In the Australian context, a carer is defined as “a person who, through family relationship or friendship, looks after a frail older person or someone with a disability or chronic illness. Carers look after these people in the community or in their own homes” (Department of Health and Aging [DoHA], 2006).

There are an estimated 2.6 million carers in Australia, one in five of whom see themselves as “primary carers”—those taking most of the responsibility for providing care to one or more individuals (Australian Bureau of Statistics [ABS], 2004). A large proportion of carers are aged between 35 and 54 years, and their responsibilities may include multiple caring roles for young children, partners and/or ageing parents. However, much of the caring burden falls on older Australians, who may themselves be frail or have a disability or chronic illness. One in five Australians aged 55 years and over takes primary responsibility for the informal care of another person (ABS, 2004). Caring for people who have severe or profound restrictions in their ability to deal with daily activities is predominantly a female occupation, although men and women are represented more equally in the care of people with disabilities (Australian Institute of Health and Welfare [AIHW], 2004).

The contributions, personal costs and resulting support needs of carers have been well documented in recent Australian reports and surveys (e.g., Bittman, Hill, & Thomson, 2007; Edwards, Higgins, Gray, Zmijewski, & Kingston, 2008) and include the effects of the onset of care on labour force participation (Hill, Thomson, Bittman, & Griffiths, 2008). The findings were well summarised in the foreword to a recent report on a national carer survey using an index of wellbeing: “There is now ample Australian and international evidence to show on the one hand, the enormous contribution carers make to society, and on the other, the great personal cost that often comes with providing this care” (Hughes, 2007, p. viii).

Research in Australia has revealed consistent patterns of unmet needs among carers, and highlighted the inefficiencies created by the fragmented structure of carer support programs (Fine, 2007a, 2007b). The importance of supporting carers in their roles is now recognised in government policy at all levels and there is ample scope for improving the service system as well as the evidence base for promoting effective interventions.

The review of effective caring

In 2006, the Centre for Health Service Development (CHSD) was commissioned by the Department of Health and Ageing to assemble and assess the evidence for interventions to support carers. The aim of the project was to identify best
practice models, as well as particular types of services that may benefit specific sub-groups of carers.

The project reviewed Australian and international academic and practice literature, and conducted a concurrent analysis of policy and practice in Australia. The findings were used to provide an evidence base both for carer interventions and for a research agenda that complements and extends the work already done on assessing carers’ needs (e.g., Ramsay, Samsa, Owen, Stevermuer, & Eagar, 2007).

The findings of the international literature review were presented at a workshop of key service delivery and academic experts. This process was used to identify priorities for improving routine practice in carer support, and to outline an agenda for research and development. Outcomes of the workshop were incorporated into the final report (Eagar et al., 2007).

Method

We searched a number of electronic databases to ensure thorough coverage of the academic literature. In addition, literature describing routine community care practice was sought from the websites of other health service research organisations, government departments, relevant non-government agencies that commission or conduct research, national libraries, service providers, peak agencies and commercial sites. We also sought expert opinion from service providers and other stakeholders.

These additional searches and consultations were designed to collect and summarise key information regarding the national policy environment, major statistical and consultancy reports, and the practice literature that would not usually surface using traditional literature search strategies. This “colloquial evidence” (Canadian Health Services Research Foundation, 2006) provided an essential context for the scientific evidence and guided the selection and implementation of effective interventions for Australian carers. Our search strategy was based on the COSI model (Bidwell & Jensen, 2003) that ranks searches in terms of their expected yield or return for time spent.

The type and strength of the evidence was summarised through the use of a classification system (see Box 1). The first five levels are hierarchical and relate to the strength of the evidence on interventions. The last five have been used to summarise evidence on carer needs.

One type of evidence—carer views—is used in the literature both as a way to understand carer needs and as an outcome measure in some intervention studies.

In addition, the review of intervention studies captured information on other relevant indicators of quality, including replication, documentation, the theoretical basis for the intervention, whether cost-effectiveness data are available, and whether it had been trialled with specific groups, including people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds.

This system of evaluating and summarising the evidence for interventions was designed at the CHSD and is based on hierarchies originally developed by other organisations, including the Cochrane Collaboration (2009), Campbell Collaboration (Shadish & Myers, 2004) and California Evidence-Based Clearinghouse for Child Welfare (2006). It acknowledges the need to be more inclusive in assessing evaluation evidence in important fields such as public health and social science, where randomised controlled trials may not be feasible or particularly informative (National Health and Medical Research Council, 1999).

Results

What are effective interventions?

A key review of interventions targeted at those caring for frail aged people (Sörensen, Pinquart, & Duberstein, 2002) concluded that, overall, they produced a significant improvement in caregiver burden, depression, subjective wellbeing, satisfaction, caring ability/knowledge and care

Box 1: Classification system for strength and type of evidence

<table>
<thead>
<tr>
<th>Strength of evidence on interventions</th>
<th>Type of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1: Well-supported practice—evaluated with a prospective randomised controlled trial.</td>
<td>Profiles of carer population (e.g., routine data).</td>
</tr>
<tr>
<td>Level 2: Supported practice—evaluated with a control group and reported in a peer-reviewed publication.</td>
<td>Eligibility for support (e.g., legislation, policy).</td>
</tr>
<tr>
<td>Level 3: Promising practice—evaluated with a comparison group.</td>
<td>Carers’ views (e.g., surveys, interviews).</td>
</tr>
<tr>
<td>Level 4: Acceptable practice—evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre- and post-testing, post-testing only or qualitative methods) or historical comparison group (e.g., normative data).</td>
<td>Expert opinion (e.g., peak bodies, government policy).</td>
</tr>
<tr>
<td>Level 5: Emerging practice—evaluated without an independent assessment of outcomes (e.g., formative evaluation or service evaluation conducted by host organisation).</td>
<td>Economic evaluation (including service utilisation studies).</td>
</tr>
</tbody>
</table>
receiver competence. Psycho-education and psychotherapy had a significant effect on all outcome variables. Multicomponent interventions—those incorporating a variety of activities—had significant effects on burden, wellbeing and caring knowledge. Respite was effective for reducing burden and depression and for enhancing wellbeing. Individual interventions had stronger effects on burden and wellbeing, while group-based interventions had larger effects on care receiver competence. People caring for a dementia patient were less likely than others to benefit from interventions. Studies with a higher proportion of spouse carers (rather than adult children) tended to find smaller improvements in carer burden and depression, but greater improvements for care receiver symptoms.

Although focusing on dementia carers, Kennet, Burgio, and Schulz (2000) summed up much of the literature when they concluded that anyone expecting to find a “silver bullet” solution to alleviating carer distress would be disappointed. “There is no single, easily implemented and consistently effective method for eliminating the stresses of caregiving” (Kennet et al., 2000, p. 79).

Nevertheless, there exists strong consensus among researchers that dementia carers are likely to benefit from enhanced knowledge about the disease, the caring role, and available resources (Kennet et al., 2000). Once information needs are met, carers may benefit from additional interventions, such as improving their problem-solving skills, treating the care recipient, or altering the social and physical environment of the carer–care recipient dyad.

In this section, we briefly summarise the evidence for the two most common interventions for Australian carers—respite and counselling—along with other promising options that are less widely used. More details can be found in the report by Eagar et al. (2007).

**Respite care**

We found seven evaluation studies of the impacts of respite care on carers. Only one provided strength of evidence at Level 1 of our classification system (well-supported practice; see Box 1). This was a randomised controlled trial of respite care for carers of Alzheimer’s patients, in which the intervention group received subsidised respite care along with ongoing case management, counselling, information and education services (Lawton, Brody, & Saperstein, 1989). Over 12 months, families who were provided with respite care maintained their impaired relative longer in the community. The difference was modest—only 22 days—but statistically significant. Although respite care was ineffective in relieving carer burden and mental health, satisfaction was very high.

Four studies meeting the criteria for Level 4 (acceptable practice) were found, all involving carers for people with dementia, but focusing on different outcome measures. Gaugler and colleagues (2003) reported on adult day service use and reductions in caring hours for dementia carers and concluded that adult day service use is potentially effective in reducing carers’ emotional and psychological distress. A small-scale randomised trial of a two-week respite intervention resulted in reduced stress responses (“sympatho-adrenal-medulary arousal”) among a sub-group of carers who lacked social support (Grant et al., 2003, p. 70). Holm and Ziguras (2003) reported care recipient outcomes from a small Australian study of host-home respite. They concluded that this model may be particularly suitable for Aboriginal carers and those from non–English speaking backgrounds, as long as appropriate support for the host was provided, because it may allow more culturally sensitive care provision. Institutional respite may provide temporary improvements in carers’ quality of sleep, although rebound effects may occur in the immediate post-respite period (Lee & Gramotnev, 2007).

Two studies, both focusing on the families of disabled children, reported carers’ views of respite care. Among parents of children with severe intellectual disabilities, respite is a valued resource, but its use is also an indicator of distress (Hoare, Harris, Jackson, & Kerley, 1998). Assessment systems that can detect the need for respite at an earlier stage would be useful for this group of carers, so that targeted services can be designed, rather than waiting for crises to generate an immediate need for respite. Similarly, Treneman, Corkery, Dowdney, and Hammond (1997) found that respite use increased when children had higher levels of dependency and more behavioural and communication problems, leading to higher stress among carers. In this British study, respite care was generally perceived as inadequate, and 88% of respondents were not aware of available services.

We identified seven previous reviews of respite or day care services that addressed a variety of outcomes for carers, including burden, depression, physical health, economic impacts and quality of life; and for care recipients, outcomes such as functioning and rate and/or timing of admission to institutional care.

Other reviewers’ conclusions are consistent with ours: the evidence for the benefits of respite is not strong. There is little evidence of benefits for dementia patients or their carers, although reviewers warn that this may simply
reflect a lack of high-quality studies (Lee & Cameron, 2004; Flint, 2005). A review of respite in palliative care found no empirical studies that could be included (Ingleton, Payne, Nolan, & Carey, 2003), while a second review in this area recommended that care plans be tailored to the needs of palliative care carers, “with clear objectives that may then be tested” (Payne, 2006, p. 445). Similarly, McNally, Ben-Shlomo, and Newman (1999) concluded that a more carer-centred approach is needed in designing and evaluating interventions, including respite, for carers of people with chronic illness or disability. Those caring for frail or disabled older people appear to experience some small benefits in terms of reduced burden and improved mental and physical health (Gaugler & Zarit, 2001; Mason, Weatherly, Spilsbury, Arksey et al., 2007; Mason, Weatherly, Spilsbury, Golder et al., 2007). Overall, however, we must concur with the statement that “the existing evidence base does not allow any firm conclusions about effectiveness or cost-effectiveness to be drawn and is unable to inform current policy and practice” (Mason, Weatherly, Spilsbury, Golder et al., 2007, p. 297).

The discrepancy between experience and evidence around the efficacy of respite care has been discussed in the academic literature on dementia. Anecdotal reports of effectiveness abound, suggesting that the paucity of evidence for respite care is due to methodological problems in the research, poor awareness of services, and the diversity of those who receive respite services (Brodaty & Gresham, 1992).

Counselling

In total, five reviews and four studies of counselling and psychosocial interventions were reviewed. Psychosocial treatments are also included in many multicomponent interventions.

Two studies, both involving carers of people with dementia, reported evidence at Level 1 (well-supported practice). Thirty family carers who were part of an experimental group in a Canadian randomised controlled trial received an intervention consisting of 15 two-hour weekly sessions of cognitive appraisal and coping strategies (Lavoie et al., 2005). Following the intervention, participants’ adverse reactions to their relatives’ behaviour problems decreased by 14%, compared to a 5% decrease in the control group (p = .04), and the frequency of these behaviour problems also decreased. An intervention that reduced carer burden, treated depression and provided supportive psychosocial or skills training for carers before the death of their loved ones was found to decrease the likelihood of complicated bereavement (Schultz, Boerner, Shear, Zhang, & Gitlin, 2006).

Carers’ views were reported in two studies. One woman caring for a husband with mental illness received training in the use of guided imagery, role-playing, humour and paradoxical intervention. A case study of this treatment showed that it eased her worry, anxiety and frustration and revived her patience, hope and strength in the process of rehabilitation (Yip, 2003). A specialist clinical assessment of care recipients led to significant reductions in the overall level of distress among carers of frail aged people, and also reduced distress related to care recipients’ underactivity and requirement for care (Venables, Clarkson, Hughes, Burns, & Challis, 2006).

Reviews of psychosocial and counselling interventions for carers have generally found positive effects, although there have been exceptions (e.g., Cooke, McNally, Mulligan, Harrison, & Newman, 2001). For dementia carers, theory-based psychosocial treatments “with a coherent and explicit rationale” may be most effective (Charlesworth, 2001, p. 106). Other reviewers have recommended that clinicians should work with dementia carers to help them develop problem-solving skills and an acceptance style of coping (Kneebone & Martin, 2003). These authors also commented on the limitations of the evidence and the methodological problems with existing studies, and called for longitudinal designs. Cooke, McNally, Mulligan, Harrison, & Newman (2001) concluded that little evidence exists for improved carer wellbeing or reduced burden as a result of interventions, although they may improve carers’ knowledge of dementia.

Results for carers of people with stroke or brain injury are mixed, but it appears that a carer’s ability to cope is enhanced by concrete approaches such as providing positive coping strategies and more information about stroke (Low, Payneb, & Roderick, 1999). Family therapy has clear benefits in schizophrenia (Pilling et al., 2002).

Looking only at randomised controlled trials for chronic illness interventions involving family members, Martire, Lustig, Schulz, Miller, and Helgeson (2004) reported that the interventions had positive effects for carer burden, depression and anxiety. The best results were for carers of people with non-dementing illnesses and interventions that targeted the carer and addressed relationship issues. Statistically significant aggregate effects were generally small. These reviewers suggested that improvements in family carer depressive symptoms and burden may have reduced the risk of carer mortality.

Multicomponent interventions

Interventions incorporating a variety of components—such as skills training, information and referral, respite, counselling, in-home environmental changes or care recipient treatments—have been widely tested with carers for frail aged people and/or those with dementia, stroke or brain injury. We found 20 reviews of multicomponent interventions but space limitations preclude a full summary here. Sörensen and colleagues (2002) concluded that multicomponent interventions had significant positive effects on carer burden, wellbeing and knowledge. The most effective interventions appeared to be those that are comprehensive, intensive and tailored to carers’ needs (Kennet et al., 2000).

Care coordination

We found seven studies evaluating care coordination or case management approaches to carer support, of which the five summarised below provided Level 1 evidence of effectiveness. Three of these studies focused on people with dementia and their carers.

Collaborative team care, led by the patient’s primary physician and managed by a geriatric nurse, was provided for up to 12 months to Alzheimer’s patients and carers (Callahan et al., 2006). The carers and patients received education on communication skills, career coping skills, legal and financial advice, patient exercise guidelines, and carer guidance provided by the local Alzheimer’s association, and patients were treated with cholinesterase inhibitors. This led to clinically significant improvements in
behavioural and psychological symptoms of dementia and reduced carer stress, with no adverse effects on patients. A large randomised trial in the US provided assessments of patients and carers, case management and care planning, including facilitated access to subsidised community-based services (Gaugler, Kane, Kane, & Newcomer, 2005). This tailored, preventative strategy appeared to help carers adapt earlier to the demands of dementia care, ultimately delaying nursing home placement of the patients.

In Finland, a randomised trial of case management included access to physicians, services, advocacy, psychological support and counselling for family carers and patients with dementia over a two-year period (Eloniemi-Sulkava, Rahkonen, Suihkonen, Halonen, Hentinen, & Sulkava, 2002). The support program had long-term effects and helped carers to return to a normal life, with more leisure activities after their caring duties ended (due to the death or institutionalisation of the patient).

A Canadian trial found that tailored packages of services delivered over 22 months to older people with disabilities and their carers reduced acute hospital utilisation by 50% compared with the control group (Béland et al., 2006). Carer satisfaction after 12 months was significantly higher than for controls, although there were no differences in carer burden between the two groups. Early supported discharge after stroke, consisting of a four-week tailored home-based program of rehabilitation and nursing services, produced good outcomes for care recipients and reduced carer burden (Teng et al., 2003).

**Education**

We found 16 evaluation studies, of which 5 provided Level 1 evidence. Successful approaches for dementia carers include a 12-month, moderate-intensity exercise program (Castro, Wilcox, O’Sullivan, Baumann, & King, 2002); small-group classes on managing anger or depression, based on principles of cognitive behavioural therapy (Coon et al., 2003); environmental skill-building with adaptive equipment (Gitlin et al., 2003); and two sessions of in-home training provided by nurses, with follow-up telephone support (Huang, Shyu, Chen, Chen, & Lin, 2003).

An Australian randomised controlled trial of a psycho-educational intervention for family carers of palliative care patients found that two home visits, a telephone call and a carer guidebook did not improve carers’ preparedness to care, self-efficacy or competence, nor alleviate their anxiety (Hudson, Aranda, & Hayman-White, 2005). However, participants who received the intervention reported a significantly more positive carer experience than those who received standard care.

**Family support**

We identified two randomised trials of family support interventions, delivered by nurses or other trained staff in the home setting, and including role modelling, problem-solving, coaching and emotional and practical support. The effectiveness of this type of intervention depends on the skills of the provider, and may be affected by the complexity of the carer’s situation, and factors such as competing demands, health problems and past family relationships (Mahoney;Trudeau, Penyack, & MacLeod, 2006). Observation of the carer–care recipient dyad is essential in order to develop individualised approaches, and more work is required to be able to identify dyads suitable for this type of intervention before a crisis occurs. A Dutch study found that female carers living with dementia patients appeared to be sensitive to the intervention (Vernooij-Dassen, Felling, & Persoon, 1997).

**Support groups**

The number of well-designed studies of mutual support groups is limited, so the evidence on support groups at this stage is not established but is emerging. Carers having something in common with each other is an obvious factor that contributes to mutual support and this is one area in which it appears that particular sub-groups of carers may benefit (Shanley et al., 2004).

**Sub-groups of carers**

There is little evidence that the needs of carers vary systematically based on the diagnosis or type of person they are caring for (e.g., frail aged versus disabled, or stroke patient versus dementia). Instead, this seems to depend on the specific needs of the care recipient, particularly for attributes such as a patient’s challenging behaviours. Interventions with carers of people with dementia have been the subject of the most research and the evidence is therefore strongest for this group. Research into effective interventions for carers of the frail aged is surprisingly sparse. For example, we could find no intervention papers on “co-dependent” carers (i.e., elderly couples who are each other’s carer and care recipient).

While there are some survey data on employed carers, no studies were found that specifically addressed how best to address their needs. There is also little evidence on what interventions are most effective for carers in different types of relationships with the care recipient: parents, spouses, children, friends, resident and non-resident carers. It is clear, however, that the same interventions may achieve different positive effects.
outcomes for different carers. For example, Sörenson and colleagues (2002) found that spousal carers benefit less from interventions than adult children, and carers of people with dementia benefit less than other carers.

One study found that spouse carers of dementia patients were more likely to feel sad, lonely and depressed after cessation of caring, whereas non-spouse carers reported feelings of relief, suggesting that different supports are needed during and after care for these sub-groups of carers (Eloniemi-Sulkava et al., 2002).

Several studies have been reported on carer interventions for specific cultural groups. But no studies were found comparing the needs of carers from different cultures or the effectiveness of interventions across different cultural groups.

Only one study was found that focused on Indigenous carers (McGrath et al., 2006). This was a study of the need for carer services for palliative care patients, rather than the effectiveness of such services. Lack of local respite services was documented to be negatively impacting the ability of carers to fulfil their caring duties and placing undue physical, emotional and economic stress upon carers, patients and their families. Lack of access to local respite services was found to be forcing rural and regional patients to relocate to metropolitan areas away from family, community and land, to which strong ties are held. The authors reported that lack of respite services was found to obstruct patients’ and carers’ wishes for death to occur in their local community setting.

Methodological issues in carer research

Little is known about the effective “dose” of carer support interventions or the best time for their delivery. Evaluation studies in community care settings often fail to provide full details about the intervention, making it difficult to judge what was actually delivered.

However, a lack of good evidence for whether an intervention is successful or not is not the same as having evidence of its ineffectiveness, as often the problems are methodological (with the design of the study) rather than associated with the logic or acceptability of what was offered to the carer. The characteristics of the research participants (carers and care recipients) are generally poorly described and very few studies appear to consider the fit between carers’ stated or assessed needs and the goal of the care or model of service provided. The notable exception was those interventions that included a comprehensive assessment.

Consequently, results from evaluative research and systematic reviews of the literature on existing programs to support carers in their role (educational interventions, respite services, support groups) have not been conclusive. The services offered do not seem to have an impact on carer burden; that is, the interventions are not therapeutic in the sense of reducing a carer’s score on a particular burden scale in the short term. Nevertheless, such services may be preventive or protective in the sense that a carer might feel better, although no less burdened, or more capable of staying in the same caring situation for longer.

A number of reasons have been outlined to explain this (Ducharme, Lebel, Lachance, & Trudeau, 2006). The outcome measures used may not have been sufficiently sensitive to change, while elements of the interventions may have not been specific enough to meet carer needs. Further, the evaluation designs often have not been adequate to enable researchers to determine which components of multidimensional interventions were effective and which were less so.

Taking into account the limitations of the research to date, as described above, the key findings across the literature are summarised in Box 2.

Discussion

Carer research is characterised by problems of controlling for the inherent variability and complexity of conducting research in community settings. The pragmatic concerns of service delivery and the attitudes of the caring professions were recognised as barriers to research on effectiveness by Cochrane (1972) in his seminal work, Effectiveness and Efficiency: Random Reflections on Health Services.
There is very little in the published literature about how to support adolescent carers.

There is a clearer picture emerging from longitudinal studies on “transitions” into and out of the carer role, and of factors that may help strengthen the capacities of the growing number of employed carers, many of whom are not linked in to the service system. This picture from the literature points to a set of useful research questions and implies a range of strategies that include: understanding why carers may not use services such as respite, getting information to people who may not identify themselves as carers, providing more flexible respite and service arrangements, and removing workplace disincentives.

Multicomponent interventions had significant positive effects on carer burden.

Policy implications

The national legislative and policy context shows increasing sophistication in the understanding of carers and their roles. Carers have moved from being essentially marginal to policy formation to now occupying a more central position and the needs of carers have become a focus of effort in the community care sector in their own right. Advocacy groups, along with state and territory governments, have highlighted a need to merge the various types of respite under a common set of guidelines and a funding model that would encourage greater equity and consistency. The different eligibility criteria for the growing range of programs, entitlements and allowances at state, territory and national levels pose a continuing challenge for integration (see, for example, Leutz, 2005). The aim of better integration is to reduce the complexity for the consumer/client/carer and improve the flow of information across the range of human services.

Overall, there is a need to define roles more clearly and to work more closely for the benefit of carers. A focus is also required on restorative and rehabilitation strategies as a common component of training and support for carers and workers in the community care sector. The caveat about a common approach is that younger people with a disability and their carers may still require tailored programs so as not to be lost in demands from the much larger numbers of care recipients in the frail aged group. That implies considerable development work on information management and the use of common assessment and care planning systems that is yet to be consistently and widely applied in the disability sector.

A consistent approach is also needed in order to avoid exacerbating fragmentation and to ensure any new approaches to carer support mesh with the wider system reform agendas: between sub-programs within the National Respite for Carers Program; with systems of income support for carers; with the disability sector; and with state- and territory-based carer support programs.

While there are some gaps and inconsistencies, the overall variability in the approaches to carers’ issues is minimal compared with the amount of common ground that they share. The various carers’ charters, schemes for companion

Practice implications

The review highlights the fact that research can add value to service provision. Building a stronger and more standardised research culture in the carer support sector is the obvious backdrop that is needed, against which a series of specific strategies might stand out. These would be: improving access to small grants so that services can evaluate themselves with consistent methods; encouraging the use of common tools for evaluation so that a lot of small-scale activity might add up to something more substantial; and providing a useful platform (or a clearinghouse) so that local lessons can be easily and practically shared with others.

Strategies for service improvement can have a strong (but still highly variable) base of evidence that could be promoted as a platform on which to build:

- There is a reasonable evidence base regarding the effectiveness of respite and counselling, although there is not much evidence about specifics such as the type of counselling or the number of sessions.
- There is a reasonable evidence base on other interventions not usually funded/provided—for example, education/psycho-education—especially for carers of people with dementia, disability and for mental illness support groups. The overall evidence is promising and there is emerging evidence about new support models; for example, the establishment of support groups via telephone and videoconferencing shows promise as a strategy to support rural and remote carers. The evidence on support groups is sufficient to justify carefully evaluated pilots.
- There is a need to be clear about the goals of an intervention. This requires good initial assessment and periodic re-assessment to determine if the goal of the intervention should change.
cards to improve access to community events, and the activities of the carer-related programs at state and territory level all have similar aims and eligibility criteria. This is a testament to what has already been achieved over the past decade in building a national approach and to the degree of coherence that can be brought about by well-networked carer advocacy and support groups.

Policy analysis, research and development work in identifying a common set of points in a national carers’ charter would be straightforward, as would the promotion of nationally consistent eligibility criteria for a range of support and entitlement programs such as carer allowances and payments and companion cards. This would improve equity and access for carers across all jurisdictions.

Research implications

The carer research literature contains multiple recommendations for well-designed randomised controlled trials and there is no doubt that these are required to strengthen the evidence base for carer interventions. That said, the methodological challenges in conducting better (and more powered) studies should not be underestimated.

Despite these challenges, there is a strong case for promoting and supporting more rigorous studies through the peer-reviewed grant processes of the National Health and Medical Research Council, Australian Research Council and other research funding bodies—so long as these are relevant to the priorities in the field of carer support. In the process, the research implications of studies to date, as described in the Effective Caring report (Eagar et al., 2007), need to be considered.

There is also a need to systematically collect better assessment data on those carers already accessing carer support services and to use that information routinely to measure outcomes for carers. This could provide a basis for the benchmarking of carer support services. Existing carer assessment tools and clinical outcomes and benchmarking centres (e.g., the Australasian Rehabilitation Outcomes Centre, the Palliative Care Outcomes Collaboration and the Australian Mental Health Outcomes and Casemix Network) provide useful examples of such models (CHSD, 2007). The Australian Institute of Health and Welfare (2007), in a submission to the national Review of Subsidies and Services, proposed a suitably protected, linked national database incorporating information from programs relevant to carers, including the Aged Care Assessment Program, Community Aged Care Packages and Extended Aged Care at Home, National Respite for Carers Program, Residential Aged Care program, and Home and Community Care.

Identifying the needs of Australian carers, and producing and using the best available evidence to shape programs that meet their needs, is a national priority and there is a role for the research community in building that priority into health and social policy. That, in turn, might strengthen a “virtuous circle” where effective services (based on better evidence), with communication of the findings, leads to better policy to support even more effective services.

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