PRIORITY BRIEFING

The purpose of this briefing paper is to aid Stakeholders in prioritising topics to be taken further by PenCLAHRC as the basis for a specific evaluation or implementation research project. They were compiled in 2-3 days.

What is the value of respite care for unpaid carers of people with dementia? (If there is some value, what forms of respite care are most beneficial?)

Question ID: 18
Question type: Intervention
Question: What is the value of respite care for unpaid carers of people with dementia? (If there is some value, what forms of respite care are most beneficial?)
Population: Unpaid carers - those who provide unpaid care to relatives, neighbours, friends or others - where the person cared for suffers from dementia.
Intervention: Receipt of respite care (any form).
Control: Comparison may be made either between receipt of respite care versus non-receipt, or between different forms of respite care.
Outcome: Benefit to unpaid carers of people with dementia (specific outcomes would need to be identified as current understanding of the expected outcomes is unclear), including the understanding that carers in different situations (older people, young people, those in paid work, sole carers, and so on) will have different needs and may benefit in different ways from receipt of respite care.

Dementia: Dementia is a common condition characterised by loss of cognitive functions such as memory and problem-solving, beyond that which would be expected from normal ageing. The diagnosis of dementia requires that the person's cognitive functions have declined to the extent that it interferes with their work, social activities, self-care or relationships with others. Treatment options that are currently available are largely limited to treating symptoms such as difficulties in maintaining attention. For the majority of people with dementia there is currently no treatment that will alter the course of the disease.

Respite Care: Respite care is any sort of help and support that enables a person to take a break from the responsibility of caring for somebody else. There are a number of different types:

> **residential respite care**: the person being cared for goes away to live and be looked after by someone else for a while,
>
> **emergency respite care:** care is provided when someone cannot fulfill their caring responsibilities due to unforeseen circumstances, such as illness,
>
> **domiciliary care**: support is provided in the home to help out with some of the carer's responsibilities for a few hours,

day centre care: the person being cared for spends time at a centre to allow the carer to have a few spare hours of their own.

The Health Problem:

The 2001 Census identified almost 6 million people providing some form of unpaid care, of whom around 1.25 million provided more than 50 hours of care per week. These figures are likely to be higher now. The value to the UK economy of the care provided by unpaid carers has been estimated at £87 billion per year (University of Leeds figures for Carers UK). This means that, in addition to the carers of people with dementia highlighted in this question, there are very large numbers of other carers who might benefit from respite care.

Approximately 600,000 people in the UK act as the primary carer for someone with dementia. The Health Economics Research Centre at the University of Oxford has estimated the annual cost of unpaid care provided to people with dementia at £12.4 billion. Between 2008 and 2011 the Government aimed to invest £1.7billion through Councils to support carers through the annual Carers Grant. Carers of people with dementia, particularly women (who form the majority of carers), have been shown to experience seriously decreased health-related quality of life compared to their peers who are not carers. Carers are significantly more likely than non-carers to experience health problems including, but not limited to, anxiety and depression[11] and they are at increased risk of premature mortality.

The National Dementia Strategy states that there are over 700,000 people with dementia in the UK (1 in 20 over the age of 65 years and 1in 5 in the over 80s) with costs to the economy of roughly £17billlion per year. In the next 30 years it is predicted that the number of people with dementia will double to 1.4million and the cost will treble to around £50billion per year (DoH, 2009). There is also wider costs from impacts on quality of life and the health needs of those caring for people with dementia. In Cornwall there are around 8000 people with dementia and in Devon there are more than 12,000 and many of these will have carers who are family or friends that may need support for and respite from their caring responsibilities.

The results of research through PenCLAHRC may inform commissioning decisions in the South West and nationally about the provision of respite care and support for carers and the forms it should take. The results may also enable carers to assess the types of respite care that might benefit them most - particularly important with the proposed individualized care budgets.

Guidelines:

NICE guidelines on dementia quality standards state that carers of people with dementia should be offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs, for which respite care would need to be put in place.

A number of national policies back support for carers: the White Paper "Our health, our care, our say" (2006) announced a new deal for carers, including specific funding for short-term home-based respite care for carers in crisis or emergency situations.

The subsequent National Carers' Strategy (2008) committed £150 million towards planned short breaks for carers. The same strategy identified a research priority for pilot trials to identify the most cost-effective forms of respite care and to identify what form of break/respite care constituted high quality provision for carers' needs, and to disseminate models of best practice.

The DoH 'Living Well with Dementia: A National Dementia Strategy (2009) also advocates for carers to have a right for a needs assessment of their own and to have access to good quality breaks from their caring responsibilities.

A report for the NIHR Service Delivery Organisation 'Person- and carer-centred respite care for people with dementia: developing methods of evaluating the effectiveness of different models' (2009) suggests that there is a lack of evidence for the cost-effectiveness of respite care models that is inconsistent with the level of emphasis the Government has on these services and evidence-based practice. The report recommends that more robust research is done in this area to better understand cost effectiveness, barriers and facilitators to implementation and replication of innovative services. The report also suggests that commissioners should map the models of services that are already available, identify ways of introducing new models, and provide training and service level agreements to develop understanding of person centered care and how it should work.

NHS Priority:

Regional

SW SHA Priorities framework 2008-11

- increase year-on-year by 5% per annum the percentage of carers of people with a long-term condition who have a carer assessment and support
- improved access for carers: assessments and initial care plans for the identified main carer within four weeks of services user assessment

QIPP agenda requires a focus on addressing variability in primary and community care.

Local

Cornwall and Isles of Scilly PCT want to strengthen access to care and support for people with dementia and their carers, this is also part of their Strategic Priority Outcomes for 2009 to 2014.

Plymouth's Health, Social Care and Well-being Strategy 2008-2020 identifies as a priority area reviewing and increasing access to support services for carers.

NHS Devon and Devon County Council, regard carers as a priority area and currently jointly provide Health and Wellbeing Checks for Carers.

The joint commissioning strategy for people with dementia in Devon also highlights that respite care and Take a Break access is variable across the county.

Existing Research:

Published research

Over the past 10 years numerous reviews of the evidence surrounding respite care or psychosocial interventions for carers of people with dementia have been conducted, including a Cochrane review in 2004[2] (which was updated in 2008). These reviews make broadly similar conclusions about research in this area[1,2,4,5,7] (despite sometimes covering a broader population of carers than carers of people with dementia[3,6,8]). That message is that most of the primary research studies are small and often of poor quality and therefore their results are inconclusive. Only one study reported that respite care might increase caregiver burden[1], all other reviews report either partial evidence of positive effects or no evidence of positive or adverse effects. On this basis most of the reviews call for high quality, larger scale intervention research to be conducted to determine the impact of respite care on carers of people with dementia. The results are likely to have implications for resourcing of health and social care.

The identified reviews cover the research literature until 2008, since then at least four primary research studies have been conducted on the topic[9,10,12,13]. Only two of these studies used larger samples to conduct their research ranging from 100[12]-367[13] carers, and one was based in Queensland, Australia[12]. The four studies all look at some form of respite care and discuss the impact on care-giver burden and psychological distress. The results suggest some forms of respite (psycho-educational and grant interventions) may be more helpful than others[13] and indicate that a caregiver-centered approach to designing respite services may lead to greater uptake and benefit for both the caregiver and the dementia patient[9,12]. The results also suggest that ‘caregiver burden’ may not be an appropriate measure of the impact of a respite care service on caregiver experience/satisfaction/QOL[10,12]. However, more large-scale research studies need to be conducted on the wide range of respite care options available.

Ongoing research

No ongoing research studies were identified relating to this question

Feasibility:

References:

1) Schoenmakers, B., F. Buntinx, et al. "Supporting the dementia family caregiver: the effect of home care intervention on general well-being." Aging Ment Health **14**(1): 44-56.
OBJECTIVES: Although high volumes of literature have been written on interventions in dementia home care, only a poor efficiency has been proved. Nevertheless, caregivers often express strong feelings of satisfaction about the proposed support. In this meta-analytic review, a quantitative analysis of the effect of the different types of professional dementia home care interventions was made. METHOD: A systematic literature search, covering the years 1980 until 2007, was performed using Medline, Embase, Cochrane DSR, Dare, CCTR, and ACP Journal Club). Limitations on publication type were determined as randomized controlled trial and controlled trial. RESULTS: Psychosocial intervention in dementia home care was found to be beneficial in a non-significant way on caregivers' burden. An almost negligible decrease in depression was found in the psychosocial intervention arm while multidisciplinary case management contributed to a larger though insignificant decrease of depression in caregivers. Respite care was responsible for an increase in burden. CONCLUSION: This review demonstrated, in accordance with other qualitative reviews, the weak evidence that supporting family caregivers could be beneficial. Although the rather small benefits of formal support, supporting family caregivers is an indispensable issue in dementia home care. Professional caregivers should keep in mind that family caregivers highly appreciate the intervention and that they feel less burdened or depressed in the short time follow up but that premature home care remains more rule than exception.

2) Lee, H. and M. Cameron (2004). "Respite care for people with dementia and their carers." Cochrane Database Syst Rev(2): CD004396. (Updated 2008)
BACKGROUND: Caring for someone with dementia can be emotionally and physically demanding. Respite care is any intervention designed to give rest or relief to caregivers. It is not clear what positive and negative effects the provision of respite care may have on people with dementia and their caregivers. OBJECTIVES: To assess the effects of respite care for people with dementia and their caregivers, in particular the effect of respite care on rates of institutionalization. SEARCH STRATEGY: The trials were identified from a last updated search of the Cochrane Dementia and Cognitive Improvement Group's Specialized Register on 2 July 2003 using the terms respite* and "day care". This Register contains up to date records from all major health care databases and many ongoing trial databases. SELECTION CRITERIA: Randomized controlled trials comparing respite care with a control intervention for people with dementia. DATA COLLECTION AND ANALYSIS: Both reviewers carried out study selection independently and reached a consensus through discussion. Data was extracted by a single reviewer. The reviewers contacted all investigators for methodological details not reported in the text and for additional data. MAIN RESULTS: Three trials were included in the review. They were different in many ways including intervention, duration and outcomes so pooling of data was not possible. Re-analysis of outcomes using data from the published studies found no significant

effects of respite care on any variable. REVIEWERS' CONCLUSIONS: Current evidence does not demonstrate any benefits or adverse effects from the use of respite care for people with dementia or their caregivers. These results should be treated with caution, however, as they may reflect the lack of high quality research in this area rather than an actual lack of benefit. Given the frequency with which respite care is advocated and provided, well-designed trials in this area are needed.

3) Jeon, Y. H., H. Brodaty, et al. (2005). "Respite care for caregivers and people with severe mental illness: literature review." J Adv Nurs **49**(3): 297-306.
AIM: The aim of this study was to review research literature over the past 10 years on respite care for people affected by severe mental illness; and identify key implications for nursing practice in provision of respite care for family caregivers of people with severe mental illness. BACKGROUND: Family caregivers play an important role in health care, but need regular breaks to maintain their own health and well-being. Respite care is one of the few services available with a primary focus on supporting family caregivers. In most developed countries the notion of respite care as an extension of the health care service has been embraced, evidenced by a growing body of literature in health and health-related disciplines. METHODS: An initial literature search was undertaken using the key words "respite", "short-term care", "shared care" and "day care" in major electronic databases for nursing, psychiatry, psychology and sociology literature between 1967 and 2002, identifying 704 articles. Closer examination of the literature from 1993 to 2002 on gaps and trends in respite care for people affected by severe mental illness was conducted. This is discussed in the context of the broader literature, particularly on dementia, where the mainstream research on respite care is found. RESULTS: The majority of family caregiving studies identified a need for greater quality, quantity, variety and flexibility in respite provision, and the literature has remained largely silent in relation to those affected by severe mental illness. There are contradictory findings on outcomes of respite care services and a lack of controlled empirical studies and evaluative research on effectiveness. CONCLUSIONS: Respite care is beneficial for caregivers, there is significant unmet need in provision of services for the mentally ill, and greater flexibility and the needs of caregivers should be recognised and addressed.

4) Pinquart, M. and S. Sorensen (2006). "Helping caregivers of persons with dementia: which interventions work and how large are their effects?" Int Psychogeriatr **18**(4): 577-95.
BACKGROUND: In recent years, many different forms of interventions for caregivers of people with dementia have been developed. However, their results have been, in part, inconclusive. METHODS: Meta-analysis was used to integrate the results of 127 intervention studies with dementia caregivers published or presented between 1982 and 2005. RESULTS: Interventions had, on average, significant but small effects on burden, depression, subjective well-being, ability/knowledge and symptoms of care recipient. Only multicomponent

interventions reduced the risk for institutionalization. Psychoeducational interventions that require active participation of caregivers had the broadest effects. Effects of cognitive-behavioral therapy, support, counseling, daycare, training of care recipient, and multicomponent interventions were domain specific. The effect sizes varied by study characteristics, such as caregiver gender and year of publication. CONCLUSIONS: Because most interventions have domain-specific outcomes, clinicians must tailor interventions according to the specific needs of the individual caregivers. Although more recent interventions showed stronger effects, there is room for further improvements in interventions.

5) Cooper, C., T. B. Balamurali, et al. (2007). "A systematic review of intervention studies about anxiety in caregivers of people with dementia." Int J Geriatr Psychiatry **22**(3): 181-8.
BACKGROUND: There is considerable literature on managing depression, burden and psychological morbidity in caregivers of people with dementia (CG). Anxiety has been a relatively neglected outcome measure but may require specific interventions. OBJECTIVE: To synthesise evidence regarding interventions that reduce anxiety in CGs. METHODS: Twenty-four studies met our inclusion criteria. We rated the methodology of studies, and awarded grades of recommendation (GR) for each type of intervention according to Centre for Evidence Based Medicine guidelines, from A (highest level of evidence) to D. RESULTS: Anxiety level was the primary outcome measure in only one study and no studies were predicated on a power calculation for anxiety level. There was little evidence of efficacy for any intervention. The only RCT to report significantly reduced anxiety involved a CBT and relaxation-based intervention specifically devised to treat anxiety, and there was preliminary evidence (no randomised controlled trials) that caregiver groups involving yoga and relaxation without CBT were effective. There was grade B evidence that behavioural management, exercise therapies and respite were ineffective. LIMITATIONS: Many interventions were heterogeneous, so there is some overlap between groups. Lack of evidence of efficacy is not evidence of lack of efficacy. CONCLUSIONS: CBT and other therapies developed primarily to target depression did not effectively treat anxiety. Good RCTs are needed to specifically target anxiety which might include relaxation techniques. Some of the interventions focussed on reducing contact with the care recipients but caregivers may want to cope with caring and preliminary evidence suggests strategies to help CGs manage caring demands may be more effective.

6) Mason, A., H. Weatherly, et al. (2007). "A systematic review of the effectiveness and cost-effectiveness of different models of community-based respite care for frail older people and their carers." Health Technol Assess **11**(15): 1-157, iii.
OBJECTIVES: To review the evidence for different models of community-based respite care for frail older people and their carers, where the participant group included older people with frailty, disability, cancer or dementia. Where data

permitted, subgroups of carers and care recipients, for whom respite care is particularly effective or cost-effective, were to be identified. DATA SOURCES: Major databases were searched from 1980 to March 2005. Ongoing and recently completed research databases were searched in July 2005. REVIEW METHODS: Data from relevant studies were extracted and quality assessed. The possible effects of study quality on the effectiveness data and review findings were discussed. Where sufficient clinically and statistically similar data were available, data were pooled using appropriate statistical techniques. RESULTS: Twenty-two primary studies were included. Most of the evidence came from North America, with a minority of effectiveness and economic studies based in the UK. Types of service studied included day care, host family, in-home, institutional and video respite. Effectiveness evidence suggests that the consequences of respite upon carers and care recipients are generally small, with better controlled studies finding modest benefits only for certain subgroups. However, many studies report high levels of carer satisfaction. No reliable evidence was found that respite can delay entry to residential care or that respite adversely affects care recipients. Randomisation validity in the included randomised studies was sometimes unclear. Studies reported many different outcome measures, and all of the quasi-experimental and uncontrolled studies had methodological weaknesses. The descriptions of the studies did not provide sufficient detail of the methods of data collection or analysis, and the studies failed to describe adequately the groups of study participants. In some studies, only evidence to support respite care services was presented, rather than a balanced view of the services. Only five economic evaluations of respite care services were found, all of which compared day care with usual care and only one study was undertaken in the UK. Day care tended to be associated with higher costs and either similar or a slight increase in benefits, relative to usual care. The economic evaluations were based on two randomised and three quasi-experimental studies, all of which were included in the effectiveness analysis. The majority of studies assessed health and social service use and cost, but inadequate reporting limits the potential for exploring applicability to the UK setting. No study included generic health-related quality of life measures, making cost-effectiveness comparisons with other healthcare programmes difficult. One study used sensitivity analysis to explore the robustness of the findings. CONCLUSIONS: The literature review provides some evidence that respite for carers of frail elderly people may have a small positive effect upon carers in terms of burden and mental or physical health. Carers were generally very satisfied with respite. No reliable evidence was found that respite either benefits or adversely affects care recipients, or that it delays entry to residential care. Economic evidence suggests that day care is at least as costly as usual care. Pilot studies are needed to inform full-scale studies of respite in the UK.

7) Etters, L., D. Goodall, et al. (2008). "Caregiver burden among dementia patient caregivers: a review of the literature." J Am Acad Nurse Pract **20**(8): 423-8.
PURPOSE: To identify current evidence of factors influencing dementia-related caregiver burden (CB), describe patient and caregiver characteristics associated

with CB, and describe evidence-based interventions designed to lessen the burden of caregiving. DATA SOURCES: Comprehensive literature review of Cumulative Index of Nursing and Allied Health Literature, MEDLINE, and Psych Info was performed for the years 1996-2006 of peer-reviewed journals using keywords CB and dementia. CONCLUSION: Dementia caregiving has been associated with negative effects on caregiver health and early nursing home placement for dementia patients. Many factors influence the impact of the caregiving experience such as gender, relationship to the patient, culture, and personal characteristics. Although various interventions have been developed with the goal of alleviating CB, evidence suggests that individually developed multicomponent interventions including a diversity of services will decrease burden, improve quality of life, and enable caregivers to provide at-home care for longer periods prior to institutionalization. IMPLICATIONS FOR PRACTICE: The ability to properly assess the dementia patient-caregiver dyad related to CB is critical to decreasing its negative physical and psychological health outcomes. Appropriately tailored interventions can improve the health and well-being of both caregiver and patient.

8) Shaw, C., R. McNamara, et al. (2009). "Systematic review of respite care in the frail elderly." Health Technol Assess **13**(20): 1-224, iii.
OBJECTIVES: To assess the effectiveness and cost-effectiveness of breaks in care in improving the well-being of informal carers of frail and disabled older people living in the community and to identify carer needs and barriers to uptake of respite services. DATA SOURCES: Major electronic databases were searched from the earliest possible date to April 2008. REVIEW METHODS: Selected studies were assessed and subjected to extraction of numerical data for meta-analysis of quantitative studies and extraction of text for thematic analysis of qualitative studies. Quality of the studies was assessed using checklists specifically designed for the current review. RESULTS: In total, 104 papers were identified for inclusion in the quantitative synthesis, 16 of which were appropriate for meta-analysis. Carer burden was reduced at 2-6 months' follow-up in single-sample studies but not in randomised controlled trials (RCTs) and quasi-experimental studies. Depression was reduced in RCTs in the short term and for home care but not for day care. These effects, however, were not significant in random-effects models. There was a trend for longer interventions to have more positive effects than shorter interventions. There was no effect of respite on anxiety, but it had positive effects on morale and anger and hostility. Single-group studies suggested that quality of life was worse after respite use. There were increased rates of institutionalisation after respite use; however, this does not establish a causal relationship as it may be a result of respite being provided late in the caregiving career. A total of 70 papers were identified for inclusion in the qualitative synthesis. Uptake of respite care was influenced by: carer attitudes to caring and respite provision; the caregiving relationship; knowledge of, and availability of, services; the acceptability to, and impact of respite care on, care recipients; hassles resulting from the use of respite care; quality of respite care; and the appropriateness and flexibility of service provision. Carers

expressed needs for active information provision about services, support offered early in the caregiving career, access to a variety of services with flexible provision, reliable transport services, continuity of care, good-quality care, appropriate environments, care that provides benefits for care recipients (socialisation and stimulation), and appropriate activities for care recipients' levels of abilities and interests. CONCLUSIONS: There was some evidence to support respite having a positive effect on carers but the evidence was limited and weak. It is difficult, therefore, to make recommendations as to the most appropriate form of delivery of respite, apart from the suggestion that a range of services is probably most appropriate, to provide flexibility of respite provision and responsiveness to carer and care recipient characteristics and needs and also changes in those needs over time. There is a need for further high-quality larger trials that include economic evaluations.

9) de la Cuesta-Benjumea, C. "The legitimacy of rest: conditions for the relief of burden in advanced dementia care-giving." J Adv Nurs **66**(5): 988-98.
AIM: This paper is a report of a study conducted to identify the conditions that favour the relief of the burden of female caregivers of relatives with advanced dementia. BACKGROUND: Respite services are a response to caregivers' needs for rest. Although they are wanted and needed services, caregivers do not always have access to or use them. The need for a caregiver-centred approach to relieving the burden of care is a conclusion which respite researchers are increasingly reaching. METHOD: Grounded theory was chosen as the research strategy. Twenty-two female primary caregivers of relatives with advanced dementia participated in semi-structured interviews between November 2006 and May 2008 in Spain. Data collection was guided by the emergent analysis and ceased when no more relevant variations in the categories were found. FINDINGS: While having a rest is legislated as a right in civil and religious laws in family care in Spain, it should meet certain conditions that in the caregiver's eyes legitimate it. In the present study these were: (i) when there is no abandonment, (ii) when others are not harmed, (iii) when having a rest is obligatory and (iv) when having a rest is acknowledged. CONCLUSION: Many caregivers experience ambivalence over accepting respite. Nurses should assess caregivers' situations and promote context-specific interventions and a relief of burden free from guilt. Exploration of the conditions that favour the relief of burden within other cultural and caregiver groups is recommended.

10) Stirling, C., S. Andrews, et al. "Measuring dementia carers' unmet need for services--an exploratory mixed method study." BMC Health Serv Res **10**: 122.
BACKGROUND: To ensure carers of people with dementia receive support, community services increasingly use measures of caregiver (carer) burden to assess for unmet need. This study used Bradshaw's taxonomy of need to explore the link between measures of carer burden (normative need), service use (expressed need), and carer's stated need (felt need). METHODS: This mixed method exploratory study compared measures of carer burden with community services received and unmet needs, for 20 community-dwelling carer/care-

recipient pairs. RESULTS: A simple one-item measure of carers' felt need for more services was significantly related to carer stress as measured on the GHQ-30. Qualitative data showed that there are many potential stressors for carers, other than those related to the care-giving role. We found a statistically significant rank correlation (p = 0.01) between carer's use of in-home respite and the care-recipient's cognitive and functional status which is likely to have been related to increased requirement for carer vigilance, effort and the isolation of spouse carers. Otherwise, there were no statistically significant relationships between carer burden or stress and level of service provision. CONCLUSION: When carers are stressed or depressed, they can recognise that they would like more help from services, even if measures of carer burden and care recipient status do not clearly indicate unmet service needs. A question designed to elicit carer' felt need may be a better indicator of service need, and a red flag for recognising growing stress in carers of people with dementia. Assessment of service needs should recognise the fallibility of carer burden measures, given that carer stress may not only come from caring for someone with dementia, but can be significantly compounded by other life situations.

11) Molyneux, G. J., G. M. McCarthy, et al. (2008). "Prevalence and predictors of carer burden and depression in carers of patients referred to an old age psychiatric service." Int Psychogeriatr **20**(6): 1193-202.
BACKGROUND: Too little is currently known about the prevalence of and risk factors for depression and carer strain among informal carers of community-dwelling elderly mentally ill. This study seeks to assess the prevalence of depression, using the Geriatric Depression Scale-15 (GDS-15), the degree of carer burden/strain, and their risk factors among the primary informal carers of patients referred to our community-based old age psychiatry service. METHODS: A cross-sectional study design was used, with the subjects comprising 100 primary informal carers of patients who live at home and were referred to our service. The main carer measures were the GDS-15 and an adapted version of Gilleard's Strain Scale. Patients were assessed the Clifton Assessment Procedure for the Elderly-Survey version, the GDS-15 and the Mini-mental State Examination. RESULTS: Depression was found in 21% of the carers (a score of 5 or more on the GDS-15). The more problem behaviors identified and the greater the functional impairment of the patient, the higher the strain score deciles and the more likely the carer was to be depressed. Spouses were associated with lower carer strain scores. Patient diagnoses did not affect carer depression or carer strain. CONCLUSION: We found high levels of depression in the primary carers of community-dwelling patients attending an old age psychiatric service. The patients' behavior and their cognitive and functional ability conferred greater risk of carer depression or strain than their diagnosis. These risk factors may help identify carers at risk of strain and depression.

12) Neville, C. C. and G. J. Byrne (2008). "Effect of a residential respite admission for older people on regional Queensland family carers." Collegian **15**(4): 159-64.

OBJECTIVE: This study undertaken in regional Queensland aimed to determine the effect of a residential respite care (RRC) admission for older people on family carers. METHOD: The study used a repeated measures, prospective design. The participants were 100 family carers and their older dependants who were studied before and after the RRC admission. RESULTS: Family carer psychological distress increased after a period of RRC [F(1, 57) = 250.9, p < .001] as did the level of caregiver burden [F(1, 57) = 189.8, p < .001]. The presence of dementia and hearing problems in the RRC recipients, the psychological distress of the family carer, being younger and a spouse of the RRC recipient all predicted carer burden. CONCLUSIONS: It is not surprising that RRC, once over, does not necessarily reduce psychological distress and carer burden if this is associated with ongoing caring responsibilities that are resumed after RRC. Nurses need to discuss these issues with family carers and inform them of the likely outcomes of RRC and how they may better utilise the 'break' provided by RRC to counteract some of this response.

13) Tompkins, S. A. and P. A. Bell (2009). "Examination of a psychoeducational intervention and a respite grant in relieving psychosocial stressors associated with being an Alzheimer's caregiver." J Gerontol Soc Work **52**(2): 89-104.
Alzheimer's disease can be particularly devastating to those who are caring for their loved one with the condition. There have been recent calls for the tailoring of caregiving interventions to examine outcome differences between groups of caregivers and the reporting of effectiveness via longitudinal and specific outcomes. The purpose of this study was to examine 3 interventions (psychoeducational training, a respite voucher-type grant, or their combination) while looking for possible group differences. A total of 367 caregivers participated in the study. Participants completed surveys and questionnaires before the intervention and at a 6-month follow-up. Positive outcomes were found, including lower depression scores, increased support service use, and increased support group usage. Possible effectiveness of the 3 types of interventions, and variation among caregiver characteristics are discussed along with implications for future research.