Implementing groupwork in primary care to meet client need

HEALTH visitors in Hertsmere, South West Hertfordshire, have been encouraged to modernise their role by working in groups with families, individuals and communities to tackle inequalities and improve health. They aim constantly to evaluate all the groups being run, in order to meet local community needs.

Working in groups is in line with the vision of the government’s white paper The New NHS: Modern, Dependable (Department of Health, 1997), which emphasises the importance of a primary care, bottom-up, developmental approach, with clinicians in the driving seat. This message has been reinforced in subsequent documents, such as Saving Lives: our healthier nation (Department of Health, 1999a); The NHS Plan (Department of Health, 2000) and Shifting the Balance of Power (Department of Health, 2001a). A recent publication Liberating the Talents (Department of Health, 2002), provides a framework for planning and delivering nursing and health visiting services in primary care.

All these documents indicate the need for health professionals to develop and improve their skills and knowledge. Modern health visitors have a family–centred public health focus, and this enables them to tackle today’s complex health challenges, which include a growing population of older people and children living in poverty. The need to develop accessible services, delivered to a high standard, is constantly emphasised.

In Hertsmere, we are striving to work in new ways, crossing traditional boundaries with a range of other professionals, voluntary workers and the public to deliver health improvement programmes. Much of this work has been achieved by setting up groups.

Some characteristics of groups

Some groups form naturally for support or a common purpose, while others are set up to deliver health-targeted messages in an innovative way.

Groups enable service delivery to be flexible, and take into account differing client needs. They can be held as one-off targeted sessions or be part of a course. Group sessions may be open for anyone to join, or a group can have a closed or targeted membership. Ongoing sessions can run continuously and have a changing membership.

Professionals and clients, however, will view the purpose of a group from different perspectives, making ongoing evaluation essential (Douglas, 2000). Box 1 lists some of the points to consider when starting a group.

Advantages of groupwork

Groupwork is cost- and time-effective because it enables a large number of clients to be seen in a short time. It is also a useful way of identifying those who require extra support, helping to ensure that they are followed up as necessary. Talking to people in groups is an effective way of delivering topical information, and this can be elaborated on with balanced discussion in a variety of settings. Yet a further advantage of bringing people together in groups is that membership is a means of reducing social isolation, leading to empowerment and improvement in mental well-being (Pitts, 1995).

In terms of professional benefits, multidisciplinary teamwork can offer a wider perspective on a situation, and facilitates the provision of enhanced services by drawing on the wide range of skills, knowledge and training of different professionals.

Once a good working format has been achieved this can be applied to other topics and in other settings. Groupwork is also an effective means of meeting national service framework targets. In Hertsmere we have had success in a range of areas (Box 2).

Disadvantages of groupwork

Where there are problems with staff recruitment and retention, it may be difficult to run regular groups. It can be difficult to tailor a group’s work to clients’ preferred hours, such as evenings or weekends, as staff tend to work 9am–5pm each day.

Recruiting members to a group may be difficult, particularly if there are language and literacy difficulties among the target client group. Personal invitation and word of mouth can work well but these are labour intensive, and it may prove difficult to reach clients who do not usually access services. Securing finance to run a group may pose a problem (money may be required for phone calls, mailings or to support client visits).

**Box 1. Points to consider when starting a group**

- Who is your target audience?
- What is the aim of your group?
- How will you contact members?
- Do you need childcare provision?
- How will you evaluate it?
- Where will you hold the group sessions?
- When will the group sessions be held?
- When do you plan to start?
- Do you need additional resources?
- Where can you access funding?
- Can you ‘piggyback’ onto an existing group?
- Where will the group sessions be held?
- Do you need additional resources?
- Where can you access funding?
- Can you ‘piggyback’ onto an existing group?
Anyone considering the option of groupwork should be aware that both staff and clients may be reluctant to participate. Staff may be unwilling because of lack of confidence that they have the necessary skills, while clients may feel threatened being in a large group. Clients in a parenting group, for example, who do not fully understand the purpose of the group may be unwilling to take part as they may perceive that they are being labelled as bad parents.

Further impediments to client participation may be a perceived lack of privacy in large groups, and limited time for personal discussion. Lack of childcare provision can also be an obstacle to participation, as can problems with the availability of a suitable venue or equipment.

Groups in Hertsmere

The homeless families hostel group

Clients in homeless family hostels often have difficulties accessing mainstream services because of the isolated location and the turmoil of their lives. A weekly drop-in group at the hostel has provided stability and a regular point of contact. In addition, clients are offered access to baby clinic facilities and antenatal sessions, as well as to short courses on topics such as parenting and first aid.

The experienced health visitor running this group has learnt to adapt sessions and respond to needs as and when required. (It is not unusual for her to arrive with a planned session only to be met with a completely different group.)

Many hostel residents are initially suspicious of the group and may need to be coaxed into coming to the communal room – some will prefer to have an individual visit for a few weeks until their confidence has grown. Professionals such as librarians and environmental health staff also join some sessions.

Referrals to the ‘exercise on prescription’ scheme are high, as is the use of the ‘Hertcard’, which enables residents on low incomes to use leisure facilities at greatly reduced prices, for example 25p for a swimming session.

The examples of groupwork in action in Box 3 illustrate how it has benefited a range of client groups.

English as a second language group (ESOL)

In Borehamwood, one of the areas where we work, there are a growing number of minority ethnic families with English as a second language. To make health care accessible to this group, the health visitor, in partnership with the local adult education college, designed a course to help parents to learn English and, at the same time, tackle their health needs. They were offered a certificate for the course and a parenting course. The new Shareplus parenting course, designed for use in situations where literacy might be an issue, was found to be an ideal resource. Each session stands alone, and many are predominantly visually based, such as the home safety ‘spot the difference’ quiz.

Baby clinic facilities and developmental checks are offered to those taking the course so that parents have an opportunity to share their concerns. A creche is provided, enabling parents to focus on their learning. Attendance has been excellent, and the number who wish to attend is growing. Funding for this group comes from the local adult education college and uses existing community staff.

The weaning group

A weaning group was started 16 years ago. We now have a group session once a month, with dates planned in advance for a year. Clients are reminded of the dates at immunisation appointments and baby clinic sessions, and encouraged to attend. Attendance has been good over the years and the talk on weaning has become part of the routine package of care, which includes six-week and eight-month checks.

The group session covers other important topics, such as dental health, introducing the use of a cup; safety in the home, food hygiene, and healthy eating for the whole family so as to reduce the risk of coronary heart disease and diabetes, based on the principles outlined in the national service frameworks.

The importance of exercise is highlighted, and a free swimming voucher is offered. The weaning group session provides a good opportunity to arrange a follow-up visit for clients needing a reassessment for postnatal depression using the Edinburgh Postnatal Depression Scale (Cox et al, 1997).

Postnatal groups

Postnatal groups are run throughout Hertsmere. Many of them are ongoing and are open to parents with babies under the age of six months. There is a rolling programme of talks, making it easy for parents to slot in at any time. Families benefit from support in the first few months of their babies’ lives and a postnatal group has the advantage of providing peer support.

Verbal feedback from members has repeatedly shown that parents value this support; in fact, many women continue to meet up to 15 years after they first attended the group.

All parents are invited by the health visitor to attend the local postnatal group at their initial new-birth visit. The programme is client-led and reviewed and changed on a regular basis to meet needs. Regular topics include baby massage, play, relationships and sexual health, and parenting and behavioural issues.
**Postnatal depression group**

A specific group has been set up for women with postnatal depression. We call it the Health and Harmony. Out of the Blue group. The women are identified as being depressed either through discussion after completion of the Edinburgh Postnatal Depression Scale or through referral from a health visitor or GP. Many of the women may already have received extra supportive listening visits.

The emphasis of this group is totally on the mother. It is held either at the local clinic or at the local sports centre. Creche facilities are provided to enable the women to participate fully. The course introduces a range of coping mechanisms. For example, to help the women feel good about themselves and to increase their self-esteem, the occupational therapist from the local community mental health team provides a relaxation session, and the women are offered taster sessions in reiki, reflexology, the Alexander technique and hand massage. A postnatal aerobics instructor runs a session on exercise. Many of the women are referred to the ‘exercise on prescription’ scheme and have taken this up.

The Herts Alcohol Advisory project provides non-alcoholic punches at the meetings and discusses the dangers of alcohol misuse. A healthy diet is encouraged by having platters of fresh fruit available during the session, and by incorporating the message of the national service framework targets for coronary heart disease and diabetes in the discussion. There is also time for the women to discuss with the health visitors how they could apply some of the coping mechanisms in their daily life.

The postnatal group helps to improve the mental well-being not only of the mother but also of the whole family in line with the targets of the National Service Framework for Mental Health (DoH, 1999c). Research shows that postnatal depression affects infant-mother relationships (Murray and Stein, 1989) and we want to do all we can to prevent this.

Funding for the group was obtained from the single regeneration budget of the East of England Development Agency. The money is provided for areas of deprivation as a means of improving the lives of residents, to offer education opportunities, and to initiate new projects. Evaluation of the group has been positive.

**Parents of children with special needs group**

This group was set up 10 years ago. Initially there were six parents but the group quickly grew in number and power. Within a year, in partnership with the statutory and voluntary sectors, a play scheme was set up to offer respite care for children and their siblings.

The group is now self-facilitating, has obtained charitable status and is a strong pressure group in Hertsmere. It has actively participated in a joint strategy between Children, Schools and Families (Hertsmere Social Services) and health services for children with disabilities. Its members have input in the parenting subgroup of the local council and parenting courses have been incorporated into play schemes at the request of parents.

**REFERENCES**


**BOX 3. HOW GROUPWORK HAS HELPED A RANGE OF CLIENT GROUPS**

**Groupwork at the homeless families hostel**

A session was set up at the hostel and facilitated by a health professional, while one of the young mothers at the hostel led the group. Her partner, a lorry driver, arrived at 2pm and joined in. His presence encouraged a couple of unemployed young fathers to attend with their partners. A Bangladeshi family hovered at the doorway, waiting for their baby to be weighed, but were soon welcomed, and joined in.

For the session, the parents were asked to bring their child’s favourite toy and to talk about their own favourite toy. This led to a discussion about their own childhood experiences, their expectations of their children and new play ideas.

Most parents had experienced vigorous physical punishment as children, and had limited experience of play with their own parents. For example, when the librarian ran a story-time session, the parents considered for the first time the value of this experience and were keen to join the library and repeat it for their children. We were able to discuss alternative and effective methods of discipline, using role-play scenarios. More importantly, the parents were able to identify potential danger zones and consider how to avoid them.

It was interesting to observe that at times the adults in the group acted like naughty children. The experienced facilitator was able to maintain her professional boundaries and gained the group’s respect – she was able to both meet the members’ needs and allow them to express challenging behaviours.

Verbal feedback from the group rated the opportunity to ‘say what you think, and be accepted, not to be judged or looked down on’ as extremely important. The success of this group resulted in the setting up of another session on how to talk to health professionals.

**The English as a second language group**

Clients were offered the opportunity to attend a course and attain a certificated first-aid qualification. This included information on how to access the doctor’s surgery, common health complaints and when to call the doctor.

A further initiative was a healthy eating session. Each family brought a favourite national food item. The foods were placed in a circle to show food groups. The facilitators also provided food to taste and try. The women were proud to share their favourite foods and to learn from each other. By taking part in the group, the women gained confidence and have become empowered in accessing services.
Stand-alone topical groups
We are keen to support national and international health promotion campaigns such as Child Accident Prevention Week, the ‘Slip, Slap, Slop’ sun safety campaign (slip on a shirt, slap on a hat, slop on the sunscreen), the Alice in Blunderland home safety campaign, as well as initiatives on road safety such as car-seat checks, fire safety – which included a chip-pan fire demonstration – and personal safety sessions with the police.

We also respond quickly to media information on issues such as food safety scares, concerns over the measles mumps rubella immunisation, and drugs and alcohol misuse, by offering one-off group discussions to provide clear, concise information.

Parenting groups
Hertsmere launched a ‘Childwise’ campaign to encourage parents to attend parenting courses. A postcard and leaflet containing information about the range of these courses is sent to every child attending a clinic appointment and this literature is widely available in the community.

This campaign is in partnership with fellow stakeholders, Children, Schools and Families, and Borehamwood Community Partnership.

The aim of the campaign is to destigmatise the term ‘parenting, because many parents feel that by attending a parenting course they are admitting to having problems – some confuse the courses with parenting orders. We would like all parents to attend a parenting course as a matter of routine.

Some of the courses piggyback onto an existing group of parents, for example those in the hostel for the homeless, and in schools, while some link into existing work with other professionals such as the ESOL group, young mothers or travellers.

Groups may also be formed at the request of parents; for example, parents of children with attention deficit hyperactivity disorder asked for a specific group, as they felt the behaviour of their children was too extreme for a routine parenting group.

Action for Older Residents Group
This group was set up in 2002 by the Community Advocacy Project, with support from the single regeneration budget. A health visitor became involved with the group after attending sessions to discuss topics such as healthy eating, keeping well and warm, and preventing falls. Many topics from the National Service Framework for Older People (DoH, 2001b) have now been incorporated into the sessions. A first-aid course is planned for members for the next school term.

Plans for the future
We are considering training health visitors to run a short course on baby massage to encourage parent-child engagement and to increase awareness and sensitivity to babies’ cues. At present, we offer one short session on baby massage, but we would like to incorporate the practical aspects of attachment theory by demonstrations on interpreting babies’ needs, and becoming in tune with the parent-child relationship (Acredolo and Goodwyn, 1996). Maternal depression and insensitive care-giving can result in insecure attachment which, in turn, can lead to emotional and behavioural problems in adolescence and adulthood. Such problems are significant in terms of public health, in that they perpetuate and sustain social inequalities. Acheson demonstrated the impact of this (DoH, 1998).

In response to the members of our teenage pregnancy prevention group identifying that many parents are embarrassed to talk to their children about sex, we recently obtained new material from the Family Caring Trust on parenting and sex. The health visitors and school nurses are willing to run the course, which we intend to offer to parents with children in year six. We will recruit parents by advertising in all local primary schools, direct mailing to parents, public participation forums and publicity in the local paper.

Homeless families have contacted us to ask whether we could run workshops for parents of teenagers to offer support and generate ideas on how to address difficult behaviour before a situation deteriorates and the child is expelled from school. School nurses have traditionally run courses for parents of teenagers – we hope to link with the Children, Schools and Families workers in the local secondary schools.

The Family Support Centre has set up a group for parents with children who attend Highscope, a small supportive group to improve social skills and behaviour, providing structured play opportunities. To engage the group, a Shareplus parenting course will be offered with taster sessions. The parents will be offered a personal invitation and encouraged to attend when dropping off their children.

There is evidence of the effectiveness of early parenting and family support interventions in the prevention of mental health problems. A preventive approach that focuses on all families and parents has the potential to make a significant impact on the total burden of disease compared with a preventive approach that focuses only on those families at increased risk of poor outcomes (Barlow, 2003).

Conclusion
Most of the groups discussed above use existing staff from a range of disciplines, therefore there is little financial implication. However, Hertsmere does not have many of the problems faced by our counterparts working in inner city areas, and we acknowledge that it would be more difficult for many health professionals to work in the way we do.

We feel that we are pioneering new ways of working with other health care professionals and voluntary workers across traditional boundaries and that we really are ‘working in new ways, across boundaries with other health care professionals and voluntary workers’ as specified in Making a Difference (DoH, 1999b).

USEFUL WEBSITES
International Association of Infant Massage: www.iaim.org.uk
Family Caring Trust: www.familycaring.co.uk
Community Education Development Centre: www.cedc.org.uk
Parentlineplus: www.parentlineplus.org.uk
Department of Health: www.doh.gov.uk
Community Practitioners and Health Visitors Association: www.amicus-cphva.org
Hertsmere Primary Care Trust: www.hertsmere-pct.nhs.uk

For related articles on this subject and links to relevant websites see www.nursingtimes.net