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REVIEW ARTICLE

Models of care for socially isolated older rural carers: barriers and implications

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ABSTRACT

Introduction: In response to population ageing, the numbers of older carers residing in rural areas are increasing. However, rural older carers are at risk of social isolation due to the decreased social networks associated with ageing and caring responsibilities, and the geographical isolation associated with rurality. This broad, systematic review of the literature was undertaken to: (1) identify barriers to social participation for rural older carers; and (2) summarise features of interventions that were effective in reducing social isolation for rural and/or older carers.

Method: Literature was obtained through systematic searches of selected electronic databases; selected Australian and international government and research based websites and Google Scholar. Searches were limited to material published from 1999 to 2009, and literature was included which either identified barriers to social participation, or outlined interventions that were effective in reducing social isolation and increasing social support in rural and/or older carers.

Results: There were 67 articles, book chapters and reports identified which addressed the review objectives. Findings indicate that rural older carers experience considerable barriers to socialisation, and six dimensions are identified that are effective in reducing barriers, decreasing social isolation and increasing social participation. Interventions must address individual needs; incorporate a dual carer–care recipient focus and/or an educational component; facilitate informal social interaction; utilise existing networks and experienced personnel; and be both sustainable and long term.

Conclusions: Reducing social isolation in rural older carers is a two-stage process. First, barriers to attendance, both logistical and perceived, must be addressed, and the focus of the intervention must be relevant to the carer. Second, opportunities for informal social interaction must be maximised within the intervention. However, a secondary focus may be necessary to ensure attendance, and the provision of education is also integral to achieving long-term outcomes. Integration of service providers in an informal

capacity is also important in providing long-term support options. Addressing these issues will assist in developing interventions for rural older carers that are both appropriate and sustainable.

Key words: ageing, Australia, carers, rural, social isolation, social support.

Introduction

Unpaid carers play an important role in society, and their contribution is becoming increasingly critical as a result of population ageing, predominantly in terms of the very old who are more likely to require care[1]. However, care provision is particularly problematic in rural areas, which generally have a higher ratio of older people than urban areas[1-3]. In addition to having a larger proportion of people needing care, rural areas are compromised by having fewer people of working age to provide care and support to older people[1], as well as a shortage of viable residential care facilities[4]. As a result, older people in rural areas are more likely to be required to provide care to ageing partners and other family members.

As the number of older carers in rural areas increases, so too does their likelihood of experiencing social isolation, as there is a strong association between being a carer and being socially isolated in later life[5]. Being involved in caring responsibilities can result in the loss of social networks[6], and for older carers this is exacerbated by factors associated with ageing, such as loss of paid work, relocation of family, and health and mobility issues[7-10]. Again, these issues are intensified in rural areas, where connections with other carers and support services are limited[11,12].

A recent Australian government inquiry has highlighted the issue of social isolation among carers, recommending that this issue be an early priority for the newly established Australian Social Inclusion Board[13]. This inquiry resulted in the inception of a National Carer Recognition Framework, which is currently being developed in conjunction with local governments, carers and service providers, and will fill a major Australian policy gap. In particular, social isolation is a serious problem in an ageing population, because evidence suggests it can lead to poor health, depression, withdrawal, and a loss of self-esteem and confidence[14]. For carers, there are additional issues, with social isolation said to increase perceived caregiver burden[15], and potentially lead to abuse of the care recipient[16]. Conversely, social networks can alleviate the stresses of caring[17], and provide emotional comfort, release and understanding[18]. This highlights the critical importance of addressing the risks of social isolation associated with being an older carer, particularly for those living in rural areas.

In recognition of the significance of this problem, an increasing number of programs and interventions are being implemented internationally to address the issue. Some are designed to meet the needs of specific population groups, or to respond to a particular barrier or risk factor. These include face-to-face, individual or group programs, as well as those conducted via virtual means, such as the telephone or internet. The intention of this article is to explore these models and, in doing so, to identify the features of effective interventions. As such, the article aims to provide a particular framework for program planners to help build effective intervention models that best reduce social isolation and increase support for older, rural carers. It also aims to highlight the implications of these findings in terms of health and social policy relating to carers.

Method

A literature review was undertaken using three approaches: (i) a search of peer reviewed journal articles located in online databases that included Informit (Rural Health, Health and Society, Family, APAIS, AMI), Ovid (AMED, Embase, Medline, PsycINFO), Proquest Health and Social Science,

CSA Sociological and Social Science Abstracts, CINAHL and Expanded Academic ASAP; (ii) a search of selected government and research-based websites, both Australian and international; and (iii) an internet search using Google Scholar, used to locate 'grey literature' in the form of unpublished reports. Searches were limited to material published between 1999 and 2009, and keywords utilised both cumulatively and in isolation included carer/caregiver, rural, old/older, ageing, social exclusion/isolation/inclusion, support groups, support programs, social support, and models of care.

From the searches, 67 articles, book chapters and reports were identified and included in this review on the basis that they either examined barriers to social participation for rural and older people, or evaluated interventions which addressed social isolation and/or had a social component. Literature that did not meet one of these criteria was excluded from the review. The literature examined included review articles, program evaluations, small-scale qualitative and larger scale quantitative studies, which were carefully evaluated by the authors prior to inclusion to ensure that methods of evaluation, particularly in the case of unpublished reports, were academically rigorous. Due to the limited range of programs for rural older populations specifically, interventions trialed on both rural and older carers were reviewed.

Results and Discussion

The review is conducted in two sections. First, the literature in relation to the barriers to social participation for older and rural carers is explored in order to provide an understanding of the factors that result in social isolation among this group. The second section presents and analyses the features of effective models contributing to reduced social isolation.

Barriers to social participation for older rural carers

The literature highlights a range of barriers inhibiting social participation among older carers, which are exacerbated by residing in a rural area. First, older carers have limited time and motivation to maintain or create social networks, because they are often fully involved in their care activities and lack time to socialize, particularly if the dependency of the care recipient increases over time[3,16]. Thus, older carers may decide that available activities are simply not worth the time investment and cost[16]. Further, activities may not be appropriate to the needs of carers, particularly those who have different cultural values or beliefs from the majority, and this may be a particular barrier for those from CALD (culturally and linguistically diverse) backgrounds[6,19].

Second, a lack of respite care limits the capacity of older carers to undertake social participation. Australian studies have noted that two-thirds of older carers do not have a substitute informal carer to call on[9], and only 50% of older carers utilise respite care[16]. Low use of respite can be attributed to supply factors, such as poor availability, flexibility or suitability, the cost of care, and limited awareness of what is available[16,20,21]. It can also be attributed to demand factors, such as older carers choosing not to use respite due to personal or cultural values, the reluctance of the care recipient to enter respite, or previous adverse experiences with the service[16,21]. Caring may be seen as the responsibility of the family[21], and as a result some older people are reluctant to define themselves as carers, particularly those from CALD backgrounds[13,19]. Accepting help or respite may result in feelings of embarrassment, weakness or guilt; with carers believing that respite time should be spent doing things which will benefit the care recipient[16,20,22]. Research has identified that for rural older carers, this sense of responsibility influences respite use and is a major contributor to social isolation[23].

Third, even if respite is available and the carer wishes to be involved in social activities, there are a number of financial and personal limitations that inhibit social participation among older carers, and the literature highlights a number of issues associated with attending face-to-face support groups for both older and rural carers[15,24-26]. In terms of general social interaction, cost is a significant barrier, particularly as older carers are more likely to reside in low-income households or be unaware of their eligibility for government allowances[6,9]. Other practical barriers include reduced

mobility, and poor physical and mental health related to caring stress[20,27]. Simply leaving the house may be seen as difficult, particularly if the care recipient needs to be cared for outside the home[22]. In addition, those who care for someone with problematic social behavior may fear the stigma that is associated with their interaction in a community setting[27].

Many of these issues, such as lack of time or respite, or concerns about costs or stigma, may be even more apparent in a rural setting. Research has shown, for example, that rural carers demonstrate increased financial hardship, poorer health and experience more stressful events than non-carers[28,29]. In rural areas, geographical isolation, the distances between houses, extreme weather conditions, and limited public transport are more likely to be barriers to social participation[12,15]. While many rural carers report stronger social networks than those of urban carers[29,30], they are less likely to have family support to draw on[10,29]. This is a significant barrier, because family support is instrumental in ensuring regular social participation for rural older caregivers[31]. However, even if family support is available, rural carers may be reluctant to rely on family members for fear of being a burden[32].

Rural communities can be rich in social capital; however, the insular nature of some of these communities and the reluctance of rural carers to admit they have a problem prevents them from asking for and accepting help, and prevents help from being offered. In rural settings where resilience is valued, receiving help may be viewed as selfish and unnecessary[33]. Carers in rural areas may also isolate themselves and their care recipients, because of the stigma associated with mental illness[33,34]. Perceived stigma is also an issue for rural carers in utilising respite services, due to fear that services will be provided by a community member known socially to the carer[32,35]. Services are particularly difficult to deliver in rural communities, and there may not be the choice of and flexibility in services that exist in more populous regions[20,28,36]. In some cases, rural carers report better awareness of services and the quality of these services but, for the reasons discussed, this does not mean that they will be utilized[30]. These issues are compounded by the reluctance of rural people to seek assistance from 'outsiders'[34].

Therefore, older carers in rural communities are at significant risk of social isolation, because there are considerable barriers to participating in social activities. While this suggests that there are numerous obstacles to addressing the issue of social isolation among older and rural carers, there are a range of programs and interventions designed to meet the specific needs of these groups. The next section draws on these programs, delivered in both face-to-face and virtual formats, in order to explore how they are designed to meet the social needs of older rural carers.

Six dimensions of effective models

This review has identified a number of barriers to social participation for older rural carers. Guidelines for best practice, therefore, need to consider these barriers, while also identifying approaches to meet the needs of this increasing group. As such, this section highlights six key dimensions that need to underpin any social support program designed to meet the needs of rural older carers. Interventions must address individual needs, incorporate a dual carer-care recipient focus and/or an educational component, facilitate informal social interaction, utilise existing networks and experienced personnel, and be both sustainable and long term. These dimensions, as well as some examples of programs that address these, are presented in Table 1.

Ability to address individual needs: As noted in the literature, effective interventions must cater for the individual needs of carers, in terms of flexibility, frequency and timing[37]. Thus, in rural areas, fewer meeting times to avoid travel and transport difficulties might be more appropriate[38,39], and given the lack of services, programs held on weekends when there are no professional services available may better meet the needs of older, rural carers[40]. Respite is also important, and needs to be both available and flexible[37,41,42]. For those new or potentially resistant to the concept of respite, it should be both gradually introduced through transitional arrangements and information sessions,

as well as being cost-appropriate and suitable[20,43]. Given the financial issues that most rural older carers will experience, costs associated with programs need to be low or non-existent. Transport provision has also been identified as critical for face-to-face programs in rural areas, with the provision of paid or volunteer drivers effective in ensuring attendance[40,44]. Due to the identified problem of stigma and fear of lack of confidentiality associated with living in a small rural community, it may be that carers would prefer to attend programs outside their community; however, this will require additional transport options[38,39].

Further, modes of delivery need to recognize the individual needs and preferences of older rural carers. For example, one-on-one support prior to attending group interventions may be required for socially isolated carers[22], and virtual interventions and one-on-one volunteer befriending programs can be a first step in this regard[45,46]. Virtual interventions may be more convenient for older rural carers, because they cater for limited time, financial constraints, mobility issues and geographic isolation[11,24,46-50]. They also provide anonymity, which may result in a willingness to share personal details not shared in a face-to-face program[24,26,46,48]. Thus, the benefits of virtual support may need to be explained to rural older caregivers, who may have less experience of these modes of delivery[26], and additional training may need to be provided.

The evidence suggests that virtual modes of delivery, particularly via the telephone, can be as effective as face-to-face support groups in providing support and education to rural caregivers[24]. However, evaluations suggest that the lack of face-to-face contact and the lack of a physical break from caring are a significant problem for older carers[25,26,46,51-53]. While one study has demonstrated that for 91% of older rural carers, videoconferencing was equally beneficial or nearly as beneficial as face-to-face interaction[48], virtual interventions cannot provide physical contact. Thus, even in cases of geographical isolation, opportunities for physical contact should be considered[26], because rural older caregivers may not identify travel as an obstacle if physical contact is important to them[28].

Thus, multifaceted interventions that incorporate respite, transportation and companionship, and are delivered in both face-to-face and virtual formats, are particularly effective in targeting isolation in rural older carers[15,42,43,54]. A notable example of this is the Australian *Older Carers Program*[42], which provided assistance to older carers through the development of integrated care plans, respite activities, volunteer support and cost effective brokering arrangements. The success of these interventions was attributed to their capacity to be needs-based and to present a coordinated approach to services and groups[54]. However, an evaluation of one such program identified that satisfaction levels were significantly lowered in older carers residing in rural areas due to poor availability of respite and reduced competence of program coordinators in these locations[42].

Dual carer-care recipient focus: While respite is an integral component of programs targeting social isolation in older rural carers, even if it is available, many carers do not utilise it due to the associated feelings of distrust, guilt, fear or embarrassment. However, respite for carers does not necessarily involve being apart from the care recipient[22]. This suggests that a dual carer–care recipient focus is important, where both the carer and the care recipient can attend an activity[37,43]. This is particularly important for spousal carers, because relationship strain is reported when support services distinguish between the carer and the care recipient[22]. This focus also eliminates the need for respite, and allows the carer to take the care recipient out in a supportive environment without fear of stigma, and helps to build the confidence of the carer[22,40,44,55,56].

Older carers may also feel more relaxed and able to socialise knowing that their care recipient is participating in an enjoyable activity[21,22], and thus providing enjoyable activities for the care recipient to attend while at the same time running support groups for the carers has proved successful in increasing social support[55,57]. A noteworthy example of this dual carer–care recipient focus is the 'Alzheimer's café' concept, which has been successfully implemented in both rural and urban areas, and provides a

location where carers and care recipients can congregate in a social setting[40,44,58,59].

Provision of an educational component: The focus of any program or intervention is important. Certainly focusing on self-care for the carer may be problematic, for the evidence suggests that older rural carers may feel guilt and shame when taking 'time out' for such activities[26], which suggests that targeted interventions that focus on the delivery of information and/or education may be better received. Examples of this include the *Savvy Caregiver Program*[28], which provided training for Alzheimer caregivers in regard to self-care, strengthening resources and disease knowledge, and the *Caring for Others* program[48], which sought to address psychological barriers restricting adaptive functioning. These approaches can be beneficial as interventions incorporating an educational, psychoeducational or cognitive-behavioral component can improve psychological wellbeing in older and rural carers[15,24,28,48,60,61]. This develops both the ability and confidence necessary to make life changes that reduce social isolation, such as increased use of respite and frequency of social interaction[62].

Educational or health-based interventions also provide additional benefits in terms of social support, when conducted in a group setting[11,15,37,60]. Group settings can also be facilitated via virtual means, including educational videoconferences which involve attendance at a central location to take part in a multi-site videoconference[47,63]. Evaluations of psycho-educational interventions demonstrate positive health and social outcomes for carers, suggesting they are effective in meeting their need for social interaction. One intervention attributes decreased depression in rural older carers to the face-to-face contacts made in the training stage of the study[28], and another suggests that psychoeducational interventions and standard support groups score similarly in terms of the wellbeing of older carers[64], indicating that it may be the group component that is significant in reducing social isolation. However, apart from providing psychological benefits, the educational component may encourage participation because carers feel that it will benefit the care recipient in some way[11], and this is therefore important in motivating them to attend. This was observed from the outcomes of one internet-based intervention targeting older rural caregivers, where over time participants used caregiving information pages less but increased their use of the email component to contact other carers[65].

However, while psycho-educational programs are thus very effective, it may be that some older carers may instead value the opportunity to be involved in activities that are not directly focused on their caring responsibilities[22,37], and these groups can also provide social benefits. One such example is the *Rural Carers Online* pilot program, which sought to increase social interaction among rural older carers through training in email and internet usage[11]. The program evaluation demonstrated broad outcomes that included increased access to social and professional networks, and stronger connections with family and community.

Ability to facilitate informal social interaction with other carers: As noted, programs that enable informal interaction with other carers can develop social networks and friendships, and reduce loneliness[51,53,66,67]. This can reduce social isolation[42,48], and create greater perceived support through identification with a group[42,48,63]. In this way, social interaction both increases psychological wellbeing and increases both the desire and the capacity to socialise[25,50,52]. Other positive benefits include greater awareness of the need for self-care[68], as well as the provision of new information and perspectives on other carers' experiences with services[42,43,69]. Carers are more likely to accept information from other carers as credible, and this may give them the needed confidence and knowledge to access these services[43,70]. Increased awareness and use of services will, in turn, allow more time for socialization.

However, interventions designed to build social interaction need to address the key barriers of access and stigma for rural populations[15], and the evidence suggests that this is best achieved through informal environments. Programs such as the Alzheimer's café concept allow friendships to be made more easily, and provide a greater sense of ownership and identification with the group. The ability for gradual integration that these environments provide is also important. In the case of dual focus interventions, carers often attend on

their own prior to bringing their care recipient[44]. The name and location of the intervention are also significant, because older rural men are often uncomfortable with 'support group' terminology because they feel they do not need support[31]. Similarly, use of the term 'carer' may alienate those who do not identify as carers, and also exclude former carers who are at risk of social isolation due to withdrawal of formal support[12]. In terms of location, meetings should be held in community facilities so they are not viewed as a medical intervention[40,44]. However, service providers can be invited to attend groups in an informal capacity, which provides easy access to, and raises awareness of rural services[38], assists carers to become familiar with staff, creates trust and provides a form of outreach[44]. Thus, it may be that special provision for informal contact needs to be made in more targeted formal interventions if these benefits are to be achieved.

Employment of existing networks and experienced personnel: The fifth dimension that needs to be considered in designing effective programs for older rural carers is the consideration of existing social networks and agencies that already have a relationship with the carer, because these can be beneficial in ensuring initial attendance. Existing contacts can assist recruitment by identifying carers, encouraging them to attend interventions and ensuring they have the necessary practical support to do so[22,43,45,59,63]. This dimension may be particularly appropriate in the rural context, because it can eliminate problems in gaining trust[34], promote program credibility[50], and encourage carers to try more innovative programs[69].

To maximize social interaction, interventions should be facilitated by experienced individuals, who are able to manage differences between individuals attending the group[31,38,39,42,48]. Furthermore, experienced personnel will be able to introduce carers to other carers with similar interests[44], prevent the monopoly of groups by particular individuals[38,39], and act as a trusted permanent contact[40]. Use of an experienced facilitator is particularly important in virtual settings due to the increased demands of group work in these environments, and the emotional impact of the abrupt end to sessions[46,69].

Ability to be sustainable and long term: Finally, the issue of sustainability is critical, because while many interventions provide short-term social support, most carers are unable to sustain these networks on a long-term basis[40]. Thus, interventions need to identify avenues for ongoing social support that can be incorporated into the caring role[43]. Most of the interventions explored in this review have been short term, with few focusing on long-term outcomes, yet sustainability of programs is critical in terms of continued attendance and applicability. Cost associated with any program is a key issue that can be addressed through the use of volunteers and the donation of time. Resources can also be supplied by the community with, for example, funding gained from community grants[38] or by registering a program as a charity[40].

In relation to virtual interventions, technical support needs to be provided on an ongoing basis, as studies have noted that older rural carers can experience issues with equipment[11,67]. Further, the use of recycled computers may assist in keeping costs low[11]. The issue of internet connections is particularly problematic, because connectivity is often difficult and costly to obtain in rural areas[11,71]. In the same way, even teleconferencing costs may be prohibitive[24,48,69]. Thus, when considering the mode of program delivery, while virtual interventions may seem more cost-effective than sending professionals to rural communities, this may not be the case[24].

Finally, rurality should be embraced, because living in a rural environment can be advantageous for carers, and may assist in achieving greater sustainability. Rural areas are notable for their community spirit, and positive aspects such as this should be drawn upon to create appropriate and sustainable support for rural areas[72]. For example, with regard to group-based interventions, a sense of local ownership can be built through creation of a local steering committee[38,44]. However, there is little research exploring how rurality can alleviate carer burden or how it is beneficial to their wellbeing[73]. Consideration of these dimensions in future interventions would be highly beneficial for rural older caregivers.

Table 1: Key dimensions of effective programs designed to address social isolation among rural and older carers[11,22,28,37,39,40,42-44,47,48,50,54,55,57-60,62,65-67,69,71,74]

Dimension	Barriers addressed	Examples of key programs/interventions [reference]
1. Ability to address individual needs	• Caters for individual needs, desires and limitations (eg availability, transport, respite) • Ensures choice and suitability in terms of level of support and method of delivery	• Australian Red Cross Older Carers Program [42] • National Dementia Support Program [54] • Ageing Carers Project [43]
2. Dual carer–care recipient focus	• Reduces carer concerns about leaving care recipient • Eliminates need for respite • Is potentially more relaxed and enjoyable	• Alzheimer's Café concept • [40, 44, 58, 59]. • Socialization Program [22] • Making Memories Program [57] • Meeting Centres Support Program [55]
3. Provision of an educational component	• Reduces carer concerns about focusing on self • Can improve psychological wellbeing • Provides access to important caring-related information • Provides sites for social interaction • Builds capacity for social interaction • Can build capacity to pursue activities outside of the caring role	• Savvy Caregiver Program • [28, 74] • Caring for Others • [48] • Carers Support and Education Project [62] • Alzheimer's Rural Care Healthline [71] • Health Education Program [60] • REACH Program [66] • Caring-Web [65, 67] • Tele-Help Line for Caregivers [50] • Alphabet Soup [47] • Carer Support Network Project [69] • Carers Education Exchange Program [39] • Healthy Carers Activity Program [37] • Rural Carers Online [11]
4. Ability to facilitate informal interaction with other carers	• Increases existing social networks and perceived support • Raises awareness of need for socialization • Allows friendships to develop more naturally • Improves psychological well-being • Reduces stigma and access issues associated with formal support groups • Allows exposure to services in an informal, low-barrier context • Enables gradual integration	• Alzheimer's Café concept • [40, 44, 58, 59]
5. Employment of existing networks and experienced personnel	• Assists in identifying vulnerable carers • Ensures they have the necessary support to attend • Eliminates issues associated with trust • Improves group dynamics • Can facilitate interaction between individuals with similar interests	• Socialisation Program [22] • Alzheimer's Café concept • [40, 44, 58, 59]
6. Ability to be sustainable and long term	• Addresses issues associated with cost • Builds support for local ownership	• Alzheimer's Café concept • [40, 44, 58, 59]

Conclusions

This review has identified six key dimensions important in designing interventions aimed at reducing the social isolation of rural older carers. However, there are considerable similarities between the issues experienced by older urban and older rural carers, because the literature suggests that older urban carers are similarly prone to issues associated with transport, perceived social isolation and limited access to respite. However, as a result of geographic location, older rural carers are more likely to experience issues associated with respite provision, particularly relating to availability and suitability, transport and the financial cost of attending services and interventions. Significantly, fears regarding loss of privacy and stigma in small communities may limit service utilisation, and result in the perception that services are not needed. Recent research has demonstrated that urban carers are more likely than rural carers to identify as socially isolated[75], which may impact upon service utilisation, but does not necessarily mean that rural carers are not in need of social interaction. Consideration of these issues is integral to addressing social isolation in the rural context for older carers.

Based on the review findings, it is suggested that increasing social participation in rural older carers is a two-stage process. First, the barriers to attending an intervention must be removed. This includes addressing practical and logistical issues, as well as ensuring that the focus of the intervention is relevant to the carer and will attract their interest. The evidence suggests that, regardless of the level of support provided, it is unlikely that rural older carers will attend an intervention unless it has benefits for their care recipient, suggesting that this needs to be at the forefront of any intervention. Second, the intervention must maximize social opportunities, which can be achieved directly by allowing older rural carers to mingle in informal settings. The provision of learning opportunities is important as a focus for the intervention, although the social dimension is critical to achieving long-term outcomes. Effective interventions also include the integration of service providers in an informal capacity, because this can de-stigmatize and raise awareness of other support services. However, given the small scale and pilot nature of many of the interventions reviewed, which is a limitation of this study, there is clearly a need to assess the long-term effects of these interventions regarding continued attendance and applicability, as well as their long-term outcomes. Thus, these findings should be treated with caution in terms of their long term applicability. In terms of limitations, it also should be recognized that although there is a large published literature outlining these programs, not all programs and models are published in the academic literature, and therefore may not be included in this review. Furthermore, the large majority of published interventions is quantitatively evaluated, and thus fails to capture the subjective views of the carers. There is also a scarcity of qualitative research examining the broad range of associated issues, such as the role of existing social networks, the level of care integration with other social and community groups, and the issues associated with accessing isolated, hidden carers, who are not utilizing services. Input of this nature is integral to developing interventions that reduce social isolation in rural older carers and will be both appropriate and sustainable, and achieve an improved quality of life for an increasingly vulnerable population.

However, this review has highlighted some key issues associated with targeting social isolation in older rural carers and is intended to provide a framework for building effective intervention models. In the Australian context, this has major policy implications, because the Australian Government is currently implementing a National Carer Strategy as part of a National Carer Recognition Framework based on the findings of recent inquiries. This strategy will guide government policies and programs relating to carer supports and services[76]. However, the inquiry on which this strategy is based[13] does not highlight the specific issues faced by older and rural carers in any detail, referring only to an increased need for respite in the rural context. This is significant, because this review has highlighted that there are a number of related issues that will impact upon social interaction for

older rural carers which need to be addressed in policy, both from a practical and financial perspective, in terms of delivering relevant and beneficial programs. Overarching policies addressing carers as a general population will not be relevant to all older rural carers, and recommendations need to be carefully considered in terms of how they can be applied successfully in the rural context.

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