Family support in general practice

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SUMMARY

At a time when social services are overburdened in Britain, family support in general practice offers one way to fill the gap. In the WellFamily Project, a 'family support coordinator' worked within a general practice in Hackney, London. In the first eighteen months she saw 113 clients. Evaluation was by semistructured interviews with a sample of these clients and with professional workers.

Comments from those interviewed indicate that the family support was valued. The general practice base was convenient and non-stigmatizing. By adopting a proactive approach, the project was able to work with clients who had previously 'slipped through the net'. Some of the professionals interviewed would have liked to provide the same help, but were unable to do so because of time and other constraints.

Family support provided through general practice was well received by vulnerable families. Although there was overlap with the remit of health visitors and social workers, the protected time and the independence of the coordinator enabled clients to obtain the help they wanted. The replicability of this strategy now needs to be assessed.

Families that experience social difficulties will often seek medical help in their distress, and there is evidence that social and emotional support protects against illness and aids recovery[1]. Over recent years, however, provision in Britain for those experiencing social difficulties has declined and the gap between the rich and the poor has widened[2]. Social services are overburdened by crisis work. As general practitioners working in an inner-city area, we are in a good position to deliver family support. Therefore, in collaboration with the Family Welfare Association, we developed a family support service that is delivered through primary care. The Family Welfare Association is a voluntary organization with an impressive track record; it founded the first labour exchange in 1870 and opened the first Citizens' Advice Bureau in 1938. The WellFamily Project offers practical and emotional support to help families build on their own resources and find ways around their difficulties. A project worker, known as the family support coordinator, began taking referrals in October 1996. Her background was in health visiting, but, once in post, she arranged additional training in family therapy, solution-focused counselling and welfare rights.

A steering group, consisting of a general practitioner and managers from the practice, the Family Welfare Association, social services and health visiting, agreed referral criteria. Although open to all registered patients (7200), the project is directed to families in need who fall below the threshold for help from social services. Isolated or depressed patients, frequent attenders with psychosocial problems and families concerned about their children's behaviour or who have difficulty providing adequate levels of care were also offered the service, as are those who initially consult about the welfare of other family members.

Adopting an action-research perspective[3], we evaluated the project as it progressed, by both quantitative and qualitative methods. Background information such as the demographics of referrals and subsequent contacts was entered on standardized forms. Clients were asked what they wanted from the referral and the nature of subsequent interventions was recorded. Additionally, semistructured interviews were conducted with 20 patients recruited during one month of the project and with professionals undertaking joint work with the project. The methodology is described in more detail in the full evaluation report[4].

WHO USED THE SERVICE?

During the eighteen months from October 1996 to March 1998, 136 patients or families were in contact with the WellFamily Project and 113 (83%) were seen by the family support coordinator. The practice has a high proportion of young families, and 81 (72%) of those seen were aged between 25 and 44. The ethnic origin of clients reflected the practice population and is shown in Figure 1. 64 (57%) wanted 'support', while more specific requests included 49 with financial problems, 45 seeking information, and 28

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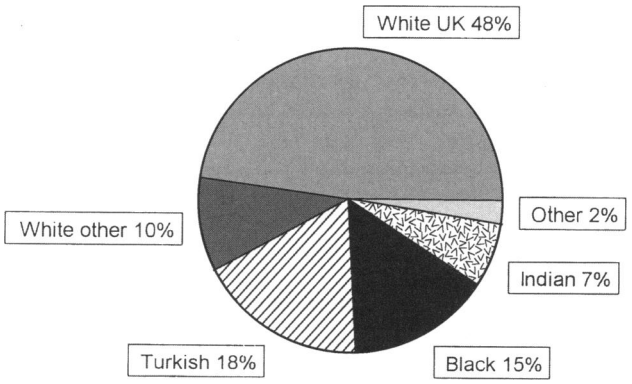

Figure 1 **Clients' ethnicity (*n*=113)**

with housing problems. Mental health relationship and parenting problems were other common reasons for accepting referrals. Box 1 shows the range of interventions provided by the family support coordinator.

From the start there was clearly potential for overlap and duplication of work, especially with health visiting and social services. 23 clients were in contact with social services at the time the referral was made, although only 5 had an allocated social worker. Any lack of clarity over roles was largely resolved by joint working with families. And the fact that the family support coordinator shared an office with the health visitors opened up channels of communication.

WORKING MODELS

Three main models of working were used with individuals and families—single-session contacts, brief work (2–5 sessions) and longer-term involvement. 38 of the 113 attenders were seen for a single session. While some wanted support in a crisis, others had straightforward information requests or were seen once and referred to another service. Using a community database and extensive contacts with voluntary organizations, the family support coordinator provided information which in many cases enabled patients to find their own solutions.

The 48 clients seen for brief work had problems including specific parenting issues, relationship difficulties, domestic violence, postnatal depression and bereavement. The intervention differed from conventional counselling in that the coordinator was actively involved in helping patients make changes—for example, by writing letters or making telephone calls. Those who lacked the skills to negotiate their way around 'the system' were thus helped to sort out practical problems or establish continuing support. This very practical approach was valued by those interviewed. One woman, who had previous experience of counselling, commented 'Counselling just would not have been the right thing . . . I needed to talk to someone who had knowledge of children's problems. The practical focus in the beginning then opened up other things.'

Longer-term work was conducted with 23 of those seen, including parents with complex problems, families where child protection issues became evident and carers in need of long-term support. Although many knew of other services, inertia had stopped them getting in touch, or a communication breakdown had left them unsupported. Although attempts were made to establish groups to combat isolation and build self-esteem, these met with variable success and we decided the priority was to concentrate on individual or family work.

GENERAL PRACTICE BASE

By basing the WellFamily Project in a general practice we aimed to maximize accessibility and minimize stigma. Other studies, such as that of Davis and Spurr[5] (in which health visitors and community medical officers were trained to counsel parents), have endorsed this potential of primary care. Our patients felt comfortable going somewhere local and familiar. As one woman put it, 'It was easy to see her because she was at the doctor's . . . because I felt she knew me. She wasn't from social services. It was more personal.' Help within the practice was often more acceptable than help from an outside agency; as a woman consulting about her son's behaviour, following a complaint from school, observed, 'I needed to take it further but I wasn't quite ready to take him to a child psychologist or psychiatrist or anything like that, but I definitely needed some sort of advice . . . I found it quite comforting to talk to someone in a GP environment.'

Both professionals and patients felt it was valuable to be independent of social services. One social worker pointed out, 'Social services holds a stigma doesn't it. You don't want to have to admit you see a social worker.' Whether stigma might transfer to the WellFamily Project remains to be seen, but since the worker is not responsible for statutory child protection work she is unlikely to generate the same fears.

Box 1 **Interventions**

- Listening and using counselling skills
- Providing information
- Giving advice about welfare benefits and grants
- Advocacy for clients to help them access services
- Setting up support groups
- Joint consultations with GPs and allied professionals
- Referral to statutory and voluntary agencies

FAMILY FOCUS

Helping families to build on their existing resources is central to the WellFamily service. Family members were commonly seen together, helping them to make connections that clarified their understanding. Support given to one person can benefit others, as this mother described: 'I was incredibly stressed and my daughter was sort of picking up on that. When I went into the first session everything broadened, I realized I was so uptight and how could I expect my children not to be?'

Some people initially consulted because of another family member's needs, but after a time the focus changed. For example, a woman who was concerned about what was happening to her daughter found it hard to talk about her feelings and initially asked her general practitioner for advice about her partner's drug abuse. Commenting on his suggested referral to the WellFamily Project, she said, 'When I first went there I was talking about my partner . . . and he [the GP] picked up that I was more concerned about my own child and my own situation at home . . . so yes, it was a great relief.' As her confidence grew she was able to explore her own experience of sexual abuse and realized that the same was happening to her daughter. Continuing support eventually allowed her to take protective action on behalf of her daughter.

Another feature of a family-centred approach is the opportunities it provides for helping those who are hard to reach, such as the delinquent son or the alcoholic mother. Support for the rest of the family may be the most effective way forward and is an approach which is widely used by family centres[6] funded by local authorities and voluntary agencies.

SLIPPING THROUGH THE NET

General practitioners are often the first port of call for those with complex social problems, and are asked to help with psychosomatic complaints for which medicine has little to offer. As one doctor put it, 'The cough may be a last straw in a chronic housing problem and the ache may be the emotional one of having been displaced from the country of origin.' Our referrals to more appropriate services often fail either because the patient's lifestyle is chaotic or because the caring responsibilities make it too difficult. Similarly, referrals to counselling usually require patients to take initiatives which they may not feel able to undertake.

By contrast, the family support coordinator was prepared to be proactive, contacting clients by telephone or letter if they missed appointments. Those interviewed appreciated her willingness to make home visits, even some who did not normally like being visited at home: 'I definitely don't like social workers here at all . . . But when you're in your own home you feel a lot more comfortable, you can explain it, you can behave freely.'

Independence from statutory responsibilities was also an advantage to the coordinator and helped her to overcome some clients' resistance, but this caused mixed feelings among other professionals. A social work manager commented, 'The WellFamily service doesn't actually offer anything to social workers, it doesn't take any of their work away; in fact it may give them more work because it may access [new] families.' Another social worker described her ambivalence about the emotional support the coordinator was giving a mother of a severely disabled child: 'That's a role I would have liked to have played, but the truth of the matter is I felt it was impossible because of this conflict between care management and resources, and emotional support. Sad for me but all right for Mrs X; she's getting her support when she needs it, that's great.'

Other strategies, such as Newpin (the New Parent Infant Network), focus on families who may be difficult to reach[7]. However, Oakley found that over half of those referred within that sample never used the service, and that the most vulnerable women were the least likely to be helped[8]. By contrast, the WellFamily service was used by those who had previously been beyond the reach of help.

CONCLUSION

While previous family support projects have differed in focus[9–11], they have all aimed to build on the existing resources of families within an integrated health and social care system. Although the WellFamily Project is small, by examining patients' experiences in depth we have been able to identify what they found most helpful in a way that could inform future initiatives. The difficulties of bridging the gap between health and social care[12] reflect the differences in culture, philosophy and approach between social and health practitioners. Social workers who have had contact with the WellFamily Project referred to their frustration with the constraints under which they worked. They coveted the family support coordinator's freedom from statutory obligations and her ability to offer emotional support without the conflict inherent in the rationing decisions they were expected to make. Although social workers had no protected time for preventive work, they recognized this was a valid role.

The Department of Health recognizes, through deprivation payments, the additional work faced by practices in areas of social deprivation, but unless there is a mechanism for providing services to address those needs, patients will not benefit. The WellFamily Project has provided us with such a tool and is now as integral to our practice as is the nursing team. Whether the success of our project should be attributed to the worker herself or to the new role we have

created is crucial to replicability. In an attempt to answer this the National Primary Care Research Centre in Manchester has been commissioned to evaluate the cost effectiveness and replicability of our project along with four more WellFamily projects which are now being piloted.

There are other approaches that could be adopted—for instance, extension of health visitor roles or enhancement of social work input in primary care settings. What is clear is that commitment, training, teamwork and protected time are needed if services are to meet families' needs. Our findings endorse the suggestion of the consultation paper[13] that health visitors are well placed to take on an enhanced family support role, and show the importance of location within an accessible, non-stigmatizing, practice environment. The work is highly skilled and time-consuming but reaches families who are often excluded from services by poverty, lack of education and lack of confidence. If we are to address the inequalities highlighted in the Acheson Report[14] and make headway towards the targets in *Our Healthier Nation*[15], those who control the purse strings will need to believe in the importance of tackling the social agenda. This challenge should be taken up by primary care groups.

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