Factors affecting the operation and success of social work attachment schemes to general practice

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SUMMARY. The attachment of social workers to general practices has increased recently and this study reports some of the factors which affect the success of such arrangements.

Access to a room in the surgery for interviewing and the use of a telephone is an important factor as the time spent by the social worker in the premises increases the chance of making good working relationships with members of the primary health care team.

When the social worker handles all the cases personally there are advantages, especially for other members of the primary health care team, although in such a situation a social worker may become relatively isolated from her own profession. The organization of the practice itself is an important variable, especially the degree of commitment by members of the primary care team, and the attitudes of the doctors. It is helpful if the doctors meet together as a group or with other professionals. Equally, the social worker must be committed to the role. Social work attachments to health centres can be particularly effective. The lack of preliminary discussion with the social work agency can contribute to difficulties in such attachments, and preliminary meetings should include discussions about the type of cases to be referred and the quantity of social work time available.

Introduction

IN the 1970s social work attachment and liaison schemes to general practice increased in number and a recent national survey indicates that just over half the local authority departments in Great Britain are involved in such schemes, two thirds having started since the end of 1973 (Gilchrist *et al.*, 1978).

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The schemes vary considerably from those where a social worker works full or part time in one or more doctors' practices to those where a social worker visits a practice once a week or fortnight to collect and discuss referrals.

This article considers the factors contributing to the success or failure of attachments and the relative advantages and disadvantages of different types of schemes in operation. Information about these factors was obtained by a review of the literature. Although many studies and reports have distinguished between 'attachment' and 'liaison' schemes (although their definitions of these terms vary), other considerations seem equally important in affecting how well a scheme works. The major factors influencing outcome of attachments will each be considered in turn.

1. Facilities for social worker at the surgery and amount of time spent there

'Attachment' schemes normally refer to schemes where the social worker concerned has access to a room in the surgery for interviewing and the use of a telephone. In 'liaison' schemes, the social workers have no such facilities; they normally visit the surgery on a regular basis for the collection and discussion of referrals.

Access to a room and a telephone often leads to a more successful attachment as these facilities usually increase the likelihood of establishing good working relationships. When social workers have access to a room, it encourages them to spend more time in the surgery as they know they can use their time profitably by interviewing clients or ringing up agencies on their behalf. The more time spent by the social worker in the surgery, the more likely it is that informal contacts will be made and the individuals concerned will get to know each other.

The development of good relationships is the primary reason for setting up social work attachments. Doctors in general know very little about social workers, their training, skills, and the resources available to them

(Rodgers and Dixon, 1960; Jefferys, 1965; Warren and Anderson, 1966; Jenkins, 1978). They often have very little contact, refer very few cases to them (Harwin *et al.*, 1970) and complain about lack of feedback when they do refer (Jenkins, 1978). Moreover this situation has probably worsened since the Seebohm reorganization (Brooks, 1977; Jenkins, 1978).

In schemes where good working relationships have been built up, the social worker has been shown gradually to have educated members of the primary care team on her skills, abilities, and access to resources (Collins, 1965; Forman and Fairbairn, 1968; Goldberg and Neill, 1972; Corney and Briscoe, 1977a; Jenkins, 1978; Corney, 1980) and in turn has been taught the skills of the other members of the primary care team, this leading to more realistic expectations on all sides. This educational process is crucial as it is necessary for doctors to learn to trust social workers with their patients and involve them in decisions about management, setting up a co-ordinated approach to treatment. It also leads to referrals becoming increasingly more appropriate as the primary care team learns what the social worker can and cannot do (Goldberg and Neill, 1972; Corney and Briscoe, 1977a).

If the social worker sees clients in the surgery, she will become more closely identified with the practice by both patients and staff, which will also increase her own feelings of identification. In addition, some doctors prefer the social worker to interview the new referrals in the surgery as they feel it is more acceptable to their patients to see a social worker in this, rather than in the local authority setting (Jenkins, 1978).

Although good relationships can be built up with schemes where the social worker visits the surgery only to collect and discuss referrals and has no facilities there, the educational process is usually much slower and in some cases does not occur (Corney and Briscoe, 1977a). In liaison schemes, there are usually fewer opportunities for informal contacts and thus social workers and practice staff may find that they never get to know each other very well in their respective roles. In addition, social workers may find that some of their time is wasted whilst waiting for the doctors to be free to see them, as if they have no facilities they are unable to fill this time with some other task. This may discourage them in future visiting. Contacts with health visitors and nurses may also be limited, especially if these professionals visit the surgery at some other time.

2. Proportion of cases handled by social worker personally and time allocated for this work

Schemes vary according to how much work is handled by the social worker concerned; in some schemes the social worker visiting the practice merely acts as a 'go-between', collecting referrals from the primary care team and passing them on to other social workers in the team for action.

The schemes where the social worker handles all the cases herself have many advantages, especially for other members of the primary care team. The doctors prefer it (Jenkins, 1978), knowing the person who will deal with all their referrals. Feedback is also much easier for the social worker if she does the work herself and if there are joint discussions about treatment. If other social workers handle the case, feedback can be delayed and discussions sometimes take place only when the social worker visits the practice (Goulstone and Jones, 1976; Jenkins, 1978).

The type of referrals may also be affected by who handles the cases. One study found that doctors are most likely to see social workers as concerned with practical or concrete tasks and place little faith in their ability to handle psychological problems (McCulloch and Brown, 1970). Without an attachment scheme in operation, they are likely to refer practical problems, patients in need of welfare services or Part 3 (Corney and Briscoe, 1977b). However, with a known and trusted social worker the doctors and other members of staff have been found to alter this attitude, referring patients with, for instance, complex psychological problems or marital difficulties (Collins, 1965; Forman and Fairbairn, 1968; Goldberg and Neill, 1972; Corney and Briscoe, 1977b; Corney, 1980). They are also perhaps more likely to refer patients at an early stage of their problems when they first become concerned about them, rather than when something critical has happened (Goldberg and Neill, 1972). If, on the other hand, the practice social worker passes on the referrals to other social workers, the doctors may know little about them and will be more wary of referring cases that need sensitive handling. They are therefore more likely to refer the same sorts of problems they referred without an attachment scheme in operation. This was found in two liaison schemes set up in Dorset, where referrals were passed on to other social workers. The setting up of these schemes did not significantly alter the type of cases referred and the slight increase in referral rate was mostly accounted for by an increase in inappropriate referrals (Goulstone and Jones, 1976).

When the social worker visiting the practice handles all the cases herself and is given a reasonable amount of time to deal with these, the type of cases she tackles will depend on the needs of the practice rather than the priorities of the social services department, although in most cases she is employed by the latter. All the detailed studies of social work attachments have described schemes where the social worker has taken this role (Collins, 1965; Forman and Fairbairn, 1968; Goldberg and Neill, 1972), being based more or less exclusively at the practice. She will thus be used in a similar way as a medical social worker, as a specialist within the medical team, providing social work skills for the use of the practice.

These types of schemes also have disadvantages. The social worker may find herself relatively isolated from

members of her own profession and lacking in support. This is particularly true of social workers who work full time in one or more general practices or part time with no other work elsewhere. However, most social workers involved in schemes also work in another social work department, the majority carrying a caseload in the local social services department (Gilchrist *et al.*, 1978). This reduces their sense of isolation unless they find resentment on the part of the other social workers who may regard the attachment as removing some of the resources of the department. This will depend on how the attachment is viewed and the pressures on the department. Social workers in these schemes may also have problems with divided loyalty, identifying with the primary care team and its problems while being employed by the local authority.

These schemes also encourage the primary care team to work with one particular social worker and thus do not increase contacts with the local social services department in general or with other social workers. In one scheme, there was no increase in referrals to the social services department or to other social work agencies when the service offered by the social work attachment scheme was reduced by half, the doctors and other staff preferring to deal with the cases themselves (Winny, 1979). This happened even when the attached social workers concerned had always resisted carrying messages between other social workers and the primary care team, encouraging them to do this themselves. Another scheme found that when the attached social worker was away on confinement leave, the practice staff referred only emergency cases to the social services department (Bursill, 1978). Thus the feelings of trust and confidence in the attachment social worker built up by these schemes do not generalize to social workers as a whole.

In schemes where the practice social worker acts as more of a 'go-between' passing on most of the cases, the scheme often develops differently. The social worker involved will probably spend less time in the surgery as well as less time on any cases resulting from the attachment and is thus more firmly based within the social services department. In addition, if referrals are to be passed on successfully, they must fit in with the priorities of the social services department. If the department is under any pressure, the referrals will be treated similarly to those from any other source and may not be taken on if less urgent than others.

In the county of Glamorgan, 15 social workers were allocated to 22 general practices. The attached social workers were instructed to deal with only a proportion of the referrals and to pass many of them on to others. This was planned specifically to encourage contacts between the primary care team and other social workers in the social services department. These schemes, although successful in many ways, did not work out as planned. Doctors and other staff still limited their contacts to the attached social worker: they would either wait until her visit to make a referral or telephone her at the office personally but they would not leave the details of a referral with any other social worker. When the schemes were evaluated, all the doctors said that having a social worker attached to their practice had little or no effect on the amount of direct contact they had with other social services department staff; for most it had continued much as before, while for some it had actually lessened since the attachment began. In addition, many of the doctors complained that feedback was inadequate when the attachment social worker did not deal with the referral herself. They were unhappy when referrals were passed on to other social workers and those who felt that there was scope for developing the attachment mostly saw this in terms of using the attachment social worker more rather than in broadening their range of contact to include other social services staff. Thus there are difficulties in increasing contacts between primary care staff and all the social workers in the team (other than the attached social worker) even with schemes specially set up to encourage this.

Another problem encountered by the schemes in Glamorgan was the reluctance of the other social workers to accept cases from the practice. The social workers in the team were already under pressure from other work and thus found referrals from general practice an additional burden. One of the original aims in setting up the schemes was to encourage the referral of patients at an early stage in the development of their problems and thus increase the preventive work carried out by social workers. However, these types of cases were not given a high priority in the social services department, precisely because they had not reached crisis stage. The practice social workers resolved these problems by dealing with most of the referrals themselves, much to the satisfaction of the primary care staff involved.

However, not all schemes of this type have experienced similar problems. In a scheme developed in an Outer London borough, no difficulties were encountered in referring cases on to other social workers. This may have been due to the type of cases referred; in this example the nature of the referrals from the attachment was very similar to that encountered by the social workers in the team (Bavister, 1979). Other factors such as the pressures of work and the social workers' attitudes to the attachment are also clearly important.

3. Social organization of the practice and personalities of staff involved

The practices taking part in attachment schemes must be chosen carefully as well as the individual social workers involved. One of the most essential features for success of the scheme is a high level of commitment by the primary care team, the social workers concerned, and the social services department (Gilchrist *et al.*, 1978). A desire to make the attachment work can make schemes

successful in spite of many other difficulties (Jenkins, 1978).

The attitudes of the doctors concerned are important. Doctors should be chosen who are aware of the usefulness of a social work attachment. They must also be willing to give up time to discuss cases and general problems with social workers. Studies have not found that the presence of social workers in a practice has increased the amount of the doctor's free time (Forman and Fairbairn, 1968; Thompson, 1977).

The social organization of the practice is also important: attachments are found to be more successful when there are adequate opportunities for informal contact as well as regular formal meetings. In a national survey, two of the major problems found by social workers in attachments were the absence of regular structured meetings and the lack of opportunity for informal discussions about patients. If the doctors do not meet together as a group, either between themselves or with other professionals, the social workers may also find problems when trying to arrange meetings. General problems do occur, such as problems of confidentiality, especially when an attachment has just been set up, and it is usually much easier to discuss these problems in a group rather than individually with each member of the team. The doctor or doctors' receptivity to previous attachments of other professionals (for example, health visitors) and the operation of these working arrangements may give a useful guide to whether a social work attachment will be successful.

The choice of the social worker involved is also important. First of all, she must be committed, interested in the type of work, and aware of the value of such a scheme. As she is acting as a representative of the social services department, she should be experienced and knowledgeable about her role and the resources of the department. She also needs to be outgoing, as she may have to seek out the doctors at first and overcome any resistance to referral. She must also be able to demonstrate how she can help and take an active part in any discussions regarding a patient. For this, she must feel professionally secure, be able to work independently, and relate effectively to other professionals.

4. Health centres

Social work attachments to health centres can be particularly effective. Other professionals may be also based at the health centre so the likelihood of informal meetings with members of staff, such as health visitors, district nurses, and midwives is increased. In surgery attachments, the other members of staff may visit the surgery at different times of the week than the social worker, so little personal contact is made and referrals are made only through the doctor. In health centres, many more cases are referred directly to the social workers from other members of staff (Corney and Briscoe, 1977a; Jenkins, 1978) and discussions are more

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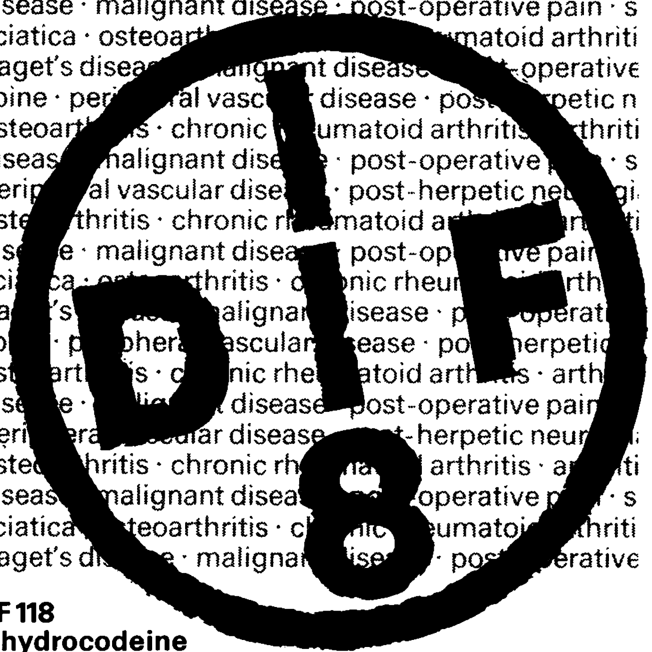

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likely to take place on the management of cases and on who can help most appropriately (Corney, 1980).

5. Preliminary discussion and liaison with local authority

Another of the most frequent problems identified by the social workers in the national survey was the lack of preliminary discussions between the social work agency and the practice team about the attachment. Their paper suggests that preliminary meetings should include discussions on the types of cases to be referred, the quantity of social work time available, accommodation, use of a telephone, secretarial assistance, and the social worker's access to medical records and recording (Gilchrist *et al.*, 1978).

In addition, other issues may need to be raised such as the aims of the attachment, how the role of the social worker is envisaged, and confidentiality. Practical matters are also important: referral procedures, who will handle the cases and their transfer, feedback of information, and who will pay for the telephone calls and the secretarial time if these are provided by the practice.

Meetings should also be held between the social work management, the practice social worker, and other social workers in the team to explain the value of the scheme and to obtain their views about the attachment. This will be especially necessary when social workers are under a considerable pressure of work and if they are expected to take on a proportion of the cases.

The role of the attached social worker in the team must also be considered. If she is also carrying a local authority caseload, it is likely that she can obtain professional support and supervision from the team as well as be fully involved in their meetings. For a social worker without this it is important to ensure that she does not become isolated and that regular supervision is arranged plus easy access to the department's resources.

Conclusions

When choosing the type of scheme to be implemented, one has to consider the aims one wishes the scheme to achieve, the amount of resources available, the organization of the practices involved and the views of their staff, and the attitudes of all the social workers and the social work management.

Schemes where the social worker is attached part or full time, handling most of the work herself, are much more of an aid to the primary care team. The types of cases dealt with by the social worker will depend more on the needs of the health care team than the practices of the social services department and she can also make a contribution to diagnosis and assessment. Primary care staff usually find these schemes more satisfactory as they need deal with only one social worker. This makes referral, feedback, and discussions a great deal easier.

This type of scheme is also preferable if one of the main aims of the attachment is to reach clients at a stage where preventive work can still be done. Many consider that general practitioners are better placed than anyone in the community to identify early signs of trouble and that general practice is therefore a good place to identify social problems when they first start (Forman and Fairbairn, 1968; Goldberg and Neill, 1972; Hicks, 1976). However, these types of cases are usually referred from the primary care team only to a social worker they know and trust.

This type of attachment scheme also offers social workers very good opportunities to carry out 'casework'. Here the social worker can use her own supportive interventions to deal with the complex psychosocial problems presented to general practitioners. In addition, this is probably the only type of scheme where it is possible to develop the attachment to its fullest potential.

Where resources are more limited, it may only be possible to develop liaison schemes, where the social worker spends only a short time in the surgery and refers many of the cases to others. This scheme aids the social services department in obtaining referrals of clients with social problems from the primary care team. It usually offers less to the health team as referrals can be taken on only if they fit in with the priorities of the social services department, and requests for assessments or for non-urgent work may be given low priority. Referrals to these types of schemes are therefore more likely to be similar to those which would occur without an attachment in operation, such as practical problems or an emergency when referral is necessary. This is partly due to the doctor not knowing who will handle the case and partly because these cases will be more likely to be taken on. Unfortunately, schemes similar to this model have not been shown to increase the numbers of contacts between the primary care team and the social services department in general, which in some cases has been one of the main reasons for setting up the scheme in this way. Particular attention needs to be paid to the views of the social workers in the team when this sort of attachment is set up, whether they will be willing to take on referrals from an additional source, and whether these new referrals will fit in with already existing work.

Where schemes have been successful and good relationships between the social workers and other members of the primary care team have been built up, there have been encouraging reports from all on the benefits of such schemes (Forman and Fairbairn, 1968; Thompson, 1977; Bursill, 1978; Jenkins, 1978; Williams and Clare, 1979). Doctors and health visitors felt that their patients had benefited from the attachment and that they could now provide a more comprehensive service to their patients. The schemes had also improved their knowledge and understanding of the nature of the social worker's roles and skills.

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