Investing in the mental wellbeing and resilience of informal carers and long-term care workers

through the identification, evaluation and promotion of good practices across Europe

Well Care

Implementation

The WELL CARE Guide to investing in care partnerships: working towards implementation

December 2024

Funded by the European Union

WELL CARE has received funding from the European Union's Horizon Europe research and innovation programme under grant agreement No 101137468

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Recommended citation:
Ludo Glimmerveen, Chantal Hillebregt, Karin Kee, Henk Nies, Francesco Barbabella, Lisa Carlstedt and Elizabeth Hanson (Dec 2024). The WELL CARE Guide to investing in care partnerships: working towards implementation. WELL CARE project.

Project details

Project acronym	WELL CARE	Start / Duration	1 January 2024 / 48 Months
Project number	101137468	Topic	HORIZON-HLTH-2023-CARE-04-02
Type of Action	RIA	Coordinator	Linnaeus University (Sweden)
Contact persons	Principal investigator: Elizabeth Hanson, elizabeth.hanson@lnu.se Project manager: Francesco Barbabella, francesco.barbabella@lnu.se		

Deliverable details

Number	D3.1		
Title	Guide for country-level tailoring, implementation and evaluation		
Work Package	WP3: Developing resources, prototypes and ecosystems for improving resilience and wellbeing		
Dissemination level	PU – Public	**Type**	REPORT
Due date (month)	31 December 2024 (M12)	**Submission date (M)**	31 December 2024 (M12)
Deliverable responsible	Vrije Universiteit Amsterdam (VUA) (the Netherlands)	**Contact person**	Ludo Glimmerveen, l.m.glimmerveen@vu.nl

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Document History

Release	Date	Changes to previous version	Status
1.0	31 December 2024	-	Submitted

Funded by
the European Union

About the WELL CARE project

Caring for someone can be mentally draining and exhausting. Both informal carers – who provide unpaid care to a close one outside a professional or formal framework – and professional long-term care (LTC) workers, face the potential risk of compromising their mental health and well-being over time. How can we safeguard their health and resilience? What if improved integration of their efforts could help mitigate such risks?

The WELL CARE project focuses on improving the resilience and mental wellbeing of informal carers and LTC workers by strengthening care partnerships. By care partnership we mean the coordination, integration, and mutual recognition of care and caring activities performed by LTC workers and informal carers, in a vision of integrated LTC. The ultimate goal is to develop a set of support measures (prototypes) to address the mental health needs of both LTC workers and informal carers, thus sustaining and enabling a vision of care partnerships between these two groups.

More about the project: *https://wellcare-project.eu/*

Acknowledgements

Earlier versions of this document have been reviewed by many of our colleagues within the WELL CARE consortium, including members from the five national Blended Learning Networks (BLNs). Their feedback contributed significantly to developing this current version. We would like to thank Licia Boccaletti, who kindly acted as an internal reviewer in the process of finalizing this document. We also acknowledge the contributions of members of the project's External Advisory Board who validated a slightly earlier version of the guide at their November 2024 online meeting.

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SECTION 1:
Introduction

1.1 About this guide

The present document *D3.1: Guide for country-level tailoring, implementation and evaluation* is a public deliverable of the WELL CARE project, developed within WP3: Developing resources, prototypes and ecosystems for improving resilience and wellbeing at month 12 (December 2024) and Task 3.1.

This guide is written to support project partners as they develop, promote, implement, and evaluate practices that support the mental wellbeing and resilience of informal carers and long-term care (LTC) workers. By providing a range of resources and references, it aims to bridge theory and practice in a way that is both instructional and inspirational. While we definitely do not aspire to provide an exhaustive 'methods book' or a clear-cut 'blueprint', we do hope that this guide allows partners – and the stakeholders they engage with – to benefit from the lessons learned by those who have gone before us.

Within the vast range of methods, tools and strategies that are available across the various academic, policy and practice communities, it can be hard to pinpoint those resources that are most helpful to reach your objectives. Or you may not know what to look for in the first place. This guide will help project partners to identify areas and issues that may (or that definitely do) require their attention when investing in supportive care partnerships. It highlights risks and opportunities from the scoping stage until the final evaluation, while also signposting partners to relevant resources, tools and methods that will help to practically address these issues. And – last but not least – it provides readers with practical guidance in navigating the various project activities.

1.2 The guide as a work in progress

We consider this guide to be a 'living document'. Throughout the project, we will periodically assess whether and how the guide needs to be updated (and who can provide input for this). This will be an ongoing process, as challenges or opportunities may emerge that were not yet foreseen when developing the current version of the guide. Moreover, this guide can be seen as an overarching resource that will be developed and specified in more detail around the various solution prototypes that will be developed later in the project. Whereas the current document has a fairly broad scope to be relevant to the potentially wide range of practices that may be addressed and developed within the project, each prototype will have a more clearly defined focus. Building on the current document, the prototypes each require what could be considered a 'mini guide', tailored to that prototype's particular purpose, challenges, and opportunities.

1.3 How and when to use this guide

The rest of this document consists of five sections that address various aspects and different phases of the WELL CARE project. The sections are set up so that they can be read separately, also to make sure that project partners can use the guide as a reference book on specific themes throughout the project.

The first two sections after this introduction act as a foundation for the subsequent sections, setting out our general approach in the project. Section 2 sets out how we understand and approach the *translation, promotion, and evaluation of good practices* by learning from existing practices elsewhere. In section 3, we try to unpack the notion of *care partnerships*, providing more clarity with regards to the various roles, relationships and dynamics that constitute such partnerships. After that, the subsequent three sections relate more directly and practically to activities in the various project phases. They cover the 'scoping' phase (section 4), the 'tailoring and implementation' phase (section 5), and the cross-cutting activities around monitoring and evaluation (section 6).

Within each section the guide links to external resources for further reading – which can be both theoretical, practical, or methodological. We hope that by providing such links, the various users of the guide will be signposted to those resources suiting their particular needs or interests. The various links to such resources are organized in boxes ('Tools and resources') throughout the text. Moreover, other boxes provide more detailed explanations of a particular concept, approach or phenomenon ('In focus'), illustrative and practical examples ('Case examples'), and additional guidance on various project activities or processes ('Project support'). An overview of these boxes can be found on page 5, directly following the guide's table of contents.

SECTION 2:
The WELL CARE approach: translating, promoting and evaluating good practices

In the WELL CARE project, we join forces as researchers, advocacy partners and other stakeholders at the European, national, and local level. We develop and promote care partnerships – i.e., the coordination, integration, and mutual recognition of care and caring activities performed by informal carers and LTC workers – in order to support the mental wellbeing and resilience of both groups. The collaborative nature of our project shapes the way we do research and, in so doing, try to positively impact the lives of informal carers, LTC workers and, consequently, care receivers. The current section elaborates on the general principles underlying our approach, before section 3 which will discuss the notion of care partnerships in more detail.

2.1 Participatory project design

To engage in a shared learning process, the research conducted in the WELL CARE project is not ‘just’ an academic exercise. Nor do we approach the development of care partnerships from the top down. Across our activities, we build on the diverse knowledges, perspectives, and experiences of our project partners and stakeholders.

- *Research methods:* The project builds on a participatory research design, making sure that we generate insights that reflect the actual needs, preferences and situations of end-users (i.e., informal carers, LTC workers, and/or those supporting them). Our approach is cyclical: we engage our partners and stakeholders in all steps of the research process, making sure that our research is geared towards practical solutions.
- *Co-creation within each country:* The main platforms for co-creation are the *Blended Learning Networks* (BLNs) that run throughout the project, and the *local implementation teams*, which are formed in year 2 of the project. In the BLNs, key concepts to the project (resilience, mental wellbeing, care partnerships) are discussed to generate a shared understanding and learn about each other’s perspectives. The BLNs provide a platform for jointly deciding (together with project partners) which practices look promising within members’ particular context(s) and will subsequently inform the development of solution prototypes (discussed in more detail later). Later in the project, the tailoring, testing and implementation of these prototypes will take place in close collaboration with local implementation teams.
- *Collaboration across countries:* The WELL CARE project brings together advocacy partners, researchers, end-users and other stakeholders from Sweden, Italy, Slovenia, Germany, the Netherlands and the United States. Learning from effective support practices across Europe is key to the project. Moreover, partners from each country contribute with unique expertise, experiences and skills to the project. This includes scientific knowledge on care and caring,

but also practical knowledge and first-hand “lived” experiences of informal carers and LTC workers.

BOX 1.

IN FOCUS: Evidence-informed practice

Our participatory approach values **different types of knowledge** that are based on *research*, *expertise,* and *experience.* This means we go beyond the idea of *evidence-based practice*, which prioritizes generalized, research-based knowledge. Instead, we acknowledge the importance of integrating research-based insights with the practical experiences and expertise of people providing and receiving care. This is referred to as **evidence-informed practice** [1].

Source: https://www.researchinpractice.org.uk

2.2 Learning and developing across countries: importance of local contexts

Key to the WELL CARE approach is that (a) we learn about effective practices that support LTC workers and informal carers’ mental wellbeing and resilience within various European contexts, and (b) we translate the lessons learned to develop new practices in other settings. This brings us to an important question underlying many of our project activities: how do you translate lessons learned in one context in such a way that they become relevant to another context?

The **importance of context** is hard to overstate here. Good practices may be ‘good’ in one context but fail to deliver in another. This basic notion is often overlooked when implementing or scaling up initiatives in the field of long-term care. Whether an intervention (or project, model, etc.) ‘works’ is not just a matter of its design or its ‘technical adequacy’. It is always the result of how it interacts with the context in which it is being implemented. For example, support practices that may be effective in one setting, may be considered culturally inappropriate in another – e.g., because of differing norms around family and/or informal care. Or work practices that led to positive outcomes in one setting, may not ‘fit’ the established work routines of LTC workers elsewhere. In other words, we cannot assume that a ‘good practice’ is effective across contexts. Consequently, this means that ‘implementation’ requires us to work with local partners to make sure practices become relevant and suitable for stakeholders within their particular context. Inherently, the original practice is changed in that process; adapted to the new circumstances.

For this reason, a key aspect of the WELL CARE project is the development, translation and implementation of **solution prototypes**. Prototypes are de-contextualized models of existing practices that have proven to effectively support informal carers and/or LTC workers. They are inspired by the good practices that we identify and study within this project (in Work Package 2),

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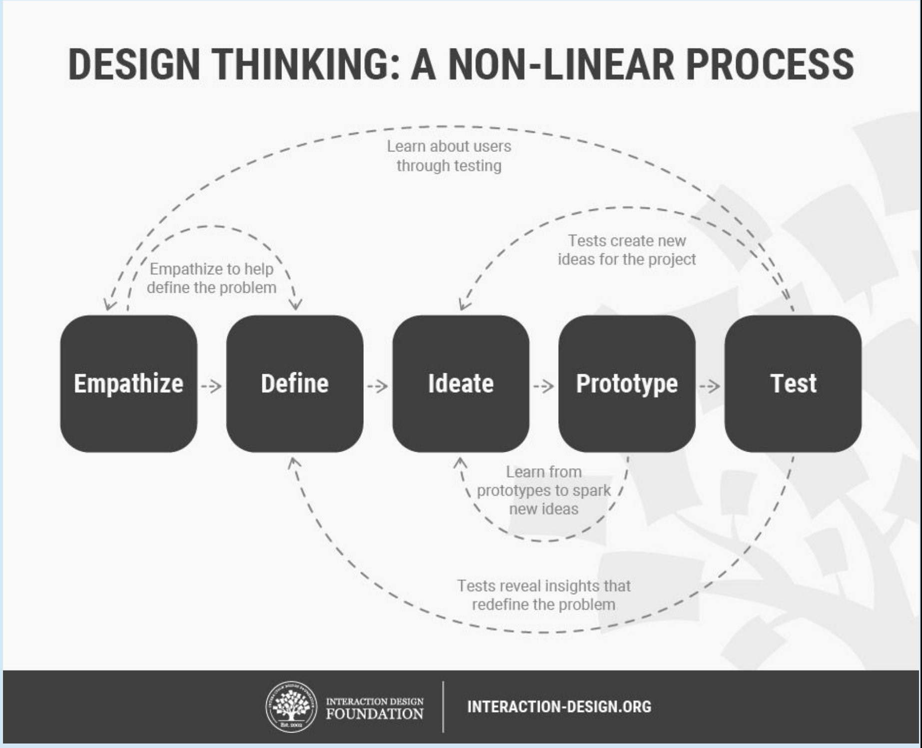
[1] Epstein, I. (2009)

capturing the mechanisms that seem to underpin their success. At the same time, they are ‘semi-finished’ products that are not ready-to-implement, as they first need to be tailored and translated to the particular context in which they will be implemented. Again, that process requires a participatory approach: engaging with the expertise, knowledge and experiences of various stakeholders within the local settings in which these practices need to ‘work’. See section 5 for more detailed information about these prototypes.

BOX 2.

IN FOCUS: Design Thinking

As we develop, translate, test, adapt and implement these prototypes, we draw on principles of **design thinking**. Design thinking is methodology for the participatory development and implementation of innovative solutions in complex environments such as long-term care. It is an iterative approach that entails five stages: *empathize* (understanding the needs and challenges), *define* (describing the problem), *ideate* (coming up with potential solutions), *prototype* (creating models for solutions), and *test* (trying out these solutions). The various activities in our project feed into these five stages. For example, the systematic literature review, the expert interviews and, importantly, the discussions during the various BLN meetings help us to understand and define the particular problems or issues that need to be addressed. The existing good practices that we identify can inspire the various project partners to come up with potential solutions that may be relevant within their own context, which in turn helps us to determine which prototypes need be developed, tailored, and tested.



For further reading on design thinking, try this article on sustainibilitymethods.org. Section 5 of this guide explains in more detail how design thinking informs our work around the solution prototypes.

Source: https://www.interaction-design.org/literature/article/stage-5-in-the-design-thinking-process-test

2.3 Evaluation activities

Our collaborative and context-sensitive approach also shapes the way we structure our **evaluation activities**. As an underlying framework, we build on the idea of Realistic Evaluation to make sure that our research and evaluation efforts practically benefit our implementation efforts (instead of providing scientific insights only). The starting point of Realistic Evaluation is that the outcomes of an intervention are not (just) determined by the intervention itself, but shaped by the way(s) the mechanisms that constitute the intervention interact with the context in which they are implemented. Where traditional evaluations ask *whether* a program works, this Realistic Evaluation asks *how* and *why* a program works, and *for whom* and in *what circumstances*. In line with the principles of design thinking and our objective of shared learning, Realistic Evaluation takes a cyclical approach: it helps us to refine our ideas about what works (for whom and in what context) on an ongoing basis, which in turn helps us to continuously improve and refine our practical efforts to develop locally relevant and effective care partnerships.

More on our evaluation efforts will be discussed in Section 6 of this guide. Later in the project, the solution prototypes will contain more tailored guidance for evaluation.

2.4 A multi-level approach

Following our context-sensitive approach, we acknowledge that the mental wellbeing and resilience of informal carers and LTC workers are not just affected by the ('micro-level') actions of those people directly engaged in the process of caregiving. Therefore, we also seek to understand how the wider organizational or societal ('meso-level' and 'macro-level') context can support or undermine carers' wellbeing. The collaborative nature of our approach also extends to **stakeholders beyond the level of individual caregiving**, such as organizational leaders, community groups, trade unions, employers, patient organizations, and policy makers.

There are multiple reasons **why such a multi-level approach is important**. The risk factors and adversities that informal carers and LTC workers face may have their roots in more structural factors that cannot necessarily be solved at the individual level alone. Similarly, the resilience of individuals is shaped by structural factors: when facing adversities, the support that people may draw upon can be rooted in organizational, community-level and/or societal resources. Just imagine how employers can implement policies that help working carers with combining their paid work and care duties, strengthening their resilience. To quote Mental Health Europe: 'Mental health is a societal issue: you can't offer an individual level solution to a structural problem'[2].

Similarly, the **development of care partnerships** is not just affected by what happens at the level of individual carers and care receivers. While such partnerships are ultimately about improved collaboration and alignment between individual LTC workers and informal carers to strengthen their mutual support, the factors that promote or impede these positive outcomes may be more structural. For example, if LTC workers and their organizations are only reimbursed for the time they provide direct care to an individual with care needs (and not for supporting or aligning with their informal carers), this provides a structural barrier for developing care partnerships. Or – as a positive example – think about citizens cooperatives' efforts to collaborate with municipalities

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2 This quote comes from a concept note shared by Mental Health Europe (2024): Concepts of resilience and mental wellbeing in the WELL CARE project.

and/or professional provider organizations (and vice versa): such organizational-level developments may help improve the alignment between individual LTC workers and informal carers (e.g., the neighbours or volunteers connected to the citizens' cooperative). In short: developing care partnerships between individual carers can be supported as well as frustrated by what happens at the organizational, policy or societal level.

SECTION 3:
About care partnerships

3.1 Defining Care partnerships

A key objective of the WELL CARE project is to develop and promote *care partnerships* between informal carers and LTC workers that support these groups' resilience and mental wellbeing. But what do we mean by care partnerships? And how can they contribute to mental wellbeing and resilience?

Care partnerships can **include a variety of actors,** and the **relationships between these actors can be equally diverse**. In the project, we embrace and explore this diversity, rather than trying to confine it by providing strict(er) definitions. At the same time, **we need to develop a shared (and more specific) vocabulary** to address the different meanings of 'care partnership'. In this section of the guide, we provide a basis for a shared frame of reference by unpacking the concept of care partnerships, and by discussing how it can relate to resilience and mental wellbeing.

BOX 3.

IN FOCUS: Defining Care Partnerships

In the WELL CARE proposal, we **define care partnerships** as the coordination, integration, and mutual recognition and respect of the care and caring activities performed by LTC workers and informal carers, in a vision of integrated long-term care[3]. As such, care partnerships refer to the cooperative and mutually supportive relationships that may exist between the two (internally heterogenous) groups. By focusing on partnerships and taking a more holistic approach to the mental health and resilience of both informal and formal caregivers, our approach is in line with the 2022 European Care Strategy.

While our focus on care partnerships directs our attention to the relationships between informal carers and LTC workers, it of course should be noted that care receivers often constitute a key part of care partnerships. They are rarely 'mere' recipients of care. Instead, they actively participate in co-producing caring activities while also actively negotiating their relationships with the various caregivers involved. So, while primarily focusing on informal carers' and LTC workers' relations and collaboration, we should always remain cognizant of how these issues relate to the people that are cared for.

We should note that the notion of 'care partnerships' has a normative element to it: it is mainly used to refer to *positive, supportive* and therefore *desirable* relationships that may exist between different caregivers. As such, it refers to a desired state – not necessarily a state that is currently

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[3] Although we use the term 'care partnership,' various other terms are used in the scientific literature to refer to the relationships and collaboration between informal and formal caregivers. These include "interprofessional collaboration" (Khemai et al., 2022), "family-staff partnerships" (Backhaus et al., 2020), "family-staff relationships" (Bauer et al., 2014; Nguyen et al., 2015), and "formal-informal care intersections" (Kemp et al., 2013).

experienced. Relationships between informal carers and LTC workers can also be full of conflict and a source of stress for both parties (as discussed in more detail in section 3.4). On the one hand, this highlights the relevance of our project's ambition to pursue and foster these care partnerships. At the same time, it means that we need to be aware of the various reasons why achieving these partnerships can be challenging, and why some caregiver relationships are *not* experienced as supportive. Failing to acknowledge this would not only lead to a naïve image of how caregivers relate to one another, but it would also frustrate our practical efforts to develop more supportive relationships.

3.2 Whose partnerships?

Both 'informal carers' and 'LTC workers' are in themselves **diverse categories, comprised of a variety of actors** who may each have their own needs, preferences, perspectives and opportunities. On the side of formal caregivers, care partnerships may include qualified nurses (e.g., registered nurses) and personal care workers. These may be employed by a formal care provider (in a home or residential settings) or directly by the care recipient/family (i.e. live-in carers, mainly in home settings). Informal carers provide – usually – unpaid care, often on a regular basis, to someone with a chronic illness, disability or other long-lasting health and/or care need, and they do so often outside a professional or formal framework[4]. While family members make up a significant proportion of the informal caregiving population, other contributors include, e.g., friends, or community members looking after their neighbours and/or work colleagues. Moreover, the categories of informal carers and LTC workers may also overlap, as people working in LTC can also be (and disproportionately are) informal carers themselves (see Box 8 for links to relevant resources in relation to this particular group).

BOX 4.

CASE EXAMPLES: Diversity across and within countries

The diversity of actors that constitute a care partnership can vastly differ, both between and within European countries. Within each national, regional or local context, different caregivers may play a more or less prominent role, presenting particular challenges and opportunities for partnership development. Moreover, the broader (economic, social or legal) context in which these caregivers provide care also influences these caregivers' relationships. Let us consider some examples.

While a rare phenomenon in other countries, it is comparatively common in **Italy** for households to directly employ **domestic family care workers**. The relationship – including the potential for care partnerships – between these workers and their host families may be affected by this particular employment situation. For example, disagreement or conflict with family members may put domestic care workers at risk of losing their job.

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[4] Eurocarers (2023)

In a very different context, LTC workers who provide care in **nursing homes** – a more common care setting in, for example, **Germany** and **the Netherlands** – work in a very different, more institutionalized and regulated environment. Also, this setting presents its particular challenges around partnership development with informal carers. For example, LTC workers may fear being held accountable (regardless of whether this fear is justified) for situations where informal carers make 'mistakes' when caring for their loved ones. This can cause stress, but also make them less inclined to seek collaboration.

Within a similar setting – such as nursing home care – we may still find very different 'partnership dynamics' (or a lack thereof) both within and between countries. For the German context, project partners reported that true 'care partnerships' between informal carers and LTC workers are hard to find, but that **hospice care** seems to provide more fertile ground for constructive collaboration and relationships between these groups. In **Slovenia**, 24h-residential care is a fairly recent phenomenon and still limited in terms of availability and accessibility. Generally, it is more affluent people who can afford to use it. This particular **socio-economic context** also matters for developing care partnerships, as earlier research has shown[5]: when LTC workers and informal carers have very different socio-economic backgrounds, this may affect the relationships that exist between these groups.

Again, a very different context is the emergence of **citizens' initiatives** in **the Netherlands**. In many of such initiatives, groups of citizens organize their own mutual support. Sometimes this goes up to the point where these initiatives hire their own staff or engage in formal partnerships with local governments or professional care providers. A contemporary challenge in the Dutch context is how such informal initiatives can best collaborate with the formal long-term care system to develop constructive partnerships.

An overview of the various national policy contexts is given in Box 7.

3.3 Care partnerships are diverse and dynamic

Partly as a consequence of this diversity of partners, **different care partnerships may have very different purposes, dynamics, challenges and opportunities**. They are dynamic and evolving, as they are constantly influenced by a wide range of contextual factors.

Imagine the relationship between a live-in care worker and someone caring for their partner. These two caregivers are likely to share a household. It is not hard to imagine how their partnership may look entirely different from that between a qualified community nurse and the adult children of this nurse's client, who may only occasionally come across one another. For some informal carers, caring may be a lifelong commitment (as for many parents of a child with an intellectual disability), while for others it may be confined to an intense, but relatively short period time (e.g., when involved in the end-of-life care of a parent).

Relationships also change over time and over people's **life course**: family members may move to a different part of the country or face other major life events, whereas LTC workers may change jobs and new care workers may enter the stage. Moreover, **care transitions** can have a major impact on the relationships between caregivers: if the person receiving care moves to a

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[5] Kemp et al. (2013)

residential care facility, an informal carer’s relationship with LTC workers changes substantially. If the health or wellbeing of an informal caregiver or a person in need of care deteriorates, this affects their relationships with other caregivers.

In other words, **care partnerships should not be considered static or fixed. They evolve over time**. Roles and relationships within the partnership are constantly subject to change[6]. This also means that, in certain settings, assessing caregivers’ wellbeing should be an ongoing process rather than a one-off effort.

BOX 5.

CASE EXAMPLES: Evolving partnership around a child with intellectual disabilities

To **illustrate how care partnerships evolve over time**, imagine the situation of two parents caring for their daughter with an intellectual disability. For almost two decades, they continue to care for their child at home. At some point, as the parents are in their late fifties and their child reaches adulthood, they decide to share the care for their child with LTC workers from a professional care agency. By sharing the care, they can still physically cope with the care for their daughter at home. Later, however, they become too fragile to sustain this situation. When their daughter moves into a residential care facility, this does not necessarily mean the end of the care partnership. For example, they still help the facilities’ workers in figuring out how to deal with situations in which their daughter refuses medication. Moreover, every other day they visit the facility to help out with dinner, which frees up precious time that care workers can spend with other clients. At the same time, they feel valued by the staff and find their time at the home enjoyable and meaningful.

Two sides of the same coin?

For both informal carers and LTC workers, a wide variety of individual, social and structural factors have been identified that positively or negatively affect their mental well-being and resilience[7]. Generally, **the two groups have been studied and addressed separately**, i.e., treating informal carers’ and LTC workers’ wellbeing as relatively disconnected issues instead of two sides of the same coin. In the WELL CARE project, **we treat LTC workers’ and informal carers' mental well-being and resilience as interconnected**. The actions and wellbeing of one, are likely to affect the other[8].

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6 Kemp et al. (2013)

7 This is elaborated in more detail in the aforementioned concept note by Mental Health Europe

8 Alliger et al. (2015); Paschoalotto et al. (2023)

BOX 6.

CASE EXAMPLES: Caregivers' wellbeing: interconnected

For example, LTC workers may 'go the extra mile' to support informal carers and sustain the latter's mental wellbeing, but they also need to make sure that this does not lead to themselves getting overburdened[9]. Conversely, if LTC workers reduce working hours, or become overburdened, it is not hard to imagine how this may increase the pressure on informal carers and affect their wellbeing – especially in a context of under-staffing and labour market shortages. Moreover, the wellbeing of both informal carers and LTC workers also influences the wellbeing of the people they care for, affecting caregivers' ability to adequately respond to care recipients' needs.

As their situations are often interdependent, caregivers also actively **negotiate** how they relate to one another in the caring process[10]. Who takes on which role and tasks? What relationship and support do caregivers seek with each other? And who can determine the terms of their mutual engagement in the caring process? Such negotiations take place within, for example, a family setting (how do siblings divide the care for their parent?), but they equally take place within the relationships between informal carers and LTC workers. The outcomes of such negotiations are likely to influence caregivers' wellbeing.

So, the wellbeing of informal carers and LTC workers is related. While this is in itself enough reason to study and address the two groups together, it is again important to emphasize that **the relationship between informal carers and LTC workers can in itself be a source of both support and stress**. Whereas section 3.5 discusses the various ways in which this relation may be supportive, let's start off with a few words on the opposite.

3.4 Stressful relationships

In spite of the supportive potential of care partnerships, the **relationship between informal and formal caregivers is regularly experienced as stressful** by both parties. Informal and formal caregivers may pursue different goals and have competing views on the types of care that someone needs, and it may prove difficult to align each party's abilities and desires[11]. Expectations around roles and responsibilities may not always align. Some informal carers express that LTC workers **make them feel guilty** for taking on too few care tasks, or that they feel **pressured** to take on too many[12]. **Suboptimal communication** is widely reported, with informal carers not feeling like true 'partners' when information is not shared with them. Especially during care transitions, or in

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9 Kee et al. (2023)
10 Kemp et al. (2013)
11 Egdell (2012); Leichsenring et al. (2013)
12 Majerovitz et al. (2009)

situations that require new caring roles or skills, informal carers may experience higher levels of stress when they do not feel supported by LTC workers. Sometimes there are few if any real opportunities for consultation with informal carers, or they feel **underappreciated**[13] as their "first hand" or lived experience of caring for their family member or significant other is not actively acknowledged or taken into consideration.

LTC workers, in turn, do not always feel respected by the people close to the person they care for. Informal carers are often inclined to advocate for their loved ones in their interactions with LTC workers, which may be interpreted by the latter as critique. In more extreme cases, they may even face threats or violence. This may especially be the case for LTC workers with a minority background, who sometimes face racist or **abusive comments** by relatives[14]. A study indicated that this type of treatment by relatives significantly predicted burnout and depressive symptoms among LTC workers[15]. Also more generally, research has shown that attempts to promote collaboration between informal carers and LTC workers may in fact lead to increased stress among the latter group. They may feel like they cannot live up to other people's expectations, which in turn can lead them to resist further involvement of informal carers[16].

In short, in spite of its supportive potential, the relationship between informal carers and LTC workers **is not inherently positive**. If anything, this highlights how important this relationship is for the mental wellbeing of both parties and, consequently, the importance of investing in constructive care partnerships.

3.5 Care partnerships: to what end(s)?

What can a supportive relationship between informal carers and LTC workers look like? And what does the supportive character of these relationships entail?

Before answering these questions, it is important to stress that – while our project focus is on the wellbeing of caregivers – constructive relationships between caregivers may also benefit the people being cared for. Moreover, care receivers can play an active role in negotiating such partnerships and the care that is provided. As such, care partnerships can be a platform for improving the quality and appropriateness of caregiving and ultimately the quality of life of care receivers, integrating the various perspectives and competences that people bring to the table.

That said, we turn to the supportive potential of partnerships for caregivers. How may informal carers and LTC workers be supported through their mutual relationships? In academic literature, care policy and care practices we see various **'models' that guide our thinking about what**

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[13] Wittenberg et al. (2018); Linderholm & Friedrichsen (2010)
[14] Duijs et al. (2024)
[15] Falzarano et al. (2020)
[16] Bramble, Moyle & Shum (2011)

constitutes a 'good' relationship between these groups, supporting the parties involved in different ways.

3.5.1 Substitution

The relationship between LTC workers and informal carers is often portrayed in terms of 'substitution'. **In some countries, informal care is – at least in policy accounts – presented as the most preferred type of care,** being provided by the people that are assumed to be closest to the person who needs care. This hierarchy is also echoed in conceptual models that try to capture the relationship between formal and informal care. For example, the introduction of formal care is often considered to replace or 'substitute' informal care[17].

The idea of informal care as the 'morally preferable' type of care has been critiqued by feminist scholars (and many others). Still, it resonates within various national care policies, but also in the everyday care practices of care providing organizations. In the Netherlands, for example, formal care providers first assess what people and their informal carers can still do themselves, before stepping in as professionals[18]. In this approach, **delaying formal care becomes a key driver defining the relationship with informal carers**. While labour market shortages may indeed drive policy makers and organizational leaders to adopt such an approach, it comes with the **risk of depleting informal carers' resources and resilience** before formal care steps in.

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[17] Kemp et al. (2013)
[18] Janse et al. (2017)

BOX 7.

IN FOCUS: Diversity in national contexts

While in some countries informal care may be presented – as well as contested – as the ‘preferable’ type of care, this is definitely not the case across all countries. This became particularly clear when discussing earlier versions of this guide. In Sweden, for example, the voluntary nature of providing informal care is highly valued and also made explicit in the national carers strategy. Here, claims that informal care would be ‘preferable’ over formal care are highly contested.. The Swedish notion of ‘voluntariness’, however, sharply contrasted with the experiences of German colleagues, who shared that informal care was generally seen as a necessity – not a voluntary choice – given how hard it could be to access formal care and support.

This diversity of norms across countries is of course intertwined with differences in these countries’ policy contexts. In what follows, we shortly discuss these policy contexts for the five WELL CARE project countries. In doing so, we draw heavily on the **report by Mental Health Europe and project partners** that gives an **overview of these policy contexts** (*WELL CARE Deliverable D4.1*).

Sweden's long-term care (LTC) system is characterized by its decentralized, social democratic welfare model. The government plays a vital role in ensuring citizens' well-being throughout their lives. This approach is anchored in the principle of universal access to healthcare and social services, supported by legislation such as the Social Services Act (SoL) and the Health and Medical Services Act (HSL). However, the system currently faces significant challenges, including fiscal constraints on municipalities, an ageing population, and difficulties in recruiting and retaining enough LTC workers. The 290 municipalities are primarily responsible for organizing and delivering LTC services. The emergence of private providers has transformed the LTC landscape, leading to variations in eligibility and service availability across municipalities, especially between urban and rural areas. Consequently, there is a growing trend of "re-familialisation" of care where family members— women to a greater extent than men—are increasingly taking on caregiving roles due to reduced access to institutional care. The National Carers Strategy, introduced in 2022, aims to support informal carers, yet inconsistencies in support across municipalities continue to pose a challenge.

In **Slovenia**, the care system reflects a hybrid welfare model, combining state-regulated formal services with informal care primarily provided by women. Care policies show a dual focus: childcare is de-familialized, while care for older persons remains largely familialistic with minimal state support. Recently, there has been significant growth in private, for-profit care services for older persons. In 2023, Slovenia adopted the Long-Term Care Act (ZDOsk-1), focusing on individual needs and independence. This Act introduces compulsory long-term care insurance and establishes a funding framework to unify fragmented services. It also supports informal carers with rights related to home care, residential care, financial benefits, and family employment. However, implementation faces delays due to staffing shortages and funding gaps. Coordination between formal and informal carers is inadequate because of missing regulations. While community nurses act as vital links between care systems, broader support for unrecognized informal carers remains lacking. Although informal carers are increasingly recognized through compensation and training, reliance on family members persists, with limited options for respite care.

Germany's long-term care system is marked by a complex blend of informal and formal care, heavily relying on family responsibility and social insurance. Long-term care insurance (LTCI), mandatory for all residents, covers around 90% of the population but reinforces the expectation that families will provide care, with an emphasis on home-based support. The formal care sector includes both private and non-profit organizations, but municipalities are not required to offer these services, resulting in significant gaps in availability. The system often fails to ensure sustainable working conditions for formal caregivers and does not adequately address the needs of informal carers. Informal carers, predominantly women, lack direct financial compensation despite their essential role. While laws exist to help balance paid work and caregiving responsibilities, benefits are mostly in-kind services, with limited cash support for these caregivers. To adapt to the demands of an ageing population, it is crucial to enhance the integration of formal and informal care, improve support mechanisms, and promote societal recognition of caregiving as a shared responsibility.

In the **Netherlands**, long-term care is supported by a mix of public, private, and decentralized systems, ensuring universal accessibility. It is governed by three main acts: the Social Support Act (WMO), the Health Insurance Act (ZVW), and the Long-Term Care Act (WLZ). The WMO decentralizes social care to municipalities, promoting informal caregiving within social networks and providing formal care only when necessary. The ZVW covers home nursing services for those requiring less than 24-hour care, while the WLZ caters to individuals needing round-the-clock supervision. Most LTC providers are private, not-for-profit organizations that are publicly regulated and funded. Caregiving tends to be gendered, with women disproportionately providing informal care. Municipalities play a vital role in organizing support for informal carers, offering resources such as respite care, training, and personal budgets (PGB). However, rising LTC costs pose challenges to the system's sustainability. Future efforts will focus on improving efficiency, addressing labour shortages, and enhancing collaboration between informal and formal caregivers to ensure the system remains high-quality and universally accessible.

Italy's long-term care system heavily relies on informal caregiving, particularly by family members, with women playing a central role. The system is influenced by a familistic culture that designates families as primary caregivers, often supported by migrant care workers known as *badanti*. Formal care services are limited and mainly supported by two pillars: the *attendance allowance*, a cash benefit of around €500 per month for families providing care, and various LTC programs managed by municipalities and regions. This structure has led to a system where informal care is predominant, while formal care services play a more supplementary role. Care provision is highly decentralized, resulting in significant regional disparities. Northern regions typically offer more structured formal residential care, while central and southern regions lean towards a cash-for-care model. Recent legislation (Legge Delega n. 33/2023) aims to restructure the system by coordinating services at the national level. However, challenges persist in terms of funding, professionalizing informal care, and ensuring equitable access across the country.

Source:
Centola, F., et al., (2024), *Report on analysis of legislation, policies, care frameworks and funding schemes*, WELL CARE project, https://wellcare-project.eu/wp-content/uploads/2024/10/WellCare-D4.1.pdf (accessed, 03/11/2024).

If the relation between LTC workers and informal carers is characterized by 'substitution', informal and formal care are **still relatively separate spheres** – for example, informal care is provided where possible, formal care steps in when informal care is not (or no longer) available. It is questionable whether this should be considered a care partnership. If anything, it **considers informal carers to be a resource to relieve the burden on LTC workers and LTC services overall**[19]. While we do not argue that this is never a legitimate consideration, it does not entail the 'coordination, integration, and mutual recognition' that define care partnerships.

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[19] Twigg (1989)

So, if we do define the relationship between informal and formal carers as a care partnership, how do both parties draw support from it? Drawing on existing research, we see at least **three means through which care partnerships support caregivers' mental wellbeing and resilience**.

3.5.2 Sharing care

Put simply, if informal carers and LTC workers share the 'burden' of care, this can sustain the wellbeing of all actors involved and **prevent either party from getting overburdened**. Care tasks and responsibilities can be distributed among LTC workers and informal carers, taking into account the abilities, expertise and desires of the different people involved[20]. Such sharing of care may **reduce the 'objective' burden of caregiving**. How care is distributed over the various caregivers may vary. For example, LTC workers and informal carers can respectively take on 'technical' and 'non-technical' tasks in a home care setting. Or informal carers may continue to take on minor personal care tasks[21] after someone moves to a nursing home facility. In some countries, sharing care can also be about LTC workers linking up informal carers with a voluntary organization that supports them with the administrative burden of their personal care budget. Across these different contexts, care partnerships enable partners to actively align their mutual involvement, making sure that caregiving stays manageable for all parties involved – and particularly to prevent informal carers from getting overburdened.

3.5.3 Sharing knowledge

Most care partnerships are not 'just' (or: not at all) about the sharing of care work, but (also) about sharing knowledge and expertise between LTC workers and informal carers. For example, **informal carers often intimately know the person who is receiving care.** They can play an important role in developing personalized care plans that cater to their family member or significant other's specific needs and preferences. They are 'experts of experience,' contributing valuable insights about a person's (past) preferences, daily habits, and values[22]. **LTC workers, in turn, may hold medical or technical knowledge that can also benefit informal carers**, e.g., as the latter may acquire skills to perform particular care tasks themselves. **Together, they may 'experiment' or 'tinker'[23] with the care that is given**, i.e., trying to find out what treatment or approach works best at a particular phase of the care recipient's illness/disability and caring situation. In short, exchanging information, integrating complimentary sources of knowledge, and jointly 'puzzling'

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[20] Janse et al. (2017)
[21] Wittenberg et al. (2018)
[22] Koster & Nies (2022)
[23] Mol et al. (2010)

on how to deal with particular situations at different moments in time[24] can be key elements of care partnerships.

The issue of sharing knowledge is closely linked to what is sometimes called '**epistemic justice**': to what extent are different sources of knowledge valued and taken seriously within the process of caring? For example, to what extent are informal carers' perspectives engaged with during decision-making processes, or when drafting care plans? To what extent do informal carers, LTC workers and others share their observations with each other – and do they value and act upon what is shared? Such questions also link to broader issues of **control**: whose voices matter most in deciding which care is to be provided and how? As such, this goes beyond the 'mere' exchanging of knowledge. It also about **recognition,** which can in itself be an important source of support.

3.5.4 Relationship as its own support

The relationship between informal carers and LTC workers is not simply about facilitating the sharing of knowledge or care work. It may also be an important source of support in and of itself. Both parties can derive a sense of satisfaction from their relationship when it is characterized by mutual recognition, appreciation, and reciprocal emotional support[25]. Even without reducing the 'objective' burden of care, the socio-emotional support that care partnerships may offer can boost people's mental wellbeing. It makes caregivers feel included – being a partner in the conversation, instead of being talked about. Positive relationships can also make caregiving more satisfying for both informal carers and LTC workers. At the same time (and as mentioned in 3.4), this positive, supportive dimension of caregivers' relationships cannot be taken for granted. Both research and practice regularly show the opposite experience of stressful or conflict-ridden relationships.

The sections above discussed the various ways in which care partnerships may support the wellbeing of caregivers. Of course, these discussions do not provide a comprehensive framework of the different relationships and dynamics between informal carers and LTC workers. That would go beyond the scope of this section. Moreover, the various ways in which care partnerships can support caregivers' resilience and mental wellbeing are not mutually exclusive. Nor do they all have to be present for a care partnership to be supportive. And as mentioned earlier, the dynamics within care partnerships can evolve, sometimes shifting the means or focus of support over time. What these discussions do provide, however, is a vocabulary that allows us to distinguish between different ways in which such partnerships may contribute to wellbeing.

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[24] Nolan et al. (1996)

[25] Duijs et al. (2024); Ekström et al. (2019); Wittenberg et al. (2018); Nolan et al. (1996)

3.5.5 Trust as a prerequisite

Whether care partnerships fulfil their supportive potential depends (among other things) on the degree to which the people involved trust one another. When trust is lacking, people become reluctant to share their caregiving with others (e.g., when they don't believe the other is capable of delivering what the situation requires). Moreover, trust forms the bedrock of effective communication. Sharing information, especially around vulnerabilities, is only likely to happen when caregivers sufficiently trust one another. Conversely, when people feel like it is risky or useless to speak up, the chances are slim that they will be comfortable enough to share their perspectives and insights[26]. In short, trusting relationships are more likely to be supportive relationships, fostering a supportive environment in which caregivers feel secure and emotionally bolstered[27].

BOX 8.

TOOLS AND RESOURCES: Fostering care partnerships

A range of tools and methods is available for improving the collaboration between informal and formal caregivers, helping to create a more sustainable and effective care partnership. These tools, among other things, aim to bridge communication gaps, clarify roles, and foster learning in caregiving tasks. Here we provide two examples:

- An *Ecogram, Sociogram or Ecomapping* is a tool that visually maps out a person's social relationships, such as friends, family and support networks. By illustrating both weak and strong connections, it helps individuals to better understand their social circle and to determine which connections could be strengthened. It can be especially useful for identifying people to turn to for support or assistance. A short guide to how this can be applied can be found here.
- The Anton Trstenjak Institute has developed a method that can be used when working with informal carers, focusing on training and in-group social learning. The method is described in more detail here.

In order to support the wellbeing of *working informal carers*, employers can also be an important partner. The University of Sheffield published this report on the particular challenges affecting the lives of working carers, and the steps that employers can take to support them. Of particular interest are so-called *'double-duty caregivers'*, i.e., people who provide care professionally while also giving informal care outside their work role. The website of NHS Employers links to a range of resources and practice examples for employers to support staff with caregiving responsibilities.

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[26] Kee et al. (2023)
[27] Duijs et al. (2024)

3.6 Care partnerships in context: a multi-level approach

In section 2 of this guide we discussed the importance of taking a multi-level approach, looking beyond the direct situations, actions and relations of individual caregivers. Individual LTC workers and informal carers do not operate in isolation. Rather, they are embedded within broader organizational and societal contexts that may significantly influence the dynamics of their relationships. The teams in which LTC workers operate, the level of cohesion within a local community, the national, regional or local care policies: such contextual factors may significantly affect the degree to which care partnerships develop, what these partnerships look like, and whether they actually support or hinder caregivers' mental wellbeing and resilience[28]. Consequently, major social changes also affect the context in which LTC workers and informal carers operate. To name a few: the digitalisation of health, care and other services, demographic changes leading to more older people and fewer adult children, socio-cultural shifts towards more gender-equal societies that also affect care role, etc.. As our project aims to develop activities that foster supportive care partnerships, understanding the relevance of such contexts in relation to these activities is a prerequisite for their effectiveness.

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28 Kemp et al. (2013)

BOX 9.

IN FOCUS: How context matters on multiple levels

What 'contexts' are we thinking of? For example, looking at the **socio-cultural context** in which caregiving takes place, there are significant differences both between and within countries with regards to expectations around family or informal care and 'appropriate' caring roles. Such expectations are highly gendered (often placing most of the burden of care among women), and they significantly affect the character of care partnerships.

On a different level, **labour market policies and workers' rights** also constitute a significant context that can shape caring roles and relations. E.g., employers offering supportive policies, flexible working hours and paid leave to informal carers can strengthen these caregivers' availability and flexibility. This can help them to combine their paid work and care duties, which may also facilitate them in developing constructive care partnerships with LTC workers.

Moreover, in the **context of their status as a professional group**, some studies point out that LTC workers feel that their professional knowledge and status is not sufficiently acknowledged, worrying that tasks within 'their' domain are increasingly shifted to informal carers. Such worries can make LTC workers less inclined to collaborate with informal carers[29]. The ambition to foster collaboration with informal carers may therefore require a re-negotiation of LTC workers' professional identities, including the skills required to achieve such a collaboration.

Lastly, within the **organizational context of LTC workers,** the availability of sufficient resources and competence – such as adequate staffing levels – affect the time and effort that LTC workers can spend on their relationships with informal carers and on coordinating their mutual efforts[30].

This list of contextual factors affecting the development and dynamics of care partnerships is, of course, not comprehensive. An interesting study by Candace Kemp and colleagues[31] highlights the multitude of factors influencing informal and formal caregivers' relationships in assisted living facilities. To name a few examples of such factors:

- *The urban or rural setting of a facility:* do staff and family members already have pre-existing ties (more likely in small towns) and/or do they come from very different backgrounds (more likely in larger cities)? Particularly in the latter case, instances of racism can be detrimental for constructive relationships to develop.
- *Family composition:* Do residents have children or grandchildren, and how nearby the facility do they live?
- *How managers relate to staff:* do they sufficiently trust their workers to freely engage with residents' family, or do they constrain or closely monitor such contacts?
- *The continuity of staff on a location:* do managers rotate staff often, or do staff members get assigned to specific residents for a longer period of time?

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[29] Da Roit (2013)
[30] Van Wieringen et al. (2015)
[31] Kemp et al. (2013)

Considering all this, the scope of our project activities – e.g., how we study the ‘good practices’ we identify, or how we develop solution prototypes – is not solely confined to the level of individual carers and LTC workers. Instead, our scope goes beyond this ‘micro-level’, also addressing the broader environment in which supportive care partnerships may or may not develop. This means we may also focus on organizational models and work process innovations, on local, regional, or national policy measures, or on training programs that may foster supportive relationships between caregivers.

SECTION 4:
Scoping: determining what needs to be done

In the first phases of the project, we identify and study existing practices that support the mental wellbeing and resilience of informal carers and LTC workers (mainly in Work Package 2). Building on the lessons learned, our later efforts aim at actually developing and promoting supportive care partnerships (mainly in Work Package 3). A key question, then, is **how we decide which existing practices are most promising and relevant to the particular contexts** in which we work.

4.1 Scoping: what, when, and how

A solid **problem analysis** provides the foundation for this decision. What issues need to be addressed in our national, regional and local contexts to better support informal carers and LTC workers and to promote their mental wellbeing? Which opportunities and challenges require our attention when investing in supportive care partnerships? These questions need to be answered within each country, shaping the scope of our project activities.

While our overall project objective is clear, it still needs to be translated to concrete activities within each project country. To do so, **a participatory approach within each country is key** to create a shared understanding of what is relevant and feasible to pursue within these contexts. The national project partners – in close collaboration with their respective BLNs – are the key drivers of this participatory process.

BOX 10.

PROJECT SUPPORT: Timeline

During the course of the project, several decisions need to be made that further determine the scope of our work. These decisions are made in close collaboration with country partners, their respective BLN members and local implementation teams:

- Deciding which good practices are reported within each country, and which are selected for the case studies (*starting in Autumn 2024*)
- Identifying suitable sites for future implementation, and exploring what practices seem relevant for stakeholders in these sites (*throughout 2025)*
- Deciding which prototypes are developed, drawing on the overview of existing good practices, case studies and an assessment of what is feasible and relevant within each country (*around end of 2025, beginning of 2026*)
- Deciding on which prototypes are actually translated to, and implemented within the five countries (*2026*)

In order to make such decisions, it is key to first create a **thorough understanding of the problems we try to address, and the opportunities to do so**. Several project activities provide help for us to develop this understanding:

- Analysis of grey and scientific literature relevant to the respective country context (second half 2024)
- Expert interviews (early 2025)
- Reporting and studying good practices within the respective country context (early 2025)
- Deliberations within the BLNs, also about the issues mentioned above (ongoing)

To support project partners in further specifying the focus of their activities, a **wealth of tools, methods, and practical strategies are available and often easily accessible online**. In the guide we will suggest a selection of such tools, signposting partners to instruments that may be helpful.

Power differences

When taking a participatory approach – and especially when involving representatives from multiple levels of the care system – **we should be sensitive to the power dynamics that exist between participants**. As our project aims to deliver concrete change that improves the situations of caregivers, our activities have the potential to affect the stakeholders' positions and interests in the process. In such situations, we should create ample space to also hear those voices that often stay marginal – often including the voices of informal carers and LTC workers themselves. For example, the person(s) facilitating the BLN meetings in each of the five project partner countries can play a key role in safeguarding an inclusive environment.

BOX 11.

TOOLS AND RESOURCES: Dealing with power differences

On participatorymethods.org, you can find this article which reflects on the issue of power which references various tools and frameworks, while they also offer this practical guide for Mapping and Power Analysis.

Another handbook that is available online on dealing with power dynamics is: Power: A Practical Guide For Facilitating Social Change (by Raji Hunjan and Jethro Pettit).

4.2 Collaborative problem analysis and situation analysis

Before deciding what partnership practices to develop and promote, it is important to have an **in-depth understanding of the issues that put informal carers' and LTC workers' wellbeing at risk**. Similarly, it helps to know where there is **leverage to actually bring about positive change**, and to use this knowledge when deciding which prototypes are to be developed (and later: tailored, tested, adapted and implemented).

It is important that this problem and situation analysis is done collaboratively. Even when their perspectives and interests do not fully align, it is important that people understand one another's perspectives and interests. Moreover, **developing a shared understanding helps to obtain a more complete overview** of contextual barriers and opportunities to promote care partnerships.

BOX 12.

PROJECT SUPPORT: Towards a shared problem definition

Different stakeholders, project partners and end-users may have **different perspectives on what constitutes the main issues** affecting caregivers' mental wellbeing (e.g., what is causing current problems, what can/should be done to solve these and improve the situation).

The **BLN sessions provide a suitable platform for exchanging perspectives and creating a shared understanding**. Within these sessions, researchers can report the findings from the various research activities (e.g., the systematic and grey literature review, expert interviews, case studies), and other participants can bring in their own expertise and experiences. Reflecting on these different sources of knowledge, this allows BLN members to seek consensus and formulate answers to the following questions (divided over several sessions):

- What do we see as key **risk and protective factors** for the mental wellbeing and resilience of informal carers and LTC workers within our particular context?
- What do we consider a **successful care partnership** within our particular context? And: successful for whom?
- What **care partnership practices seem most promising** (i.e., relevant, feasible, effective) within our particular context?
- Which **barriers** may impede the development and promotion of these care partnerships?
- Which **opportunities** do we see to leverage care partnerships? How do we exploit these?
- **What role can each stakeholder take** to successfully develop and promote these care partnerships? Who is not yet engaged, but should be?

In order to come up with a shared answer to these questions, it helps to build on **tools and methods that support the exchange of perspectives**, or that propose creative ways to generate new insights. Below we list an – of course not exhaustive – overview of such tools and methods.

BOX 13.

TOOLS AND RESOURCES: Collaborative problem analysis

Stakeholder analysis – It is key to identify **who is affected by particular developments or initiatives, who needs to be involved**, and which relationships and spheres of influence need to be accounted for. On page 12-15 of this guide book (the 'Co-create handbook for creative professionals') you find more information and an example of a tool for stakeholder analysis. Or check out this article on sustainabilitymethods.org with a step-by-step approach to stakeholder mapping.

Mirror meetings – These meetings can help informal carers and LTC workers to **exchange experiences and perspectives**. First, informal carers sit in an inner circle, with LTC workers sitting around them.

People in the inner circle share their perspective and experiences around a topic of choice. The outer ring only listens. After that, people in the outer ring can ask questions and respond, and then they swap positions and roles. The method has been described in this and this research article. In applying this method, it may also help to look at this section on emphatic listening on sustainibilitymethods.org.

Journey Maps – A journey map visually outlines the **stages and experiences that (formal and informal) caregivers go through** in the process of caregiving. This can be applied to how their relationship and (potential) partnership evolves: highlighting key touchpoints, emotions, and challenges in the process. Here you find an example of a caregiver journey map in the context of dementia care, made by the AgingWellHub.

Personas – User personas are often developed within user-centered design. They are detailed fictional **representations of individuals that help designers to sustain their focus on the behaviour and needs of primary users**. Developing user personals for various (subgroups of) LTC workers and informal carers can help to create a shared understand of who these people are: what are their characteristics, backgrounds, strengths, pitfalls, needs, etc.? Here you find a description of caregiver user personas that were developed within an earlier H2020 project.

The aforementioned publication 'Power: A Practical Guide For Facilitating Social Change' also has a dedicated section on problem analysis (page 28 of the pdf file) and discusses several methods for doing a collaborative problem analysis, including an outline for a full day workshop (page 34 of the pdf file).

BOX 14.

TOOLS AND RESOURCES: Session on care partnerships

The following example outlines a session that helps to create a shared understanding of the influence of individual, organizational and societal dynamics on care partnerships, and how these may affect the mental wellbeing and resilience of LTC workers and/or informal carers. A session like this could be a useful exercise within, for example, the Local Implementation Team (with involvement of relevant project partners and/or BLN members) to explore the various factors that may support or impede the development of care partnerships.

Goal: Create a shared understanding of what makes for a successful care partnership and how this is affected by factors within the day-to-day (individual), organizational, and societal context.

Break up into groups and make sure that all stakeholder groups (e.g., LTC workers, informal carers, researchers, etc.) are mixed and represented within each group. Each round, answer the questions listed below, write down key responses on post-it notes, and collect these on a large piece of paper.

Round 1: What are the opportunities and barriers for developing care partnerships within the day-to-day interactions between LTC workers and informal carers? How could these partnerships affect their wellbeing? What are the various actors' perspectives and needs within these day-to-day situations?
Round 2: Same questions, but viewed from an organizational perspective: are there aspects at the organizational level that either hamper or support the development of care partnerships?
Round 3: Same questions, but viewed from a macro-societal perspective: how do societal developments, national policies, politics, etc. influence the development of care partnerships?
Round 4: Wrap-up: each group provides a recap about the key aspects discussed. What do we learn about what constitutes a successful care partnership, and about the interventions, policy measures, projects, etc. that are needed to develop and promote these?

4.3 Selection process: which care partnership practices to develop and promote?

Building on the problem analysis, project partners, BLN members, local implementation teams and possible other stakeholders decide which existing practices seem promising to adopt, tailor and implement within their own national, regional, or local context. Again, this **selection process is not confined to one single decision**:

- Before we select – on the overall project level – which good practices are developed into prototypes, national partners discuss with their BLN members which practices are particularly inspirational to them. Moreover, they can identify potential **implementation sites** (i.e., organizations, initiatives, local networks, etc.) with stakeholders that are interested in investing in care partnerships. With these stakeholders it can be explored further what practices may be of particular interest to caregivers in their context (drawing on examples identified in Work Package 2). Building on this input we can make sure that the 5 to 8 prototypes that we develop are **in tune with the interests, needs and opportunities of our target groups and stakeholders within the five project partner countries**.

- Later on, national partners, BLN members, local implementation teams and possible other stakeholders discuss and **decide which prototype(s) will actually be adopted** and used to develop and promote care partnerships within their particular context.

To reach consensus around these decisions, several existing **tools and methods can be helpful to ensure a balanced and inclusive discussion, assessment and decision** – weighing the different opportunities and challenges around the various options and taking into account the sometimes competing interests of different stakeholders.

BOX 15.

TOOLS AND RESOURCES: Selecting ideas

Some tools are fairly straightforward and can be **helpful to 'score' or otherwise assess the various options**. The first three tools below are described in (some) more detail in this article on innovationmanagement.se:

Pass/fail evaluation – This is a useful tool to **quickly narrow down a long list of ideas or options**. Participants formulate a simple criterion to assess whether options should be further scrutinized in a more in-depth evaluation, or whether they can be discarded.

Evaluation matrix – This is a more elaborate application of the previous methods, in which participants formulate a **broader set of criteria to evaluate the remaining options**. Participants can score each option on these criteria, with the sum of these scores constituting the overall assessment.

SWOT-analysis – This is again a more elaborate (and for most of us probably familiar) method to evaluate ideas. Participants can identify the **Strengths, Weaknesses, Opportunities and Threats** particular to that idea, and/or score the ideas on these four categories in order to compare the various options.

Impact-effort matrix – This method, described step-by-step in this article on asq.org, helps to assess different ideas based on (1) **how much impact** is expected that these ideas may yield if successfully implemented, and (2) **how much effort** seems required to indeed come to implementation.

Nominal Group Technique (NGT) - This is a structured method for **group brainstorming** that encourages contributions from everyone. People have to **prioritize ideas or solutions** through a collective decision-making process.

Given the nature of our WELL CARE activities, it is not a matter of simply selecting an option and then executing it. For example, the prototypes that are developed are not 'fixed' and ready-to-implement. They still need tailoring and further elaboration in order to translate them into locally relevant and feasible support practices. Therefore, we also suggest tools and methods that go beyond 'scoring and selecting' the various options. The following tools provide strategies that may help participants to brainstorm about how particular ideas may be developed and translated to participants' particular national, regional or local context.

BOX 16.

TOOLS AND RESOURCES: Elaborating ideas

World café – This is a useful method to **facilitate discussion among large numbers of participants**. To prevent group discussions from being dominated by a select number of strong speakers, participants are divided into smaller subgroups, who 'wander together through a parcourse of stations with different questions' (for a more elaborate discussion, see this article on sustainabilitymethods.org). At each station subgroups can, for example, discuss the relevance and potential translations of an existing good practice or particular prototype(s) to their particular context.

Disney method – In this **structured approach for collaborative brainstorming**, groups alternate to play the role of 'dreamer', 'critic' and 'realist' to come up with, and then further develop, ideas – e.g., around how certain practices may foster the development of care partnerships. The Disney method is described in more details in this article on sustainabilitymethods.org. Or check out this video on YouTube.

Failure Modes and Effects Analysis Tool (FMEA) – This tool can be used for **identifying and acting on potential risks prior to implementation**. The tool is geared to improving reliability, safety and quality, while reducing the likelihood of failures. You can download this tool from the Institute for Healthcare Improvement. For more information, see the following resources: 1, 2, 3, 4, 5.

To develop particular ideas even further, the *Theory of Change* approach provides a helpful and practical framework. As this approach can also provide a basis for our evaluation activities, it will be discussed in more detail in section 6 of this guide.

SECTION 5

Tailoring and implementing prototypes: getting things done

Once project partners have decided what course of actions is pursued within their particular national, regional or local context – i.e., once it is decided which prototype they will work with to foster the developments of supportive care partnerships – **it is never a matter of 'just implementing'**. Much effort will go into tailoring and translating the 'generic' prototypes to the specific setting in which partners and stakeholders try to bring about positive change for informal carers and LTC workers. It is a matter of testing things out, evaluating if that worked (and how, and for whom, and under what conditions), and sometimes going back to the drawing board for several iterations to improve the plans. This section will provide some initial guidance and tools that may help project partners and other stakeholders during this process.

BOX 17.

PROJECT SUPPORT: Engaging with the local context: different terms

An essential part of our project concerns the active engagement with actors within the local context in which implementation activities take place. In this guide, we have already used several terms in discussing this issue (i.e., implementation sites, local implementation teams, supportive ecosystems). We will now clarify and differentiate these terms in some more detail.

***Implementation site* –** An implementation site refers to the specific location, organization, and setting where the **solution prototypes will be introduced and implemented**. This could be any environment where informal and formal caregivers interact and potentially collaborate. Such sites may include care provider organizations (e.g., home care agencies, nursing homes, clinics), community-based settings (e.g., community centres, citizens' initiatives), or networks or joint initiatives by different organizations or agencies (e.g., a network that tries to improve social support for older people and their caregivers in a particular city, region, town or neighbourhood).

Identifying and **selecting an implementation site** can take place through a **collaborative process involving national partners** in close collaboration with the Blended Learning Networks. For example, BLN members can help project partners by jointly discussing, identifying and helping to set criteria for selecting a suitable implementation site. These criteria can be tailored to the context and scope within that project country, e.g., to a particular type of care setting, to a particular population served (such as older people or people with intellectual disabilities), to the nature of an intervention that seems promising (whether it's a digital tool or a care process), or to other aspects of the local environment. By thoroughly considering these criteria, the BLNs increase the likelihood that selected sites are conducive to the successful introduction and testing of solution prototypes.

Box 15 in this guide contains various **practical tools** that may be useful for this selection process.

Local implementation teams **–** A key step in developing the infrastructure to actually get things done, is the **formation of local implementation teams**. The goal is to form these teams before mid-2025. That being said, as the ideas and plans around the actual implementation efforts will still evolve after that, it is advised to periodically evaluate whether the right people are still at the table to make implementation a success. Who should be member of these local implementation teams depends on the issues that are to be addressed and the actions that will be implemented.

As also mentioned in section 4, it is helpful to conduct a **stakeholder analysis** (see Box 13) to find out who is affected by activities that are pursued, and which actors can make or break successful implementation. It makes sense to not just engage people who are directly involved at the sites where implementation will take place, but to also include actors from the wider (organizational, policy, community) context – **people who can help to create the necessary space for the 'people on the ground' to get things done**. Who these more 'distant' people are can differ depending on the character of activities, but they can include organizational leaders, care commissioners, local chapters of trade unions and/or community leaders.

The **role of the local implementation teams is different from the role of the BLNs**: whereas the BLNs function more as an overall and strategic sounding board to the project activities, the local implementation team is hands-on involved with the day-to-day operations to get things done. That said, it is **likely (and advisable) to have some overlap between members of the two platforms**, allowing smoother coordination of project activities while fostering mutual learning across participants.

Supportive ecosystems – Whereas the local implementation teams constitute a discrete platform within the project (i.e., with a more-or-less fixed set of members and a series of meetings), the term 'supportive ecosystems' refers **more broadly and loosely** to elements in the **environment** of implementation activities that can make the development and implementation of care partnerships a success. Even when actors are not part of a local implementation team, they can still be engaged with (e.g., to **create awareness** or **generate support**) in order to smoothen the development of supportive care partnerships. For example, an awareness raising campaign among employers to identify stress or burnout among working informal carers can contribute to an environment in which caregiver wellbeing is higher on the agenda. Or by engaging with managers of a care providing organization, one can highlight the importance of collaboration between LTC workers and informal carers. These managers' support may foster the development of care partnerships, even when they are not directly part of any local implementation team.

More on this issue in section 5.2., including references to tools and resources that may be helpful for investing in such supportive ecosystems.

5.1 Prototypes

As discussed, the **prototypes that are developed will not contain clear-cut blueprints** of what needs to be done but can be considered as 'semi-finished' products. This way, the prototypes provide ample space to engage in a **cyclical process of tailoring, testing, adapting, and implementing**. This iterative process is key, as a lack of adaptability is often highlighted as a key barrier to implementing support practices[32]. For this reason, each prototype will contain what could be considered as a mini-guide that is tailored to that prototype's particular purpose, challenges and opportunities.

BOX 18.

PROJECT SUPPORT: Prototypes – and a note on the project timeline

A **social designer** will be involved at the project level to help us ideate what the various solution prototypes could look like. Within the WELL CARE Grant Agreement , we already set out a number of elements that we think the prototypes need to contain:

- (Visual) descriptions of key mechanisms generating the (original) practice's impact;
- Descriptions of its (potential) target group(s);
- Key roles to be fulfilled for its proper functioning;
- Key conditions, processes and contextual requirements for sustainable implementation and governance;
- Strategies for testing and tailoring (elements of) the prototype in target setting;
  Methods for monitoring and evaluation

The final report that contains the descriptions and visualizations of 5 to 8 **prototypes** (i.e., Deliverable D3.2) is due in the Autumn of 2026 (M33). It is already in mid-2025 (M18), however, that the **local implementation teams** are established. This may seem like a bit of a **paradox**: how to establish local implementation teams if we do not yet know which prototypes can be implemented? We see several reasons why it is still important to already develop a local infrastructure for implementation earlier in the project:

- If we wait for the solutions prototypes to be ready before identifying sites and stakeholders that are willing and able to work with prototypes, there will be very little time left within the project for actual implementation.
- **When selecting which prototypes are developed**, we take into account what is **relevant and feasible to implement** within the five countries. Without knowing where implementation may take place (and which stakeholders may take part in this), we cannot assess which prototypes will indeed be relevant and feasible. As such, knowing our (potential) implementation sites and teams will help us during this selection process.
- While the report with prototypes is due for the Autumn of 2026, **(earlier versions of) the individual prototypes** are likely to be available before that.
- If necessary, the **composition of local implementation teams** can of course still be **adjusted** if developments after M18 require such adjustments.

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[32] Zhu et al. (2023)

In what follows, we already provide some overall guidance to inform this process of tailoring, testing and implementation, and signpost tools and resources that may be helpful along the way.

5.2 Investing in supportive ecosystems

As mentioned before, the success of implementation does not just lie in the 'technical adequacy' of the prototypes. Rather, it is highly dependent on how well the proposed support practices fit the context in which they are being implemented. These practices interact with other elements in this context, which may either support or hamper effective implementation. Therefore, **we set out to invest in 'supportive ecosystems'** in the settings in which implementation will take place. This includes creating awareness, generating support, and developing constructive working relations among the various parties that are able to influence the outcomes of WELL CARE activities. These could include care providers and professional networks, informal carers and citizen collectives, employers, service users, funders, local governments, regulatory agencies, and other parties within the local, regional and/or national settings in which we work.

BOX 19.

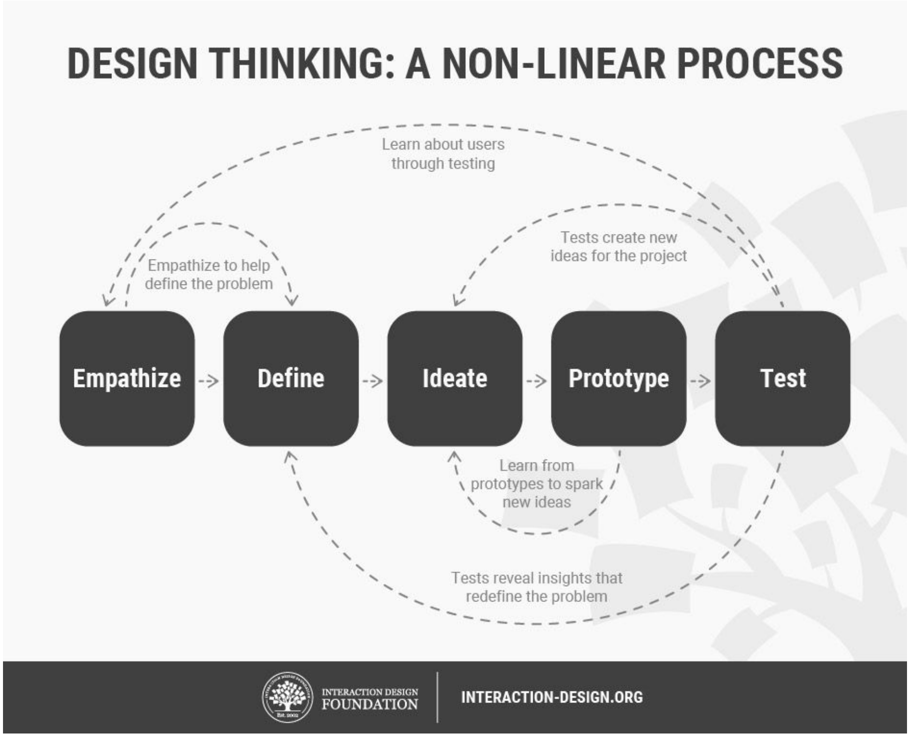
TOOLS AND RESOURCES: Supportive ecosystems

Stakeholder engagement – In addition to identifying *who* needs to be involved, there is also the question of ***how* to involve and mobilize them**. This short article suggest tools that can help with stakeholder management, whereas this publication discusses the challenge of mobilizing stakeholders in your project in more detail. An even more extensive collection of tools can be found in this resource by the Asian Development Bank, which mainly focuses on policy change ('Mobilizing Multi-stakeholder Action for Reform: Performance Support Tools').

Awareness raising – As part of mobilizing stakeholders and broader audiences, and to get issues on (policy) agendas and generate support for your activities, it can be important to undertake awareness raising activities. E.g., are informal carers sufficiently within the scope of formal provider organizations? This article gives some initial guidance and practical tips for public outreach campaigns (focusing on the Sustainable Development Goals, but with broader relevance), whereas this article describes various tactics to identify your target audience, craft a compelling message, and leverage relevant channels of communication.

5.3 Tailoring and testing prototypes

Building on principles of design thinking, the actions by which we tailor, test, adapt and implement prototypes are part of a cyclical process. This means that once project partners and stakeholders have decided to work with a particular prototype, we engage in multiple iterations in which we try things out and adjust them to make sure that activities indeed help to develop supportive care partnerships. As visualized in the figure below – that we already showed in the section on design thinking – testing (parts of) the prototypes provides us with new insights that will sometimes lead us back to the drawing board to adjust and improve the support practices that we develop.



Source: https://www.interaction-design.org/literature/article/stage-5-in-the-design-thinking-process-test

When going through these steps of tailoring, testing, and adapting the prototypes in the actual setting where they are implemented, the various tools and resources that have been in section 4 may still be useful. For example, the world café or Disney method may be used to ideate how emerging insights or challenges may give cause to alter the design of the practices you try to implement.

BOX 20.

PROJECT SUPPORT: Integrating our implementation, monitoring and evaluation activities

As we tailor, test, adapt and implement the solution prototypes, the iterative process described above allows us to continuously learn about ‘what works, for whom, and under what circumstances’. This means that **implementation activities and monitoring and evaluation activities are not confined to separate project phases**. The cyclical nature of design thinking fits well with the cyclical nature of Realistic Evaluation, the general approach underlying our evaluation activities.

At the core of these cyclical approaches, data collection and emerging insights will continue to inform the support practices that we develop. As such, the national research partners still have a major role during the implementation phase by **generating insights that do not just describe, but also actively contribute to the ongoing implementation work**. E.g., conducting interviews or observations with LTC workers and informal carers may provide the local implementation teams with insights into user experiences, which they can use to attune their work to what matters for the target groups, while addressing emerging challenges.

Monitoring and evaluation are discussed more elaborately in Section 6 of this guide.

5.4 Project management

Part of successful implementation is good project management. While it goes beyond the scope of this guide to discuss this in much detail, we do want to suggest a number of tools and resources that project partners may draw upon if wanting to learn more about project management practices – including how to draft an implementation plan.

BOX 21.

TOOLS AND RESOURCES: Project management and implementation planning

Many of the tools and resources listed in section 4 and 5 will provide project partners, BLN members and (other) stakeholders with useful insights in preparing for and executing their implementation activities. To create an overarching structure for these activities, this page on the website of Asana presents a concise step-by-step approach for drafting an **implementation plan**. Such a plan may provide structure to the work of Local Implementation Teams, helping them in the process of listing objectives and deliverables, setting targets, dividing roles and responsibilities, etc.

The American Society for Quality (ASQ) gives a short introduction to the project management process. Although not all project management practices will automatically fit the cyclical approach of tailoring, testing, adapting, and implementing, the website still provides useful tools to manage the implementation process. These include:

Gantt charts – A Gantt chart can be helpful to schedule project tasks, communicate plans with partners and monitor progress. The ASQ provides a short article on how to create and use these charts.

PDCA cycle – More in tune with a cyclical approach, the Plan-Do-Check-Act (PDCA) cycle is a common four-step model that is geared towards continuous improvement of project activities. Again, the ASQ provides a short article describing when and how to use it.

SECTION 6:
Assessing care partnerships: monitoring and evaluation

As discussed earlier in this guide, evaluation is not just the end phase of our project. It is not 'merely' about assessing whether our various project objectives were met. Instead, evaluation – and our research activities more broadly – are also geared to generating actionable insights *during* the project. These insights help us to learn from, and immediately try to improve, our efforts at developing supportive care partnerships.

This section introduces our approach to evaluation in the WELL CARE project. As the project continues, we develop a more specific and elaborate evaluation framework, also attuning our monitoring and evaluation activities to the particular solution prototypes that will be developed.

6.1 Realistic Evaluation

To broadly structure our evaluation activities, we draw on the principles of Realistic Evaluation. In line with our project's context-sensitive and action-oriented approach, **Realistic Evaluation does not just assess *whether* an intervention works, but also asks *how* it works, for *whom,* and under *what circumstances***[33]. Where traditional, quasi-experimental evaluation approaches try to exclude 'context' from the equation – as it would distort the image of an intervention's effectiveness – Realistic Evaluation deliberately draws context into the equation: treating it as a key factor to explain whether or not an intervention delivered the outcomes that were intended.

BOX 22.

IN FOCUS: Context + Mechanism = Outcomes

This simplified equation forms the core of Realistic Evaluations: assessing the relationship between the **context** in which an intervention is implemented, the **mechanisms** within an intervention that (may) produce a particular effect, and the **outcomes** that result from the interaction between the two. Together, these three elements allow evaluators to develop **C-M-O configurations**. These are essentially explanations or theories of how an intervention or practice leads to particular outcomes for particular actors within a particular context.

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[33] Pawson & Tilley (2014)

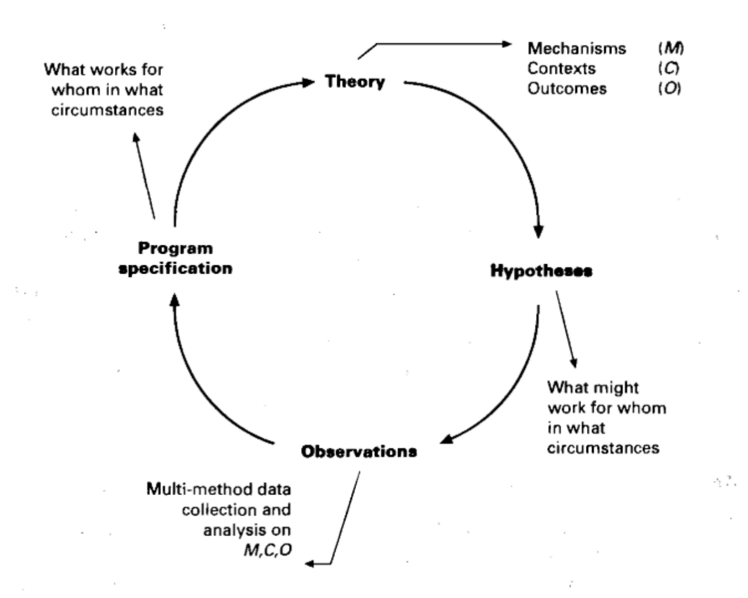
All interventions are to some degree, explicitly or implicitly, based on such a C-M-O configuration. We assume that ‘if we do X under these particular circumstances, then Y is likely to happen’. For example: if we start a coaching program for LTC nurses in our organization, then the hope is that these coaching sessions will boost their confidence and improve their mental wellbeing. Such ‘program theories’ can be based on existing scientific literature and theory, but they are also informed by the professional expertise and/or lived experiences (and often: assumptions) of the people involved.

Subsequently, if we empirically test and refine such C-M-O configurations by collecting and analyzing relevant data, this can automatically help us to refine the program theories underlying our interventions. This, in turn, can provide the basis for improving the design of these interventions or practices. To continue with the example: it can be empirically assessed whether the coaching program indeed led to improved mental wellbeing (outcome), how this happened (mechanisms), for whom and under what circumstances (context)? If outcomes were positive, did the sessions indeed boost nurses’ confidence? Or did their wellbeing improve for other reasons – for example, because nurses felt seen and heard by their employer, who offered them this coaching program (mechanism)? And were outcomes different for colleagues from different teams, e.g., from teams with varying degrees of social safety (context)? By empirically answering such questions, we can provide actionable insights that support the improvement or refinement of the particular practice of interest.

BOX 23.

IN FOCUS: The Realistic Evaluation cycle

The cycle in which program theories are formulated, tested, and refined are the foundation of the realistic evaluation process. This cyclical process, depicted below, can inform efforts to refine and improve the intervention or practice under scrutiny.



Notice how this process resonates with the cycle in which we tailor, test, adapt and implement the solution prototypes within the five partner countries. By continuously refining the ‘program theories’ on which we base our actions, we also provide a basis for the gradual improvement of the support practices that we try to implement.

For further reading about the realistic evaluation approach and examples of its application, the following scientific publications may be interesting:

Source: Pawson & Tilley (1997), p.85

- Pawson, R., & Tilley, N. (2010). *Realistic evaluation*. SAGE.
- Dalkin, S. M., Greenhalgh, J., Jones, D., Cunningham, B., & Lhussier, M. (2015). What's in a mechanism? Development of a key concept in realist evaluation. *Implementation Science*, 10(1), 49. https://doi.org/10.1186/s13012-015-0237-x
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- Goodman, C., Davies, S. L., Gordon, A. L., Dening, T., Gage, H., Meyer, J., Schneider, J., Bell, B., Jordan, J., Martin, F., Iliffe, S., Bowman, C., Gladman, J. R., Victor, C., Mayrhofer, A., Handley, M., & Zubair, M. (2017). Optimal NHS service delivery to care homes: A realist evaluation of the features and mechanisms that support effective working for the continuing care of older people in residential settings. *Health Services and Delivery Research*, 5(29), 1–204. https://doi.org/10.3310/hsdr05290
- Lauzier-Jobin, F., & Houle, J. (2021). Caregiver Support in Mental Health Recovery: A Critical Realist Qualitative Research. *Qualitative Health Research*, 31(13), 2440–2453. https://doi.org/10.1177/10497323211039828
- MacArthur, J., Wilkinson, H., Gray, M. A., & Matthews-Smith, G. (2017). Embedding compassionate care in local NHS practice: Developing a conceptual model through realistic evaluation. *Journal of Research in Nursing*, 22(1–2), 130–147. https://doi.org/10.1177/1744987116678901
- Pittam, G., Boyce, M., Secker, J., Lockett, H., & Samele, C. (2010). Employment advice in primary care: A realistic evaluation: Employment advice in primary care. *Health & Social Care in the Community*, 18(6), 598–606. https://doi.org/10.1111/j.1365-2524.2010.00929.x

6.2 Theory of Change

As mentioned above, the program theories that are formulated, tested, and refined within this realist evaluation cycle can be based on academic literature and research, but also on other sources, such as the 'lay expertise' and experiences of a program's end-users and other stakeholders. The *Theory of Change* method may provide guidance and practical tools for drawing on these diverse sources of knowledge to collaboratively develop (and refine) such program theories.

BOX 24.

IN FOCUS: Theory of Change

An often used and well-documented approach for collaboratively formulating theories about how and why a desired change is expected to occur, is the **Theory of Change** (or ToC) method. This method helps to inform and improve the design of activities at the beginning of a project, but – in line with the realistic evaluation cycle – it can also be used to test and adjust such theories after activities have commenced. The Theory of Change method is often conducted in a workshop setting with a diverse set of stakeholders, so it is highly suitable to our BLNs. A brief introduction to the ToC method is provided here on the website of Erasmus University Rotterdam, whereas a more elaborate guidebook by the Dutch NGO Hivos can be downloaded here.

6.3 Methods-neutral

While the realistic evaluation cycle can help us to structure our research and evaluation activities, it does **not specify (or prioritize) a particular method of data collection**. Realistic Evaluation is presented as being 'methods neutral', i.e., the process can be informed by data that is collected through a **variety of qualitative and quantitative methods**. E.g., qualitative interviews and observations could help uncover how and why an intervention works in a specific context, while quantitative methods may be used to measure certain expected outcomes.

In the following project phases, we will **identify and outline a set of qualitative and quantitative instruments for measuring the outcomes that we strive for in the project**: improving informal carers' and LTC workers' mental wellbeing and resilience. Moreover, we will explore whether there are other outcomes for which we want to provide some basic instruments (e.g., quality of relationship between informal and formal caregivers? Quality of inter-organizational partnerships?). For each prototype that is developed, we will also explore whether there are helpful methods for **assessing contextual elements as well as mechanisms** that together explain whether certain outcomes are produced.

6.4 Social Return on Investment (SROI)

At this stage, we already do highlight one particularly methodology that can be a valuable part of our evaluation toolbox: Social Return on Investment. SROI is a methodology for **assessing the social value that is created for the various stakeholders** involved in a project, intervention, or program[34]. It measures the social impact of something (an organisation, intervention, project) and shows how much this impact matters. SROI uses elements of accounting and cost-benefit analysis to **assign monetary values to outcomes that are generally not accounted for** in standard

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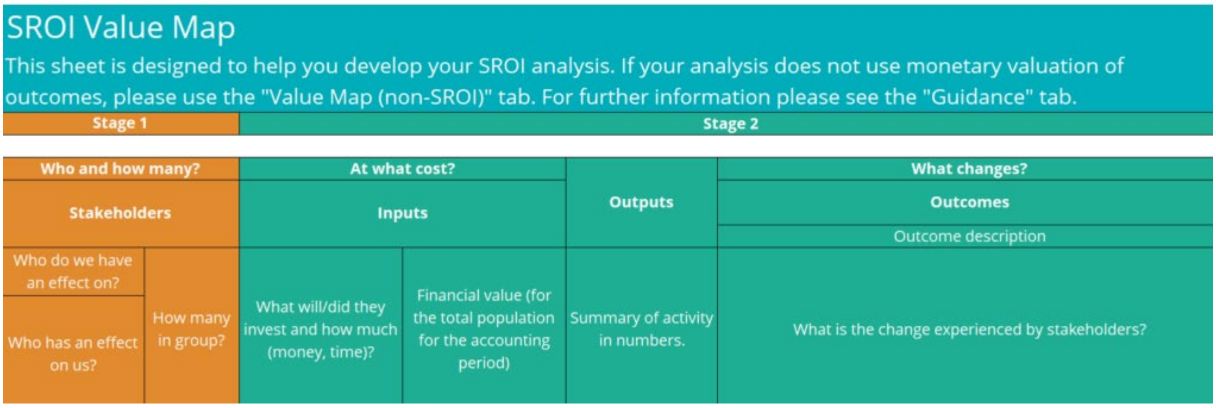
[34] Hopkins et al. (2023)

financial accounts. The methodology uses financial proxies to monetize (social) benefits, allowing us include these benefits into otherwise monetary cost-benefit assessments. This results in a ratio of all benefits and costs, called ‘the ratio of monetized social value.’ For example, an SROI ratio of 2:1 means that €2 of social value was created for each euro invested[35].

Schematically, an SROI analysis includes the elements depicted in the figure below.



SROI Value Map

This sheet is designed to help you develop your SROI analysis. If your analysis does not use monetary valuation of outcomes, please use the "Value Map (non-SROI)" tab. For further information please see the "Guidance" tab.

Stage 1		Stage 2			
Who and how many?		At what cost?		Outputs	What changes?
Stakeholders		Inputs			Outcomes
					Outcome description
Who do we have an effect on? Who has an effect on us?	How many in group?	What will/did they invest and how much (money, time)?	Financial value (for the total population for the accounting period)	Summary of activity in numbers.	What is the change experienced by stakeholders?

Source: https://socialvalueuk.org/resources/sroi-value-map/

6.4.1 Why use SROI?

SROI is a promising methodology for WELL CARE partners in multiple ways. It is often used for doing **ex-ante cost-benefit analyses**, which can play a valuable role in assessing the feasibility of the interventions, projects, practices, etc. under consideration. Moreover, such ex-ante assessments may also serve a practical purpose for stakeholders who need develop a ‘**(social) business case**’ for their (proposed) activities; for example, when trying to mobilize funds or other resources necessary for implementation.

SROI can also be used **retrospectively**. For example, following the cyclical approach of Realistic Evaluation, initial ex-ante SROI-assessments (forecasting the social value created by an intervention or practice) can be **validated and adjusted with actual empirical data** after implementation has started. This may lead to a refined, more accurate SROI ratio.

6.4.2 SROI+

Of course, attempting to assign monetary values to all relevant outcomes of a particular intervention or practice has its limits. If you push this too far, you will aggregate things that are difficult or impossible to aggregate. Consequently, you lose important information and/or create an environment of pseudo-precision. Therefore, we believe it is also important to supplement the

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35 Hutchinson et al. (2019); Millar & Hall (2013)

quantified assessments of SROI with qualitative data on outcomes and user experiences. Hence, we coin the term SROI+.

BOX 25.

IN FOCUS: Further reading about Social Return on Investment

Social Value International offers an elaborate and practical ‘Guide to SROI’, which is available (among other languages) in English and Italian. This guide can be downloaded here, and includes detailed step-by-step guidance on how to conduct an SROI assessment.

SROI is regularly used, described and reflected upon in scientific publications, for example in the following articles:

- Kadel, R., Stielke, A., Ashton, K., Masters, R., & Dyakova, M. (2022). Social Return on Investment (SROI) of mental health related interventions—A scoping review. *Frontiers in Public Health*, 10, 965148. https://doi.org/10.3389/fpubh.2022.965148

- Toms, G. R., Stringer, C. L., Prendergast, L. M., Seddon, D., Anthony, B. F., & Edwards, R. T. (2023). A Study to Explore the Feasibility of Using a Social Return on Investment Approach to Evaluate Short Breaks. *Health & Social Care in the Community*, 2023, 1–11. https://doi.org/10.1155/2023/4699751

- Willis, E., Semple, A. C., & De Waal, H. (2018). Quantifying the benefits of peer support for people with dementia: A Social Return on Investment (SROI) study. *Dementia*, 17(3), 266–278. https://doi.org/10.1177/1471301216640184

- Bellucci, M., Nitti, C., Franchi, S., Testi, E., & Bagnoli, L. (2019). Accounting for social return on investment (SROI): The costs and benefits of family-centred care by the Ronald McDonald House Charities. *Social Enterprise Journal*, 15(1), 46–75. https://doi.org/10.1108/SEJ-05-2018-0044

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