The health of clients of a social service department

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SUMMARY. A survey was undertaken of the health problems and current medical care of new clients making contact with the Social Service Department of an outer London borough. The findings indicated that social-service clients represent a high-morbidity group of the population: 47 per cent of the survey sample showed evidence of major physical illness or disability, and 16 per cent of major mental illness. A sub-group was identified, corresponding to about 300 new clients annually, who suffered from serious ill-health or disability, but were at the time not under medical care.

These findings support the argument for closer liaison between medical and social services in the community and, in particular, for more social-worker attachments in general practice.

Introduction

Problems of illness and social welfare are often closely inter-linked in general practice. Clinical experience has been reflected in the findings of statistical surveys based on defined populations (Ciocco *et al.*, 1953; 1954). In the United Kingdom, studies of hospital and of general-practice patients alike have reported a high incidence of social problems (Pemberton, 1951; Jefferys, 1965). Follow-up studies have shown that many patients discharged from hospital quickly relapse in the face of adverse social conditions and inadequate after-care (Ferguson and McPhail, 1954).

Research findings have thus underlined the need for collaboration between doctors and social workers, whether in hospital or in the community (Department of Health and Social Security, 1974). The present structure of the services, however, does not serve to promote such collaboration; indeed, there are fears that the integration of medical and social care may be growing harder, rather than easier, to achieve. Since 1971, when local-authority social service departments were created by the amalgamation of pre-existing welfare, children's and mental health services, progress with medical liaison schemes has been slow (Ratoff *et al.*, 1973; 1974).

Aim

Most social work in Great Britain is now being undertaken with no medical cover, even of a nominal order. Our aim was to obtain information about the health of social service clients and about the medical care they receive, either in conjuction with, or independently of, the help given by social workers.

Method

As a small step in this direction, we have carried out a survey of new clients coming to the Social Service Department of one outer London borough. This study enquired into the

current physical and mental health of the clients, their recent contact with medical agencies, and the extent to which their social problems arose from, or were linked with, illness and disability. Special inquiry was made about recent consultations with general practitioners.

The sample

For practical reasons, the sample had to be restricted to one month's intake of new clients at each in turn of the six local area offices, the special section dealing with the physically disabled, and the special section dealing with psychiatric and mental-welfare problems. In this way, a representative sample for the department as a whole was built up over a period of eight months. Two research social workers organised and monitored the recording, which required the co-operation of about half the field social workers in the borough.

Questionnaire

A short questionnaire was completed by the social worker after first contact with each new client, the latter being defined as one who had not been in touch with the department for at least one year previously. The questionnaire covered the following:

(1) Source of referral or, for self-referred clients, of the suggestion to seek help from the department.

(2) Nature of the presenting problem, coded according to the problem-classification currently in use in the department.

(3) Details of current treatment by any medical agency, with details of any recent contact with a general practitioner.

(4) An assessment by the social worker of the client's state of health, based on the information about medical treatment and on observations made at interview. For this purpose, two simple rating-scales were provided:

A. Impression of client's physical health

(a) In good physical health.

(b) Minor ill-health only.

(c) Major illness and/or disability.

B. Impression of client's mental health

(a) No psychiatric disturbance.

(b) Minor psychiatric disturbance only (depression, neurosis, personality disorder).

(c) Major psychiatric disorder (psychosis, dementia, chronic alcoholism, or hard-drug addiction).

The questionnaire was designed to be completed partly at the time of first interview and partly within the following two weeks. Additional information often had to be sought from the client's relatives, from the referral agency, or from the earlier case-notes. A systematic attempt was made to complete every item for each client.

When this had been done, the research team reviewed the material and made their own ratings of physical and mental health for each client, using the same three-point rating-scales.

Results

(1) *Completeness of the data*

Social-service contacts, unlike general-practice consultations, are usually taken to include telephone enquiries from, or on behalf of, prospective clients. In this sample,

the initial contact was made by telephone in 45·2 per cent of cases, and by letter in 20·9 per cent. Nearly one third of these contacts were classed as ' informal inquiries ' requiring no further action; hence the clients were not interviewed and the questionnaire could not be completed.

In what follows, basic demographic data are supplied for all 518 new contacts in the sample, but information on health and medical care only was recorded for the 422 clients (81·5 per cent) who were interviewed.

(2) *Type and distribution of social problems*

Conspicuous features of the sample were the high proportions of women and of old people. Analysis of the distribution was complicated as family groups were sometimes referred, or referred themselves, rather than individual clients. The sample included 52 family referrals, comprising 10·0 per cent of the total. The social workers were instructed to take the wife or mother as the key figure in each such referral when completing the questionnaire. Excluding this sub-group, the male: female ratio of the sample was 1:1·9.

In table 1, the age-distribution of the sample is compared with that of the borough population, showing a relative excess of elderly people in the sample. Clients over 65 years formed 45 per cent of the sample.

TABLE 1

AGE-DISTRIBUTION OF THE SURVEY SAMPLE AND OF THE BOROUGH POPULATION

Age-group	*Survey sample*	*Borough population (1971 Census)*
	%	%
0–14	*5·4*	*25·4*
15–24	*9·6*	*15·4*
25–44	*21·5*	*19·2*
45–64	*18·2*	*26·6*
65 and over	*45·3*	*13·4*
TOTAL	*100·0*	*100·0*
Number of people	501	310,993
Age unknown	17	—

Sources of referral were mainly non-medical, including the local housing authority, schools, voluntary agencies, the police, and the courts. In 46·9 per cent, contact was instigated by the client himself, or by a relative, friend or neighbour on his behalf: a reminder that the department was functioning partly as a primary-care agency. Medical referrals, comprising in all 21·6 per cent, came from the local hospitals (9·8 per cent), public health departments (6·4 per cent) and general practitioners (5·4 per cent).

The frequency of health-related social problems was much greater than this referral pattern might suggest. Although the problem-classification then in use did not list ' medical ' or ' psychiatric ' problems separately, the social worker had noted physical or mental illness as the main presenting problem in 34·4 per cent of cases. This proportion did not include all the old people thought to be ' at risk ' or in need of Part III accommodation. Altogether, 36·7 per cent of the sample were judged to need residential, day-care, or other special services, including registration under the Disabled Persons Act. The findings thus indicated a high rate of chronic morbidity among the clientele.

(3) *Assessment of physical and mental health*

More direct evidence was provided by the assessments which were made of the clients' physical and mental health. As full clinical evaluation was impossible in the circum-

stances of the inquiry, these assessments are best regarded as a rough screening procedure to identify probable, or suspected, cases. In tables 2 and 3 the ratings made by the social workers at the time of interview are compared with those made later by the research team, which were probably the more accurate, being based on more information and greater medical knowledge (the implications of treatment with digoxin, insulin, or anti-convulsants not always being grasped by the social worker). They indicate that 47 per cent of the sample probably suffered from major physical illness, and 16 per cent from major mental illness, at the time of referral. Altogether, 58 per cent of the interviewed clients were judged to have serious physical or mental ill-health.

TABLE 2

ASSESSMENT OF PHYSICAL HEALTH STATUS OF THE SURVEY SAMPLE

Social worker's assessment	*Research team's assessment*			
	Major illness	*Minor illness*	*In good health*	*Not assessed*
	%	%	%	%
Major illness or disability	*74·7*	—	*0·8*	*10·0*
Minor ill-health only	*19·2*	*77·9*	—	—
In good physical health	*5·1*	*21·7*	*97·7*	*10·0*
Not assessed	*1·0*	*0·2*	*1·5*	*80·0*
TOTAL	*100·0*	*100·0*	*100·0*	*100·0*
Number of clients	198	83	131	10

TABLE 3

ASSESSMENT OF MENTAL HEALTH STATUS OF THE SURVEY SAMPLE

Social worker's assessment	*Research team's assessment*			
	Major disorder	*Minor disorder*	*No psycho-logical disorder*	*Not assessed*
	%	%	%	%
Major psychiatric disorder	*66·1*	—	—	—
Minor psychiatric disorder	*29·4*	*86·8*	—	—
No psychiatric disorder	*3·0*	*12·4*	*100·0*	*15·4*
Not assessed	*1·5*	*0·8*	—	*84·6*
TOTAL	*100·0*	*100·0*	*100·0*	*100·0*
Number of clients	68	129	212	13

The range of organic conditions was wide, but, as might be predicted with such an age-distribution, cardiovascular and arthritic diseases predominated. Major psychiatric disorders comprised affective psychoses (42·6 per cent), organic and senile psychoses (22·0 per cent), schizophrenic psychoses (19·1 per cent), severe mental retardation (10·3 per cent), and chronic alcoholism (6·0 per cent).

(4) *Current medical care and treatment*

At the time of interview, 8·3 per cent of the clients were hospital inpatients, and 26·8 per cent day-patients or outpatients. Altogether, 35·1 per cent were under specialist medical care, while a further 31·3 per cent were receiving treatment from their general

practitioners. In order to evaluate these data, we computed them against the ratings of physical and mental health made by the research team. The results are shown in table 4.

TABLE 4

HEALTH STATUS OF THE SURVEY SAMPLE, BY CURRENT MEDICAL CARE

Current medical care	*Rating of physical and mental health*			
	Major illness	*Minor illness*	*In good health*	*Not assessed*
	%	%	%	%
Hospital inpatient	*11·4*	*6·1*	—	—
Hospital day-patient or outpatient	*35·5*	*15·8*	*12·3*	*16·6*
General-practitioner care only	*39·6*	*31·6*	*3·5*	—
No medical care	*10·2*	*38·6*	*61·4*	—
Not known	*3·3*	*7·9*	*22·8*	*83·4*
TOTAL	*100·0*	*100·0*	*100·0*	*100·0*
Number of clients	245	114	57	6

The most striking feature of the table is that, of the clients with major ill-health or disability, one in ten was under no current medical care or supervision. Assuming the sample to be representative, this corresponds to about 300 new clients seen annually in one social service department, or roughly one per 1,000 of the general population.

The proportion of clients with minor illnesses who were under no current medical care was, understandably, much higher: nearly 40 per cent. The term ' minor illness ' as used here is inevitably vague, and cannot be equated with need for medical treatment. The findings suggested, nonetheless, that some of the clients in this group would have benefited from therapy: 34, for example, were reported to suffer from depressive or anxiety reactions.

The category ' general-practitioner care ' used in table 4 is also imprecise and may have concealed some unmet needs. From their own statements, it appeared that 28·1 per cent of the clients in this sub-group had not seen their family doctors for more than one month and 6·7 per cent for more than six months, at the time of interview. Current medical treatment for these individuals was limited to the giving of repeat prescriptions.

(5) *Social problems and the general practitioner*

On the other side of the coin, 45·5 per cent of clients had consulted their family doctors within the previous month. It is reasonable to assume that most of these had had an opportunity to seek medical help for their social problems. The evidence showed that many had indeed done so: 40·3 per cent of the client sample reported that they had already discussed the presenting problems with their general practitioners, and of these nearly half considered that they had benefited to some extent.

Most of the doctors whose help was thus sought had confined themselves to discussion and advice, and had not suggested social-service referral. Only 5·9 per cent of the interviewed clients had been sent to the department, and a further 3·3 per cent advised to come, by their general practitioners.

Since many of the local health visitors had general-practice attachments, it was possible that referrals made by them had been initiated by the practitioners. Health visitors and practitioners together, however, accounted for only one tenth of all referrals.

Discussion

In 1970, a Working Party of the British Medical Association declared that:

". . . in future, primary medical care will be concerned increasingly with patients who seek advice for difficulties which are as much social as medical. Such patients may require not only the skills and expertise of a doctor, but also those of nurses, health visitors, and social workers. Consequently, we advocate a wider adoption of the teamwork already developing in some practices" (British Medical Association, 1970).

Ironically, this report appeared in the same year as the new legislation which drove a deep wedge between the medical and social services in England and Wales. Arguments as to whether or not a unified service could have been achieved at that time, or whether the emergence of social work as a new profession made the split inevitable, are now academic: the opportunity, if it did exist, is unlikely to recur for a generation. In the meantime, there remains the practical problem of fostering co-operation between the medical and social services in those large areas where their responsibilities overlap.

Obstacles to co-operation have grown up partly from the administrative structure, partly from inter-professional tensions and misunderstandings. The latter have been examined in a useful discussion-paper (Ratoff *et al.*, 1974), which advocates periods of shared training as the best long-term solution.

More immediately, the need for research into the operation of medical and social services in the community, and the nature of their interaction, requires emphasis. In recent years, there has been a spate of pronouncements on this subject—many of them highly emotive—but a dearth of empirical research. Very little attempt is being made to monitor the effects of large-scale reorganisation.

Our findings, though tentative, suggest that social-service clients represent a high-risk group for morbidity, with a partially-unmet need for medical care. The similarity of our sample to those studied in a number of earlier surveys encourages the belief that it was representative of the social service clientele (Jefferys, 1965; Nursten *et al.*, 1972; McKay *et al.*, 1973). No doubt the efforts being made to identify cases of chronic disability, under the Disabled Persons' Act of 1971, helped to swell the proportion of sick people in the sample. Since, however, a more ambitious survey undertaken in Bradford six years earlier (Nursten *et al.*, 1972) reported a chronic-illness rate of 36·5 per cent among social-service clients, we do not regard our findings as an artefact of recent legislation.

The method of investigation—a questionnaire survey—did not allow full clinical evaluation of the data. The tendency, already noted, for social workers to underestimate ill-health among their clients, suggests that some cases may have gone unrecorded. This casts no reflection on the social workers concerned, who were not expected to provide an accurate medical assessment of each client. It does argue that any bias in the reporting probably tended to favour underestimation of morbidity rates, rather than the reverse.

A survey of this type can tell us nothing about the patients who consult their family doctors with social problems, but do not afterwards make any contact with social service departments. Information about this group of the population, which must be very large, would undoubtedly help to put the matter into a truer perspective. In the meantime, it appears that a large section of the general public still turns to the family doctor as a source of help and guidance for social problems but that he, in dealing with such problems,

makes remarkably little use of the existing social-service departments. Here again, our data agree well with those of other workers (Jefferys, 1965; Shepherd *et al.*, 1966; Martin, 1970).

Taken together, these findings lend support to the view that a large proportion of social-welfare problems could be tackled at an earlier stage, and perhaps more effectively, if social workers were attached to, or co-operated more closely with, primary medical-care teams (Goldberg and Neill, 1972).

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Addendum

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THRUSH

Candida albicans is now the most common infectious agent found in women attending clinics for sexually transmitted diseases.

REFERENCE

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