Counselling for dementia caregivers—predictors for utilization and expected quality from a family caregiver's point of view

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Abstract Caregiver counselling has proved to be effective in reducing the burden of family caregivers of dementia patients. Nevertheless, little is known about the influencing factors for utilization and quality expectations of family caregivers. In this article, we address the following questions on the theoretical base of the Andersen/Newman model: Which variables of the care situation, the caregivers and their attitudes act as predictors for the utilization of caregiver counselling? What are the views of caregivers about the quality of caregiver counselling? The cross-sectional study was carried out as an anonymous written survey of family caregivers of dementia patients in four regions, both urban and rural, of Germany. Quantitative and qualitative data from 404 family caregivers were analysed using binary logistic regression analysis and qualitative content analysis, respectively. The only significant predictor for utilization is the assessment of how helpful caregiver counselling is for the individual care situation. In the sensitivity analysis 'accessibility of caregiver counselling' was additionally predictive for usage. Family caregivers most frequently expressed a wish for advice about further 'support offers' by qualified counselors. In order to increase the rate of utilization, family caregivers must be convinced of the relevant advantages of using caregiver counselling. Counselling services should

provide information about further support offers and give practical help in filling out application forms.

Keywords Caregiver counselling · Dementia · Family caregiver · Utilization · Quality

Introduction

Two challenges are identified in the research into professional care for dementia patients. First: How can the largest possible number of patients be provided with the appropriate care (Fairbairn et al. 2006; Gräbel et al. 2003) to positively influence the progressive course of the illness and raise the affected person's quality of life? Second: How can support for the family caregivers be optimized? Which factors influence the decision whether support offers (Gallagher-Thompson and Coon 2007; Pinquart and Sörensen 2006; Thompson et al. 2007)—assuming area-wide availability—are actually utilized or not? This study deals with the second question particularly regarding caregiver counselling.

Caregiver counselling, in addition to providing information, includes interventions to improve caregiver's resources, so that instrumental, cognitive and emotional components of social support are provided for family caregivers (Gallagher-Thompson and Coon 2007; Selwood et al. 2007). In a meta-analytical study, caregiver counselling has proved to be effective in reducing caregivers' subjective burden and depression (Gallagher-Thompson and Coon 2007; Pinquart and Sörensen 2006). However, the degree of utilization of caregiver counselling, according to international studies, ranges from 3.5% (USA) (Toseland et al. 1999) to over 4.1% in Europe (Lamura et al. 2006) for family counselling. The utilization rate of all information providers (including

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telephone counselling) is higher: 16.2% in Germany and 30.8% in the USA (Lamura et al. 2006; Toseland et al. 1999).

In order to specifically influence the low level of utilization, it is important to know the predictors for utilization and particularly those that represent the perspective of the family caregivers. Andersen's model of health service utilization (Andersen 1995; see also Andersen and Newman 1973) revealed that the factors which influence the utilization of health services can be arranged in the categories 'predisposing', 'enabling' and 'need'. In the early model Andersen referred to the 'need' as 'illness level' which can be subjectively perceived and objectively evaluated. Predisposing variables contain demographic and social structure variables as well as beliefs about disease and health services. Enabling variables constitute community and family characteristics. Toseland and his colleagues (2002) showed that predisposing factors and enabling factors are more important than need factors in predicting utilization of services. But they also report that there are studies in which the 'need' variables were the most important predictors for utilization of health services. Our study is intended to investigate which variables of these three predictor groups are really important for the use of counselling, especially since the importance of the three factors differs depending on the type of service.

This constitutes the *first objective* of this study: Which variables concerning the family caregiver's point of view influence the utilization of caregiver counselling?

Fulfilment of quality standards is the main characteristic of a professional service. These quality standards normally reflect expert opinion. The quality of caregiver counselling as regards 'user-friendliness' would be improved if the customers'—i.e. family caregivers'—concept of quality were systematically taken into consideration. To date, no scientific study has been published on the quality of caregiver counselling which includes the quality requirements of dementia caregivers.

Therefore the *second objective* is: Which quality characteristics of caregiver counselling should be fulfilled from a family caregiver's point of view, dependent on whether caregiver counselling has already been used ('user') or not ('non-user')?

Methods

Design

The database of the study is a written anonymous survey of family caregivers of dementia patients living in the community. The cross-sectional study was carried out in four regions in Germany—in Erlangen and district (Southern region), in Dortmund and district (West), in Kassel and

district (North central) and in the Federal State of Brandenburg, specifically in the region around Potsdam (Northeast). Each study region has urban and rural areas with a minimum number of 250,000 inhabitants and therefore at least 2,500 dementia patients.

The survey papers consisted of a letter, the questionnaire, a stamped addressed envelope and an information brochure titled 'Das Wichtigste über die Alzheimer-Krankheit' (The most important facts about Alzheimer's disease) (DAIzG 2001). The anonymity of the study in particular was emphasized in the letter. The objective was, on the one hand, to reach family caregivers who had no previous experience with caregiver counselling ('non-users') and on the other to gain information from those who had already used or were using it ('users').

200 questionnaires were to be distributed in each study region within the recruitment period of 6 months through the Medical Services of the Health Insurance offices at the initial appraisal within the framework of the long-term nursing care regulations. The 'initial appraisal' means that a level of care is defined and financial support from the Health Insurance is applied for. Two care diagnoses are required for the initial appraisal. If one of the two care diagnoses made at the appraisal was 'dementia', the survey papers were to be given to the family caregiver.

Additionally 300 questionnaires in each study region were to be distributed through the regional offices of the Alzheimer's Society and other caregiver counselling services.

Of the 2,000 questionnaires (500 in each region) sent to the distributors, 404 were returned, giving an inter-regional response of at least 20.2%. Divided into regions, the response was 152 for the Brandenburg region (30.4%), 87 for the Dortmund region (17.4%), 83 for the Kassel region (16.6%) and 82 for the Erlangen region (16.4%). This response rate is based on the questionnaires which were sent to the distributors, not on those that actually reached the caregivers. It can be assumed that Brandenburg, being a federal state and the largest of the regions involved, was able to distribute more questionnaires than the other regions. The fact that its Alzheimer Society is centrally organized on the federal level, and not on the municipal level as in the other regions, might also have influenced this figure.

Instruments

The three-page questionnaire was tested on 12 family caregivers for comprehensibility and acceptability in a pilot phase.

Quantitative data: Besides the socio-demographic variables (see Table 1) [predisposing variables according to Andersen's model—see "Introduction" section], characteristics of the care situation and variables in connection with counselling were collected: The care situation is

Table 1 Sample characteristics ($N = 404$)

Variable	Mean (SD) or Frequency in %
Family caregiver	
Age (years)	61.3 (11.9)
Gender (female)	73.3%
Education level	
No school certificate	0.8%
Secondary school (9 years)	47.7%
Vocational school (10 years)	30.7%
Grammar school (13 years)	20.8%
Employed	28.6%
Relationship to patient	
Spouse	43.8%
Adult children	43.9%
Others	7.3%
Place of residence (city) ^a	44.4%
Caregiver/patient sharing accommodation (apartment/house)	75.0%
No caregiving help by others	34.8%
Dementia patient	
Age (years)	78.8 (9.1)
Gender (female)	63.6%
Status of care level assignment (health insurance) ^b	
Not yet applied for	5.8%
Applied for	19.2%
Level 1	29.6%
Level 2	31.6%
Level 3	13.7%
Duration of dementia (years)	4.2 (3.3)
Time for care per day (h)	5.1 (4.7)

^a 100,000 or more inhabitants (=city)

^b The higher the level, the higher the necessary help

fundamentally characterized by the amount of care time required by the caregiver [need], whether he/she gets help from others [enabling], the duration of the illness [need] and whether the patient has been classified within the health care insurance system [enabling]. First, the ‘counselling’ offer was described briefly. Then the questions ‘Do you know about counselling?’ [predisposing] and ‘Do you use counselling?’ [outcome] were to be answered dichotomously (yes/no). The assessment of how helpful counselling would be to the family caregiver in his/her care situation was carried out on a 5-step self-report scale (from ‘0 = I don’t need it’ to ‘4 = I need it urgently’) [need] with the addition of ‘independent of whether you have previously used counselling or not’. In addition, family caregivers were to grade the accessibility of caregiver counselling according to the three categories ‘Don’t know’, ‘Not easily accessible’ or ‘Accessible’ [enabling] and

whether they were living in a rural or urban area [enabling]. The categorization of our variables into the categories of the Andersen model is based on Fig. 4 of his original publication which gives detailed examples for variables in the predisposing, enabling and need category (Andersen and Newman 1973). Therefore, variables in all three categories of the Andersen model were assessed.

Qualitative data: The data for qualitative analysis was collected using an open question: ‘Independent of whether you have already used caregiver counselling services or not: What would you personally expect from a ‘good’ counselling service?’ The collection of data on the quality of caregiver counselling was carried out using open questions for two reasons. (a) A standardized, validated questionnaire which includes all relevant quality aspects did not exist. (b) The ‘free recall’ of one’s own reflections represents the family caregiver’s concept of quality without being influenced by extrinsic arguments.

Description of the sample

The features of the family caregivers and the dementia patients can be seen in Table 1.

Statistical procedure

Quantitative data analysis

The quantitative questions were answered by 97.5% of the 404 family caregivers on average. In order to ascertain which variables significantly influence the utilization of caregiver counselling, binary logistic regression analysis was carried out (coding see Tables 2, 3). The dichotomous dependent variable was the ‘use’ (code = 1) or ‘non-use’ (0) of a counselling service. The explained variance in the regression model is reported with Nagelkerke’s R^2 . The significance of potential predictors was measured using Wald’s coefficient ($\alpha = 0.05$). After a multicollinearity test ($r > 0.40$), the following variables were not included in the multivariate regression analysis: relationship between caregivers and dementia patients, shared accommodation, employment of caregivers, level of care (health insurance), accessibility of caregiver counselling. Relationship and employment correlated with age of the caregiver with high significance and to a high degree ($\eta = 0.682$, respectively, $\eta = 0.609$). Shared accommodation correlated highly significantly with age, relationship, employment and education level. Additionally there were 88 missing values in the variable ‘shared accommodation’. For these two reasons it was omitted. Level of care was substantially correlated to duration of illness ($\eta = 0.577$). There was also a significant correlation with level of care and age, while the correlation between duration of illness and age was not significant. For

that reason level of care was omitted but not duration of illness. Accessibility was significantly correlated to knowledge of counselling services ($K = 0.456$) and was omitted because the relation was stronger than the defined level of .4 concerning multicollinearity.

As an additional sensitivity analysis, bivariate comparisons between the omitted variables and the utilization of counselling were carried out by χ^2 -tests. The variables with a significant relation to utilization were included in a sensitivity regression analysis. This was carried out like the logistic regression described above but had additional predictors.

Qualitative data analysis

The question about the quality of caregiver counselling was evaluated using Morgan's (1993) content analysis method. In the first step, passages with the same or very similar content were paraphrased. In the second step, similar statements were merged into categories, modelled on the choice of words used by the interviewees in order to keep the level of abstraction to a minimum. Two independent researchers undertook assignment to the individual categories. The categories were assigned to the quality criteria 'structure' (S), 'process' (P) and 'results' (E). Each criterion was divided into two subcategories (I and II): Non-personal structural factors (S I), personal-related structural factors (S II), content aspects of procedure (P I), formal aspects of procedure (P II), aims concerning dementia patients (E I), aims concerning family caregivers (E II).

Consensus between the two researchers had to be achieved in individual cases of divergence. For 10% of the material interrater-reliability was calculated. Cohens Kappa was .66. Greatest divergence could be found in the categories 'Counsellor: good listener, understanding, takes everyone seriously' and 'Having enough time for listening'. The design respects general performance criteria of qualitative research as described by Mayring (1993) such as that the research process should follow clear rules, be exactly documented and that interpretation be well founded. The frequency of citation of the categories is shown in Table 4.

Finally, the individual conclusions were assigned to the three quality categories, 'Structure', 'Process' and 'Quality of results' (Donabedian 1966).

Results

Quantitative analysis

At 59.0%, the existence of caregiver counselling is comparatively well known to family caregivers. More than one-third (38.6%) of the respondents use this kind of service. In the assessment of how helpful this offer is, over one-third of the responding family caregivers (39.5%) need caregiver counselling very urgently (10.1%) or urgently (29.4%) while another one-third think they don't need it at all (14.4%) or hardly ever (17.9%). The remaining 28.2% were indifferent ('might need it to some extent').

Table 2 Binary logistic regression analysis with use of caregiver counselling as dependent variable: basic analysis ($N = 404$)

	Regression coefficient β	Standard error	Wald coefficient	df	p	Odds ratio	95% Confidence interval for odds ratio	
							Lower value	Higher value
Gender of family caregiver (1) ^a	-0.185	0.432	0.183	1	0.669	0.831	0.357	10.937
Age of family caregiver	0.010	0.017	0.379	1	0.538	10.010	0.978	1.044
School certificate (1) ^b	0.090	0.362	0.062	1	0.804	1.094	0.539	2.222
Gender of dementia patient(1) ^a	-0.432	0.404	1.143	1	0.285	0.649	0.294	1.433
Age of dementia patient	-0.013	0.019	0.446	1	0.504	0.987	0.952	1.025
Help from others (informal or formal caregivers) (1) ^c	-0.202	0.345	0.342	1	0.559	0.817	0.416	1.607
Duration of illness	-0.002	0.004	0.284	1	0.594	0.998	0.990	1.006
Hours per day spent on care (H)	-0.053	0.038	1.917	1	0.166	0.948	0.880	1.022
Place of residence (city) (1) ^c	0.020	0.338	0.004	1	0.952	1.021	0.526	1.980
'Knowing' about counselling ^c	-21.953	3504.409	<0.001	1	0.995	<0.001	<0.001	
'Need' for counselling	0.599	0.143	17.474	1	<0.001	1.820	1.375	2.411

^a Gender: 0 = male, 1 = female

^b School leaving certificate: 1 = secondary school/grammar school, reference value: less than 10 years education

^c 0 = yes 1 = no

df number of degrees of freedom; p significance

$p < 0.05$ values are given in bold

Table 3 Binary logistic regression analysis with use of caregiver counselling as dependent variable: sensitivity analysis ($N = 404$)

	Regression coefficient β	Standard error	Wald coefficient	df	p	Odds ratio	95% Confidence interval for odds ratio	
							Lower value	Higher value
Gender of family caregiver (1) ^a	−0.398	0.495	0.647	1	0.421	0.671	0.254	1.772
Age of family caregiver	<0.001	0.028	0.000	1	0.993	1.000	0.946	1.057
School leaving certificate (1) ^b	0.451	0.406	1.234	1	0.267	1.570	0.708	3.479
Relationship caregiver—patient (1) ^c	0.997	1.046	0.908	1	0.341	2.709	0.349	21.042
Relationship caregiver—patient (2) ^c	0.660	0.754	0.767	1	0.381	1.934	0.442	8.471
Gender of dementia patient(1) ^a	−0.157	0.512	0.094	1	0.759	0.854	0.313	2.333
Age of dementia patient	0.007	0.031	0.046	1	0.831	1.007	0.948	1.069
Help from others (informal or formal caregivers) (1) ^d	−0.209	0.383	0.298	1	0.585	0.811	0.383	1.719
Duration of illness	−0.003	0.004	0.369	1	0.543	0.997	0.989	1.006
Hours per day spent on care (H)	−0.070	0.042	2.716	1	0.099	0.933	0.858	1.013
Place of residence (city) (1) ^d	−0.003	0.381	<0.001	1	0.993	0.997	0.472	2.105
‘Knowing’ about counselling ^d	−21.529	3609.682	<0.001	1	0.995	<0.001	<0.001	
‘Need’ for counselling	0.566	0.160	12.509	1	<0.001	1.762	1.287	2.411
Accessibility of counselling (1)^e	−1.152	0.425	7.356	1	0.007	0.316	0.137	0.726
Accessibility of counselling (2)^e	−1.631	0.708	5.305	1	0.021	0.196	0.049	0.784

^a Gender: 0 = male, 1 = female^b School certificate: 1 = secondary school/grammar school, reference value: less than 10 years education^c Relationship: 1 = spouse, 2 = children/in-laws, reference value: other relatives^d 0 = yes 1 = no^e Accessibility: 1 = accessibility is unknown, 2 = not easy to access, reference value: easily accessible df number of degrees of freedom; p significance $p < 0.05$ values are given in bold

Essentially, the family caregivers’ opinions about the accessibility of caregiver counselling are divided. While almost half (45.1%) are of the opinion that caregiver counselling is available and accessible in their area, another half (49.9%) of the responding family caregivers did not know anything about the distance or accessibility of the nearest caregiver counselling service. Five percent of the respondents report that caregiver counselling services are not accessible to them.

The binary logistic regression analysis showed that with an explained variance of 63.4% (R^2) a significant regression model ($\chi^2(13) = 206.920$; $p < .001$) characterised by one significant predictor (Table 2) could be identified. So 82.2% of the respondents can be correctly assigned to the categories ‘user’ or ‘non-user’. The probability of using caregiver counselling increases significantly when the degree of ‘need’ increases. The utilization of caregiver counselling services is not associated with age, gender, level of education, rural versus urban living, help from others or to specific parameters of the illness such as length of the patient’s illness or the hours per day spent on care.

The variables excluded for reasons of multicollinearity were investigated as a sensitivity analysis. There was a significant difference in utilization in the variables

relationship ($\chi^2(2) = 6.917$; $p = .031$) and accessibility of counselling ($\chi^2(2) = 100.496$; $p < .001$) in the bivariate analysis. No differences in utilization were obvious regarding employment of the caregiver, shared accommodation and insurance level of care. The two variables: (a) relationship of patient and caregiver and (b) accessibility were included in a logistic regression additional to the control variables in the basic analysis (Table 2) with utilization of counselling as outcome parameter. The results of the sensitivity analysis can be seen in Table 3. In addition to the ‘need’ of counselling, the accessibility of a counselling service is a significant predictor. Persons who state that counselling is not easily accessible for them and persons who state that they do not know how to access counselling have a significantly lower probability of using this service. The model explained 67.0% of variance (R^2) and, like the basic analysis, shows a significant overall result ($\chi^2(15) = 208.640$; $p < .001$).

Qualitative analysis

The family caregivers’ quality requirements deal most frequently with the procedure of counselling (‘What is

Table 4 Family caregivers' quality requirements ($N = 306$)—ranking of most frequent requirements ($\geq 5\%$)

Users ^a : Quality requirement (classification ^c)	Number (%)	Non-users ^b : Quality requirement (classification ^c)	Number (%)
Counselling about support offers (P I)	42 (33)	Counselling about support offers (P I)	56 (32)
Counselling on dealing with dementia patients (P I)	16 (12)	Counselling on dealing with dementia patients (P I)	32 (18)
Professional/well-qualified counsellor (S II)	15 (12)	Help with applications (incl. health insurance) (P I)	19 (11)
Help with applications (incl. health insurance) (P I)	14 (11)	Practical advice (P I)	17 (10)
Counsellor: good listener, understanding, takes everyone seriously (P II)	13 (10)	Counselling on aspects of care (P I)	15 (8)
Receiving information brochures (incl. addresses) (S I)	9 (7)	Counselling on alleviating tedium (P I)	13 (7)
Counselling on alleviating tedium (P I)	9 (7)	Professional/well-qualified counsellors (S II)	10 (6)
Help (in general) (P I)	9 (7)	Counselling in legal matters (P I)	10 (6)
Receiving psychological support (encouragement, consolation etc.) (P I)	8 (6)	Individual counselling (P II)	10 (6)
Counselling in financial matters (P I)	7 (5)	Counselling on 'good care' (P I)	9 (5)
		Counsellor: good listener, understanding, takes everyone seriously (P II)	9 (5)

Multiple answers were possible

^a 155 family caregivers (38.4%) were users; of these 129 supplied details of quality requirements

^b 247 family caregivers (61.1%) were non-users; of these 177 supplied details of quality requirements; 2 family caregivers (0.5%) gave no details about utilization

^c Classification of quality criteria

Structural quality (S): non-personal factors (S I); person-related factors (S II)

Process quality (P): content aspects of procedure (What is done?) (P I); formal aspects of procedure (How is it done?) (P II)

Quality of result (E): aims concerning dementia patients (E I); aims concerning family caregivers (E II)

done?', P I, and 'How is it done?', P II). The top 10 requirements overlap for users and non-users in six categories (Table 4): counselling about respite offers (e.g.: 'providing helpful addresses', P I), counselling on dealing with dementia patients (e.g.: 'how to deal with the ill person?', P I) professional/well-qualified counsellor (e.g.: 'staff should be skilled', S II), help with applications (e.g.: 'they should help me with the correspondence with the health insurance' P I), counsellor: good listener, understanding, takes everyone seriously (e.g.: 'should be ready to listen to family caregivers' problems' P II), counselling on alleviating tedium (e.g.: '... and how daily life problems can be solved more easily', P I). In both groups, advice about support offers tops the list (33 and 32%, Table 4) and in second place counselling about the correct way to deal with dementia patients (12 and 18%). While the counsellor characteristics are very important to the users—third place (12%) for well-qualified counsellors and fifth place (10%) for social and communicative skills (good listener, understanding, takes everyone seriously), these quality aspects are less important for non-users (rank 7 at 6% and rank 10 at 5%, respectively). Instead, practice-oriented counselling is important for non-users—fourth place (10%) for the quality criterion 'practical advice' (e.g.: 'helpful suggestions that one can apply to daily life') and fifth place (8%) for counselling on aspects of care (e.g.: 'how to facilitate

care?'). By users these categories are cited with a frequency of only 3 and 4%, respectively. Neither users nor non-users mentioned result criteria with a frequency of 5% or more.

Discussion

Although the objectives of this study, utilization and quality, are highly relevant for the further development of the content of support offers and community services, a systematic search of three databanks—Medline®, PsychINFO®, and Cinahl®—shows that there has been little scientific research in these areas to date. There are very few empirical studies about utilization or quality. Specific studies regarding counselling for dementia caregivers alone are missing, since either several support offers or community services were considered jointly or the results were not specifically related to dementia. Therefore, in this case we are—scientifically speaking—breaking new ground.

The sample of family caregivers was taken in four regions throughout Germany, which were suitable from an urban and rural point of view with varying coverage of caregiver counselling. It was not, however, a representative sampling. By using various recruiting pathways, the

medical services of Health Insurance companies, regional offices of the Alzheimer's Society and other caregiver counselling centres, it was possible to reach family caregivers with varying experience of caregiver counselling. The response rate was more than 20%. This value corresponds exactly with the empirically established response in anonymous written surveys of family caregivers who received no reward for answering (Georges et al. 2008; Gräßel 2002). However, a recruitment bias cannot be ruled out. The variation in quality criteria and the number of times these were mentioned should therefore be regarded as an initial orientation. But by using various recruiting pathways, it was possible to affirm that a substantial fraction of the family caregivers had never used caregiver counselling previously, as would be expected in a representative sample.

The fact that over 50% were non-users has also been seen in other studies (Brodaty et al. 2005; Lamura et al. 2006; Philip and Ghosh 1992; Toseland et al. 1999). It is noticeable that only slightly more than half of the respondents (59%) know about caregiver counselling, which is comparable with statements by family caregivers in North America (awareness quotas between 55.6% and 63.2%) (Toseland et al. 1999). In our study 39.5% said that they needed caregiver counselling urgently or very urgently. This percentage is markedly higher than that reported by Toseland et al. (1999) (3.7 to 7.4%). It is, however, comparable with the results of the Colantonio et al. study (2001), where 40% of the interviewed persons stated the need for professional caregiver counselling. In total, only 5% of respondents maintained that caregiver counselling services were difficult to access for them. This value is comparable with those in other studies (4.9–6.2%) (Toseland et al. 1999). But the lack of knowledge of the nearest caregiver counselling services is more predominant with 49.9% (in comparison: 36.8–44.4% in Toseland et al. (1999).

The relatively low degree of awareness is naturally a fundamental reason for the rather low degree of utilization. However, Brodaty et al. (2005) report that the utilization of support offers by family caregivers is low, even though these are well known and even when the services are free of charge (Kosloski and Montgomery 1993). This means that there must be other more significant variables that determine utilization. In our study, the family caregivers' assessment of the helpfulness of caregiver counselling ('I need it') is a highly significant predictor for using it. This corresponds with the findings of Gill et al. (1998), who showed that need variables explain more variance in service utilization of in-home and out-of-home services than predisposing or enabling variables, speaking in terms of the Andersen model. In a study by Toseland et al. (2002), it was demonstrated that this assessment of helpfulness is not a significant predictor for utilization in the range of

professional health and human services. It must be taken into consideration that this study is not specific to any one offer, either. If utilization refers to a single service, as in our study, utilization depends not only on how well known a service is, but also on the assessment of helpfulness. If there are plans to relieve as many family caregivers as possible, the service should not only be made known to family caregivers, but the advantages of utilizing caregiver counselling for himself/herself should also be pointed out.

In the sensitivity analysis, the regression analysis yielded accessibility as a significant predictor for utilization. Persons who did not know anything about the accessibility of counselling and also persons who stated that counselling was not easy to access for them had a much lower probability of using this support offer. It is known from other studies (Kosloski and Montgomery 1993; Toseland et al. 2002), that easy access to support offers is positively associated with utilization and in our study, the majority of respondents knew nothing about the accessibility of their nearest caregiver counselling service. Therefore, one practical objective should be to explain the helpfulness of this offer as well as to give clear information about the location of the nearest caregiver counselling provider and how to get there. Another objective should be to inform the referrers, i.e. the patients' doctors and/or caregivers, about support and respite offers and their accessibility. These people can provide guidance in the health system and actively procure caregiver counselling. Even better, proactive forms of counselling should be implemented in which the counsellor contacts the caregiver. Before that counsellors could be introduced to the caregivers by for example the doctor. Interventions like this are being developed and their implementation has been studied (Holle et al. 2009; Spijker et al. 2009).

Although moderately positive effects on subjective burden and depression of family caregivers by a psychosocial intervention that includes elements of counselling and education have now been proven in reviews (Cooke et al. 2001) and in meta-analytical studies (Sörensen et al. 2002), little is known about what constitutes effective intervention. Quality criteria have either been defined as expert standards (Chodosh et al. 2007) or the outcome variables of studies of family caregiver interventions (for example reduction of caregiver's burden) are regarded as quality criteria (Mahoney et al. 2001). To date, there are no empirical studies of the various characteristics of caregiver counselling regarding their effectiveness, although specific characteristics, such as counselling about the various forms of dementia appear sensible and necessary (Ibach et al. 2004).

Therefore, this study intends to contribute to a broader consideration of family caregivers' views in the scientific discussion about quality standards of caregiver counselling. For family caregivers of dementia patients, the process

quality aspects are of primary importance namely, counselling about further support offers and help in filling out application forms.

In research into community services for patients who are cared for at home, more consideration of the unmet needs of family caregivers is called for (dello Buono et al. 1999). Unmet needs are defined as dissatisfaction with a special service or wishes about more or different support (dello Buono et al. 1999) and therefore conform to the term quality wishes in our study. To meet these wishes is very important because consideration of the family caregivers' quality requirements reduces the barrier to utilization (Winslow 2003).

Conclusions

- In order to increase the utilization of caregiver counselling to relieve family caregivers, the caregivers should not only be informed about the existence of the offer but also about the concrete advantages for themselves, if they use counselling services.
- It was found that the quantitative results of this study correspond to the 'health service utilization model' by Andersen and Newman. However, not all three factors of the model appear to be relevant for utilization of counselling of family members: predisposing variables did not contribute, enabling variables only in the sensitivity analysis.
- A counselling service meets the family caregiver's requirements if it provides information about further support offers and the correct way to deal with dementia patients and gives support in filing applications associated with care.
- In supplement to the quality expectations of family members, research into the quality expectations of professional counsellors and experts, who are independent from counselling like a coordinator of health services in the community, would make it possible to develop an inclusive concept of quality criteria for family counselling programmes.

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Conflict of interest statement

The authors declare that no conflicts of interests exist.

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