

International Encyclopedia of Rehabilitation

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Residential Housing for Persons with Serious Mental Illness: The Fifty Year Experience with Foster Homes in Canada

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The provision of decent and affordable housing is one of the most important elements for integrating persons with serious mental illness into the community, and is fundamental to their recovery. Housing is a basic human right and a requirement for living in society. Over the past fifty years, a continuum of professionally controlled housing models has been developed for people with serious mental illness in several developed countries, including Canada and the United States. These housing models range from highly structured professionally staffed, to more autonomous arrangements, and include hostels, group homes, foster homes, and supervised apartments. For mental health consumers, placement into such housing is usually tied to the acceptance of formal mental health rehabilitation services, and the requirement of “graduating” along the housing continuum toward the goal of independent living in the community (Ministry of Health and Social Services 2005; Ridgway and Zipple 1990). Over time, alternative supported housing models linked to greater consumer choice in housing and more flexible rehabilitation support services, have evolved (Dorvil, Morin, Beaulieu, and Robert 2002; Hopper and Barrow 2003; Macpherson, Shepherd, and Edwards 2004; Nelson and Peddle, 2005).

In North America, the current trend is to advocate for supported housing where housing is separate from rehabilitation services, as numerous groups have been critical of the traditional housing system for persons with serious mental illness (Carling 1995; Ministry of Health and Social Services 2005; Nelson, Aubry, and Lafrance 2007; Sylvestre et al. 2005; Sylvestre, Nelson, Sabloff, and Peddle 2007; Trainor 2002). Foster homes, also known as board and care homes, have been a major target of this critique, as creating dependency for people rather than promoting their autonomy and recovery. While foster homes in Canada were flourishing by the 1960s amid the first wave of deinstitutionalization, foster homes came to be viewed in a negative light as a result of early, but influential, research. Murphy et al. (1972) described an absence of daytime activity in psychiatric foster homes, and asserted that they did little more than replicate institutional care models in communities.

In Québec, similar critiques prompted the Health Ministry to respond by taking on responsibility for the functioning and quality of Québec foster homes through specific legislation (Bill 120, Law respecting Health and Social Services) (Gouvernement du Québec 1995). An evaluation study of foster homes in Montreal, Canada, revealed that new foster homes were being developed as late as 2000 in order to accommodate bed closures in the major psychiatric hospitals (Piat, Ricard, and Lesage 2006). Even today, most of the mental health budget for residential rehabilitation services is allocated to traditional structured housing such as foster homes. There are 3841 persons with serious mental illness living in traditional structured housing in Montreal. While current mental health policy is advocating for more autonomous housing, with a recommendation of 50 places per 100,000 persons in

supervised apartments (Ministry of Health and Social Services 2005), foster homes remain an important residential option for people with psychiatric disabilities.

In 2007 there were 1979 persons living in 323 foster homes in Montreal. The average length of stay in a foster home is six years. Despite the rehabilitative focus of these facilities, and the rising expectations of caregivers; low turnover rates have been similarly reported elsewhere: in the US (Geller and Fisher, 1993), in Italy (de Girolamo et al. 2002) and in Britain (Trieman, Smith, Kendal, and Leff 1998). For all the above reasons foster homes continue to merit serious attention from researchers and rehabilitation service providers.

This chapter will focus on six themes related to the viability of foster homes in psychiatric rehabilitation: 1) the origins and evolution of foster homes as a residential milieu for persons with serious mental illness; 2) the values, qualities and skills of the non-professional foster home caregivers in relation to the professional mental health providers; 3) the forced partnership between foster home caregivers and professional mental health providers; 4) housing preferences among mental health consumers; 5) the role of families in mental health recovery for persons living in supervised, community housing; and 6) the future of foster homes in a recovery-oriented mental health system. Québec will be used as a case example.

Origins and evolution of foster homes

Adult psychiatric foster home care has its historical roots in Belgium, where over 600 years ago families in Gheel began taking mentally ill persons into their homes (Carpenter, 1978; Linn, Klett, and Caffey 1980; McCoin 1987). As Linn reports, the concept of caring for someone in a family environment spread to other European countries during the 1800s, and was introduced to the US in 1885. While US foster homes have tended to evolve toward private, for-profit housing services, Canadian foster homes are generally funded and operated as public community-based services (Trainor, in Pelletier, Piat, Côté, and Dorvil 2009).

Québec foster homes, also known as family-type residences, are important in the rehabilitation of persons with psychiatric disabilities. Foster homes are structured around a traditional, non-professional caregiving model which operates within an overarching structure of professional supervision and in close liaison with hospital-based multidisciplinary teams. In this “professional” model developed under Bill 120 (Gouvernement du Québec, 1995), mental health professionals (social workers, nurses) act as intermediaries between formal services and the foster homes, as well as between foster home caregivers and their residents (Dorvil, Guttman, Ricard and Villeneuve 1997). A case manager and a residential resource worker are assigned to each home. It is important to note that even though mental health professionals supervise foster homes in Québec, the non-professional caregivers who operate foster homes on a daily basis have remained outside of formal services, maintaining the original family-based mandate of their homes and a social model of community care. Foster homes are the usual first step in the housing continuum for persons emerging from psychiatric hospitals.

The values, qualities and skills of foster home caregivers

Non-professional foster home caregivers are usually women with experience as homemakers, who may house up to nine residents. Caregivers are increasingly expected to rehabilitate their residents and reintegrate them into the community. Although no specific training is required to become a caregiver; support groups and continuing education are offered. Foster home

caregivers are expected to work in collaboration with both hospital and community-based multi-disciplinary teams.

Piat et al. (2007, 2008) found that Quebec caregivers have their own “professional” or “vocational” standards and orientations to work. Caregivers articulate values grounded in the essential dignity of human life, and the individual’s right to respect and care. Despite their lack of formal education, or power and status in the mental health system, foster home caregivers combine the qualities of natural helpers with professional attributes that reflect self-awareness, intuitive ability and maturity. Caregivers describe their skills as a balance between authority and egalitarianism, as well as rationality, mental preparedness, flexibility and a good heart. One caregiver summarized these qualities as “the tools of being human.” The majority of caregivers operate foster homes more for altruistic motives than for profit (Blaustein and Viek 1987; Mousseau-Glaser 1988; Rhoades and McFarland 1999, 2000).

Caregivers describe themselves as both parents and rehabilitation agents for their residents (Piat et al. 2004). Caregivers claim that they are “professionals” in their own right, as they are uniquely positioned to make accurate assessments of resident needs based on a more intimate acquaintance with them than is possible within professional-client relationships. As well, foster home caregivers claim that they are in the best position to provide a first response in crisis situations. In short, caregivers consider themselves the “real frontline workers” vis-à-vis professional mental health providers (Piat, Ricard et al. 2008).

Working conditions for caregivers in Québec are less than ideal. While caregiving offers advantages such as a flexible schedule, the possibility to be one’s own boss, learning opportunities, and the rewards of seeing good results with residents, foster home caregiving also involves a 24/7 time commitment and considerable responsibility, accompanied by high levels of stress and burden (Karp and Tanarugsachock 2000; Olshevski, Katz, and Knight, 1999; Stengard, Honkonen, Koivisto, and Salokangas 2000). Although foster home caregivers are paid per diem for supporting adults with serious mental illness in their homes, they lack formal accreditation as mental health workers. They have no job security; are not part of the hospital multidisciplinary teams that oversee their work, and lack official representation at a governmental policy level. Ongoing deinstitutionalization has exacerbated these difficulties due to the discharge of patients with increasingly complex psychiatric and physical problems into foster homes. As well, caregivers have reported that foster home residents are being pressured to accept premature relocation to more autonomous supervised apartments, creating another source of stress for both residents and caregivers (Piat, Ricard, Lesage, and Trottier 2005). Caregivers assert that hospital and community resources and support services for them, including respite services, are insufficient. The transformation of residential services to more autonomous housing models is challenging foster home caregivers to move beyond a focus on social protection and to acquire rehabilitation skills, yet with very little return, or recognition, for their efforts.

The forced partnership between caregivers and professional mental health providers

The notion of partnership has been a major thrust in the orientation and reorganization of mental health services in Quebec (Fleury, Tremblay, Nguyen, and Bordeleau, 2007; White and Mercier 1989; 1991). Partnership refers to coordination between mental health consumers, families, service providers, and government in the planning and delivery of mental health services. Since 1989, mental health policies have promoted the extension of

professional involvement beyond formal healthcare institutions to include partnerships between professionals and non-professionals, without specifying the partnership roles and responsibilities of each entity (Beal, Crawford, and O'Flaherty 1997). In encouraging mental health rehabilitation workers to adopt the partnership vision, Québec's mental health policy further promoted the recognition of open, mutual communication, and the adoption of common objectives among individuals and sectors. Underpinning the reforms of the 1990s was the assumption that the new terminology of partnership would automatically translate into good will and enthusiasm on the part of mental health workers.

Partnership remains a key concept in current mental health strategies (Israel, Schulz, Parker, and Becker 1998; MacGillivray and Nelson 1998; Mental Health Commission of Canada 2009; Ministry of Health and Social Services 2005; The National Consumer Advisory Council (NCAC) 2006; Wendel, Burdine, and McLeroy 2007), despite important critiques of its implementation in both formal and informal sectors of the mental health system (Boudreau 1998; Dorvil et al. 1997; Everett 2000; Lamoureux 1994; Panet-Raymond 1991; Twigg 1989; White and Mercier 1991).

Difficulties in relationships between non-professional foster home caregivers and mental health professionals, reported earlier by Moxley and Keefe (1988), have also been documented in a series of more recent studies on the partnership between mental health professionals and foster home caregivers in Quebec. Research by Piat et al. (2005) on the perspectives of foster home caregivers toward the transformation of the mental health system to a professional model reveals an awareness among caregivers of rising expectations with regard to their work. Specifically, caregivers are now required to develop the autonomy of residents living in their homes. Caregivers have begun to take part in multidisciplinary team meetings involving individual planning for residents, and to work on social reintegration and rehabilitation activities with residents.

Reactions of foster home caregivers to their new roles have been mixed. In a positive sense, caregivers report that these reforms validate the work they are already doing, promise a better quality of life for residents, and give themselves, as non-professionals, an opportunity for self-affirmation vis-à-vis licensed, professional workers. The changes also allow caregivers to advocate for greater voice in decisions regarding which prospective residents they accept, or refuse, in their homes. On the negative side, caregivers are concerned about their increasing responsibilities for "heavier patients" combined with insufficient services, and other resources such as respite.

Other research has reported difficulties in relationships between non-professional caregivers and their supervising professionals on multidisciplinary teams, from the perspectives of both groups (Piat et al. 2004; Piat, Ricard, Lesage, Trottier et al. 2005). The overall picture that emerged was that forced partnerships between caregivers and other members of the health and social services network were fraught with daily frustrations and disillusionment for everyone. The authors conclude that improved relationships between formal and informal partners in the adult foster home system would depend upon a more precise and comprehensive description of the tasks, responsibilities, and rights of foster home caregivers and their supervisors, as well as improvements in working conditions for non professional caregivers, including more adequate financial recognition of their work.

Housing preferences among mental health consumers

Housing has different meanings and functions for individuals with psychiatric disabilities. Research supports the view that no single housing model can successfully accommodate everyone, and that a range of housing and support services is required (Bond, Salyers, Rollins, Rapp, and Zipple 2004; Canadian Mental Health Association (CMHA) 2004; Chilvers, Macdonald, and Hayes 2008; Fakhoury, Murray, Shepherd, and Priebe 2002; Rog 2004). While some studies on autonomous supported housing show positive outcomes, other studies have found that independent living may also lead to isolation and loneliness (Browne and Courtney 2005; Morin, Robert, and Dorvil 2001; Nelson 2004; Walker and Seasons 2002).

From the consumer perspective, independent living is consistently preferred over traditional, structured residential services (Browne & Courtney, 2005; Gélinas, Lesage, & Bisson, 2000; Keck, 1990; Ogilvie, 1997; Palmer et al., 2000; Srebnik, Livingston, Gordon, & King, 1995; Tanzman, 1993; Thomas, 1987). In a study of housing preferences based on a sample of 315 persons living in heavily supervised housing services, Piat et al (2008) found that 44% of consumers interviewed would prefer to live in their own apartment without subsidies. Social housing (18%) and supervised apartments (15%) followed in popularity. By contrast, while 26% of case managers preferred supervised apartments for their clients, over half preferred traditional housing arrangements, such as foster homes (25%), group homes (15%) and hostels (12%). This comparison of housing preferences between consumers and case managers reveals that, whereas consumers favoured more autonomous housing as the ideal arrangement, case managers were more conservative and preferred a gradualist approach along the traditional housing continuum.

It should be emphasized that the personal, subjective views of mental health consumers with regard to housing preferences and housing satisfaction are particularly important. Persons with serious mental illness are usually able to reliably evaluate and report on their quality of life (Voruganti, Heslegrave, Awad, and Seeman 1998), of which housing is an important element. As Warner (1999) cautions, objective circumstances do not necessarily predict subjective evaluations of those circumstances, and vice versa. Hence, Nelson, commenting on housing satisfaction studies conducted in Ontario, Canada, reported that residents of boarding homes rated their subjective quality of life higher than did people living in alternative apartments and group homes, and further suggested that their dissatisfaction may be a motivator for further recovery (Nelson, in Pelletier et al. 2009).

The role of families in mental health recovery for persons living in supervised, community housing

In some countries, the presence of an effective and available social support system outside residential services, such as family, is a key factor in decisions to discharge mental health consumers into more independent accommodations (de Girolamo et al. 2005); while in other countries, such as Canada, families of persons with mental illness decry their exclusion from treatment and decision making processes (Kirby 2008). Influential research on expressed emotion has described family involvement as problematic for persons with serious mental illness (e.g., Bebbington and Kuipers 1994; Vaughn and Leff 1981) leading to a consideration of family as a “second client”, and development of a myriad of psycho-education, training and stress management programs for family caregivers (Drapalski, Leith, and Dixon 2009; Watkins 2007). While some research has pointed to the importance of neighbourhood ties for integrating residents of supervised housing into their communities, and minimizing social

isolation (Aubry, Tefft, and Currie 1995; Cook 1998), the family as a link to the wider community has been largely ignored. By contrast, an appreciation of family as important for mental health outcomes is increasingly recognized in research grounded in a recovery perspective, although not necessarily in relation to housing (Corrigan and Phelan 2004; Deegan 1988; Mancini, Hardiman, and Lawson 2005; Moos and Moos 2007; Pernice-Duca 2010).

In the context of an ongoing multisite study on housing and recovery from serious mental illness, Piat et al. (2010) asked residents of supported housing facilities in Montreal the question: “Who believes most in you and in your recovery?” Against all expectations, family members were identified by nearly 40% of the sample, more frequently than mental health professionals (21%), friends (18%), non-professional caregivers (14.5%) or others. Families were cited for their unwavering conviction that their loved ones would recover from mental illness, and expressed their support by: 1) providing affection and a sense of belonging; 2) offering emotional and material support; and 3) staying actively involved, often through advocacy activities. These results were consistent across housing types regardless of the level of supervision provided.

Housing and recovery: Is there a future for foster homes?

While we speak about “recovery-oriented services” in mental health, recovery is not about identifying the ideal housing type, but about developing a particular mindset among service providers, and mental health consumers, toward mental health services in general. Recovery-oriented care is person-directed, meaning that care is based on the person’s own goals, priorities and life circumstances as expressed through an individualized recovery plan. Recovery planning must be the result of collaboration and shared decision-making between mental health consumers and providers (Connecticut Department of Mental Health and Addiction Services 2007; Deegan and Drake 2006; National Social Inclusion Programme 2007; New Zealand Mental Health Commission 2004; Ontario Ministry of Health and Long Term Care 2009). Evidence for the importance of individualized planning has also been obtained in a randomized controlled trial of one psychiatric rehabilitation approach (Gigantesco et al. 2006). With respect to housing, recovery-oriented service requires that consumers choose their own living environments and become actively involved in planning, and evaluating, their own housing (Carling and Allott 2000; Cohen and Anthony 1988; Glass, 1995; Gustafson 1991; Lebow 1983; Lord, Schnarr, and Hutchinson 1987; Rapp, Shera, and Kisthardt 1993; Warren 2000).

What emerges from research on housing preferences is the urgent need for recovery training, and for a shift in the mindset of mental health professionals toward their work with people in recovery. Provider decision making in housing continues to be based on knowledge of clients’ clinical characteristics (often deficit-based), on risk avoidance, and on the presumption of professional expertise. As well, mental health professionals tend to automatically prefer housing that is part of the formal health and social service network, as opposed to community-based housing alternatives for their clients, as professionals are more familiar with mainstream, traditional housing services, and exercise a certain amount of control over them. The idea of allowing consumers to choose their housing, and supporting more autonomous housing models for consumers, is gradually becoming part of the mainstream professional culture in mental health care.

Ongoing research on housing and recovery reveals that recovery for people with serious mental illness is not linked exclusively to autonomous housing models, but is primarily about

people building a life of their own wherever they live. For some, recovery means living alone, whereas for most, recovery means living with significant others. People with psychiatric disabilities demonstrate considerable skill at weighing up the benefits and drawbacks of different living arrangements. Earlier research by Piat et al. (2008) on the decision making process around staying in a foster home versus moving on, revealed competing views of the foster home: some residents considered the foster home as a “springboard” to more independent living, whereas those faced with poor physical health or advancing age saw their foster home as a secure living arrangement. Current research suggests that mental health consumers presented with different housing possibilities do a careful cost-benefit analysis of their current homes in terms of overall quality of life, services, and relational issues. Very often, simple economics tells them they can’t live on their own.

Both mental health providers working in residential services, and non-professional caregivers, need to shift away from protective or negative attitudes toward their clients as passive recipients of care in all life domains. The ultimate purpose of residential services for persons with psychiatric disabilities is to serve as a launching point for people journeying from the client role to a citizen role through the medium of housing, as well as through education and work opportunities. This is the continuum of recovery. From this perspective, foster homes are no less likely to promote recovery than other housing models, as long as living in a foster home reflects a valid consumer choice, and meets the specific requirements of advancing recovery for each individual.

References

- Aubry TD, Tefft B, Currie RF. 1995. Public attitudes and intentions regarding tenants of community mental health residences who are neighbours. *Community Mental Health Journal* 31(1): 39-52.
- Beal G, Crawford E, O'Flaherty P. 1997. La création de partenariats: perspectives et possibilités. *Santé mentale au Québec* 22: 154-169.
- Bebbington P, Kuipers L. 1994. The predictive utility of expressed emotion in schizophrenia: An aggregate analysis. *Psychological Medicine* 24(3): 707-718.
- Blaustein M, Viek C. 1987. Problems and needs of operators of board-and-care homes: a survey. *Hospital and Community Psychiatry* 38(7): 750-754.
- Bond GR, Salyers MP, Rollins AL, Rapp CA, Zipple AM. 2004. How evidence-based practices contribute to community integration. *Community Mental Health Journal* 40(6): 569-588.
- Boudreau F. 1998. Partnership as a new strategy in mental health policy: The case of Quebec. In: D Coburn, C D'Arcy, G Torrance, editors. *Health and Canadian society: sociological perspectives*. 3rd edition. Toronto: University of Toronto Press. p. 495-516.
- Browne G, Courtney M. 2005. Housing, social support and people with schizophrenia: A grounded theory study. *Issues in Mental Health Nursing* 26(3): 311-326.

- Canadian Mental Health Association (CMHA). 2004. Housing, health, and mental health. Retrieved from http://www.cmha.ca/data/1/rec_docs/116_election_housing.pdf
- Carling PJ. 1995. Return to community. Building support systems for people with psychiatric disabilities. New York: The Guilford Press.
- Carling PJ, Allott P. 2000. Assuring quality housing and support for Walsall residents with mental health needs: An action research report. Birmingham: University of Central England in Birmingham, Centre for Mental Health Policy.
- Carpenter MD. 1978. Residential placement for chronic psychiatric-patient - review and evaluation of literature. *Schizophrenia Bulletin* 4(3): 384-398.
- Chilvers R, Macdonald GM, Hayes AA. 2008. Supported housing for people with severe mental disorders (Review). *The Cochrane Library* (4): CD000453.
- Cohen M, Anthony W. 1988. A commentary on planning a service system for persons who are severely mentally ill: Avoiding pitfalls of the past. *Psychosocial Rehabilitation Journal* 12(1): 69-72.
- Connecticut Department of Mental Health and Addiction Services. 2007. Practice Guidelines for Recovery-Oriented Behavioral Healthcare.
- Cook JR. 1998. Interactions between group homes and neighbors: Neighbor preferences. *Journal of Behavioural Health Services and Research* 25(4): 425-436.
- Corrigan PW, Phelan SM. 2004. Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal* 40(6): 513-523.
- de Girolam G, Picardi A, Micciolo R, Falloon I, Fioritti A, Morosini P. 2002. Residential care in Italy. National survey of non-hospital facilities. *British Journal of Psychiatry* 181: 220-225.
- de Girolamo G, Picardi A, Santone G, Falloon I, Morosini P, Fioritti A, et al. 2005. The severely mentally ill in residential facilities: A national survey in Italy. *Psychological Medicine* 35(3): 421-431.
- Deegan PE. 1988. Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal* 11(4): 11-19.
- Deegan PE, Drake RE. 2006. Shared decision making and medication management in the recovery process. *Psychiatric Services* 57(11): 1636-1639.
- Dorvil H, Guttman H, Ricard N, Villeneuve A. 1997. 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: Gouvernement du Québec, Ministère de la santé et des services sociaux.

- Dorvil H, Morin P, Beaulieu A, Robert D. 2002. Housing as a social integration factor for people classified mentally ill. *Le Logement comme facteur d'integration sociale pour les personnes classees malades mentales* 26(4): 497-515.
- Drapalski AL, Leit J, Dixon L. 2009. Involving families in the care of persons with schizophrenia and other serious mental illnesses: History, evidence, and recommendations. *Clinical Schizophrenia and Related Psychoses* 3(1): 39-49.
- Everett B. 2000. *A fragile revolution. Consumers and psychiatric survivors confront the power of the mental health system.* Waterloo: Wilfrid Laurier Press.
- Fakhoury WK, Murray A, Shepherd G, Priebe S. 2002. Research in supported housing. *Social Psychiatry and Psychiatric Epidemiology* 37(7): 301-315.
- Fleury MJ, Tremblay M, Nguyen H, Bordeleau L. 2007. *Le système sociosanitaire au Québec: gouvernance, régulation et participation.* Montréal: Gaetan Morin Editeur.
- Gélinas D, Lesage A, Bisson J. 2000. Identification of housing resources and modalities of follow-up required to undertake psychiatric treatment in an ambulatory context at Charles LeMoynes Hospital [in French]. Greenfield Park, Québec: Charles LeMoynes Hospital, Louis-H. Lafontaine Hospital.
- Geller JL, Fisher WH. 1993. The linear continuum of transitional residences: debunking the myth. *American Journal of Psychiatry* 150(7): 1070-1076.
- Gigantesco A, Vittorielli M, Pioli R, Falloon IR, Rossi G, Morosini P. 2006. The VADO approach in psychiatric rehabilitation: A randomized controlled trial. *Psychiatric Services* 57(12): 1778-1783.
- Glass A. 1995. Identifying issues important to patients on a hospital satisfaction Questionnaire. *Psychiatric Services* 46(1): 83-85.
- Gouvernement du Québec. 1995. *Loi modifiant la loi sur les services de santé et les services sociaux.* Québec: Éditeur officiel du Gouvernement du Québec.
- Gustafson D. 1991. Expanding the role of patient as consumer. *Quality Review* 17: 324-325.
- Hopper K, Barrow SM. 2003. Two genealogies of supported housing and their implications for outcome assessment. *Psychiatric Services* 54(1): 50-54.
- Israel BA, Schulz AJ, Parker EA, Becker AB. 1998. Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health* 19: 173-202.
- Karp DA, Tanarugsachock V. 2000. Mental illness, caregiving, and emotion management. *Qualitative Health Research* 10(1): 6-25.
- Keck J. 1990. Responding to consumer housing preferences: The Toledo experience. *Psychosocial Rehabilitation Journal* 13(4): 51-58.

- Kirby M. 2008. Mental health in Canada: Out of the shadows forever. *Canadian Medical Association Journal (CMAJ)* 178(10): 1320-1322.
- Lamoureux J. 1994. Le partenariat à l'épreuve.
- Lebow J. 1983. Research assessing consumer satisfaction with mental health treatment. A review of findings. *Evaluation and program planning* 6: 211-236.
- Linn MW, Klett CJ, Caffey EM, Jr. 1980. Foster home characteristics and psychiatric patient outcome. The wisdom of Gheel confirmed. *Archives of General Psychiatry* 37(2): 129-132.
- Lord J, Schnarr A, Hutchinson P. 1987. The voice of the people: Qualitative research and the needs of consumers. *Canadian Journal of Community Mental Health* 6(2): 25-36.
- MacGillivray H, Nelson G. 1998. Partnership in mental health: What it is and how to do it. *Canadian Journal of Rehabilitation* 12(2): 71-83.
- Macpherson R, Shepherd G, Edwards T. 2004. Supported accommodation for people with severe mental illness: A review. *Advances in Psychiatric Treatment*, 10(3): 180-188.
- Mancini MA, Hardiman ER, Lawson HA. 2005. Making sense of it all: Consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal* 29(1): 48-55.
- McCain J.M. 1987. Adult foster care: Past, present, and future. *Adult Foster Care Journal* 1(3): 170-180.
- Mental Health Commission of Canada. 2009. Toward recovery and well-being. A framework for a Mental Health Strategy for Canada.
- Ministry of Health and Social Services. 2005. Plan d'action en santé mentale. La force des liens. Québec: Ministry of Health and Social Services.
- Moos RH, Moos BS. 2007. Protective resources and long-term recovery from alcohol use disorders. *Drug and Alcohol Dependence* 86(1): 46-54.
- Morin P, Robert D, Dorvil H. 2001. Housing as a factor for social integration of persons classified mentally ill and persons classified as intellectually impaired [in French]. In: H Dorvil, P Morin, editors. *Nouvelles pratiques sociales: Le logement social et l'hébergement*. Volume 14, number 2. Ste-Foy, Québec: Presses de l'Université du Québec. p. 88-105
- Mousseau-Glaser M. 1988. Les Responsables de Familles d'Accueil pour Adultes et Jeunes Adultes : Leur Motivation, leurs Perspectives et leur Vécu. Montreal: McGill University.
- Moxley DP, Keefe MJ. 1988. Factors influencing the satisfaction of residential providers with the services of a central administrative agency. *Adult Foster Care Journal* 2(3): 185-201.

- Murphy HBM, Pennee B, Luchins DJ. 1972. Foster homes: The new back wards? Canada's Mental Health, Supplement 71(Sept-Oct 1972).
- National Social Inclusion Programme. 2007. Capabilities for inclusive practice. London: Department of Health.
- Nelson G. 2004. Shifting the paradigm in housing and mental health. From institutions to housing to homes. Waterloo: Wilfred Laurier University.
- Nelson G, Aubry T, Lafrance A. 2007. A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry* 77(3): 350-361.
- Nelson G, Peddle S. 2005. Housing and support for people who have experienced serious mental illness: Value base and research evidence. Ottawa: Centre for Research on Community Services, Université d'Ottawa.
- New Zealand Mental Health Commission. 2004. Our lives in 2014. Wellington.
- Ogilvie RJ. 1997. The state of supported housing for mental health consumers: a literature review. *Psychiatric Rehabilitation Journal* 21(2): 122-131.
- Olshevski JL, Katz AD, Knight R. 1999. Stress Reduction for Caregivers. Philadelphia: Brunner/Mazel.
- Ontario Ministry of Health and Long Term Care. 2009. Every door is the right door. Towards a 10-year mental health and addictions strategy. A discussion paper.
- Palmer HP, Macfarlane D, Stuart H, Durbin J, Cochrane J, Goering P. 2000. Kingston Psychiatric Hospital comprehensive assessment project final report. Kingston, Ontario: Kingston Psychiatric Hospital.
- Panet-Raymond J. 1991. Partnership between state and voluntary organizations in Quebec: myth or reality? *The Community Development Journal* 1-15.
- Pelletier JF, Piat M, Côté S, Dorvil H. 2009 . Hébergement, logement et rétablissement en santé mentale : Pourquoi et comment faire évoluer les pratiques? Volume 42. Québec: Presse de l'Université du Québec, collection Problèmes sociaux et interventions sociales.
- Pernice-Duca F. 2010. Family network support and mental health recovery. *Journal of Marital and Family Therapy* 36(1): 13-27.
- Piat M, Lesage A, Boyer R, Dorvil H, Couture A, Bloom D. 2008. Housing for persons with serious mental illness: Consumer and service provider perspectives. *Psychiatric Services* 59(9): 1011-1017.

- Piat M, Perreault M, Lacasse D, Ioannou S, Pawliuk N, Bloom D. 2004. Stakeholder perspectives on psychiatric foster homes: Residents, families, caregivers, and professionals. *Psychiatric Rehabilitation Journal* 27(3): 228-234.
- Piat M, Ricard N, Lesage A. 2006. Evaluating life in foster homes for persons with serious mental illness: Resident and caregiver perspectives. *Journal of Mental Health* 15(2): 227-242.
- Piat M, Ricard N, Lesage A, Trottier S. 2005. Le point de vue des responsables des ressources de type familial sur les transformations des services de santé mentale au Québec. *Santé mentale au Québec* 30(2): 209-231.
- Piat M, Ricard N, Lesage A, Trottier S, Vachon N, Crago B, et al. 2005. Le point de vue de travailleuses sociales sur le partenariat entre les responsables de résidences d'accueil et le réseau de la santé et des services sociaux du Québec. *Revue canadienne de service social* 22(2).
- Piat M, Ricard N, Sabetti J, Beauvais L. 2007. The values and qualities of being a good helper: A qualitative study of adult foster home caregivers for persons with serious mental illness. *International Journal of Nursing Study* 44(8): 1418-1429.
- Piat M, Ricard N, Sabetti J, Beauvais L. 2008. From the real frontline: The unique contributions of mental health caregivers in Canadian foster homes. *Health and Social Work* 33(1): 43-53.
- Piat M, Ricard N, Sabetti J, Beauvais L. 2008. Building life around the foster home vs. moving on: The competing needs of people living in foster homes. *Psychiatric Rehabilitation Journal* 32(1): 32-39.
- Piat M, Boyer R, Fleury MJ, Lesage A, Sabetti, J. 2010. The role of families as “primary believers” in recovery from serious mental illness: Perspectives of mental health consumers living in supervised community housing (manuscript in preparation).
- Rapp CA, Shera W, Kisthardt W. 1993. Research strategies for consumer empowerment of people with severe mental illness. *Social Work* 38(6): 727-735.
- Rhoades DR, McFarland KF. 1999. Caregiver meaning: A study of caregivers of individuals with mental illness. *Health and Soc Work* 24(4): 291-298.
- Rhoades DR, McFarland KF. 2000. Purpose in life and self-actualization in agency-supported caregivers. *Community Mental Health Journal* 36(5): 513-521.
- Ridgway P, Zipple A. 1990. The paradigm shift in residential services: From the linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal* 13(4): 11-31.
- Rog DJ. 2004. The evidence on supported housing. *Psychiatric Rehabilitation Journal* 27(4): 334-344.

- Srebnik D, Livingston J, Gordon L, King D. 1995. Housing choice and community success for individuals with serious and persistent mental illness. *Community Mental Health Journal* 31(2): 139-151.
- Stengard E, Honkonen T, Koivisto AM, Salokangas RK. 2000. Satisfaction of caregivers of patients with schizophrenia in Finland. *Psychiatric Services* 51(8): 1034-1039.
- Sylvestre J, Nelson G, Durbin J, George L, Aubry T, Ollenberg M. 2005. Housing for people with serious mental illness: Challenges for system-level development.
- Sylvestre J, Nelson G, Sabloff A, Peddle S. 2007. Housing for people with serious mental illness: A comparison of values and research. *American Journal of Community Psychology* 40(1-2): 125-137.
- Tanzman B. 1993. An overview of surveys of mental health consumers' preferences for housing and support services. *Hospital and Community Psychiatry* 44(5): 450-455.
- The National Consumer Advisory Council (NCAC). 2006. Power imbalance, paternalism, partnerships, and letting go. *Journal*. Retrieved from http://www.cmha.ca/data/1/rec_docs/1336_Power%20Paternalism%20and%20Partnerships.pdf
- Thomas JE. 1987. A study of expatients' perspectives on their housing experiences and options. *Smith College Studies in Social Work* 57(3): 199-217.
- Trainor J. 2002. Housing discussion paper. Toronto: Centre for Addiction and Mental Health.
- Trieman N, Smith HE, Kendal R, Leff J. 1998. The TAPS Project 41: homes for life? Residential stability five years after hospital discharge. Team for the Assessment of Psychiatric Services. *Community Mental Health Journal* 34(4): 407-417.
- Twigg J. 1989. Models of Carers : How do social care agencies conceptualise their relationship with informal carers? *Journal of Social Policy* 18(1): 67-89.
- Vaughn CE, Leff JP. 1981. Patterns of emotional response in relatives of schizophrenic patients. *Schizophrenia Bulletin* 7(1): 43-44.
- Voruganti L, Heslegrave R, Awad AG, Seeman MV. 1998. Quality of life measurement in schizophrenia: Reconciling the quest for subjectivity with the question of reliability. *Psychological Medicine* 28(1): 165-172.
- Walker R, Seasons M. 2002. Supported housing for people with serious mental illness: Resident perspectives on housing. *Canadian journal of community mental health* 21(1): 137-151.
- Warner R. 1999. The emics and etics of quality of life assessment. *Social Psychiatry and Psychiatric Epidemiology* 34(3): 117-121.

- Warren. 2000. An exploratory investigation into the housing preferences of consumers of mental health services. *Australian and New Zealand Journal of Mental Health Nursing* 9: 195-202.
- Watkins P. 2007. The family dimension of recovery. In *Recovery. A guide for mental health practitioners*. Elsevier.
- Wendel ML, Burdine JN, McLeroy KR. 2007. The evolving role of partnerships in addressing community public health issues: Policy and ethical implications. *Organizational Ethics* 4(1): 53-64.
- White D, Mercier C. 1989. Ressources alternatives et structures intermédiaires dans le contexte québécois. *Santé mentale au Québec* 14(1): 69-80.
- White D, Mercier C. 1991. Coordinating community and public-institutional mental health services: Some unintended consequences. *Social Science and Medicine* 33(6): 729-739.