From the Real Front Line: The Unique Contributions of Mental Health Caregivers in Canadian Foster Homes

Myra Piat, MSW, Ph.D.^{1,2}, Nicole Ricard, Ph.D.^{3,4}, Judith Sabetti, MSW⁵, and Louise Beauvais, M Sc.⁶

¹Douglas Mental Health University Institute, Montreal, Canada

²McGill University, Montreal, Canada

³Fernand Séguin Research Centre Montreal, Canada

⁴University of Montreal, Canada

⁵Douglas Mental Health University Institute, Montreal, Canada

⁶Douglas Mental Health University Institute, Montreal, Canada

Abstract

This article reports the findings of a qualitative study on the contribution of foster home caregivers for persons with serious mental illness. Traditionally social workers have played a key role in the supervision of foster homes. Little is known about how the help caregivers provide is similar to, or different from, that provided by mental health professionals. Twenty semi-structured interviews were conducted with caregivers operating foster homes in Montreal, Canada. With no pre-set theoretical framework, data analysis was inductive and ongoing, involving the identification of categories and themes. Overall findings reveal that caregivers consider themselves the real front-line workers. They claim to be available 24/7, to combine egalitarian and affective relationships with their residents, and provide them with personalized care. Caregivers are well positioned to respond immediately to crises. Caregivers also believe that their intimate and thorough familiarity with their residents allows them to assess residents differently than would social workers. These findings have implications for mental health professionals. The combined skills and expertise of non professional caregivers and social workers are essential in promoting the residents' reintegration into the community.

Keywords

Non professional caregivers; adult foster homes; informal care giving; mental health

Foster homes have existed in North America for the past fifty years, as many patients discharged from psychiatric hospitals were placed into these homes (Deci & Mattix, 1997; McCoin, 1985; Murphy, Penne, & Luchins, 1972; Trainor, Morrell-Bellai, Ballantyne, &

Boydell, 1993). These community based residences provide an important source of housing for persons with mental health problems, often after years of institutional life. Unlike most services for persons with serious mental illness, which rely on professional staffing (ie. Assertive Community Treatment), non professional caregivers operate foster homes, which are indistinguishable from ordinary homes in the community.

Foster homes originated in Belgium where over 600 years ago families in Geel took persons with mental illness into their homes (Carpenter, 1978; Linn, Klett, & Caffey 1980; McCoin, 1983; Roosens, 1979). The concept of caring for someone in a natural family environment spread throughout Europe during the 1800s and was introduced in the United States in 1885 (Linn, 1981; Tuntiya, 2006). Although in recent years emphasis has shifted to more autonomous housing, such as supported housing, foster homes remain the oldest form of housing for persons with serious mental illness (McCoin, 1985).

Canadian foster homes¹ are analogous to the traditional adult foster home model in the US, defined as three or more individuals in a residential care facility, small group home, or family type setting under state regulation (Deci & Mattix, 1997). Yet adult foster care is only one alternative in a plethora of US residential options for persons with serious mental illness, including board and care homes (Morgan, Eckert, & Lyon, 1995), the Homeshare program where single clients are integrated into private homes (Rhoades & MacFarland, 1999), or supervised community residences (Getty, Perese, & Knab, 1998). Whereas Canadian foster homes are a public sector service, in the U.S there is a trend toward the development of private, for-profit housing services under managed care (Shera, 1996; Byrne, 1999).

Although foster homes have flourished, in Canada they have *not* been viewed in a positive light. This poor image dates to a study by Murphy et al. (1972) criticizing foster homes as places that merely provide room and board, are too structured and controlling, and do little to reintegrate people with serious mental illness into the community. Over time foster care in Canada has evolved from a “caretaking” to a “professional” model in which social workers play a key role. They supervise these homes, ensure quality service, and act as intermediaries between foster homes and the mental health system (Dorvil, Guttman, Ricard, & Villeneuve, 1997). Social workers are responsible for recruiting caregivers, as well as matching and placing clients in these homes. A social worker is also assigned to each resident, serving as case manager. According to Quebec Ministry of Health directives, an *Individual Service Plan* for each resident must be developed collaboratively between a resident’s social worker and caregiver.

Caregivers are nonprofessionals, mostly women, who house and care for up to nine residents, whom they are mandated to reintegrate into the community. They and their residents are initially strangers who contract to live together; and, when successful, usually do so for many years (Douglas Hospital, 2006). The Quebec Ministry of Health stipulates that caregivers be paid a per diem for supporting persons with serious mental illness in their

¹In Quebec, Canada foster homes are also known as “*family type residences*”, and are regulated by provincial jurisdiction, Bill 120, *Law Respecting Health and Social Services*, Government of Québec.

homes. Care giving offers advantages such as a flexible schedule, the possibility to be one's own boss, opportunities to learn, and the rewards of seeing good results with residents. Yet care giving also involves a heavy commitment of time and energy. As 24/7 workers, caregivers must be either present in the home or available by telephone round the clock. Caregivers must contend with illness-related issues, difficult resident behaviors and crises, and the stress of never "shutting off".

Non-professional care giving is unique for a number of reasons: 1) foster home caregivers lack formal status or accreditation as mental health workers; 2) they have no job security; 3) they have no official representation at a policy level; 4) they are not part of the hospital residential teams that oversee their work; and 5) caregivers have no specific professional identity to guide them. Despite the acknowledged struggles between social workers and caregivers in achieving a *true partnership*, social workers are in a strong position to validate and formalize the position of caregivers in the mental health system (Piat, Ricard, Lesage, & Trottier, 2005).

While current policy in both Canada and the US favors more autonomous housing for persons with serious mental illness (Kirby & Keon, 2006; MSSS, 2006; United States Government, 2003; Rog, 2004), there is also consensus among mental health professionals that foster homes remain an important form of housing for people with serious mental illness. Thus, it is critical to examine caregiver perspectives on their work, since little is known about how non-professional caregivers help their residents, and how the help they provide compares with that of social workers. This article addresses this question in the context of a larger study on the helping relationship in Montreal foster homes.²

PREVIOUS RESEARCH

Professional versus informal helping is an important distinction in the literature, and is pivotal to this study. Training around helping skills remains a central concern in social work curricula (Brammer & MacDonald, 2003; Egan, 2002; Hepworth, Rooney, & Larsen, 2002). By definition, professional helping relationships are contractual and time-limited (Lapworth, Sills & Fish, 2001); purposeful and goal-directed (Brill, 1990). By contrast, informal helping, whether by family and friends of "help-seekers" or employed caregivers, is viewed as less structured, more personal, and biased (Nystul, 2003).

Research on informal helping has focused primarily on family caregivers (Lefley, 1996; Biegel, Sales, & Schultz, 1991). Most studies emphasize the negative aspects of caregiving including: stress and burden (Cook, Pickett, & Cohler, 1997; Jones, Roth, & Jones, 1995; Karp & Tanarugsachock, 2000; Ricard, 1991; Ricard & Fortin, 1993; Song, Biegel, & Milligan, 1997; Tucker, Barker, & Gregoire, 1998) and coping strategies (Hatfield, 1987; Olshevski, Katz, & Knight, 1999; Stengard, 2002; Turnbull & Turnbull, 1988). Some research has begun to look at the positive aspects of caregiving (Chen & Greenberg, 2004). However these studies focus on families and relatives of the mentally ill and foster home caregivers have not been included.

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The literature on foster home caregivers is limited. The majority of caregivers are women with no professional training, who may have gained care giving experience through raising their own families (Beatty & Sealy, 1980; Sickman & Dhooper, 1991). Other research has examined the characteristics of caregivers, their motivation, and their relationships with residents (Blaustein & Viek, 1987; Mousseau-Glaser, 1988; Rhoades & McFarland, 1999, 2000). These studies conclude that the majority of caregivers chose to operate a foster home for altruistic reasons, rather than for profit. Moxley and Keefe (1988) reported on caregiver satisfaction with service providers and found that caregivers expected to be included in the multidisciplinary team.

Recent Canadian studies explore life in the traditional adult foster home (Piat, Ricard, & Lesage, 2006), the helping relationship in foster homes (Piat, Ricard, & Bloom, 2000) and the caregiver's role and responsibility in the Canadian mental health system (Piat, Ricard, Lesage, & Trottier, 2005). While social workers are heavily involved in the provision of residential services to mental health populations, there is no known research on how the work of foster home caregivers compares with that of social workers.

OBJECTIVES

The overall objective of this study was to explore the perspectives of foster home caregivers and their residents on the nature or type of help offered in Montreal foster homes. The viewpoints of caregivers and residents were elicited. The study emerged from the practice milieu. Social workers on the multidisciplinary teams first identified the need to better understand how non professional caregivers help persons with serious mental illness. Ultimately, it was hoped that new information would emerge which would be used to improve mental health professionals' interventions with caregivers and their residents. The findings presented in this article emerged from a question in the caregiver interviews on how the help they provide compares with the help provided by social workers.

METHODS

This qualitative study employed a naturalistic approach, as developed by Lincoln and Guba (1985). The objective of naturalistic inquiry is to "develop shared constructions that illuminate a particular context and provide working hypotheses for the investigation of others" (Erlandson, Harris, Skipper, & Allan, 1993, p. 45). We chose this approach as most appropriate to explore the helping dynamics that occur between foster home caregivers and residents.

The setting for the study included foster homes for persons with serious mental illness supervised by two university-affiliated psychiatric hospitals mandated to provide community based housing for mental health consumers. At the time of this study, there were 1402 individuals living in 242 foster homes on the island of Montreal. Residents participating in the study ranged in age from 28 to 72 years, and had lived in their foster homes for six years on average. The majority were diagnosed with schizophrenia, major depression and bipolar disorders.

Sample selection was purposeful, and involved a two step process. First, a list of all foster homes (n=242) was compiled according to: 1) the caregiver's years of experience as a foster home caregiver (less than five years; five to nine years; ten to fourteen years; fifteen or more years); and 2) the number of residents living in the foster home (one to three residents; four to six residents; seven to nine residents). Following this, maximum variation sampling was used to select a sample of caregivers that would reflect the greatest diversity of caregiver experience. These two selection criteria were used based on consultations with social workers, who felt that these were important issues to consider when selecting a sample of foster home caregivers. Table 1 presents the final sample of foster homes selected for the study.

In all, twenty-one foster home caregivers were contacted to participate in the research. Twenty agreed to participate, and one refused because of difficulties in her home. Their average age was 54, but they ranged from 31 to 66 years. Their care giving experience ranged from 2 to 26 years with an average of 13 years. Eleven caregivers were born in Canada, whereas nine were immigrants from the Philippines, Africa, or the Caribbean. Thirteen caregivers were married, five were divorced, widowed or single, and two did not respond. Four caregivers had children under eighteen living at home and one had a grandchild; three had grandparents in the home; and another caregiver had her brother living with her.

Caregivers were evenly divided between those with less than high school, and those with higher education. Three caregivers were university educated. Eleven of the twenty stated that they had previously worked as nurses' aides, or educators for persons with disabilities or behavioral problems, which provided hands-on preparation for care giving. Fifteen caregivers had received more formal training through courses in care giving, nursing, psychology, counseling, rehabilitation, or special education. For seventeen caregivers, the foster home was their primary source of revenue.

The ethics review boards of both hospitals approved the research. Participants gave written, informed consent, and retained a copy of the consent form. Caregivers did not receive financial compensation for participating. No identifying information is reported in the findings.

Semi-structured interview guides were developed from a series of consultations between the research team and members of the multidisciplinary teams. The final interview guide included thirteen open-ended questions in the following areas: 1) the qualities and skills of caregivers; 2) how caregivers learned their job; 3) perceived difficulties, needs and expectations of residents; 4) goals in caring for residents; 5) approaches to helping; 6) caregiver-resident relationships; 7) caregiver-professional relationships; 8) comparison between care giving and professional helping; 9) their time allocation between work, family and social life; and 10) the advantages and disadvantages of care giving.

The principal investigator and two research assistants conducted semi-structured interviews with twenty caregivers between February and September, 2003. Interviews ranged from 45 to 90 minutes in duration, were audio recorded and transcribed verbatim. A short

demographic questionnaire was administered after each interview. Interviewers took notes during the interviews to improve understanding or to generate new questions (Patton, 1990). The interview guide was pre-tested with two caregivers, and resulted in minor modifications.

Data analysis was inductive and ongoing throughout the study (Erlandson et al., 1993; Lincoln & Guba, 1985). Conceptualization of the phenomena under investigation was dependent on the findings that emerged from the data. Data analysis involved several stages. First, 25% of the interviews (raw data) were coded individually by three members of the research team, and the remaining interviews were coded by a research assistant. Inter-rater reliability was high (between 70–80%), which meets acceptable standards for qualitative research (Boyatzis, 1998). Initial codes were developed from the questionnaire and new codes were added as they emerged from the data. In all, there were nine iterations of the codebook. The codes were then grouped into categories (i.e., sharing home/daily life; egalitarian/open relationships; holistic help; 24/7 help; better assessments) and into themes (i.e., advantages of care giving). Analytical summaries, a detailed reconstruction of each interview, retaining all information, were written for 50% of the interviews, at which point saturation was attained (Kuzel, 2000). Each analytical summary was then compared and contrasted and rewritten as a single analytical summary. The codes for the remaining 50% of the interviews were merged into the single summary. The entire process was conducted over a one year period, from November, 2003 to November, 2004.

Specific efforts were taken to ensure the trustworthiness of the study. Data analysis was a shared process involving constant feedback and discussion among all members of the research team, namely the principal investigator, the co-investigator and two research assistants. The entire team read drafts of the findings individually and met as a team twelve times between January and November, 2005 to discuss and revise each set of findings. A detailed audit trail was kept over the course of the study. This included: raw data (interview guides/transcriptions); and data reduction and analysis materials (analytic summaries, codebooks, and field/process notes).

RESULTS

New findings not previously reported in the literature emerged from the study. When caregivers were asked to compare their work with the work of professionals, who, in the foster home system, are primarily social workers, seventeen out of twenty caregivers described the ways in which they felt that care giving was unique, and different from social work. Caregivers articulated six reasons for their uniqueness: (1) caregiving is more than a job; (2) caregivers share their lives with their residents; (3) caregiver-resident relationships are egalitarian; (4) caregivers provide holistic help; (5) caregivers are the real front line workers and (6) caregivers make accurate assessments of resident needs.

Care Giving is More Than a Job

Caregivers stated that their work is “*more than just a job*”, as care giving is “*almost a vocation*”. Caregivers described their work as professional work in its own right. They argued that, because of their unique skills and experience as helpers, caregivers have a competitive edge over social workers in terms of what they are able to achieve with their

residents. Caregivers described with great intensity the responsibility and dedication involved in the work of caring for vulnerable people:

You have to love what you're doing. You have to treat the person like you would treat your own, and you have to care and fear for that person.

(Gwen, 16 years experience, 8 residents)

Caregivers must be prepared to sacrifice time, or subordinate their personal interests to their residents' needs, because *"the house... no matter what, the house has to run. No matter what happens, this house has to keep on running; because we have people who are depending on us"*. (Fausta, 2 years experience, 9 residents). Two caregivers added that they have to put aside a concern for remuneration to commensurate with the investment of time and energy demanded by their work. Referring to negative public perceptions of foster homes, one caregiver challenged those whose ideas of the foster home were based on hearsay to visit her residence, in order to appreciate the work that takes place there.

Caregivers Share Their Lives with Their Residents

Foster home caregivers stated that they have an advantage over social workers, because caregivers share their homes and family life with their residents. As 24/7 workers, caregivers share all the daily moments of life with their residents, including the emotional ups and downs. According to caregivers, their unique contribution, often lacking in professional relationships, is true availability and the affection that caregivers give to their residents. As one caregiver explained:

I would say the main thing is love. They (residents) know that you care, and you're there for them... We will give them a hug if they feeling down, and we will say: 'Don't worry; I'm here; talk to me.' And they can talk to you. And I think... that's important.

(Fausta, 2 years experience, 9 residents)

As opposed to those in institutional settings, residents in foster homes can count on a family environment and human affection:

The group home is not an institution – remember that. So, it's going to be different. I mean, if you've ever gone to a hospital or been admitted...you know; maybe you may have a good staff. They treat you very nice, and maybe (they) may not . . . (but) the atmosphere there is so different when you compare to when you're at home around your family and friends.(Stephanie, 9 years experience, six residents)

Another caregiver described a lack of physical boundaries in her home, which provides a level of intimacy, affection and sharing between herself and her residents that is similar to the bonds shared by family members:

This house is a home; it's a home for the clients and myself. My clients are not separated from my home; they are allowed to go anywhere in the house. My clients are not different from us. On Sunday we all sit, we dance; we talk; we laugh . . . They are not different from us, so this is why you will get all their love. I am not

separating my clients from my family ... No; my clients are my family . . They are no different from me. I love them.

(Gwen, 16 years experience, 8 residents)

Living together allows caregivers to know their residents intimately, and to provide more personalized care than social workers could offer, with their large caseloads. As Gwen explained: *“(caregiving) it’s more personal, in the sense that . . . you get to learn a lot about them, because you literally live with them, and you see them on a daily basis, and you’ve seen them in different contexts . . .”* Another caregiver asserted that professionals may know a patient’s illness, but will not know the person in the same way as the person’s caregiver:

We’re not health professionals like social workers, doctors or nurses ... It’s daily life that we experience with them. It’s the helping relationship...we experience it daily...it’s those moments, of sadness, the big events we live through with them, I think that’s what makes the difference. They’re not numbers like in the hospital.. the human side is very important in a foster home. I think that’s the strength of foster homes...

(Bianca, 19 years experience, 9 residents)

Caregivers described various ramifications of living together with their residents. The caregiver’s presence or availability is cited as a key advantage in maintaining a good atmosphere in the home:

But if you sit down and take the time to answer, they will be happy... they’ll say to themselves “look she takes the time to speak to me”. Its like Mark (a resident) and others who told me “no one from the (hospital) hostels would be there to talk... she (caregiver) would be there with us to play cards or to smoke a cigarette...it would never happen elsewhere.

(Pauline, 24 years experience, 8 residents)

Caregiver-Resident Relationships are Egalitarian

Caregivers characterized their relationships with residents in terms of basic equality and an absence of barriers, as opposed to the asymmetrical relationships typical of professionals and their clients. Not only do caregivers know their residents well, but the residents also know their caregivers from seeing them under all conditions. Neither party can maintain a façade:

They see everyday. They see me at supper, well dressed, they see me when I do the housework, or when I’m in pyjamas all day.. they see me without makeup,... they see me when I have a cold and I come upstairs my eyes stuck together, they see all sides of me in the same way that I see all sides of them... so this puts us on an equal footing.

(Dorice, 3 years experience, 7 residents)

The familiarity between caregivers and residents contrasts with this caregiver’s critical image of the social worker: *The social worker...they will see her dressed in her work clothes, well groomed, with her social work vocabulary, at specific times.* (Dorice)

Another consequence of their equal relationship with residents was that caregivers are able to enjoy a more positive relationship with residents than is possible for social workers, whose intervention often involves crisis situations. One caregiver observed that social workers tend to focus on the “*negatives*”:

The social worker is more there . . . to more or less help us with whatever little problem the client (has)... and we sit down, we talk of the negative . . . most of the time . . . when they do come, it's more for the negative things, never for the positive.

(Tamara, 12 years experience, 7 residents)

Another caregiver spoke in favor of the “*non-clinical*” perspective of caregivers as a unique contribution to the wellbeing of residents. In developing an understanding of what's really going on with the residents, she stated that professional training could be more of a liability than a help. This caregiver delineated the essential difference between the caregiver's approach and that of the professional helper as:

...that conscious decision not to keep a professional barrier . . . without a wall, without a professional distance . . . is the main difference . . . I deliberately de-professionalize; I deliberately keep it . . . human. It's about humanity.

(Bertha, 19 years experience, 2 residents)

Caregivers Provide Holistic Help

Caregivers spoke about a fourth advantage to care giving, which is that their working conditions allow caregivers to provide holistic help. Holistic helping implies that caregivers can do everything or be everything for their residents. As one caregiver put it, “*it's the whole atmosphere that you're giving these people . . .*” (Stephanie, 9 years experience, 6 residents) Another caregiver spoke of the many “hats” that she wears with her residents: “*You're the nurse, you're the doctor, you're everything, you know, everybody; you can play the role of anybody here . . . You can be a mother to them, a sister, a friend . . . because you're there*”. (Roseanne, 12 years experience, 7 residents) Caregivers considered themselves as experts in dealing with the practical aspects of daily life faced by persons coping with mental illness. Finally, care giving is holistic in the sense that caregivers have to deal with all aspects of support including the material aspects of running a household.

The very concrete, or “hands-on” nature of their work allows caregivers to interact with residents and “*go through the steps*” with them toward their goals. Caregivers found this aspect of their work particularly satisfying, as one caregiver explained:

I think the help (we give) is hands on. There might be a book that... gave them (professionals) the tools, but . . . I think concretely, they (residents) will come to you and ask you: ‘well, what do I do next?’ So I think that you are more like ‘hands on help’... whatever it is.

(Debbie, 13 years experience, 5 residents)

By contrast, caregivers described professional help as time and issue specific. They characterized the work of social workers as “*shift work*”, after which they leave their work

behind. According to caregivers, foster home residents are aware that it is the caregiver, and not the social worker, who is really there for them:

... they know, the residents that the social worker is paid to be there. Me-they know that I'm also paid. But I'm there all day... they are part of my life and it's not a question of money. So...I think that there's a lot of differences between the social worker and a foster home caregiver.

(Dorice, 3 years experience, 7 residents)

Caregivers are the Real Front Line Workers

Caregivers stated that because they live and work with their residents they are the *real front line workers* and better positioned than social workers to respond to resident needs and difficulties. Caregivers stated that they control the flow of information to social workers, keeping them apprised of what goes on in the foster homes. Caregivers have the advantage of being on site when difficulties arise. For instance, whenever a resident is at risk of relapse, the caregiver will intervene rapidly. With close observation, caregivers can discern from a resident's looks, or from slight alterations in affect, that trouble is brewing:

From the time that person comes into the room, you know that something is missing; or you know that he's okay. Whether it's his . . . mental state, . . . (you have to) observe constantly, it's important. And that way, it also brings out the behaviour pattern; if their illness is . . . either at a stable level, or if they're too high, or if they're too low, you know. You need to be constantly observant...

(Fausta, 2 years experience, 9 residents)

Caregivers, with their experiential knowledge, claimed to be so attuned to their residents that they are able to intervene on the spot:

If you observe them. . . know them quite well, which I do with all my clients, . . . I can approach them and say, you know, if a client comes in, and . . . it's not genuinely her; I can say: 'You're not yourself today; you're looking very sad; do you want to talk?' You know, 'What happened?' Did something happen outside?' 'Did you have an argument with somebody?' 'Was it a bad day at group?'

(Stephanie, 9 years experience, 6 residents)

Caregivers provided other examples of what happens on the front line. They must determine to what extent symptoms may be threatening to a resident or to others. One caregiver illustrated this:

. . . he wants to kill his roommate . . . or . . . he wants to kill somebody else . So you always have to be there; once you know his eyes, his looks, you know, he looks at you differently; he's very quiet. Right away you deal with it, that thing, right away because . . . he'll get voices like a volcano; he will just explode.

(Roseanne, 12 years experience, 7 residents)

Another caregiver spoke about a resident with schizophrenia whose voices appeared as "demons"; and how she took the risk of entering into his delusion and confronting the voices herself. As she explains below, is not something that one learns at school:

I entered into his delusions... I entered into his world and I spoke to the demon to send him away to chase him away. It worked...it's really the strangest thing that I have ever done. Because I didn't... you know one doesn't learn this at school. To enter and chase a demon away... there's no course on "Chasing the Demons-101".

(Gabrielle, 9 years experience, 8 residents)

Finally, from their vantage point, caregivers are able to focus on preventing problems. They follow closely and work with emotional state of their residents:

... when your clients are well, you feel like you're doing things to keep them that way, you know, because...as opposed to the professional, you get to see first hand when they're depressed, because that depression is what sets the whole cycle in motion. And if you can get there first, then ... it's not going to be full blown, it will still be there, but it's not going to be that bad...they won't end up in the hospital.

(Debbie, 13 years experience, 5 residents)

By contrast, social workers usually become involved after the crisis has passed, or after it has escalated beyond hope of prevention. This caregiver described the difference:

Well, the specialists are only available between certain times. So, it's kind of delayed and by the time the delay occurs the problem could ...have escalated. So, I think the fact that ... you're actually available to help that problem 24 hours is tremendous. Because if you were to wait for the professional ...it would be too late.

(Debbie)

Caregivers Make Accurate Assessments of Residents' Needs

Finally, caregivers argued that, living and working with their residents gives caregivers certain advantages over social workers in assessing resident needs. Caregivers with no formal training expressed confidence that they know exactly what their residents are like, what to expect of them, what kinds of people they are, and what are their true capabilities. One caregiver described how she draws on her instincts and experience to form her own judgments of residents and their state of mind:

If somebody comes and says: 'Oh, he is bad', I can say: 'oh no; he is not bad' – because I know what I am talking about ... I know each and every one ... So, when I see one depressed, I could tell ... If I see one of them is not sleeping good at night, because ... I hear every movement they make up there...

(Darlene, 12 years experience, 4 residents)

There were a number of cases where social workers had either recommended residents for a supervised apartment prematurely, in the opinion of the caregiver, or had inaccurately described new residents, leaving caregivers to make adjustments based on their own period of observation.

Caregivers also pointed out that social workers usually see the residents when they are "*not themselves*" – either on their best behavior, for example, or in a hospital context where

everything is controlled. As one caregiver observed, it is sometimes as if the caregiver and the social worker were talking about a different person in their assessments of the same resident:

Most of the time, they (social workers) see them (residents) in the foster home . . . they (residents) complain about the caregiver, or. . . they (social workers) walking up the front door, and (residents) say 'hi' to them, and they're being polite and sweet, you know, they (workers) see the good side... Because it's amazing when workers come into the home, and they would say: 'this client is this and that' – and totally different than what you see.

(Tamara, 12 years experience, 7 residents)

Another caregiver commented on some of the unnatural aspects of the hospital environment for a resident who had been admitted: *"they are watched over (in hospital), and they're cut off, she said, ...it's not the same thing."* (Linda, 8 years experience, 3 residents)

In summary these findings help us better understand the unique contribution of caregivers in helping people with serious mental illness live in the community. They also shed some light on how caregivers distinguish themselves from mental health professionals, and specifically social workers.

DISCUSSION

This study is the first time that non-professional foster home caregivers describe their lived experience in helping persons with serious mental illness. The major contribution of this study is that foster home caregivers describe their work as unique and perhaps more advantageous in certain ways than social work. Foster home caregivers view themselves as dedicated helpers, with a high level of responsibility for those in their care, their own area of expertise and helping style. Caregivers in this study consider they are the real front-line workers. They are available 24/7 and provide more personalized care than do social workers. Caregivers are able to combine egalitarian and affective relationships with their residents. They provide a permanent home for those persons who may never be able to live independently; but also prepare others for independent living. Caregivers believe themselves in better position than social workers to respond immediately to, and prevent, mental health crises. Their intervention usually precedes that of social workers, who, in turn, depend on the caregivers for information. Finally, caregivers in this study argue that their assessments and interventions, because they are based on a more intimate acquaintance with residents, are more accurate than those of social workers.

These findings have important implications for mental health professionals, particularly those who work with community based housing for this population. Findings suggest that professionals can learn a great deal from the perspectives of informal helpers. While our findings suggest that social workers and caregivers collaborate well, their work could be better integrated. Social workers are in an excellent position to appreciate the contribution of caregivers and their expertise. For example, they could consult more often with caregivers and include them in residential team meetings. They could also involve caregivers in

individual treatment planning and decisions around residential placements. Social workers should attempt to formalize the caregiver's contribution in the mental health system.

What is most important to consider is how the formal and informal help provided by caregivers and social workers meets the needs of foster home residents. The reality is that professional intervention and informal care giving involve different helping skills, and that foster home residents need both if they are to successfully reintegrate into the community. What caregivers describe as their advantage over social workers involves competencies that would not necessarily correspond to the standards of a good professional-client relationship. Social workers combine values such as respect, empathy and genuineness with controlled emotional involvement, and work toward specific goals such as client empowerment.

The timing of these findings is critical, as autonomous housing is the emerging model of choice in Canada and the US for mental health consumers. An important transition is currently underway in Montreal whereby mental health workers have been mandated to transition a third of all mental health consumers to more independent living arrangements such as supervised apartments and supported housing (MSSS, 2006). Foster home caregivers, with their long-term experience and expertise, can offer invaluable assistance to social workers charged with implementing these changes. Caregivers should also be part of this process as advocates for the viability of these "family-type residences" in situations where independent living does not accord with the autonomous preferences of residents (Korr, Encandela, & Brieland, 2005). Here also, social workers should actively promote a collaborative approach which integrates a strengths perspective and builds on the competencies of caregivers.

The strength of this research is that the findings capture the lived experiences of informal caregivers with a wide variety and length of experience in the mental health field. The spontaneity of caregivers reflects their concern for critically important issues in their work. Yet, the findings also need to be nuanced by certain limits. While caregivers were selected in order to reflect the maximum variation in the types of caregivers/homes, the sample does not represent a generalized portrait of all foster home caregivers. The sample is small, not representative and biases of social desirability must be acknowledged. Further comparative studies might involve the viewpoints of foster home residents on the care provided by caregivers and social workers.

CONCLUSIONS

Informal caregivers and their foster homes are an indispensable link in the rehabilitation and reintegration of persons with serious mental illness into the community. The provision of decent and affordable housing is one of the most important elements in promoting recovery. Social workers, as well as foster home residents, are beneficiaries of the expertise and experience that foster home caregivers have to offer. As well, social workers are best positioned to advance the unique, experiential knowledge of caregivers within the mental health system. Social workers should take the lead in formalizing the position of foster home caregivers in the system, so that the important contribution of caregivers will be recognized.

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TABLE 1

Final Sample - Foster Homes Selected

Years of Experience as Caregiver ^L					
	< 5 years	5–9 years	10–14 years	15 + years	Total
Number of residents living in foster home					
1–3 residents	1 (10)	1 (8)	0 (4)	1 (22)	3 (44)
4–6 residents	1 (20)	1 (33)	1 (16)	4 (26)	7 (95)
7–9 residents	2 (22)	2 (17)	3 (22)	3 (42)	10 (103)
Total	4 (52)	4 (58)	4 (42)	8 (90)	20 (242)

^LThe total number of foster homes is in parentheses. The number of foster homes selected for the study is in bold.