INTERNATIONAL PERSPECTIVES ON SOCIAL WORK IN HEALTH CARE

PAST, **PRESENT** AND ***FUTURE***

Gail K. Auslander, DSW

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International Perspectives on Social Work in Health Care: Past, Present and Future

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International Perspectives on Social Work in Health Care: Past, Present and Future

CONTENTS

ABOUT THE EDITOR

Gail K. Auslander, DSW, is Senior Lecturer and Deputy Director of the Paul Baerwald School of Social Work at The Hebrew University of Jerusalem in Israel. She has taught and written extensively on quality assurance and improvement in social work in health care, computerized information systems for social work in health systems, and the role of social networks and social support in coping with serious illness and disability. Dr. Auslander served as Chairperson of the Scientific Program Committee of the First International Conference on Social Work in Health and Mental Health Care, from which the chapters in this book were selected.

Introduction

Gail K. Auslander, DSW

The First International Conference on Social Work in Health and Mental Health Care, held at The Hebrew University of Jerusalem, Israel in January 1995, brought together social work practitioners, educators and researchers from around the world. Over the course of five days of meetings and deliberations, more than 350 scientific papers were presented, dealing with key issues, trends and innovations in social work in two related fields–health and mental health. The papers included in this volume represent a selection from those focusing on social work in health, while those dealing with mental health will appear in a future volume.

Whether by fortuitous coincidence or as a developmental milestone, the convening of the conference took place as social work in health marked its centenary as a field of professional practice. Antecedents of professional involvement in the health field were already evident in the earliest hospitals, where clergy and volunteers cared for the social and spiritual needs of patients both during and following hospitalization (Cannon, 1930; Stillman, 1920). Professional social work in health care is generally traced to the seconding of lady almoners from London's Charity Organization Society (C.O.S.) to the Royal Free Hospital in 1894. A decade later, social workers were employed in Boston's Massachusetts General Hospital in the U.S., with other countries following suit in the decades to come (Cannon, 1930; Cabot, 1909).

While the ensuing years have borne witness to numerous changes in both the profession and the context in which it is practiced, many of its early foci and concerns are still relevant today. For example, early practitioners noted the interaction between individuals' psychosocial and physiological states and the need to see the patient as an integrated whole. Thus,

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one report of the London C.O.S. claimed, "Illness in the working classes is so frequently the result of some social problem that to treat with medicine and advice only, is now beginning to be generally recognized as unscientific" (Bosanquest, 1914, p. 222). The need to coordinate between hospital and community and the importance of discharge planning were also recognized early on: "To be effectual, even to be equitably administered, medical charity must act in allegiance with general charity" (Cannon, 1930, p. 8).

Issues which occupied the profession's founders in its infancy have continued to occupy us through the years. They include attempts to arrive at a reasonable balance between preventive and curative interventions, interdisciplinary relations and problems of professional accountability (Lubove, 1980; Trattner, 1979). Likewise, difficulties in conceptualizing and classifying interventions and outcomes were evident almost from the outset. As Cabot (1909) noted, "I think the value of the social worker and his proper recognition are considerably limited by the fact that he cannot often recognize himself or tell you what the value of his profession is" (p. 38).

Social work in health has since developed into one of the largest sectors in the profession in most developed countries (Hopps and Collins, 1995). Along with that growth have come numerous changes in our practice environment. Life expectancies have increased, leading to a need for more and better services for older persons. Advances in medical science and technology, while creating opportunities for improved health and well-being have also raised previously undreamed of dilemmas and problems around the end of life as well as its beginnings. As treatments improve for some ailments, new ones arise, many clearly tied to trends and changes in our psychosocial environment. The organizational surroundings in which social workers practice is likewise changing–resources are being reallocated, priorities are being redefined; hierarchies are becoming flatter; workers and clients alike are being asked to team up in improving the quality of care. And on a broader scale, national boundaries and priorities have changed, enemies have become allies and vice versa; communication has accelerated incredibly, with technology facilitating the transfer of information while posing new threats to personal privacy and professional confidentiality. Social work in health the world over has developed alongside and in concert with these changes in its environment.

The First International Conference on Social Work in Health and Mental Health Care was based on the premise that knowledge is transferable across boundaries, be they geographical, political or cultural. It aimed to uncover common issues and themes which transcend boundaries and encourage practitioners and academics from different backgrounds to exchange in-

formation and learn from each others' experience and expertise. Several such themes were predetermined as part of the conference program. Others emerged from presentations and ensuing discussions. Many of them find expression in the papers selected for publication in this volume.

Common to most of the countries represented at the conference was a rapidly changing socio-political and economic context in which health services are offered. Social workers are faced with the need to adapt to those contexts. Key among them is the move away from in-patient care and towards the provision of care in the community. Social workers are increasingly expected to adopt a public health philosophy, with its emphases on identifying high risk groups, prevention and health promotion. The well-being of both patients and institutions requires knowledge and skills in networking, mediation and advocacy on the part of the social worker, in order to successfully link communities and the institutions which serve them. While the development of these links have provided opportunities for innovation and professional development, they have also proven problematic, with the decentralization of decision-making both on a service and individual case level exacerbating existing shortcomings in resources and service delivery mechanisms.

Most countries are also attempting to regulate the continually rising costs of health care. The most common tools for doing so are based on prospective funding and managed care, aimed at enabling more rational planning and prioritizing of needs. However, such mechanisms are fraught with difficulties for social workers and their clients. On the one hand, social workers have been called upon to advocate for the needs of clients whose characteristics and treatment needs deviate from the norms upon which such systems are based. On the other hand, they have challenged social workers to more clearly delineate exactly what it is that they do and for whom, in order to assure that those activities are included in the various schema of planning and financing of patient care.

These demands, we should note, come not only from outside the profession, but also from within. A recurring theme of the conference was the need for social workers to be accountable for their own practice and provide evidence of their achievement. This included numerous efforts to conceptualize, quantify and measure the outcomes of social work interventions. Attempts to assess the resolution of specific client problems have been expanded to include more comprehensive measures of quality of life and well-being, among families, communities and organizations as well. Together with this targeting of outcomes, we also witnessed a renewed emphasis on the *process* of caregiving. This reflects both a concern with conceptualizing and demonstrating what it is that social workers do,

as well as the need to specifically link interventions with outcomes in the accountability process.

Changes in the organizational environment have also presented social workers with opportunities to change and expand their roles. Many social workers have redefined their roles to include new tasks and take on others which might previously have been done by other professionals. Key among them seems to be an educational and training function, aiding other members of the multidisciplinary team to cope with those same organizational changes. Social workers are also being encouraged to identify and capitalize on their unique skills, as case managers, coordinators, evaluators and researchers, for example, to carve out new roles within the changing organization. Likewise, they are being encouraged to expand their domain across functions.

Another common thread reflected throughout the conference was the need to develop new and innovative theoretical and practice models. Existing models were criticized as being biased or irrelevant for some of health care social work's target populations and high risk groups. New models were suggested and evidence presented supporting their validity. Similar patterns could also be observed in research methodology, where a need was expressed for increased flexibility in research design. With more and more practitioners heeding the call to become actively involved in studying their own practice, we also observed a proliferation of small studies, requiring designs which are valid in such situations.

Finally, participants in the conference were provided with numerous opportunities to "see ourselves as others see us." In particular the centrality of the client to the social work process was stressed. Drawing on models of quality assurance and improvement, social work clients are increasingly seen as customers or consumers of services, whose satisfaction is a central indicator of effectiveness. Other models stressed the importance of providing clients with the information necessary for them to make appropriate choices regarding their care now and in the future. Yet others provided examples of systematic research aimed at describing the clients' views of their needs and the extent to which they are met by social work interventions.

These are just some of the common themes which echoed throughout the conference. The papers which appear in this volume relate to many of these themes, although this was not a criteria for their selection. Rather they were selected from among numerous submissions, based first and foremost on their quality and relevance as determined by the editors and a team of anonymous reviewers. The large number of quality submissions allowed for the publication of two collections: health and mental health.

The mental health collection is being edited by Uri Aviram, who served as Chairperson of the conference's organizing committee and played a key role in the publication of both volumes.

Owing to the multinational nature of the conference, an effort was made to include papers from a variety of geographical areas. The 700 participants in the conference hailed from 21 countries, six of which are represented among the authors. Most of the participants and authors come from the developed countries of Western Europe, North America, Australia and Israel. In spite of our concerted efforts to the contrary, less developed countries, the Far East and South America were underrepresented at the conference. If international cooperation and collaboration are to be the aims of future conferences, further efforts need to be made to broaden the base of participation.

The papers presented here also represent a mix of practitioners and academics, including several papers which reflect a collaborative process between the two. Following their review, the papers accepted fell naturally into four main content areas: health policy and social work; social work practice issues in health; developments in health social work research; and social work administration in changing health care organizations. These areas provide the framework for this volume. Each of the four sections is preceded by a brief introduction which sets the context for the papers and highlights key points. Taken all together, they attest to the common interests and concerns of social workers in health and provide evidence of a wealth of social work knowledge and potential in a range of contexts and countries.

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I. HEALTH POLICY AND SOCIAL WORK

Introduction to Section I

Gail K. Auslander, DSW

The four papers in this section address various aspects of the evolution of health care policy, and the implications of those policies for social work. They present critical analyses of past policy decisions and their consequences for the current state of health care systems. All of the authors consider health as a social utility, but each paper explores different paths of change for social work and social policy as regards health.

Gary Rosenberg and Gary Holden focus on the role of social work in relation to the community and the changing health care system. They suggest that social work should play a major role in connecting communities and health care institutions, with a goal of improving communities' quality of life. In carrying out this role, they suggest that social workers concentrate their efforts in five domains: establishing services to enhance community health; preventive interventions with vulnerable populations; improving screening, assessment and evaluation of practice, linking social agencies to the health system and managing a range of health related activities. The move into these areas will require social workers to adapt

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and broaden their knowledge and skills, cutting across traditional organizational and intellectual boundaries.

Miriam Dinerman also examines future roles for social work in health, in light of the transformation of health care in the U.S. into a market commodity. This evolving marketplace is characterized by a move to managed care, organizational integration and an overriding concern with costs. During the period of transition, Dinerman contends, it is imperative that social work stake out its domain, including such areas as case management, interweaving care of the chronically ill with that provided by informal networks, provision of crisis and other counseling services and improvement of compliance. Maintaining its primacy in these areas will require that social work demonstrate its effectiveness on at least two fronts: it must show both that it makes a difference in patient care outcomes as well as contributes to the mission and goals of the organization.

One of the main areas of social work concern vis-à-vis health care policy is the allocation of services. Hans S. Falck suggests that the use of membership theory will enable us to more clearly define health as a public good, so that the health of an individual member is seen as having consequences for other members of society as well. In his view, rational planning for the allocation of services could be further improved by arriving at a clear definition of adequacy. Adequacy, in turn, rests on the simultaneous consideration of two concepts: conditionality and prioritization. The first is a boundary-setting determination; the second, a process of ranking the importance of various health care elements in relation to each other and in relation to other societal needs. Their interaction is then central to making judgments about the adequacy of health services for the membership of a specific community.

The final article in this section presents a critical analysis of health systems in general and the Israeli health system in particular as they relate to women. Amy Avgar draws upon feminist theory to try to explicate and understand gender differences in health and health care. She argues here that men dominate among health care providers as well as in relationships between physicians and patients. Gender differences also affect the development of knowledge, with much of what is known regarding the causes and treatment of disease deriving from research done on men. To correct these biases, a broader approach to health and health care is suggested, based on wellness and health promotion in addition to curative interventions, and in which femaleness is considered an operative norm. While focused on imbalances in the provision of care along one particular axis (gender), the remedial steps suggested here offer valuable suggestions for social work's development and contribution to health care systems in general.

The Role of Social Work in Improving Quality of Life in the Community

Gary Rosenberg, PhD
Gary Holden, DSW

INTRODUCTION

What are the appropriate roles for social work now and in the future within the health care area of practice? Why is it so difficult to reach consensus about this issue? Why does our literature consist of studies, theories and descriptions of practice that foster dissension, lack a coherent approach and are replete with unresolved conflicts? Conflicts abound in social work. Among the most prominent are: an emphasis on policy vs. practice; individual casework vs. group and community practice; agency work vs. private practice; practice vs. research; quantitative vs. qualitative; cause vs. function; advocacy vs. social control; town vs. gown; individual vs. environment; psycho-social services vs. resource needs. In health care social work we can add inpatient vs. outpatient; hospital vs. community; individual vs. family intervention; high tech vs. high touch.

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Past, present and future professional conflicts aside–we think that social work's future in health care is in connecting members of communities to health and the treatment of illness by providing a range of social services that no longer fall neatly under the rubric of health care social work. The profession, with others, will provide a full range of psychosocial services to community members, mostly outside inpatient hospitals, directed towards health promotion through lifestyle changes; prevention programs in the style of the settlement movement, using educational and group methods; services to vulnerable populations including the aging and the medically and psychiatrically chronically ill in community, primary and tertiary care settings; provide cross functional program management in a variety of health care and social agency settings; continue to provide transition planning in inpatient settings; and provide clinical social work services to those persons, couples, families and groups seeking clinical services. One of the more difficult problems confronting the profession is to successfully manage the transition from where we are now to what we envision as future practice domains.

The issue of community cuts across all of these domains to some degree. The American health system is anti-community. Coverage is provided for *insurance communities*–groups of persons who may or may not share much in common beyond the fact that they are insured by one of the thousand companies who provide such insurance–usually at a huge profit. The health needs of a geographic community are not met–nor even assessed by–a single provider. Rather they are addressed by multiple providers who are encouraged to compete in the marketplace. In a shifting health care landscape American social work has been focused on:

- the individual *rather than* the person and their significant memberships (Falck, 1988);
- the sources of funding *rather than* the needs and programs that should be developed to strengthen families and communities;
- on treating illness and its psychosocial consequences *rather than* providing these services *and* also developing programs that promote health.

In relation to this last point, Cowen (1994) has recently pointed out that many involved in primary prevention, including NIMH, seem to conceptualize primary prevention as the prevention of dysfunction *rather than* the prevention of dysfunction *and* the promotion of psychological health.

There are numerous possible explanations for these developments. Falck might point out that it is inherently flawed to conceptualize our work as being with individuals *and* with some larger unit of attention. His view is

that to overcome this flawed conceptualization we need to focus on membership–and the 'fact' that every person is a permanent "element in the community of men and women" (p. 30). Whether or not one chooses to adopt the membership perspective it seems clear that this American fixation with individualism continues to be a major obstacle at both the practice and policy level for health social work in America (cf., Specht & Courtney, 1994).

While American health care policy lags behind western Europe, particularly in access, American health policy has worked well when we deal with real and visible shortages–or as Richmond and Fein (1995) have noted, we operate best on the basis of a deficit model. When there was a deficit of hospital and nursing home beds, and with physicians and other health personnel, we dealt effectively with these deficits. Acute care general hospital beds increased, and there was an increase in the numbers of physicians and other health professions including social workers. During the same period, legislation abounded, such as:

- Medicare and Medicaid;
- Regional medical programs;
- Comprehensive health planning assistance;
- Health Professional Educational Assistance amendments;
- Maternal and infant care under Title V;
- Neighborhood health care centers and Head Start as part of the Economic Security Act.

Three consequences of the deficit model emerged. A for-profit delivery system materialized and rapidly grew. Health care expenditures increased rapidly without controls, and the increased dollars available to hospitals were used for further growth and increased debt service rather than to meet community need. No one asked how much is enough or what does the community need? Health care is not just another good or service in the marketplace. Future social work practice will take place in an environment of confusion and complexity. Resolution will slowly occur only as the public comes to understand the need for universality within the context of limited resources and as successful state and federal experiments in health delivery and financing are disseminated. American social work will need to help resolve several policy issues that effect practice and service delivery. These involve questions such as:

- How do we fulfill our commitment to equity–that all citizens are assured of access to quality services?
- How do we insure that health care expenditures are constrained at levels society judges to be reasonable?

- How do we increase resources *for* and emphasis on health promotion and disease prevention?
- How do we support the continuation of biomedical and psychosocial research in health?

Policy debates must focus on patient, community, and health care system needs and on the health care resources required to meet those needs in a responsible, effective and efficient manner. There are at least four reasons why hospitals, health systems and social agencies should focus on the community.

> The first reason is institutional self-interest, including the safety, cleanliness, and attractiveness of the physical setting. . . . The second reason . . . includes the costs (financial, public relations, and political) to the institution that result from a retreat from the community as well as the benefits that accrue from active, effective engagement. . . . The third reason involves the advancement of knowledge, teaching, and human welfare through academically based community service focused on improving the quality of life in the local community. . . . Promoting civic consciousness . . . is the core component of the fourth reason for significant . . . involvement with the community. (Harkavy & Puckett, 1994, pp. 300-1)

This paper explores the terrain in very broad terms, focusing on the role of social work in relation to the community and a changing health care system. It is not by any means a comprehensive review of the vast literature in this area–but rather a modest initial attempt to grapple with some of these issues.

COMMUNITY

While we will discuss the role of social work in the community, we will in fact be referring to the relationship between a relational community–the profession of social work– and the territorial communities, such as neighborhoods–that it works with (Gusfield, 1975, cited in McMillan & Chavis, 1986). If social workers are going to increase their work with territorial communities, then one of the first questions we will need to grapple with is: What are the objectives of such an intervention? We think at the broadest level our objective should be to improve communities' quality of life.

QUALITY OF LIFE

What is quality of life? Probably most of you have seen the construct being used to assess the impact of some health related intervention. From the medical perspective, Schipper, Clinch and Powell (1990) propose the following definition:

> 'Quality of Life' represents the functional effect of an illness and its consequent therapy upon a patient, as perceived by the patient. Four broad domains contribute to the overall effect: physical and occupational function; psychologic state; social interaction and somatic sensation. This definition is based on the premise that the goal of medicine is to make the morbidity and mortality of a particular disease disappear. We seek to take away the disease and its consequences, and leave the patient as if untouched by the illness. (p. 16)

This view is limited. It is limited to illness and the treatment of illness. Do we still think that health–as an element of quality of life–is comprised entirely of illness and treatment? The Schipper, Clinch and Powell definition is also limited in the same way that social work is often criticized for being limited–it is individually focused.

McDowell and Newell (1987) have advanced the more general view that: "Quality of life relates both to the adequacy of material circumstances and to people's feelings about these circumstances. . . . Health is generally cited as one of the most important determinants of overall life quality" (pp. 204-5). While Schipper, Clinch and Powell focus on the impact of the illness and therapy on the individual, McDowell and Newell at least refer to "material circumstances." What can be explicated regarding those material and other circumstances that contribute to an assessment of community quality of life? While much more work is needed in the conceptualization and development of quality of life measures, we think the construct can serve as a broad objective of social work interventions.

Social work will provide services in five domains as we transition into the future. Perhaps the title of an American movie is apt in describing our perspective–namely back to the future. The five domains are:

1. Establishing programs to enhance community health.
2. Identification and intervention with vulnerable populations–especially with primary prevention.
3. Utilization of social epidemiological and social science techniques to improve screening, assessment and evaluation of practice.

4. Linking community agencies to health care in order to achieve comprehensive social services.
5. Provision of cross-functional program management.

The first domain is to establish programs to enhance community health. These programs are more than primary prevention in the public health model. They are based on the concept of developmental provision advanced by Alfred Kahn (1969). Social work will help provide "those social utilities designed to meet the normal needs of people arising from their situations and roles in modern life" (p. 188). No pathology or problems are stated or implied. Social work along with others helps provide the social architecture for enhanced community living.

Dever (1991) views the current period and near future, as the third phase in the historical course of health. He terms the current period the Social Transformation phase and states:

> By the year 2000 and beyond, this continuing shift to service occupations will play a major role in formulating disease patterns. The interaction of the increasing rate of change, technology shifts, greater crowding (density), information overload, and stress–all characteristics of the service and transformation society–play a role in creating new disease patterns. (p. 12)

Brown, Ritchie, and Rotem (1992) note the suggestion that "the present European population may be the healthiest the human species will ever know, with a life expectancy of 80 years sandwiched between the defeat of infectious and lifestyle diseases, and the risk of projected environmental hazards" (p. 225). These authors propose that in terms of health promotion:

- there is an integral relationship between people's health and their environment, to the extent that confronting the actual infective and causative agents of disease is of secondary importance to changing the social and physical environmental conditions which permit the onset of a disease;
- vulnerability to new waves of health risk is greater for the economically disadvantaged in every community in the industrialized and newly industrializing worlds, so that improvements in living conditions becomes, by definition, a health promotion strategy (pp. 221-2; cf., Bullard, 1990).

Responses to hazards in our environment will depend upon our understanding of them. Many authors have noted that the conclusions we arrive

at about environmental risks are value laden and socially constructed–that they may differ according to the role of the observer (e.g., Baxter, Eyles, & Willms, 1992; Cvetkovich & Earle, 1992; Dake, 1992; Fitchen, 1989). For instance, residents of a neighborhood exposed to some toxic contamination may continue to react "hysterically," even though government officials have provided them with an "objective assessment" that determines the risk is "minimal."

Health care social workers through the use of social epidemiology and survey methods may be very helpful in both identifying health risks and in resolving differences in perception regarding them. But the larger question is: What else does social work have to add to community level, health promotion beyond what is now being done? Chavis' recommendations are appropriate for social workers moving into more community-based interventions.

> help institutional leaders . . . to develop the capacity within their institution to reach out to learn about the strengths, needs and dreams of their communities. . . . help these institutions develop the capacity to respond to the needs of their communities by identifying models, distilling the research knowledge, linking them with others with similar dreams, brokering resources with other institutions, developing the social technologies to be tested and refined, and engaging in an efficient collaborative planning process. . . . build the capacity of local institutions to initiate comprehensive programs. . . . increase the accountability of institutions. . . . increase citizen control over institutions. (1993, pp. 172-3)

Haglund, Weisbrod and Bracht provide some specific questions in four areas that are important for assessing health related quality of life at the community level. These are:

> What are the geographic features of this community? What are its unique concerns, health related community agendas, and recent civic actions? . . . What are the behavioral, social, and environmental risks to the population and/or special subgroups? . . . What are the levels of ill health and disability? Indicators of wellness? . . . What programs, resources, skills and provider groups already exist? What is the level of participation in these programs? In what areas is there a need to develop or expand? (1990, p. 97)

If we can answer these questions then we have taken our first step in this domain of establishing programs that will improve quality of life at the community level.

The move toward this domain is, in part, a return to our settlement house roots. Harkavy and Puckett (1994) remind us that Hull House provides an important model for three reasons.

> First, the Hull House residents emphasized amelioration and reform. Although they too frequently acted for rather than with their neighbors, they believed in and espoused the ideal of empowering community residents to address social problems. Second. . . . their ameliorative, reformist approach to social science integrated the production of new knowledge and the uses made of that knowledge. Third, Addams and her Chicago colleagues recognized that the social problems of the city are complex, deeply rooted, interdependent phenomena that require holistic ameliorative strategies and support mechanisms if they are to be solved. The settlement house provided, albeit on a small neighborhood scale, a comprehensive institutional response to social problems. (p. 309)

Harkavy and Puckett are not alone. Specht and Courtney advocate a move away from individually focused psychotherapy to a system of community service centers. They describe these centers as follows:

> A community-based system of social care will be *universal*–that is, available to everyone; *comprehensive*–providing on one site, all of the kinds of social services required by an urban community; *accessible*–easily reached by all people in the area designated as the service area; and *accountable*–with community residents having a prominent role in making policy for the service and overseeing its implementation. . . . the center will provide programs to meet the normative needs of all community residents. . . . The first order of priority in the establishment of center programs should be the development of child care and parent education related to child care. . . . the second order of priority should be services for older adults, a service bureau, and a citizens' advice and education bureau. . . . A third order of priority . . . should be the establishment of self-help groups . . . adult education classes . . . a program of physical education, and programs for older teenagers. . . . The community service center should have a mix of some qualities of a public school, a settlement house, an adult education center, and a community center. (1994, pp. 152-61)

While we disagree with aspects of the positions taken by these and other current authors, we do agree with the broad general theme–the need for social work to move back toward the community.

The second domain we see emerging in the profession's future is identification and intervention with vulnerable populations–especially with primary prevention. This in no way is meant to demean the excellent ongoing efforts of those providing clinical interventions. A vast number of research studies have clearly demonstrated that psychological, educational and behavioral interventions are "efficacious in practical as well as statistical terms" (Lipsey & Wilson, 1993, p. 1199). The point is that we need to expand our practice.

We know that in the United States, for instance: "By virtually every health status indicator–life expectancy, mortality, morbidity, and utilization of and access to health resources–minorities fare more poorly than the general population" (USDHHS, 1993, p. 3). If we narrow this down to the community where we work, McCord and Freeman (1990) report that the rate of survival beyond the age of 40 was lower for men in Harlem than it was for men in Bangladesh. The results for women in Harlem were similar. More recent data demonstrate that Harlem continues to be at risk for poor health outcomes. Women from Harlem giving birth had more preventable risk factors than women in New York City as a whole. The death rates per 100,000 population are higher in Harlem than in New York City as a whole for: all causes combined, AIDS; pneumonia and influenza; cerebrovascular disease; chronic obstructive pulmonary disease; chronic liver disease and cirrhosis; drug dependence and accidental drug poisoning; homicide; and undetermined injuries (NYCDOH, 1994).

Another group with vulnerabilities is older adults. The U.S. Department of Health and Human Services (1990) notes that:

> In 1900, people over 65 constituted 4 percent of the population. By 1988, that proportion was up to 12.4 percent, by 2000 it will be 13 percent and by 2030, 22 percent. . . . The prevalence of disability increases with age, as one would expect. . . . More than one out of five people aged 65 and older is limited in one or more . . . major activities, and nearly half of those aged 85 and older need assistance in activities of daily living. (USDHHS, 1990, pp. 23, 40)

The estimated probability of using a nursing home increases as age at death increases–from 17% for those who die between 75 and 84, to 60% for those who die between 85 and 94 (Kemper & Murtaugh, 1991).

Another group with vulnerabilities which often but not always overlaps with the elderly are those individuals with a chronic illness. In the United States, approximately: "33 million people have functional limitations that interfere with their daily activities, and more than 9 million have limitations that prevent them from working, attending school, or maintaining a

household" (USDHHS, 1990, p. 73). It is very likely that we will see a growing population of chronic care persons, who with advancing technology, will be able to receive care in ambulatory settings or in the home.

Social workers will need to provide continuous psychosocial interventions with these vulnerable populations. It will become increasingly essential for social workers to intervene directly within the family system itself, not only with the person but within the caregiving context. When such caregiving or social support is unavailable, as it often is, social work must also be equipped to integrate formal and informal systems of care. While the work will be carried out in both traditional and nontraditional settings, the objectives will always be to reduce the years of unhealthy life and enhance those years of healthy life beyond medical notions of health as simply the lack of disease.

Finally, as we work with these vulnerable populations, we will need to be vigilant regarding the medicalization of social services. Health promotion is more than medicine. Terris states clearly that, "Medical care is the least significant of the basic triad of public health. The most important determinants of health status are preventive services on the one hand, and living standards on the other" (1994, pp. 5-6).

The third domain involves utilization of social epidemiological and social science techniques to improve screening, assessment and evaluations of practice. Primary care is not the place for large numbers of social workers. But as Simmons (1994) has pointed out–it is very appropriate for social workers (and nurses) to provide both assessment and personal care planning for frail patients with multiple needs. Related findings amplify the needs that are present in such settings. Summarizing work done prior to 1989, Morlock writes:

> Studies on the prevalence of mental disorders in ambulatory care settings have usually reported that between 15 and 40 percent of patients have some significant psychosocial problem deserving of provider attention. . . . Results from several studies . . . suggest that 7 to 13 percent of patients seen in primary care settings suffer from chronic mental disorders with some degree of functional disability or impairment. (Morlock, 1989, p. 40)

It's clear that social workers are capable of providing assessment and planning services in ambulatory care and that there is a large need for such work.

Could it be that one way to move ahead with high risk screening is to explore the incorporation of standardized assessments into the screening mechanism? What might be gained if we found the time and resources to

do more in-depth screening? What if every patient that might need or want social work services got an in-depth screening? Would this result in improvements large enough to justify the increased expenditure of resources?

What standardized assessment? There are a variety of approaches that could be considered–ranging from behavioral or eco-systemic assessment; to Hudson's Clinical Measurement Package; to expert systems; to the PIE or Person-in-Environment system (Hudson, 1982, 1984; Karls & Wandrei, 1992, 1994; Mattaini & Kirk, 1991; Mullen & Schuerman, 1990; Nizza, 1992). It seems to us that the time for initial development and debates regarding the relative merits of such assessment systems has passed. It's time to engage in systematic, empirical comparison of the various systems.

In terms of the fourth domain, linking social agencies to the health system–comprehensive social services require a network of services that cannot be provided by a single health system or hospital. It is necessary to link community agencies to health care, in order to achieve comprehensive social services. Simmons has addressed the goal succinctly in her discussion of services for the elderly: "An integrated delivery system is needed that melds biopsychosocial assessment and interventions, self-care regimens and coordination of complex medical in-home supportive services as an alternative to acute and skilled nursing facility care" (1994, p. 40). What other professional group has the same mix of experience and skills in assessment and coordination of caregiving in the community?

The fifth domain concerns an important change in the social work management role–the move towards cross-functional management. Just as the sea of changes in health care have impacted dramatically on all of the topics that I have discussed today–the same is true in the management arena. Dimond (1993) describes the change well:

> The generation of managers who did the thinking and let employees do the implementation is being swept aside by the new wave of management downsizing, in which cross-functional management and cross-functional teams are reshaping organizations, making management structures flatter and working units leaner and more efficient. . . . a "systems" viewpoint, personnel expertise, communication and negotiation skills, and value-based decision-making–all these are essential attributes for the cross-functional manager. (Dimond, 1993, 1, 9, 12)

Managers of the settlement houses were responsible for a wide variety of activities, as well as professional and nonprofessional staff. The current organizational environment requires a return to such cross-functional com-

petency. Social workers are highly qualified to provide cross-functional management of programs that cut across traditional organizational boundaries and provide support to improve quality of life, and services to those with defined psychosocial problems.

CONCLUSION

To conclude, social work in the next century must become more generalist; we must broaden ourselves. We need to extend the sites of our work into the community; we need to think about quality of life in broader terms; and to expand the types of work we do. These exhortations to broaden your view, to learn more–in a world where the volume of information increases on a daily basis–can seem overwhelming. But the reality is that we will have to maintain a broad range of knowledge, as the amount of knowledge continues to increase.

To move back to the vision of the founders of the Settlement House Movement and combine their vision with those who founded the Charity Organization societies, will bring back into better balance social works' contributions to its community and the society in which it works.

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