Relative support groups

IT is well-known that the statutory and voluntary services (with the exception of the home-help service) play little part in supporting the elderly in the community[1] and that confused elderly people are cared for mainly by their relatives at home. The caring relatives are often isolated and under stress; adequate and appropriate support must be provided for them if the care of the elderly in the community is to be improved.[2] In this issue of the *Journal* there is a discussion of developments in the field of community health which highlights the emergence of community health initiatives. These may be particularly valuable for the carers of disabled and confused older people. Groups providing support for relatives of the elderly are useful and their formation is to be encouraged.

These 'relative support groups' usefully have at least one professional in attendance. The professionals involved may include general practitioners, social workers, nurses, occupational therapists and psychiatrists. They are able to give some input to the group, but are also able to perceive the reactions and stresses of the various carers. Relative support groups have some of the elements of self-help groups. Individuals can benefit from the sharing of experiences, with members offering each other empathetic support and advice. Practical support and counselling from a fellow sufferer has great value.[3] Some relative support groups are set up by voluntary organizations or charities, such as the Alzheimer's Disease Society, but others may be organized by social services or health districts. Too few groups currently exist, however, and too little is known about them and the value of their work.

The kinds of problems discussed by the relatives may be related to the behaviour of the confused elderly person, for example wandering, incontinence, or aggressive behaviour. There may, however, be problems that are related to the carers themselves, such as physical infirmities, feelings of isolation, and feelings of frustration centred on missed career opportunities, or there may be practical matters to discuss, such as accommodation and finance. Many relatives are concerned about long-term care; it is common for carers to suffer feelings of guilt and inadequacy about allowing their loved ones to enter residential care. Some people will talk at length about the former life of their confused elderly relative, almost as if he or she were already dead; the term 'living bereavement' has been used to describe this state.

Relative support groups deal with the problems of carers by considering each difficulty and offering some type of solution. The help may involve practical advice from those who have had similar experiences, for example coping with shopping, or bathing difficulties. However, a large component of the help is the mutual recognition that feelings of frustration, anxiety about institutional care and concern about bereavement are shared by many members of the group.

Professional workers within the relative support group act as facilitators or counsellors, and should try to help the group find its own solutions to the problems raised. The professionals involved gain much from the group, particularly in their understanding of the problems and needs of the carers of confused elderly people. We are still a long way from finding a biological solution to dementia. The urgent needs remain the provision of adequate services for the elderly and the active support of their caring families.[4] Regular meetings of the caring relatives seem to have many advantages, both for the relatives and for the professionals involved.

Relative support groups are one example of community health initiatives which are self-help groups, community health groups, or community development health projects. The inclusion of professional workers within relative support groups, which would otherwise be self-help groups, helps break the traditional barrier between the expert professional view and the suffering patient or caring relative. Consideration of social systems alongside health experiences and the role of the voluntary sector is particularly useful for the primary health care team.

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The third national study of morbidity statistics from general practice

IT is impossible to make rational decisions concerning the allocation of resources within health care services without good information about patterns of health needs. Need is notoriously difficult to define and measure. There may be differences between medical and sociological concepts of need and even more problems emerge when attempting to give priorities to different health needs. This challenges us to produce the most comprehensive and objective assessment of need possible. Information about resource allocation, and by implication about health need, can be gained from morbidity surveys. These surveys can be based on total populations, as in the General Household Survey, on hospital patients, as in the Hospital Inpatient Enquiry, or on consultations in general practice. The organization of family care in the United Kingdom is particularly useful in providing information on morbidity patterns because the list system provides a denominator which permits the calculation of prevalence rates of illnesses and health problems.

The preliminary results from the third morbidity survey in general practice which was carried out in 1981 are published in the *Office of Population Censuses and Surveys (OPCS) Monitor* and are distributed with this issue of the *Journal.*† Like its predecessor (the second national morbidity survey), this third

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