

## PRACTICE OBSERVED

*Essays on Practice***Successful liaison between the health team and social workers in Blackburn, West Lothian**

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Many forms of liaison between social workers and primary health care workers have been described.<sup>1,2</sup> In Blackburn for the past 10 years we have held weekly meetings for all the health professionals who work in our health centre, members of the area social work team, and the local officer of the Royal Scottish Society for Prevention of Cruelty to Children. We thought we should take stock of the value of the meetings and look at how our workload and the type of work have changed over the 10 years.

Until the 1960s Blackburn was a small mining town. The building of a large truck manufacturing plant nearby led to a large influx of people, mainly from the Glasgow conurbation. They were housed in high rise, flat roofed accommodation, which quickly became damp and uninhabitable. Over the past eight years the plant wound down its operations and has now closed, leaving Blackburn with one of the highest unemployment rates in Britain: >25%.

Until last year large tracts of the town consisted of boarded up buildings and a few occupied flats, many of which have now been razed to the ground or converted to good, well insulated accommodation. The town also includes West Lothian's "homeless accommodation," where families who have been made homeless owing to domestic violence, rents arrears, or other causes are housed for up to three months while they await new homes. Blackburn has more than its fair share of social problems, and it is in this atmosphere that Dr W Gilmour, our former senior partner, started the weekly meetings.

**The meetings**

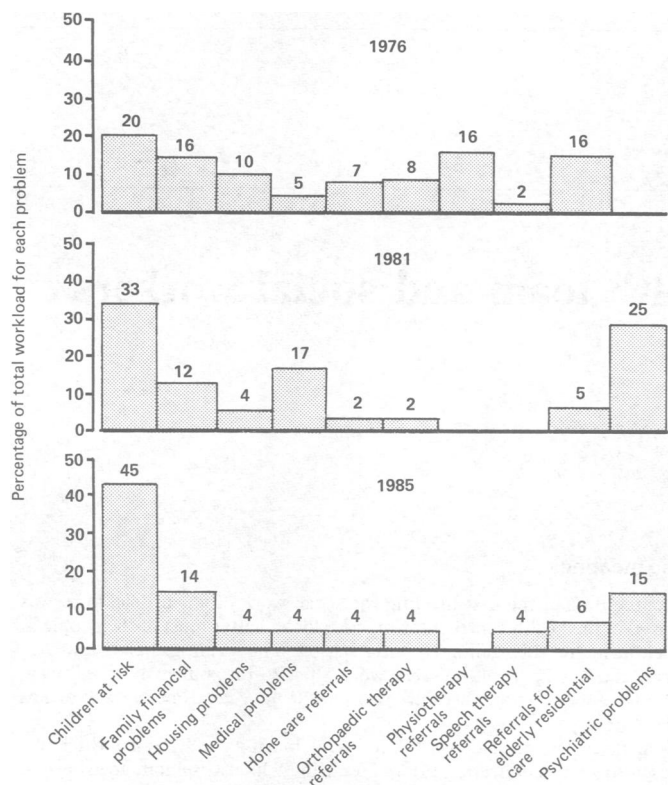
At the time of the first meeting the social work office in Blackburn was housed in the health centre. Our practice looked after most of the people in Blackburn, and this facilitated initial liaison. The meetings have, however, survived the removal of the social work office to Broxburn, six miles away, although a social worker uses a room in the health centre once a week to do a local "surgery."

The meetings are held every Wednesday morning at 9.00 am, which was chosen to keep the meeting brief and business like. It seldom goes beyond 9.30 and usually takes about 25 minutes. The number of people and the professions of the participants have varied over the years but usually the meeting is attended by general practitioners (usually three), social workers (usually three or four), district nurses and treatment room nurse (four), health visitors (two), community psychiatric nurse (one), home help organiser, RSSPCC officer, and an occupational therapist, physiotherapist, and speech therapist attend occasionally.

A brief minute is taken of the proceedings, particularly a note of what action has been decided and who will carry it out. Discussion of the cases in the previous week's minute and any new referrals takes place each week, and a decision is made about whether to keep the case on the meeting file when problems are resolved or fade away. On average we discuss about nine problems, from as few as three to as many as 19.

The greater part of the discussion is about families with problems (figure). The major concern is for children who are thought to be at risk from neglect or other ill treatment. For example, we recently discussed an alcoholic woman whose husband had deserted her who was not looking after her three schoolchildren and new baby, a single mother in the "homeless block" who had struck up a relationship with a man who is known to have abused children in the past, and a low birthweight baby living with its teenaged mother in damp, poorly furnished surroundings. Problems with elderly patients have included an 80 year old spinster who has refused everyone's advice to move to a residential home despite failing health and maximal nursing and home help and the concerns of the home help supervisor that one of her charges is becoming increasingly confused and unable to cope. Another problem was of a middle aged woman with disseminated sclerosis whose personality change led to marital difficulties and depression in her husband and the danger of a complete breakdown of the relationships within the family. These all require multidisciplinary solutions, and the meeting ensures that all those who can help are at least aware of the problems.

The meetings are also used to make referrals for home help and occupational therapy. We believe that much more useful information is passed on at the meeting than can be achieved on a simple referral card. Social workers who are concerned about the medical health of their clients may wish elucidation of the long term prognosis of patients who are terminally ill or demented. This often leads to more appropriate and timely help for the patients. The main purpose of the meeting, however, is to pool information, to detect early on families who are under stress, to make all the professionals in the area aware of this, and to decide on the best way and the best person to help ease the situation. Financial advice or day care for children or an elderly person can often be provided without "red tape" before a crisis occurs. Feedback is quick—we know right away if a ramp has been ordered or a home help allocated. The meeting prevents wasteful overlap and ensures that someone has taken responsibility for action in a case. Not all cases are of equal relevance to all the participants, but they consider that the better communication about their interests overrides this.



Change in workload over the 10 years expressed as a percentage of the total workload for each type of problem discussed at the meeting. Child abuse and neglect are taking up more and more time at the meetings. Since 1980 the physiotherapist and speech therapist have attended less and less often. A community psychiatric nurse was attached in 1979.

Over the past 10 years the numbers and types of cases discussed have varied (figure). The overriding trend has been that a greater amount of time is taken up with problems concerning children and young people. We are not sure why this should be, as the number of children in the practice has stayed at a high but roughly constant percentage of the practice population. We believe that increasing unemployment and poverty are to blame for this but have no evidence for it. Other variations of workload reflect the changing compositions of the meeting in both professions and personalities (figure). The tone of the meeting, however, is largely unchanged, and those who have been attending since the early stage think that they are as valuable as ever.

### Spin offs and problems

A major spin off is the breaking down of professional barriers. We all have good relationships with each other and have become aware of each other's professional role. This has been and is undoubtedly still a problem for many other workers.<sup>3</sup> The biggest problem for the doctors, and particularly the community psychiatric nurse, is that of confidentiality and loyalty to patients.<sup>3</sup> The mother of the child who

is being neglected is also our patient, and it may not be ethical to reveal information prejudicial to her. We often walk a tightrope trying to do what we think is best for a family, at the risk, for instance, of appearing to that mother that we are compromising her. Is it fair to reveal a past depressive illness in a mother who is not looking after her baby as well as she might, or that the child who is being disruptive in class has a father who 15 years ago revealed to a psychiatrist he had paedophilic fantasies? Can we reveal to a social worker who is also a patient's parole officer that the patient was drunk and abusive at the local casualty department if we are asked? Our social work colleagues are aware of this problem and indeed face it themselves.<sup>4</sup> It is something we have to resolve if it can be resolved.

Social workers have been attached to general practices since the 1960s, and this accelerated in the early 1970s.<sup>1</sup> The attachment has varied from full time to simple liaison. In 1978 over half of the social work areas in the United Kingdom boasted some link with general practitioners.<sup>1</sup> Rosalind Corney and Monica Briscoe compared liaison with attachment and found that attachment to a practice was more effective and rewarding for those taking part.<sup>5</sup> The major drawback was the lack of liaison with health professionals apart from general practitioners. They also found that contacts were more frequent and less formal. We believe that we have overcome this in Blackburn by having multidisciplinary meetings. Though the meetings are brief, they are informal, and the improved relationships they have produced have made contacts at other times much simpler and rewarding.

We know of one other similar but more restricted group meeting in West Lothian but do not know of others in which such a range of professionals participate. Though such meetings may be difficult to set up initially, once going they are well worth the effort.

### References

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- 3 Dingwall R. In: Briggs T, Webb A, Lonsdale F, eds. *Team work in health and social services*. London: Croom Helm, 1979:111-37.
- 4 Fogarty M. Loyalty under stress. *Social Work Today* 1984;15 (5 Mar):19.
- 5 Corney R, Briscoe M. Investigation into two types of attachment schemes. *Social Work Today* 1977;9 (6 Dec):10-4.

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### 100 YEARS AGO

A letter has been addressed by Lord Henry Bruce to members of the House of Commons, asking their support in bringing the question of the dwellings of the poor in our large cities to a final and successful issue. As regards London, he maintains the evil has been allowed to increase so enormously that the figures are now so large that it is quite impossible for private enterprise to cope successfully with them; and that this movement must be undertaken by the Metropolitan Board of Works, which has failed in carrying out what were the intentions of Lord Salisbury's Commission. He adds that the Metropolitan Board of Works condemns a district, but in many instances does nothing further. "The result is that the landlord declines to do anything more for the improvement of his property, increases the already exorbitant rent, and fills these awful dens with more families (many of whom live underground) in order to get a greater value for the compulsory purchase of his property." "This," he adds, "is no exaggeration, and no other country but England would dream of tolerating such a transparent and inhuman fraud. It is well known that there are more than 50,000 families in London alone who have only one room each to live in, and who exist more like vermin than human beings. They are driven out of one place into another, although no better accommodation is provided for them. The Peabody Trustees have certainly done a great deal of good, but they have not gone down to the lowest stratum." Lord H. Bruce expresses himself confident that better dwellings for the poor, if only given a fair trial, would positively pay their own way, and adds, "it is idle to talk about State-aided emigration when we neglect the primary duties of fellow-citizenship." (*British Medical Journal* 1887;ii:80.)