

Experiences of Social Workers in Primary Care in Ireland

Abstract

This article presents the findings of research conducted with social workers in primary health care teams in Ireland. Data from questionnaires and from a focus group were analysed. The findings draw attention to the nature of the role of the primary care social worker, including both the satisfying and challenging aspects of this role. It was evident that the participants liked the generic nature of their role and the fact that they worked with non-mandated clients. However, they encountered challenges related to resources, management structures and interdisciplinary work. The findings shed light on an area of social work that has been under-researched.

Key words

Social Work, Primary Care, Health, Ireland.

Primary Care – the context

The importance of a comprehensive primary care service has long been recognised in health policy. In the UK for example, a major policy document on creating primary health care teams dates back to the 1980s with the White Paper on Primary Care *Promoting Better Health* (Secretaries of State for Social Services, Wales, Northern Ireland and Scotland, 1987). It endorsed the idea that social workers, though employed at the time by local rather than district health authorities, might work from the same premises as the family general practitioner. In Ireland, community based social workers have been employed within the health sector since the 1970s. However, due to the complex mix of public/private provision

of health care in Ireland, historically general practitioner services have been provided separately from the community-based interdisciplinary teams comprising of key professionals such as public health nurses, social workers, physiotherapists, dieticians and occupational therapists.

In Ireland, the framework for establishing a more comprehensive primary care service, with a pivotal role for general practitioners within it, was introduced in the Health Strategy (Department of Health, 2001a) and developed in detail in the policy document, *Primary Care - A New Direction* (Department of Health, 2001b). Primary care was to offer a single point of entry for any person in need of health and/or personal social services. It was envisaged that between 90-95% of all presenting issues could be dealt with by the provision of an 'integrated, interdisciplinary, high quality, team based and user-friendly set of services for the public' (2001:7). The core team was to comprise of general practitioners, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel with a wider primary care network of other professionals such as speech and language therapists, dentists and psychologists that would be linked to more than one team. The core team would be based in one, easily accessible location to enable the formal team structure to be augmented by informal ongoing contact between the different team members in the interests of maximising patient/client care. The plan was to introduce a number of pilot projects in 2002. Ten projects were to be developed in different locations throughout Ireland, with a view to developing a comprehensive primary care service based on best practice and responsive to local need.

A National Primary Care Steering Group was established to oversee this process and this group reported on progress to date in 2004. However, the Group's report on the ten pilot

projects did not include details about the availability of social work services within each project team (Department of Health and Children, 2004). The Primary Care Strategy was subsequently rolled out so that by the end of 2010 there were 350 teams in some level of operation defined as 'teams which are holding clinical team meetings on individual client cases' with the aspiration of 518 primary care teams being created by the end of 2011. However, with the advent of the economic downturn and the ongoing budgetary issues, the possibility of achieving this goal diminished. Where teams exist they are often without the full complement of professions available to provide the comprehensive primary care service.

Even when times were better economically, an inadequate and complex system of funding has been and continues to be, an impediment to the development of such a service. First, there is the mixture of public and private provision of general practitioner care whereby a minority of the population are entitled to free general practitioner service while the remainder must pay a, not insubstantial, sum per visit. This can serve as a direct deterrent to accessing a core primary care service that is pivotal to health care in Ireland (Nolan et al, 2007; Burke, 2009). In the current economic crisis, payment for general practitioner services is a financial burden for an increasing proportion of the population liable for such payment. Furthermore, the need for a long-term funding programme for primary care (Tussing and Wren, 2006) has become all the more important now that there is little prospect for increased funding in the foreseeable future. The current Minister for Health has committed to the introduction of a comprehensive health insurance model to replace the present system of funding. Whether or not this results in more resources for primary care is uncertain.

The publicly funded community based services, social work included, that have grown up separate to the general practitioner services have been chronically under-resourced. When

first developed in the 1970s, it was envisaged that social work services would be available to all categories of clients who would benefit from such a service. However, over time, the community-based, social worker's brief diminished in its scope to dealing only with cases involving child welfare and child protection. Hence, the development of Primary Care teams offered renewed opportunities for providing a more comprehensive, community-based social work service.

As such, the findings of this small-scale study offer valuable insight into the nature of social work in primary care settings, within a particular context where the service is in its infancy. The findings suggest that, in Ireland, social workers in primary care experience a mixture of challenging and satisfying aspects of their roles.

Literature review

Internationally, little is known about the role of the primary care social worker. While some research in relation to other social work services has identified what social workers find rewarding or satisfying about their roles (e.g. de Fatima de Compos Françaço & Smeke Cassorla, 2004; Walker et al., 2007), research specifically relating to primary care social work is limited. However, several studies, in various international contexts, shed light on the role (or potential role) and contribution of social workers to this area of practice, drawing on the perspectives or practices of other members of primary care teams. In particular, attention has been drawn to the role of social workers in addressing the psychosocial problems experienced by patients (Bikson et al., 2009; Gross et al., 1996). For example, the prevalence of psychosocial issues such as financial problems, personal stress and legal issues (amongst others) has been identified in research by Bikson et al (2009), where the researchers found that patients reported an average of five psychosocial problems, with 32% of patients wanting to see a social worker. The literature suggests that social workers are viewed as particularly well equipped to deal with such issues (Gross et al., 1996). For example, Keefe, Geron &

Enguidanos (2009) conducted a study in the US of perceptions by physicians and nurses of social workers in primary care in relation to the provision of health care to older adults. These researchers point to social work training in psychosocial intervention, assessment and care management as serving an important role in addressing the needs of frail older adults in primary care. Both nurses and physicians felt that a social work service would result in 'improved patient care and patient outcomes, both in response to patient problems and as a preventative measure to avoid crisis situations for older patients' (p.590). Indeed, in a study by Rock and Cooper (2000) it was found that increased social work interventions within a primary health care setting led to a decrease in depression, anxiety and adjustment reactions among patients. In turn, this led to fewer physician visits. The study concluded that 'biopsychosocial intervention contributes to quality and cost containment' (Rock & Cooper, 2000: 15).

The study by Keefe, Geron & Enguidanos (2009) referred to the many psychosocial issues presented by older adults in primary care settings, thus suggesting the broad remit attached to social work in primary care, even in relation to one specific client group. Elsewhere, Lesser (2000) discusses an example of a holistic approach to primary care practice, whereby the social worker and other members of the team work collaboratively. Again, attention is drawn to the multiple roles performed by the social worker, ranging from assessment, counselling and case management, to advocacy, information provision and referral. The social workers referred to by Lesser (2000) work with a range of clients, including children, adolescents, adults, families and the elderly in relation to diverse issues ranging from self esteem and social skills to depression and caregiving. Similarly, Van Hook's (2004) research, suggested that social workers in primary care needed to be prepared to work with clients in relation to a range of different issues. Her study was based on content analysis of records of individuals referred to social workers in urban primary health care settings in the US.

Reflecting the diverse psychosocial issues presented by clients in primary care settings, the literature suggests that social workers in primary care use a wide variety of interventions in their work, something which is again satisfying for the workers. For example, a study by Firth et al (2004) revealed the diversity of work undertaken by social workers. It was found that more social work time was spent on direct work (i.e. addressing personal and intrapsychic issues) as compared with indirect work (i.e. interventions related to the 'externals' of the client's material environment).

The literature has also made reference to the challenging aspects of the primary care role. For example, the issue of professionals not understanding each other's roles has been identified as a barrier to inter-professional collaboration (e.g. Easen, Atkins & Dyson, 2000). A lack of understanding of the scope of the social work role has been identified in several studies (Bikson et al., 2009). In relation to primary care social work specifically, the research by Keefe et al (2009) identified the need for the social work role to be clearly articulated as 'a necessary precondition for effective collaboration by social workers with other team members (p.593)'. Similarly, based on their research with physicians in Israel, Gross et al (1996) suggest that social workers should disseminate material which clearly describes the contribution that they can make in relation to psychosocial problems, particularly given that physicians are often the first point of contact with clients and make decisions about whether referrals to social workers should be made. Gross et al (1996) also point to the need for social workers to meet regularly with physicians in order to create a collaborative atmosphere and in order to discuss joint treatment. Elsewhere, Peterson (2012:905) has highlighted that shared decision making is cost effective and is important to consumers but that it requires 'real collaboration between members of the health care team, as well as between the providers, the consumer and their family'.

D'Amour et al (2008:1) comment that collaboration between professionals is at the core of providing 'accessible, continuous and comprehensive services'. In regard to primary care, team-work across disciplines 'is well established as an integral part of effective primary care' (Shaw et al, 2005:396). However, Shaw et al (2005) found that lack of shared objectives, the inability to recruit, poor communication and hierarchical structures were all barriers to the development of effective teamwork. As Gaboury et al (2009:708) point out, healthcare professionals 'often enter the collaboration with very different paradigms of healthcare and visions of health and illness'. Moreover, '...effective working together can be inhibited by the lack of knowledge or assumptions made about the responsibilities of one profession by members of another' (Asquith et al, 2005:34).

Hudson (2002) identifies three key features that must be considered in relation to interdisciplinary practice – those of professional identity, status and discretion/accountability. Professional identity, he argues, is very much linked to having a body of knowledge that is perceived to have intrinsic worth. Writing about social work in a multidisciplinary, multiagency context, Frost et al, 2005:195) observed that the social work role in the teams tended to be 'complex and contested....there are actual and potential conflicts about models of understanding, about status and power, about information sharing and around links with other agencies'. In relation to perceptions of professional worth, Lymbery (2006:1124) refers to the 'uncertain professional status of social work' as being an impediment to collaborative work with other disciplines of perceived higher status such as medicine or those having the same status but, at the same time, greater 'public acceptability of their work' such as nursing. Clarity (re role) confers more power on practitioners, who are thereby enabled to define the essence of their work in ways that can be accepted by more powerful groups – in this case, not only the medical profession but also the managers (Asquith et al,1998). Carpenter et al ((2003) found that role clarity, as well as role conflict were good predictors of job satisfaction

in a multidisciplinary setting. In relation to the latter, they found that high role conflict arose in situations of incompatible requests and inadequate funding, leading to high stress levels among professional staff. In the context of primary care, Fickel et al (2007:213/4) identified the most common barriers to inter-professional and inter-agency collaboration to be understaffing and insufficient resources, a finding very pertinent for the current economic difficulties of today.

Methods

To date, no research has been carried out in Ireland on the role of the social worker in primary care and, as indicated above, there is very limited international research on this topic. The Irish Association of Social Workers has a special interest group for social workers in primary care teams. Anecdotal evidence from this group was that not all teams had social workers attached and that the social work role could vary quite markedly from one team to another. Moreover, special interest group members had reported cutbacks leading to social workers in some teams having to switch to child welfare and protection work, which is not part of the primary care social work brief.

The purpose of the study, therefore, was to examine the existing and potential role of social work within primary care teams in Ireland. It sought to establish current levels of provision, including categories of clients, sources of referral and types of interventions undertaken, both direct and indirect. The experiences of social workers were elicited in relation to team membership and any perceived barriers to optimal practice.

The research, carried out with the support of the Health Services Executive and approved by [the University's] Research Ethics Committee, used both qualitative and quantitative methods and was conducted in two phases:

In the first phase, anonymised questionnaires (using both open and closed questions) were sent to all social workers attached to primary care teams in Ireland. A reminder was sent after three weeks and results analysed using SPSS. In the second phase, a focus group with primary care social workers was conducted, using a general interview guide along with anonymised data from the questionnaires to inform the discussion.

Findings

Of the 80 questionnaires sent, 45 were returned, giving a response rate of 56% overall. The vast majority of respondents were female (83%) and 75% had been qualified for more than four years. Just over half (53%) had been working in primary care for less than two years, 29% for between two and four years and 18% for more than four years. Almost three-quarters indicated that they were involved in the Irish Association of Social Workers Special Interest Group in Primary Care. Of the 45 respondents, 7 indicated that they were in management positions. As the focus of this article is front-line social work practice, the responses of the 7 who were in management positions, have been excluded from the findings reported below which are an amalgam of the data gathered from the questionnaire respondents (n=38) and from the focus group discussions and are presented thematically.

Satisfying aspects of the PCSW role

The questionnaire data revealed the reasons why the respondents decided to work in Primary Care Social Work (PCSW). While some of the participants gave very practical reasons such as 'I was offered the post', 'permanent job offer' or 'post became available', the majority talked about being attracted to the nature of the role, with different aspects being identified. These included the variety of work that the role offered, the opportunity to work on an

interdisciplinary team, to work in a different type of social work setting, to engage in early intervention or preventative practice, or to work with communities. A number of participants also referred to their desire to work with clients who were not mandated to attend a social work service. One participant stated that s/he subscribed 'to the WHO principles in the Alma Ata Declaration on primary care of 1978'.

Within the focus group, when talking about the most satisfying aspects of their role, the themes that arose were similar. Many of the participants identified the generic aspects of the role as something that they valued. They liked the fact that they were not social workers with a specific remit, such as child protection or mental health, but rather that the remit was broad and diverse and that it responded to the needs of the community. As such, an 'open door' policy was in place for members of the public. One participant stated:

It was everything I expected in terms of me, my own self-resilience and enthusiasm was really enhanced because I felt that this was what social work was about for me. This is what I wanted to be in social work, providing a face to the community. We're not behind closed doors, we don't have a child protection remit necessarily. It's open door, it's self referral, you know, all the things I wanted social work to be.

This generic remit meant that the social workers had diversity within their workload. In the questionnaires, participants were asked about the primary issues that were prevalent within their current case loads. They were provided with a list of 15 closed options, and were informed that they should tick all of the categories that were relevant. The list included items such as 'difficulties coping with physical illness', 'bereavement', 'financial problems' and 'relationship difficulties'. The diversity within the participants' case loads was evident from the fact that respondents ticked an average of 10.63 primary issues. In addition, 50% of the respondents (n=19) ticked an additional open category named 'other' and provided examples of various other issues that were prevalent in their case loads but that had not been identified

in the list. Overall, the most frequently identified issues were ‘financial difficulties’ (ticked by 94.7%, n=36), ‘loneliness and isolation’ (92.1%, n=35), ‘difficulties arising from disability’ (89.5%, n=34), and ‘difficulties coping with physical illness’ (86.8%, n=33).

Many of the participants, both in the questionnaires and in the focus group, referred to this diversity as something that attracted them to the post or as something that they found satisfying about their role. Participants mentioned the ‘variety’ associated with the role, its ‘generic’ nature, and the ‘eclectic mix of cases’. One participant pointed to the flexibility and autonomy associated with the diverse nature of the role:

We have quite a lot of flexibility and autonomy in our roles, being able to set up groups, being able to do health promotion, being able to get involved with schools, go out and do presentations, being able to set up plans with 45 agencies, being able to do group work, community work, and individual work with clients.

Related to this, others also talked about the fact that individual social workers could develop their role:

We’re all still shaping the role of primary care social work. It is an area that is very much in flux and in development.

It was very much given the remit of being told to spend the next couple of months finding out what the needs are of your community and actually set up based on that, so you’re told to basically set up the service.

To some degree, this flexibility accounted for the fact that while some social workers engaged primarily in individual work, others focused more on group work or community work. Many tried to achieve a balance between all three. All of the questionnaire respondents engaged in both ‘individual therapeutic work’ and ‘individual practical support’. The former was used ‘frequently’ by 73.7% (n=28) and the latter was used ‘frequently’ by 92.1% (n=35).

However, the questionnaire data suggested that a significant number of respondents did not engage in group work or community work: 39.5% (n=15) indicated that they never used group work as a form of intervention; 21.1% (n=8) indicated that they never used community work. In the focus group, the participants offered a variety of explanations for why primary care social workers did or did not engage in these types of interventions. The reasons identified included the availability of physical facilities, the workers' levels of experience and confidence, and the type of catchment area (e.g. geographically condensed or not). Within the focus group, while one manager expressed frustration that social workers on his team were focusing on individual case work - thus suggesting that having autonomy and flexibility was not always considered a good thing - other participants pointed to the satisfaction associated with being able to tailor the job in line with your own specific interests:

It's all down to the individual and their special interest as well.

I would be very involved in group work and it's about taking your own initiative and seeing, within the primary care teams what are the most common kind of issues that are coming up, can these be met at group level.

In discussing what satisfied them about their role, some of the participants talked about their clients. 32 questionnaire respondents indicated that they had not entered primary care social work straight after qualification. Of these, 40.6% (n=13) stated that they had worked in child protection immediately prior to their current primary care post. Given this relatively high proportion, it was perhaps not surprising that the fact that clients were 'voluntary' rather than 'mandated' was something that both the questionnaire respondents and the focus group participants valued. One questionnaire respondent stated that s/he was interested in working

in a voluntary social work service where clients ‘have free choice to engage or not’. Another worker referred to the fact that she felt appreciated and acknowledged in her role:

I had a guy who sat with me and [said] ‘I can tell you I don’t know where I would be now if I hadn’t met you. I’d be under the ground or in a mental hospital.

The participants also talked about the important contributions that they felt social workers could make within primary care teams. It was evident that these aspects contributed further to their feelings of satisfaction about their role. Focus group participants referred to the values of social work, to the fact that clients were given time and space to tell their stories, and to the fact that social workers were willing to meet people in their own homes. In identifying these aspects, the participants tended to speak comparatively, thus situating social work as ‘different’ from other professions:

We give people time. Other disciplines are all caught up with turnover, how many they see in the day. We bring the very important value of respect for people, self-determination and empowerment. It doesn’t fit in with the medical model.

We do it (social work) with people in their own homes, with their own families, in their own communities, whereas other services are asking people to come to them. So we’re getting them in their own space

Finally, while many frustrating elements of interdisciplinary team work were identified (as will be discussed in the next section), the focus group participants also named positive aspects of working on a team that comprised of different disciplines. In particular, the team members highlighted the benefits of learning from other professions and the benefits of other professions learning from social work:

It’s also looking at other ways to do things instead of the way you have always done it.

Challenges

The respondents also identified challenging aspects of their roles as primary care social workers. To a large extent these challenges were attributed to cut backs and to a lack of resources. In particular, these conditions meant that there were insufficient numbers of primary care social workers in place. While it had been originally envisaged that there would be 250 primary care social workers in the country, at the time of the research there were fewer than 80. Thus, individual workers were attempting to meet the needs of a number of different teams, resulting in an inability to respond to all cases. Of the 38 basic grade social workers who completed the questionnaire, 84.2% (n=32) stated that they were attached to more than one team. Of the 32 attached to more than one team: 12 were attached to two teams; 9 to three teams; 9 to four teams; 1 to five teams and 1 participant did not indicate the number of teams to which s/he was attached. One focus group participant was covering a population of 50,000 people. While some focus group participants felt that primary care social workers should not have waiting lists as immediate contact with clients should be prioritised, others felt that waiting lists were necessary. In relation to this, 42.1% of respondents (n=16) had indicated that they had cases on a waiting list at the time of completing the questionnaire. One worker, who was responding to elder abuse cases as well as primary care cases (because there was no senior case worker for elder abuse in place), stated:

One of the challenges for me would be saying no to cases... It's really hard to tell people you are on the waiting list.

In some cases, only clients with the most complex needs could be seen because of resource and personnel issues:

We only take very complex cases now, particularly because we are covering double the population that we should. Like I'm covering [a population of] over 30,000 and they are very high need patients and because of that only the most complex cases are the ones that I will actually work with and a lot of time it is about giving advice to the other professions on the team about other services in the community that they can refer on to.

In addition, many of the participants worked under a constant threat of redeployment to child protection social work:

You are taking social workers out of the multi d context and not replacing them so obviously that's a major impact, but it also has an effect on the expectation of us as primary care social workers, you know, because it's like one minute you are going to give us a service and the next minute you are just going to pull it away ... And it's not just confusing for us, it is confusing for other members of the multi disciplinary team.

As well as the challenges posed by lack of resources, the participants also referred to difficulties associated with the management structures within which they were working. Many of the participants were supervised by social workers who were not employed on primary care teams: instead they were working in the areas of elder abuse, mental health or child protection. Inevitably, this led to difficulties:

Their knowledge of primary care would be very limited. My supervisor would say to me that she's learning an awful lot more from me than I'm learning from her.

Several of the challenges identified by the participants related to interdisciplinary issues. It was identified that many teams were not fully staffed, with some disciplines missing altogether from the teams. It was evident that while the social workers were part of interdisciplinary teams, the extent to which the disciplines worked as a team was questionable. For example, participants talked about teams not being co-located, about

professionals who did not attend team meetings, about a lack of team work and about a lack of understanding of roles. In relation to this latter point, while the generic nature of the PCSW position meant that social workers could shape their role and could work in diverse ways, at times the generalist nature of the role posed challenges at an interdisciplinary level. Other disciplines sometimes struggled to understand the social work role. One participant gave an example of a client who was assessed as having no occupational therapy needs and no physiotherapy needs, but who needed 'support', and was therefore referred to the social worker. The participant asked 'who decides it is the social worker's job to give longer term support?' and suggested that other professions made assumptions about the social work role. Another participant suggested that social workers had to define a role for themselves:

You have to fight to carve out a niche ... You're not specialist in any area. You're an expert in everything but you specialise in nothing. That to me is what describes primary care social work.

Reference was also made to the fact that in complex situations the social worker was often referred the case. One participant gave the example of a client who had been 'historically difficult'. A number of team members were working with the client but when the social worker started to work with her, she found that all of the work was passed on to her. The participant stated:

They just thought, we've had enough of her

While questionnaire respondents indicated that the majority of the referrals that they received were appropriate, most participants received at least some inappropriate referrals (89.5%, n=34). A wide range of referral types were classified as inappropriate, perhaps reflecting that not all respondents offered a service to the whole community. 34.2% (n=13) stated that, within their team, the social worker does not offer a service to all, with particular client groups excluded (e.g. over 65s, clients with mental health problems). Respondents gave

examples of inappropriate referrals which ranged from ‘child protection and welfare referrals’ and ‘clients who are already linked into other social work services’ to ‘form filling’, ‘social welfare problems’ and ‘referrals related to elder abuse’.

Several of the focus group participants talked about the expectations that other professions had in relation to the social work role in primary care. One participant felt that social workers were considered ‘protection workers’:

With elder abuse, it goes back to the perception of social work in the community as being protection workers... rather than prevention. It's like, you are a social worker, therefore you must be a protection worker so therefore it's your responsibility, if we have no elder abuse worker it's your responsibility as a social worker to fill that gap.

However, not all of the participants agreed with this contention that social workers were considered ‘protection workers’.

Some participants felt that different disciplines had varied perceptions about how an interdisciplinary team should work. For example, one participant talked about ‘ownership of cases’ and about the fact that ‘ideally it should be a team approach to a clinical case’, whereas in reality this did not usually happen. S/he felt that it would take time for other professions to ‘come on board to that way of thinking’:

....it is all well and good to give us clinical team meeting forms that we fill out and what is the plan for this person but the plan may only be that the social worker continues working with them....but it's not a multidisciplinary approach. It's only one member of the team working with that person.

Thus, there was a sense that clients were the responsibility of individual professionals rather than being the responsibility of the team as a whole.

Regarding attendance at team meetings, the questionnaires suggested that General Practitioners (GPs) were frequently absent from the team meetings. As stated previously,

most of the 38 respondents were attached to more than one primary care team. In total, they were members of 99 teams. In 41 of these teams, GPs were the professionals most often identified as being 'frequently absent' from team meetings. To put this in context, the next largest category identified as being 'frequently absent' were nurses but they were only identified in 12 cases. Within the focus group too, the absence of GPs from team meetings was raised as a source of frustration:

In name only, we don't have GPs at meetings, they don't attend, they're running as they were before primary care team came into effect... GPs don't attend at all, they've just withdrawn.

However, not all participants shared this experience. On some teams it was evident that GPs attended meetings. One participant contended that, in fact, GPs had the best understanding of what the social work role involved:

GPs really see the benefit of a social work service in the community, they are our biggest advocates, in terms of advocating for our role and for [its] continuance.

Discussion

In identifying what they found satisfying about their jobs, the primary care social workers in this study drew attention to the generic nature of the role with its associated diversity and flexibility; the fact that clients were attending on a voluntary basis; the opportunity to work with various disciplines; and the belief that social workers could make an important contribution to primary care teams.

As mentioned at the outset, the prevalence of psychosocial issues such as financial problems, personal stress and legal issues (amongst others) has been identified in research by Bikson et al (2009), where the researchers found that patients reported an average of five psychosocial

problems, with 32% of patients wanting to see a social worker. Similar issues were identified by the primary care social workers in Ireland. Issues such as financial difficulties, loneliness and isolation, and difficulties arising from disability and physical illness were identified most frequently. The literature suggests that social workers are viewed as particularly well equipped to deal with such issues (Gross et al., 1996; Keefe, Geron & Enguidanos, 2009; Rock and Cooper, 2000)

The broad remit attached to social work in primary care has been referred to in a number of studies (Keefe, Geron & Enguidanos, 2009; Lesser, 2000). As with the social workers in the Irish study, the social workers referred to by Lesser (2000) work with a range of clients, including children, adolescents, adults, families and the elderly in relation to diverse issues ranging from self esteem and social skills to depression and caregiving. The findings of the Irish research suggest that social workers are not only prepared to undertake work in relation to diverse issues, but that, in fact, this is something that social workers find satisfying about their role. It is interesting to note, though, that while the literature tends to focus on the contributions that social workers make in terms of responding to the psychosocial needs of clients, focus group participants in the Irish study tended to see their contributions as being related to the values of social work and their particular ways of engaging with clients (meeting clients in their own homes, giving them 'space' to talk).

The literature suggests that social workers in primary care use a wide variety of interventions in their work (Firth et al. 2004), something which is again satisfying for the workers. In the current study, it was found that the social workers engaged in a range of individual work (including both practical and therapeutic), group work and community work.

While the Irish participants identified many satisfying aspects of their roles, challenges were also described. These included a perception that primary care teams were not actually functioning as teams (e.g. an absence of team responsibility for clients, a lack of co-location,

team members not attending meetings), an insufficient number of primary care social workers (resulting in waiting lists and the ability to work only with the most complex cases), the threat of redeployment to child protection services, and other professionals not adequately understanding the role of social workers. Related to this latter point, while it was clear that the generic nature of their role was something that the Irish-based participants identified as satisfying, it was also evident that having a generic and diverse remit can result in confusion amongst other professionals and can lead to referrals that are seen to be inappropriate. As such, it can also lead to challenging consequences, as has been found in other research (e.g. Easen, Atkins & Dyson, 2000; Bikson et al., 2009; Keefe et al. 2009; Gross et al. 1996)) . Thus, within the Irish context, the noted absence of general practitioners from team meetings is a worrying issue, both for social workers as they attempt to establish and clarify their role and for clients who will benefit from inter-professional collaboration.

Notwithstanding the fact that some of the Irish-based primary care social workers were only able to deal with the most 'complex' cases because of their workloads, the participants reported that other professionals often referred clients who were viewed as 'complex' or 'difficult' to the social worker, regardless of the presenting issue. This tendency might be partly explained by other professionals believing that their social work colleagues do not have the time to deal with less complex issues. However, it was evident that, to some extent, social workers felt that the referral of 'difficult' or 'complex' cases to them was because of a lack of clarity about the social work role. The suggestion was made that when other professionals 'had enough' of a particular client, a referral to social work was made. Yet, perhaps this could be viewed in a different way. Gross et al (1996) suggest that physicians often do not have the time or the expertise to deal with many psychosocial problems. Elsewhere, Netting & Williams' (2000) qualitative study in the US identified that primary care physicians are faced with trying to address the diverse needs of growing numbers of

older patients who have chronic conditions. Physicians in the study reported that they could not deal with the many psychosocial issues presented by older people yet this was the expectation of these patients and their families. The study concluded that there are opportunities for social workers to collaborate with physicians, demonstrating their skill in dealing with the ‘cans of worms’ or ‘unsolvable problems’ (p.240) that characterise this type of work with an older population. Thus, this suggests that while the referral of complex cases or of clients who are seen to be - as one Irish social worker put it - ‘historically difficult’ can be viewed as ‘passing the buck’, it could equally be viewed as a recognition of the skill set of social workers, who are seen as having the expertise to work with such clients. This reinforces the importance of the findings of Keefe et al (2009:593) which identified the need for the social work role to be clearly articulated as ‘a necessary precondition for effective collaboration by social workers with other team members’.

Conclusion

To conclude, the current study and the literature both point to the range of psychosocial issues dealt with by primary care social workers. It was evident in relation to the social workers in Ireland, that they liked the generic nature of their role, thus suggesting that specialising was not what they wanted. It is clear that the generic role led to job satisfaction for many of the social workers. Yet, while this might be the case, there is little evidence to inform us of whether or not the generic role is in the best interest of clients. This is a significant gap in the available literature which needs to be addressed. There may be room for some level of specialisation within the generic role. For example, if there were a number of primary care social workers on a given team, perhaps some could develop expertise in particular psychosocial issues, whilst also holding a more generic caseload.

The fact that the participants liked working with non-mandated clients is particularly important to note. In the context of the national and international recession, there is a danger that services to such clients will be further curtailed, with resources being focused more on mandated clients, particularly in child protection. However, given the evidence that the role and skill set of the social worker is valued by interdisciplinary members of primary care teams, and given the important role that social workers play in dealing with a range of psychosocial problems – some of which stem from issues relating to the recession – it is crucially important that every effort is made to protect front line generic services such as primary care social work.

Finally, it is important to note that most of the participants in this research were relatively experienced social work practitioners. This may have meant that it was easier for them to be clear about their role, to establish priorities, to work to their strengths and to recognise the importance of their contribution. This might be more challenging for inexperienced social workers, particularly in a context where there are no other social work colleagues on their team. In particular, it might be challenging for them to clearly establish their role and its boundaries. This in turn could lead to a lack of clarity amongst other professionals on the team. Overall, this points to the importance of primary care social workers receiving regular professional support and supervision from more senior staff within primary care, rather than from senior staff working in other areas of social work.

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