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Exploring Formal Care Providers' Perspectives of the Support Needs of Older Male Spousal Care-givers: A Focus Group Study

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Abstract

Formal support comprises services provided by health, social care and community-based agencies (CBAs), including charities. Evidence indicates poor uptake of formal support by older male care-givers who often fail to accept help until a crisis point is reached. Given the growing recognition of caregiving as gendered, there is a need for an enhanced understanding of how support providers can assess and address the needs of this caregiving sub-group. The aim of this study was to explore formal care providers' perspectives of support for older male spousal care-givers through focus group interviews. The study was conducted in a region in the United Kingdom (UK) with four CBAs (participants: $n=33$), and five statutory healthcare providers (participants: $n=51$). Thematic data analysis resulted in the identification of three themes: Service Priorities, Engaging Men, Assessment of Need. Findings revealed that service flexibility was key to providing support; difficulties in engaging men in support and low take-up of carers' assessments were potential barriers to support. Social workers should have an in-depth understanding of how caregiving is gendered and how this may influence the support needs of older male spousal care-givers. Enhanced carers' assessment training, which highlights collaboration in planning and delivery of tailored support, may result in support that enables older male care-givers to sustain their caregiving role.

Keywords: care-giver, gender, male, masculinity, spousal, support

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Introduction

A global ageing population and rise in the number of long-term chronic conditions are resulting in an increased necessity for informal care-givers (van Groenou and De Boer, 2016; OECD, 2018). Whilst informal care-giving has traditionally been the domain of females, evidence indicates an increase in the numbers of male care-givers (Poysti et al., 2012). In the UK, older male care-givers are more likely than older female care-givers to provide care for a spouse. According to the Office for National Statistics (ONS) this may be because females typically provide care for a range of family members, however, when a female needs care, often her spouse/partner is the only person who can provide it (ONS, 2019).

As well as experiencing satisfaction and reward from care-giving, older male spousal care-givers can be subject to declining physical and psychological well-being, declining intimacy and profound social isolation (Milligan and Morbey, 2013; Fee et al., 2019). Older male care-givers are also more likely to live with a spouse than older females (Steppler, 2016), and there is evidence to suggest that spousal care-givers are at greater risk of depression, coronary heart disease and stroke than non-spousal (Haley et al., 2009; Ji et al., 2012).

Care-givers (regardless of gender) who receive support experience better health outcomes and physical/psychological well-being than those who do not (Dam et al., 2016). Given this evidence, and the likelihood that older care-givers will also have their own health concerns, it is vital that they receive effective support, not only to sustain their own well-being, but also to maintain the informal caregiving system, thus reducing state costs (Kaschowitz and Brandt, 2017; Verbakel et al., 2017). Despite these negative care-giver outcomes, a poor take-up of formal support services (such as respite or practical help) has been reported in the general caregiving population (Singh et al., 2014). A study by Lindahl et al. (2009) in Sweden found that when healthcare professionals entered the home, power and status issues could potentially arise, due to 'home' being the place where family values predominated. This made the establishment of a 'professional friendship' (based on collaboration between professionals and care-givers), which Lindahl suggested was a core component of effective support, difficult. This suggestion has been supported more recently by others who have noted that establishing and maintaining trusting relationships between care-givers and healthcare personnel could be challenging (Büscher et al., 2011; Singh et al., 2014).

In recent years, gender differences in the take-up of care-giver support have been highlighted in the literature (Milligan and Morbey, 2016). Given that older male care-givers may not identify with the care-giver label and are reported to have an independent and stoic approach to caregiving (Milligan and Morbey, 2013; Robinson et al., 2014), they may

be particularly vulnerable to lack of support. Although previous research found that in general older male care-givers were reluctant to use formal support, reasons for this remain unclear. Various causes for male care-givers' reluctance to access support have been highlighted, including non-supportive interactions (such as previous bad experiences of support; Neufeld and Kushner, 2009); men being outside the care system (Schwartz *et al.*, 2015); and guilt about asking for help (Sanders, 2007).

Although some literature has highlighted health and social care (HSC) professionals' perspectives of providing care-giver support in illness-specific settings, such as cancer care or dementia (Aldaz *et al.*, 2016; Beiber *et al.*, 2018), research about HSC professionals' perspectives of support needs that are common to care-givers collectively (such as respite, training or practical help) is sparse, but necessary from a public policy perspective.

Within the UK, there are separate arrangements for the delivery of public HSC services. Devolved administrations for the UK and Northern Ireland resulted in an HSC provision that was unique to these jurisdictions. This study was conducted in Northern Ireland, where HSC services are integrated and are delivered by teams of HSC professionals (including social workers and nurses) within state-funded Health and Social Care Trusts (HSCTs). In addition, some social care services (such as befriending and respite) are provided by paid staff, such as community support workers, based in non-government agencies, also known as 'community-based agencies' (CBAs). Although both HSCTs and CBAs provide support to care-givers, there are some notable differences in how they provide these services. This includes HSCTs adherence to the application of regional eligibility criteria which aims to provide fair access to support services for services users. In contrast, CBAs are not obliged to apply these criteria.

As there is a dearth of research in this area, there is a need to consider the perspectives of formal care providers in determining the support needs of older male spousal care-givers. This is important given reported barriers for male care-givers in accessing formal support (Greenwood and Smith, 2015), the 'male approach' to caregiving (Robinson *et al.*, 2014), and the suggestion that male care-givers are more likely than female care-givers to provide care for a spouse (ONS, 2019). Insight into the relationship between formal care providers and older male care-givers, and the identification of factors that hinder or enable engagement and the provision of support may help to inform future support for this population group.

This study was part of a larger project which aimed to examine the support needs of older male care-givers in Northern Ireland. Although this study explored perspectives of formal care providers, a different phase of the larger project explored the use of support services from the perspectives of older male care-givers using qualitative interviews.

A project steering group comprising representatives from HSCTs and CBAs; academics and a male care-giver were involved in this study and the larger project.

For the purpose of this study, the term ‘formal care provider’ will be used as a collective term to incorporate HSC staff who work across both statutory and community/voluntary sectors. Older care-givers are defined as care-givers over sixty-five years of age as this is the definition of ‘older’ in western societies (World Health Organisation, 2014).

The aim of the study is to explore the perspectives of formal care providers about support services for older male spousal care-givers.

Design and method

Design

A qualitative exploratory approach, using thematic analysis was employed (Braun and Clarke, 2006). This comprised focus groups ($n=9$) with formal care providers across Northern Ireland.

Sample

Participants ($n=84$), included a range of HSC professionals (including social workers, nurses and mental health professionals), employed by state-funded HSCTs. CBA personnel included community support staff (including community support workers and managers) who were paid employees of a non-government agency (including Alzheimer’s Society and Marie Curie), in Northern Ireland. Kitzinger (1995) suggests that the ideal size for a focus group should be four to eight participants, however, Krueger and Casey (2015) maintain that group size can be as large as twelve. This study had a minimum of five and a maximum of fourteen participants.

Recruitment

Inclusion criteria were: health/social care professionals within mental health for older people or older people’s services (over sixty-five), within an HSCT or a CBA.

Recruitment of participants was undertaken in liaison with local collaborators within selected agencies. Study information was circulated, and focus groups were arranged at a mutually agreed venue and time (during staff working hours) for relevant teams. All participants signed a

consent form prior to the commencement of the focus group, and all sessions were digitally audio recorded (with informed consent).

Data collection

According to [Kitzinger \(1995\)](#), focus groups are useful for exploring not only peoples' experiences, but also what, how and why they think certain things. In this study, focus groups were moderated by the researcher (A.F.), who had previous experience of working within a healthcare setting, and who was trained in facilitating focus groups. The focus group schedule was developed in accordance with the study's aims and findings from the relevant research literature and was piloted with one CBA. After the pilot, the schedule was altered to improve the flow by changing the question sequence and adding further prompts. [Krueger and Casey \(2015, p. 7\)](#) suggest that focus group questions should be predetermined, sequenced, open-ended and logical. Questions in this study began with general questions to encourage involvement—such as 'Can you give me a general indication of the number of older male caregivers on your caseload?' Thereafter, questions aimed to encourage open discussion about participants' experience of identifying, assessing and supporting older male care-givers. Probes were used frequently by the moderator to explore practical examples in more depth.

After four focus groups with CBAs, and five with HSCTs, the researcher determined that data saturation had been reached, as no new information was being discussed ([Krueger and Casey, 2015](#)). In addition to the focus group schedule, the researcher (A.F.) maintained in-depth field notes to record information such as context, prior communication, number and composition of the group, interactions and overall flow and energy of the session.

Data analysis

An inductive thematic analysis was employed to systematically organise, condense, categorise and refine data ([Braun and Clarke, 2006](#)). This approach involved six key phases: (i) familiarisation with the data, (ii) generating initial codes, (iii) searching for themes, (iv) reviewing themes, (v) defining and naming themes and (vi) producing the report. Following the initial focus groups, data collection and analysis were undertaken simultaneously to inform later stages of data collection. Focus groups were professionally transcribed verbatim. The researcher (A.F.) read and re-read transcripts for accuracy and familiarity. Next, a coding framework was developed by the researcher (A.F.), which included twenty-four initial codes (including coping strategy, carers' assessments,

crisis and service flexibility). Underlying meanings of the categories were discussed with the project steering group, and the other authors (S.M. and A.R.), to identify overarching themes. Data were imported into QSR NVivo version 12 qualitative software, for management and refinement.

Rigour

Strategies for ensuring rigour (Lincoln and Guba, 1985) in this study included: (i) The rich mix of participants (including social workers, nurses, community support workers and mental health professionals) ensured credibility. (ii) Detailed descriptions of the data collection and analysis procedures, along with the use of Nvivo software to organise and interrogate data demonstrated confirmability and transferability. (iii) Credibility was enhanced through peer debriefing—reviewing, refining and validating initial emerging themes. Also, the project steering group was involved with the development of the focus group interview guide. (iv) Researcher bias was addressed through the use of a reflexive journal and peer debriefing.

Ethical approval

Ethical approval for the study was granted by Ulster University Filter Committee, and governance approval was obtained from the following HSCTs: Northern HSC Trust (Ref: NT18-0638–10), South Eastern HSC Trust (Ref: SET 18–30) and Western HSC Trust (Ref: WT 18/27).

Findings

Nine focus group interviews with personnel from HSCTs and CBAs (participants: $n = 84$) were undertaken. Data analysis resulted in the identification of three themes: Service Priorities, Engaging Men, Assessment of Need.

Theme 1: Service Priorities: 'doing something that's actually going to be beneficial'

Findings in this theme revealed several key differences in approach between HSCTs and CBAs to the delivery of support for older male care-givers. One factor that seemed to influence support prioritisation was eligibility criteria that were applied by HSC professionals within HSCTs during assessment. Social workers explained that application of

these criteria meant that only care-givers who were at ‘breaking point’, or those in ‘critical’ need received support. However, this often resulted in prioritisation whereby ‘physical needs override emotional needs’. One social worker described her difficulty in obtaining care-giver respite:

The Trust doesn't really view it as a critical need or essential, whereas we view it as essential on our cases, but we know how difficult it is. So, we aren't even really offering it to people because we know we can't get it. It has to be proved that this person can't be left on their own... It has to be breaking point, and somebody is going to walk out the door... And even at that... You might not even get it. (HSCT4, Social Worker)

By contrast, CBAs who were not constrained by the same eligibility criteria, appeared able to provide support at an earlier stage, thereby potentially delaying the need for more intensive support. This was illustrated by one CBA participant who explained that their organisation did not close cases, which enabled them to respond to need more proactively.

It's about us being, I suppose, proactive, and reactive, but we change with their needs. The beauty about going forward now is, we keep a case open now, where before we used to close it. (CBA3, Service Manager)

HSC professionals did have the option of referring older male care-givers to CBAs for support, and there was evidence to suggest that some did, however, this was inconsistent across services. Reasons for the inconsistency in referrals were not discussed in depth, however, one participant explained that there was a wide variation of the services provided by CBAs and this may have been caused by geographical factors.

I think the service provision from the voluntary sector community-based services is quite variable. For example, in the XXXXX area, the Alzheimer's Society provides services where the carer can go, and they go into one group while the person with dementia goes into another group that runs simultaneously. It doesn't create difficulties. In the XXXXX area, we don't have that. They have a brilliant thing in XXXX and it's a wee bit too far for our client group. (HSCT 1, Social Work Team Leader)

Differences in the ‘flexibility’ of services offered by formal care providers were also noted. For example, participants from HSCTs appeared to be limited to ‘in house’ support measures (residential respite or packages of care) which, despite the efforts of HSC professionals to be creative, still did not allow them to match services to male care-givers’ individual requirements. One social worker explained that a male care-giver on her caseload had been offered a care package (agency staff assisting with personal care and medication) but had declined this as he preferred to undertake these tasks himself. He had subsequently

requested a sitting service to enable him to go out once a week, but this had been refused as he had already declined a care package. The social worker described how she could 'see the deterioration in his health', because of this situation. This type of scenario often led to frustration amongst social workers, as they acknowledged the lack of choice and control with current support options, with one social worker commenting 'It would be more person centred doing something that's actually going to be beneficial' (HSCT 3, Social Worker).

On the contrary, CBAs appeared to have greater flexibility, in that they seemed to have more scope to meet individual needs, because either they offered a range of services from their own agency, or they referred to another agency. A noteworthy perspective from one CBA participant was that services offered by HSCTs had the effect of 'disempowering' care-givers due to a feeling of services being 'imposed' on them and a loss of control. It was observed that flexibility and a focus on tailoring individual support could result in appropriate and sustainable support. As exemplified by a support worker from a CBA:

A service user that we would have had... he cared for his wife totally himself. She was bad at that stage. He said, I don't have children. He wants to learn a bit of skype, so he could skype with the family. Prescriptions, order prescriptions on-line and check his bills. All those things that took the pressure off, and order groceries, because trying to get groceries was impossible. So, we organised for somebody to come into the house then to teach him IT skills. (CBA1, Service Manager)

The importance of companionship (for example, a befriending scheme), was also emphasised, and that matching older male care-givers with someone similar was crucial to making this support effective. A community support worker gave an example of this:

We had one gentleman who used to play rugby, and he was matched with a gentleman who just loved rugby, and their friendship was just, it was great... and they would have walked down to XXXX Stadium, and just chatted about it, come back. He would have been exhausted from his walk, but he slept on the sofa, and the volunteer gave about twenty minutes to the wife. It was probably one of the most simplistic but most effective matches in our service. (CBA1, Community Support Worker)

Although some HSCT participants recognised care-giving as a gendered phenomenon, and the implications of this for support, findings from the current data did not indicate that this was being addressed from within the organisation. An HSC social worker explained the current situation:

Social services are generally very female dominated at this level, at Band 6 and 7. I wonder if there were more male domiciliary carers in

agencies and more male social workers – there is a heavy dominant female perspective there – would it be easier for those male carers relax and take up services as they are available? (HSCT3 Social Worker)

Theme 2: Engaging Men: ‘we need to reach out to men in a different way’

Participants generally acknowledged that male care-givers were harder to engage than their female counterparts, and there was evidence of staff skills as several described that ‘we need to reach out to men in a different way’, or that support staff had to ‘do a bit of prying’. Some social workers explained that female care-givers may engage at an earlier stage of their caregiving trajectory than males, due to the tendency for females to be more familiar with the healthcare system than males.

Sometimes, with male carers, you really have to do some work with them to encourage them to accept or even try a package of care. It will reduce the burden on them. I don’t know whether it stems back to the fact that we’re working with older male carers and that generation had traditional roles, so they wouldn’t have been as freely engaged or involved with health professionals. (HSCT3, Social Worker)

Many participants attributed difficulties in engagement and subsequent support to ‘masculine traits’. Specifically, an apparent reluctance of male care-givers to verbalise their stress, or to talk about any difficulty associated with their caregiving role.

Men don’t talk about these things. They don’t talk about feelings, or maybe they don’t know how to bring the conversation up. Maybe women are able to bring it more easily... Women are, they’re quite open about how they feel and the difficulties of caring as well as the rewards of it. (HSCT5, Social Worker)

It was reported that men’s reluctance to engage, or to discuss caregiving difficulties often resulted in situations reaching crisis point. This was frustrating for HSC professionals as they observed that earlier intervention could potentially have prevented crisis. One mental health practitioner described a situation where not only had a crisis taken place that resulted in distress for care-giver, but also for the care recipient:

He was quite a frail old man himself and his wife had problems with depression, which had progressed into dementia. By the time it was referred to us in the team and we went out, it was just a mess. She hadn’t had her medication, she was quite dishevelled, but he felt he had to cope with that. He downplayed it and said he could manage, but he really wasn’t managing. It took a couple of visits to get him to actually admit... I think he did feel embarrassed that he couldn’t cope. (HSCT1, Mental Health Practitioner)

Several participants explained that time spent on building trusting relationships could encourage engagement with male care-givers. Whilst building relationships with all care-givers is important in providing support, it was commonly suggested that it took more time to build relationships with male care-givers.

I can find sometimes going out that it takes longer to build up a relationship with a male carer than a female carer. A female carer will chat to you a lot sooner and will ring you up about things. . . . I find that a lot of male carers lost out by not ringing you back about things. So, it just takes that bit longer for a male carer for whatever reason it is than a female carer. (CBA1, Service Manager)

However, as one mental health practitioner described, no matter how hard they tried to establish or maintain a relationship, sometimes this was not enough to prevent care-giver breakdown.

You knew going in that they weren't giving you the full experience of stress. . . . You would try to get as many openings as you could, but they wouldn't necessarily let you in or acknowledge that emotion. You knew that if you went back into that house in three months' time, they could be at breaking point. . . . They reached the point where they were in tears. I remember seeing someone shaking with stress. It was completely beyond what he could cope with. (HSCT1, Mental Health Practitioner)

Theme 3: Assessment of Need: 'a carers' assessment wouldn't tend to be a priority'

Given that care-giver support was based on assessed need, all formal care providers had a protocol for such assessments. CBAs had their own assessment processes, whilst HSCTs implemented formal carers' assessments. Findings revealed that some HSC professionals did not routinely offer carers' assessments to care-givers. One CBA community support worker suggested that older male care-givers were unaware of services offered by the HSCT:

They don't know the carers' assessment exists, or they don't know that respite exists, or how you might access it if they were. (CBA3, Community Support Worker)

However, an HSC social worker emphasised that whilst carers' assessments were offered to both male and female care-givers, the take-up was mainly from female care-givers. Even though this imbalance may reflect the numbers of male and female care-givers who were known to formal support providers it was also noted that male care-givers took

less time to complete the carers' assessment than their female counterparts, as explained by this social worker:

I have mostly women who accepted it. One or two men. I even find that I would spend a shorter period of time with the men than the women. Maybe half an hour or 45 minutes. You can be going for an hour and a half with ladies, maybe longer. (HSCT3, Social Worker)

More generally, evidence indicated a lack of confidence from HSC professionals in the system of carers' assessments and their overall effectiveness. Arguably this could have impacted on the uptake of carers' assessments by male care-givers.

A carers' assessment is never a priority. I mean, it should be, but realistically, a carers' assessment wouldn't tend to be a priority. (HSCT2, Social Worker)

Despite this, some evidence showed that when male care-givers had a carers' assessment it could have resulted in a request for specific support. One example of this was that male care-givers tended to need time away at the weekends to take part in sporting events, and often requested a 'sitting service' (agency staff who provide care while the primary care-giver has time away) to meet this need. However, 'sitting services' were more difficult to secure at weekends, due to unavailability of agency staff and cost, which meant that often the request for a sitting service at the weekend could not be met.

I know some males now, for them to get a break from the caring role, it would mean them maybe going out for a few hours, maybe going golfing, maybe going with friends for a longer period of time. Sometimes that's difficult to get and have somebody sitting in for respite or for day care, so generally they don't go because they're maybe away for a more prolonged time. Again, that's a generalisation but that could be a reason too, why people are having difficulties. (HSCT4, Service Manager)

It was generally agreed that household tasks such as cooking and cleaning could potentially pose challenges. Participants explained that this may be more of a problem for men within this age group (over sixty-five). This was because their spouse/partner may have traditionally undertaken these tasks within the home. Several mentioned services such as 'home helps' (i.e. agency staff who provide help with household tasks such as cleaning and ironing), and disappointment from male care-givers when they realised that this service no longer existed. Even though many male care-givers were resourceful in overcoming household challenges—such as using YouTube to learn how to use the washing

machine—formal care providers often had to address this specific need with male care-givers, more so than females.

So, the practicalities of running a home, in a sense, sometimes men need a wee bit more help, because it was always something that the woman always did. So, the cooking, and the cleaning, and fixing the curtains, and doing those things... So, some of that, I hear more of that than the other way around. (CBA4, Regional Service Manager)

Discussion

This study explored the perspectives of formal care providers about support services for older male spousal care-givers through focus group interviews. Data analysis resulted in the identification of three themes: Service Priorities, Engaging Men, Assessment of Need.

Study findings highlighted some key differences between the approach of HSCTs and CBAs. As mentioned in the Introduction, HSCTs adhere to regional eligibility criteria which aims to provide fair access to support services for service users. This is because HSCT operates within a legislative and policy framework (Carer's and Direct Payments Act [Northern Ireland] 2002; 'Caring for Carers' Strategy NI, 2006). Aforementioned eligibility criteria determine how services are provided by the HSCT, however, the application of these criteria can pose challenges. The example of one social worker who maintained that 'physical needs override emotional needs' may have implied a restrictive approach. This appeared to oblige HSC professionals to primarily focus on addressing the physical needs, due to care-givers having to be in 'critical' need to meet eligibility criteria for respite. This not only resulted in frustration amongst some HSC professionals that these constraints limited their ability to offer effective support, but also that care-givers who did not meet the 'critical' criteria were placed on a long waiting list for support services. By contrast, CBAs, although also experiencing constraints around lack of resources, appeared to show greater flexibility in addressing both the physical and emotional needs of older male care-givers. Some data suggested that this was achieved through collaboration with care-givers to identify individual needs which led to tailored support, along with availability of appropriate resources, such as matching male care-givers with male befrienders to attend a rugby match or delivering bespoke IT training.

The importance of close collaboration in tailoring support has also been noted by other authors. In their qualitative study of older male care-givers' experiences of formal support by [Sandberg and Eriksson \(2009\)](#), authors concluded that healthcare services were trying to 'induce them to withdraw from the caring role'. This conflicted with male care-givers who expected to maintain their marital relationship and preferred

to be actively involved in the care process with care services. Expectations of a collaborative approach to care were more likely to be met when healthcare professionals regarded care-givers as equal partners and a 'professional friendship' was established (Lindahl *et al.*, 2009). This was supported by Stephan *et al.* (2015) which showed that successful collaboration between healthcare providers and dementia care-givers ($n = 30$) was due to well-trained empathic healthcare staff.

It could be argued that such collaboration is equally important for female care-givers as male care-givers. However, given older male care-givers' reported isolation, limited perception of care-giver support and reluctance to report care-giver strain (Milligan and Morbey, 2013; Robinson *et al.*, 2014), they may be particularly vulnerable to lack of support, therefore, formal care providers should be aware of this potential gap in service provision.

Study data revealed some men's reluctance to talk about, or a tendency to 'downplay' caregiving stress, meant that situations tended to escalate, and sometimes resulted in crisis. Although some healthcare professionals attributed this reluctance to gender (specifically masculinity), others categorised these men within a certain 'generation'. Previous literature has suggested that the 'silent generation' (those born between 1925 and 1945) was conservative and independent, often showing a reluctance to seek help (Strauss and Howe, 1991). However, other caregiving literature has found that 'gender' is an important indicator of care-giver coping styles (Snyder *et al.*, 2015; Hong and Coogle, 2016), with male care-givers often drawing on dominant masculine 'norms' in their caregiving approach (Robinson *et al.*, 2014). Connell's hegemonic masculinity theory has previously been used to explain male care-givers' reluctance to seek or accept help with their caregiving role (Connell and Messerschmidt, 2005; Robinson *et al.*, 2014). Connell posited 'hegemonic' masculinity as the dominant masculine ideal within western society. In her theory, hegemonic masculinity was characterised as strong, independent and competitive, and men who identified with hegemonic masculinity distanced themselves from female traits such as expressing emotions or showing vulnerability. Although hegemonic masculinity provides important insight into cultural norms of masculinity, according to Hanlon (2012) it is incompatible with aspects of men's emotional lives, such as the need to express emotion or intimacy. Furthermore, Hanlon (2012) outlined costs to hegemonic masculinity when men are unable to meet masculine ideals. These 'costs' were also evident in the current data, with one social worker who described a male care-giver in tears, and 'shaking with stress', which she attributed to challenges within his caregiving role. Elliott's practice-based model—caring masculinities—proposed a focus on relational and positive emotion rather than dominance or control (Elliott, 2016). By examining the actual practice of caregiving men, caring masculinities integrated values of care into

masculine identities, therefore, this model may be useful in informing future practice of providing the support that aligns with masculinity.

Within the arena of men's mental health, authors have highlighted specific approaches to engaging men, and the delivery of support measures targeted at men (Seidler *et al.*, 2016; Pirkis *et al.*, 2018). For example, in their Australian study of 'active ingredients' in men's mental health promotion, Pirkis *et al.* (2018), emphasised the importance of recognising the gendered expectations and societal pressures on men.

In this study, along with personal barriers to support, there was evidence of systemic barriers. HSCTs in Northern Ireland have a statutory obligation to offer all care-givers a formal carers' assessment (Department of Health Social Services and Public Safety, 2005). Assessment can be undertaken by any health/social care professional. Individual assessment of need is at the heart of social work practice, and social workers are uniquely positioned for establishing relationships and facilitating comprehensive assessment (Milne *et al.*, 2014). Current findings revealed that although CBA personnel reported that carers' assessments were not routinely offered to care-givers, HSC professionals reported the opposite—that they were. However, some social workers also explained that the take-up was low, and that carers' assessments were not a priority. This finding is consistent with previous work by Seddon and Robinson (2015), who examined carers' assessment from the perspectives of social care practitioners in the UK ($n = 383$). The longitudinal study which spanned twenty years revealed that practitioners were ambivalent about carers' assessments, often resulting in failure to formally identify care-giver support needs. Reasons for this ambivalence included a lack of acceptable support measures to meet care-giver needs, causing practitioners to be cautious about raising expectations through assessment; and high caseloads meaning that assessments were not completed in a timely manner, if at all. Separate assessments for the care-giver and care recipient also caused confusion both for practitioners and families. The authors concluded that practitioner ambivalence and confusion resulted in variations in the carers' assessment process and reactive response to care-giver support need. Seddon and Robinson (2015) emphasised that post-qualifying carers' assessment training is required for HSC practitioners. Additionally, a shift in priority for care-giver support needs is required at a commissioning and policy level to address the lack of innovative support measures which results in the reported ambivalence of social care practitioners.

It could be suggested that a limitation of this study was the facilitation of separate focus groups for HSC professionals and CBA personnel. If focus groups had comprised a mix of these agencies, this may have allowed for more in-depth debate between organisations on key issues. As it was, views were given on issues (such as carers' assessment), which differed, and there was no opportunity to challenge or debate

differences in opinion. Mixing the groups would also have allowed each organisation to gain a deeper understanding of the other. Nevertheless, there was also strength in undertaking focus groups with separate organisations. For example, each group already had a shared language, organisational culture and understanding of their role. This facilitated straight-forward engagement of the group, and potentially less time spent on establishing intragroup rapport.

Conclusion

Although not an objective, findings of this study shed some light on key differences between statutory and CBAs, in the provision of support for older male spousal care-givers. Given the shifting policy environment with a greater emphasis on choice and control it would be important for social workers and other formal care providers to have an in-depth understanding of the support needs of older male spousal care-givers.

This study highlighted challenges faced by HSCTs in providing effective support to older male care-givers despite evidence of staff skills in this area. CBAs appeared to have greater flexibility of service provision, and examples of innovative care-giver support provided by some CBAs were highlighted. Although HSCTs operate within a different legislative framework, there may still be scope to improve effectiveness of support though greater engagement and collaboration with male care-givers, and a deeper understanding of their approach to their caregiving role. Second, most study participants acknowledged gender-related influences on engagement with older male spousal care-givers and subsequent take-up of care-giver support. Current data indicated that many older male spousal care-givers preferred to maintain an element of choice and control over their caregiving role, resulting in a preference for the support that facilitated this. Third, the implementation of carers' assessment was recognised as potentially ineffective in accessing the support needs of older male care-givers. Therefore, although some HSC professionals recognise caregiving as a gendered phenomenon, there is a lack of gender-specific training for staff, and of gender-specific assessment and care-giver support. Effective assessment leading to collaboration in planning and delivery of support, and increased awareness of gender differences in caregiving may result in support that aligns with masculinity and enables male care-givers to sustain their caregiving role.

Further research, drawing on the wider areas of men's help-seeking within healthcare could inform HSC practitioner training, and could also explore male-centred support which could be more effective for male care-givers. A deeper understanding of personal and systemic barriers that influence the take-up of support for older male spousal

care-givers is important to plan for future support, given the rising numbers and limited research about this population group.

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