A Safe and Sober Home –
An Integral Part of the Recovery Process

Housing Needs for Recovering Women with Children

Experts generally agree that families should, to the extent possible, be able to receive treatment in the least restrictive environment possible in the community where they live. Some individuals, however, need the structure and support of supervised, chemical-free housing in order to succeed in treatment. Inadequate shelter can seriously interfere with clients’ efforts to address other problems in their lives (Gibson & Noble, 1991). Substance-free housing outside the drug culture, therefore, is critical for recovering women to sustain a changed way of life (Sprague, 1991). This need has enormous implications for clients of the Abandoned Infants Assistance (AlA) programs who, in addition to dealing with their addiction and/or HIV, as well as a newborn child, often have no or inadequate housing.

The Continuum of Residential Programs

The continuum of housing needs for many of these families can be broken into three distinct stages — in-patient treatment programs, transitional housing, and permanent housing in a substance-free environment. While these three phases of residential programs often overlap in definition and conception, this article distinguishes them based on the resident’s point in her recovery process.

In-Patient Treatment Programs

Traditionally, providers have felt that substance abusing women need time to stabilize themselves before addressing the needs of their children. Shelter rules, the child welfare system, and substance abuse treatment programs typically have reflected this belief by separating substance abusing and recovering women from their children. Research, however, indicates that work with the child and parent independent of each other usually has not altered the parents’ capacity to deal with the child in the home setting (Barth, 1993). Instead, providers have found that when the children’s program is an integral part of the total treatment program, the recovery process is strengthened for the entire family (Zimmer & Schretzman, 1991).

Based on these findings, increasing numbers of in-patient treatment programs for chemically dependent, parenting women are being designed to accommodate their infants and young children. These programs typically include intensive, comprehensive services, and last an average of three to twelve months. While the primary focus is often the mothers’

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sobriety, these residential programs also concentrate heavily on the children’s physical and mental development, as well as parenting and general family functioning.

Even residential programs that seek to keep parents and children together, however, may not fully succeed. Most in-patient treatment programs limit or prohibit other children (i.e., older siblings) from residing with their mothers. The number of children commonly is limited for programmatic reasons based on a belief that the more children a woman has to deal with while in recovery, the slower the recovery process (Friar, 1989). To address this concern, some housing programs are structured in phases to give women time to adjust to a drug-free life and, perhaps, caring for a newborn before dealing with the added responsibilities of other children (Friar, 1989). For example, while Tarzana Treatment Center in Long Beach, CA accepts up to two children per woman in their in-patient treatment program, they generally attempt to stabilize women for 30 days before admitting their children. This policy is based on Tarzana’s experience that many of the women already have had their children removed when they enter the program, and approximately 60% of women who drop out of the program do so within the first 30 days (Ken Bachrach, personal conversation, December 1993). They find that the less a woman has to deal with during this time, the better her chances of success in the program. When children are admitted to Tarzana’s residential program, mothers learn to interact with them in the on-site therapeutic nursery which is staffed by a master’s level child development specialist.

For some programs, the number of children admitted may be limited due to state or local regulations. In Ventura, CA, for example, fire department regulations force Moms and Kids Recovery Center to limit the number of children to ten in its six-bed in-patient treatment program, and six in its four-bed, communal “sober living” home (Catherine Lee Puccetti, Project Director, personal conversation, 1993).

**Transitional Housing**

Frequently, women in or graduating from in-patient programs have lost their housing or have inadequate living arrangements. Without sufficient transitional and permanent housing, short-term residential treatment programs can become a set-up for failure as women leave structured, drug-free communities and return to living arrangements that are chaotic and unsafe (Sprague, 1991).

Transitional housing, often seen as a stopgap for homelessness and as an impetus toward life improvement, becomes an alternative for many of these women, and typically lasts a minimum of three months and as long as two years. During this period, there is a continued emphasis on maintaining sobriety, often achieved through individual and group counseling, as well as 12-step meetings. Other services, which may be provided directly or through referral, are intended to help families establish a foundation for long-term stabilization. These services may include parenting skills development, education and vocational training, respite and therapeutic child care, health education, medical services, and housing services. During this period, many programs also provide services to help families become reunited with older children who have been removed.

FOCUS, an AIA program in Stockton, CA, provides transitional housing for up to 14 families while they participate in the FOCUS day treatment program (up to nine months). The *Inner Voice Transitional Housing* facility, which FOCUS leases from a landlord, contains studio and one-bedroom apartments for women and their children under age five. Families all have their own apartments and must pay one-third of their income in rent. Another third of their income is put into a savings account to help with their transition into permanent housing. Paraprofessional staff provide 24 hour on-site supervision and assist residents with transportation, shopping, and parenting. All other services are provided at the FOCUS day treatment center four blocks away (Frances Hutchins, FOCUS program, personal conversation, 1994).

It is critical that transitional programs have the flexibility to accommodate different needs and varying rates of recovery, and ensure that graduating families have the necessary resources and support systems to be self-sufficient. Otherwise, temporary housing solutions may result in even more instability as families move through a series of time-limited shelters and several stages of “transitional housing” (Women & Housing Task Force, 1990).

**Permanent Housing**

Unfortunately, the supply of safe, affordable housing in this country continues to be inadequate to meet the ever-increasing demand. Obtaining permanent housing which is safe, affordable, and drug-free, creates a particularly major hurdle for recovering women with children. For many of these families, inadequate housing or homelessness is a main factor leading to foster care placement or preventing children from returning home (Nelson, 1992). In recognition of this, Congress authorized the *Family Unification Program* in 1992 to help prevent children from being placed in foster care due to lack of appropriate housing (see article on page 1).

While initiatives like this are critical, “life stabilization . . . is necessary before poor women who head households can take advantage of affordable, permanent housing” (Sprague, 1991; p. 28). Additionally, many mothers in recovery continue to require various support services in order to maintain permanent housing and stay sober. To address these needs, many programs encourage the use of their services as a center of support after the families move to permanent housing.

*Women In Need* (WIN), in New York City, has housing specialists who, after helping families locate permanent housing to move out of WIN’s emergency and transitional facilities, assist clients in procuring a lease, coordinate moving services with the WIN van, and provide after-care services once the family has moved in. These services range from child care to apartment upkeep and employment location services (Rita Zimmer, personal conversation, 1991).

*Human Service Associates* (HSA), in St. Paul, MN, developed partnerships with two real estate companies that rent vacant housing units to graduates of HSA’s transitional housing program. The real estate companies forgo security deposits, negotiate on the cost of the units, and allow residents to work in return for reduced...
rent. HSA provides up to two months of follow-up services to help these families become self-sufficient (Cornish, 1992).

**Structural and Programmatic Issues in Residential Programs**

**On-site vs. Neighborhood-based Services**

Residential programs offer varying combinations of on-site and community-based services. The extent of services provided on-site is influenced by the program goals, as well as the setting, design, and management of the facility. Short-term, in-patient treatment programs for families typically provide intensive, on-site services for women and their children. San Francisco’s Jelani House, for example, provides comprehensive medical and therapeutic services for 15 pregnant crack-addicted women, their newborns, and 10-16 of their other children up to age five, in a 24-30 bed facility. During their stay of up to 18 months, program staff coordinate with a local hospital and other community agencies to address the social, health, support, recovery, and educational needs of the women and their children (National Center for Education in Maternal and Child Health, 1993). On-site services include therapeutic child care, 12-step meetings, individual and group counseling, basic life skills training, parenting education, and limited prenatal, postpartum, and pediatric care. “By having services coordinated in-house, the women can better follow a structured daily routine, reducing their dependency on drugs” (Friar, 1989; p. 21).

On the other hand, many providers recommend that transitional housing residents secure some services in the wider neighborhood to establish ties that can be sustained after they move to permanent housing. For example, in order to prevent residents from becoming too isolated from the community, the Vision Teen Parent Home, a transitional residence for adolescent mothers in Yarmouth, MA, provides child care off-site in nearby family child care homes (Sprague, 1991).

While services provided off-site also can help programs avoid state licensure and zoning regulations, they must be located near the residential facility or include adequate transportation. By providing services in a separate facility, for example, Turning Point’s DEMAND program, in Minneapolis, MN, avoided zoning law requirements in their two apartment buildings which house substance-abusing women and up to two of their children under six. Residents receive substance abuse treatment, day care, and other services from the outpatient program located across the street; while partners of these women (who must reside elsewhere) are offered support and counseling through Turning Point’s African American Male Partnering Program. Although the women and children in the DEMAND program do not receive specific services on-site, “caretakers” provide support and supervision at the building 24 hours a day (CSAP National Resource Center, 1993; & Peter Hayden, Director, personal conversation, December 1993).

Similarly, Women in Need (WIN) in New York has a comprehensive alcohol treatment center for women, which is centrally located near many of WIN’s emergency and transitional residences for women with children. Van transportation is available for all clients and, in addition to substance abuse treatment, services at the center include child care, tutoring, parenting education, and assistance with child welfare problems and parenting issues (Zimmer, 1991). WIN found that an off-site treatment program can work for women with children if it is nearby, provides transportation, and offers a comprehensive array of centrally-located services for both mother and child. Unlike Project DEMAND, however, WIN provides additional counseling and child care at the residential facilities.

**Hutchinson Place** in Philadelphia, a six to nine month transitional facility, provides a combination of on- and off-site services for up to 20 substance abusing women and 40 of their children. Residents receive formal therapy and a full range of health, medical, and vocational services at the off-site Diagnostic and Rehabilitation Center. In addition, on-site counselors and lay staff persons (some of whom are in recovery) provide informal services to help residents learn how to live with their children and others in a sober environment (White & Shandler, 1991).
Finding and Funding Sober Housing for Women and Children

Establishing a quality residential program for substance abusing women with children can be a long and frustrating process that requires diligence, creativity and perseverance. Likewise, helping these families find affordable, permanent housing that is drug-free takes knowledge of available resources, coordination with housing professionals and the community at large, and a lot of time and money.

This article offers a 7-step process and informational resources to help providers establish or obtain sober homes for women and children. Because the Institute for Children and Poverty strongly advocates comprehensive, on-site services, the emphasis is on transitional residential treatment programs that enable clients to overcome addiction and become self-sufficient in permanent housing. The suggestions and resources, however, also are useful for professionals helping their clients secure permanent housing.

Step 1. Formulate your objectives. Do you want to establish a new, residential program or help clients secure existing housing in the community? If you plan to establish a new program, how many women and children will you serve? What services will be offered? Will they be provided at the residential facility, at a nearby, off-site center or by other community resources? If the services are not easily accessible to the clients, they will not take advantage of them.

Step 2. Research the characteristics and needs of the population you plan to serve. What are the special needs of women in treatment and their children, and the different methods used in treating substance abusing women? Obtain statistics on drug abuse in your community, and information (e.g. ethnicities, ages, types of families) about the chemically dependent population in your community.

Step 3. Speak with other agencies and organizations. Contact organizations in your general area, as well as model programs throughout the country. How did they go about starting up their programs? What difficulties did they incur and how did they overcome them? If they had it to do over again, what would they do differently? What are their major sources of funding? (They may be reluctant to divulge this information to a potential "competitor."). Were they able to recruit a local politician(s) to garner support for their project? Where do local providers see a need for residential programs in their area? Many nonprofit organizations and state and local agencies offer technical assistance — some at no cost — and would be good resources for getting "how to" information for any aspect of your program, including the start-up process. (The following Resource List includes resources which provide this kind of information and assistance.)

Step 4. Research the community where you plan to establish the program. Are there residential treatment programs already located in the area? Is transitional or sober permanent housing available? Is so, what is the eligibility criteria, exactly what services are provided, and how long is the waiting list? Who are the local nonprofit housing developers in the area? Have they developed housing for women with children or chemically dependent individuals? Is there a history of "NIMBY" (Not In My Back Yard) syndrome in the community? Will the community board need to approve the plan for establishing a residential treatment program? Who are your potential allies — churches, child advocates, city officials, other providers — and potential adversaries — neighborhood associations, parent-teacher organizations at local schools, local politicians? What are the local zoning regulations? These vary among jurisdictions and can be obtained from your city or county government. What kind of state licensure is required to operate a residential program, and what is the process for obtaining a state license? Do you need more than one license in order to serve children and potential AIDS patients as well as chemically dependent women? How many months does the licensing process take? Again, these policies and procedures vary regionally, and information about your state can be obtained from your State Office on Substance Abuse Services or Health and Human Services. Residential programs which serve other populations (e.g., developmentally disabled and chronically mentally ill) also may be helpful in learning about local resources and potential obstacles/constraints.

Step 5. Network, network, network. Attend training sessions, coalition meetings and conferences on substance abuse and housing development. Put yourself on mailing lists for newsletters. To help establish your program, recruit community leaders (business and political), experts in the field, respected program administrators, homeless and housing advocates and providers, public housing officials, churches, landlords and realtors, and advocates for women and children.

Step 6. Search for a site. Look for vacant apartment buildings, houses for sale/rent, surplus government properties (e.g., abandoned HUD homes), and closed schools, hospitals, military buildings, college residences and hotels. Be sure that the facility is in a relatively safe neighborhood, close to public transportation and community services, and is able to meet local building codes and state licensing requirements. You may also consider developing partnerships with property owners and management companies, in which they make vacant rental units available and you act as an intermediary between management and your clients. Frequently, they will wave the security deposit and/or allow
Step 7. Seek funding. A multiplicity of federal, state and local programs provide funding for obtaining residential treatment facilities and individual housing units for people with special needs. Be sure to put your name on Request For Proposal (RFP) lists with federal, state and city agencies to receive notice about new and available money. Other potential sources include foundations, corporations, local businesses, religious congregations and individual donors. The Resource List below identifies good starting points for information about different funding streams.

Many of the federal programs are administered by the U.S. Department of Housing and Urban Development (HUD). Community Development Block Grants (CDBG), for example, are available for building acquisition, operations, and services, including treatment. Under the McKinney Act (also administered by HUD), organizations can receive funding from federal and state agencies to house, educate, train, and treat homeless people, including those afflicted with alcohol and drug addiction and AIDS (see Federal

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PAR Village, a long term residential treatment community in Largo, Florida, is designed for individuals who have substantial histories of substance abuse. When the women come to the program, they are not only struggling with their addiction. Most of them come from alcohol or drug abusing families where physical and sexual abuse often occurred. They need to spend a lot of time taking care of themselves and nurturing themselves. Their substance exposed children are in need of developmental interventions so they can compete with their non-substance exposed peers when they get to school.

Operation PAR tried to create a model which would meet the needs of both the women and their children. The women participate in a structured therapeutic program where they have individualized treatment plans, parenting classes, educational and vocational training, recreational activities, and counseling. Children are provided therapeutic day care at an on-site, professionally staffed developmental center.

Operation PAR has accepted women, those who are pregnant and those who are not, since it began in 1973. One of the greatest barriers for mothers seeking drug treatment is the lack of child care facilities at a treatment program. Operation PAR staff noticed that the retention rate for women in the program was much lower than the retention rate for the men. When the women dropped out, more often than not it was to care for their children. After all, it's not easy to find someone to watch your children for 18 months while you are in a drug treatment program. In recognition of this problem, Operation PAR started looking for a solution.

Establishing PAR Village

Through a series of fortuitous events, all of which occurred within about a six month period, the dream of the Village became a reality. In 1989, Operation PAR received a National Institute on Drug Abuse (NIDA) demonstration research grant to study the retention rates of women who had their children with them in treatment. Around that time, the County donated to the program 14 three and four bedroom houses which were to be destroyed for road expansion. Operation PAR also was able to purchase nine acres of land which became available behind its Therapeutic Community. The County paid to have the houses moved to this land, and the program obtained Community Development Block Grant funds to renovate the houses, one of which was converted to a child development center. In April of 1990, Operation PAR expanded its female treatment bed capacity and developed on-site infant and child development facilities at its therapeutic community program.

PAR Village now has a funded capacity for approximately 27 mothers and 33 children ranging in age from birth through ten.
The initial three year demonstration project was designed to overcome a major limitation in current residential treatment of addicted mothers, namely the lack of child care facilities for infants and children. Because it was funded by NIDA there had to be a control group for the research component. Women who were eligible for the study drew lots. Half of the women were allowed to bring up to two children with them into treatment and the other half had to make arrangements for someone to care for their children while they resided at the Therapeutic Community. Fifty-three women participated in the NIDA study. As can be seen in Figure 1, women in the demonstration condition (who could bring their children with them) had longer stays in residential treatment than the women in the standard condition (who had to place their children during their stay).

The majority of women who participated were African American (81%), with a mean age of 27.4 years (range=18-44) and an average of three children. Seventy percent had never married, and the majority (59%) had their first pregnancy by age 17. Most of the women (68%) had less than 12 years of education, and nearly all were required to enter treatment by a child protection agency (57%) or court (21%).

The majority of the women (79%) had previously been treated for substance abuse and nearly half (47%) had been in treatment two or more times.

The Program

PAR Village recently received funding from the Center for Substance Abuse Treatment to continue the project. The control condition has been eliminated and now comparisons are made in retention rates between women in PAR Village and women who are receiving outpatient treatment at Operation PAR. All women currently participating in the PAR Village program may bring up to two children under the age of ten with them into treatment. However, women generally do not bring their children into residential treatment until they have been in the program for 30 days.

Prior to their enrollment in PAR Village, women receive a comprehensive bio-psychosocial assessment which measures substance use, living environment, educational and employment background, economic resources, legal history, leisure activities, mental and physical health, mobility, social relationships, and activities of daily living. The information generated from the assessment is used to assist in determining the appropriate level and intensity of treatment needed. Only women who are suitable for long-term residential treatment (those with substantial histories of substance abuse) are enrolled in PAR Village. While in treatment, women receive individual counseling, support groups, therapeutic groups, case management services, parenting skills classes, vocational and educational training, medical services, transportation, urinalysis testing, and other therapeutic interventions and services.

There are six phases of treatment designed so that women may complete treatment in approximately 18 months. Length of stay is individualized and may be somewhat longer or shorter depending on the progress made by each woman. Women are forbidden from communicating with individuals outside the community during the first thirty days of treatment while they learn to focus on their recovery programs. Levels I and II (months 0 - 2) are designed to familiarize women with the residential treatment program (i.e., its philosophy, expectations, structure, and rules), provide a basic knowledge of group dynamics, and provide opportunities for women to learn and practice appropriate social interaction. Level III (months 3 - 6) is the initial treatment phase where women learn and demonstrate parenting and child care skills, coping and stress management skills, and participate in vocational or educational opportunities. Level IV (months 7-10) is designed to refine the client's core issues which were identified in Level III. In this phase, women begin to restructure their belief and value systems, develop and demonstrate appropriate social and communication skills, improve life skills, expand outside supports, and continue pursuing vocational opportunities. During Level V (months 11 - 13) women accept and demonstrate significant peer leadership, identify and express appropriate feelings, engage in relapse prevention planning, and make appropriate career or educational plans for the post-treatment period. Level VI (months 14 - 18) is the re-entry phase where issues revolve around the theme of life adjustment outside of treatment. The emphasis during this phase is on the attitudes, values, and interpersonal skills concerning social, work, and family relationships.
A New Approach to Recovery

When I arrived at Operation PAR, I had three treatment centers and 23 years of drug use under my belt. My drug of choice was crack/cocaine, but any sort of drug would do. In 1986, my life began to slip away as I allowed drugs and alcohol to take over. I began quitting job after job, entered three treatment centers, lost contact with family and friends and began to neglect my child. In 1993, I finally decided I had had enough. I grabbed my daughter, left home and entered PAR Village in Largo, Florida.

For the first thirty days I had to leave my daughter with my sister so I could get stabilized in treatment. At first I was a bit reluctant, then I remembered my commitment: to do whatever it takes to get clean.

This thirty day separation was good advice, for it gave me the opportunity to acclimate myself to the type of treatment PAR has to offer and to clear my head so I could find out what really motivates me: a desire to stay clean, the willingness and openness to take risks with others and to rebuild my relationship with my daughter.

Operation PAR’s Therapeutic Community, of which PAR Village is a part, offers a caring, motivational, confrontational, tough love, therapeutic setting, where honest self-disclosure, risk taking and relationship building takes place. Addiction is a behavioral problem and my behaviors needed to change in order for me to live. The only way my behaviors can change is to hear from others what they see in me that needs changing. As an addict, my decision making skills and communication skills are underdeveloped. So here at PAR I rely on others to confront me on these areas and then use the information to change. I am able to experience, in a safe environment, new relationship building techniques that I could not experience elsewhere. This controlled environment ensures safety and allows me to build trust, thus enabling me to communicate and build relationships with others.

The idea of having my child with me in treatment is wonderful. As previously mentioned, I have been in three other treatment facilities. All three did not allow children which is very distracting for me. The last was a six month half-way house where I had to leave my daughter in my sister’s care. At the half-way house I missed out on the real treatment I receive here at PAR, and for six months I focused more on my daughter than my recovery program. With my daughter here in treatment I am able to learn how to be a responsible parent, by attending parenting classes, using the child development center staff’s wealth of knowledge, having her here to practice what I learn, and allowing her the opportunity to grow right along with me.

What is taught here is a very loving, caring, gentle method of child rearing. It truly gives children the opportunity to develop their intellectual and creative abilities and parents the opportunity to gain back some self-esteem and self-worth. The children are enrolled in an excellent child development center here on the property where drug and alcohol addiction problems are taught and discussed. This is a great way to head off these problems right from the beginning.

The curriculum itself includes structured learning and play time. There is a wealth of educational toys, two playgrounds and a very caring and loving environment to build trust, thus enabling me to communicate and build relationships with others.

Laura MacDonald
Program Evaluation Specialist
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because all the mothers have the same stress filled schedule. Not only am I working a program of recovery, I am also learning how to be a responsible parent. I not only must care for myself, I must care for my child too. This hectic schedule leaves little time for relaxation for myself. There are times when I wish my daughter was not here, but the alternative is unacceptable to me. I would rather give up some free time than give up my daughter.

Since coming to PAR Village, my life has changed tremendously. I have changed unhealthy, dishonest behaviors, developed new stress management and coping skills so very important to an addictive personality and worked on issues never dealt with before. Along with new behaviors and skills, I have developed a support system outside of the PAR community and best of all I have developed a true, loving and respectful relationship with my daughter that will last for a lifetime.

— Lauren Cook

Drawing of her home in PAR Village by Nicole Cook, age 4

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Programs to Help Homeless People. The Emergency Shelter Grants Program and the Supportive Housing Program are two components of the McKinney Act particularly applicable to serving substance abusing women with children who require treatment and housing assistance. Another McKinney Act program, Supplemental Assistance for Facilities to Assist the Homeless (SAFAH), also provides funds which can be used to help families' transitions to permanent housing by paying security deposits and first month's rent. Section 8 certificates and vouchers, and Housing Opportunities for People with AIDS are two other HUD programs which subsidize transitional and permanent housing for disadvantaged and special needs families. The U.S. Department of Health and Human Services (see Resource List) also administers various funding programs, usually through state and local agencies, for substance abuse, emergency health and mental health services for homeless families and those at risk of becoming homeless.

Also be sure to explore other state and local programs when helping your clients secure permanent housing. Many states operate subsidized housing programs independent of Section 8, and some have housing trust funds or other mechanisms that provide loans or grants to help with things such as furnishing, security deposits, back-rent and utilities, in addition to rehabilitation and capital expenses.

Securing funding and a facility(ies) are two critical and difficult steps in the process. A truly comprehensive program will provide a full array of services in residential treatment, as well as post-treatment housing assistance and follow-up services during the following six months or year. This requires strategic planning, resourcefulness and coordination, and is expensive and time consuming. However, it may be the only way we can effectively help these women and children to help themselves — not just for a few months or years, but for the rest of their lives.

— Kathy Kniep

Institute for Children and Poverty
A Project of Homes for the Homeless
Shared Foster Family Care

Given the intense demands of serving drug-affected, medically-troubled, and HIV-infected children and their often similarly affected parents, alternatives to foster care that maintain the mother-child connection and ensure adequate supervision are much needed.

This article will describe programs which fall under the rubric of "shared family care" which has been defined as the "planned provision of out-of-home care to parent(s) and children so that the parent(s) and host caregivers simultaneously share the care of the child and work toward independent in-home care by the parent(s)" (Barth, 1993, p. 273). In shared family care, the living arrangement crosses the traditional precipice between "in-home" and "out-of-home" child welfare services; shared family-care arrangements provide both.

Models of Shared Family-Care

At least five types of shared family-care living arrangements have evolved to keep parent and child together. These are: (1) child care homes (residential treatment 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 expressly developed to offer care to pregnant and parenting mothers; and (5) foster homes that offer care of parent and child. Whereas the other forms of shared family care have been addressed elsewhere (Barth, 1993; Price, this issue; Sprague, 1991), this article will focus only on the latter and least used form of shared care: shared foster family care.

Foster Care For Families

Foster family care is most often thought to be for children only. Yet, foster family care has been provided for adults who are identified as developmentally disabled, mentally ill, and frail (Myers, 1992; Sherman & Newman, 1988). While these programs—and extensions of foster care to families—are largely unavailable in the U.S., a few exceptions have emerged.

Children’s Home and AID Society of Chicago

For several years, the Children’s Home and Aid Society (CHAS) of Chicago has been operating the "Adolescent Mothers' Resource Homes" program which provides out-of-home, shared family care for adolescent mothers and their children. These mothers may enter the program as foster youth 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.

"Resource parents" undergo eight weeks of training and 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 monthly foster care rate (which covers mother and child) is roughly twice the adolescent rate but below a group home rate.

CHAS builds 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), in which each party clarifies what they are willing to do. The plan also specifies ways that the mother will use other agencies (some mothers are involved with three outside agencies), and clarifies that if the mother is not happy with the resource parents, she can give 30-days notice that she intends to leave.

The mother must take full responsibility for the child. Resource parents are encouraged to support but not supplant the mothers. They may provide baby-sitting but are encouraged to exchange it for something else. Although these guidelines for resource parent and mother exist, much is unwritten and many understandings have to be hammered out on the anvil of everyday living.

Each of three social workers serves ten mothers and their child(ren), who they meet with weekly, then bi-weekly. A maximum of two mothers may reside with each resource family. Mothers cannot be so drug-involved that they cannot function as parents. Yet, no drug-testing is required and the program is well prepared for the fact that these adolescents—like all other adolescents—will "screw up." This is not reason for dismissal from the program.

The outcomes, to date, are impressive with few runaways or referrals to CPS. Although young mothers who have graduated continue to connect to the resource parents, the program director worries about the adequacy of parenting and wants to expand the provision of individual child assessments and education.

Project DEMAND

Project DEMAND in Minneapolis uses shared care arrangements in two ways. Substance abusing women and up to three of their children can live in an apartment cluster with supervision and across-the-street day care and substance abuse treatment. Upon graduation from this program, arrangements are developed with resource families who provide residence to the...
mothers and their children. The mothers pay for their own board and care from their paycheck, AFDC payment, or other available funds. Since AFDC-FC funds are not used for this purpose, the resource families receive varying payments, but they are generally not as high as the special foster care rate provided by CHAS homes, and only a fraction of the cost of drug treatment group homes.

**Human Service Associates: Whole Family Placements**

Since 1990, Human Service Associates (HSA) of Minnesota has sponsored placements of whole families with "host families" trained to mentor them through the transition to independent living (Nelson, 1992; Cornish, 1992). The program serves homeless and disenfranchised parents, including those affected with HIV, coming out of chemical dependency treatment, and leaving battering relationships.

In 1991, HSA began the whole-family foster care program as an alternative to removing the child. The model's staffing, training, and foster parent reimbursement are similar to treatment foster care. Recruitment of host families has not been difficult as media and word-of-mouth have been largely sufficient. Several conventional foster parents have become host families and many of the host families have experienced homelessness, abuse and/or chemical dependency. Host families are expected to become active members of the treatment team and they are responsible to provide for basic needs of the family and share in parenting tasks by modeling nurturing discipline. Although they do not receive federal or foster care funds, they do use Title IVA and Title IVB funds and are expected to meet foster care standards. Families receive $54/day for the first two family members and $13.50 for each additional child. 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 transitioned into their own housing for at least six months (Cornish, 1992). Among 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 upon 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 infants and 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 feelings of institutionalization and allows women to feel connected to their community. Clients and their mentors are primarily African American. 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 benefit from day treatment services and longer stays in treatment. The average stay in mentor homes was 3.4 months during the first year of operation.

**Texas Baptist Children's Home**

Shared family care can also be provided by residential treatment programs. Europeans have been doing so for decades and models now exist in the U.S. For over ten years, the Texas Baptist Children's Home (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" (Nelson Nagle, personal communication, May 23, 1991). Maximum capacity in each of the two Family Cottages is eight residents or up to three client families at a time, in addition to a staff family. Each family has personal living space of at least one bedroom or more and a personal kitchen and eating area. The average length of stay is a little more than 3 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 assisting children in school readiness. The staff develops individual service plans with each mother and provides group and individual counseling.

Day care also is provided for each family while the mother is applying for employment, making appointments, working, or taking a break. Children are not taken into protective custody at the outset. Among the 20 resident parents who indicated that placement of their children in substitute care was imminent, only 2 families ultimately required the placement of their children. Their residential spell helps them get started on public housing waiting lists, job and educational training, and obtaining child support or protective restraining orders from fathers and boyfriends. Approximately 75% of the mothers have become 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 along with some financial assistance.

The 1990 cost of this approach is less than $30 per 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). In this way the program averts licensing regulations around staffing and staff costs are limited to social services. (Under this arrangements, TBCH is not eligible for IV-E reimbursement, but mothers can keep their AFDC.) The program is aimed at clients with very limited income, housing, and parenting skills.

"... children and parents have a right to remain together as long as the child's right to a safe family life is preserved."
The dearth of outcome data on shared care arrangements make it difficult to identify the most critical program elements. The most obvious advantages of such programs are that they offer opportunities for mothers and children to grow together in a safe setting. From a treatment standpoint, they also provide appropriate developmental experiences for parents and children in homelike settings; they offer many teachable moments regarding appropriate parenting; they typically provide more structure and support than residing with birth parents; and they provide enhanced opportunities for community integration.

Certainly, community-based family preservation efforts are—all other things equal—likely to be more cost-effective because they are brief and do not require the transition from the residential setting back to the community, which has been such a challenge to residential care providers. Simply stated, all things are not equal. Some families have totally inadequate housing and need an alternative. Some are characterized by the problems most typical of families that do not succeed in family preservation services—i.e., having more children, more poverty, and more years of welfare dependency. Other families do not succeed in family preservation programs because they are too short lived. This may be particularly true for very young mothers and drug-involved mothers who may experience relapses. They may look successful at three-month termination and three-month follow-up, but are not successful after a year. Some children require more protection than can be provided by social workers, even if social workers are in the home for as many as ten hours per week.

There are at least two assumptions of shared foster family care for drug-involved families that require analysis as this model develops. 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 (without professional counseling on-site), and attending auxiliary 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 detoxed parents and children. Certainly the horror stories in the media about the crack cocaine epidemic will not encourage such voluntarism. Conventional pay rates for caring for children that make foster parenting all but volunteerism will not encourage this development. Indeed, the lack of financial pay for conventional foster parents is supposed to be offset by the pleasures of having another child around the hearth, but would not be so readily offset by having the additional responsibility and inconvenience of an additional parent in the home. Supplemental board rates will probably be necessary, but need not be extraordinary, and routine funding strategies must be established. In states which included shared foster family care in their plans, for instance, IV-A funds could be used to support limited periods (up to 6 months) of care.

At the same time, we expect to see a continuation of the trend toward having multiple generations under one roof. Making room for one (or two more) kin in need is not uncommon; whether families will be willing to open their doors to strangers is another question. Still, children and parents have a right to remain together as long as the child’s right to a safe family life is preserved. Foster family care for children can be expanded to include women and children together, and profiles of families who can benefit from these arrangements during the recovery period must be drawn by evaluating researchers. Because this model has been successful in other countries and can offer a flexible, community-based approach, additional pilot programs should be developed to test its efficacy. Certainly it has been done and is being done in several cities throughout the country. The promise is there.

— Rick Barth, PhD

REFERENCES


Balancing Shared and Private Space

Residential treatment programs must also address the degree of privacy afforded each family. Experts generally agree that living with others in similar situations and working toward similar goals, reinforces sobriety (Sprague, 1991). To this end, numerous supportive housing programs exist for individuals who are, for example, recovering addicts, elderly or developmentally disabled. Experience also shows that single mothers recovering from substance abuse may benefit from spontaneous cooperation in babysitting, pooling resources, and other household tasks (Sprague, 1991). Shared spaces may include living and dining rooms, kitchens, bathrooms, laundry facilities, meeting rooms, recreational rooms for adults, play space for children, and day care. Typically, as families move from short-term treatment programs toward permanent sober housing situations, the amount of shared space decreases, and they are given more privacy. Programs find that shared spaces are more successful when adequate private space is also provided (Sprague, 1991).

Visions Teen Parent Home in Massachusetts is set up to reflect the growing independence of teen mothers. When they enter the program, each young woman lives with her baby in a single private room in a group setting. These women cook and eat with the four other teen mothers in their cluster. As they progress in the program, each mother moves to a private one-bedroom transitional apartment in the same building. These young women are responsible for their own meals, except for one community meal per week. Each bedroom in both settings has an alcove for a crib and changing area (Sprague, 1991).

Women's Alcoholism Center's (WAC) Pomeroy House in San Francisco, CA, is a residential recovery program for eight to ten recovering women and up to 11 of their children. Located in a large house, the program is based on sharing and group living. Household work and meal preparation is shared among the residents. Also, although children live in the house with their mothers, they share rooms with two to three other children on the same floor where mothers share rooms with each other. This unique strategy is intended to help maintain an environment as close as possible to a real home, and to foster healthy boundaries between mothers and their children.

Informal support through sharing

Some experts contend that once people have established sobriety, they require less on-site staff or formal program activities (Wittman, 1989). Programs which encourage residents to take over management, share cooking, and become active in peer support, require a lower staffing level and help residents become more independent (Sprague, 1991).

Oxford House, Inc., headquartered in Silver Spring, MD, exemplifies this concept in its system of self-run, self-supported recovery houses in which recoveries individuals of the same sex help each other remain sober and rebuild their lives. In each of the 470 houses across the country, members pay a weekly sum which covers rent, utilities and staples, and they have weekly, self-run meetings to make all the decisions which affect the house. There is no paid staff, and the only "services" provided are done so on an informal basis, in which older residents help newer ones with employment, medical care, and other needs. While over 15 years of experience shows that the Oxford House model works for individuals of the same sex, it remains unclear whether it can be effectively used for women with children.

Other programs specifically for women and children encourage residents to share in the provision of informal child care and other support services through structural and programmatic design, such as connecting apartments, informal children's care spaces, and/or house rules. Women In Need, for instance, created "swing" bedrooms which can be incorporated into either of the connecting private apartments in their transitional residence. This not only encourages women in adjacent apartments to help each other in babysitting, it also helps the program adjust space for various size households (Sprague, 1991).

Women's Transition Services' Transitional Housing in Portland, Oregon took another approach by creating a house rule which states that "other house members may provide child care for another mother by trading child care or contracting for pay with the other house member." (Women's Transition Services, 1993).

Shared responsibility also plays a major role in The Solid Foundation's Mandela Houses in Oakland, CA. These homes are six to twelve month residential treatment programs for chemically dependent women and their young children, in which the women share all cooking, cleaning, and other household chores. Additionally, on a weekly rotating basis, one woman from each house helps the nursery aide(s) care for the children while the other women attend classes.

Getting Started – Collaboration & Financing

Bridging the gap between housing and social services

Clearly, expertise in substance abuse treatment and other social services for women and children is critical in the management and maintenance of residential programs for many AIA families who need more than economic assistance. At the same time, service providers often lack knowledge about housing development and are unfamiliar with the full range of available funding resources and community organizations involved with housing (National Institute on Alcohol Abuse and Alcoholism Interagency Council on the Homeless, 1991). While housing professionals and service providers traditionally have operated in completely separate arenas, their mutual cooperation and commitment is vital to the development of residential programs for recovering women and their children.

In recent years, an increasing number of innovative strategies has begun to bridge this gap, resulting in a variety of residential programs which integrate social and economic supports in an effort to preserve or reunite families. These programs, as illustrated above, exist in a variety of buildings and settings which reflect program needs as well as available resources, and include: single homes, adjacent houses, houses with additions, cluster housing, apartment buildings, scat-
tered houses, host families' homes, and converted schools, hotels, college dormitories and hospitals. In addition to housing professionals, service providers have engaged the support of other key players such as local, state and national government officials, community and civic leaders, the business community, local churches, landlords, housing finance agencies, realtors, and foundations to identify and develop sober housing for recovering women and their children.

Some social service programs have established formal relationships with housing providers in order to capitalize on the expertise of each profession. Lee Goodwin Residence in New York City, for example, is a transitional and permanent residential facility in which Phipps Houses, a non-profit housing developer, sponsors and manages the building, and Women In Need, a social service organization for homeless women and children, provides the social services on and off site. New York City's Department of Housing Preservation and Development's Capital Budget Homeless Housing Program financed the building rehabilitation, and New York City's Human Resources Administration and the New York State Department of Social Services provided social service funding (Sprague, 1991).

Similarly, Transition Housing, Inc. (THI), in a joint venture with Near West Housing Corporation, formed Women's West Housing Corporation (WWHC). WWHC purchased, rehabilitated, and manages the transitional housing facility located in Cleveland, OH, and THI operates the programs for the residents (Meister et al., 1993).

Other service programs have taken a different approach by engaging themselves in the housing business. By working with non-profit public housing and other community organizations, Turning Point's DEMAND Program was able to obtain a low-interest loan to purchase two apartment buildings. As owners of the property, DEMAND manages the transitional housing facilities and provides the support and recovery services to the residents (CSAP National Resource Center, 1993).

Paying for Residential Programs

Residential programs along the continuum are financed through a variety of sources which may include: federal, state and local grants; Section 8 vouchers; low-interest loans; churches; foundations; and private donations (see article on page 4). Additionally, some programs help finance operating expenses through rental fees from their clients. Women's Alcoholism Center, for instance, charges each resident of Pomerooy House (almost all of whom receive public assistance) $400 to $600 a month for rent, food, and treatment during their six to twelve month stay (Sprague, 1991).

Similarly, each resident of Women's Transition Services' Transitional Housing pays one-third of her income for rent. The staff deposits a portion of it into a savings account for the women to use as they transition out of the program into independent living. In order to remain eligible for AFDC, these savings are used for necessities such as furniture, damage deposits, and bills, rather than direct payments to the women (Dorothy Steele, Women's Transition Services, personal communication, 1993).

A challenge for AIA providers is to continue to establish innovative collaborations, and obtain support from nontraditional programs and funding sources, in order to ensure that families have appropriate living arrangements that support their sobriety, health and safety.

— Amy Price

REFERENCES


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