Although family caregivers provide a tremendous amount of care to loved ones, they often carry out these activities with little to no formal training (McDonald, Stetz, & Compton, 1996; Navaie-Waliser et al., 2001; Navaie-Waliser, Feldman, et al., 2002). Lack of training and support for the caregiver often exacerbates the caregiver’s distress (Knight, Lutzky, & Macofsky-Urban, 1993; Gallo, Reichel, & Andersen, 1995; Schmall, 1995). Recent studies have shown that family caregivers experience considerable anxiety about the provision of care (Hennessy, John, & Anderson, 1999; Miller, Shewchuk, Elliot, & Richards, 2000; Silliman, Bhatti, Khan, Dukes, & Sullivan, 1996), have difficulty coping with psychological needs of patients and themselves (Hennessy et al., 1999), have concerns about decision making and communication problems with secondary support systems and the formal health-care system (Hennessy et al., 1999; Silliman et al., 1996), and feel less than adequately prepared to take on challenging tasks such as medication management (Miller et al., 2000).

Increasing family caregivers’ confidence and competence requires training in the skills they need to provide care. Past studies have repeatedly shown that family caregivers often express interest in, and have a need for, education and support programs (National Alliance for Caregiving & American Association for Retired Persons, 1997; Navaie-Waliser et al., 2001; Navaie-Waliser, Feldman, et al., 2002). Despite their expressed interests and needs, however, only between 30 and 60% of “eligible” family caregivers actually use education and support programs (Anderson et al., 2000; Boothroyd, Kupping, Evans, Armstrong, & Radigan, 1998; Cox, 1999; Gallagher-Thompson, Solano, Coon, & Arean, 2003; Laditka, Pappas-Rogich, & Laditka, 2001; Morgan, Semchuk, Stewart, & D’Arcy, 2002; Pedlar & Smyth, 1999). Differential access to education and support programs has been reported, with some caregivers being harder to reach than others (Braithwaite, 1998). The practice and policy implications of not reaching or engaging caregivers with needs can have serious and negative consequences for the caregiver, the care...
recipient, and the long-term care system. Given increasingly limited resources, family caregiver support and educational interventions that fail to reach their target populations are inadvertently wasting scarce resources, leaving caregivers in need feeling unsupported and more isolated, and escalating the vulnerability of care recipients who rely on a significant amount of dependent care from loved ones.

The purpose of this chapter is to provide (1) a comprehensive review of the literature to highlight (a) the benefits of family caregiver education and support programs, (b) the various operational definitions of hard-to-reach family caregivers, and (c) the common characteristics of hard-to-reach family caregivers; (2) an overview of barriers to accessing caregiver education and support programs; and (3) recommendations for future directions in practice, research, education/training, and policy/advocacy that could enhance the accessibility of caregiver education and support programs.

**Literature Review**

**The Benefits of Family Caregiver Education and Support Programs**

Meta-analytic and integrated reviews of family caregiver education and support intervention studies conducted during the past two decades can be categorized into three groups: (a) *psychosocial and support group programs* that primarily focus on helping caregivers develop the knowledge base needed to assume caregiving tasks and coping with their responsibilities; (b) *educational and skills training programs* that aim to help caregivers improve care recipient outcomes, such as daily functioning, behavioral management, cognitive stimulation, and social skills; and caregiver outcomes including better ability to problem solve, manage care provision, cope with stress, learn to relax, and experience life satisfaction; and (c) *family or individual psychotherapy programs* that focus on improving caregivers’ emotional/mental health and coping by employing various counseling strategies (e.g., cognitive/behavioral vs. psychodynamic, grief counseling vs. cognitive/behavioral, problem solving vs. emotional expression, professional counseling vs. peer counseling) (Acton & Kang, 2001; Brodaty, 1992; Bourgeois, Schulz, & Burgio, 1996; Farran, 2001; Glueckauf, Ketterson, Loomis, & Dages, 2004; Sorensen, Pinquart & Duberstein, 2002; Toseland & Rossiter, 1989; Visser-Meily, van Heugten, Post, Schepers, & Lindeman, 2005; Whittier, Scharlach, & Dal Santo, 2005).

Most caregiver education and support interventions have been multifaceted, incorporating several types of caregiver support strategies. An overview of these past studies suggests that participation in family caregiver education, training, and support programs is beneficial as evidenced by improvements in caregivers’ understanding of disease processes and symptom recognition; reduced social isolation; improved ability to deal with emotional and practical problems of caregiving; enhanced coping skills; increased confidence in performing caregiving tasks; improved communication and problem solving skills; reduced feelings of depressions; better management of care recipients’ problem behaviors, anxiety and
anger; reduced caregiver strain, stress, and burden; and improved quality of life (Belmin, Hee, & Ollivet, 1999; Brodaty, 1992; Buckwalter et al., 1999; Corbeil, Quayhagen & Quayhagen, 1999; Corcoran & Gitlin, 1992; Gerdner, Hall, & Buckwalter, 1996; Gitlin, Corcoran, Winter, Boyce & Hauck, 2001; McMillan et al., 2006; Mohide et al., 1990; Ripich, 1994; Robinson & Yates, 1994; Sorensen et al., 2002; Teri, 1999). By directly enhancing caregiver skills, knowledge, and coping abilities, family caregiver education and support programs also benefit care recipients whose health and well-being rely heavily on their family caregivers (Whittier et al., 2005).

Operational Definitions of Hard-to-Reach Caregivers

When considering which family caregivers are typically hard to reach, various operational definitions have been used in the literature (Fig. 2.1). In general, caregivers, who are difficult to contact at one or more stages of the program delivery process are considered hard to reach. Typically, however, caregivers are not considered hard to reach until multiple outreach efforts have been unsuccessful. There are three key stages of caregiver education and support program delivery processes. Each stage presents a relatively unique set of challenges that impact the ability of programs to successfully contact caregivers, including (1) identification of caregivers, (2) recruitment of caregivers, after they have been identified, and (3) engagement of caregivers on an ongoing basis.

![Fig. 2.1 Defining hard-to-reach caregivers: a conceptual model](image)
During the *identification* stage, programs tend to rely principally on care recipients to identify their primary (i.e., caregivers providing the most care) or secondary family caregivers. Therefore, if care recipients are reluctant to provide identifying information about their caregivers, those caregivers would be “labeled” as hard to reach (Coe & Neufeld, 1999). Under certain circumstances (e.g., when care recipients are cognitively impaired), programs may have direct access to persons who are either providing direct care or coordinating care for care recipients. However, research has revealed major challenges in providing outreach to family caregivers, even when formal providers believe they have already identified the caregiver to whom they could target services (Hoffmann, 2002; Kutner, 2001). Terms such as “hidden” or “unacknowledged” caregivers have recently been used by researchers, practitioners, and policymakers to refer to persons who do not consider themselves as caregivers, albeit they provide unpaid care to a family member or friend. Recent studies have revealed that the term caregiver does not invoke a common understanding, resulting in many caregivers not automatically identifying themselves as such even when they take on caregiving responsibilities (Kutner, 2001; National Alliance for Caregiving & Center for Productive Aging, 2003; Navaie-Waliser et al., 2001). These reports have found that approximately 15% of persons who carry on various caregiving activities are not self-identifying as family caregivers (Hoffmann, 2002; Kutner, 2001). This significant level of caregiver disconnect from caregiver terminology points to the issue that a relatively large fraction of caregivers are unfamiliar with the definition of the term, dislike being labeled as a caregiver, have a reluctance to give any name or title to what they do, and object to any term that is used to “label” themselves (National Family Caregivers Association & National Alliance for Caregiving, 2001). Most of these studies point to the common finding that when the term “caregiver” is used, it resonates with unacknowledged caregivers to be someone who gets paid for the care they provide (National Family Caregivers Association & National Alliance for Caregiving, 2001). Among these unacknowledged caregivers, disproportionate groups are men and racial/ethnic minorities (Kutner, 2001). Identifying oneself with the term “caregiver” has been found as one of the most significant predictors in determining the extent to which persons become proactive in seeking resources to facilitate their caregiving roles (Hoffmann, 2002; National Family Caregivers Association, 2001). Therefore, many hard-to-reach caregivers who do not self-identify as caregivers often do not seek out needed education and support services.

After caregivers have been identified, programs are faced with the task of recruitment and engagement. During the *recruitment* stage, the mode of contact used by programs can affect their ability to effectively reach caregivers. The most common forms of outreach typically used by caregiver education and support programs are telephone, in-person meetings, newsletters, and print materials distributed by mail to either the care recipient’s or the caregiver’s home, and technology-based contact (e.g., telehealth networks, videophones). Reviews of past studies have shown in-person contact with caregivers to be the most effective recruitment strategy and distribution of print materials by mail to be the least successful (Sorensen et al., 2002). The choice of recruitment strategy is driven most often by financial and other resource limitations. Unfortunately, the most cost-efficient
recruitment approach often results in the inability to contact a high number of hard-to-reach caregivers. The recruitment phase is not only contingent upon the methods used to reach potential participants, but much of the success of recruitment depends on personal attributes of the caregivers themselves. Studies have shown that service-seeking actions among caregivers are heralded by caregiver appraisals of changes in their physical or emotional health and associated control over the health risk of the care recipient (Brown, Chen, Mitchell, & Province, 2007; Murphy et al., 2007). Moreover, results from Murphy et al. (2007) show that willingness to participate in support programs is a result of the confluence between the caregiver’s recognition of the need for help and becoming aware of the available support service. Timeliness of recruitment, therefore, plays a major role in the success of enrollment.

Once family caregivers have been identified and successfully recruited, programs must help caregivers overcome the many barriers that could impact their ongoing participation. The engagement stage of caregiver education and support programs may last from a week to several weeks (Sorensen et al., 2002). Depending on the duration and length of a program, some caregivers can remain engaged while others become hard to reach because of either inconsistent participation or by premature attrition. As shown in Fig. 2.2, among the many approaches of services delivery used by education and support programs, those programs most likely to have difficulty reaching family caregivers are non-home-based services which often present logistical barriers to consistent participation (Acton & Kang, 2001; Brown et al., 1999; Chambers & Connor, 2002; Colantonio, Cohen, & Pon, 2001; Rosswurm, Larrabee, & Zhang, 2002).

**Common Characteristics of “Hard-to-Reach” Caregivers**

To develop a richer understanding of why many caregiver education and support programs face the challenge of extending services to hard-to-reach caregivers, it is helpful to examine what the literature reveals as shared characteristics among such caregivers. These common characteristics can be categorized into four main domains: (a) sociodemographic attributes, (b) social and environmental contexts, (c) service delivery system factors, and (d) emotional and physical health attributes. Despite the categorization of these characteristics, it is important to recognize that many of the factors affecting caregivers’ ability or decision to participate in education and support programs are often interrelated and point to a complex set of issues that are not easily overcome.

**Sociodemographic Characteristics**

A review of the literature suggests that hard-to-reach caregivers tend to be racial/ethnic minorities, living in poverty, younger than 55 years of age, employed, and male (Anderson et al., 2000; Bullock, Crawford, & Tennstedt, 2003; Coe & Neufeld,
A wide range of explanations have been suggested for why these characteristics would reduce the likelihood of caregivers engaging in education and support programs. Among racial/ethnic minorities, studies have found that race and ethnicity per se may not significantly contribute to service utilization upon adjusting for confounding factors. Rather, race and ethnicity act as proxies for other factors related to service use, including familial closeness and contribution as well as cultural norms (Scharlach, Giunta, Chow, & Lehning, 2008). Greater prevalence of mistrust towards the health system and formal care providers, fear and language barriers also affect decisions to participate in programs (Cox, 1999; Monahan, Greene, & Coleman, 1992). Among employed caregivers (most 55 years of age or younger), who account for over 15% of the workforce (Wagner, 1997), difficulties balancing caregiving responsibilities with employment obligations
Accessibility of Caregiver Education and Support Programs

are often cited as a primary reason for not engaging in programs (National Alliance for Caregiving & Center for Productive Aging, 2003).

Men constitute nearly 30% of all caregivers and over 36% of all spouse caregivers (Kramer, 2002; Kramer & Lambert, 1999). They are far less likely than women to participate in caregiver support and education programs (Kaye & Appelgate, 1990; National Family Caregivers Association, 2000) while having a greater propensity to solicit the support of formal services (Brown, Chen, Mitchell, & Province, 2007). Thus, with regard to caregiver education and support programs, men caregivers are harder to reach and engage, as compared to their female counterparts. Although relatively few studies have examined gender differences in service utilization (National Family Caregiver Association & National Alliance for Caregiving, 2001; National Alliance for Caregiving & Center for Productive Aging, 2003; Navaie-Waliser, Spriggs, & Feldman, 2002), issues related to gender roles regarding masculinity (Brown, Chen, Mitchell, & Province, 2007), stigma associated with men as caregivers (National Family Caregivers Association & National Alliance for Caregiving, 2001; National Alliance for Caregiving & Center for Productive Aging, 2003), and negative self-image reduce the likelihood of men to self-identify as a caregiver (Hirsch, 1996). Thus, lower participation rates often are observed in caregiver programs among men (Houde, 2001). An observational study by Calasanti and King (2007) found that men approach caregiving work like a job often time separating their emotions from tasks. By contrast, women often see caregiving as a natural extension of their gender roles across the life course. Gender differences in caregiving styles may impede the help-seeking process for male caregivers because gender roles have instilled in them the values of independence and pride in skills. There are also logistical reasons that reduce the likelihood that men will participate in caregiver programs, including being a long-distance caregiver (National Alliance for Caregiving & Center for Productive Aging, 2003) and difficulties balancing caregiving responsibilities with employment (Carmichael & Charles, 2003).

Social and Environmental Contexts

Commonalities in the social and environmental contexts of hard-to-reach caregivers include the absence of secondary family caregivers, social isolation, rural residence, being a long-distance caregiver, not living in the same household as the care recipient, and lack of transportation (Anderson et al., 2000; Bruce & Paterson, 2000; Buckwalter, Davis, Wakefield, Kienzle, & Murray, 2002; Houde, 2001; Morgan et al., 2002; National Family Caregivers Association, 2000). In considering the social and environmental factors that affect access to family caregiver education and support programs, it is clear that caregivers often face the challenge of overcoming a multitude of barriers. For example, the absence of a secondary support system to rely on often leaves caregivers with little choice but not to engage in programs because they do not have someone else to help care for the care recipient. Similarly, being socially isolated is often correlated with living in a rural community which has also been linked with inadequate transportation.
Service Delivery System Factors

Several system factors have been identified consistently in the literature to be associated with family caregivers’ access to education and support programs. These factors include caregivers’ general lack of awareness about the range of available services, the longitudinal nature of caregiving support programs, lack of culturally appropriate services, and non-home-based modes of service delivery most often utilized by programs (Bruce & Paterson, 2000; Colantonio et al., 2001; Gallagher-Thompson et al., 2003; Laditka et al., 2001; Morgan et al., 2002; National Family Caregiver Association & National Alliance for Caregiving, 2001; Whittier et al., 2005).

Despite the relatively fast growing number of caregiver education and support programs nationwide, in general, many caregivers are not aware of these existing services as resources. Lack of sufficient or strategic marketing of these programs has resulted in inadequate outreach to all caregivers. Another system factor that affects caregiver access to education and support programs is their structural design, requiring caregivers to participate over a specified length of time with certain frequency. Studies have found that when longer and more frequent meetings are required by programs, especially in non-home-based settings, the likelihood of inconsistent participation and higher attrition increase significantly (Boothroyd et al., 1998; Botsford, 1994; Bruce & Paterson, 2000; Colantonio et al., 2001; Eaves, 1999; Gallagher-Thompson et al., 2003; Monahan et al., 1992; Morgan et al., 2002; National Family Caregiver Association & National Alliance for Caregiving, 2001).

Emotional and Physical Health Attributes

Several factors related to the emotional and physical disposition of family caregivers have been found to be common among hard-to-reach caregivers. Given that a typical family caregiver provides, on average, 20 or more hours of care per week (National Alliance for Caregiving and American Association of Retired Persons, 1997; Navaie-Waliser, Feldman, et al., 2002), many feel heavily burdened. These heavily burdened caregivers often experience high levels of stress and lack the time flexibility to participate in support or other types of programs (Barusch & Spaid, 1991; Colantonino et al., 2001; Laditka et al., 2001; National Family Caregiver Association & National Alliance for Caregiving, 2001). Another factor that is common among hard-to-reach caregivers is their inability or unwillingness to leave care recipients to partake in support programs (Farran & Keane-Hagerty, 1994). A third factor affecting family caregivers’ access to education and support programs is their physical health. Studies have shown that caregivers in more frail health are more likely to attend support programs, perhaps because they have greater concern about their ability to provide care, and thus are more motivated to attend (Scharlach, Giunta, Chow, & Lehning, 1998).
Barriers to Accessing Caregiver Education and Support Programs

A useful model to draw on when examining barriers faced by caregivers in accessing education and support programs is the behavioral model of health services utilization proposed by Andersen and Newman (1973). The model examines service utilization according to three sets of factors, namely predisposing, enabling, and need.

**Predisposing factors** are characteristics of a caregiver that affect his/her propensity to access programs and services. Examples of predisposing factors found as barriers to accessing education and support programs among family caregivers include:

- Male gender
- Middle-aged and younger caregivers
- Racial/ethnic minority background
- Negative or mistrusting attitudes towards the health system and formal care providers, often rooted in a history of discrimination
- Cultural beliefs (traditional values and norms)
- Primary spoken language being non-English

**Enabling factors** are measures that affect a caregiver’s ability to access education and support programs. Examples of enabling factors that have been found by past studies to serve as barriers to accessing caregiver education and support programs include:

- Disjointed care systems, which often do not provide caregivers referrals to education and support programs
- Rural communities as primary residents of caregivers
- High caregiving demands
- Part-time or full-time employment by caregivers
- Lack of secondary caregiver support systems
- Transportation difficulties
- Unavailability of obtaining alternative care for the care recipient during periods of attendance
- Caregiver and care recipient not living together
- Unawareness about availability of programs
- Characteristics of health-care system and individual staff members

**Need factors** are a caregiver’s characteristics that indicate vulnerability for which education and support groups serve as an intervention. In essence, need factors are the “motivating force” behind a caregiver’s decision to engage and maintain his/her participation in education and support programs. The most prominent need factors reported in the literature as barriers to accessing caregiver education and support programs include:
• High levels of subjective caregiving burden
• High levels of depression
• Poor physical health, particularly limited mobility
• Perceptions of low or inadequate knowledge and skill levels
• High level of functional dependence among care recipients

Future Directions: Implications for Practice, Research, Education/Training, and Policy

As practitioners, researchers, evaluators, program planners, policymakers, and advocates continue to realize the invaluable contributions of family caregivers, outreach and support efforts must become more tailored and better focused in order to be more inclusive of all caregivers, especially hard-to-reach caregivers who are likely to have many unmet needs. The summary findings highlighted in this chapter offer insights that can help ameliorate some of the challenges faced by family caregiver education and support programs as they strive to provide outreach to hard-to-reach caregivers. Although there are many future directions to consider for enhancing practice, research, education/training, and policy/advocacy, a selected set of recommendations that are feasible for more immediate implementation are provided in the following sections.

Implications for Practice

Based on existing evidence and knowledge as surmised from the literature, implementation of the following recommendations are encouraged, several of which have recently been implemented to enhance practice (Whittier et al., 2005):

1. There is a tremendous need for caregiver education and support programs to increase their visibility by using diverse marketing strategies. Lack of awareness of available programs remains one of the most frequently cited reasons among hard-to-reach caregivers for not participating in programs. Marketing strategies that have been shown to be most effective in reaching caregivers include sending media messages that focus on the concept of “ask for help” rather than “take care of yourself”; use of specific languages such as “family caring” or “family care” rather than “informal caregiver” which carries negative connotations, particularly along gender lines; avoidance of phrases such as “don’t” or “shouldn’t” which may be perceived as negative criticism; use of campaign tones that are comforting, reassuring, and empowering; and providing multiple means of contact including telephone, mail, fax, and website communication (Atlee, 2001).

2. Marketing and public relations efforts focused on caregiver education and support programs would benefit from targeted, culturally appropriate messaging
that aims to increase engagement by racial/ethnic minority caregivers. These messages also will need to be sensitive in providing recognition and inclusion of nonkin caregivers (i.e., friends) given their significant involvement in the broader network of caregivers among racial/ethnic minority care recipients.

3. The aggregate literature strongly suggests that caregiver support and education programs will function more effectively in serving caregivers if they are a part of a more coordinated system of intervention. Therefore, using an “added on” model of service delivery rather than a disjointed and fragmented service delivery approach would likely enhance a program’s ability to increase participation among hard-to-reach caregivers. In addition, providing a wide range of services that include a home-based component, with flexible schedules within this model of service delivery is important because it recognizes that not all services and modes of service delivery will appeal to all caregivers.

4. Given that the residential location of family caregivers, in particular rural communities, affects their accessibility to education and support programs, establishing satellite programs within rural settings could offer an opportunity to engage hard-to-reach caregivers who would otherwise not be easily reachable.

5. Offering some form of transportation assistance, such as vouchers for taxi rides and program-sponsored van pick-ups, is another approach to improving accessibility of hard-to-reach caregivers to education and support programs.

6. Providing temporary respite care (e.g., adult day care or home care) for care recipients would offer short-term relief for family caregivers and enhance the likelihood that hard-to-reach caregivers could participate in education and support programs.

7. Programs should avoid using the term “caregiver” during outreach activities without providing an expressed definition of the term and activities that would qualify someone as a caregiver. This approach would likely increase the probability that “hidden” or unacknowledged caregivers would self-identify (Pickett-Schenk, 2003). The choice of an optimal term to identify caregivers is not straightforward. For example, internationally focused caregiver education and support programs have had success reaching caregivers by using the term carer (Loyd & Carson, 2005; Stoltz, Uden, & Willman, 2004), however whether adoption of such a term in the United States would be well received remains unclear.

**Implications for Research**

Future research on hard-to-reach caregivers can contribute to the current knowledge by investigating:

- The efficacy of employing different strategies to engage hard-to-reach caregivers based on the stage of service delivery (e.g., identification, recruitment, engagement) at which caregivers become classified as hard to reach.
- The degree to which caregiver self-identification affects caregiver actions: Do these caregivers perceive any benefits or risks in being identified as caregivers?
What is the best strategy for improving self-identification of caregivers to trigger self-help actions? Are there negative health and social consequences of not self-identifying oneself as a caregiver? What factors affect a person’s decision or ability to self-identify as a caregiver?

- The effectiveness of large-scale, well-controlled gender-specific interventions on outcomes among men caregivers, including propensity to self-identify as a caregiver and participation level in education and support programs.
- The benefits of caregiver engagement level in education and support programs on the health and well-being of care recipients. Although such measures are more distal to caregiver education and support program outcomes, they would lend a more comprehensive picture of the potential impact of such initiatives. At present, rigorous longitudinal or controlled intervention studies have not been performed to adequately inform the literature on this research topic.

**Implications for Education/Training**

The two most prominent themes from an education/training perspective that would likely impact caregiver education and support programs’ ability to reach hard-to-reach caregivers are the following:

1. Programs need to provide more clear messages to family caregivers about their purpose and how participation benefits caregivers.
2. More multilingual staff need to be hired so that culturally appropriate outreach is provided in various languages as an effort to reduce communication barriers among non-English speaking family caregiver populations.

**Implications for Policy/Advocacy**

The literature shows that family caregivers, formal care providers, and policymakers concerns and priorities often contrast (Chappell, Reid, & Dow, 2001). Understanding needs from a caregiver’s perspective is critical to maximizing service use, particularly among hard-to-reach caregivers. From a policy/advocacy perspective, it is paramount that caregiver programs support campaigns that address the following issues:

- Studies have shown that employer costs related to employee’s caregiving are significant, costing employers nearly 4.7 billion dollars in replacing employees who resign because of their caregiving responsibilities (Lilly, Laporte, & Coyte, 2007). Employer-sponsored support of caregiving activities would likely reduce the many challenges faced by hard-to-reach caregivers who experience difficulty balancing employment with caregiving responsibilities and program participation as well as potentially reduce financial loss to employers.
• The idea of family caregivers as political constituents is very foreign to most caregivers. However, the potential advantages of political mobilization are clear and powerful to some caregivers. Therefore, programs need to increase efforts in assembling and training groups of family caregivers in public policy advocacy techniques. The impact of the voices of empowered caregivers cannot be underestimated in setting policy agendas.

• Continued reliance on family caregivers without adequately engaging the diverse populations of caregivers can create a stressful and potentially unsafe environment for the caregiver and the care recipient. Thus, policies that support the development and implementation of a broader array of accessible, culturally diverse, and tailored caregiver education and support programs increase the likelihood of reaching as many caregivers as possible, especially hard-to-reach caregivers, many of whom have high levels of unmet needs.

Conclusions

This chapter summarizes the literature, presents an overview of the barriers to accessing family caregiver education and support programs, and offers recommendations for future directions. The chapter highlights what is known and unknown about hard-to-reach family caregivers and what is needed to improve outreach to, and engagement of, these caregivers. As education and support programs continue to strive to serve family caregivers, more creative and tailored avenues of service delivery are necessary to engage the many hard-to-reach caregivers who could benefit from participation but remain at-large unsupported.

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