Silver Empowerment

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1. Introduction

Most care for older persons who are ill or disabled is provided by informal caregivers (Suanet et al., 2012). Many of these informal caregivers provide care in ‘mixed care arrangements’, together with formal care services. As in many other European countries, there is a growing awareness of the importance of the role of informal caregivers and the necessity of ensuring adequate support in Flanders (Belgium). A strengthening environment and sufficient resources are vital for the process of empowerment and the resilience of informal caregivers and older persons (Janssen et al., 2011; Sakanashi & Fujita, 2017). As Chapter 1 pointed out, resilience can be defined as ‘patterns and processes of positive adaptation and development in the context of significant threats to an individual’s life or function’ (Janssen, 2013, p. 21). Empowering informal caregivers, for instance by acknowledging them as an equal partner in the care team, strengthens their resilience. Formal care can provide respite for the informal caregiver and specialised care an informal caregiver does not have the formation for. Working together in a partnership can be a ‘win’ for all those involved, including formal caregivers.

However, there are several barriers for persons with care and support needs and their informal caregivers to make use of formal support. Some studies (e.g. De Koker, 2018) even associate the presence of formal support with greater burdens on informal caregivers. In this chapter, we explore this ‘support paradox’ and its caveats to overcome this. Informal care is not
only provided by family caregivers. Neighbours and, more broadly, citizen initiatives for care are gaining importance as well (de Jong et al., 2014). We also explore how formal care can collaborate with these ‘new forms’ of informal care, taking into account their specific nature. In this case as well as with family caregiving, the well-intended logic of the health and welfare sector taking over andfitting the initiatives into the traditional structure of formal care (with planning, steering, regulations, etc.) should be avoided.

The Covid-19 pandemic posed several challenges for informal caregivers and the interplay between formal and informal care. We discuss some recent studies in Flanders on this topic and the implications for policy and practice.

2. Informal caregiving in Flanders, Belgium from an international perspective

In Belgium, there is a growing awareness of the importance of informal care for the long-term care system. Informal care is considered an intrinsically valuable social phenomenon and a prerequisite for ageing in place. Public authorities in Belgium have been advocating an active policy of support for informal caregivers (Criel et al., 2014). As a consequence, in 2016 the first policy plan for informal care (2016–2020) was launched.

According to data from the European Quality of Life Survey, 30 per cent of adults in Belgium self-report as informal caregivers. This is the highest prevalence in the EU, after Greece. Also, the biggest difference between men and women is found in Belgium, where 13 per cent more women than men provide care (Zigante, 2018). Figure 5.1 demonstrates that when it comes to the intensity of caregiving, Belgian caregivers spend on average eleven hours a week on their caregiving tasks. In all countries, the intensity of caregiving has increased over the years.

From an international perspective, the use of formal home-care services among older people in Flanders is also high. In a comparison of eleven European countries, Suanet et al. (2012) report that Belgium has the highest percentage of older people combining formal and informal care – around 13 per cent. Stated reasons include the high availability of home-based services as well as a relatively strong familial culture (Suanet et al., 2012). In general, the Belgian long-term care system is a mixed system with extensive and diverse publicly financed formal care services. The system is also characterised by freedom of choice. Many organisations of diverse political or religious backgrounds are involved in home care within the same geographic area, and users are free to select the organisation they want to receive care from (De Almeida Mello, 2018; De Koker, 2018). This has advantages, but it also renders
communication and coordination of care more difficult and complicated. Integrated care and continuity of care therefore become important elements of quality. A coordinated follow-up is essential for creating, updating and evaluating the care plans at different times and by different care professionals (De Almeida Mello, 2018). Collaboration between formal and informal actors in a broad sense is also important to provide proactive integrated care and to make sure that care is tailored to the individual needs of care recipients (Gobbens, 2017; De Witte & Van Regenmortel, 2019).

### 3. Conceptual framework

The interplay between formal and informal care is a topic of increasing research attention. Many studies have focused on patterns of service usage among older persons and the question whether the two types of care function as complements or rather as substitutes (e.g. Geerts & Van den Bosch, 2012; Litwin & Attias-Donfut, 2009). Less attention has been paid to the perceptions of informal caregivers with regard to the use of formal services and how this relates to their empowerment. Insight into these experiences is, however, essential for being able to offer services that are suited to the needs of both clients and their caregivers as well as to create a supportive environment.
In their literature review, Sakanashi and Fujita (2017, p. 2) mention the support of professionals as a major factor for promoting empowerment in family caregivers. Empowerment for family caregivers is defined by these authors as

*positive control of one’s mind and body, cultivating a positive attitude, proactively attempting to understand one’s role as a caregiver to improve caregiving capabilities, focusing on others as well as oneself, supporting the independence of the care-receiver, and creating constructive relationships with other people surrounding them.* (Sakanashi & Fujita, 2017, p. 2)

While Sakanashi and Fujita focus on the micro level and on empowering relationships, it is just as important to take into account the contextual domain. On a broader political-societal level, the accessibility of care, the availability of material resources and social policy are crucial to promote empowerment (Janssen et al., 2011).

Caregiving is a dynamic process that is based in relationships (Büscher et al., 2011; Lindahl et al., 2010). The interplay between formal and informal care has been described as a process of ‘negotiating helpful action’ (Büscher et al., 2011). Sims-Gould and Martin-Matthews (2010) developed a conceptual ‘triadic’ model to include the interactive nature of care provision. The relationship between the caregiver and professional is defined as ‘assistive care’, while care provided by formal home-care workers to the person in need of care is defined as ‘direct care’. With regard to direct care, it is clear that care recipients are not passive receivers of formal support. Assistive care also is a bidirectional relationship that can benefit both informal caregivers and formal caregivers. In a triadic approach, all three roles are acknowledged and valued in terms of associated responsibilities and needs. Each party ‘brings to the equation a dedication to participate as a respectful and valuable care team member’ (Talley & Crews, 2007, p. 227).

Informal caregiving is also often studied from a stress-theoretical perspective. This implies that formal services are also assumed to be a source of support for informal caregivers (De Koker, 2018). It is often hypothesised that an increased use of formal services will reduce caregiver burden and alleviate the negative effects of caregiving (Yates et al., 1999). The relationship between the presence of formal home-care services and caregiver outcomes, however, is not straightforward. Formal home care apparently does not automatically result in ‘relief’ or a lower burden for informal caregivers (De Koker, 2018; Roelands et al., 2008; Wiles, 2003). Quantitative studies (including in Flanders) have reported that the perceived burden of informal care...
caregivers can even be higher when formal services are in place than when they are not (De Koker, 2018; Sussman & Regehr, 2009). There are several reasons for why this might be the case. First, it could be that caregiver burden prompts (rather than results from) the use of formal help. Previous studies that considered the impact of caregiver burden as a risk factor for the use of formal community services have found that caregivers sometimes exhaust their resources before turning to formal help. Second, the methodological quality of existing research has been criticised, with major issues including the failure to examine multiple outcome variables, the lack of differentiation between types of services and the need to identify moderators of intervention effectiveness (Sörensen et al., 2002). Third, Nolan et al. (2003) argue that a predominant focus on stress and burden is too narrow, overlooking aspects of caregiving dynamics and the interplay between formal and informal care. In the next section, we will turn to this ‘support paradox’ in more detail.

4. Support paradox

A central theme in the study by De Koker (2018) is the ‘ambivalence’ of informal caregivers regarding the use of formal home care. In this study, focus groups with spouses and adult children providing care for an older person, while also using formal support, showed that formal support can be helpful for informal caregivers by providing task relief, temporary respite and assurance. At the same time, such services confront informal caregivers with negative consequences, especially a loss of privacy and autonomy as well as the need to monitor the quality of care. This can be perceived as stressful, especially for co-residing caregivers. Home is a private space in which people can live according to their own habits and wishes (Lindahl et al., 2010). Given that home care involves having ‘strangers’ come into the home and provide services (often of an intimate nature), it presents a challenge to all those involved. Starting to use formal support represents a significant and often difficult transition for both clients and informal caregivers. Many caregivers in the De Koker’s study (2018) reported having felt resistance on the part of the care recipient to bringing in ‘help from outside’. The caregivers found it difficult to cope with this resistance, as they wished to respect the preferences of their parents or spouses. Several caregivers mentioned they had experienced the introduction of formal support as a failure. They felt as if they were abandoning the older person and they had failed to live up to the expectations of being a ‘good’ spouse or child. Third parties (e.g. other family members, healthcare practitioners and social workers) played an important
role in overcoming this resistance. People who insisted on the use of outside assistance were helpful in the process of acknowledging the need for formal support for both caregivers and older people. Sharing the responsibility for this decision seemed to ‘legitimise’ the use of support. It is clear that the care recipients played an active role in the process of introducing formal support, either by holding back or by promoting the use of such services. Several husbands mentioned that their wives had not wanted them to do the ironing or cleaning, preferring to leave these tasks to the formal home-care worker. Several daughters also reported that their parents preferred to be assisted by formal workers for personal care tasks, as a way of preserving their dignity. The process of becoming accustomed to formal support was easier when the care recipients had a positive attitude towards help. Once formal support was in place, informal caregivers described how it had been necessary to learn how to ‘let go’ and become accustomed to the idea of not doing everything themselves.

Informal caregivers struggle to find a balance between the ‘benefits’ and ‘damages’ of using formal support. From the perspective of older clients, there appears to be a ‘trade-off’ (Martin-Matthews, 2007). By accepting formal support, they are enabled to continue living at home for longer than would have been possible otherwise. Given that many caregivers are motivated to provide care in the home for as long as possible, they are likely to feel as if they have no ‘real choice’. Because of this dependency, they may try not to be overly critical of the assistance that they receive. The ambivalence towards using formal support has also been reported in a quantitative study of Belgian caregivers for individuals with dementia (Roelands et al., 2007). While almost all the informal caregivers perceived positive effects from the assistance provided by formal home-care workers, about one in three also perceived negative consequences, including lack of control in daily scheduling and decreased privacy (Roelands et al., 2007). Concerns of informal caregivers include the limited number of hours of assistance, rotating schedules and the lack of continuity, as these caregivers are the ones who must absorb structural deficits and fill the gaps. Overall, even when support is in place, informal caregivers feel a ‘never-ending’ responsibility for the well-being of the older person and the organisation of care. Informal caregivers are not merely ‘users’ of formal support. They are also often in charge of coordinating it, which involves hiring services and monitoring the quality of direct care.

From the perspective of the informal caregivers and older persons, continuity of staff is very important. Having one or two formal home-care workers allows care recipients to feel more comfortable about support and to develop a relationship of trust. Once formal home-care workers and care recipients had
enough time to become acquainted with each other, the initial resistance often transformed into an appreciation of the presence of support. In this respect, it was remarkable to note that several spouses described how home-care workers had become like friends or family over time, for themselves as well as for the care recipients. Although adult children did not use words like ‘friends’ or ‘family’, they did provide accounts of close, supportive relationships with formal home-care workers (De Koker, 2018).

A sense of being acknowledged as a co-client is an important element for the ‘assistive care’ relationship, meaning that professionals are willing and able to look beyond the perspective of the older person and attend to the needs of caregivers. Working together implies that both parties can count on each other. Informal caregivers who were very satisfied with the support services described this as a relationship of ‘trust’. In addition to providing a good level of quality in ‘direct care’, such a relationship requires that formal home-care workers honour what has been agreed with the informal caregiver, as well as being easily accessible. The theme of working together refers to a reciprocal, give-and-take relationship. Some informal caregivers mentioned that they tried to make it easier for the home-care workers to do their jobs and that they expected the same on their behalf. The most commonly mentioned types of interactions involved sharing information and helping each other with practical support. Informal caregivers and formal home-care workers helped each other with tasks such as lifting the older person and devising practical solutions. Both spouses and adult children considered it important to be involved as valuable partners in care and to have their skills and knowledge recognised. This was not always the case. Several of the participants mentioned that they had been criticised or had not been taken seriously (De Koker, 2018). As mentioned by, for example, Nolan et al. (2003), it is important that informal caregivers are viewed as ‘co-experts’, and they should be involved in negotiations concerning the allocation and implementation of assistance, both on the organisational level and in individual situations.

**Good practice: Triadic approach in general hospital Maria Middelares**

There is still much to be gained in the field of preventive work with informal caregivers and preparing them for the challenges they face (De Almeida Mello, 2018). Research shows that ‘key events’ such as a hospitalisation cause important changes in the care triad (Lambotte et al., 2020a) and can also be opportunities to provide support. The general hospital Maria Middelares, situated in Ghent, initiated a triadic approach a couple years ago to better support persons with dementia and their caregivers during and after a hospital stay. At the intake, informal caregivers are asked whether they wish to continue to carry out several
tasks while in hospital (e.g. helping with meals, being present in case of anxiety and risk of falling, helping with dressing, sleeping over), without any obligation. Information on the preferences and the specific needs of the person with dementia is gathered in a ‘my habits’ document that provides staff members with valuable information on the person with dementia during their stay. Informal caregivers receive psycho-education, psychosocial support and information during the hospital stay and after discharge. A nursing team and occupational therapists, among others, provide support and education for family caregivers. Three times a year, family caregivers can participate in a psycho-education programme. This triadic approach focuses on working in local networks with other care providers (e.g. home-care organisations and social work departments of health insurance associations).

Good practice: Informal care coordinators
Several organisations and local networks are investing in the function of an informal care/family care coordinator. An informal care coordinator is a professional who individually monitors and guides informal caregivers. In addition to providing individual guidance, such a coordinator is also responsible for awareness raising, training and activities for informal caregivers (De Witte & Van Regenmortel, 2020). The research report by De Witte & Regenmortel (2020, p. 76) shows the benefits are numerous:

indeed, those family caregivers can appeal to those coordinators to ask practical information about which services exist, but also to talk about social and ethical considerations. Indeed, the family caregivers find this role extremely valuable because those coordinators can offer a more neutral perspective on their situation which could help them make decisions (about which care to use), get all siblings in line […]

A family care coordinator can contact the family caregivers (and seniors) to talk about their needs and try to formulate a response. In this respect, it could be useful that all those actors belong to the same covering organisation which seems to enhance their communication.

5. About neighbours and citizen initiatives

Apart from family caregivers, neighbours and, more broadly, citizen initiatives for care are (re)gaining importance as a source of informal care as well (Soares da Silva et al., 2018; van der Knaap et al., 2019). This corresponds with the general policy goal of ‘care in the community’ (Plovie, 2019). Regarding the
first, neighbours as informal care providers, the rise of the policy concepts of
neighbourhood-oriented care and caring neighbourhoods can be considered
important drivers for this increasing attention (see Chapter 4). Besides the
increasing focus on neighbours as a source of informal support, citizen initia-
tives have boosted as well over the past several years (Soares da Silva et al.,
2018). This can also be related to the increasing policy focus on informal care
and the appeal from governments for citizens to engage in the community.
This is not only the case in Flanders (Belgium). Other examples are the Big
Society in the UK and the Dutch Social Support Act in the Netherlands
(Soares da Silva et al., 2018; Plovie, 2019). The empowerment of citizens can
be considered one of the underlying goals (Soares da Silva et al., 2018).

Informal care by neighbours or citizen initiatives significantly differ in
nature from care by family caregivers. Neighbourly support tends to be more
non-binding compared with informal care by family caregivers and less intense
and frequent. Neighbourly support usually encompasses more small and
spontaneous help like helping with groceries, keeping an eye on each other,
emotional support and creating a sense of security (Heylen & Lommelen,
2016; Smetcoren et al., 2019). Informal care by neighbours is often characterised
by a type of reciprocity (Heylen & Lommelen, 2016). This reciprocal nature
has a positive, beneficial effect on both older persons and society in general:
being able to give (and not only receive) positively affects the quality of life of
older persons, among others, by reinforcing their connectedness with others
and that way enhancing empowerment. It also increases feelings of self-worth
and self-esteem and a general sense of belonging and of feeling needed by
society (De Witte & Van Regenmortel, 2019; Heylen & Lommelen, 2016).

Citizen initiatives also significantly differ in nature from family caregiving.
A citizen initiative is set up by the citizen, and citizens come together as a
collective, a group. De Jong et al. (2014) noted a number of characteristics
of citizen initiatives in the care and welfare sector in order to define them
as such. For one, these types of initiatives must always be organised for and
by citizens. Second, they must concern the care and welfare of citizens.
Third, they have a local character and, fourth, involvement of citizens and
reciprocity are key values which are also found to enhance resilience (see
Chapter 1). Like other type of citizen initiatives, they start from citizens,
who voluntarily want to tackle a problem (De Jong et al., 2014), in this case
regarding the care and well-being of citizens. Generally, citizen initiatives
arise in case of unmet needs within the society where neither the government
nor the market have an adequate supply of care and support. They thereby
aim to fill a care vacuum (van der Knaap et al., 2019) and take responsibility
to provide public goods (Soares da Silva et al., 2018).
To summarise, both neighbourly support and citizen initiatives, as types of informal care, are characterised by their voluntary and reciprocal nature. While support by family caregivers can be burdensome (De Witte & Van Regenmortel, 2020), these types of informal care generally have predominantly positive outcomes, such as feeling connected with others and a positive self-image (De Witte & Van Regenmortel, 2019) (see also Chapter 3).

5.1 The have-nots and the have-nots

Although these types of informal care generally have positive effects on the well-being of the informal care providers (the neighbours and citizens involved), there are some risks involved in relying too much on them.

For neighbourly support, it is important to keep in mind that people generally tend to help others they know and with whom they feel connected. Social networks, however, are unequally distributed, and a higher socio-economic status is often correlated with stronger and larger social networks. Vulnerability, on the other hand, goes hand in hand with a higher risk for social isolation (De Witte & Van Regenmortel, 2019). Therefore, the most vulnerable are generally the least likely to receive or be involved in neighbourly support (see also Chapter 4).

A similar risk exists for citizen initiatives. Plovie (2019) interviewed 364 leading figures of Flemish citizen initiatives and compared the profile of these leading figures with the average profile of the Flemish population. The results show that more highly educated people were over-represented, and citizens with a migration background were under-represented. In addition, these groups tend to be homogeneously composed as to level of education, employment and migration background (Plovie, 2019). In this respect, van der Knaap et al. (2018) concluded in a study on citizen initiatives on care in the Netherlands that capacity for concerted action is the most important mechanism in explaining differences in the presence of citizen initiatives. This capacity refers to the social capital of the community, measured by, among others, the educational level of the inhabitants (van der Knaap et al., 2018). Citizens have to possess certain social skills and capacities to be involved in these initiatives. Not all citizens, specifically the more vulnerable among them, have developed these skills. Counting too heavily on citizens’ initiatives therefore risks widening the gap between resourceful citizens and more vulnerable ones (Soares da Silva et al., 2018). Citizen initiatives themselves, however, are often not aware of these inequalities. Where they often preach to be open to everyone, this does not necessarily correspond with reality (Plovie, 2019).
5.2 The ambiguous interplay between ‘new forms’ of informal care and formal care

As both neighbours and citizen initiatives on care have gained importance over the past several years, their interplay with professionals has gained attention as well (Soares da Silva et al., 2018). There tends to be some friction in the cooperation and there are risks involved. First, the bottom-up nature of these types of informal care is a mismatch with the top-down logic of formal care. Specifically, citizen initiatives risk being taken over and professionalised, for example, by being integrated within an existing care structure (Braes, 2018). For neighbourly support, the risk is that expectations of this type of support become too high, for example, when support is expected on a structural, frequent basis, and neighbours tend to disengage (Heylen & Lommelen, 2016). Professionals risk placing an excessive workload on citizens, specifically in the care sector (Soares da Silva et al., 2018). Building a good interplay between these rising types of informal care and formal care therefore needs specific attention.


In an article in The Lancet (Chan et al., 2020), informal caregivers are called the ‘forgotten healthcare workers’ during the Covid-19 pandemic. Indeed, there is limited knowledge about the impact of the Covid-19 pandemic on family and other informal caregivers and their support needs. Lorenz-Dant and Comas-Herrera (2022) identified five key themes in literature that highlight the impact of Covid-19 on informal caregivers of people living in the community: changes in care responsibilities, concerns about Covid-19 infections, changes in the availability of formal and informal support, and financial as well as physical and mental health implications. The authors conclude that the Covid-19 pandemic is likely to have exacerbated all the risks that are generally associated with intensive informal care, such as diminished mental and physical health, decreased ability to engage in paid employment, and lower incomes.

Lambotte et al. (2020b) present results of an online survey on experiences of informal caregivers during the first wave of the Covid-19 pandemic in Flanders. Data from 651 informal caregivers were gathered in the second half of May 2020. Results indicate that two thirds of the informal caregivers in Flanders experienced their caregiving role as more difficult than before the pandemic and that more than half spent more time on informal care. This is
partly due to a reduction in professional help and support from ‘secondary’ informal caregivers or the social network. Informal caregivers more often than usual had the feeling of being under constant stress (56 per cent) and had trouble sleeping or were lying awake more often (45 per cent). Informal caregivers noticed that the person they cared for was more depressed, that they had more memory problems and that they took up more of their time with requests for help. Groups that reported a higher burden and required specific attention were co-resident caregivers as well as persons caring for someone with psychological problems or a handicap.

During the first lockdown, the interplay with formal services was under pressure. Lambotte et al. (2020b) found that, before the pandemic, 71 per cent of informal caregivers were (rather to very) satisfied with the level of professional help, and 12.8 per cent of the caregivers were dissatisfied. During the pandemic, the percentage of dissatisfied caregivers increased from 12.8 per cent to 22.9 per cent. When it comes to cooperation between formal and informal care, 53.5 per cent of informal caregivers were satisfied, and 20 per cent of the informal caregivers were rather or very dissatisfied.

De Witte & Van Regenmortel (2020) did a qualitative study, based on in-depth interviews of community-dwelling older persons (eighty years and older) and their family caregivers. For family caregivers of older persons with high care needs, the burden of care increased significantly because they took over various tasks that had been carried out by professionals and other family caregivers before the pandemic, and because many forms of respite care were no longer available. Family caregivers of older persons with high care needs are confronted with a burden of care, which results from the pressure of constantly having to be available, seeing close ones deteriorate, feelings of guilt, a lack of flexibility and demonstrated appreciation from the older persons, and, for partners, also social isolation and feelings of loneliness. Older persons themselves indicate that, although they are in general very satisfied with informal care, some of them do have trouble asking their close ones for support.

Regarding new forms of informal care, the Covid-19 crisis boosted new initiatives among neighbours and citizens across the country as well, specifically during the first lockdown in the spring of 2020. Schools, care organisations and citizens did groceries for their neighbours, helped in the garden and made face masks for professional care providers, for example. Several cities and municipalities launched several online and offline initiatives to connect citizens who were willing to help with citizens in need of help (Plovie & Heylen, 2020).

During this first lockdown, an online survey was conducted on solidarity and support among citizens at the time (Plovie & Heylen, 2020). Across
Flanders (Belgium), 2,057 adults (eighteen years or older) participated. When we look at those who received help from their neighbours, there are interesting differences. Women received neighbourly help more often than men, and university graduates received help more often than those with a secondary education degree. There were no differences according to age, health, financial difficulties and work situation. This means that those who were expected to be in need of care (due to, for example, their health situation or financial difficulties) did not necessarily receive more support from neighbours. Contrarily, the higher educated were more likely to receive help from their neighbours. Building too strongly on this type of informal care risks reinforcing or creating new inequalities in social support: those who already have will receive even more; those who don’t will receive even less (see also Chapter 4). This was also the case during the Covid-19 crisis. When we turn to the results for initiatives on care and support citizens took on themselves or were involved in, the hypothesis again was confirmed that people generally tend to support people they know. Family and neighbours with whom they have a good relationship were the main target groups. Next were friends and acquaintances. Everyone in the street or neighbourhood or specifically neighbours with a vulnerable profile had the lowest score and were thus the least likely to be supported. Interestingly, those who were engaged in more informal initiatives, not initiated by a local authority or organisation, were less likely to support vulnerable people (Plovie & Heylen, 2020). On the other hand, this implies that formal organisations, like a local authority, do have an important role in the democratisation of these citizen initiatives (Plovie, 2019).

7. Discussion and conclusion

Informal caregiving is a matter of growing interest. The interplay of formal and informal care and questions concerning how best to support informal caregivers are an important part of current discussions on the sustainability of the long-term care system (Anthierens et al., 2014). Over the past decade, informal caregivers have increasingly been recognised as ‘partners’ and persons with their own needs, but there still is some work to do. The paradox of support that does not always help, despite all the efforts of care providers is a reality and requires new ways of working (Driessens et al., 2016). As research and several good practices demonstrate, professionals can support and facilitate the empowerment process of older people and their family by creating enabling conditions (Sakanashi & Fujita, 2017).
Several of the themes mentioned in this chapter can be related to the framework of Van Regenmortel (2020). Strengthen, connection, trust and resistance to disempowering practices are four pillars of empowerment. Connection and trust are prerequisites for positive outcomes of the ‘interplay’. Stable and trusting relationships between the client, professionals and informal caregivers, and the recognition of everyone’s role in the ‘care triad’, is essential. Approaching informal caregivers as co-experts and ‘people with their own needs’ is relatively new, and the systematic assessment of caregivers’ needs remains far from routine (Lamura et al., 2008). Guberman et al. (2012, p. 212) state that baby boomer caregivers ‘have a better understanding of their rights, seek precise and complete information, and question norms’. This generation clearly states their needs, compared to older spouse caregivers ‘who expect and ask little’. At the meso and macro level, it is important that home-care policies include policies designed to support and empower informal caregivers. As argued by Sims-Gould and Martin-Matthews (2010), a comprehensive caregiver support policy should be inclusive of home-care policy and vice versa. Triadic care asks for time and specific strategies, for example, to share information and provide specific support. The Covid-19 pandemic shows that much more is necessary to make informal care more visible and to mitigate the risks of overload, diminished well-being and psychosocial as well as financial hardship (De Witte & Van Regenmortel, 2020).

Specific attention is needed for new forms of informal care, such as neighbourly support and citizen initiatives on care. For one, the expectations of this type of informal care have to be realistic. The bar, often set by policymakers and professionals, should not be too high. This kind of support is often less frequent and of a more voluntary, ad hoc nature. Nevertheless, this kind of care and support can be very empowering for older persons. It can enhance their self-esteem and sense of belonging. Being able to give and to contribute to society has positive effects on people’s general well-being and their empowerment (De Witte & Van Regenmortel, 2020).

Second, for these types of informal care, we have to be aware of the risks of social exclusion. Both neighbourly support (see also Chapter 4) and citizen initiatives are generally more reserved for citizens who are better off. The most vulnerable citizens are less often involved in these informal care networks. Professionals have a key role in counteracting these inequalities. Initiatives organised or facilitated by local authorities or professional organisations have the potential to broaden the coverage of informal support networks and to include more vulnerable citizens or those who lack the social skills (Heylen & Lommelen, 2016). In addition, professionals can play an important role in strengthening citizen initiatives on several aspects such as partnerships with...
other stakeholders, addressing the homogeneity of these groups and making room for a diversity of opinions in order to increase the democratic nature of citizen initiatives in this manner (Plovie, 2019).

Third, strengthening the cooperation and partnership between this kind of informal care and formal care can be a valuable way to address the increasing needs of the ageing population. As informal care providers such as neighbours or citizens involved in initiatives often are well informed of the care needs in their neighbourhood, they can be of great importance in guiding people towards professional care and support (Braes, 2018). However, in building these partnerships, both policymakers and professionals should take care not to take over these bottom-up, informal initiatives, but respect their informal, often organic nature, which is often their actual power. Acting on the basis of equity is a guiding, empowering principle in this respect. Specific attention is needed for the relationship between citizen initiatives in care and professional actors, as citizen initiatives are relatively new. How can the partnership between citizen initiatives and the professional care and welfare sector be shaped in practice with respect for one another’s individuality? And how can this be done without the, admittedly well-intentioned, logic of the health and welfare sector taking over and citizen initiatives being fitted into the traditional structure of care (with planning, management, regulations, etc.) (Braes, 2018)? In this respect, Braes (2018) argues for complementarity and partnerships in which professional actors and the government can play a supporting and facilitating role.

The Covid-19 pandemic has boosted new initiatives among neighbours and citizens across the country. At the same time, it became clear that the interplay with formal care needs further attention. Given the high pressure on informal caregivers, it is essential to make them more visible, to create a strengthening environment and to mitigate the risks of overload, diminished well-being and psychosocial as well financial hardship.

Notes

1. We use the term ‘informal caregiver’ to refer to persons providing care to their relatives, friends and neighbours, and the terms ‘formal care/caregiver’ and ‘professional caregiver’ to refer to professionals providing care that is paid and which they provide in the context of a professional organisation.
References


