers. During the day, while parents are involved in groups and rehabilitation training, children are in day care or school or are provided care on site. The general aim of these programs is to improve parenting through sobriety, whereas programs that are expressly for mothers and children are as likely to emphasize responsible parenting as a route to sobriety. (Although some of these programs do have parent support groups, many do not have parenting classes.)

The Rectory, in Vallejo, California, is an example of a program that has evolved from a women's alcohol treatment program into one that also accommodates children. This eclectic program emphasizes a social model involving self-help, a sober living environment, and a program that shifts from very structured to quite unstructured as the woman and child's stay lengthens. The residents write recovery plans that are facilitated by staff. The Rectory, like most homes for drug-using mothers and their children, typically restricts the number of children (to one)

and the age of children (to younger than six) allowed to be in care. The assumption is that the more children the mother must care for, the slower her recovery (A. Becnel, director, The Rectory, personal communication, May 21, 1990). This program, like others of its kind, does not accept pregnant women. A six-month follow-up of women enrolled voluntarily in the program showed eight of 13 women sober and drug-free. Out of five enrolled involuntarily due to referral by child protective services, one was sober and drug-free.

Whale's Tale Family Treatment Center in Pittsburgh may be typical of a therapeutic community approach to mother and child services. The program lasts from six to 12 months; it is funded by grant money and by copayment from the mothers (they turn their Aid to Families with Dependent Children [AFDC] payments over to the program). Program staff conduct weekly random drug testing and conduct their own drug treatment program. Relapse prevention is fostered by women's groups; parenting skills training; alcohol and drug information; Narcotics Anonymous and Alcoholics Anonymous meetings; encounter groups; and responsibility for the cooking, cleaning, and child care. The director of Whale's Tale underscores the program's philosophy: Women are the clients, not the children. Residential agencies like Whale's Tale are primarily committed to the recovery of the mother and secondarily concerned about the children. These programs may lack the facilities and weekend and evening coverage for children if parents are absent without making arrangements for their children. The roots of these programs grow deeper in the women's movement and the drug treatment culture than in the child welfare community. Yet programs such as those outlined are beginning to face the inseparability of these issues.

A long-standing barrier for mothers seeking drug treatment is the lack of child care facilities at a treatment program. Operation PAR in Largo, Florida, has accepted women, those who are pregnant and those who are not, since it began in 1973 (MacDonald, 1994). Operation PAR staff realized that the retention rate for women in the program was much lower than the retention rate for men; when the women dropped out, more often than not it was to care for their children. In response, in 1990 Operation PAR expanded its female treatment bed capacity and developed on-site infant and child development facilities at its therapeutic community program. (Most beds are in three- or four-bedroom houses on nine acres of land behind their therapeutic community.) PAR Village now has a funded capacity for about 27 mothers and 33 children ranging in age from infancy through 10 years. An initial three-year research project showed that women in the demonstration project (who could bring their children with them) had longer stays in residential treatment than women in the standard rehabilitation project (who had to place their children during their stay).

A long-standing barrier for mothers seeking drug treatment is the lack of child care facilities at a treatment program.

Mother and Child Group Homes

Homes for mothers and children have traditionally cared for pregnant teenagers for periods that extend from pregnancy through a few months postpartum when the mother relinquishes her child for adoption or returns to the community. Residential programs for pregnant adolescent mothers and their newborns were immensely popular in the United States in the 1950s and 1960s. By the 1970s, however, "policy analysts began to recommend alternatives to the costly, cloistered, segregated residential institutions" (Sedlak, 1982, p. 458) in favor of community-based settings and services. Legal barriers to integration into the public schools have been largely overcome through Title IX of the Education Amendments of 1972. These advances, however, have been at the cost of reducing access to residential care. In addition, the number of these homes has dropped sharply because of greater acceptance of adolescent and single motherhood. Yet programs are still available for a few women who would otherwise be without housing.

In the United States, Florence Crittendon homes provide residential services to pregnant adolescents and, for a short time, their newborns if the women would otherwise be incarcerated or

in foster care. There are about 25 homes (about half are in the South), and a small proportion of them have begun to provide substance abuse treatment services (*Florence Crittendon Agency Directory,* 1991). In contrast, Germany has approximately 70 Mother and Child Houses available for troubled mothers to care for their children in a cooperative setting.

Drug Treatment Group Homes for Women and Children

The need for drug treatment homes expressly designed for women and children is great. Several new programs have been developed under federal, state, and local initiatives. Yet at the end of 1990, New York State had only one residential treatment facility for women and children, and Pennsylvania had just three (Dinis, 1993).

Mandela House is one of America's first programs expressly serving drug-addicted (primarily crack cocaine–addicted) pregnant women. Nearly 70 percent of the women used crack cocaine as their primary drug of choice, and 25 percent used two other drugs regularly when entering Mandela House (Redmond, 1990). Nearly two-thirds of the women had two or more children, and 29 percent had four or more children. Children other than infants cannot join their mothers at Mandela House, but reunification is a primary program goal.

Mandela House embraces an abstinence model program, and staff are prohibited from using drugs or alcohol 24 hours before their shift begins (Thomas, 1989). The program is designed to last 12 to 18 months; the client commits to staying at least one year. During its first two years of operation, more than half of the women remained six months or more, and a third remained the full year until graduation (Redmond, 1990). (One-third of the women left within the first three months.)

Initially, the program focuses on breaking ties to drug use and does not endeavor to foster contacts between mothers and their social support systems. Visits are allowed only after the first 90 days and with advance approval by the program manager.

Mandela House has not had a formal evaluation but has been judged successful enough by the community of service providers and funders to warrant expansion to a second home. The first nine graduates of the second home left in December 1988, the last in December 1989. As of June 1990, most were living independently. All 21 infants born to mothers in the program were full term and full birthweight. This healthy start for newborns may offset the $25,000 per year program cost, even if their mothers did not complete the program.

Child Care Homes for Families

In Sweden, nearly half of children in residential care are with at least one parent (Barth, 1992). However, the author could find only one published report of a shared family care program hosted by a child care agency in the United States—the Texas Baptist Children's Home (Gibson & Noble, 1991).

For more than a decade, TBCH has operated a 24-hour child care facility that provides residential service for single mothers and their children (Gibson & Noble, 1991). The intent of the program is to "prevent the separation of mother and child if at all possible but not at all costs" (N. Nagle, director, TBCH, personal communication, May 23, 1991). The program is aimed at clients with very limited income and inadequate housing and parenting skills. TBCH has two family cottages, and maximum capacity in each cottage is eight residents. Because each cottage has a staff family living in it, in addition to the client families, the cottages can serve only three two-person client families at a time. The average length of stay is a little more than three months. The three full-time staff provide role modeling and coaching of appropriate child guidance and discipline procedures, effective communication skills, leisure-time planning, meal preparation, and promotion of children's school readiness. Each family has personal living space of at least one bedroom and a kitchen and eating area. Group and individual counseling sessions are provided. Day care is provided for each family while the parent is applying for employment, making appointments, working, or receiving respite care. Service plans are developed with each resident parent.

Children are not taken into protective custody at the outset. Among the first 20 resident parents who indicated that placement of their children in substitute care was imminent, only two families ultimately required the placement of their children (Gibson & Noble, 1991). Their time in a residential setting helps mothers get on public housing waiting lists, receive job and educational

training, and obtain child support or protective restraining orders from fathers and boyfriends. About 75 percent of the mothers became employed or returned to school full-time while in the program. Aftercare lasts for one to two years and consists of two to three contacts per month and some financial assistance. (TBCH also serves families in their own homes.)

The cost of this approach was less than $30 a day per person, and "the program is significantly less expensive than residential care, since mothers, rather than staff members, provide much of the child supervision" (Gibson & Noble, 1991, p. 377). In this way the program averted licensing regulations for staff. Staff costs are limited to social services. Under this arrangement, TBCH is not eligible for federal foster care reimbursement, but mothers can keep their payments from the AFDC program.

Shared Foster Family Care

Foster family care has been provided for adults who are identified as developmentally disabled, mentally ill, and frail (Sherman & Newman, 1988). The practice of opening one's home to unrelated, dependent adults has been in operation for centuries in Europe. In this country, the first foster family care program for mentally ill adults dates back more than 100 years. Yet these programs—and extensions of foster care to families—are neglected by the social work community and other professions as well; they remain largely unknown and unavailable in the United States. Indeed, in Oktay's (1987) review of adult foster care in the *Encyclopedia of Social Work*, there is no mention of foster care for families.

Children's Home and Aid Society of Chicago

The Children's Home and Aid Society (CHAS) of Chicago has operated a program beginning in 1989 that provides shared family care for minor mothers. These mothers may enter the program as foster youths who get pregnant or as parents of small children who come to the attention of the agency as a result of child abuse and neglect.

CHAS has developed an innovative Adolescent Mothers' Resource Homes Program to care for adolescent mothers and their children in out-of-home care. Foster parents (CHAS calls them "resource parents") undergo eight weeks of training. Black resource parents are more likely than white or Latino resource parents to complete the training and join the program. Resource parents are typically single women who have raised their own children. Many are employed, but flexible employment is a must. Most are not experienced foster parents. The role seems to appeal to a distinct population who are particularly interested in supporting these young mothers (perhaps because they had once had a need for such support). The foster care compensation rate was roughly twice the standard adolescent rate but well below a group home rate.

All mothers are dependents of the child welfare system. CHAS creates a placement agreement with every young mother and her significant others (including grandparents, the baby's father or the mother's current beau, the social worker, and the foster parents). Each party clarifies what they are willing to do. The plan also specifies ways the mother will use other agencies; some mothers are involved with three outside agencies. The plan also specifies that if the mother is not happy with the resource parents, she can give 30 days notice of her intention to leave. The program is staffed by three social workers who each serve 10 mothers and their children. A maximum of two mothers may reside with each resource family. Social workers meet with the mothers weekly at first and then biweekly. Young mothers can continue in the program until they reach age 21.

Mothers cannot be so drug involved that they are unable to function as parents. Yet no drug testing is required, and the program is prepared for the fact that these adolescents—like all other adolescents—will "screw up." Drug use is not a reason for dismissal from the program.

The early outcomes have been promising. Few children have been referred to child protective services through the child abuse hot line. Still, the program director has worried about the adequacy of parenting: "Lots of our kids are getting substandard parenting" (S. Merry, personal communication, April 21, 1991). CHAS added individual child assessments and derivative parent education to their 1992 budget. Organizations in eight other states contacted the program to express interest in developing a similar program (CHAS, 1991).

Human Service Associates: Whole Family Placements

Since 1990, Human Service Associates of Minnesota has sponsored placements of whole families

with "host families" trained to mentor them through the transition to independent living (Cornish, 1992; Nelson, 1992). Homeless and disenfranchised parents, including those infected with HIV, coming out of chemical dependency treatment, and leaving battering relationships, use this service. The model's staffing, training, and foster parent reimbursement are similar to treatment foster care. Recruitment of host families has not been difficult; media and word of mouth have been largely sufficient. Several conventional foster parents asked to become host families. Host families are expected to become active members of the treatment team. Although they do not receive state foster care funds (the program is privately funded), they are expected to meet state requirements for foster care. One full-time social worker works with 15 families at a time.

About two-thirds of the families placed have co-resided for a period of four to six months and successfully made the transition to their own housing for at least six months (Cornish, 1992). For the families that did not complete the program, the principle reasons were return to drug use, conflict with the host family, and lack of follow-through on goals. As could be expected, affordable, permanent housing is identified as the greatest barrier to maintaining self-sufficiency on exit from the family-to-family program.

A New Life Program

A New Life is a pilot program in Philadelphia that works with substance-abusing women in several ways, including placement in the homes of mentors concomitant with day treatment (Keyser, 1993). The program is intended to address the needs of pregnant women and women with infant children who cannot gain admittance to a residential program or who reject an institutional setting because they judge the time commitment (six months to two years) or intensity of the program unsuitable. Living in a family home appears to remove a sense of institutionalization and allows women to feel connected to their community. Clients are primarily African American, as are their mentors. Mentors establish relationships with the women and their infants that facilitate ongoing support beyond the treatment process. Preliminary evaluation suggests that women in mentor homes received more benefits from day treatment services and longer stays in treatment. The average stay in mentor homes was three months during the first year of operation.

Conclusion

Are proposals to preserve families through placement in residential care necessary in an era with growing use of family preservation services that help families in their own homes? Shared family care serves the same purposes as intensive family preservation services, but critical differences call for their mutual use. Shared care is a particularly helpful program when it removes parents from environments that are not conducive to their recovery, such as homeless shelters, transitional hotels, or neighborhoods imbued with drugs and crime. Family preservation programs may be especially difficult to implement in such situations, where struggles with horrid housing and neighborhoods are demoralizing to staff and overwhelming to families. Given Crittenden's (1992) findings that many of the most chronic neglecting families do not receive services because the services are not there, the family cannot get to them, or the social worker does not fulfill the service agreement because of his or her combined pessimism and fear, shared care arrangements may be more conducive to the delivery of services for neglecting families.

Certainly, community-based family preservation efforts are more cost-effective with some families because such intervention is brief and does not require the transition from the residential setting back to the community that has been such a challenge to residential care providers. But not all families are able to benefit from such intervention. Some families have totally inadequate housing and need an alternative. Other families do not succeed in family preservation programs because the programs are too short lived. This may be particularly true for very young mothers and drug-involved mothers who experience relapses; they may look successful at termination and brief follow-up but are not adequate parents a year later. In addition, some children require more protection than can be provided by social workers, even if social workers are in the home for as many as 10 hours per week.

Any mention of residential care also evokes concern about costs. Certainly, residential care is not cheap. Yet Swedish providers who had converted from conventional foster care to family care consistently indicated that the costs did not

increase (Barth, 1992). Including parents in their programs did not change their budget totals. Texas Baptist Children's Home found the cost of residential care to families to be about one-third the cost of their conventional group care program. These cost savings are partly attributable to the ingenuity of service providers in finding ways to include parents in activities so that their participation yielded a net contribution to the operation of the agency.

Barriers to developing shared family care arrangements can be surmounted. Perhaps the foremost deterrent to effective involvement in residential programs will continue to be staff doubts about parents and about their own ability to work with parents (U.S. Department of Health and Human Services, 1981). When staff and parents interact on a long-term basis, a more helpful attitude can develop (Van Hagen, 1983).

Although the types of shared care arrangements described in this article all have common features—especially their inavailability—they are certainly not equivalent. Shared foster family care represents the most flexible program because it costs less, operates under conventional fire and safety regulations (for example, requiring smoke detectors but not a sprinkler system), and adapts capacity as demand fluctuates. Its ability to help drug users is not clear, however. Mother and child homes have the longest history in the United States but have fallen out of favor and generally do not provide care for drug-involved women. Drug treatment programs that have expanded to include children may have trouble focusing on them, especially when the parents are not reliable. Residential children's centers have great capacity for this kind of work but may have the greatest barriers to change.

Shared foster family care costs less, operates under conventional fire and safety regulations, and adapts capacity as demand fluctuates.

The currently favored strategy of group homes for pregnant or parenting substance-abusing women deserves to continue, but such programs appear fraught with difficulty. Mandela House and the Women's Alcoholism Center, another well-regarded program in the San Francisco Bay area, have received funding to open other residences but have had difficulties with various regulating and planning bodies, such as the fire department.

Another program that managed to put out the welcome mat may not stay full because women are limited to having one child with them. A proprietor of a group home for women that accents pregnant and parenting women also had some difficulty keeping her beds full and indicated that she knew more professionals than clients. Other similar programs have long waiting lists, but when there is a vacancy there may not be anyone on the waiting list who is ready to move in. Because the intensive staffing of such programs makes any vacancies prohibitively expensive, more flexible alternatives must be developed.

The greatest need for each of these program types is to respond to substance-abusing families. If they cannot, society will continue to see increases in the foster and group home care of children. However, at least two assumptions of foster care for drug-involved families require analysis. The first is that parents can improve their functioning without an on-site social model treatment program. Clients must be assumed to be able to benefit from living in a safe and well-managed environment, working through a variety of milieu arrangements with foster parents (but not getting professional counseling on-site), and attending auxiliary day treatment programs outside the foster family. The second assumption is that foster families will come forward and make themselves available to provide care for drug-involved or recently sober parents and children. Existing programs have not found recruitment to be unusually difficult. Supplemental board rates and services are necessary but they need not be extraordinary.

Mechanisms to pay for shared family care must be institutionalized. Group residences and pilot shared foster family care arrangements have been supported by grants and local contributions. Federal foster care reimbursements under Title IV E are not available because the mother continues to reside with the child. Title IV B funds allocated for general child welfare services and family preservation and support are certainly an appropriate

source of funds. Title IV A funds could also be used to develop such a program but could only serve families in care for a limited period each year in states with an approved plan. Evaluations of drug and alcohol treatment programs for mothers and children have been under way for some years under the Center for Substance Abuse Prevention and the Abandoned Infants Assistance demonstration programs. Funding for demonstration work on the capacity of other approaches—especially shared foster family care—has not been so available. Foundations might initially help to develop this approach as they did for family preservation.

The next decades will see a continuation of the trend toward having multiple generations under one roof. Making room for one (or two or more) kin in need is not uncommon. Whether a lot of families would be willing to open their doors to strangers is another question. No doubt some families will find such an arrangement consistent with their cultural histories, values, and lifestyles. Shared family care is operating informally in many settings and formally in a few. The promise is there to be developed. Some day, the provision of shared family care may be presumed as the option of choice for families that do not benefit from in-home family preservation services. As a result, parent–child separations may be as much the exception as the rule. ■

References

Adoption Assistance and Child Welfare Act of 1980, P.L. 96–272, 94 Stat. 500.

Barth, R. P. (1992). Child welfare services in the U.S. and Sweden. *Scandinavian Journal of Social Work, 1,* 36–42.

Barth, R. P., Courtney, M., Berrick, J. D., & Albert, V. (1994). *From child abuse to permanency planning.* New York: Aldine de Gruyter.

Berry, M. (1992). An evaluation of family preservation services: Fitting agency services to family needs. *Social Work, 37,* 314–321.

Children's Home and Aid Society. (1991). *Final report to the Chicago Community Trust on CHAS's adolescent mother resource homes.* Chicago: Author.

Cornish, J. (1992). Fostering homeless children and their parents: A unique approach to transitional housing for homeless families. *Community Alternatives: International Journal of Family Care, 4*(2), 43–59.

Crittenden, P. M. (1992). The social ecology of treatment: Case study of a service system for maltreated children. *American Journal of Orthopsychiatry, 62,* 22–34.

Davis, L. V., & Hagen, J. L. (1988). Services for battered women: The public policy response. *Social Service Review, 62,* 649–667.

Dinis, M. (1993). Drug treatment and outcomes. In R. Barth, J. Pietrzak, & M. Ramler (Eds.), *Families living with drugs and HIV: Intervention and treatment strategies* (pp. 144–176). New York: Guilford Press.

Fanshel, D., & Shinn, E. B. (1978). *Children in foster care—A longitudinal investigation.* New York: Columbia University Press.

Florence Crittendon Agency Directory. (1991). Washington, DC: Child Welfare League of America.

Gibson, D., & Noble, N. N. (1991). Creative permanency planning: Residential services for families. *Child Welfare, 70,* 361–382.

Goerge, R. M. (1990). The reunification process in substitute care. *Social Service Review, 64,* 422–457.

Grusznski, R. J., Brink, J. C., & Edleson, J. L. (1988). Support and education groups for children of battered women. *Child Welfare, 67,* 431–444.

Haffner, S. (1979). A refuge for battered women. *Victimology, 4,* 100–112.

Kadushin, A., & Martin, J. A. (1988). *Child welfare services* (4th ed.). New York: Macmillan.

Keyser, J. (1993, December). *"A New Life" Program: The evaluation of a community-based program in the prevention of child maltreatment.* Paper presented at the 4th Annual Conference of the National Association for Perinatal Addiction Research, Chicago.

Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping families together.* New York: Aldine de Gruyter.

Krona, D. (1980). Parents as treatment partners in residential care. *Child Welfare, 59,* 91–96.

Kufeldt, K., & Allison, J. (1990). Fostering children-fostering families. *Community Alternatives, 2,* 1–18.

Landsman, M., Nelson, K., Saunders, E., & Tyler, M. (1990, Fall). New research: Chronic neglect in perspective. *Prevention Report,* p. 4.

Littauer, C. (1980). Working with families of children in residential treatment. *Child Welfare, 59,* 225–234.

Loewe, B., & Hanrahan, T. E. (1975). Five-day foster care. *Child Welfare, 54,* 7–18.

MacDonald, L. (1994). PAR Village: Comprehensive treatment for mothers and children. *The Source: Newsletter of the National AIA Resource Center, 4*(1), 6–9.

Nelson, K. M. (1992). Fostering homeless children and their parents too: The emergence of whole-family foster care. *Child Welfare, 71,* 575–584.

Oktay, J. S. (1987). Foster care for adults. In A. Minahan (Ed.-in-Chief), *Encyclopedia of social work* (18th ed., Vol. 1, pp. 634–638). Silver Spring, MD: National Association of Social Workers.

Oxley, G. B. (1977). Involuntary clients' responses to a treatment experience. *Social Casework, 58,* 607–614.

Redmond, S. P. (1990). *Mandela House: Residential treatment program for substance-abusing pregnant women.* San Francisco: Zellerbach Fund.

Rossi, P. (1992). Assessing family preservation programs. *Children & Youth Services Review, 14,* 77–97.

Sedlak, M. W. (1982). Youth policy and young women, 1870–1972. *Social Service Review, 56,* 448–499.

Sherman, S. R., & Newman, E. (1988). *Foster families for adults: A community alternative to long-term care.* New York: Columbia University Press.

Simmons, G., Gumpert, J., & Rothman, B. (1973). Natural parents as partners in child care placement. *Social Casework, 54,* 224–232.

Spaid, W. M., & Fraser, M. (1991). The correlates of success/failure in brief and intensive family treatment: Implications for family preservation services. *Children and Youth Services Review, 13,* 77–99.

Sudia, C. (1990). *In-home services for crack-using mothers in Detroit.* Washington, DC: U.S. Department of Health and Human Services.

Tatara, T. (1993). *U.S. child substitute care flow data for FY 92: VCIS research note.* Washington, DC: American Public Welfare Association.

Thomas, M. (1989). *The Solid Foundation's Mandela House: Admissions and operations policies and guidelines.* Hayward, CA: Mandela House.

U.S. Department of Health and Human Services. (1981). *Family involvement in residential treatment: A support system for parents.* Washington, DC: Author.

Van Hagen, J. (1983). One residential center's model for working with families. *Child Welfare, 62,* 233–241.

Whittaker, J. K. (1978). The changing character of residential child care. *Social Service Review, 52,* 22–35.

Wulczyn, F. (1991). Caseload dynamics and foster care reentry. *Social Service Review, 65,* 133–156.

Wulczyn, F., & Goerge, R. M. (1992). Foster care in New York and Illinois: The challenge of rapid change. *Social Service Review, 66,* 278–294.

Richard P. Barth, PhD, ACSW, is Hutto–Patterson Professor, School of Social Welfare, University of California at Berkeley, 120 Haviland Hall, Berkeley, CA 94720. *Fieldwork for this article was begun while the author was a Senior Fulbright Scholar at the University of Stockholm, School of Social Work. Preparation of this article was supported by a Senior Faculty Fellowship Award from the Lois and Samuel Silberman Fund and the National Abandoned Infants Assistance Resource Center for Drug-, HIV- and Medically Involved Children.*

Accepted December 17, 1992