

“There is more that we can do!”- Health professionals’ perspectives on supporting the health and wellbeing of older carers of older people: a qualitative interview study

Aislinn F Lalor

aislinn.lalor@monash.edu

Monash University

Keith D Hill

Monash University

Maira Watson

Murdoch University

Natasha Layton

Monash University

Den-Ching Angel Lee

Monash University

Christina Bryant

The University of Melbourne

Anjali Khushu

Peninsula Health

Elissa Burton

Curtin University

Deborah Oliveira

Universidad Andrés Bello

Natasha K Brusco

Monash University

Susan Slatyer

Murdoch University

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Abstract

Background: Older carers of older people provide essential support that enables many older people to live well at home. Many do so while neglecting their own health, which has detrimental impacts to their quality of life. Despite this, healthcare services often do not consider the health and wellbeing needs of carers and focus only on meeting the older person's needs. We aimed to identify health professionals' perspectives of i) the nature of advice and support provided to older carers of older people about their own health and wellbeing, ii) the strengths and weaknesses of existing services in supporting older carers of older people, and iii) elements of a preferred model of carer support.

Methods: This study formed part of a larger mixed-methods study to co-design a new model of care for older carers in Australia. Semi-structured interviews were conducted with health professionals whose care recipients attended specialist outpatient clinics or community services in Victoria or Western Australia. Interviews were audio-recorded and thematically analysed.

Results: Interviews were completed with 21 health professionals across seven disciplines in two states in Australia. Twenty health professionals (95%) were female, with the majority (80.9%) having >10 years of clinical experience. Five themes were identified: (1) health professionals recognise the challenges experienced by older carers; (2) carer assessment and support are inconsistently embedded within health services; (3) existing support for older carers is limited and fragmented; (4) system constraints limit support for carers; and (5) features of an optimal support model for older carers. Across themes, participants demonstrated a strong awareness of the challenges experienced by older carers and identified substantial gaps in current service responses. While many health professionals described having the knowledge and skills to support carers' health and wellbeing, they reported being constrained by existing models of care, funding arrangements and competing service priorities.

Conclusions: Health professionals consider that current service models limit their ability to comprehensively assess and meet carers' needs. Findings informed the development of a Carer Health and Wellbeing Service to support older carers of older people.

Background

Carers are defined as people who provide "unpaid care and support to family members and friends" [1] and represent a substantial component of the unpaid workforce [2]. Carers of older people provide essential care and support to older people with health conditions to help them to continue living in the community. Much of the research about carers includes carers of all ages. However, as populations age, a substantial proportion of carers in many countries are themselves older adults. While many factors influence the health and wellbeing of carers across the lifespan, some factors may be particularly important for older carers and may require tailored support strategies and interventions. These include being less likely to seek support, experiencing higher levels of loneliness and social isolation, and managing their own age-related health conditions while providing care for a person with complex care needs [3–7]. Older carers of older people (defined in this study as carers aged ≥ 50 years providing

informal care for an older person aged ≥ 65 years) therefore represent a group with distinct support needs that may benefit from targeted approaches to maintaining health and wellbeing.

Providing care can exacerbate and/or compound carer health issues. Interactions of older carers with health professionals in Australia are often focused on the health and care needs of the person for whom they care [8], with limited focus on their own health [9]. An Australian survey of 189 older carers of older people highlighted that, even when they saw a medical doctor for their own health, 17% indicated the doctor was not aware of their carer role, and 46% said they only sometimes or rarely discussed or received support for their carer role [10]. Most survey respondents (57%) had attended a specialist multidisciplinary geriatric service for the health of their relatives ($n = 103$), whilst only 19% ($n = 20$) had received any advice or support for their carer role [10]. Similarly, a qualitative study of older people and carers (aged 54 to 92) receiving specialised geriatric support in the United Kingdom identified a strong need for such services to enhance attention to informal carer needs [11]. The findings emphasised the key role of health professionals in optimising the health and wellbeing of older carers of older people.

Effective multidisciplinary approaches to address the specific issues that affect older carers' health are likely to have positive effects on their wellbeing and quality of life [12, 13], such as psychosocial programs, physical activity/exercise [14–18], occupational therapy programs [19], and educational programs [20], and multi-component interventions that combine two or more approaches [21–24]. Such interventions may also enhance carers' capacity to sustain their caregiving role over time. However, despite growing evidence regarding potentially beneficial interventions, an international study mapping interventions and outcomes specifically for older carers identified several important research gaps, noting that evaluations rarely considered impacts of interventions on carers' physical health, quality of life, and social and financial wellbeing [25].

In this study, we explored the perspectives of Australian health care professionals about (1) the nature of referral, information, advice, and support provided to older carers of older people to optimise their own physical and mental health, (2) the strengths and weaknesses of existing services in supporting older carers, and (3) their views regarding the design of a preferred model of support for older carers of older people.

Methods

Study design

This study employed an exploratory qualitative descriptive design, using in-depth semi-structured interviews to explore health professionals' perspectives regarding support for older carers of older people.

Participants

Health professionals who were currently providing health services and support for older people (aged ≥ 65 years) living in the community who had an older carer (aged ≥ 50 years) were eligible for inclusion. Recruitment targeted staff of hospital out-patient services, specialist geriatric services (e.g. Falls and Balance Clinics, Geriatric Evaluation and Management Clinics), and community health services/clinics under the management of the two participating health services (Fiona Stanley Fremantle Hospital Group in Western Australia and Peninsula Health in Victoria). Health professionals from any discipline, including medical, nursing, and allied health professions, were invited to participate through a general email distributed to relevant clinical teams by managers. To minimise potential power imbalances and protect privacy, managers were not informed who chose to participate. Staff interested in participating contacted the research team directly, and no information regarding expressions of interest or participation was shared with managers or colleagues. All participants provided written informed consent prior to participation.

Data collection

Data were collected through semi-structured, in-depth interviews between December 2021 and April 2022. In Western Australia, all interviews (n=9) were conducted face-to-face in a private room within the hospital clinic, providing a quiet and confidential setting that was convenient for both participants and the interviewer. In Victoria, due to COVID-19 restrictions, interviews were conducted either online via Zoom (n=4) or by telephone (n=8). For all modes of data collection, participants were provided with study information and informed consent procedures prior to interview commencement. Interviews followed a semi-structured interview guide designed by the research team, drawing on relevant literature and the team's previous clinical and research experience. The interview guide comprised seven questions and associated prompts (Supplementary file 1). Interviews were conducted by two researchers (AL, an experienced occupational therapist, and SS, an experienced nurse; both were female, had a PhD, and qualitative research expertise). Researchers and participants were unknown to each other. Interviews were audio-recorded and transcribed verbatim. Interviews lasted from 12 to 76 minutes to accommodate participants' role activities, although most were around 20-40 minutes.

Ethics approval

Research in this study was conducted in accordance with the Declaration of Helsinki (<https://www.wma.net/policies-post/wma-declaration-of-helsinki/>), and the study findings are reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [26]. This project was approved by the Human Research Ethics Committees at Peninsula Health (Frankston, Victoria; ID 76671), and South Metropolitan Health Service (Perth, Western Australia; ID RGS 04661), and reciprocal approvals from ethics committees at Monash University (ID 27379) and Murdoch University (ID 2021/083).

Data analysis

Interview data were analysed using inductive thematic analysis as described by Braun and Clarke [27]. Analysis was conducted at a semantic level, focusing on participants’ explicit accounts and experiences rather than interpretive or latent meanings. Interviews were transcribed verbatim and de-identified by a professional transcription service. Each participant was assigned an individual code comprising a number and their role (e.g., P10, Social Worker). Following transcription, four researchers (AL, SS, MW, KH) familiarised themselves with the data through repeated reading of the transcripts. Initial codes were then generated inductively using NVivo and Excel, with coding focused on content relevant to the research questions. The researchers subsequently examined patterns across the coded data to develop preliminary themes and subthemes. Themes were reviewed, refined, and defined through team discussions to ensure they accurately reflected the dataset. Representative participant quotations were selected to illustrate each theme and subtheme. Participants were not invited to review or provide feedback on the findings.

Results

A total of 21 health professionals from Victoria and Western Australia participated from seven disciplines: Social work (n=5), Physiotherapy (n=5), Nursing (n=3), Occupational Therapy (n=3), Dietetics (n=2), Geriatric Medicine (n=2), and Psychology (n=1). Twenty (95%) were female, and 81% had >10 years of clinical experience (Table 1). Five themes were identified: (1) health professionals recognise the challenges experienced by older carers; (2) carer assessment and support are inconsistently embedded within health services; (3) existing support for older carers is limited and fragmented; (4) system constraints limit support for carers; and (5) features of an optimal support model for older carers (Figure 1).

Table 1. Participant demographics (n=21).

Characteristic	Total number
Age (years)	
20-30	2
31-40	7
41-50	3
51-60	6
61+	3
Location (State)	
Victoria	12
Western Australia	9
Years of experience	
0-5 years	1
6-10 years	3
11-15 years	7
16-20 years	1
21-30 years	2
30+ years	7
Work status	
Full-time	6
Part-time	15
Years working in current service	
<5 years	9
5-9 years	4
10+ years	8
Health professional's clinical service:	
Falls prevention service	4
Memory clinic	3
Community rehabilitation/ community health	2
Geriatric Medicine service	1
Parkinson's Disease clinic	1
Works across two or more clinical services (Geriatric Medicine, Memory Clinic, Parkinson's Disease)	6
Other (e.g. Allied Health Outreach, stroke program)	4

Theme 1: Health professionals recognise the challenges experienced by older carers

Health professionals consistently described older carers as facing considerable personal, health, and system-related challenges. Participants highlighted the responsibilities associated with caregiving, its impacts on carers' lives and wellbeing, the complexity of accessing support, and the particular experiences of some older male carers. These findings are presented across five subthemes.

Caring is viewed as a personal responsibility

Health professionals often described older carers as viewing caregiving as a personal responsibility and a central part of their role within the family. According to participants, many carers prioritised the needs of the person they supported above their own health and wellbeing, often focusing their attention on the care recipient rather than themselves. Health professionals also perceived that some carers were reluctant to seek additional support or discuss their own difficulties, viewing caregiving as a commitment they were expected to manage independently and not to be seen as weak or not coping.

"not seeking help because ... [they say] ... 'that's my responsibility'" (P16, Physiotherapist)

One participant observed that concerns about the care recipient often took precedence over carers' own health needs:

"and a lot of them will say "oh, no, I'm not sleeping well but that's okay" because the focus is, from their end, supposed to be on the patient" (P17, Social Worker)

Several health professionals suggested that some carers consistently placed the needs of others before their own, which could limit attention to their own wellbeing and support needs.

"I often say you're a carer, not a saint ... you've got needs that need to be met first as being a person" (P19, Social Worker)

"because people who become carers tend to have that nature, that they will just kind of go - oh, you first, me later" (P04, Nurse)

Lastly, participants also perceived that some carers may be hesitant to disclose emotional difficulties or seek help when struggling with the caregiving role.

"and a lot of carers probably feel that it's a weakness to admit that they're not coping emotionally" (P01, Social Worker)

The life-changing impacts of caregiving

Health professionals described caregiving as a major life transition that often changed multiple aspects of carers' lives. Participants observed that carers could assume the role suddenly following an acute health event, such as a stroke, or gradually as a loved one's health and functional abilities declined over time. Regardless of how the role developed, health professionals noted that older carers were often required to adapt to new responsibilities and changes in daily routines, relationships, future plans, and sense of self, frequently with little preparation, training, or support.

"[older carers] are thrust into this saint-like caring role where they are effectively expected to drop what they're doing and assume carer responsibilities" (P03, Psychologist)

Participants also highlighted the emotional impact of these changes, noting that carers often experienced feelings of grief, loss, and adjustment as they came to terms with changes in their expected future and personal circumstances.

“they don't feel they are allowed to feel guilty, feel sad, feel angry about their own dreams that have now changed because of what has happened [becoming a carer after partner had a stroke]” (P17, Social Worker)

Health professionals further described how caregiving could alter existing relationships and family dynamics. They noted that the quality of the relationship before caregiving commenced, as well as changes in roles and responsibilities over time, could substantially influence carers' experiences and mental wellbeing.

“the relationships can make a massive difference, like what the quality of the relationships are, you know, like - because we do have people come in and they've had difficult relationships [with the care recipient] and now they're carers” (P14, Occupational Therapist)

Participants also described how caregiving could affect carers' identity and social connections, particularly when longstanding relationship patterns and social participation changed.

“she was just talking about her loss of identity of them as a couple. She felt that they were being excluded from their social circle ... and there was just that sense of grief and loss, and she hadn't realised she was feeling that” (P01, Social Worker)

Physical and emotional impacts of caregiving

Health professionals frequently described older carers as experiencing substantial physical and emotional impacts associated with their caregiving role. Participants observed that many carers presented with stress, fatigue, exhaustion, worry, and feelings of being overwhelmed, often while trying to manage complex care responsibilities alongside their own needs. Emotional distress was also linked to witnessing the progressive decline in the health and functioning of the person for whom they cared.

“a patient comes in with a carer who is exhausted emotionally and psychologically. Also, they are frustrated as well, but also very grief-stricken because they can see all of these changes in their loved one” (P10, Social Worker)

“they're worried, they're concerned. They're really stressed. They never feel they have enough time” (P19, Social Worker)

Health professionals also linked these challenges to carers feeling overwhelmed by the demands placed upon them and uncertainty regarding available sources of support.

“sense of being overwhelmed and not sure how to get things - not being aware even of - of what's available in the community to support them” (P16, Physiotherapist)

Participants further noted that the physical and emotional demands of caregiving could be compounded by carers' own health conditions. This was particularly evident among older spousal carers, many of whom were managing age-related health issues while continuing to provide care.

“and they're [spouse carers] more burnt out because they're also elderly and they have their own health problems” (P06, Physiotherapist)

Some health professionals expressed concern that caregiving responsibilities could negatively affect carers' ability to manage their own health, potentially leading to a deterioration in existing conditions or reduced engagement in self-care activities.

“or even exacerbating their own chronic diseases if they're going sort of beyond their capabilities” (P11, Dietitian)

“sometimes they might say I haven't had time to look after myself” (P04, Nurse)

Navigating complex health and support systems

Health professionals recognised that accessing appropriate sources of support was often challenging for older carers. Participants perceived that identifying appropriate services, understanding available support options, and accessing assistance could be challenging and often contributed to feelings of stress, uncertainty, and overwhelm. Many health professionals reported that carers appeared unsure about what services were available or how these could be accessed.

“often overwhelmed and ... and confused maybe... not sure what services are available and ... how to access them” (P14, Occupational Therapist)

Several participants noted that carers were not always aware of the range of support options available to them and, as a result, may have held inaccurate assumptions about available services.

“a lot of people [older carers] that I've spoken to have the impression that to have a break, the only way is to put them into respite. They didn't know that ... you can get in-home respite” (P02, Nurse manager)

Health professionals also described the complexity of the service system itself as an additional burden for carers who were already managing substantial caregiving responsibilities.

“and confused by the whole system and the thought of doing another thing, you know, is just another stress” (P 11, Dietitian)

“the carers ... have a lack of information about the services they can access” (P02 Nurse Manager)

Participants further highlighted challenges related to communication and understanding health-related information. Some health professionals recognised that the language used within healthcare settings

could make information difficult for carers to understand, which they believed could further hinder carers' ability to access available supports.

“they're reading it, but they don't understand it because it's in our sort of medical jargon language” (P10, Social Worker)

“the lack of, I guess, health literacy ...; a lot of people come to me saying we don't understand a lot, and we don't get told a lot” (P12, Geriatrician)

Unique challenges for older male carers

Several health professionals noted differences in how some older male and female carers adapted to the caregiving role. Participants perceived that some older male carers were less likely to seek help, disclose when they were struggling, or engage with support networks, which could increase the challenges associated with caregiving.

“Men don't ask for help. I find that women are quite - they don't mind asking for help or letting you know when it's - they're overwhelmed. Whereas I have to try and read the body language with a lot of the males” (P19, Social Worker)

Health professionals also suggested that some older male carers experienced greater difficulty developing social connections and support networks following the transition into caregiving.

“and make friends, whereas men won't do that. They lose everything when they become carers.... they really struggle” (P19, Social Worker)

Participants further noted that changes in household, family, and caregiving responsibilities could be particularly challenging for some older male carers, especially where caregiving involved substantial changes to established roles and routines.

“so, there's either a role reversal, but definitely a change in role ... and I find that women deal with that better than men” (P12, Geriatrician)

Theme 2: Carer assessment and support are inconsistently embedded within health services

Health professionals described a range of ways in which they sought information about older carers' health and wellbeing. However, these activities were rarely embedded within formal service processes and instead relied largely on individual clinicians' initiative, clinical judgement, and opportunistic interactions with carers. Three subthemes were identified.

Health care service models remain primarily focused on the care recipient over carers

Participants consistently described health services as being organised around the assessment and treatment of the care recipient, with little formal attention directed towards the health and wellbeing of

older carers. Although clinicians frequently recognised that carers were experiencing their own health, wellbeing and caregiving challenges, they noted that these issues often sat outside the primary purpose of the consultation. Consequently, opportunities to identify and address carers' needs are limited by service structures, funding models, and assessment processes that positioned the care recipient as the central focus of care.

As one participant explained, carer concerns were addressed only informally because "technically I'm assessing the patient and not the carer" (P06, Physiotherapist). Others reported the tension of recognising carers' needs while remaining focused on the client:

"so it sort of does make it hard ... you're focussed on the client but then you see that the carer has got that stuff going on as well" (P12, Physiotherapist)

Participants further acknowledged that support for carers was often absent within existing service models:

"we're very good at treating and supporting the patient but we just don't have anything for the carers really" (P02, Nurse manager)

Identification and support of carers relies on clinician judgement and informal interactions

Health professionals described identifying and supporting older carers largely through informal and opportunistic interactions rather than structured assessment processes. Participants commonly relied on clinical judgement, observation, and incidental conversations with carers to gauge their wellbeing and caregiving challenges. Opportunities to speak with carers separately from the care recipient were particularly valued, as these enabled carers to discuss concerns more openly:

"but sometimes the carer will walk with me out to the car if we're in the home, or sometimes you'll catch them on the phone without the client there" (P12, Physiotherapist)

"when the doctor's doing the cognitive testing, the carer actually comes in with the clinician into a different room and that's an opportunity for the carer ... to say anything they felt that they couldn't say in with the doctor ... what we use that for really is to check in on the carer and also to educate the carer ... And often, we would be speaking to them about their own health if they're really, really stressed" (P14, Occupational Therapist)

Assessment of carers was described as largely informal, with participants reporting that carer needs could easily be overlooked in the absence of dedicated assessment procedures:

"no [I don't use a formal assessment] - I find it's more about letting them talk ... (P19, Social Worker)

"ad hoc, only picking up based on clinical judgement and a very limited interaction that we actually have with the caregiver" (P03, Psychologist)

Most participants reported that formal assessment or follow-up of carers was uncommon, with support generally delivered indirectly through services for the care recipient:

“there's no formal assessments [of older carers]” (P02, Nurse manager)

“we don't offer any formal service or help [for carers] We offer through the patient, but it's not targeted at the carer ... we don't follow-up if the carer's doing ok” (P06, Physiotherapist)

Although this informal approach was common, one participant described routinely incorporating questions about carers' health, wellbeing and caregiving responsibilities into their assessment. However, this appeared to reflect individual clinical practice rather than a standardised service approach.

Health professionals recognise the need for more systematic assessment and support of carers

Despite describing substantial barriers to assessing and supporting carers within existing service models, many participants believed that greater attention should be directed towards carers' needs. Participants frequently highlighted the need for more formal and consistent approaches to identifying carers, assessing their wellbeing, and providing targeted support. Several suggested that routine screening, dedicated consultations with carers, or standardised assessment tools could help ensure carers' needs were recognised and addressed within health services.

“I definitely feel like there is more, that we can do or making it more of a priority when they do come on to the [clinic] program to have one session with the patient and one session with the carer” (P17, Social Worker)

“I think we can do a lot more for our carers, both formally and screening them” (P02, Nurse Manager)

Participants acknowledged that implementing more systematic assessment processes would require additional resources and clinic time, but nonetheless viewed this as an important direction for service development:

“formally assessing or screening, or somehow capturing the carers ... it would take more clinic time and all of those sort of things, but that is definitely where I think we need to go” (P02, Nurse Manager)

“maybe we should be using a more formalised carer assessment tool” (P01, Social Worker)

Theme 3: Existing support for older carers is limited and fragmented

Health professionals reported that support available to older carers was generally limited and fragmented. Most support involved providing generic, rather than tailored information, education, resources, or links to external organisations (e.g. for support groups for carers) rather than services specifically designed to assess and address carers' individual needs. Three subthemes were identified.

Support largely consists of information, education and referrals

Health professionals reported the most common form of support provided to older carers involved information sharing, education, and referrals to external organisations. Rather than providing ongoing, tailored support, health professionals commonly directed carers to community organisations, advocacy services, websites, and condition-specific resources.

“we’d say, if carer stress is identified, you know “Do you mind if we send you some information where you can get some – some support; or would you like the phone number now to give them a call [for a carer support service]” (P11, Dietitian)

“I can give them a Carers WA brochure or direct them to the website” (P06, Physiotherapist)

“other supports that we provide are ongoing education ... so referring to Carers WA” (P07, Geriatrician)

In some instances, some participants also directed carers to condition-specific organisations that provided information, education and peer support for both care recipients and carers.

“I refer carers and families if they’ve got a stroke to the Stroke Foundation have the EnableMe website ... which is a set-up for people who have a lived experience of stroke and their carers ... and there are both forums, there’s chatlines, there’s sort of resources there” (P07, Geriatrician)

Support groups and educational programs were also described by participants, although these were often attended by both carers and care recipients. Education focused on increasing knowledge of the care recipients’ condition, developing caregiving skills, and providing strategies to manage the emotional and practical impacts of caring.

“and we have for our patients with memory problems a memory and thinking group, which is both for patients and carers to come” (P07, Geriatrician)

“a lot of it is about education around the condition and on how to deal with particular aspects of care” (P12, Geriatrician)

One participant described facilitating support groups and a structured education program covering topics such as grief and loss, family relationships, stress management, anger management, self-care, and the physical and emotional impacts of caring (P19, Social Worker).

Carer support often relies on individual staff initiatives

Where more direct support for carers was described, this was typically provided through the initiative of individual health professionals rather than dedicated carer support programs. Participants reported that support for carers was often incorporated into existing clinical roles, particularly those of social workers and allied health professionals, rather than delivered through formalised service pathways.

“in terms of more work with carers, that’s where they typically delineate that to the social worker ... it’s not a dedicated carer support role, but it is there” (P03, Psychologist)

Several physiotherapists described providing practical assistance to carers as part of supporting the care recipient. This commonly involved teaching carers strategies to safely assist with mobility, transfers, and other activities of daily living, while also reducing the physical demands associated with caring.

“[for a client with new mobility problems] we need the carer to come in and see how to safely do that while looking after themselves and their health as well” (P05, Physiotherapist)

“usually I get the carer to come into the appointment with them ... they come in and watch the physio session so they know what's happening ... so that when they go home, they know what to do with the patient” (P06, Physiotherapist)

These examples highlight how support for carers was often available only when individual clinicians chose to incorporate carers into their routine practice, rather than through services specifically designed to address carers' needs.

Carers' wellbeing needs are addressed through informal support

In a small number of instances, health professionals noted providing direct support to carers' emotional wellbeing. However, this support was generally informal, consisting of brief encouragement, wellbeing check-ins, or short-term counselling rather than ongoing intervention. Where carers required more substantial assistance, health professionals typically referred them to external services for longer-term support.:

“I put a reminder to them to look after themselves” (P10, Social Worker)

“we basically will do follow-up phone calls for people, and if it feels like they are needing some extra counselling or support, we would give short term of that, and then we would refer on to someone if they needed that on a longer-term basis” (P13, Clinic Manager)

This approach reflects the limited capacity of health services to provide sustained support for carers' own wellbeing, with assistance often restricted to brief interventions and referral to other providers.

Theme 4: System constraints limit support for carers

Health professionals described several structural barriers that limited their capacity to assess and support older carers. Participants highlighted insufficient time, funding models centred on the care recipient rather than the carer-care recipient dyad, and limited pathways for carers to access dedicated healthcare support. Three subthemes were identified.

Limited time constrains supports for carers

Health professionals consistently identified time pressures as a major barrier to assessing and supporting older carers. Participants described struggling to meet the clinical needs of care recipients

within existing appointment times, leaving little opportunity to address carers' health and wellbeing.

"I don't have time for that [carer assessment tools]" (P07, Geriatrician)

"it's also about my time ... I struggle to get everything done for that patient in a half hour because I do like to go in deep" (P04, Nurse)

Participants noted that while clinicians often had the skills to identify carers' needs, they frequently lacked the capacity to provide additional support.

"I think we have the skillset in our clinicians to identify when there are issues, but in terms of actually providing the carer support - we don't have the capacity to do that" (P20, Occupational Therapist)

Funding and service models prioritise care recipients over carers

Participants frequently described funding arrangements and service models as barriers to providing more comprehensive support for carers. Existing systems were largely centred on the person receiving care, limiting opportunities to assess, document, or manage carers' own health and wellbeing needs.

"for example, we couldn't really go in and write an entry about a carer because they're not actually our client" (P11, Dietitian)

"Oh, we'd love to do so much, but we just, yeah, its funding. It's really simple" (P10, Social Worker)

"But because we're not funded, I suppose, to look at the family [of the person with dementia]" (P13, Clinic Manager)

Several health professionals noted that carers often needed to be referred separately as patients before services would formally assess or support them.

"the way the system is now, they [carers] would have to get referred essentially as a patient even though they're not the initial patient coming to see us" (P06, Physiotherapist)

"there's no ABF [Activity Based Funding] for funding for carers. They have to be referred in separately by their GP [to have carer problems managed]" (P07, Geriatrician)

Some participants further argued that current funding arrangements overlooked the substantial and critical contribution older carers make to maintaining care of older people in the community and reducing demand on health services.

"and nobody seems to put importance on them. But I've always said you're very important because you're the ones [carers] that's saving the hospital money" (P08, Social Worker).

Carers often require separate pathways to access healthcare support

Health professionals also highlighted encouraging older carers to seek support through their own healthcare providers, particularly their general practitioner (GP), when their needs extended beyond the remit of the service supporting the care recipient. This reflected a broader system in which carers' health needs were frequently addressed through separate care pathways rather than within services focused on care recipients.

"so, it'll be getting them to go back to their own GP" (P04, Clinical Nurse)

"so I will often encourage them to have a different doctor ... that focuses on you" (P19, Social Worker)

However, participants acknowledged that primary care services also faced significant pressures that could limit their capacity to support carers.

"I think the biggest problem is engaging primary care physicians ... they're the one most hard pressed for time to address everything that they need to ... but they are a key player in all of this" (P12, Geriatrician)

Theme 5: Features of an optimal support model for older carers

Health professionals described several features they considered important for an optimal model of support for older carers. These included dedicated and carer-centred services, early assessment and tailored support, access to relevant resources and peer support, and greater recognition of carers throughout the health system. Four subthemes were identified.

Dedicated, carer-centred and multidisciplinary services

Many participants envisioned a dedicated service that recognised carers as clients in their own right rather than solely as supporters of the care recipient. Participants described the value of a "one-stop-shop" model that could provide coordinated, multidisciplinary support and facilitate access to a range of services within a single location.

"a one stop shop, you know ... it makes sense to have somewhere to walk in and talk to somebody" (P10, Social Worker)

"the ideal would be, if you had something like a service that was specifically for the carers. ... therefore, they would be the client of the service" (P11, Dietitian)

"having a dedicated carer supporter role, knowing that we could refer, knowing that person was directly there to work for and with the carer" (P03, Psychologist)

Participants highlighted the importance of multidisciplinary expertise within such a model, particularly nursing, social work, occupational therapy, and professionals with psychological skills.

"and in terms of it being multidisciplinary, in terms of a stepped model, it could be a stepped model within the clinic but certainly I know our nursing staff do a fantastic job in the first instance ... and maybe

even nurse-led, but definitely social work being the integral part” (P03 Psychologist)

“[valuable disciplines as well as nursing might be] occupational therapy” (P02, Nurse Manager)

Some participants suggested that support should remain integrated with services for the care recipient and focus on the care recipient-carer dyad, rather than creating entirely separate services.

“when you treat a person, you have to treat the person and the carer as a unit - you can't segregate the two” (P12, Geriatrician)

Early assessment and flexible, tailored support

Participants emphasised the importance of routinely assessing carers' health and wellbeing and providing support that could be tailored to their changing needs. They recognised that carers differ in the level and type of support required and that needs often evolve throughout the caring journey.

“a more streamlined process to identify carer stress early and have some specific path that we could follow” (P01, Dietitian)

“formal assessment, possibly a dedicated clinic, and follow-up ... the support that each carer requires is going to vary for every patient” (P02, Nurse Manager)

Several participants advocated for assessment and intervention early in the caring role, before carers reached crisis point.

“getting in there early, putting supports in place, is much better than them trying to be a rescue centre for triaging burnt out carers” (P04, Nurse)

Participants also suggested a stepped-care approach that could be adapted as carers' circumstances changed.

“we can step it up in terms of thinking of things as more of a stepped model” (P03, Psychologist)

Access to education, resources and peer support

Participants identified education, practical resources, and opportunities for peer support as important components of an optimal support model. Suggested resources included information specifically designed for carers, education about health and wellbeing, assistance with technology, and structured support groups.

“have more specific resources designed for carers” (P11, Dietitian)

“peer support is very beneficial” (P19, Social Worker)

“to have something where you could actually educate carers or provide support to carers would be fantastic. And if it was, you know, something where they got support, where they got to meet other carers as well, that would be really good” (P14, Occupational Therapist)

One participant also highlighted the need for support to improve carers' confidence using technology and accessing online resources (P11, Occupational Therapist).

Greater recognition of carers across the health system

Beyond dedicated services, participants believed that they and other health professionals more broadly should better recognise, value, and respond to carers' needs. They suggested that training and education could improve awareness of carers' roles and encourage more proactive support throughout the health system.

“training for practitioners ... because that's where I think that it's falling down” (P03, Psychologist)

“Caring for carer study days [training for health professionals]” (P04, Nurse)

Participants emphasised that improving outcomes for carers would require a broader cultural shift towards recognising carers as an important part of the care partnership and deserving of support in their own right.

Discussion

This study explored health professionals' perspectives on the health and wellbeing needs of older carers of older people, current approaches to identifying and supporting these carers, barriers to providing support, and features of an optimal model of care. Five themes were identified. Health professionals recognised that older carers experience substantial physical, psychological and social challenges associated with caring, often in the context of their own age-related health conditions. However, assessment and support of carers were reported to be largely informal, opportunistic and clinician dependent. Existing support was described as limited and fragmented, while system constraints, including time pressures, funding arrangements and service models focused on care recipients, restricted opportunities to address carers' own needs. Participants consistently advocated for more systematic, carer-centred approaches, including formal assessment, tailored interventions and dedicated pathways for support.

These findings extend existing evidence by providing the perspectives of health professionals involved in the care of older people, an area that has received considerably less attention than research focused on carers themselves [3, 10, 28, 29]. Previous qualitative studies have primarily documented older carers' experiences of inadequate support, high caregiving burden and declining health [3, 10, 28, 29]. The present study suggests that many health professionals share these concerns but perceive themselves as working within systems that do not routinely recognise older carers as clients in their own right.

Consistent with previous research, participants acknowledged that older carers frequently experience stress, fatigue, declining physical health and psychological distress while receiving little formal support [3, 5, 10, 11, 28-30]. Health professionals reported that current practice largely relies on informal conversations, clinical judgement and opportunistic interactions to identify carers' needs. Support mostly involved provision of information, education and referral to external organisations, with few opportunities for comprehensive assessment or ongoing follow-up. Although participants frequently identified funding models and time constraints as barriers, the findings also suggest that carers remain peripheral to many healthcare encounters because services are primarily organised around the needs of care recipients. Similar observations have been reported internationally, where carers' needs are often viewed as secondary to those of the person receiving care, regardless of resource setting or healthcare system structure [3, 10, 28, 29].

The limited assessment and support identified in this study highlights the need for structured mechanisms to identify carers' health and wellbeing needs early and to provide timely intervention. Given the high prevalence of chronic health conditions among older carers, holistic approaches that consider physical health, mental health, social wellbeing and caregiving demands simultaneously may be required to sustain caregiving roles over time [28, 31, 32]. Improving support for carers may also have broader benefits, including delaying or reducing the need for additional community services or residential aged care for the person receiving care.

In the United Kingdom, specific policies have been implemented to formally position family carers, including older carers, as integral parts of the health and care system who warrant special focus on assessment of their own health and care needs, and the right to have eligible needs met [32]. While this appears a commendable recognition of the critical role of carers, Seddon et al [32] have reported that translation of this into practice has not systematically occurred over the more than 20 years since these policies were introduced. A number of barriers to wider implementation were identified, including that practitioners remain reluctant to incorporate separate formal carer assessment processes, lack of focus on prevention, high caseloads and limited time, and difficulties associated with capturing the important dynamics of caregiving and caring relationships [38]. These barriers closely mirror those identified by participants in the current study and suggest that formal policy recognition alone may be insufficient to improve carer support without accompanying changes to workforce practices, service models and organisational priorities.

The holistic health and wellbeing needs of older carers of older people do not appear to be a focus in current research or practice. This gap has also been identified in an international evidence map of interventions and outcomes [25]. Only 42 of 205 studies (20%) included in their analysis focussed specifically on older carers of older people, with Spiers et al advocating for greater focus on this important sub-group of carers. Particular areas for future focus recommended for this group included approaches to address older carers' physical and financial wellbeing, their social wellbeing, and their quality of life [25]. The current study adds to this evidence by highlighting how existing healthcare

systems may inadequately identify and respond to these needs, even when health professionals recognise their importance.

Given the lack of systematic opportunities for holistic assessment and management of the health and wellbeing of older carers of older people, there appears a need to consider innovative approaches to address this important gap. Participants consistently advocated for a model that recognised older carers as clients in their own right and provided coordinated, multidisciplinary support. Key features included formal assessment of health and wellbeing, flexible and tailored interventions, access to information and peer support, and greater workforce awareness of carers' needs. Importantly, participants emphasised that older carers may require support that extends beyond that offered through general carer services because they are often managing their own age-related health conditions while simultaneously caring for an older person with complex needs.

Drawing on findings from this study, related research involving older carers [10], and broader evidence in the field [7, 33-38], a co-design process involving carers, health practitioners, service managers, researchers, and policy advocacy representatives developed recommendations for a new service model designed to improve the health and wellbeing of older carers of older people [38]. This new Carer Health and Wellbeing Service has been developed and is currently being implemented and evaluated [39].

There may be other approaches that may be considered in tandem with, or instead of a new service. One participant advocated for a dyadic approach in which equal emphasis placed on the health and wellbeing assessment and management of both the care recipient and carer. This approach has also been proposed and advocated for elsewhere [9]. In Australia, implementation of a dyadic model would likely require changes to funding arrangements and models of care, which currently focus primarily on individual care recipients. Barriers to implementation have also been reported, including challenges with data protection and sharing (both within and between organisations), and the need for workforce upskilling and training [9].

Another recommendation arising from this study was greater involvement of general practitioners in identifying and supporting carers. Participants viewed primary care as an important avenue for recognising older carers' health and wellbeing needs, coordinating management, and facilitating referrals. However, this was not seen as routine practice, and participants also recognised the substantial pressures facing primary care providers [10]. Future research should investigate how primary care, specialist services and dedicated carer support services can work together to provide more coordinated care for older carers of older people.

Strengths of this study include the broad mix of health professionals across several health service types and across two states of Australia who participated in the interviews. A limitation of the study is that health professional participants were recruited primarily through two health services involved in the care of older people, and therefore the findings may not be representative of all services or of carers whose family members are not cared for by specialist geriatric services. In addition, the findings reflect health professionals' perceptions and interpretations of older carers' experiences, needs and priorities rather

than carers' accounts directly. While participants drew on extensive clinical experience working with older carers, these perspectives may not fully represent how carers themselves understand or prioritise their own needs. As a result, the findings should be interpreted as insights into professionals' understandings of older carers' needs, recognising the potential for differences between professional assumptions and carers' lived experiences.

In conclusion, study findings highlight a substantial unmet need within current health service models to adequately support the health and wellbeing of older carers of older people. The findings also identify an underutilised opportunity within the existing aged care workforce. Health professionals working with older people demonstrated considerable awareness of older carers' needs and described having relevant skills and expertise that could contribute to supporting carers' health and wellbeing, benefiting both carers and care recipients. However, participants highlighted a range of systemic, organisational and service-level constraints that limit their ability to provide such support in routine practice. These findings suggest that new models of care are needed to better leverage existing workforce capability and embed support for older carers within health service delivery. Participants also offered practical recommendations for strengthening current approaches and reducing barriers to carer support. Study findings have been used to inform the development and evaluation of a new service to improve the health and wellbeing of older carers of older people [39].

Declarations

Ethics approval and consent to participate: This project was approved by the Human Research Ethics Committees at Peninsula Health (Frankston, Victoria; ID 76671), and South Metropolitan Health Service (Perth, Western Australia; ID RGS 04661), and reciprocal approvals from ethics committees at Monash University (ID 27379) and Murdoch University (ID 2021/083). Informed consent was obtained from all participants prior to participation. Research in this study was conducted in accordance with the Declaration of Helsinki (<https://www.wma.net/policies-post/wma-declaration-of-helsinki/>).

Consent for publication: Not applicable.

Availability of data: De-identified quotations from the interview transcripts are included in this article. Anonymised transcripts may be shared with qualified researchers upon reasonable request to the corresponding author, subject to participant consent and applicable ethical approvals.

Competing interests: The authors declare that they have no competing interests.

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Authors' contributions: KDH conceptualised the study and all authors secured funding. AL and SS recruited participants and conducted data collection. AL, KDH, MW, and SS conducted data analyses.

KDH, AL and SS developed the initial drafting of the manuscript. All authors contributed to the review, editing and approved the final manuscript.

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Figures

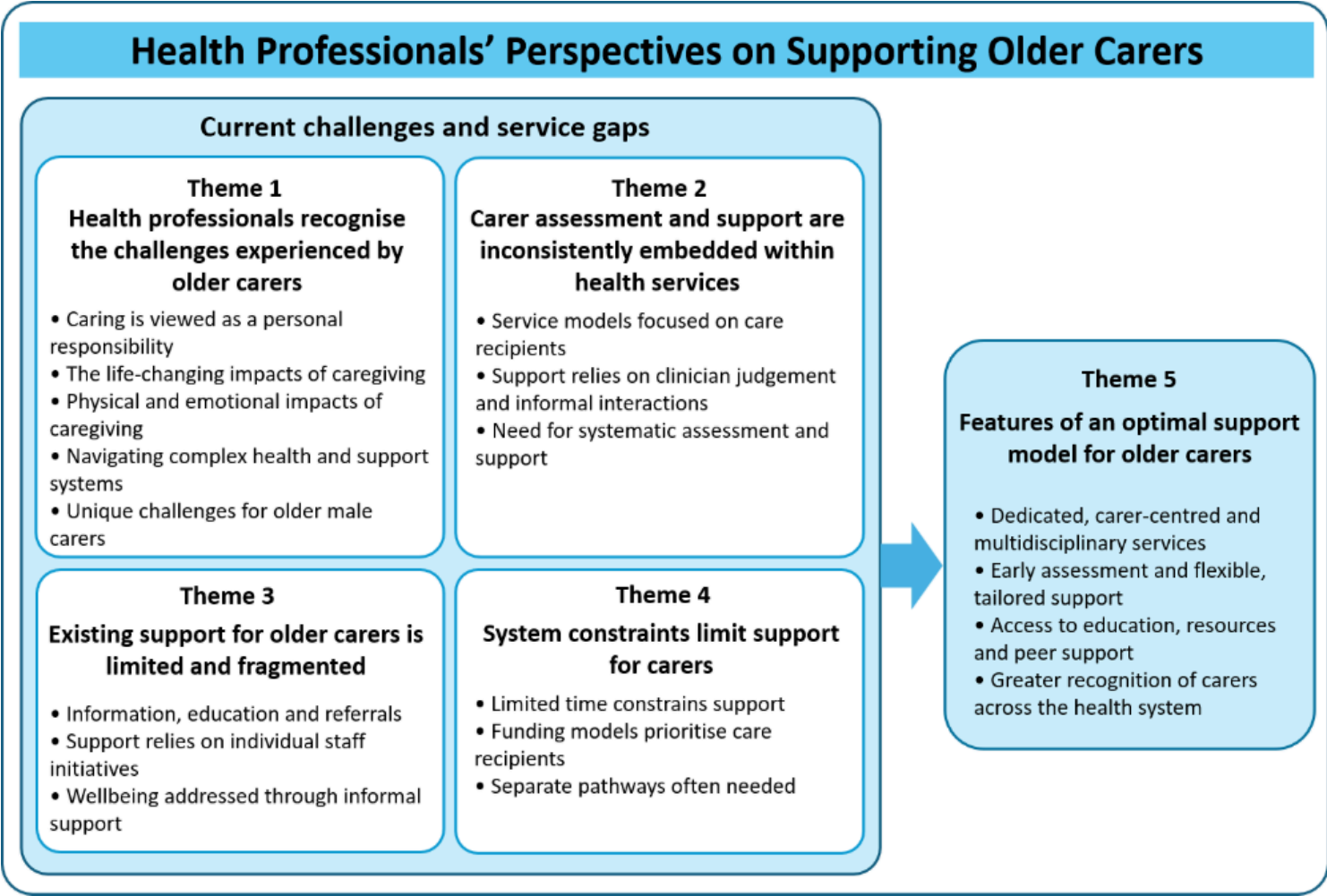


Figure 1

Schematic of themes and subthemes.

Supplementary Files

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