Social work in general practice

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PATTERNS of health have changed dramatically in recent years with social and emotional problems now constituting the second most common reason for attending a general practitioner.[1,2] It has also been found that people with social problems are more likely to contact their doctor than any other social service.[3] Effective treatment of these patients thus requires a knowledge of social resources as well as social and psychological skills.

In addition, a high proportion of clients visiting the social service departments have been found to be either physically or mentally ill.[4,5] This is partly due to the statutory responsibility of the social services department which includes the care of the chronically sick and disabled, the mentally ill and those with serious child care problems. This means that there is a large overlap between those attending social workers in a social services department and those visiting their family doctors.

A number of official reports have recognized this and have emphasized the importance of cooperation between the primary care team and social workers in order to provide a better service for patients and clients. However, there is considerable evidence not only for a general lack of liaison between general practitioners and the social services but also for a degree of hostility and antagonism.[6-8]

There are a number of barriers to good communication between the two professions; these include differences in age, sex, educational attainment, work setting, focus and orientation, knowledge, ideology, status and prestige.[9] In general, social workers have a very different training to medical workers and are unfamiliar with the language and preoccupations of medical practice, often devaluing the importance of health. They also tend to work at a different speed, taking more time to make decisions as they work within a large bureaucratic system.[7,9] Status differences can also act as a barrier between the two professions. The medical profession enjoys high social prestige while social workers are still trying to achieve full professional recognition. It has been said that doctors treat other professionals in the primary care team as paramedicals whose function is to execute a plan of action prepared by the doctor. Social workers, on the other hand, may resent being expected to provide domiciliary, residential and other social resources without question.[9,10]

One way to increase communication and cooperation between the two professions is to set up schemes where social workers are attached to or liaise with the primary care team for the referral of patients and for discussion of cases in common. A survey published in 1978 by Gilchrist and colleagues indicated that just over half of the local authority departments in Great Britain were involved in such schemes, two-thirds of these having been started since the end of 1973.[11]

While reports have emphasized the need for greater cooperation, they are usually uncertain as to how this should be organized. In practice, two strategies have been tried and reported in the literature. The first strategy is an attachment scheme in which a social worker takes referrals from a general practice and uses the practice premises as a full- or part-time base. The second strategy is a liaison scheme where a social worker visits the practice at certain times to collect referrals or discuss cases.

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The different arrangements can also be categorized by two models.[12] In the first, the 'medical social work model', the emphasis is placed on providing social work skills for the use of the practice, with the social worker based almost exclusively at the practice. Decisions as to how to use these skills, the areas of work to concentrate on, and so on, are made largely within the practice with little reference to the range of work or priorities of the social services department. This model was recommended in the report, *Organization of group practice.*[13]

In the second model, 'the social services model', the social worker is more firmly based within the department and the work accepted from the general practice will be controlled by the constraints and priorities of the department rather than the needs of the general practice. Most liaison schemes fit this second model, the social worker visits the practice on a regular basis but is based with the area team. In addition, the social worker may not be personally involved with any of the referrals, passing them directly to social work colleagues. In one survey of social workers in all local authorities, nearly 60 per cent of respondents said that they were attached either part or full time to a general practice, while the remainder were involved in liaison schemes.[11]

Attachment schemes using the medical social work model usually offer more to the primary care team than liaison schemes and most reports conclude that effective collaboration is greatest for attachment schemes.[12,14-16] In attachment schemes, the social workers usually have access to a room and a telephone, enabling them to work from the practice. As time is spent in the practice, the number of informal contacts with other staff will increase and this will allow the exchange of skills and abilities and also access to resources. In this way doctors learn to trust social workers with their patients and learn to involve them in decisions about management. This results in a more coordinated approach to treatment. Referrals also become more appropriate as the primary care team learns what the social worker can do.

However, the social worker in an attachment scheme may suffer from professional isolation and inadequate clerical support. Although most 'attachment' social workers are based in the social services department for part of the time, this can lead to problems of divided loyalties and resentment from other social workers.

In liaison schemes, the educational process is much slower and in some cases does not occur.[14] There are fewer opportunities for informal contacts and thus individual workers may never know each other very well. In these schemes, where the liaising social worker visiting the practice is merely passing referrals to other social workers for action, feedback can be delayed and case discussions infrequent.[12,17] Some schemes have been deliberately set up in this way to encourage contact between the primary care team and the social workers in the area team. However, in most cases the primary care team limit their contact to the liaising social worker and resent the fact that all the cases are not dealt with by this social worker.

The type of referral may also be affected by which social worker handles the case. One study found that doctors tend to regard social workers as concerned with practical tasks.[18] In the absence of an attachment scheme, doctors are likely to refer practical problems — patients in need of welfare services — to social workers.[19] However, with a known and trusted social worker, the attitudes of doctors and other members of staff have been found to alter. Patients with complex psychological problems may be referred, often at an early stage rather than after something critical has happened.[20,21] If on the other hand a liaising social worker passes referrals to other social workers, the doctors may be wary of referring cases that need sensitive handling.

In the study conducted by Gilchrist and colleagues, social workers were asked about the problems they had encountered in attachment and liaison schemes.[11] The average number of problems per scheme was four, the most common of which were inadequacy of preliminary discussions, lack of regular structured meetings and inappropriate referrals. However, two-thirds of the social workers said that they had enjoyed a rewarding professional experience and many felt that there had been a growth in mutual understanding. This suggests that although difficulties are common they are not insurmountable.

Owing to the many problems inherent in these schemes, it is important to investigate not only whether these schemes increase effective collaboration, but also whether they benefit the patients involved. While there are extensive data for the advantages of locating social workers alongside general practitioners there are, in comparison, few research data for the effectiveness of social work in this setting or comparing the effectiveness of social workers with other, more commonly attached workers such as health visitors.

The General Practice Research Unit at the Institute of Psychiatry has carried out two clinical trials in this area, one focusing on patients with chronic neuroses, the other on depressed women patients aged between 18 and 45 years.[22,23] The results of these two trials suggest that the involvement of social workers had a beneficial effect on certain groups of patients. Patients with longstanding depressions and neuroses, particularly those with marital difficulties, were helped more by the involvement of social workers than those whose symptoms had a very recent onset. The two studies also emphasize the importance of practical help; many of those who had improved considerably had practical difficulties with which the social worker could assist.

Another approach to the assessment of social work is to ask the clients for their views. A number of studies in this area have shown that clients favour the idea of attaching social workers to their general practice.[24,25] One study which compared the clients of attached social workers with those referred to a local authority setting, found that more of the former were satisfied with the service and felt that they had been helped than the latter.[26] Clearly, more research is necessary to identify those who benefit most from referral so that the most appropriate use of the time and skills of the social worker can be made.

Antagonism between the professions reduces the benefits from these schemes. For effective, collaborative working, some changes in the present system are necessary. Education is regarded by some as the most hopeful method of achieving these changes. More joint training, at both the undergraduate and postgraduate level, should lead to a better mutual understanding of the roles and skills of both professions.[10,27] However, the results of these training courses are mixed.[28,29] Other commentators consider that education is irrelevant without considerable structural changes. They feel that equality between team members can never be achieved in the present situation where the general practitioner is an independent contractor with overall responsibility and other members of the team are salaried members of other organizations.[30]

The results of the schemes described in the literature suggest, however, that with careful selection and matching, properly motivated representatives of both professions can work together in harmony. However, it is unwise to draw too many conclusions from these pilot schemes and to argue for a more comprehensive, integrated and personal social services because of the many difficulties involved, especially in the present economic climate. Further progress will probably be slow and will involve schemes of different kinds, depending very much on the interest, enthusiasm and attitudes of the professionals and the individual organizations concerned.

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