Evaluating life in foster homes for persons with serious mental illness: Resident and caregiver perspectives

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Abstract

Background—In Montreal Canada, the majority of persons with serious mental illness discharged from psychiatric hospitals were placed into foster homes. Very little updated information exists on life in foster homes, and the level of autonomy allowed in this residential setting.

Aims—The purpose of the study was to elicit the foster home residents' opinions about their lives in this setting and their caregiver's perception of the level of autonomy allowed.

Method—Two questionnaires were administered to 102 foster home residents and their caregivers: (1) *Patient Attitude Questionnaire* and (2) *Hospital and Hostel Practices Profile Survey*.

Results—Consumers are satisfied living in this type of milieu and do not desire to change their housing. The foster home provides residents with a sense of security and well being. Foster homes rank second in terms of autonomy when compared to hospitals and hostels. Only supported apartments rank higher.

Conclusion—These findings shed a new light on this type of residential milieu. Over time the structure of foster homes has evolved. This study points to the need to value the opinions of consumers and not force people to move onto other types of housing.

Keywords

Mental health; persons with serious mental illness; housing; foster homes; caregivers

Introduction

Foster homes have existed for more than 40 years in Montreal, Canada, as the majority of patients discharged from psychiatric hospitals were placed into these homes. After many years of institutional life, foster homes provide an important source of housing for people unable to maintain themselves independently in the community. Although in recent years,

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emphasis shifted to other forms of alternate housing, such as supervised apartments and supported housing, foster homes have managed to survive as the oldest form of housing for persons with serious mental illness (Dorvil, Guttman, Ricard, & Villeneuve, 1997). In certain cases, this housing model is the only realistic housing option. After many years of institutional life, patients discharged from psychiatric hospitals have lost contact with family members, and have few social supports. Often, the foster home is an ex-patient's permanent home and their primary link to the community. Very little updated information exists on life in foster homes, particularly from the perspective of those living there. This article reports foster home residents' assessments of their lives in these homes, and the level of autonomy allowed by their caregivers.

Foster homes: An overview

Foster care for adults has its historical foundations in Belgium, where over 600 years ago families in Geel took mentally ill persons into their homes (Carpenter, 1978; Linn, Klett, & Caffey, 1980; McCoin, 1983). The concept of caring for someone in a family environment spread to other European countries during the 1800s, and it was introduced in the United States in 1885 (Linn, 1981). In Canada, foster homes flourished during the 1960s, as the majority of patients discharged from psychiatric hospitals were placed into foster homes (Murphy, Penne, & Luchins, 1972).

Historically, foster homes in Canada have *not* been viewed in a positive light. This poor image dates back to the 1970s when Murphy et al. (1972) completed one of the earliest studies on foster care in Canada. This study's findings were highly critical of foster homes. Based on personal observations, the authors describe the absence of daytime activity. A "room and board" structure was replicating the institutional model in the community. Over time, foster care evolved from a "caretaking" model to a "professional" model, in which professionals (social workers, nurses) act as the intermediary between formal services and the foster home (Dorvil, Guttman, Ricard, & Villeneuve, 1997). Characterized as ordinary homes in the community, foster homes are regulated by the Law Respecting Health and Social Services in Quebec (Government of Quebec, 1995).

Unlike other external services for persons with serious mental illness, which rely heavily on professional staffing (i.e., Assertive Community Treatment), non-professional caregivers operate foster homes. These caregivers, the majority of whom are women, may accommodate up to nine persons in their homes (Bill 120). Although no specific training is required to become a caregiver, support groups and on-going training is offered. Caregivers work in collaboration with hospital and community-based interdisciplinary teams. A case manager and a resource worker are assigned to each home. The interdisciplinary team oversees the overall well-being of residents, and responds when problems or crisis situations arise.

The recent transformation of mental health services (1997–2000) in Montreal saw two major psychiatric hospitals downsized considerably. Between them, 582 hospital beds were closed and services were decentralized into the community (Statistics from Douglas Hospital, 2001 and Louis H Lafontaine Hospital, 2001). New foster homes were developed in order to

accommodate these closures. Presently there are 1586 persons with serious mental illness living in 261 foster homes in Montreal (Regional Health Board, 2004). Out of a population of about 1.8 million inhabitants in Montreal, a decrease of about 30:100,000 beds; the Quebec Government plans to reach a standard of 40 psychiatric care beds per 100,000 inhabitants.

Previous research on psychiatric foster homes

Previous research has focused on the outcome of placement into community residential facilities by reporting different measures of resident adaptation: community tenure, housing stability and quality of life, to name a few. Most often, community tenure and re-hospitalization rates are used as the criteria for measuring success. Carpenter's (1978) review of over 60 outcome studies, examined the environment, patient selection, staffing, programming, and length of stay. Findings confirmed that it was less costly to house persons with mental illness in the community than in hospital. Murphy, Engelsmann, & Tchong-Laroche (1976) reported that patients living in foster homes showed no improvement in social functioning after 18 months. Another study contradicted these findings, maintaining that foster homes improved social functioning within four months regardless of patient characteristics (Linn et al., 1980). Goering et al. (1997) reviewed housing support for persons with serious mental illness and reported that few conclusions could be made about the effectiveness of any housing model. Recent studies have suggested that the characteristics of the environment are more predictive of outcome than the characteristics of the individual (Boydell & Everett, 1992; Boydell, Gladstone, Crawford, & Trainor, 1999; Nelson, Hall, & Walsh-Bowers, 1998).

Studies provide a descriptive profile of caregivers and their motivation for operating foster homes. Beatty and Seeley's (1980) investigation of 39 foster homes revealed that the typical caregiver is female, has raised a family, and then becomes a caregiver. Blaustein and Viek (1987) reported that 81% of caregivers chose to operate a foster home to "help people". Sickman and Dhooper (1991) revealed that 35% of caregivers had seen a family member function as a caregiver and decided to follow this example. Mousseau-Glaser (1988) reported that the primary reason for becoming a caregiver was to offer a home to those who were less fortunate. Moxley and Keefe (1988) revealed that caregivers were concerned about how they were treated by professionals, and expected to be included as members of the professional team. In contrast to Murphy et al (1972), Sarner (1985) revealed that foster homes are not viewed as merely room and board, and that the family aspects of the home are important for both residents and caregivers. Rhoades and McFarland (1999) explored meanings, motivations, rewards and difficulties among caregivers. The principal meaning caregivers accorded to their work included: altruism, self-actualization and existentialism. A recent Canadian study explored the partnership between foster home caregivers and the health and social service network (reference withheld for blind review). However little updated research exists on the resident's perspective of life in a foster home and the level of autonomy allowed in this residential setting.

Objectives

The purpose of the study was to elicit both the residents' opinions about their lives in foster homes for persons with serious mental illness and the caregiver's perception of the level of autonomy allowed in this milieu. The overall research question was: What are residents' opinions about their life in foster homes and what is the level of autonomy allowed by their caregivers?

Methods

Settings and samples

The sampling frame included all foster homes housing persons with serious mental illness affiliated with two major university-based psychiatric hospitals in Montreal, Canada: the Douglas and Louis-Hippolyte Lafontaine Hospitals. The geographic area covered by these two institutions (east and west Montreal) encompasses a vast sector, representing 70% of all foster homes for this population in Montreal. At the time of the study this included 1586 persons living in 261 foster homes (Regional Health Board, 2004).

Sample selection involved a three step process. First, in order to recruit foster home caregivers, a random sample of one hundred foster homes was selected. Following this, one resident in each foster home was randomly selected. In the case where a caregiver or resident refused to participate, or was excluded from the study, another caregiver/resident was randomly selected until the sample size of 102 was attained.

In all, 27 residents were excluded because they were either on public guardianship (19 clients), or because their health professional did not recommend them for the study (eight clients). Another 15 residents refused to participate because of their mental condition (12 residents), or they felt uncomfortable to undergo the interview (three residents).

In all, 11 caregivers refused to participate. Five caregivers were not interested, four stated that the timing was not convenient; one caregiver did not think the study was useful, and another did not want to discuss her residents with the researcher. By the end of this process, we conducted 204 interviews (102 with caregivers and 102 with foster home residents) between January and May 2001. All interviews took place in the foster home and were between 30–60 minutes in duration.

Ethical considerations

Participation in the study was voluntary. Both hospitals' Ethic Review Boards approved the research. Before the interview, participants were informed about the nature of the research, its objectives, its potential benefits and risks, the data collection procedures and how the information would be used in the future. All participants signed and received a copy of the consent form. In reporting the findings, no identifying information was used. Residents were given a small honorarium for participating.

Description of sample

Residents—Foster home residents included 102 respondents, 45% male and 55% female. The average age was 54 years (SD 11.5). Seventy-three percent of respondent's were French speaking, 22% were English and 5% were bilingual. On average, the residents had lived 5.4 years (SD 5.0) in their foster homes.

Foster home caregivers—Caregivers included 102 respondents, 42% of whom were from the Douglas Hospital and 58% from Louis-H Lafontaine Hospital. Eight percent of the sample was male, 85% female, while 7% of respondents refused to answer demographic questions. The average caregiver age was 51 (SD 12.8). Caregivers had an average of 16 years (SD 8.6) experience as foster home caregivers.

Instruments

Two questionnaires were administered: (1) *The Patient Attitude Questionnaire* and (2) *The Hospital and Hostel Practices Profile Survey*. Both questionnaires were administered in English and French, depending on the language used by respondents. These two questionnaires were utilized because both instruments have been successfully used in the long term TAPS studies in Britain as well as in Québec. In addition both instruments are well suited to the Quebec reality as no other known instrument captures the living conditions and autonomy allowed in this residential setting. *The Patient Attitude Questionnaire* (Thornicroft, Gooch, O'Driscoll, & Reda, 1993) consists of 15 open-ended questions that evaluate opinions of psychiatric patients toward their residential setting and staff. The questionnaire explores residents' views about daily life in the home, activities, the experience of living in a residential setting and the help provided by the staff. The first four questions measure the ability of residents to answer the questionnaire.

This questionnaire is not based on scales or sub-scales, and it is more like a semi-structured interview in which residents are allowed to give their opinions. Some answers are recorded verbatim, following which they are coded into the existing categories. New categories may be created when an answer does not fit into the pre-existing ones. The test-re-test reliability of the original research instrument is 0.50 and the inter-rater value is 0.82. The French version of the instrument was translated by a bilingual expert panel and used previously in a study undertaken in Montreal (Bandeira, Lesage, Morissette, & Granger, 1994). Utilization of this questionnaire confirms that the majority of long-term psychiatric patients are able to articulate clear and consistent views about their daily living arrangements. They also appreciate that their opinions are being asked. The type of questions asked, and the fact that it is administered by the same person make the instrument very easy to comprehend.

The Hospital and Hostel Practices Profile Survey (O'Driscoll, 1985; Wykes, 1982) measures the level of autonomy allowed in the residential milieu. This questionnaire consists of 55 dichotomous items reflecting the various aspects of living in a foster home, including the following dimensions: activities (19 items), personal effects (12 items), meals (7 items), health and hygiene (8 items), rooms (5 items) and services (4 items). Respondents are asked to indicate whether each item is "true" or "false" in their residential milieu. The score attributed for each item is either 1 (true) or 2 (false) with a higher score reflecting a higher

level of autonomy. The global score varies between 55 and 110. In addition to these 55 items which are distributed in several sub-scales, there are another 8 items dealing with access to public facilities, such as proximity to a restaurant, bookstore, cinema, and the level of environmental safety. Findings from the Bandeira et al. (1994) study demonstrate that this instrument can distinguish different residential milieus according to the level of autonomy allowed. This questionnaire was translated by an expert panel of bilingual persons working in the field of mental health. Its repeated usage in previous studies demonstrates that the questions are both acceptable and easily understood.

The psychometric properties of the French version of this questionnaire were verified in a recent study (Corbière et al., 2001). This study confirmed the factorial structure, in which seven dimensions emerged, based on 23 out of 55 items in the questionnaire. These were house rules, activities-morning, health and hygiene, activities-curfew, personal effects, activities-night time, and meals. Sixty-five percent of the accumulated variance is explained by this factorial solution. In this present article results are presented using the 55-item original version. However, in order to compare the level of autonomy allowed in foster homes to other residential milieus, such as inpatient hospital units, hostels and supervised apartments, the results of this study will also be contrasted with those of Corbière et al. (2001).

Results

Patient Attitude Questionnaire

Table I presents the overall distributions obtained for the different questions in the *Patient Attitude Questionnaire*. These responses provide a profile of residents' opinions about the diverse aspects of their life in a foster home. Although the majority of respondents (59%) did not choose to live in a foster home – most often a family member or someone else chose for them – the majority did want to leave the hospital and preferred living in a foster home (89%). Even though living in a foster home was a personal choice for only 35%, adapting to this new type of living arrangement took place without difficulty for more than half of the residents. However over 40% of the residents reported having some type of difficulty – (26.7%) in adapting or difficulties with other residents in the home (9%). A small minority (6%) mentioned specifically that they encountered some problems with their caregiver or problems with the physical organization and functioning of the home.

When directly questioned about those aspects most appreciated about their life in a foster home, 17–20% of residents describe feeling “free”, a sense of “well being”, of liking “the food”, or the “lifestyle”. It should be noted that a small proportion of residents (13%) mentioned their appreciation of the staff or the caregiver. Over half of the residents interviewed did not identify any sources of dissatisfaction. However, those reporting some source of dissatisfaction most often described the rules and structure (19%) and the presence of other residents (11%). These responses suggest a relatively high level of satisfaction for residents living in foster homes. This finding is consistent with the fact that over two thirds of residents interviewed responded affirmatively when asked if they wanted their foster home to be their permanent residence. For those who did not view their residency in a foster

home as permanent (25%), the majority did not identify their residential preference and only 17% preferred to live in their own apartment.

The findings suggest that residents do not feel that they benefit from organized activities offered in the foster home, with the exception of domestic tasks (83%), which the majority of residents view as helpful. In contrast, close to 60% of respondents report participating in activities outside the foster home, such as day centre activities, social clubs, and a minority (13%) work in a sheltered workshop. Though a majority of respondents view external activities as useful, some feel that these activities do not help them (15%), close to one third would prefer other types of activities, and the majority (53%) do not seem interested in participating in different forms of activities outside the residence.

In terms of help-seeking and the availability of resources, slightly more than half of the residents do not ask for help, but when they do, the majority (56%) report not having difficulty in obtaining the help. When they ask for help, residents seek help primarily from staff in the foster home (14%) or the psychiatrist (13%) and their friends or family members (10%). Respondents do not view other residents in the foster home as a source of help. Residents expressed a positive perception of the help they received. Among those persons perceived as most helpful, the psychiatrist and the foster home personnel ranked first, followed by the social worker and the family doctor. These persons respond primarily to the residents' physical and medical needs and very little to their emotional needs. Slightly more than half of the residents do not receive any help from nurses with whom they are in contact with, for neither physical, nor emotional needs. In addition, the family and friends are perceived as a helping resource in 60% and 22.3% of cases respectively.

A majority of residents (80%) noted positive changes since their arrival in the foster home and felt better. The majority of residents believe that these changes are linked to their adaptation to their illness and to support from their family and social network. They consider life in the foster home to be very different than in the hospital and state atmosphere and freedom as the principal benefits. Almost all residents (95%) recommend the foster home as a place to live.

The Hospital and Hostel Practices Profile Survey

Table II presents the results obtained from foster home caregivers regarding the level of autonomy allowed in these residences. The total global score is 82.18 on a maximum score of 110. This table indicates that the average score for the different dimensions varies between 1.37 and 1.59/2, with the lowest scoring dimensions being activities and meals. The findings indicate that the level of autonomy in the dimensions of personal effects, services and health and hygiene are very similar. Statements about the activity dimension make reference to practices which limit residents' autonomy, including door locking requirements, weekend curfew, visiting hours and residents' whereabouts. Those aspects where greater autonomy is given include bedtime hours and wakeup hours on weekends. In most cases, the residents do not have a choice of their main course at meal time, however, in the majority of cases they are involved in meal planning and preparation. They can make themselves tea or coffee and they can choose their beverages at mealtime. The consumption of beer and alcohol in the foster home is not authorized in the majority of residences.

For the dimension of personal effects, findings reveal that in almost all situations staff administer medication, and in more than two thirds of the cases residents are not permitted to lock their personal effects, nor are they authorized to park their car next to the residence. Upon admission to the foster home the majority of the residents' personal effects are checked for prohibited items. In almost all cases, residents are permitted to have their own money, and they assume full responsibility for their personal effects. They are permitted to decorate their rooms and have sufficient clothing.

In almost all foster homes, numerous restrictions are imposed: residents can not smoke, nor have persons of the opposite sex in their rooms; the staff or caregiver can enter a resident's room at any time; and residents are not permitted access to their rooms outside of naptime hours. Regarding hygiene, residents are supervised for dress, baths and showers in a large majority of cases and are not responsible for cleaning their clothes. The findings also reveal that psychiatrists do not meet regularly with residents in their foster home. In addition, half of the residences do not offer group meetings for residents. Finally, in most cases residents cannot communicate with their family doctor without asking for permission from their caregiver.

Discussion

The results from this study are of interest from numerous points of view. Very little research to date has elicited the opinions of residents living in foster homes. Few studies have evaluated the level of autonomy allowed in these homes from the foster home caregivers' point of view. These two sources of data are complementary and permit us to specify characteristics of resident satisfaction, and link this level of satisfaction to rules and practices in the residences. This study also allows comparisons between the autonomy authorized in these residences with other residential resources. Finally, the results may inform certain criticisms regarding current practices in foster homes that discredit their reputation.

Though the majority of residents did not personally choose to live in a foster home, nearly all respondents stated that they felt better since their arrival in this resource. The majority would like to live in their foster home permanently and they recommend this type of housing to other persons discharged from hospital. The feelings of freedom and well-being, expressed by the respondents, are linked to an appreciation of the lifestyle afforded by foster homes and the accessibility of professional help when the need is felt. Nevertheless, a minority of residents seemed to be dissatisfied with the rules and structure.

The results of the resident questionnaire (*Patient Attitude Questionnaire*) may be viewed in relation to those of the caregiver questionnaire (*Hospital and Hostels Practices Profile*). The results of the HHPS demonstrate a relatively high level of autonomy in the majority of homes, and in various aspects of life within. In fact, of all the rules or activities evaluated, one observes that only a minority of residences (20–25%) systematically impose rules or restrictions deemed “not useful” in the activities and daily life of the residents. Such rules, which might be viewed negatively by residents such as locking doors, smoking in bed, alcohol consumption, and medication dispensation, are applied by the caregivers for the

security and health of the residents. This consideration, however, should not preclude the critical evaluation and modification of rules that infringe upon the autonomy and privacy of the residents. Examples of questionable rules included: the supervision of residents while they dress, the caregiver's right to access their rooms at all times, forbidding residents to keep their belongings locked away, or have members of the opposite sex in their rooms. These examples were also noted by Murphy et al. (1972) who pointed out that foster home life held many similarities with life in an institutional setting. As well as limited activities in the foster home Murphy et al. also described strained interpersonal relationships, a finding also supported by this study. It should also be noted that rehabilitation activities, intended to develop residents' interpersonal skills and autonomy, are not practised by all caregivers.

Findings from the HHPPS questionnaire may lead to the conclusion that the level of autonomy found in the foster homes is relatively high and can be seen as contributing to the satisfaction of the residents. It is, nevertheless, pertinent to compare this with data on other residence types. A study completed by Corbière et al. (2001) applied a shortened version of the HHPPS, of 23 items divided among 7 categories, to four other residential housing types: inpatient hospital unit, hostel, group homes and a supervised apartment. Table III presents our results alongside those of Corbière et al., according to the seven dimensions of the modified questionnaire. With regards to the overall autonomy scores, the foster homes in our study placed second after the supervised apartments, thus ranking above the inpatient hospital unit, the hostel, and the group home- it should be noted that the supervised apartments ranked highest in every category). In two categories, the foster homes ranked lower than they did for overall autonomy; for "Activities: curfew", the group home and hostel provide greater autonomy, while for the category of "Personal Effects", the group home again ranked higher.

The foster homes provide a higher level of autonomy than the hospital units in all categories; a finding unequivocally confirmed by the opinion of the residents, who were partial to the more flexible lifestyle in the foster homes. We can conclude that, with the exception of supervised apartments, foster homes are characterised by fewer rules regulating daily life than the other residential types, providing a relatively permissive supervised setting – a conclusion that is in keeping with the high level of satisfaction expressed by the residents.

Strengths and limitations

It is important to keep in mind that though the foster homes and residents were randomly selected for this study, it does not represent a generalized portrait of all foster homes in Montreal, Canada. As interesting and pertinent as the findings of this study are, it is important to note that different cultures exist in the anglophone and francophone health settings of Montreal. The findings must be nuanced by certain limits of this study and its research methods. The study is merely a descriptive study and does not measure long term outcomes. In addition, biases of social desirability may have influenced respondents: though confidentiality was assured, the caregivers might have exaggerated the permissiveness of their homes out of fear of an evaluation. Even though the interviews with residents were confidential, and held in settings away from the caregiver, the residents may have limited their criticisms, for fear they would be overheard by those on whom they are dependent for

their daily needs. Nevertheless, the interview's open questions may limit the power of suggestion of pre-formed answers, and examination of the residents' responses indicate that they felt free to express their opinions.

Although the use of the HHPPS is advantageous its dichotomous nominal scale (true/ false) does not permit a precise measurement of the autonomy authorised in a home. For example, rules may be applied more or less stringently among individual residents, depending on their capacities of independent functioning; such a nuance falls beyond the reach of the HHPPS.

Conclusion

The provision of housing is a basic human right for all individuals regardless of their condition. Housing is a key determinant of health and thus it is important to learn about how different residential resources contribute to the health and well being of persons with serious mental illness, perhaps one of the most disenfranchised and vulnerable groups in society.

Foster home residents and their caregivers have been left aside for many years. They have not been consulted nor asked their opinions about their housing. This study for the first time elicited the opinions of both groups around their life in foster homes in Montreal, Canada. This study has demonstrated how this chronically ill population is able to respond to questions around their housing. If anything, this study reveals the importance of housing in the lives of this group. Similar to ordinary citizens, their home plays a central role in their lives.

The study's originality lies in the fact that both the caregivers' and residents' opinions were elicited. This dual perspective, those living in foster homes, and those providing the care, provides a more complete portrait of life in this residential milieu. Having both sources of information allows us to compare and contrast, thus strengthening the study's findings. In addition, the random sampling method used for the study, provides us with a representative group of foster homes and caregivers.

Overall findings indicate that consumers living in foster homes are satisfied living in this type of residential milieu and do not desire to change their housing. The foster home provides residents with a sense of security and well being. Foster homes rank second in terms of autonomy when compared to hospitals and hostels. Only supported apartments rank higher in terms of autonomy. These results indicate that over time the structure and organization of foster homes has evolved. As caregivers become better informed about the notions of rehabilitation and recovery, they are able to integrate these into the autonomy allowed in the foster home. These findings shed a new light on this type of residential milieu. In contrast to previous studies which portray a negative image of foster homes, these updated findings allow us to question previous myths and prejudices against foster homes.

This study points to the need to value the opinions of consumers. Given that in Québec the most common form of housing is foster homes, other long term studies with larger samples of residents should be conducted. The two questionnaires should also be updated to better reflect current realities.

This study has important implications in terms of overall planning of housing for this population. In Quebec, as elsewhere, recent social policies call for the reduction in foster homes in the coming years, and in some cases even the abolishment of this type of housing in favour of supported housing. Although some foster homes residents may be interested in moving into supported housing this may be difficult to achieve since the foster home network and the supported housing network currently operate in isolation. Specific efforts must be taken to open up communication and develop collaborative relationships between these two networks. Ultimately the goal is to facilitate the integration of consumers into their preferred housing whether it is supported housing or foster homes.

This study also has implications for mental health practice. Multi-disciplinary teams that work with this population should make every effort to listen to the opinions of users. Findings suggest that a specific group of chronically ill persons need the structure and support offered in foster homes. Thus, forcing people to move onto a less structured environment such as supported housing, may be unwarranted, particularly if certain consumers are satisfied with their current housing.

Finally it should be noted that foster home caregivers are pivotal to the well being of consumers living in foster homes. They are important partners in the delivery of mental health services and as such we need to support them as well as recognize their contribution to the integration of persons with serious mental illness into community life.

References

- Bandeira M, Lesage A, Morissette R, Granger L. Évaluation de l'efficacité à long terme de la réinsertion sociale de patients psychiatriques. *Santé Mentale au Québec*. 1994; 19:178–190.
- Beatty L, Seeley M. Characteristics of operators of adult psychiatric foster homes. *Hospital and Community Psychiatry*. 1980; 31:774–776. [PubMed: 7429450]
- Blaustein M, Viek C. Problems and needs of operators of board-and care-homes: A survey. *Hospital and Community Psychiatry*. 1987; 38:750–754. [PubMed: 3610071]
- Boydell K, Everett B. What makes a house a home? *Canadian Journal of Community Mental Health*. 1992; 10:109–123.
- Boydell K, Gladstone B, Crawford E, Trainor J. Making do on the outside: Everyday life in the neighbourhoods of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*. 1999; 23:11–18.
- Carpenter M. Residential placement for the chronic psychiatric patient: A review and evaluation of the literature. *Schizophrenia Bulletin*. 1978; 4:384–398.
- Corbière M, Lesage A, Reinhartz D, Contandriopoulos AP. A French abridged version of the Hospitals and Hostels Practices Profile Schedule. *International Journal of Methods in Psychiatric Research*. 2000; 10:183–190.
- Dorvil H. Les ressources alternatives au C.H. Louis-H. Lafontaine. *Administration hospitalière et sociale*. 1984 Nov-Décembre;:31–41.
- Dorvil, H., Guttman, HA., Ricard, N., Villeneuve, A. Défi de la reconfiguration des services de santé mentale: pour une réponse efficace et efficiente aux besoins des personnes atteintes de troubles mentaux graves. Québec: Ministère de la santé et des services sociaux du Québec; 1997.
- Douglas Hospital. Statistics. Montreal: Douglas Hospital; 2001.
- Goering, P., Cochrane, J., Durbin, J., Lesage, A., Rogers, J., Trainor, J., Wasylenki, D. Best Practices in Mental Health Reform. Health Systems Research Unit, Clarke Institute of Psychiatry; Toronto: 1997.

- Gouvernement du Québec. Loi modifiant la loi sur les services de santé et les services sociaux. Éditeur officiel du Gouvernement du Québec; Québec: 1995.
- Linn, M. Can foster care survive?. In: Budson, B., editor. New directions for mental health services: Issues in community residential care. San Francisco: Josey-Bass; 1981. p. 35-47.
- Linn M, Klett CJ, Caffey E. Foster home characteristics and psychiatric patient outcome: The wisdom of Geel confirmed. *Archives of General Psychiatry*. 1980; 37:129–132. [PubMed: 7352844]
- Louis H Lafontaine Hospital. Statistics. Montréal: 2001.
- McCoin, JM. Adult foster homes: Their managers and residents. New York: Human Sciences Press, Inc; 1983.
- Mousseau-Glaser, M. Les responsables de familles d'accueil pour adultes et jeunes adultes: leur motivation, leurs perceptions et leur vécu. Montréal: Centre de services sociaux du Montréal métropolitain; 1988.
- Moxley D, Keefe M. Factors influencing the satisfaction of residential providers with the services of a central administrative agency. *Adult Foster Care Journal*. 1988; 2:185–201.
- Murphy HBM, Engelsmann F, Tchong-Laroche F. The influence of foster-home care on psychiatric patients. *Archives of General Psychiatry*. 1976; 33:179–183. [PubMed: 3146]
- Murphy HBM, Penne B, Luchins DJ. Foster homes: The new back wards? *Canada Mental Health*. 1972 Sep-Oct;(71)
- Nelson G, Hall G, Walsh-Bowers R. The relationship between housing characteristics, emotional well-being, and the personal empowerment of psychiatric consumer/survivors. *Community Mental Health Journal*. 1998; 34:57–69. [PubMed: 9559240]
- O'Driscoll C, Leff J. The TAPS Project: Design of the research study on the long-stay patients. *British Journal of Psychiatry*. 1993; 162(Suppl 19):18–24.
- Regional Health Board, Montreal. Statistiques: répartition des ressources d'hébergement par établissement gestionnaire pour Montréal et environs. Montréal, Québec: Régie régionale de Montréal-Centre; 2004.
- Rhoades D, McFarland KF. Caregiver meaning: A study of caregivers of individuals with mental illness. *Health and Social Work*. 1999; 24:291–298. [PubMed: 10605634]
- Sarner, M. PhD Thesis. Columbia University; 1985. Role expectations of psychiatric patients and foster care sponsors.
- Sickman J, Dhooper S. Characteristics and competence of care providers in a Veterans Affairs community residential care home program. *Adult Residential Care Journal*. 1991; 5:171–184.
- Thornicroft G, Gooch C, O'Driscoll C, Reda S. The TAPS Project: The Reliability of the Patient Attitude Questionnaire. *British Journal of Psychiatry*. 1993; 162(Suppl 19):25–29.
- Wykes T. A hostel-ward for "new" long-stay patients: An evaluative study of a ward in a house. *Psychological Medicine Monograph Supplement*. 1982; 2:57–97. [PubMed: 6817358]

Table I

Patient Attitude Questionnaire (Thornicroft et al., 1993).

Q. 4b	What was the reason for the change of residence?	
	1. Personal choice	35.2%
	2. Someone else's choice	50.5%
	3. Family choice	8.8%
	4. Other answers	5.5%
Q. 5	Did you want to leave hospital?	
	1. No response	2.0%
	2. No	15.8%
	3. Yes	82.2%
Q. 6	Which do you like better – living here or living in the hospital?	
	1. Here	89.0%
	2. Hospital	4.0%
	3. Other responses, such as by myself or with my family	7.0%
Q.7	What do you like about living here?	
	1. No response	12.0%
	2. Nothing	5.0%
	3. Other residents	3.0%
	4. Neighbourhood	1.0%
	5. Inside the residence	8.0%
	6. Food	20.0%
	7. The owner of the residence	13.0%
	8. Life style	17.0%
	9. Freedom, feeling of well-being	21.0%
Q. 8	What do you dislike about living here?	
	1. No response	7.0%
	2. Nothing	54.0%
	3. Other residents	11.0%
	4. Neighbourhood	3.0%
	5. Inside the residence	2.0%
	6. Food	2.0%
	7. The owner of the residence	0.0%
	8. Life style	19.0%
	9. Lack of freedom	2.0%
Q. 9a	Would you like to make your home here permanently?	
	1. Yes	66.0%
	2. No	25.0%
	3. No response	9.0%
Q. 9b	If no, where would you like to live?	
	1. Personal apartment	16.9%
	2. With family of friend	6.7%

	3. In another foster home	12.4%
	4. Hospital	2.2%
	5. Don't know	61.8%
Q. 10a	Do you have any regular activities/duties here?	
	1. House work	83.2%
	2. Protected Workshop	0.0%
	3. Social activities	6.9%
	4. No response	9.9%
Q. 10b	Overall, do you find the organized activities helpful or unhelpful?	
	1. Helpful	92.9%
	2. Unhelpful	7.1%
	3. No response	0.0%
Q. 11a	Do you have any activities/work outside the home?	
	1. Supervised job	12.9%
	2. Day Center & Social Club	59.4%
	3. None	21.8%
	4. Others	5.9%
	5. No response	0.0%
Q. 11b	Overall, do you find the organized activities helpful or unhelpful?	
	1. Helpful	80.2%
	2. Unhelpful	14.9%
	3. No response	5.0%
Q. 12	Are there any activities that you would like to be provided?	
	1. No	53.0%
	2. Job	5.0%
	3. Social activities	8.0%
	4. Other, such as travelling	30.0%
	5. No response	4.0%
Q. 13a	Have you experienced any difficulties since coming here?	
	1. Adaptation	26.7%
	2. Other residents	8.9%
	3. Residents/owner	3.0%
	4. Neighbourhood	1.0%
	5. Inside the residence	3.0%
	6. No	54.5%
	7. No response	3.0%
Q. 13b	Did you ask anyone for help?	
	1. No	54.5%
	2. Psychiatrist, social worker	12.9%
	3. Residence owner	13.9%
	4. Friends, family	10.9%
	5. Other residents	1.0%
	6. No response	6.9%

Q. 13c	Have you experienced difficulty in obtaining services from any of the following?	
	1. No	56.6%
	If yes	
	2. Psychiatrist, social worker	2.0%
	3. Residence's owners	3.0%
	4. Friends, family	1.0%
	5. Other residents	0.0%
	6. No response	21.2%
	7. Yes (unclear answer)	16.2%
Q. 14	In your contacts with any of the following people, have you found helpful or unhelpful: The psychiatrist?	
	1. Medication & other physical needs	88.1%
	2. Emotional support	4.0%
	3. No	7.9%
	4. No response	0.0%
	The GP?	
	1. Physical needs	64.4%
	2. Emotional support	3.0%
	3. No	32.0%
	4. No response	1.0%
	The nurse?	
	1. Physical needs	42.6%
	2. Emotional support	2.0%
	3. No	53.5%
	4. No response	2.0%
	The social worker?	
	1. Physical needs	67.3%
	2. Emotional support	5.0%
	3. Social integration	3.0%
	4. No	23.8%
	5. No response	1.0%
	Staff at home?	
	1. Physical needs	85.0%
	2. Emotional support	8.0%
	3. Social integration	1.0%
	4. No	5.0%
	5. No response	1.0%
	Other?	
	1. Family	57.4%
	2. Friends	22.3%
	3. Social integration	3.2%
	4. Others	5.3%
	5. No	11.7%
Q. 15a	Have you noticed any changes in yourself since coming here?	

	1. Yes	80.8%
	2. No	4.0%
	3. No response	15.2%
Q. 15b	If yes, what kind of change?	
	1. Better	82.0%
	2. Worse	11.0%
	3. No response	7.0%
Q. 15c	What do you think has brought about the change?	
	1. Adaptation, following the death of family member or following the illness	34.4%
	2. Residents, friends, social environment	21.5%
	3. Staff of the home	8.6%
	4. Neighbourhood	8.6%
	5. Living inside the residence, such as food, small bedroom, etc.	10.8%
	6. No response	15.1%
Q. 16	If another person living in hospital asked you about the home, would you recommend it as a good place to live?	
	1. Yes	95.0%
	2. No	5.0%
	3. No response	0.0%
Q. 17a	Do you feel that your life here is much different from life in the hospital?	
	1. Yes	92.1%
	2. No	2.0%
	3. No response	5.9%
Q. 17b	If yes, in what way?	
	1. Food	16.3%
	2. Atmosphere	48.0%
	3. Freedom	24.5%
	4. No difference, feel safe in both places	2.0%
	5. No response	9.2%
Q. 18	If you are on medication, do you find your medication helpful or unhelpful?	
	1. Helpful	92.9%
	2. Unhelpful	1.0%
	3. No response	6.1%

Table IIHospital and Hostels Practices Profile Questionnaire (55 items) ($N = 102$).

Activities' items		False (2)	True (1)	Total
1	Some precautions are taken such as outside doors are locked during the day to avoid residents leaving without informing the caregiver/staff.	0.56	0.44	1.56
2	Visiting times are restricted to certain hours.	0.17	0.83	1.17
3	Residents are not allowed out alone in the evening without telling the caregiver/staff where they are going.	0.32	0.68	1.32
4	Residents must ask for authorization to go out after 7 pm.	0.21	0.79	1.21
5	Caregiver/staff verifies that residents are in the home at night.	0.29	0.71	1.29
6	Residents are not permitted to watch TV after 11 pm.	0.38	0.62	1.38
7	The front door of the foster home is locked at night.	0.03	0.97	1.03
8	Residents must be in bed by a given time.	0.91	0.09	1.91
9	Caregiver/staff checks that residents are in bed during the night.	0.51	0.49	1.51
10	Residents should be up by a given time on weekdays.	0.34	0.66	1.34
11	Caregiver/staff verifies and makes sure that residents are up mornings on weekdays.	0.31	0.69	1.31
12	Residents are expected to be in by 10 pm during the week (Monday to Friday).	0.47	0.53	1.47
13	Residents are expected to be in by 11 pm during the week (Monday to Friday).	0.29	0.71	1.29
14	Residents are encouraged to be in bed by 11 pm on the weekend.	0.91	0.09	1.91
15	Residents should be up by a given time on weekends.	0.64	0.36	1.64
16	Caregiver/staff verifies and makes sure that residents are up mornings on weekends.	0.36	0.64	1.36
17	Staff likes to be informed about where the residents go if they leave for the weekend.	0.01	0.99	1.01
18	Residents are encouraged to be in home by given time on weekends.	0.08	0.92	1.08
19	Residents do not have the key to the front door of the foster home.	0.4	0.6	1.40
Total		7.19	11.81	26.19
Mean				1.37
Meals' items		False (2)	True (1)	Total
20	Residents are not involved in planning meals and the menu.	0.72	0.28	1.72
21	Beers is not allowed in the foster home.	0.02	0.98	1.02
22	The consumption of alcohol is not allowed for residents.	0.04	0.96	1.04
23	Residents cannot make tea or coffee for themselves.	0.64	0.36	1.64
24	Residents cannot make a snack in between meals.	0.55	0.45	1.55
25	There is no choice of main meals.	0.47	0.53	1.47
26	There is no choice of beverage at meals.	0.87	0.13	1.87
Total		3.31	3.69	10.31
Mean				1.47
Personal effects items		False (2)	True (1)	Total
27	Residents are not allowed razors, knives, or scissors in their personal possession.	0.67	0.33	1.67
28	Residents are not allowed matches or lighters in their personal possession.	0.72	0.28	1.72
Personal effects items		False (2)	True (1)	Total
29	Medication is administered by the caregiver/staff.	0.03	0.91	0.97

Activities' items		False (2)	True (1)	Total
30	Residents are not allowed to have personal money.	0.94	0.06	1.94
31	The resident's personal belongings are catalogued.	0.96	0.04	1.96
32	Residents' personal effects are checked for forbidden items upon admission.	0.36	0.64	1.36
33	Residents' personal effects are checked for forbidden items periodically.	0.5	0.5	1.50
34	Residents cannot lock their personal effects.	0.31	0.69	1.31
35	Residents are restricted in displaying their personal effects and decorating their room.	0.84	0.16	1.84
36	Residents do not possess an adequate amount of clothes.	0.76	0.24	1.76
37	Residents are not allowed to park their vehicle next to the foster home (if they had a car).	0.16	0.84	1.16
38	Residents are not fully responsible for their own possessions.	0.85	0.15	1.85
Total		7.1	4.84	19.04
Mean				1.58
Rooms' items		False (2)	True (1)	Total
39	Residents cannot rest in bed during the day apart from naptime.	0.95	0.05	1.95
40	Caregiver/staff can enter the resident's room at any time.	0.35	0.65	1.35
41	Apart from the caregiver/staff persons of the opposite sex are not allowed in the resident's rooms at any time.	0.46	0.54	1.46
42	Residents are not allowed to smoke in their rooms.	0.02	0.98	1.02
43	Residents do not make their bed. They are made by the caregiver/staff.	0.92	0.08	1.92
Total		2.7	2.3	7.7
Mean				1.54
Health and hygiene items		False (2)	True (1)	Total
44	Residents are weighed on admission to the foster home.	0.72	0.28	1.72
45	Residents are weighed periodically.	0.75	0.25	1.75
46	Dressing is supervised by caregiver/staff.	0.26	0.74	1.26
47	Residents cannot lock the door while they are in the toilet.	0.85	0.15	1.85
48	Residents cannot lock the door while they are in the shower.	0.81	0.19	1.81
49	Residents cannot choose themselves when to take a bath or shower.	0.78	0.22	1.78
50	Residents' bath or shower is supervised.	0.27	0.73	1.27
51	Residents do not wash their own clothes.	0.21	0.79	1.21
Total		4.65	3.35	12.65
Mean				1.58
52	Residents must ask the caregiver/staff to communicate with their family doctor.	0.18	0.82	1.18
53	A psychiatrist visits the residents routinely.	0.99	0.01	1.99
54	A hairdresser visits routinely the foster home to cut and style the resident's hair.	0.72	0.28	1.72
55	There are no resident-staff meetings held on a regular basis.	0.5	0.5	1.50
Total		2.39	1.61	6.39
Mean				1.59

Table III

Means for the HHPPS scales according to residential setting.

	In-patient	Hospital Unit	Hostels ¹	Group Homes ²	Foster Family	Supervised Apartment
House rules	4.00	5.10	4.90	6.11	7.50	
Activities – morning wake-up	4.84	4.80	4.90	5.65	7.50	
Health and hygiene	3.10	3.70	4.43	5.46	5.50	
Activities – curfew	3.16	4.10	4.38	3.97	5.50	
Personal effects	3.28	3.60	5.29	4.82	6.00	
Activities – night-time surveillance	3.00	3.10	3.19	3.81	5.00	
Meals	4.67	5.00	4.52	5.06	6.00	
Autonomy global scores	26.02	29.40	30.67	34.88	43.00	