*More social work for general practice?**

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The handful of doctors and social workers who are establishing methods of collaborating is growing slowly. The Seebohm Report (1968) regarded teamwork between general practitioners and the social services as vital, and recommended that social services should make a determined effort to collaborate with general practitioners.

Social work in general practice dates back to 1948. It grew up in university departments of general practice and in a number of highly motivated service practices (Paterson, 1949; Scott, 1949; Backett *et al.*, 1957). Several enthusiastic reports of these experimental schemes have been published and all point to the value of these forms of joint working (Forman and Fairbairn, 1968; Goldberg *et al.*, 1968; Ratoff and Pearson, 1970). On the other hand, studies of unselected general practitioners show that the majority are indifferent to social work and have little idea of the professional ability and area of competence of trained social workers (McCullock and Brown, 1970).

The Social Work Act, Scotland of 1968 and the Local Authority Social Services Act of 1970 led to the establishment of social services departments. In Scotland they are called social work departments and incorporate the probation and aftercare services. Each department is headed by a director and the larger departments may have several assistant directors.

Social workers are divided into a varying number of area teams consisting of a team leader, one or more senior social workers, and differing numbers of basic grade social workers, with welfare assistants and supporting secretarial and administrative staff. It was the intention of the Seebohm Committee that area teams should be adequately housed within the districts they serve and be easily accessible to their clients. Decentralisation is being attempted, but is inhibited by shortage of adequate building sites and scarcity of money.

Social services departments vary immensely in size and complexity. They range from huge monolithic organisations in large cities, employing hundreds of social workers, down to small rural authorities employing less than ten. This leads to great variation in the methods of liaison with general practitioners. The re-organisation of both the National Health Service and local government, which are due to occur in 1974 and 1975 will affect the future. Some directors of social services are unwilling to contemplate the attachment of social workers to general practices until these administrative changes have been completed.

A postal survey of all departments of social services which I carried out with two colleagues in 1972 has shown only marginal improvement in the field of social work and general practitioner collaboration since the implementation of the Seebohm Report (Ratoff *et al.*, 1973).

Over half the social services departments have no medical attachment of any kind: (115 out of 225 departments, 51 per cent), but there are now eight social workers from local authority social services departments attached full time to doctors working in health centres and group practices, and a total of 82 social workers in varying forms of part-time attachments to general practices. If we look at the general-practice attachments another way, regarding ten part-time sessions as the whole-time equivalent of one social worker) then only the equivalent of 16·9 social workers are attached to general practices in Great Britain representing between 0·1 per cent and 0·2 per cent of the social worker force of 11,793. About 47 (or 20·9 per cent) of the social services departments have been unable to meet requests from general practices for a social worker attachment.

Methods

The purpose of this study, in the light of the findings of the postal questionnaire, was to find out how the existing social work/general-practice liaison schemes were functioning. I made an intensive study of selected authorities and contrasted these with authorities lacking any liaison arrangements.

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Full-time involvement in general practice made it impossible to visit a representative sample of social services departments throughout Great Britain. Thus, my sample was not random, being based on two criteria: the presence of social work/general practice liaison schemes and nearness to my home. I visited 27 departments, 13 of which had liaison schemes and 14 did not. The study was carried out sporadically between June and October 1972, while two weeks in July were devoted to intensive visiting in Scotland and southern England.

TABLE

DISTRIBUTION OF AUTHORITIES VISITED

Grouping	*Total number in group*	*Authorities with liaison schemes**	*Authorities without liaison schemes**
London boroughs	32	2	2
English counties	45	3	1
English boroughs	79	5	5
Welsh counties	13	0	2
Welsh boroughs	4	0	0
Scottish counties	28	2	1
Scottish boroughs	24	1	3
		13	14
TOTALS	225	27	

* Details of existing liaison schemes on 1 April, 1972 obtained from a postal questionnaire.

The table shows the distribution of social services departments visited and the marked emphasis on Northern and Western authorities.

I spoke to directors and assistant directors, to area team leaders and social workers working in the field. I was able to speak to trainees and social work students. Wherever I went I was very well received, all authorities going out of their way to be helpful despite the fact that I sometimes arrived with a minimum of warning. The need for the study was readily acknowledged by all the workers I met.

Findings

(1) *The attachment of social workers to general practice*

Implicit in any attachment scheme is a commitment for joint and continuing care of a defined practice population. Attachment may be full-time or part-time, but in either case the social worker assumes full responsibility for the initial assessment of all patients referred from the practice and she is available to work directly with them. Naturally, she may enlist the help of specialist colleagues or refer patients to appropriate helping agencies.

Most social workers agreed that the functions of the attached social worker in general practice can be summarised as:

(a) social assessment and evaluation—a diagnostic service.
(b) casework—a therapeutic service.
(c) resource mobilisation, provision of services and referral—a liaison service.
(d) educational work, with patients, students and colleagues.

The first three functions are well documented, but the educational role of the social worker has not received much emphasis. Vocational trainees and undergraduate medical students are increasingly attached to general practices working with social workers. Some of our future doctors will therefore have an insight into the role of the social worker and the social services.

Established practitioners themselves may well derive an educational benefit. Nowhere was these educational aspects explicitly mentioned although their results were obvious to the observer.

I visited a number of existing attachment schemes and was struck by their great diversity. Many were carried over from the old health department days, and the greatest emphasis was on mental health attachments. In some of these schemes, as in one Midland city, psychiatric social workers (PSW) had been attached to group practices to provide a specific social work service to psychiatric patients. In a small number of cases the psychiatric social worker saw herself as a psychotherapist, while in yet others the PSW had to resist the tendency of the general practitioners to use her as a consultant psychiatrist.

The lack of a theoretical framework or basic philosophy governing the attachments was strikingly underlined by the very few authorities where such a conceptual approach did exist as in a small county town,

> " The social worker attachments are to six group practices. The liaison and the links with the local authority health service district nurses, midwives and health visitors, are the result of a planned programme of prevention (originally in the mental health department) based on the theories of Professor Caplan (1969). Since amalgamation this has been widened to include the preventive aspects of child and family care also ".

In another northern city the arrangements were different. Social workers were deployed in a ' patch system ', which enabled the social worker to identify strongly with the population for which she was responsible. This was a department which had an excellent pre-Seebohm record for co-operation with general practitioners. In both these authorities departmental morale was high and the enthusiasm of the social workers for the attachment schemes was apparent.

In contrast, I visited departments where the opposite was the case—where the attachments had been made arbitrarily. In one authority the area leader had been told to arrange an attachment by the director of social services, who happened to be a patient of an interested, but not fully informed, general practitioner. This arrangement was manifestly not a success if judged by the report of the attached social worker:

> " The experiment so far has not produced benefits proportional to the amount of time spent on it. The cases which most concerned the practice were those with which the department is least able to cope, and the doctors have become more enlightened but very disillusioned. My role is an embarrassing one as I have constantly to apologise for lack of action ".

Probably a model for future attachments is seen in a new health centre in Scotland where a social worker from the local area team is attached full-time to one moderately large group practice. She has her own office and secretarial help within the building and does all the social work associated with the practice, while at the same time being a full member of her area team. She is enthusiastic about the arrangement and explained that she is able to carry out the whole range of her functions for the practice but still has the support of her colleagues in the area team, with whom she shares stand-by duty rotas. The only embarrassment in her case is the fact that she is unable to take referrals from other practices in the health centre, who are as yet without an attached social worker and who have to refer to the area team for social work needs.

In another full-time attachment scheme in a London Borough the social worker was so closely identified with the general practitioners that she experienced problems with her colleagues, who seemed resentful of her opportunity to accept referrals from the doctors without participating in the area's own allocation procedure. The social worker recognised this as a disruptive tendency which would need immediate and careful attention.

(2) *Other methods of inter-professional collaboration*

The employment of a *Liaison Social Worker* is another important method of joint collaboration. Here a social worker from the department makes regular contact with the practice but does not necessarily accept direct responsibility for all cases referred for social work help. She provides close links between the practice team and the patient, on the one hand, and the social services department on the other.

This arrangement works best where populations are scattered, the number of cases referred

by the doctors likely to be few, and the social services department small. These conditions occur in rural areas.

I found this form of co-operation well established in a small county authority (population 45,000) which employed only 15 social workers. The liaison worker was trained in medical social work. She visited the practice weekly, discussed all cases referred by the general practitioners and health visitors, and assigned suitable workers. If a case was already known to the department, the worker involved would continue working with the client. Alternatively, the case would be allocated to a specialist social worker. Sometimes the liaison worker herself accepted the case.

The advantage of the liaison scheme may be summarised as follows:

(a) one identifiable social worker is familiar to the practice and is usually available in emergency,
(b) all the resources of the social services department are still available to the practice,
(c) the liaison worker provides a trusted channel for information in both directions,
(d) she acts as a consultant to the practice and may be available to advise about the management of problems without needing to see the patients themselves,
(e) she interprets to the social services department the needs and actions of the doctors and acts as a consultant to her colleagues when specific medicosocial aspects appear in their own work.

Good communication and mutual trust between doctors and social workers is essential for the successful operation of these liaison arrangements.

Some authorities think that close proximity of services will help closer liaison. I have called this relationship ' association '. In some areas there are plans to build the local social services departments close to or beside health centres. In others the health centre accommodates the offices of the area team in the same building. I visited some centres where social services and general practitioners worked from the same building and I found that physical proximity of social work agencies and general practitioners did not guarantee that close working relationships would develop. In fact, hostilities and antagonisms can be perpetuated in the most ideal settings.

In one health centre where the social workers and general practitioners shared a pleasant common room, the assistant director confided that in any future health centre in the county he hoped the social workers would have a common room of their own, separate from the doctors. A doctor practising in the same health centre mentioned the importance of "preventing the social workers' empire from getting too big ".

These three methods; attachment, liaison and association, represent the current form of interprofessional co-operation, but other ideas are being discussed. The idea of ' rotating attachments ' is familiar to any hospital doctor. The social workers as members of a social services department would be seconded on a regular basis; say two years at a time, to work in hospitals, child guidance clinics, health centres, or other community agencies. Finally, Goldberg and Neill (1972) in their recent book, advanced the interesting idea of ' time limited attachments ' of social worker to general practice.

> " By the end of the attachment the local social services area office and other agencies would have worked out appropriate methods of collaboration which may render a specific attachment of a social worker to a general practice unnecessary ".

It must be obvious that field experimentation in interdisciplinary collaboration remains open for further exploration.

Social work and the primary care team

Increasingly general practitioners are working in multidisciplinary teams based on purpose-built health centres. It is with these primary care teams that the social worker often collaborates.

The association between the growing health-centre movement and the attachment of social workers to general practice is striking. The postal questionnaire did not ask for specific information on this subject but the comments of the directors showed that in at least 34 local authorities (nine in Scotland and 25 in England and Wales), existing health centres already had some sort of collaboration with the social services. In 38 authorities (20 in Scotland and 18

in England and Wales) the directors indicated that health centres being built or planned would have some provision for social work.

The relatively superior position of Scotland in the health centre programme becomes more apparent from these figures particularly when one realises that the population of Scotland is approximately one tenth that of England and Wales. These figures are in no way authoritative, but they indicate a trend.

In some health centres a liaison social worker attends regularly to pick up referrals, and uses a doctor's surgery to interview a client. In others, the social worker is fully integrated into the practice team and may share a purpose-built centre with the general practitioners. In some cases whole teams of social workers are accommodated in the health centre.

I found a wide range of attitudes on the part of social workers towards health visitors. In one town a social worker claimed that, " relations between health visitors and social workers could not be worse ". In others there were good working arrangements, free from tension. An interesting trend was noticed in the correspondence with some directors who saw the health visitor as an intermediary between the social worker and the general practitioner. Several mentioned the possibility of the social worker visiting the health visitor to receive referrals from the general practitioner.

I met several instances of gross confusion of the health visitor's role. When discussing social workers with one general practitioner he told me that he had a " very nice lady " who visited him daily and saved him quite a bit of work. Further discussion elucidated the fact that he was referring to a health visitor and that he did not know what a social worker was. He had not heard of Seebohm (this in 1972!) and knew nothing of the social services department. When pressed further he did recollect that " the lady almoner " in the local hospital was a social worker.

On another occasion, I was speaking to a duty social worker in a London area office when she mentioned she had met a social worker attached to a general practice when visiting the surgery. A letter to the general practitioner revealed that he had a health visitor attached but no social worker.

There is a general lack of awareness on the part of social workers of the true role of health visitors. When the two professions meet in general practice there needs to be a considerable amount of mutual education if role confusion is to be avoided.

Where interdisciplinary teams (containing general practitioners, nurses, social workers and health visitors), were working well there was little real evidence of role conflict. Discussion revealed that these teams were less aware of their professional training or the formal labels attached to the particular worker, but rather developed an awareness and understanding of the particular colleague's skills and capabilities. It was these perceptions that governed referrals rather than the formal designated role of the team member.

These perceptual factors came vividly to light when one individual member of the team left and was replaced by a colleague. The dynamics of the new group were dramatically altered and a change in the patterns of referral were instantly discernible. This had happened in a small number of groups, and each time the workers have switched their referrals to different team members selected as the most appropriate in the new situation.

Discussion

My visits showed that both in urban and rural areas, the ' top management ' was housed in prestigeous accommodation, often in the existing county hall or municipal building. On the other hand, it was not easy to find suitable buildings for the new area teams (where nearly all the social work is carried out). Often these were housed temporarily in ill-equipped buildings, converted schools or remand homes, which were quite unsuited for their purpose. I visited an area office in a church hall which lacked interviewing facilities for clients; the only private room belonged to the team leader, and clients were interviewed in the entrance hall. Another office was outside the area it served, hidden several floors above the local registrar of births and deaths and without adequate signposts. It was a bus ride away from the people it served. In some cases new area offices were under construction and all teams looked forward to better accommodation in the future.

I found that when social workers and general practitioners are already working closely

together there are few misconceptions about each others roles. Where there was no such professional contact a whole range of attitudes was observed.

Social work is a young profession and compared with medicine is still in its adolescence. Indeed, adolescent conflict was frequently observed and remarks such as " we call psychotherapy casework so as not to annoy the doctors " was significant. Some young social workers chose to dress flamboyantly.

Many of the social workers I spoke to were frankly sceptical about the professional competence of the general practitioners with whom they worked. In particular, they were scathing about their deficiencies in the mental health field. I heard innumerable ' horror stories ' about professional incompetence but no doubt had I interviewed an equivalent number of general practitioners, I would have heard similar stories about social workers.

A director of one of the London boroughs put the problem in a nutshell when he said:

> " Present problems seem to do with feelings of professional rivalry between social workers and doctors and at times mutual misunderstanding of each others roles and capabilities."

The most consistent and uniform complaint voiced by social workers was the general practitioners' ignorance of the social worker's role. This has been systematically explored by Harwin and his colleagues and their findings were amply confirmed by a variety of remarks which may be summarised as " general practitioners just don't know what sort of animal we are ".

General practitioners were seen to have little understanding of the functions of the social services departments themselves and little knowledge of their statutory duties, which extend far beyond the confines of medicosocial collaboration. At the other end of the spectrum, one found older social workers often from the old welfare departments, whose attitudes towards doctors were those of extreme deference.

However, doctors may not have contact with social workers, social workers, both as patients and in their professional capacities, inevitably have some personal experience of doctors. They, therefore, have an idea of the general practitioner's role, though it may not be a realistic one.

Marriage analogy

Successful co-operation between social workers and general practitioners and social workers and other health workers does not just happen. Strong motivation, goodwill and preparation are all essential. In the most successful schemes there has been a logical evolution analagous to the phases of courtship, engagement and marriage between young lovers.

Tracing the earliest development of these schemes one finds that often they arise from the chance informal meeting of one social worker and one general practitioner. Having met, there is a period of further meetings for discussion and mutual appraisal. Next, comes a commitment to work together, during which time material details are discussed and practical arrangements made. Finally, the marriage takes place, the social worker and general practitioner start working together. As in real life, some marriages work well, while others break down. Frequently there are initial difficulties of mutual adaption at the beginning of the experiment, but given goodwill these can mainly be overcome by frank discussion between the parties.

Importance of training

Professional attitudes are implanted early in one's training and if a long-term view is to be taken of this problem then serious consideration will have to be given to finding methods whereby medical students and students of social work, nursing and other related disciplines can meet together at an undergraduate level so that they may learn something of the professional skills and area of competence of their respective professions. I believe the teaching general practice is the ideal setting for this type of educational experience. Students of all disciplines should qualify with some knowledge of the roles and functions of the professions with whom they will be co-operating for the rest of their professional lives.

At a more practical level, when interdisciplinary co-operation is mooted, (and this particularly applies to the planning stages of new health centres) it is vital that social workers and

doctors should spend a considerable amount of time clarifying their various roles and expectations.

The Council of the Royal College of General Practitioners has urged its faculties to start various forms of meetings between general practitioners, social workers, health visitors and nurses. The responses of the faculties have varied from a single evening meeting to the remarkable interdisciplinary residential course held at Cumberland Lodge, Windsor (Bennett *et al.*, 1972).

From these and other meetings have grown several interdisciplinary workshops where the professions meet to discuss mutual problems. Two such groups exist in London, one growing out of the Windsor meeting, and another associated with the Tavistock Clinic. In the second group a consultant psychiatrist holds weekly seminars at which six or more professions are represented. It is hoped that a paper about their work will appear soon (Brook, 1973). In Manchester a similar interprofessional workshop has been established, based on Darbishire House. These are small but promising beginnings to a movement which will have to increase in size and importance if the present unsatisfactory situation is to be changed.

Conclusion and recommendations

The title of this paper poses the question, *More Social Work for General Practice?* The study has demonstrated that the trend for interdisciplinary collaboration between social workers and general practitioners is growing and there is every reason to encourage it. The accelerating health-centre movement, the re-organisation of the National Health Service and of local government are all factors which will enhance this growth.

However, such progress is likely to be jeopardised by the known conservatism of large numbers of today's family doctors. There is an overriding need for mutual education and change in attitudes. It is particularly important for doctors to understand the roles and functions of the social worker and the social services department. This kind of understanding can only be achieved by face to face contact.

The dialogue must start now if the opportunity is not to be lost.

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REFERENCES

Backett, E. M., Maybin, R. P. & Dudgeon, Y. (1957). *Lancet*, **1**, 37–40.
Bennett, P., Dewar, A. & Dick, A. (1972). *Journal of the Royal College of General Practitioners*, **22**, 603–609.
Brook, A. (1973). Personal communication.
Caplan, G. (1969). *An approach to community mental health.* London: Tavistock Publications.
Forman, J. A. S. & Fairbairn, E. M. (1968). *Social casework in general practice.* London: Oxford University Press.
Goldberg, E. M., Neill, J., Speak, B. M. & Faulkner, H. C. (1968). *Lancet*, **2**, 552–555.
Goldberg, E. M. & Neill, J. (1972). *Social work in general practice.* London: Allen & Unwin.
Harwin, B. G., Cooper, B., Eastwood, M. R. & Goldberg, D. P. Z. (1970). *Lancet*, **2**, 559–561.
McCulloch, J. W. & Brown, M. J. (1970. *Medical Social Worker*, **22**, 300–309.
Paterson, J. (1949). *The Almoner*, **1**, 230–233.
Ratoff, L. & Pearson, B. (1970). *British Medical Journal*, **2**, 475–477.
Ratoff, L., Cooper, B. & Rockett, D' (1973). *British Medical Journal*, Suppl. **2**, 51–53.
Scott, R. (1949). *The Almoner*, **1**, 209–214.
Seebohm, F. (1968). *Report of the committee on the local authority and allied personal social services.* London: H.M.S.O.