

## 'Not another form!': lessons for implementing carer assessment in health and social service agencies

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### Abstract

This article addresses some of the issues that need to be considered in implementing carer assessment in health and social service agencies. It is based on findings from three studies involving the use of the CARE (Caregivers' Aspirations Realities and Expectations) Assessment Tool in Canada, a comprehensive psychosocial instrument. The first study, carried out between 1999 and 2001, was aimed at developing the CARE Tool, and had as one of its objectives to evaluate the feasibility of its implementation into ongoing practice. The second study, conducted between 2000 and 2003, was designed to evaluate the impact of using the CARE Tool, and also had an objective concerning implementation. A third study was undertaken in 2005–2006, in part, to gain more understanding of the barriers and outcomes of implementing carer assessment. All three studies used focus groups and individual interviews as the main data collection method. In all, this article is based on 13 focus groups and five individual interviews with home care professionals and 19 individual interviews with home care managers or supervisory staff, all having experience with carer assessment. Similar themes emerged from the thematic analyses of the data from all three projects. All studies point to the following as preconditions to successful implementation: clarification of carer status within policy and practice; making explicit agency philosophy with regard to the role and responsibilities of families in care and conceptions of carer assessment; and agency buy-in at all levels. Four themes emerged as issues for implementation: integration of the carer assessment tool with existing tools; ensuring training and ongoing supervision; work organisation and resources required for carer assessment; and logistical questions. It would appear essential that a clear rationale for moving towards carer assessment and its place in a global approach to long-term care and carers are essential to its implementation.

**Keywords:** carer assessment, implementation, health and social service agencies

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The issue of carer assessment is becoming increasingly present in policy, practice and academic literature. Noteworthy examples include the pioneering legislation in the UK mandating carers' right to an assessment, the development of specific carer assessment tools in Canada, Australia and throughout the USA, and the call by the National Consensus Project for Carer Assessment

Report to integrate carer assessment as a basic component of practice in the USA.

Despite all these advances and the increasingly widespread interest in incorporating carer assessment into the daily practice of comprehensive care for frail elders and adults and children with chronic or disabling conditions, there is little literature on the actual use of

carer assessment in practice settings and even less on the conditions for the implementation of carer assessment. This article, based on findings from three studies involving the use of the CARE (Caregivers' Aspirations, Realities and Expectations) Assessment Tool in Canada and to a lesser extent in the USA, considers enhancers and barriers to implementing carer assessment. We begin by presenting some background on carer assessment philosophy and content, before examining what is known about implementing carer assessment tools into health and social agency practice. We then describe the studies that inform this article and their results with regard to the implementation of carer assessment.

### What is carer assessment?

Carer assessment can mean many things. Definition and scope of carer assessment, the tools developed and the process chosen to implement the assessment, for example, are all a corollary of one's underlying philosophy concerning the basis of a valid and reliable assessment, one's perceptions of carers and their responsibilities, and the role of services with regard to carers. Perceptions of carers and their responsibilities range from consideration of the carer as the principal actor responsible for care to family members and friends with disabilities, to a view of the carer as only one of the potential partners in care, alongside other groups in society such as public and community services, voluntary organisations, and so on.

In line with these different perceptions of carers and the level of their responsibility, there are a variety of ideas concerning the way services should interact with carers, which in turn influence how one understands the purpose of carer assessment. For some, the justification for intervention with carers is to support them so that they can continue in their caregiving role as long as possible, while others consider that service support should consist of any action that helps carers to take up or decide not to take up, to continue in or to end their caregiving role (Nolan *et al.* 2001). The first-mentioned understanding of the role of services leads to assessment that serves to determine who is at the breaking point so that short-term and often intensive services can be put into place in order to avoid carer breakdown. The latter perception promotes assessment that is an interactive, personalised and contextually determined helping relationship aimed at promoting carers' well-being and freedom to have a life of their own (Nicholas 2003). How assessment is conceptualised is thus very dependent on the beliefs one has with regard to the respective responsibilities of carers and of services.

Despite these varied ideas concerning what carer assessment is, there seems to be growing consensus as

to what to include in carer assessment tools (Fancey *et al.* 1999, Feinberg 2004). Most tools used in practice settings reflect the complexity of caregiving by using a combination of carer-specific and generic dimensions. Typically these tools include: type and frequency of care provision, such as help for activities of daily living and instrumental activities of daily living; other responsibilities that may interfere with caregiving, such as employment; informal support; service needs; personal health (often seen as a barrier to providing care); burden and emotional reactions to giving care; ability to continue with care; and basic demographic and contextual information, such as living arrangements and ethnicity. Some tools also include financial and legal information needs (out-of-pocket expenses, emergency contacts, knowledge and use of advanced directives, guardianship and other legal planning tools); information about specific tasks; and information about housing and home environment (Guberman 2005).

Feinberg (2004) and others (Nolan *et al.* 1995, Guberman *et al.* 2001) point to some areas that are often neglected: actual work involved beyond hands-on personal care; quality of care provided; skills necessary to provide the care; values and preferences of the carer and the care receiver; positive aspects of caregiving; the history, quality and potential stresses of the care receiver – carer relationship; the relationship with other members of the family; crisis and future planning; relationships with formal providers; and access to information. In line with their vision of assessment as a tool to promote carer choice, Nolan *et al.* (2005) feel that questions about the carer's willingness and ability to assume or pursue caregiving should be central to any assessment. Carers should know exactly what they are getting into and what is involved, and should they agree to go forward, assessment should determine what skills and support they need to do so.

### Implementing carer assessment

While there is a growing body of writings on the implementation of carer assessment, few are based on empirical studies. One pilot project testing a carer assessment tool in Australia advances that commitment from senior management, policy-makers and funders towards carers and their assessment is essential for successful implementation (Maddock *et al.* 1998). Many researchers and practitioners who have worked at implementing carer assessment concur that the major challenge to implementation is getting assessors to see the carer as the client. To address this issue Feinberg & Newman suggest that having a specific tool and offering training are key (2004).

Worker resistance is cited in much of the literature as a major barrier to successful implementation (Baxter

2000, Bass 2001, Nicholas 2003). Several concerns lie behind practitioner resistance to carer assessment: excessive paperwork; lack of time due to care receivers' already overwhelming needs; lack of resources to meet the assessed needs of carers; fear of intruding into carer's time and privacy; and the fear of raising sensitive issues with which workers are not prepared to deal (Wright 2000, Bass 2001). In the UK, the most critical factor determining how case managers approached carer assessment was caseload size (Audit Commission 2003). The related issue of time surfaces in almost all discussions of carer assessment.

A further challenge to implementing carer assessment based on the UK experience is identifying carers and mobilising them for assessment. The terms 'carer' and 'assessment' may turn people away because they see themselves as family members, not as carers, and because the term assessment is interpreted as a process of passing judgement on their fitness to care rather than an examination of their situation and their needs (Robinson & Williams 2002). Identifying carers is also daunting as this population constantly changes. In the UK, for example, more than one-third of carers cease to provide or begin assuming care in any one year (Hepworth 2003). Even where assessment is mandated, an estimated half of carers are not known to service agencies (Audit Commission & Glendinning 2004). The reasons, besides lack of awareness and self-identification as carers, include lack of knowledge of entitlement, ambiguity as to the outcomes of assessment and difficulty asking for help.

The multicultural composition of populations in Western countries poses yet other implementation challenges, including the issues of language and cultural values around caregiving and service use.

Based on empirical studies evaluating the enhancers and barriers to implementing carer assessment tools in health and social service agencies, this article proposes to contribute to our knowledge and to support managers, professionals and agencies interested in developing carer assessment.

## Methods

The CARE Tool was developed as a global psychosocial assessment tool aimed at enabling carers to tell their stories and allowing practitioners to hear the carers' perception of their situation and any difficulties they might be having. Aimed at developing an individualised, contextualised understanding of the person's needs, the CARE Tool makes no assumptions about the carer's willingness to undertake a range of tasks or to continue caring. It recognises that the stress of caring is highly mediated through factors particular to the individual, and the ensuing intervention is defined, at

least in part, from the carer's perspective (Twigg & Atkin 1994, Qureshi 2000). It helps raise carer awareness of their situation, facilitate discussion and interaction between family and professionals so as to help both partners gain as complete a picture of the caregiving situation as possible and devise the most appropriate and timely kinds of support.

To construct the tool, we first collected carer assessments developed around the world, as well as research on tools that described what they should contain. We also organised separate focus groups with carers, practitioners and managers to help identify the key elements to be included in a carer assessment tool. The final version was pretested, tested and modified, resulting in a tool that covers 10 major themes (caregiving work – physical, emotional and organisational; informal and formal support; relationship with service providers; housing and transportation; juggling responsibilities, including employment; physical and emotional health; financial impacts of care; relationship with the person requiring care and with other members of the family; planning for crises and for the future; and support needs). Each section has both open and closed questions. The data gathered through the focus groups were instrumental in determining the choice and wording of many of the questions in the assessment tool.

This article addresses the implementation of carer assessment in day-to-day practice. It is informed by three studies. The first, referred to above, was aimed at developing the CARE Tool, but also had as one of its objectives to evaluate the feasibility of its implementation into ongoing practice. The second, designed to evaluate the impact of using the CARE Tool, also had an objective concerning its implementation. Both of these studies were carried out in home care agencies in Canada with home care professionals conducting the assessment of carers of home care clientele. A third study was specifically undertaken to gain greater understanding of the barriers and outcomes of implementing carer assessment, as well as to develop a condensed and more user-friendly version of the CARE Tool. In addition to contacting participants of the two previous studies, professionals and managers of other agencies in North America that had used or were offering carer assessment, with or without the CARE Tool, were included in this third study.

Focus groups with assessors and interviews with managerial and supervisory personnel of home care agencies were the main method of data collection of all three studies. Each focus group and interview was designed to capture feedback on the content of the CARE Tool, its usefulness and appropriateness, and issues concerning its eventual implementation into practice (see Box 1). This article will focus on the last theme.

**Box 1** Practitioner interview guidelines from Studies 2 and 3

**Practitioners' Group Interview Guide: Study 2**

**Functionality of the CARE Tool:**

First we would like general feedback on the Tool. I'll start by asking you ...

- What is your general impression (appreciation) of the CARE Tool?  
(Probe: length, comprehensiveness, context of the caregiving situation)
- Do you think it is suitable to identify caregiver needs?  
(Probe: comprehensive, accurate, adequate)
- Was the CARE Tool useful? In what ways?
- Was the CARE Tool a hindrance? In what ways?
- What sections or questions were the most useful to get a feel for the caregiving situation?
- What were the least useful?
- Were there differences using the CARE Tool with caregivers of persons with ADRD versus caregivers for persons without ADRD?
- Are there characteristics of the caregiving situation which impact on the use of the CARE Tool?  
(Probe: age, sex, ethnicity of CG, CG/CR relationship)

**Impact or change as a result of using the CARE Tool Assessment:**

One of the objectives of our study is to understand, from your perspective, the impact of using the CARE Tool on your daily practice. Thinking prior to your participation in this project ...

- How did you usually respond to caregivers? Has that changed? Can you give us an example? (Probe: ADRD)
- What role did caregivers play in relation to service? Has that changed? Can you give us an example? (Probe: ADRD)

Since your involvement in this study ...

- Have there been any changes regarding the steps you have taken to address the caregivers' needs? (Probe: ADRD)
- What should have changed as a result of the use of the CARE Tool but didn't?
- Has your knowledge and/or understanding of caregivers changed? How? (Probe: ADRD)
- Has your knowledge of and/or understanding of services available to caregivers changed? Are they satisfactory? (Probe: ADRD)
- Have your practices as an assessor changed as a result of using the CARE Tool? If yes, what has this meant for the CG and/or CR?
- What challenges and barriers did you face in acting on the results of the CARE Tool?

**Feasibility of integration:**

Given our discussion and your experiences using the CARE Tool:

- What would permit you to better meet caregiver's needs?
- Is there a need to integrate the tool into agency practice?
- What structures and mechanisms enabled you to integrate the CARE Tool into your existing practice?
- What would have to change in your agency for the CARE Tool to become a permanent compulsory tool?

**Practitioners' Interview Guide – Study 3**

**Functionality of the CARE Tool:**

- What is your general impression/opinion of the CARE Tool?
- What is it like to use the CARE Tool? How easy or difficult?
- In what ways is the CARE Tool useful?
- What are the positive or negative aspects of doing caregiver assessments?

**Structure of the CARE Tool:**

- What sections or questions are the most useful for getting a feel for the caregiving situation? For informing the summary page?
- Are there questions in the CARE Tool that are redundant, or not pertinent?
- Are there questions in the CARE Tool that do not feed into the summary page?
- What would you want to see in a shortened CARE Tool? (i.e. how many pages, how much time should it take, what should it cover, what should be eliminated)

**Impact of the CARE Tool:**

- From using the CARE Tool did you discover anything that you did not know about the caregivers before?
- Has your knowledge and/or understanding of caregivers' needs changed? How?
- In what ways did using the CARE Tool impact on your development of a service plan?
- What challenges and barriers did you face in acting on the results of the CARE Tool?
- To what extent was the introduction of the CARE Tool linked to changes in services or service delivery?
- In what ways did using the CARE Tool impact on the caregiver? The care receiver?
- Have there been any other outcomes of using the CARE Tool?

**Implementation of the CARE Tool:**

- What structures or mechanisms enabled you to integrate the CARE Tool into your practice?
- If the CARE Tool is not fully integrated into your agency or into your practice, why not?
- What would it take for a shortened CARE Tool to be implemented in your agency?

In the first study, which took place between 1999 and 2001, seven home care agencies in Canadian provincial home care programmes, four in Québec and three in Nova Scotia, were chosen as research sites. These sites were chosen to provide diversity in terms of urban and rural settings, size of agglomeration, dominance of French- or English-speaking clientele, and socioeconomic status of clientele. There were no other inclusion or exclusion criteria. Letters were sent to all existing home care agencies inviting them to participate and the sample is made up of those that agreed. From the seven agencies involved, a heterogeneous group of 40 home care practitioners were involved in the project including social workers, nurses and rehabilitation professionals. Focus groups were held in each of the agencies with the participating assessors at the end of the test phase during which the tool was administered twice to 168 carers (336 assessments). In each agency, an individual interview was held with the management or supervisory person connected to the project. The second study (2003–2006) involved 34 assessors, mainly social workers and nurses, from five public agencies in Québec, four regions of the provincial home care agency in Prince Edward Island, as well as four offices of Veterans' Affairs Canada. The same criteria for diversifying the sample as in Study 1 were once again applied. There were no other inclusion or exclusion criteria, other than a willingness to be involved. Following the testing phase during which the CARE Tool was administered to 183 carers (with a similar number in a control group who were not assessed), five focus groups, involving 25 assessors were organised, sometimes bringing together workers from more than one agency. As well, three individual interviews were conducted with assessors and seven more with management personnel. For the third study, individual and group interviews were conducted in 2005–2006 with 11 practitioners, and six managers from Canadian home care agencies, and US agencies and government departments at the state level. We sought out individuals who had experience in carer assessment and in particular with the CARE Tool. In all, this article is based on 13 focus groups and five individual interviews with home care professionals and 19 individual interviews with home care managers or supervisory staff, all having experience with carer assessment (see Table 1).

While 12 out of 13 focus groups and most interviews were conducted in person, prohibitive distances for practitioners and managers resulted in conducting interviews by telephone in some situations. All focus groups and interviews, including those conducted by phone, were audio-taped and transcribed verbatim. Individual interviewees' contributions were not

identified on a personal basis. The transcripts were thematically coded and analysed by the research team. Transcribed verbatim were analysed using traditional thematic analyses. Analyses took into account comparisons both within data sources and between data sources and asked questions of the data in order to search for both similarities and differences. Conceptual themes, ideas or assumptions located in the data were identified. These were then defined and refined until we achieved an interjudge consensus on categories, which were exhaustive, exclusive, homogeneous and relevant to the research question. Both intra- and inter-study analyses were undertaken.

## Results

Very similar themes emerged from the analyses of the data from all three projects and we will thus present the merged results, while indicating when a specific theme was unique to a particular study.

### Prerequisites to implementation

Feedback from informants raised a number of important questions regarding the implementation of the CARE Tool, or any carer assessment tool, within health and social service agencies and pointed towards a number of conditions that need to exist before agencies can move in this direction. These include the clarification of carer status within policy and practice; the need to make explicit the agency's philosophy with regard to the role and responsibilities of families providing care as well as its perceptions of carer assessment; and agency buy-in at all levels, from management to front-line staff.

### Defining carers as clients

Before carer assessment can be implemented into policy and practice, professionals and managers believe that it is essential that carers be given an explicit status in policy and within the service package. Respondents indicated that because of insufficient resources, lack of time and inappropriate tools, there is a culture of normalcy regarding the situation of carers leading to some incomprehension as to why they should be assessed. In many agencies the implementation of the CARE Tool raised numerous questions about whether carers should be considered as clients. There was even some controversy on this issue in a number of agencies, as it was felt by some professionals that carers can fluctuate between being clients and partners in care, while other professionals, not sensitised to carer issues, may totally ignore carers or simply see them as complementary resources to the service system, but certainly

**Table 1** Synopsis of the three studies\*

	Objectives		Methods	Sample
<b>Study 1 Developing and validating the CARE Tool</b>	1. To develop a screening and an assessment tool for assessing the context, the conditions and the needs of family caregivers 2. To test and <b>evaluate these tools in CLSCs in Québec and in home care agencies in Nova Scotia.</b>	Two phases: 1. Development 2. Testing/ <b>validation</b>	1. Literature review, focus groups 2. Interjudge reliability, internal coherence, <b>qualitative focus groups</b>	7 home care agencies, 168 carers of home care clients, <b>7 focus groups with 40 assessors and 7 interviews with managers</b>
<b>Study 2 Evaluating the impact on caregivers of being assessed with the CARE Tool</b>	1. To evaluate the differential impact of using the CARE Tool on the change in risk to the well-being of caregiving situations of persons with and without AD 2. To evaluate the impact of the assessment process using the Caregiver Assessment Tool on practitioner's knowledge and attitudes toward caregiving 3. To evaluate the impact of the assessment process using the CARE Tool on practices and/or responses to caregivers of persons with and without AD 4. To evaluate the feasibility of integrating the CARE Tool into the regular practice of home care professionals		A pretest–posttest quasi-experimental design with quantitative and qualitative methods	3 sites of provincial home care services in Prince Edward Island, 4 home care agencies in Quebec, and 3 sites of Veterans' Affairs 6 focus groups and 7 individual interviews with practitioners and managers at the conclusion of the testing to provide further information about the implementation process
<b>Study 3 Understanding the barriers to implementing carer assessment</b>	To gain more understanding of the barriers and outcomes of implementing carer assessment		Qualitative individual and group interviews	24 informants – 7 caregivers, 11 practitioners, and 6 managers

\*Elements pertinent to this article are in bold.

AD, Alzheimer's disease; CLSC, Centre local de services communautaires (Local Community Service Centre – provides home care).

not as partners, nor as potential clients. According to one manager, 'it was very difficult when this programme came about for the service providers to think of the carer as recipient of services, so I think this assessment helped a great deal in recognising the carer as client.' Many informants discussed the need for a shift in perspective. One focus group participant stated that some of her colleagues do not share her outlook on carers needs: 'Some feel, "don't turn carers into clients", they feel "let them be family carers ... it's just a normal part of life, why are we medicalising it?" ...'

Clearly, agencies wishing to consider implementing carer assessment will first have to arrive at a common understanding of carers and their situations and responsibilities, so as to justify attributing them the status of potential clients requiring assessment. However, one respondent believes that implementing carer assessment can be in and of itself a strategy to redefining them as clients. 'If we had a tool that would allow us

to have a really good picture or evaluation of the carer, then they would become our clients as well.'

### Carers must be an agency priority

There can be resistance, within agencies, to the implementation of new tools that require time, training, and new perspectives. According to informants, it seems that one of the keys to 'sell' carer assessment to practitioners is to have managers and supervisors who believe in it fully. One manager from a US agency stated that at first it was a hard sell but then they 'got in a supervisor who believed in it, had staff changeover, and just mandated it.' That supervisor herself was also interviewed, and she stated that she was simply 'insistent' that the CARE Tool be implemented systematically. She said that it 'took someone who is very strong to get in there and really push it.' These comments indicate that agencies may need to begin in a 'top down' way to

establish the right conditions for implementing carer assessments.

### **Staff must be on-board**

Front-line workers must nonetheless also be on-board. Our informants agree that given potential worker resistance to added responsibilities and in particular resistance given additional tools to administer, in-take workers, assessors and front-line practitioners must be consulted and included in all implementation decisions from the outset.

If you arrive with another tool and tell them from now on you have to use this, I think there would be some negative reactions. You have to really think out how you're going to present it, explain its usefulness and the approach which underlies carer assessment and the validity of having yet another tool. You have to really explain it well for there to be openness and for it to be well understood and well accepted. (Focus group participant)

Indeed, one manager whose agency participated in the second study believed that the tool was successfully implemented in the context of the study because support to carers was already a worker preoccupation:

The impact of the project was to develop worker openness to this clientele. And it fit very well with their interests, because carer respite and support is something they take to heart.

Informants from agencies in which the tool was not being implemented, contacted for the third study, stated that it did not move forward because the practitioners did not buy into it.

One worker sums up by indicating how both management and workers must believe in the importance of supporting carers for carer assessment to be successfully implemented:

It's feasible to integrate the CARE Tool into daily practice to the extent that you want to do something for carers and our bosses don't get on our cases because we haven't been able to do other things ...

### **A common conception of assessment**

Once carers are designated as an agency priority and their status has been clarified, it is important that all agency personnel arrive at a common understanding of the purpose and the use of an assessment tool. Several perceptions of the potential use of the assessment tool were voiced by assessors and administrators, including: a statutory tool to be administered to all carers identified by the agency; a tool to be used as needed, based on worker discretion; a tool for crisis situations or for high-risk carers; and a tool to determine eligibility for

services. The type of tool to be used and its place in workers' practice is very dependent on the anticipated outcomes.

Several practitioners indicated that the use of the tool provoked discussions among their colleagues as to the nature and the time accorded to all assessments and led to the questioning of certain shifts in their current practice due to administrative constraints. A manager concurs: 'It's also engaged people in discussions about how we assess. You know, how much time we allow ...'

Indeed, given current assessment practices in agencies which tend to be based on tools evaluating care receivers' functional limitations in order to determine eligibility for services, the introduction of new tools and, in particular, a comprehensive psychosocial assessment tool such as the CARE Tool, presents major challenges.

One clinical supervisor suggested that the use of this type of tool is beneficial in that it questions current practices and forces professionals to focus on clinical interventions.

They are very accustomed to working under a lot of pressure and speed and fast. And I think this tool fortunately asks them to do more clinical work. So it is not just a case of managing the situation ... they are moving away from their case management role [towards a more clinical role].

Another aspect of the same question raised by some respondents is the gap between current pressures to 'get in and get out fast', given the present context of under-funding and overwork, and the assessment goals of in-depth analysis of a situation and a focus on prevention.

Not everybody in the system believes that the time spent front-end is well spent. (Focus group participant)

We run after the fires, we put out the major fires and we leave the embers and move on to the next one. We're not in a preventive mode. (Focus group participant)

Clearly, before carer assessment can be introduced into an agency, several issues related to values concerning carers and their roles and responsibilities, philosophies and practice approaches with regard to carer assessment and intervention must be discussed with all levels of agency personnel in order to develop common goals, understandings and commitments.

### **Issues for successful implementation**

#### **Integration of the carer assessment tool with existing tools**

As indicated above, front-line assessors are generally leery of 'more paperwork' given the multiplication of

forms and assessments they must already complete. As one practitioner indicates: 'I think there is also a passive resistance to more paper work, we have a lot of it, it's very cumbersome.' The carer assessment tool must thus be adapted to each agency setting and the tools and forms currently in place. A supervisor concurs: 'You'll have to make sure that the carer assessment tool doesn't duplicate the other forms we use.'

### **Ensuring training and ongoing supervision**

Practitioners and managers alike consider that the success of tool implementation is linked to adequate training in the use of the tools and ongoing clinical supervision to ensure adequate interventions to respond to the identified needs.

We would need more, I think, clinical supervision, in order to pick up on the needs of the carers [ ... ] both before the tool and after, particularly in the initial stage. (Focus group participant)

Informants suggest that training cannot just pertain to *use* of the assessment tool, but must also encompass comprehensive caregiving issues. They consider essential that the practitioners involved in using the tool be fully aware of the potential impacts of caregiving (emotional, physical, financial, social), the resources available to carers, and that they have the opportunity to reflect on their own values systems and biases.

### **Work organisation and resources required for carer assessment**

Perhaps the most delicate issue with regard to the future implementation of carer assessment raised by respondents is that of the potential human and financial resources that will have to be allocated. It is generally believed that mandating carer assessment will likely require new investment, both in terms of the additional staff needed to support this new group of potential clients and in terms of developing the services and resources that carers need in order to manage their responsibilities without undue negative effects to their own well-being. Otherwise, assessment would become an additional responsibility of already burdened agency professionals. Comprehensive assessments require time, a rare commodity in today's health and social service agencies. The question of the time required to do assessment was repeatedly mentioned by practitioners, and to a lesser extent, by managers.

If you want tools that are done well, that takes time. We can't go fast, fast, fast, and do everything well. I don't believe in that. We'll stumble somewhere along the way if we go too quickly, and have to start all over again. This is a valid tool, but

we can't just dodge the issue of the time it takes. (Focus group participant)

While most respondents felt that additional human resources may be needed if time is to be allocated to carer assessment and intervention, some agencies were able to implement the CARE Tool by liberating one or two workers from part of their regular caseload to become specialists in carer assessment and intervention, without investing in more staff.

Rethinking work organisation and the allocation of work with carers also raised the issue of how carer assessment and intervention will be indicated in agency statistics. As one supervisor pointed out:

And statistically it is probably good to know how many get done. And again it reflects what people did with their own time and that it is a big chunk of time. It deserves recognition and we are functioning in a system that recognises work through statistics.

At another level, the observation that assessments are done in a context where few if any community services and resources exist for carers, leads to frustration on the part of both the assessor and the carer.

'What do we do after?' It's in the 'after' that I have questions. A carer could say to me, 'Well, I've answered all your questions, now what are you going to do with that?' I wouldn't know how to answer them. So I have some reservations. (Focus group participant)

### **Who should be assessed? When? By whom?**

Some of the focus group and interview participants discussed more concrete aspects of implementation of carer assessment including the determination of which carers should be assessed and by whom. As well, varied opinions as to the optimum timing for administering the tool were expressed. Questions were raised as to its appropriateness for use at intake when the family first contacts services. Some respondents felt that carer assessment could be done at the same time as evaluation of the person needing care, while many felt it would be more suitably administered once services for the person requiring care had been put into place.

The question of which carers should be assessed was also debated. Most respondents, taking into account their current practice context, time factors and workloads, propose that only 'high-risk' carers be assessed, using a screening instrument to detect levels of risk, burden or depression, etc., and only assessing those with high scores. Many agree that, ideally, all carers should have access to an assessment in order to get, at a minimum, their perception of the care situation and its impacts, both positive and negative, on their lives. Indeed, if carer assessment is seen as a tool to prevent potential or

future carer breakdown, then limiting assessment to those already in distress may be questionable. As informants point out, prevention is not easy, especially since many carers turn to their health and social service providers only in times of crisis. But, according to some respondents, it is all the more difficult to deal with prevention within agencies in which there may be resistance to providing services to carers who are not showing signs of intense distress or burnout. Proper training for staff and management can help to deal with these challenges.

Finally, although the CARE Tool was conceived so as to be administered by most health professionals, informants, particularly in the third study, tend to feel that social workers are best suited to do psychosocial assessments.

I'm not a social worker, there's a difference [ ... ] so in the beginning I was really uncomfortable letting people open up about things over which I had no control [ ... ] I had the impression that I was just making a real mess ... (Interview with an assessor)

## Discussion

Manifestly, the introduction of the CARE Tool, or any comprehensive carer assessment tool, into health and social service agency practice, will occur only under a particular set of circumstances, some of which have direct implications for policy and the organisation of service delivery. In order to integrate carer assessment, a series of steps are necessary, including clarification of agency and staff values and understandings with regard to carers and assessment, the development of a common understanding of the status to be given carers, and the place and the role of assessment in service delivery (Guberman 2005).

Based on their experience in Australia, Maddock *et al.* (1998) conclude that assessment must be part of a comprehensive strategy for developing a multidimensional approach to carers that sets out how agencies/governments are proposing to support them. To that extent, policy-makers, agency management and staff must all be involved in serious discussions about the rationale for moving towards carer assessment and its place in a global approach to long-term care and carers. Certain experiences point to the advantages of designating specialist staff to lead the development of effective support for carers and to shape an overall carer strategy (Carers Australia 2003). Analyses from Australia also suggest that there be a clearly articulated multi-agency local carer strategy that translates into an agreed action plan with achievable time-limited objectives in districts, regions or communities planning to invest in carer services.

Several issues raised by respondents in our and other studies will also have to be addressed. While the majority of respondents in our studies suggest that social workers are best suited to administering comprehensive psychosocial assessments to carers, others consider that properly trained nurses and other professionals with psychosocial skills can successfully do these assessments (Deveraux Melillo 1995, Bradley 2003). But each agency will have to designate the most appropriate staff to this new area of work. Choice of assessors will also have to take into account the diversity of caregivers who will potentially be assessed in terms of ethnocultural origin, socioeconomic class, caregiving situation, sexual orientation, etc., and the capacity of assessors to develop relations of confidence with these different groups. This also holds true for the choice of the assessment tools, which must be both relevant and appropriate to the diversity of caregivers (Geron 1997).

In a context of restraints and fears of skyrocketing long-term care costs as the baby-boom generation reaches old age, allocating resources to carers may seem like a luxury. And yet, can we afford not to move in this direction without seriously compromising the well-being of millions of people given the levels of stress, distress and illness experienced by carers (Guberman *et al.* 1991, Guberman *et al.* 1993, Neal *et al.* 1993, Zarit & Edwards 1996, Keefe & Fancey 1997, Schulz & Beach 1999, Cannuscio *et al.* 2002, Lee *et al.* 2003).

What needs to be recognised is that, in many cases, the assessment of carers' needs early on in the process will lead to delay, reduction or even elimination of future crises (Feinberg 2004, Nolan *et al.* 2005). As such, assessment can often be more efficient in the long run, as managing crises is generally time-consuming, as well as costly to the agency and to the system in general (Guberman 2005).

Furthermore, one must consider that the assessment process is a service in and of itself with many potential positive outcomes for carers. When assessment does uncover needs that cannot be met by the agency, it acts as an important tool for identifying gaps in services, and possibly preventive responses. It is also important for agencies to recognise that not all services need to have additional budgets attached to them.

Empirical studies (Qureshi 2000, Guberman *et al.* 2003, Lundh & Nolan 2003) have shown that the introduction of carer assessment tools legitimises the right of practitioners to treat carers as potential clients, to hear their stories and to determine service plans based on a full understanding of the global care situation, not just the needs and reality of the person needing care. An effective carer assessment tool enables practitioners to identify areas of concern to the carer and develop

ways to respond creatively (Pickard 2004, Gaugler *et al.* 2000). Having a clear rationale, including a holistic understanding of the carer's view and desired outcomes, along with the care receiver's perspective, enables limited resources to be targeted appropriately and interventions to be improved (Ellis 1993). Even when little change can be made in service delivery, the very act of recognising carers as separate individuals with their own needs has been shown to have positive impacts (Lundh & Nolan 2003).

## Conclusion

This article presents three Canadian studies based on interviews with professional assessors and managers who had considered or were using the CARE Tool, a comprehensive psychosocial assessment of caregivers' aspirations, realities and expectations. Its aim was to examine different challenges to implementing this and similar assessment tools into ongoing agency practice. It is thus a small contribution in an area where little research exists. For example, despite the reality of mandated assessment in the UK, few studies actually examine how the law is applied at the local level in terms of the implementation of specific assessment tools and the difficulties encountered (Seddon & Robinson 2001, Robinson & Williams 2002, Audit Commission & Glendinning 2004). In North America where there is an ongoing push for mandated assessment by the Family Caregiver Alliance in the USA, which convened a National Consensus Conference for Caregiver Assessment in 2005, and by the Canadian Caregiver Coalition which has policy papers written on the issue, there is almost no empirical data on how to go about implementing carer assessment into daily practice in local agencies. Given this dearth of empirical evidence on carer assessment implementation, this article documents some of the elements that must be considered by agencies moving in this direction.

However, the studies presented are limited in that they did not actually examine the implementation process but are based on assessors' and managers' perceptions of what helps and hinders this process. Further research should document and assess the actual implementation process to draw out other issues and aspects to be considered from the points of view of all involved.

While the implementation of carer assessment appears to promote positive outcomes for all involved, it must be remembered that carer assessment is only a tool, not an end in itself. For assessment to matter, the rationale and philosophy underlying support to carers and the status of carers within the health system need to be made explicit. Values with regard to the roles and

responsibilities of families, friends and neighbours, the private and public sectors are central. Are carers to be assessed only to control their access to resources, to offer them minimal support so they can carry on despite major hardships and long-term dangers to themselves? Or will assessment give them an opportunity to take stock of their situation and participate in a process that enables them to better balance their own needs with caregiving and other responsibilities?

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