UNIVERSITY OF CANBERRA

SOCIAL WORKERS IN GENERAL PRACTICE PILOT PROGRAM

EVALUATION REPORT

phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

UNIVERSITY OF CANBERRA

SOCIAL WORKERS IN GENERAL PRACTICE PILOT PROGRAM

EVALUATION REPORT

phn ACT
An Australian Government Initiative

Capital Health Network
Partnering for better health

ACKNOWLEDGEMENTS

This is the evaluation report of the Social Workers in General Practice Pilot program, which was commissioned by the ACT Primary Health Network, Capital Health Network. The Social Workers in General Practice evaluation was undertaken by researchers from the Health Research Institute at the University of Canberra.

The evaluation team would like to acknowledge and thank the Social Workers, Practice Managers, general practitioners (GPs), staff, patients, and carers at the 4 general practices who participated in the pilot program. We are also grateful for the contributions of the Health Care Consumers Association for their time and valuable insights around consumer and carer participation.

The Research team acknowledges the contribution of the following staff on the project:

- Professor Rachel Davey — study Chief Investigator
- Ms Andrea Gledhill — research officer; project manager and conducted data collection, general practice liaison, and completed the evaluation of the study
- Dr Debbie Noble-Carr — social work research consultancy; conducted Social Worker qualitative evaluation, data analysis and independent evaluation review

The opinions expressed are those of the authors and do not necessarily reflect those of the funding body.

This evaluation of the Social Workers in General Practice pilot program is supported by funding from the ACT PHN through the Australian Government's PHN Program.

Suggested citation: Gledhill A., Davey R. Social Workers in General Practice Program: Evaluation Report. Capital Health Network (2024).

ACKNOWLEDGEMENT OF COUNTRY

Capital Health Network acknowledges the Ngunnawal people, the Traditional Custodians of the country on which we work and live, and recognises their continuing connection to land, waters and community. We pay our respects to them and their cultures, and to Elders both past and present.

CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACRONYMS

ACRONYM	EXPLANATION
AASW	Australian Association of Social Workers
ACT PHN	ACT Primary Health Network
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AMHSW	Accredited Mental Health Social Worker
CALMS	Canberra After Hours Locum Medical Service
CHN	Capital Health Network
DSP	Disability Services Pension
ED	Emergency Department
EOI	Expression of Interest
FPS	Focused Psychological Strategies
FTE	Full Time Equivalent
GP	General Practitioner
GPMP	General Practice Management Plan
HCCA	Health Care Consumers Association
HREC	Human Research Ethics Committee

ACRONYM	EXPLANATION
HRI	Health Research Institute
LoC	Locus of Control
MBS	Medical Benefits Scheme
MDTR	Multidisciplinary Team Care Review
NDIS	National Disability Insurance Scheme
NHS	National Health Service
PHN	Primary Health Network
PROMS	Patient-related Outcome Measures
PROMIS	Patient Reported Outcomes Measurement Information System
PTSD	Post Traumatic Stress Disorder
SWiGP	Social Workers in General Practice
TCA	Team Care Arrangement
UC	University of Canberra
VPR	Voluntary Patient Registration
WAPHA	Western Australian Primary Health Alliance

EXECUTIVE SUMMARY

INTRODUCTION

Multidisciplinary patient care within a primary health care setting increases the capacity of primary care professionals to deliver high-quality services at the right time and place, contributing to reduced health care costs and improved health outcomes.

Studies from the USA and UK describe models of social work integration in primary health care that are often focused on the role they play in mental health care.[1] Social Workers assist people living with a wide array of issues, including chronic conditions, chronic pain, disability, Post Traumatic Stress Disorder (PTSD), substance use disorders, family violence, elder abuse, child abuse, housing, finances, life transitions, and access to social services. The inclusion of social work services can significantly enhance patients' overall wellbeing and engagement with medical care. For instance, someone with Type 2 Diabetes may struggle to follow their doctor's advice on managing the condition due to financial or emotional challenges. Social work practice encompasses assessments, crisis intervention, counselling, and evidence-based therapeutic interventions, as well as case management, group work, service coordination, advocacy, education, and practical support.[1]

Literature suggests that such integration has benefits for patients' and carers' physical, social and emotional wellbeing.[2] There is a consensus that multidisciplinary care teams that include Social Workers yield positive outcomes for individuals, health professionals and the broader health care system. While Social Workers are established in hospitals and community care in Australia, their inclusion in general practice settings is an emerging concept.

PROBLEM

In the 2021–24 Annual Needs Assessment, Capital Health Network (CHN) found that around 52.3% of adults in the ACT have a chronic health condition and that social determinants greatly impact health and social service accessibility in the region.[3] CHN is focused on exploring solutions to complex care issues and enhancing access to health and social services in the ACT.

SOLUTION

In July 2022, CHN funded the Social Workers in General Practice (SWiGP) pilot program to address some of these challenges within general practice. The program funded the employment of Social Workers as members of a multidisciplinary primary health care team across 4 general practices in the Australian Capital Territory (ACT). Each practice employed an on-site Social Worker for 0.4 to 1.0 FTE hours.

All Social Workers worked within their current scope of practice as outlined by the Australian Association of Social Workers (AASW). Their role was tailored to each practice's target population e.g. older adults aged over 65 years, marginalised groups, those requiring low level mental health support, patients with complex care needs, and those requiring help to access other services such as the National Disability Insurance Scheme (NDIS), and My Aged Care (MAC) packages.

SWiGP welcomed referrals for current patients of the practice from general practitioners (GPs), Practice Nurses, other practice staff, and external organisations. Patients had an option to self-refer.

FINDINGS

There were 533 patient referrals across a 12-month evaluation period between April 2023 and March 2024. Of these referrals, 513 were accepted into the SWiGP program after social work assessment. The average age range of SWiGP participants reflected the needs of individual practices — one practice had a mean patient age of 46 years, while the other 3 practices averaged 63 to 76 years. Female patients comprised 66% of referrals. The most common reasons for referral across all practices included:

- help with accessing services e.g. MAC, NDIS, etc.
- emotional and psychological support and brief intervention
- contribution to care plans, management of complex social circumstances and chronic conditions.

Social Workers found that they were working across their full scope of practice in the SWiGP program. Their integration into the team allowed general practices to provide comprehensive care to patients, address broader social health issues and reduce issues related to limited GP consultation times. The findings from the evaluation period are discussed briefly below:

1.

Adding a Social Worker to general practice enhanced the practice's ability to assist patients and caregivers with complex needs or concerns related to social determinants of health.

Their services provided:

- enhanced psychosocial support capacity: practices increased their capacity to provide psychosocial supports and service access for patients and carers. Social Workers provided support for programs which expanded services (i.e. parenting groups and smoking cessation programs).
- increased accessibility: co-location and accessibility of services reduced stigma for patients and carers, normalising the service, and helping to overcome practical and financial barriers for those who may otherwise not access psychosocial services.
- assistance with providing practical supports to patients (service and system navigation): GPs had an improved understanding of patients' social health needs.
- support for staff wellbeing: education and debriefing fostered a supportive work culture.
- specialist advice and education: interprofessional advice and education on health and welfare issues, such as NDIS and Aged Care policies, enhanced knowledge and capacity of general practice staff.
- community engagement: Social Workers built connections with external agencies and contributed to improved referral pathways to services. GPs and Social Workers felt that the inclusion of Social Workers in primary health care may have an impact on reducing hospitalisation and premature use of aged care facilities.

2.

The SWiGP program improved patients' and carers' ability to access "the right care, at the right place, and the right time." Program participants indicated a positive experience of support and assistance from Social Workers. They indicated over 80% satisfaction with Social Worker assistance, high satisfaction with mental health and counselling services in the practice as well as accessibility to the Social Worker.

3.

The presence of the Social Worker in the practice increased GPs capacity to provide care for the individual and improve understanding of patients' life circumstances that may impact on their ability to engage with health recommendations and care plans. Referrals to Social Workers across the 4 practices focused on accessing support services and the provision of psychological support.

- approximately 70% of all referrals related to accessing government services and assistance with service navigation
- between 30% and 40% of all referrals included the provision of psychological support

Having a Social Worker in the practice increased the likelihood of patients engaging with psychosocial supports gave GPs a sense of wrap around care that they felt often lacked when referring to an external service provider.

4.

Social work integration in primary health care settings must be flexible to accommodate the unique needs of different patient populations. These roles must be tailored to the specific context of each practice to ensure the optimal service delivery for the target population.

5.

The long-term sustainability of the SWiGP program depends on having an appropriate funding model that ensures Social Worker roles are financially viable for general practices. The most critical factor affecting the immediate and long-term sustainability of the SWiGP program is appropriate and secure funding to support social work positions in general practices.

Current Medicare Benefits Schedule (MBS) arrangements limit billing for social work services, with specific item numbers available for Multidisciplinary Team Care Reviews (MDTR), focused psychological strategies and pregnancy and eating disorder support to delivery by an Accredited Mental Health Social Worker (AMHSW). However, coordination challenges in general practices and limitations on billing for these services impact longer term sustainability.

CHALLENGES AND FUTURE DIRECTIONS

The financial sustainability of the SWiGP program is a critical issue for its future. Developing a strong evidence-base for cost-effectiveness and objective outcome measures will support advocacy for government investment in multidisciplinary primary health care teams. While the pilot program demonstrated value for patients, GPs, and primary health care staff, any expansion or scaling up will require development of a sustainable funding model. Development of service models that identify targeted outcomes for patients requiring social work, established parameters around episodes of care, definition of entry and exit criteria, and potential service capacity limitations are crucial for measurement of cost benefits and establishment of cost effectiveness of the SWiGP program.

BACKGROUND — THE SOCIAL WORKERS IN GENERAL PRACTICE PROGRAM

PURPOSE OF THIS REPORT

This report describes the findings of an evaluation of the Social Workers in General Practice (SWiGP) pilot program commissioned by Capital Health Network, ACT's Primary Health Network (ACT PHN), and delivered in partnership with 4 general practices located across Canberra.

Capital Health Network (CHN) engaged the University of Canberra (UC) — Health Research Institute (HRI) in July 2022 to undertake an independent evaluation of the SWiGP pilot program to explore the integration of Social Workers as part of a multidisciplinary primary health care team.

The SWiGP evaluation focused on:

- collection and analysis of data and information from Social Workers, General Practitioners (GPs), patients and carers within the scope of a codesigned evaluation framework — incorporating interviews, surveys and other qualitative and quantitative data collection
- exploring the approaches taken by practices engaged in the pilot program, seeking to identify strategies for integration of a Social Worker in general practice
- production of an evaluation report that communicates the SWiGP pilot program findings with respect to the program implementation, impact, benefits acceptability and sustainability
- identifying considerations for future programs exploring integration of social work roles into general practice settings.

This report presents evaluation findings completed between April 2023 and March 2024. It represents a 12-month period of data collection where Social Workers engaged by the 4 general practices were actively managing a patient case load.

SWIGP PROGRAM

The SWiGP pilot program was established to trial the integration of Social Workers into multidisciplinary general practice teams across the ACT. The program aimed to improve primary health care capacity to support patients with complex issues that cannot be effectively addressed through stand-alone general practice 'fee for service' consultations. These include issues for example related to housing, access to social services, financial advice, occupational, and other broader socio-economic drivers of individual health and wellbeing.

The SWiGP pilot program sought to:

- build capacity for greater support for the general practice workforce through interdisciplinary collaboration
- improve patient capacity for system navigation and access to services
- increase the efficiency and effectiveness of primary health care services for patients, particularly where they were at risk of poor health outcomes.

From July 2022, CHN provided funding for 4 general practices in various ACT locations to employ an on-site Social Worker. ACT general practices were invited to submit expressions of interest for delivering the SWiGP program via a tender process. An on-site Social Worker (0.4 to 1.0FTE based on service contracts with CHN) was integrated into each primary health care team for an initial 18-month term.

Funding for the program was later extended to March 2025. It pays for the Social Worker positions, administrative overheads at each practice, and clinical supervision.

Each of the 4 general practices have distinct patient populations and socio-demographic characteristics. They developed a tailored service with the Social Workers to meet identified practice level needs. The practice characteristics and focus areas for the Social Worker role are in **Table A1**, **Appendix 1**.

Each general practice had the individual responsibility of recruiting and employing the Social Worker and creating a care model best suited to their patients. CHN provided practices with a set of core requirements. These are:

- Engagement of a suitably qualified and registered Social Worker for an 18-month period. This was varied with a contract extension.
- Nomination of a key contact (GP champion) who will participate with the Social Worker in program meetings and regular communication.
- Ensuring services provided are in line with the Australian Association of Social Work (AASW), Social Worker Scope of Practice in Health.
- Support, promotion and integration of the Social Worker with GPs and other clinicians in the practice.
- Contribution to quality improvement activities within the general practice.
- No-fee Social Worker services i.e. no charges for MBS, NDIS or other Commonwealth-funded schemes.
- Ensuring that the Social Worker had access to clinical supervision in line with AASW's supervision standards.
- Maintenance of reporting and data management requirements with CHN.
- Participation in evaluation activities and data collection as directed by CHN, including any evaluation activity conducted by external providers.

POLICY CONTEXT

Primary health care plays a substantial role in the delivery of health services in the community, providing care across the biopsychosocial spectrum to people at all stages of life and those with wide and varied socio-economic experiences. The general practice setting and the health professionals who work in this space strive to provide the highest quality services, link people with specialist and hospital services, facilitate access to social and community services and serve their communities to improve health outcomes.

The SWiGP program aligns with the Australian Government's objectives for Primary Health Networks (PHNs) across Australia to:

- increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes
- improve coordination of care to ensure patients receive the right care in the right place at the right time.

In the Australian context, there is a growing interest in exploring how models of integrated and multidisciplinary care operate in a primary health care setting. The Australian Government has prioritised this area for policy development over the next 10 years, identifying possibilities for funding reform to incentivise multi-disciplinary team-based approaches and address gaps in care for population groups at risk of poorer outcomes.[4]

The evolution of telehealth and provision of ongoing support for primary health care through the Medicare Benefits Scheme (MBS) provide high quality and safe services to support a continuity of care between people and their usual general practitioner (GP). This is an area of focus for the Australian Government through development of *MyMedicare* and Voluntary Patient Registration (VPR) with general practice.[4] While in early stages of policy development and implementation, the VPR framework of quality and safety (for the continuation of MBS telehealth for general practice) lays the foundation for future general practice funding reform.

Through *MyMedicare*, GPs and practices will become eligible to increased benefits for providing quality care and improving health outcomes of their registered patient population.

The outcomes of the SWiGP program could help pilot practices identify specific population groups and areas where VPR has a significant impact on service provision and health outcomes.

Approximately 52.3% of adults in the ACT have a long-term health condition, as revealed by the CHN Annual Needs Assessment 2021–24. The report reveals that mental illness is a leading factor in chronic disease. In primary health care, 39,606 people in the ACT received Medicare-subsidised mental health services, with the majority being GP mental health services (120.9 services per 1000 people).[3]

The Needs Assessment highlighted the crucial role of social determinants of health in determining access to health and social services in the region such as transport, employment, housing, living affordability, safety, access to good nutrition and food sources, sporting facilities, and exposure to domestic violence/abuse. CHN places priority on exploring solutions for improving access to services and addressing complex care issues in the ACT.[3]

The Needs Assessment also found positive factors that enable people in the ACT to access healthcare and improve their wellbeing. Among these were self-management support, affordable service access, transportation availability, support and knowledge for navigating services, and staying informed for decision-making. Similarly, positive factors that enable health professionals to deliver quality care include rebate and subsidy systems (like NDIS and MAC), multidisciplinary team care, support in service and information, and collaborative working relationships.[3]

The cost of services, particularly mental health services, was found to be a major obstacle for people seeking access. Barriers included poor coordination and communication, fragmented care, and limited understanding of different health professional roles.[3]

CHN also recognised the need for after-hours primary health care services in the ACT. Despite the availability of after-hours services in general practice, ACT Health Walk-in Centres, Canberra Afterhours Locum Medical Service (CALMS), and the National Home Doctors Service, there continues to be high rates of utilisation of the Emergency Department (ED) for low acuity concerns.[a]

a Assessment of the impact of SWiGP on after hours service utilisation was outside of the scope of this evaluation.

INTEGRATED CARE

"Collaborative care" and "integrated care" are used interchangeably to refer to the integration of social services into primary health care. The distinction lies in having an allied health clinician as part of the healthcare team — this defines "integrated care." It implies a routine aspect of patient care.

"Collaborative care" is a service that operates adjacent to the primary health care clinician in a primary health care setting. Integrated care approaches aim to help identify patient needs, including care coordination, brief counselling, managing chronic conditions, and addressing complex needs within a practice population.[5]

The World Health Organization (WHO) defines integrated care as "...the management and delivery of health services so that clients receive a continuum of preventative and curative services, according to their needs over time and across different levels of the health system".[6]

The integration of a Social Worker within a general practice setting offers a comprehensive, person-centred approach, reducing fragmentation of services and providing opportunities to improve patient outcomes in an increasingly complex health system. Recognising the influence of social factors on physical health, the crucial role of including them in primary health care teams has been identified.[1]

SOCIAL WORK SCOPE OF PRACTICE

The Social Worker role is diverse and adaptable to the needs of the population group they work with, delivering support in one-on-one or group counselling settings, face-to-face in clinic or home visits, or via telehealth appointments.[7]

"Professional Social Workers consider the relationship between biological, psychological, social, and cultural factors and how they influence a person's health, wellbeing, and development... They maintain a dual focus on improving human wellbeing; and identifying and addressing any external issues (known as systemic or structural issues) that detract from wellbeing, such as inequality, injustice, and discrimination... The scope of social work practice includes assessments, crisis intervention, counselling and other evidence-based therapeutic interventions, group work, case management and service coordination, advocacy, education, and practical support. Social Workers support people across a range of issues including mental health, family violence, child abuse, elder abuse, disability, housing, poverty, alcohol, and other drugs."

Australian Association of Social Workers (AASW) 2021[8]

SOCIAL WORK MODELS OF CARE IN PRIMARY HEALTH CARE

The social work role is well-recognised within hospital and community care settings. Its inclusion in primary health care and particularly, in general practice, is a more recent development in Australia. Much of the current literature on models of Social Worker integration within primary health care settings has explored the implementation of these models across the United States of America (USA) and the United Kingdom (UK) and the impacts of integrated care on the physical, social, and emotional wellbeing of patients and carers.[1]

Approaches to social work models in primary health care settings in the USA were examined by Fraser et al. The study found that Social Workers were frequently employed in such settings to perform specific functions for identified patient populations.[1] This included:

- behavioural health specialist roles focused on assessment and treatment of mental health and substance use problems.
- care manager roles focused on situations where socio-demographic, family or other social situations may interfere with care recommendations, especially where patients experience chronic health problems.
- community engagement specialist roles focused on liaison with and navigation of social service systems and practical problem solving.

In certain situations, these roles overlapped, and Social Workers also took on case management duties.[1]

Intervention models are extremely varied in the approaches utilised. Including a Social Worker in a primary health care team is widely recognised to improve social and emotional wellbeing for patients and carers, particularly those facing chronic, complex, and comorbid conditions, disadvantaged backgrounds, vulnerable groups, and ageing populations. [1,2,5,9]

The UK has taken a different approach to integration of services in primary health care. The National Health Service (NHS) has broadly adopted social prescribing as part of the NHS Long Term Plan "to make personalised care business-as-usual across the health care system." It is a population approach "to empower people with more complex needs, including those living with multi-morbidity, to experience co-ordinated care and support that supports them to live well, minimise the risk of becoming frail and minimise the burden of treatment."[10] Social prescribing and care navigation services aim to alleviate pressure on GPs and the healthcare system caused by social determinants of health.

Gibbons et al. (2019) examined social prescribing approaches used in the UK in their report on Social Prescribing in the Greater Manchester region.[11] Approaches vary based on local health district needs and commissioning priorities. There are variations in models used in practical and community-based settings, as well as in the individuals and professional groups involved in these roles. "Link Workers" or "Care Navigators" are the terms used for social prescribing roles which include practice receptionists, community volunteers, and health trainers. Link Workers and Care Navigators must obtain diploma level qualifications and pass competency-based assessments. These models are associated with general practices and community organisations, but they may not be physically located within the practice. GPs direct patients to the link worker to help them access services or community supports.[11]

Australian PHNs have implemented different methods of social prescribing and social work in general practice by funding programs and services that address the specific needs of their area. Presented below are various approaches taken across the country:

- Western Australia Primary Health Alliance implemented a year-long program involving a Social Worker in 8 Primary Health Care Practices for 2 days a week. The Social Worker joined the primary health care team to assist patients with social determinants of health and empower GPs and clinicians in participating practices to work at their full scope.
- COORDINARE (Southern New South Wales PHN) commissioned Social Rx, a short-term program that utilises social prescribing to connect people with local support services and community resources. GPs in the Illawarra region referred patients to Social Rx to address non-medical obstacles to health and wellbeing, including housing, social connections, family dynamics, and socioeconomic factors.[12]
- Wentwest Healthcare (Nepean Blue Mountains PHN) commissioned a program aimed at enhancing social connections among elderly individuals. The initiative sought to alleviate social isolation and loneliness among older persons by promoting connections to services and support, with the intention of enhancing their mental health and wellbeing. The program used trained practice nurses as health connectors, utilised members of the public as community connectors, and relied on a website-based services directory.[13]
- Hunter New England and Central Coast PHN (The PHN) commissioned HealthWISE, a Care Navigation program. It aimed to assist Ezidi refugees in Armidale by focusing on health goal identification and building their agency and capacity to make informed health decisions. Care Navigators worked with GPs and local specialists to provide assistance to clients in interpreting the Australian healthcare system, navigating health services, facilitating referrals to support groups or other organisations, and empowering them to take control of their health outcomes.[14]
- In collaboration with James Cook University School of Social Work, North Queensland PHN assisted in the creation of social work curriculum for students in general practice. Student placements were established in four general practices. The project examined the factors that support and hinder social work in general practice and identified the roles of students in this setting.[15]

The exploration of social work in general practice and social prescribing models in Australia is still in its early stages. In their systematic review, Zuchowski et al examined the implementation of social work in general practice, focusing on enablers, benefits, and challenges.[16]

In February 2024, Aspire convened a National Roundtable in Australia, joining forces with 50 leaders in integrated health and social care. The objective was to evaluate the current evidence and future prospects of social prescribing models in the country.[17]

The groundwork is being laid to drive forward models of social work and social prescribing, aiming to improve how primary health care addresses the social and environmental factors that influence patients' health and well-being.

EVALUATION APPROACH

EVALUATION PLANNING

An evaluation framework was developed through a co-design process with the stakeholder group between November 2022 and February 2023. The stakeholder group consisted of the CHN project team, SWiGP Practice Managers, GP champions, Social Workers, Health Care Consumers Association (HCCA), and an AASW representative.

Development of the framework was conducted in 3 stages:

1. Use of existing literature, documentation and consultation to define program logic
2. Definition of the evaluation questions and scope, including establishment of data collection tools and requirements to inform the evaluation questions in consultation with program managers and the stakeholder group
3. Agreement on final evaluation framework by CHN representatives and key members of the stakeholder group.

The evaluation framework, program logic and data collection tools were submitted to the UC Research Ethics Committee (HREC) in January 2023 and approved — HREC ID 12037.

The evaluation report was created by analysing and reviewing all the data submitted to the evaluation team. Throughout the evaluation, minor adjustments were made to the data collection tools and approaches based on stakeholder feedback and practicality for participants.

PROGRAM LOGIC

The program logic acknowledges that there were activities and outputs unique to each of the practices involved in the project, and that these were identified through development of service models which suited the demographics and needs of each setting.

The program logic for the SWiGP evaluation (**Table 1**) includes program inputs and activities, program outputs, short, medium and longer-term outcomes. The scope and timeline of this evaluation prevented the complete evaluation of medium and long-term outcomes for the pilot program. The program logic reflects the broad outcomes that would be anticipated from the inclusion of a Social Worker as a member of the general practice team.

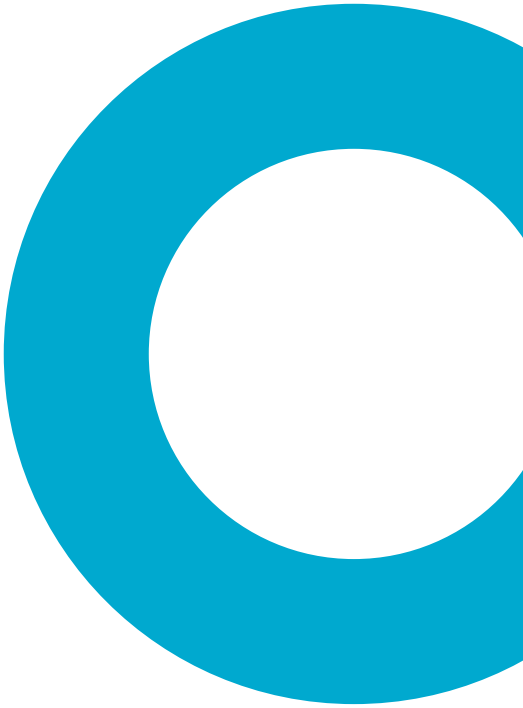


TABLE 1. PROGRAM LOGIC

PROGRAM EVALUATION GOAL: TO EVALUATE THE INCLUSION OF A SOCIAL WORKER ROLE IN GENERAL PRACTICE, AND EXAMINE THE IMPACT AND BENEFITS ON THE INDIVIDUAL, SERVICE AND WIDER COMMUNITY

INPUTS	ACTIVITIES	OUTPUTS	SHORT TERM OUTCOMES	MEDIUM-LONG TERM OUTCOMES
CHN Funding • 4 general practices to establish Social Worker roles in general practices • General practices recruit to SW positions to meet needs of individual practice goals of pilot program. • GPs, Practice Nurses, receptionists, Practice Managers working within the practices form part of the multidisciplinary team Contract management and pilot coordination by CHN Social Worker clinical supervision support Co-located in-kind services at practices Community service sector programs and services Practice software systems and research tools Social Worker workforce — skilled and qualified Research Team at UC — Health Research Institute Consumer and Carer organisations	**Identified Social Worker activities for each practice:** • intake and assessment • triage as required • individualised care plan development and social work support services • ongoing review • follow up Social Worker service model for individual practices developed Individual practice referral pathways to meet the needs of each practice Community and support services identified to support SWiGP pilot and referrals Community of Practice group established (Virtual) Clinical Supervision access for Social Workers Program integrated within practice operations and multidisciplinary teams	**Service model and clinical pathways established:** • data collection methods and frequency to monitor program delivery statistics • process and system development for program delivery and continuity • consumer consent and feedback mechanisms established • interprofessional learning and professional development including staff training • establishment of program promotion within individual practices **Social work services for patients referred into SWiGP** • service navigation and coordination for patients • supported application to assistance schemes (NDIS etc) • Active holding for patients with access issues • mental health support • improved community sector — primary health care communication and engagement	**Patients and carers participating in the program:** • feel supported by the Social Worker to access services and supports • are aware of the reason for their referral • feel that they can trust the Social Worker as a member of their primary health care team • feel that working with the Social Worker has improved their experience of care in the general practice **As a result of the SWiGP program, the General Practice has:** • increased capacity for multidisciplinary team care • established systems and processes to support SWiGP program delivery • improved access to psychosocial supports, assistance with care coordination and case management and community sector liaison/ administration support is increased • data collection measures are established for SWiGP program **General Practitioners report they have:** • increased agency to support patients with socioeconomic health determinants that may impact their health • improved time management • increased opportunities for professional collaboration **System level outcomes:** • improved linkage between general practice and community /social services sector via identification of community services and cross professional collaboration • Community of Practice established • Social Worker clinical supervision program established	**Individual** • program participants (patients and carers) report benefits of Social Worker program • participants have improved access and advocacy for access to services • program participation supports mental health of patients and carers **Service** • access to right service, right place at the right time is demonstrated • improved multidisciplinary collaboration in the practice setting • improved practitioner agency (Health professionals feel like they have an avenue to do something to help) • social services sector is accessible, and access is coordinated for patients utilising SWiGP program • increased access and facilitation of access to community and service sector information • opportunities for program sustainability at the practice level identified • professional skills and knowledge (of all primary health care team members) relating to social work are increased in practices **System** • increased professional capacity for collaboration across the social and community sectors within general practice • referral options have been established for Social Workers in general practice, and these can be adapted for future use

TABLE 1. PROGRAM LOGIC *CONT.*

PROGRAM EVALUATION GOAL: TO EVALUATE THE INCLUSION OF A SOCIAL WORKER ROLE IN GENERAL PRACTICE, AND EXAMINE THE IMPACT AND BENEFITS ON THE INDIVIDUAL, SERVICE AND WIDER COMMUNITY	
Assumptions	**External Factors**
• practice staff will participate actively in the program, undertaking necessary training and develop an understanding of the SWiGP program goals and target population for individual practices • patients referred into SWiGP will actively participate and follow through with referral and care plan advice • local community service and other supports have the capacity to accept referrals and provide access to services and supports in a timely, culturally appropriate and responsive approach • programs and patient interactions that are funded through sources other than directly through the SWiGP program funding are outside of scope for this evaluation	• Australian Government policy changes in relation to primary health care • changes to operational capacity and function of the community services and volunteering sector; for example, reduction in capacity of community organisations • changes to operational capacity relative to staffing in the practices • staffing continuity and or succession of Social Workers employed by practices

EVALUATION QUESTIONS

The evaluation questions and data collection sought to understand aspects of SWiGP pilot program **implementation**, **program experiences**, **benefits** and **sustainability** as they relate to:

- the 4 individual general practices contracted to pilot the program and the broader application of multidisciplinary teams in a primary health care setting (Social Workers and GPs)
- the experiences of the individuals referred to SWiGP program (patients and carers).

The evaluation used a mixed methods approach to explore:

- implementation of the SWiGP program including program design, variations in general practice approaches, development of systems and processes associated with implementation, and alignment with intended objectives
- investigate stakeholder experiences and program relevance
- program benefits from the viewpoints of patients and carers, GPs and the practice in general
- funding models for sustainability of the SWiGP program.

Table 2 outlines the questions used in the program evaluation.

METHODS

A mixed methods approach was used to assess the program in each of the 4 general practices. Quantitative and qualitative data collection included de-identified aggregate data, Social Worker activity diaries, survey tools, focus groups, and semi-structured individual interviews. Evaluation participants included Social Workers, GPs, patients, and carers.

Social Workers

Data collection

Social Workers at each of the practices completed monthly quantitative data collection reports in Qualtrics. This comprised the same set of questions and reporting information for each month between the 1 April 2023, and 31 March 2024. A total of 6 Social Workers took part in data collection over the 12-month period. However, at completion of the data collection period, only 4 Social Workers were engaged in the program — one per practice.

One practice did not have an active Social Worker for 6 months of the data collection period. Another practice had 2 Social Workers commence in a job-share arrangement, with one resigning and the role being taken over by the remaining Social Worker. Social Workers collected their own practice level data and maintained records using their personal systems. Monthly Social Worker data collection included referral numbers, referral types, patient demographics, and collection of Social Worker activity across a range of categories, requiring approximate time spent in each category across the month. Social Workers were asked to submit relevant case studies demonstrating real life examples of their work in practices. The data collection tool completed by Social Workers is outlined in **Appendix 2**.

In addition to monthly reporting, Social Workers participated in 2 semi-structured interviews at 6-monthly intervals. These were in-person small group discussions, with 2 Social Workers present at each interview. Group interviews provided an effective way for participants to share, question, debate perspectives and practice experiences, and to uncover issues yet to be considered by researchers.[18,19]

TABLE 2. SWIGP EVALUATION QUESTIONS

DOMAIN	EVALUATION QUESTIONS
Implementation	• Was the SWiGP pilot program implemented as intended across the practices? • Was the pilot successful in identifying and reaching the intended population in each practice? • Has the pilot program identified aspects of implementation which are important considerations for future SWiGP projects?
Program experience	• Does the integration of Social Workers into general practice improve how primary health care supports patients who have additional needs around complex presentations or social determinants of health? • Does the SWiGP program improve the capacity for general practice to assist patients with navigating non-medical issues which otherwise impact on their health?
Program benefits	• Do patients and carers referred to a Social Worker feel that the service is beneficial, feel supported, view the Social Worker as a trusted health professional, and feel that a Social Worker improves their experience of care in the practice? • In what ways does the inclusion of a Social Worker as part of a multidisciplinary team in general practice benefit health professionals in that practice? • Does the SWiGP program improve how general practice connects with the broader health and community services sector? • What are the program enablers and challenges identified as considerations for future iterations of SWiGP programs?
Sustainability	• What are the considerations needed to create long-term sustainability of the pilot program?

Every Social Worker had enough time to participate in the discussion and 2 small-group interviews allowed for further examination of their responses using critical questions commonly used in focus group analysis.[20,21] By taking this further analytical step, they were able to deliberate on prominent issues and find points of consensus and divergence.

An external social work researcher with over 25 years' experience in both social work and qualitative research conducted interviews with the Social Worker in August 2023 and March 2024. The interviews sought to understand the perspectives, experiences, practices, and practice contexts of Social Workers currently working in the SWiGP pilot program. The key themes and issues are included in the interview guide for Social Workers. This has been provided in **Appendix 4.1**. Interviews were digitally recorded and transcribed. All participants provided informed consent to take part in data collection activities for the purposes of the evaluation.

Data analysis

Quantitative data from monthly Qualtrics reports was aggregated and screened for missing data using Microsoft Excel. Case studies were collated and any details that would make an individual practice identifiable were removed. Qualitative (interview) data was analysed using thematic analysis, and NVIVO coding software assisted the identification of key themes and patterns within the data.[22,23]

Findings were deductively and inductively derived; reflecting key themes and issues outlined in the interview schedule and included line-by-line analysis of the Social Workers' interview responses and discussions.[24] Direct quotes from Social Workers are provided throughout the report to add insight and evidence for key themes and issues. Social Workers used various terms to describe the people they worked with in their general practices including "patients," "clients," "individuals," and "people." For ease of reporting, the term "patients" is used in this report.

General practitioners

Data collection

GPs from each of the participating practices were invited to contribute their experience of the SWiGP program in semi-structured individual interviews. A total of 9 GPs were interviewed for the evaluation between December and January 2023. The interviews were conducted online via Microsoft Teams by one member of the research team. Interviews were focused on the GPs understanding of the Social Worker role, their professional relationships with the Social Worker, referral pathways, patient acceptability, perceived benefits from a GP perspective and sustainability of the model. An interview guide was developed (included in **Appendix 4.2**).

Recruitment of GPs was undertaken with assistance from Practice Managers who coordinated times for GP interviews to suit individual schedules. Interviews were digitally recorded and transcribed. All participants provided informed consent to take part in qualitative interviews.

Data analysis

Similar to Social Worker interviews, qualitative (interview) data was analysed using thematic analysis, and NVIVO coding software assisted the identification of key themes and patterns within the data.[22,23] Findings were deductively and inductively derived — reflecting the key themes and issues outlined in the interview schedule, and analysis of the GPs interview responses.[24] Direct quotes from GPs have been provided throughout the report to add insight and evidence for key themes and issues.

Patients and carers — program participants

Data Collection

A sample of 50 participants — patients and carers from the SWiGP program — were recruited to complete a "Participant Feedback Survey." Social Workers at each of the participating practices were asked to distribute the survey tool to patients and/or carer program participants from November 2023 with the intention of making these available to all SWiGP participants. An information sheet outlining the purpose of data collection and SWiGP evaluation was included with survey instruments along with an opt-in indicator of consent. Patients and carers (or someone else completing the questionnaire) were differentiated, if a person other than the patient was responding by a question in the survey. A copy of the survey and associated information sheets have been included in **Appendix 5**.

Feeback surveys and information sheets were distributed in both digital and paper-based formats. A total of 36 completed paper surveys were received and 14 were completed on *Qualtrics* (Total number respondents: 50). The option to complete the survey digitally was provided to those who received a paper-based survey via a QR code link to the digital survey.

The digital version of the survey tool was hosted on Qualtrics and provided the same patient information sheet, indication of consent to participate, and survey instrument. The practices indicated their preference as to whether they would use a paper-based survey or a digital version. One practice elected to use only the digital version of the survey tool and 3 elected to distribute paper versions based primarily on the age and digital literacy of the patient populations in those practices. All paper-based survey information was subsequently entered by the evaluation team into Qualtrics for analysis.

Patient and carer feedback surveys were focused on the patient experience of seeing a Social Worker in their general practice. The survey was intended to gather feedback about patient and carer experiences of the program. It included questions to demonstrate how patient feedback represented the broader SWiGP patient population (demographic data).

Factors relating to patient and/or carer experience were captured through a Likert scale on the patient feedback questionnaire. Participants self-rated using a 5-point rating scale from *1: Never* to *5: Always*; or Not Applicable (N/A). Survey responses for individual questions were not mandatory, hence there is some variation in the response rates for each question. Where the patient or carer felt that they did not require this aspect of the service, they may have left the question blank or indicated N/A.

The survey included an open text option for patients to provide any personal input about their experience with the SWiGP program.

An overview of demographic data collected in this survey is provided in **Table A3**, **Appendix 3**. The age range of patients and carers completing the feedback survey was between 74 and 84 years (34.9%, n=16) and over 85 years (21.3%, n=10). 80.9% of survey respondents were female (n=38). The survey was predominantly completed by the patient themselves (66.6%, n=30) or a partner (11.1%, n=5).

Data analysis

Quantitative data from patient feedback surveys were aggregated and descriptive statistics and frequencies calculated. The qualitative data collected from the survey were analysed in NVIVO. Content analysis of open text responses was conducted using an inductive approach to condense raw text data and identify themes throughout the feedback provided.[22]

REVIEW OF OTHER PROGRAM INFORMATION

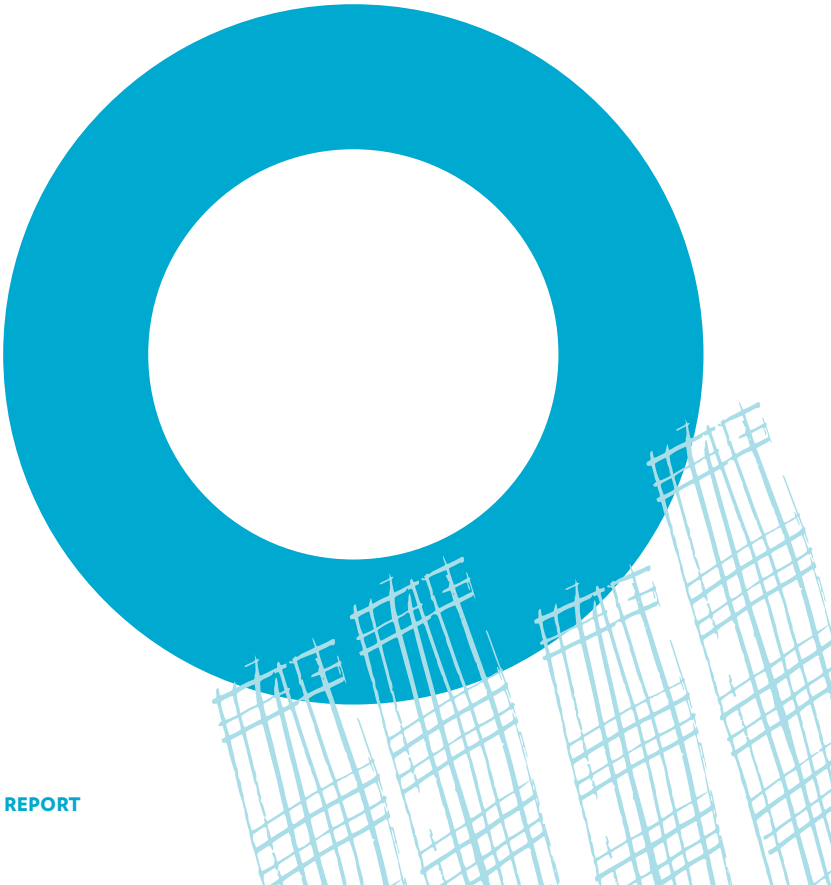
CHN examined relevant PHN contracts and project reporting from participating general practices to gain a deeper understanding of program delivery and approaches.

ETHICAL CONSIDERATIONS

Ethical approval to conduct the evaluation study was obtained from the University of Canberra Human Research Ethics Committee (UC HREC Reference: 12037). The evaluation and data collection has been conducted in compliance with National Health and Medical Research Council guidelines (NHMRC), the World Medical Declaration of Helsinki and all amendments. Privacy and confidentiality of data complies with the Federal Privacy Act 1988, the ACT Information Privacy ACT 2014, and the ACT Human Rights ACT 2004.

The Social Workers, GPs and consumer/carer participants received evaluation details and information regarding ethical considerations, provision of consent and data storage details. All individual participants provided consent to participate in the evaluation. This is in line with the NHMRC's 'National *Statement on Ethical Conduct in Human Research*,' 2018.

Due to the small number of practices involved in the pilot and for confidentiality, details on practice results and case studies that may be identifiable were not included in this report.



FINDINGS

IMPLEMENTATION

Social Workers

Recruitment for Social Worker roles began in September 2022 and continued until December 2022 as suitable candidates were found. Most of the Social Workers were female, except for one. They were highly qualified with specialised skills for their jobs. The characteristics of the Social Workers are listed in **Table A3**, **Appendix 3**. At the start of the program, the 4 general practices hired Social Workers for different full-time equivalent hours (FTE) as agreed with CHN.

Throughout the evaluation period, a total of 6 Social Workers were employed, with each practice retaining one by the end of the data collection period. Practice A initially had 2 individuals sharing a job, but one resigned in June 2023. The remaining Social Worker took on their hours for the entire evaluation period. The Social Worker in Practice D resigned in July 2023, and the position remained vacant until December 2023. The new Social Worker started in January 2024. Practice B and C kept the same Social Worker they initially hired.

One practice initially thought they needed an Accredited Mental Health Social Worker (AMHSW), but later realised that their referrals did not require this additional skill set. The other 3 practices hired Social Workers with 7 to 10 years of clinical experience and different practice backgrounds to meet the needs of their patient populations.

SWIGP SUPPORT FRAMEWORK

Community of Practice

The implementation plan for promoting collaboration and knowledge sharing among Social Workers, GP champions, Practice Managers, and CHN involved organising online Community of Practice meetings. Initially, these meetings took place during business hours, but Social Workers and GPs had difficulties attending due to conflicting clinical duties. They perceived the meetings as an extra task that reduced their time dedicated to patient care. In response to their feedback, the meetings were rescheduled outside of clinical hours.

The purpose of these meetings was for Social Workers and GP Champions to discuss their progress and program development, occasionally sharing successful case study examples. However, after 3 months, Social Workers expressed that the meetings did not provide professional benefits and felt overwhelmed by their frequency. They believed that there were sufficient opportunities to exchange learning and practice approaches through Clinical Supervision, stakeholder group meetings, and data collection for evaluation.

To generate more interest, the format was adjusted to include presentations on topics such as Elder Abuse and by the AASW. However, despite these changes, the Community of Practice meetings still did not offer Social Workers additional professional value. As a result, the meetings were discontinued after June 2023.

Internal professional support

The success of a program involving Social Workers in a general practice setting depends on the practice's readiness to welcome them and develop a shared understanding of their role. This shared understanding is especially important for key practice staff, such as GPs, practice nurses, administrative staff, and Practice Managers.

It is crucial that staff members trust and value the Social Worker's ability to identify and address patient needs. Positive relationships and shared understanding also help in developing appropriate referral processes and allow Social Workers to adjust their role based on patient needs.

Professional Clinical Supervision

The SWiGP program highlighted clinical supervision for sustainability of a social worker role in general practice. It is a core component of their practice. Reflective practice and open discussions about case studies, ethical dilemmas, and the theory-practice relationship require a supportive environment to ensure ethical and autonomous decision-making.

CHN facilitated group clinical supervision for the SWiGP program on a monthly basis. Social workers discussed the difficulties and occasional loneliness they face in their job. They thought that personalised supervision would be valuable when they encounter challenges in patient care, practice, or working relationships, ultimately enhancing the program. In addition to the group sessions, Social Workers had the opportunity to receive 3 one-on-one clinical supervision sessions, starting from November 2023.

GP champions

As part of SWiGP, CHN funded GP champions to establish the program within their teams. The role required an existing GP from each practice to work closely with their Practice Manager, other GPs in the team, and CHN to ensure effective integration and utilisation of the Social Worker services. GP champions took part in stakeholder meetings and Community of Practice meetings whenever possible. Social Workers highlighted that GP champions played a critical role in fostering a positive environment for their integration as part of a multidisciplinary team.

Consistent check-ins with GPs indicate confidence in their capacity to bring about change, leading to a feeling of fulfillment in their position. The presence of scheduled meetings with Principal GPs, support from the Practice Manager, and a positive practice environment all aided in fostering effective communication and teamwork.

Practice infrastructure

Social Workers believed that having dedicated physical spaces for patient consultations and meetings should be a standard requirement in their job. Ensuring they have adequate resources and support was vital in showing their importance as a member of the general practice team. This entailed having a suitable working area and essential resources, such as a personal computer and administrative support.

REFERRAL PATTERNS AND PATHWAYS

SWiGP participants

Table 3 displays demographic details of patients referred to the SWiGP program between 1 April 2023 and 31 March 2024. The information was collected by Social Workers and reported monthly across the evaluation period. Between the 1 July and 31 December 2023 recruitment period, Practice D could not offer social work services and did not receive referrals.

The average age of patients per practice shows Practice B as an outlier, with a mean age of 46.8 years old. This is a clear difference compared to Practice A (79 years old), Practice C (76.5 years old) and Practice D (63.5 years old). This aligns with the focus of the Social Workers at each practice, as indicated in Table A1 (Appendix 1). Patients who identify as female comprise approximately 66% of referrals at all practices except for Practice D, where it is principally female (82.6%).

Practice B had the highest proportion of patients who identify as an Aboriginal and/or Torres Strait Islander person (20%, n=24). They also had the highest proportion of patients who do not speak English as the primary language at home (18%, n=22). This is reflective of the socio-demographic area where Practice B is located.

TABLE 3. DEMOGRAPHICS OF SWIGP PATIENT AND CARER PARTICIPANTS

CATEGORY	PRACTICE A	PRACTICE B	PRACTICE C	PRACTICE D+
GENDER				
Male (%)	36.8	33.2	34.1	17.4
Female (%)	63.2	63.3	65.4	82.6
Gender non-identifying (%)	0	3.5	0.5	0
AGE				
Average client age (years)	79	46.8	76.5	63.5
Youngest — Oldest	17–92	11–86	11–106	19–100
BACKGROUND				
Aboriginal and Torres Strait Islander status	1 (0.06%)	24 (20%)	2 (0.1%)	2 (3%)
English not the primary language spoken	5 (3%)	22 (18%)	7 (4%)	3 (4%)
Total number of referrals	**160**	**121**	**183**	**68**

+ Note: During recruitment period. Practice D did not have active data collection between August 2023 and January 2024.

SWiGP program referrals

Referrals into the SWiGP program during the evaluation period were collated through monthly reporting to the evaluation team. Referral numbers do not reflect the total number of patients seen throughout the pilot program as Social Workers had been accepting referrals before the formal evaluation began. As such, Social Workers had an existing case load at commencement of data collection.

There was no limitation placed on referral numbers into the program. Data provided by the PHN through contract reporting indicated 1023 referrals to the SWiGP program between July 2022 and June 2024. During the evaluation period there were 533 patients and/or carers seen by the Social Workers with 513 patients and/or carers accepted into the program. This represents 96% of patients referred being accepted into the SWiGP program, as shown in **Table 4**.

A flexible referral criteria was established at practice level. It was based on whom the GP or practice staff felt may benefit from Social Worker support. Each Social Worker defined their own assessment procedures, entry criteria, episodes of care, and exit criteria for patients. In most cases, referrals into the program were accepted, except where the service was considered inappropriate for patient needs. There were times throughout data collection period where Social Workers indicated that they were at capacity and needed to establish case management and triage strategies.

Table 4 shows referral numbers and sources of referrals at each of the practices and across the program. Social Workers received referrals from GPs, practice nurses, administrative staff, self-referral, other service providers and RACH staff (external).

GPs were the primary source of referral in all practices, representing 66% of the total referrals to SWiGP. Practice Nurses at Practice B (35%, n=42) and C (25%, n=45) also contributed significantly to referrals.

External referrals from other providers or agencies were accepted if the patient was an existing patient at the SWiGP practice or had the capacity to register as a new patient. The latter was not encouraged at practice level. Practice C had a significantly higher proportion of referrals from external sources comparative to other practices (29%, n=53). This is attributed to engagement within care homes during Practice C's GP outreach services to their patients.

A smaller percentage of patients chose to self-refer to the SWiGP program. Patients gained access to the Social Worker through in-practice advertising via waiting room flyers or information on television screens within the practice. Social Workers emphasised the importance of patients being able to self-refer.

Where identified, Social Workers expanded their services to meet the needs of carers or family members. This was evident in practices where there was a larger number of patients over 65 years (Practice A, C and D). Thus, there were higher referral numbers where a carer was involved in addition to the patient or acting on behalf of the patient.

Using patient feedback surveys, patients and carers were asked to reflect on their source of referral to the program and whether they understood the reason for referral. The results from these surveys aligned with data collected from Social Workers. Most patients indicated that the GP (84.8%, n=39) initiated their referral. They indicated that they understood the reason for their referral (91.1%, n=41). A small portion partially understood how a Social Worker would be able to assist with their concern (9.9%, n=4). These results are available in **Table A4**, **Appendix 3**.

TABLE 4. REFERRAL NUMBERS AND INFORMATION RELATING TO SOURCE OF REFERRALS

CATEGORY	PRACTICE A	PRACTICE B	PRACTICE C	PRACTICE D+	TOTAL
Total number of referrals 1st April 2023 – March 31st 2024	160	121	183	69	**533**
Total number of referrals accepted 1st April 2023 – March 31st 2024	144	121	180	68	**513**
Number of referrals involving a carer (in addition to patient): 1st April 2023 – March 31st 2024	43	8	24	25	**100**
REFERRAL SOURCES (N)					
GP	149 (93%)	63 (52%)	75(41%)	67 (97%)	**354(66%)**
Practice nurse	3 (2%)	42 (35%)	45 (25%)	2 (3%)	**92 (17%)**
Administrative staff	5 (3%)	9 (7%)	8 (4%)	-	**22 (4%)**
External (includes other service providers and self-referral)	3 (2%)	7 (6%)	53 (29%)	-	**63 (12%)**

+ Note: During recruitment, Practice D did not have active data collection between August 2023 and January 2024.

Reasons for referral to Social Worker

Over time, referral numbers and identified needs increased as GPs became more familiar and established professional relationships with Social Workers.

Each month, Social Workers submitted quantitative data which specified primary and secondary reasons for referrals into the program. Primary refers to the main reason on referral documentation, while secondary may be determined by the Social Worker during the initial assessment. In most cases, patients had multiple reasons for an initial referral. The indicated numbers for referral reasons do not match the total patient referrals to the SWiGP program.

Figure 1 provides an aggregate of the 10 most common primary reasons for referral to Social Workers across all practices. Aggregated data across all practices showed the top 3 primary reasons for referral were:

- assistance with MAC applications (n=164)
- domestic assistance (n=117)
- Advanced Care Planning (n=82)

Grief or loss (n=78), and transitions of life (n=67), assistance with access to government services such as the NDIS (n=70) and, housing (n=71), DSP applications (n=68), social connections support (n=64) and assistance with multi co-morbid or ongoing issues (n=66) also featured in the 10 most commonly presenting primary reasons for referral.

Data shows that referrals across all practices primarily aim to assist individuals in accessing government programs and services and coordinating related services (domestic assistance includes activities such as house cleaning, gardening, personal carers, etc.). This is consistent with 3 of the 4 (Practice A, C, D) practices having a patient population mostly over 65 years old.

Figure 2 provides an overview of the 10 most common secondary reasons for referral.

There are instances where the referrer identified multiple initial reasons for referral, and instances where Social Workers identified a secondary reason for referral after evaluating the patient's needs. The 3 most common secondary reasons for referral included:

- mental health/brief intervention support (n=64)
- social connection support (n=55)
- mental/family stress (n=42)

Transitions of life (n=36), assistance with access to government services (DSP n=27; housing n=27), advanced care planning (n=27), domestic assistance (n=28), grief or loss (n=33) and multi co-morbid issues (n=33) were also in the 10 most commonly presenting secondary reasons for referral.

Mental health support was identified as the most common co-occurring reason for referral to Social Workers. Sometimes, this is identified by the GP during the initial referral, while at other times it was uncovered during a social work assessment. The association of mental health supports with the primary presentation was uncertain. Social Workers frequently saw people who had co-morbid or complex presentations suggesting that there is a role for Social Workers in general practice supporting people with chronic and complex conditions.

Supporting access to government-funded services and mental health support were overarchingly the most common reasons for referral to the Social Worker across both primary and secondary reasons for referral. A breakdown of findings at practice level is provided in **Appendix 6, page 55**.

Referral pathways

The development of referral pathways between health professionals and the SWiGP program, as well as the systems and processes used to introduce and refer patients happened with an open approach to continuous improvement, using both formal and informal methods. Practices and GPs collaborated with the Social Worker to develop these systems and processes.

They used informal conversations for Care Planning — coined as "corridor conversations" — and internal messageing within software systems to convey patient details. A paper trail (electronic or paper-based) for referrals was also maintained.

GPs identified the co-location of Social Workers within the practice as significant, facilitating warm referrals and timely access to supports. GPs found that educating patients on the service helped to build trust and reduce barriers to accessing social services. Evaluation findings relating to co-location of services and ease of access for patient and carers are further discussed in the program enablers and challenges section of this report (**page 25**).

> **"Having the Social Worker in the practice, it's so much easier than referring out to any other. If we had an external Social Worker, you wouldn't have the same connection. You wouldn't have the same handover. Patients wouldn't engage in the same way — being in the practice means that she's got access to our notes — the continuity of care is there."**
> *GP*

Social Workers affirmed that positive relationships with GPs and a shared understanding of the social work role were critical to ensuring appropriate referrals and increased capacity to respond in a timely manner. This allows them to accommodate referrals from practice staff.

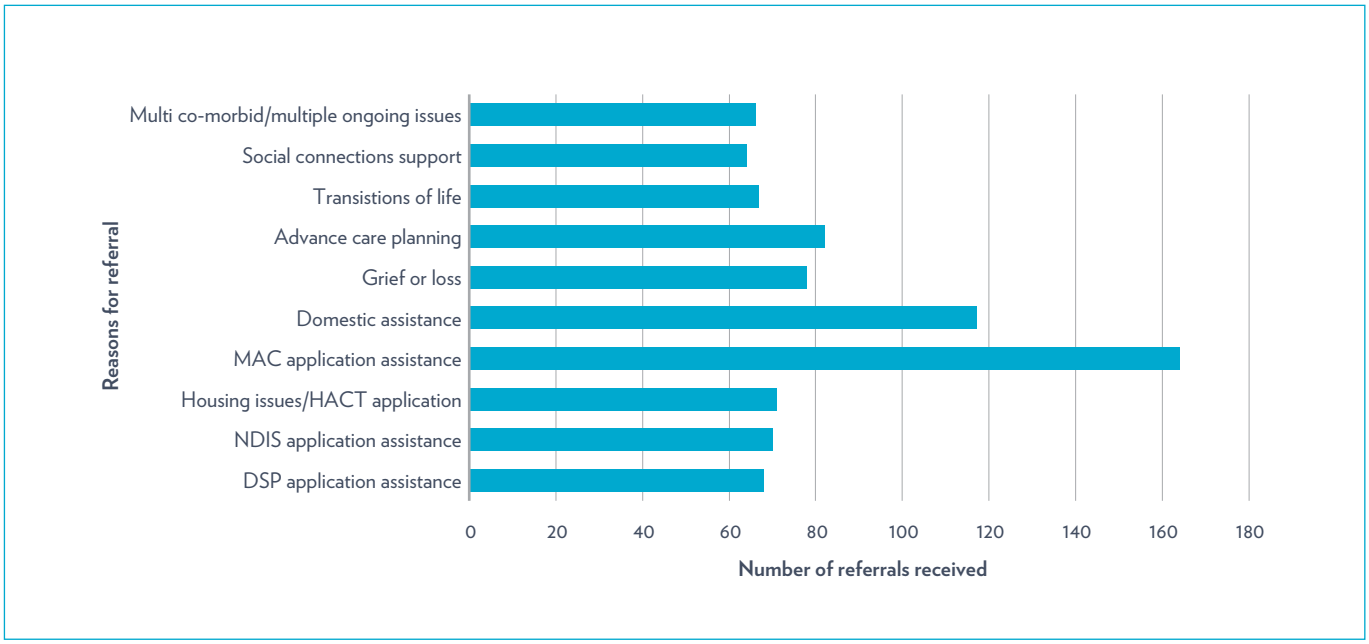


FIGURE 1. PRIMARY REASONS FOR REFERRAL – 10 MOST COMMON REFERRAL PRESENTATIONS

+ Note: Due to recruitment, Practice D did not have active data collection between August 2023 and January 2024.

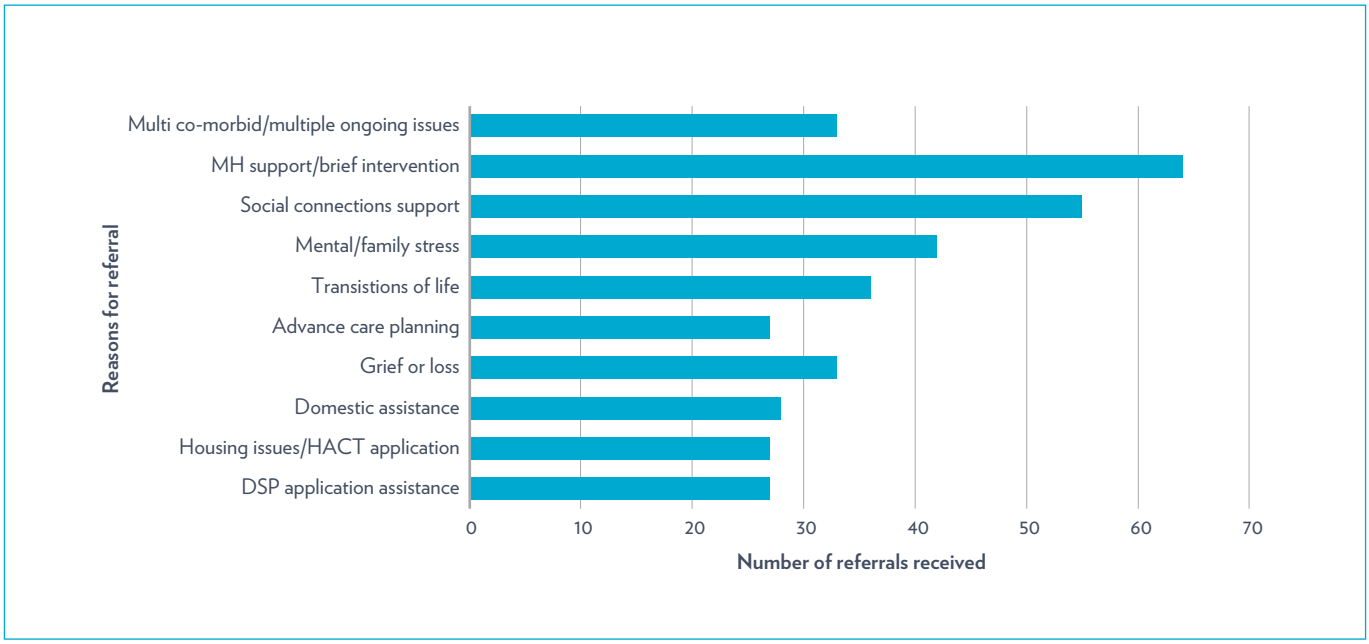


FIGURE 2. SECONDARY REASONS FOR REFERRAL – 10 MOST COMMON REFERRAL PRESENTATIONS

+ Note: Due to recruitment, practice D did not have active data collection between August 2023 and January 2024.

THE SOCIAL WORK SERVICE

Expectations of the social work role

Most GPs interviewed had a core understanding of the role and how they could work with the Social Worker to support patient needs. GPs noted their previous experiences with Social Workers had primarily been within the hospital system or community sector. Some of the GPs interviewed previously worked with a social worker in a general practice or primary health care setting.

GPs indicated in interviews that their understanding of the Social Worker role included:

- **service navigation:** assisting patients with accessing community services and government programs like MAC and NDIS, helping patients who may not be aware of or know how to navigate these services
- **support for mental health and social needs:** providing both acute and ongoing mental health support, addressing social needs such as family issues and family violence issues, and navigating complex social service and medical systems.

GPs recognised that Social Workers enhanced the multidisciplinary team, facilitating integrated primary health care and enabling GPs to focus on clinical care. They valued the ability to provide social care to patients internally through the Social Workers.

Development of the role

Social Workers used their skills to identify unmet patient needs. They stressed the importance of autonomy to utilise their expertise effectively. They also acknowledged the need to expand their skills to cater to diverse patient needs. The discussions revolved around taking on case management responsibilities and offering long-term help to vulnerable patients. As they became integrated into practices and GPs gained a better understanding of their role, their scope of practice adapted. Adjustments were made to align expectations and prioritise patients with the most pressing needs.

> **"The Social Workers' scope of practice is probably broader than what we had first envisaged. I would refer someone elderly for help around My Aged Care and supports at home and the Social Worker would come back to me and say, 'Thanks so much for their referral, you might not have realised, but [the patient] also had some underlying mental health issues and we ended up having quite a few consultations together'. Things came out with the Social Worker that did not always have time to come up in usual general practice consultation."**
> *GP*

Their services extended to include family, carers, and other services/agencies, aiming for positive patient outcomes. They described their various roles in managing broader patient and family support as:

- **coordinating family meetings:** facilitating meetings involving patients, their families, and homecare service providers to address issues, resolve conflict, coordinate care and improve service delivery.
- **supporting government program applications:** assisting families with applications by acting as a liaison between the patients and program processes, helping to navigate the complex application process.
- **addressing service provider issues:** helping families address dissatisfaction with service providers by setting up meetings, providing information on how the system works, and maintaining a neutral stance.
- **supporting families:** providing emotional and practical support to families dealing with medical diagnoses, transitions to residential care, or other challenges related to patient care.

Social Workers explained that some aspects of their role expanded to include unexpected services such as:

- therapeutic counselling
- facilitation or contribution of expertise to support groups or psychoeducational or therapeutic programs
- provision of education or debriefing support to general practice staff.

> **"While my background is in aged care, I have had a few referrals for domestic violence, young people with major depression or looking for employment. I've had to do a lot of upskilling and reading, but use my social work skills to explore with this person and peel away what they are after."**
>
> *Social Worker*

Social workers feel frustrated and stressed when their role and responsibilities are not understood or appreciated. They also struggle with the increasing demands and complexity of their work. Multiple sessions are required to accurately assess patient needs, provide emotional support, and establish practical and long-lasting psychosocial services. The number of sessions varies depending on the patient's needs, ranging from one to over 20. Some patients require a few sessions, while others need more intense support. They spend 45 to 70 minutes with referred patients, allowing enough time for thorough discussions and additional support if needed.

Episodes of care were not defined, and specific data around episodes of care were not collected for this evaluation. Social Workers had flexibility within their own service models to determine whether they would keep patients in 'open' or 'closed' status.

> **"I saw a lady [I] have been helping with housing — we'll resolve her issue with the housing. I do not close it, because she's still a patient."**
>
> *Social Worker*
>
> **"The average appointment with social Worker is...4 to 5...I've got a few that are 17 to 20 appointments. Yeah, but that's the average, 4 to 5."**
>
> *Social Worker*

Social Worker scope of practice

Models of care, program design, and implementation of social work were customised to meet the specific needs of each practice. Social workers collaborated with practice managers and GPs to develop systems and processes. Interviews revealed themes related to scope of practice, role expectations, and potential benefits for the practice, patients, and carers. The interviews also addressed the challenges and processes involved in implementing the SWiGP pilot.

The Social Workers had a broad scope of practice in the pilot, addressing various areas based on each practice's specific needs. Their scope of practice included, but was not limited to:

- chronic health condition management and support
- multi-comorbid/ongoing issues
- Advance Care Planning
- mental health support/brief intervention
- gender issues
- transitions of life
- grief or loss
- mental/family stress
- unemployment/work stress
- family violence
- family case management
- homelessness
- child and youth protection services
- domestic support (often associated with existing MAC & NDIS packages)
- My Aged Care application (MAC)
- NDIS application
- housing/HCAT application
- Child and Youth application
- Disability Services Pension application (DSP)
- Post Hospital Support Program (PHSP)

This overview aligns with typical social work practice indicated by the AASW.

Social Worker activity

Social Workers were asked to keep a record of their day-to-day activities across the data collection period. This was reported monthly as quantitative data. It covered the broad categories of clinical hours, patient-related administration, professional development, multidisciplinary liaison, travel, and other tasks (see Figure 3). This was done to evaluate how practices handle the allocation of clinical work and case load management from a practice management viewpoint.

During the 12-month data collection period, Social Workers allocated the majority of their time to clinical hours (41%) and patient-related administration (23%). When including multidisciplinary liaison in these 2 categories, 75% of their time went to patient-related tasks. Patient-related administration is an essential aspect of the role, requiring significant time and effort to advocate for patients, connect them with resources, and collaborate with different agencies.

An aggregate of Social Worker activity across all practices is provided in Figure 4.

According to Social Workers, they regularly handle complex case management involving patients, carers, and various agencies across health and social service sectors. This underscores the importance of recognising the time needed for this specific type of work. The remaining time was divided among professional development (9%), travel (6%), and other activities (11%). Program-related meetings (evaluation activities, data collection, stakeholder meetings, and Community of Practice) were scheduled in a way that limited social workers' clinical and patient-related time, which they expressed concerns about.

FIGURE 3. SOCIAL WORKER ACTIVITY CATEGORIES

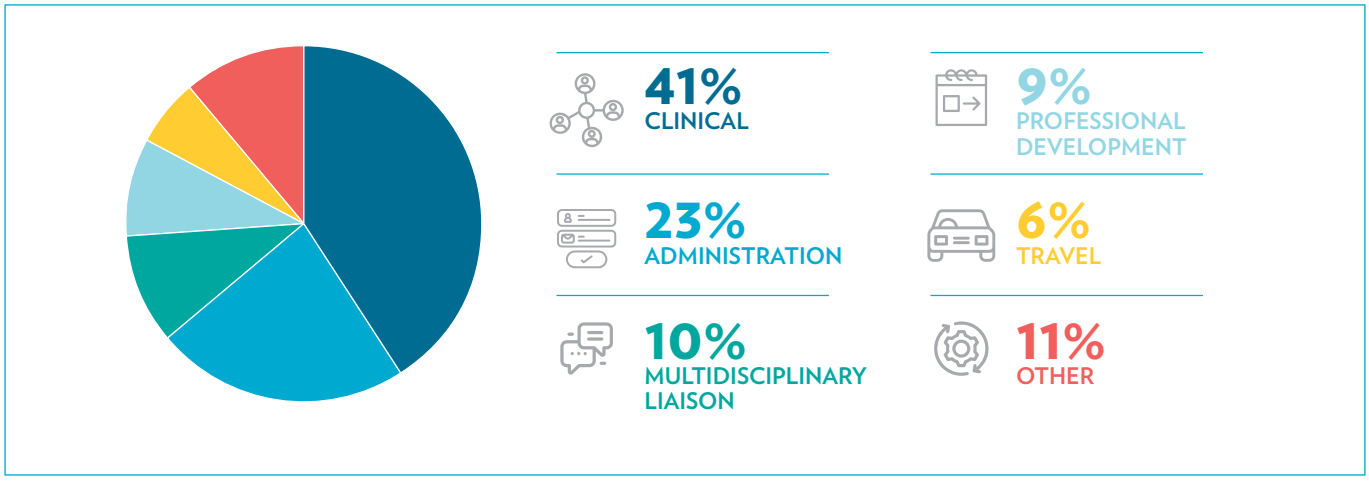


FIGURE 4. AGGREGATED SOCIAL WORKER ACTIVITY

PROGRAM EXPERIENCE

The evaluation examined the experiences of Social Workers, GPs, patients, and carers, the program's relevance to those involved, and its alignment with its intended purpose.

General practice supporting patients and carers with complex psychosocial needs

Social workers and GPs recognised the importance of addressing complex presentations and psychosocial needs in their work with patients and carers. GPs emphasised the benefits of having a specialised allied health professional, such as a social worker, to handle complex needs within the practice, leading to improved practice management and access to the right expertise. They also noted that the limited time of a typical 15-minute appointment hindered their ability to address the social issues underlying medical conditions. By including a social worker in their team, they could provide comprehensive health services, resulting in time savings for GPs and reduced mental strain.

Expanding care to address and empower patients' psychosocial health and wellbeing

Social Workers articulated that addressing psychosocial needs improves patient care by providing better access to community services. However, some patients require extra support to fully comprehend this approach. This ensures that patients feel comfortable seeking and obtaining support from their primary care provider.

> **The process of referring that person through My Aged Care and all those sorts of things to get all those services in place was really time consuming for a GP to do. Basically, I felt like I was doing a lot of those referrals and advocacy in my own time."**
> *GP*

Social Workers noticed that many elderly patients and caregivers found the additional assistance in navigating the system beneficial. GPs also reported overwhelmingly positive feedback from patients regarding the SWiGP program. Patients expressed surprise and gratitude for the on-site service, which has helped them with psychosocial and non-medical issues.

CASE STUDY
EMPOWERING PATIENTS

A female patient, aged 68, who had mobility issues due to severe osteoarthritis, could no longer climb the steps to her ACT housing property. As a result, the patient became increasingly house bound. By collaborating with ACT Housing, the Social Worker successfully obtained a ground floor unit with disability modifications for an aged person. This gave her the opportunity to take full advantage of the facility. She has been relocated to a unit that is suitable for her needs and declining health and function. She can now participate in the community again and is becoming more socially engaged.

Enhancing patients' physical health outcomes

GPs stressed the importance of having a service that can quickly and professionally provide practical support alongside mental health care. The SWiGP program gave practices more tools to assist and empower patients in following health advice from health professionals. Patients facing issues like income, housing, family violence, and life transitions may struggle to act on treatment advice from their GP. Social Workers play a vital role in helping patients and carers navigate these challenges.

Including a Social Worker in the multidisciplinary team is necessary as disadvantaged individuals often lack the time or money to seek assistance. GPs shared examples where limited resources or transportation issues prevented patients from attending appointments for physical health services. The presence of a Social Worker in the general practice helped patients experiencing family violence access additional services. GPs and Social Workers collaborated to address social needs, enabling patients to access medical services related to their conditions.

PROGRAM BENEFITS

Patient and carer experience of SWiGP

The patient and carer experience of the SWiGP program reflects the feelings and experiences of a sample of program participants across all practices, as described in the Methods section (see **page 8**).

SWiGP participants experiences of support and assistance

In the patient feedback survey, the majority of patients and carers reported positive experiences with Social Workers. **Figure 5** shows the experiences of support and assistance indicated by respondents of the SWiGP participant feedback survey.

Over 80% of respondents felt supported by the Social Worker to:

- understand the support they needed (82.6% n=38)
- find support services in the community (85%, n=34)
- access appropriate services (84.1%, n=37)
- gain access to identified support and follow up where necessary (90.9%, n=40)
- complete forms and letters to access services (89.6%, n=26) (Many respondents indicated that assistance with form completion was not something they required from the Social Worker).

Participants in the SWiGP program felt that Social Workers offered a higher level of care and support compared to GPs due to time constraints. Patients and carers valued the empathy, caring nature, and dedicated time shown by Social Workers. They felt supported and acknowledged the effectiveness of Social Workers in following up on issues and delivering results. Practical supports in navigating MAC, arranging assessments, and providing guidance on managing home care packages and services, were helpful.

CASE STUDY
ENHANCING PHYSICAL HEALTH

"The Continence Assessment Program, which if patients need incontinence pads, for example, there is a form, a very lengthy form. Those incontinence pads can be sourced in a subsidised way, it is a very long form before the Social Worker came on board I used to have to sit with our patients, spend way more than 15–20 minutes trying to help them fill out this form and a lot of the time it would be not done because I do not have the time and the patients find it too tedious. We've had so many successful applications for the Continence Assistance scheme, where patients have been able to source their products in a subsidised way because our Social Worker has sat with them and helped fill out that form." (GP)

"Having a Social Worker at the practice has helped me with accessing additional care that the GPs do not have time to give. Accessing extra health services in the community provided me with information, support and resources. I found the Social Worker to be caring, empathetic and gave me time. I felt this was valuable."
SWiGP participant

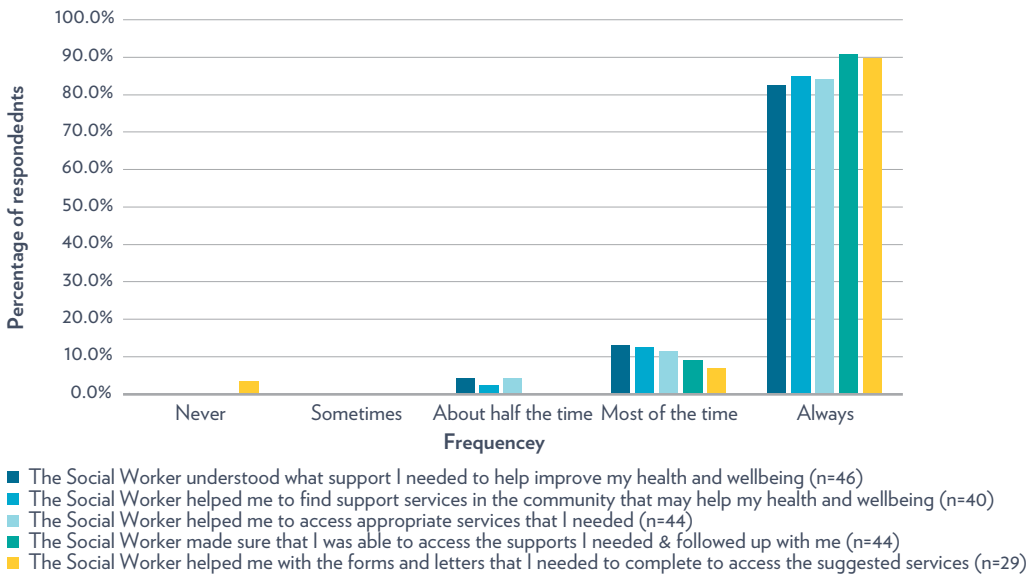


FIGURE 5. PATIENT AND CARER EXPERIENCES OF SOCIAL WORKER SUPPORT

Social Worker expertise in improving patient wellbeing by offering extended support, explaining complex information, and helping patients establish connections was also recognised. Patients and carers expressed that this support helped ease distress and anxiety. Overall, Social Workers in general practice were considered an asset, providing a wealth of information, support, and relief.

SWiGP participants' experience of care

SWiGP program participants described Social Workers as competent and professional. They viewed them as a source of comfort and felt cared for and supported, not just by the Social Worker but by the practice as a whole. Patients and carers believed that Social Workers had a positive impact on their emotional well-being and helped them manage day-to-day challenges. They appreciated the kindness and respect shown by Social Workers, which emphasised their ability to treat patients with dignity and assist them in identifying their needs.

Overall, patients and carers found the service provided by Social Workers to be invaluable and believed it should continue.

Results relating to how patients and carers experienced care from the Social Worker and more broadly within the general practice are demonstrated in **Figure 6**.

Patients and carers agreed that having access to a Social Worker in their general practice:

- improved their overall experience of care at the general practice (Always 84%(n=37) and most of the time 13.6%(n=6)
- received emotional support or counselling (Always 91.1 (n=41); most of the time 4.4%(n=2))
- that the support or care received from the Social Worker met their needs (Always 86.4% (n=38); most of the time 11.4% (n=5).

SWiGP participants' development of trust in the Social Worker

Patients and carers were asked about their experience of developing trust in the Social Worker. They were asked about feeling welcomed and safe using the service, having access to it when needed, including family and friends in their care, and having their individuality and personal values respected by the Social Worker (including their culture, faith, gender identity, etc.). The feedback survey showed that:

- they felt welcome and safe with the Social Worker (95.6%, n=44)
- could access the service when they needed (81.8%, n=36)
- that their individual needs and values were respected (92.9%, n=39).

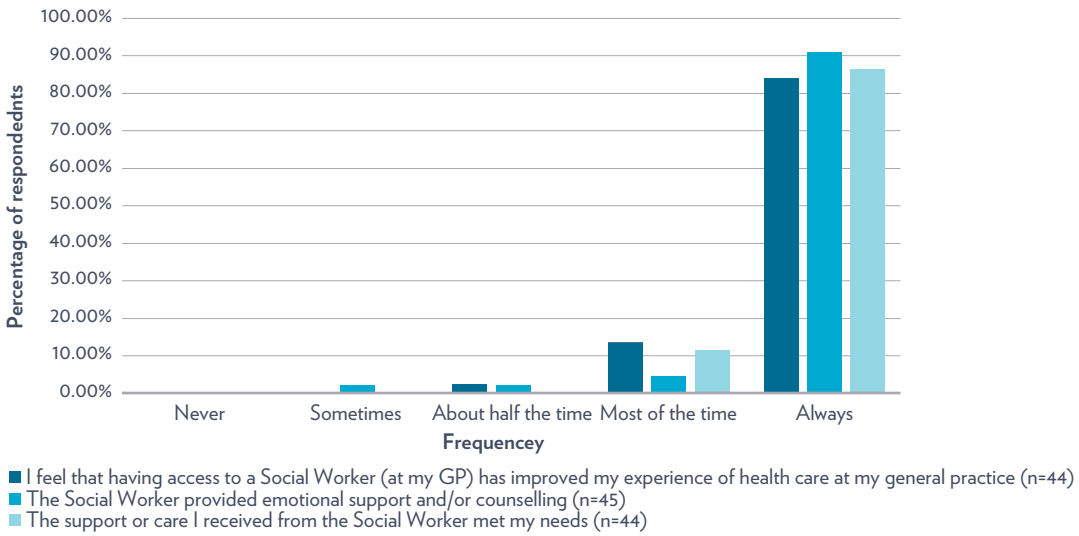


FIGURE 6. PATIENT AND CARER EXPERIENCE OF CARE RECEIVED FROM THE SOCIAL WORKER

A lower proportion of respondents felt they could include friends and family in their care if required. Fewer participants answered this question compared to others in this section (total responses n=30). However, 86.7% of those who did respond indicated they felt able to include family and/or friends when needed. There were also participants who indicated the N/A response to this question. This may suggest that they did not feel the need to include friends and family. Participants used words like trustworthy, comfortable, safe, friendly, supportive, and helpful to describe their experiences working with the Social Worker. **Figure 7** shows these results.

> **"This is such a great program; it would be excellent if it continued and was scaled up. The Social Worker has been fantastic, it is wonderful that the service extends to family members."**
> *SWiGP participant*

Health professional beliefs about benefits of SWiGP to patients and their carers/families

Social Workers and GPs believed that SWiGP improved capacity in practices to meet the core needs of patients and carers. It facilitated improved access to "the right care, at the right place, and the right time." The perceptions of GPs and Social Workers regarding the benefits of SWiGP to patients and carers are discussed below.

Patients and carers had an increased capacity to feel heard

SWiGP Social Workers had a unique role within practices. They spent more time with patients, which allowed for thorough needs assessments and the application of their specific social work skills.

Practices understood that it was part of the Social Workers' role to listen and be with patients. They supported the Social Workers in taking the service outside of the practice setting and into homes and community-based delivery when necessary. This was important for identifying patients' broader psychosocial needs and allowed for meeting the patients where they were.

Social Workers shared instances where patients were unsure about the need for a SWiGP referral. In many cases, patients referred for unrelated matters ended up discussing deeper issues with the Social Worker. Patients often felt more comfortable discussing certain issues during social work assessments rather than with their busy GP, as they believed it was not the right time nor place.

> **"A lady came in about mobility and she started to get emotional. I said, 'how about you come back and see me, [my] services are free.' After some counselling, she commented: 'Thanks for listening to me. A topic I have buried for 50 years now feel much lighter'. After working with the patient to peel away some layers she is now unburdened by something she had been carrying for 50 years."**
> *Social Worker*

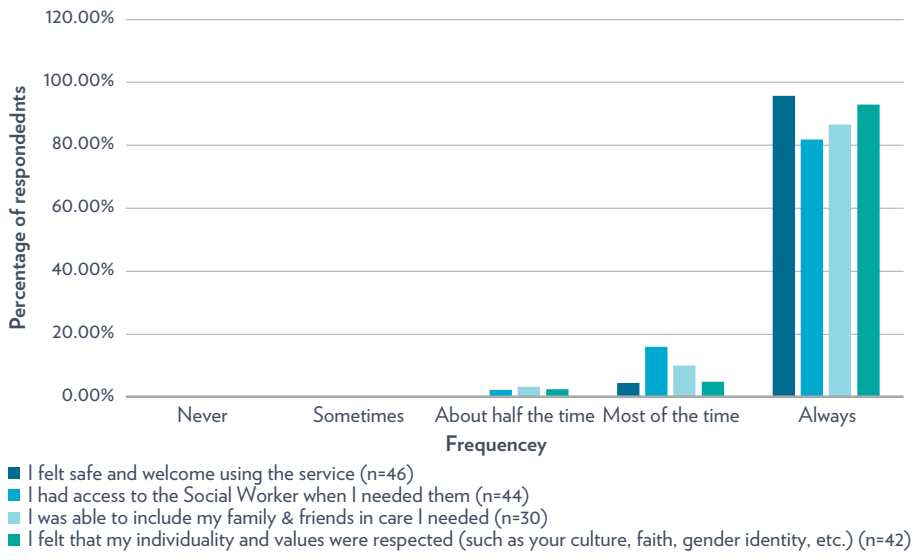


FIGURE 7. PATIENT AND CARER EXPERIENCES OF DEVELOPING TRUST IN THE SOCIAL WORKER

Linking patients to required services and supports within a wide range of complex needs

Social Workers need to be knowledgeable about available government and community supports and services. This ensures that patients can access and benefit from them, saving time, money, and reducing stress for patients, carers, and family members.

Patients often need someone who understands the system to help them adhere to GP recommendations. Without assistance, patients and carers may struggle to navigate complex service systems on their own, potentially missing out on vital support. Accessing government services can be challenging, especially for non-native English speakers or those with negative past experiences.

> **"When you're stressed and upset, you can wonder — what do I do? The advice is 'Oh, just go to the website and have a look at that information…' Often it just doesn't sink in. You need somebody to talk you through. It just helps so much. It's very simple for me to do as a Social Worker. I think the benefits that those people gain from having somebody outside [to] go 'OK. Just have a look at this page. Have a look at this tab, just go down a little bit, though, there's your answer, perfect!'"**
>
> *Social Worker*

Patients value having a dedicated health professional with the right skills and knowledge to turn to for information and support. Social Workers and GPs found that involving a Social Worker enhances patient care and facilitates access to necessary services. Social Workers provide essential information in an easy-to-understand way, ensuring patients understand their rights. They may also provide advocacy or warm referrals to external agencies.

GPs agree that Social Workers have the right words to use with services and the right knowledge of community sector services that fit patients' needs. This improves their ability to facilitate access to services. Integration of Social Workers in practices expands the range of issues they can address and assist with locally.

> **"There are wait lists at the end of all of the counselling services …But you can provide that holding for people and you build that sense of trust and safety."**
>
> *Social Worker*

Social Workers assist with various issues, including helping patients return to daily function after traumatic experiences, reducing substance use as a coping strategy, aiding patients escaping family violence situations, and returning to the workforce after injury. There are very few issues that Social Workers would not attempt to support patients with. They also provide active holding support to keep patients safe while they wait for access to specialist services, such as mental health services when necessary.

CASE STUDY
SERVICE AND SYSTEM NAVIGATION

Bob and Brenda, whose names have been changed, were referred to the Social Worker for MAC support. They felt that their current provider was not providing enough support. During the assessment with Bob, it was discovered that he faced significant issues and barriers. Bob is Brenda's carer, and Brenda has dementia. Bob needed to go to the hospital for surgery, but Brenda was hesitant to go into respite due to her trauma history.

A meeting was organised with Bob and Brenda's next of kin to discuss Brenda's reluctance to attend respite. This meeting helped everyone understand what needed to be done to ensure her needs were met. The Social Worker also worked with the GP and next of kin to provide wrap around support for everyone, including Brenda. They discussed an Advance Care Plan to address Brenda's needs and talked about guardianship because there was no witnessed Enduring Power of Attorney. This would allow decisions to be made in the future if Bob needed to be admitted to the hospital.

This case required a lot of time and effort, but the collaboration between the Social Worker and the GP gave Brenda's family, who live in another state, a sense of security. Bob received the support he needed, which reduced his caregiver stress and burnout. Having a Social Worker as part of the multidisciplinary primary health care team made this outcome possible.

Supporting patients at times of crisis and challenge

Social Workers explained that visits to general practices often occur when patients have new health concerns or face changes in their life circumstances. For patients dealing with a new diagnosis or other stressful life transitions, having a Social Worker alongside their GP for psychosocial support has been invaluable. Sometimes, these patients need only a few sessions, but as their needs change, the Social Worker remains available for ongoing support.

At 2 practices, Social Workers primarily assist patients, their caregivers, and family members with in-home aged care and transitioning into residential aged care homes (RACHs). GPs agree that this support is crucial, especially for those without external family networks, as it makes these life transitions easier.

Benefits of SWiGP to GPs and the General Practice

The integration of Social Workers into the team increases the practice's ability to offer specialised programs and targeted services, as well as improved professional education and support for staff.

CASE STUDY

ASSISTANCE AT TIMES OF CRISIS

Sally (not real name) is an Aboriginal and/or Torres Strait Islander Woman and a mother of 3 children under 15. She left a 16-year relationship due to family violence. Sally had trouble paying rent and fell behind, leading to an eviction notice. She could not work because of a significant physical health issue. Her GP referred her to a Social Worker for help. Sally was facing eviction while scheduled for major surgery. She had no housing options and risked becoming homeless. The Social Worker advocated for her with the Department of Communities and Justice and NSW Housing, helping her access the rent choice program and tenancy assistance program to save her tenancy. The rent choice program now covers 75% of her rent, and the tenancy assistance program paid off her rental arrears.

Sally also received support from the escaping violence program through Wesley Mission for her recovery and employment. Her children stayed in the same school and housing remained stable. The Social Worker worked with the Aboriginal Liaison Office (ALO) at the hospital to ensure culturally appropriate care for Sally and her children. The ALO provided youth support programs for the children while Sally was in the hospital.

Relieving burden or pressure felt by GPs

Social Workers help reduce the load on GPs by taking on tasks that align with their skills and knowledge. GPs and other practice staff, like practice nurses, primarily focus on biomedical aspects of healthcare and often lack the time, capacity, or expertise to address the social and practical issues faced by patients. Integrating Social Workers to the multidisciplinary team enables efficient handling of tasks such as MAC and NDIS applications.

A co-located Social Worker facilitates system navigation and follow-up with social services, with information communicated back to the GP through practice software. GPs highly value the time saved, specialised knowledge, and the ability of Social Workers to communicate effectively in a multidisciplinary approach.

Both Social Workers and GPs agree that the role is valuable — enabling wrap around care and relieving the GP of the sole responsibility. GPs recognise that the additional clinical time that Social Workers provide in their scope complements the GPs' role and ability to support patients and caregivers.

Informing and enhancing health assessments and outcomes

Social Workers believe that their work provides essential information for patient health assessments, advice, and plans made by GPs. GPs highly value the ability of Social Workers to conduct welfare checks and review home situations with elderly patients. When a social work referral is made, it creates an opportunity for GPs to receive feedback on circumstances and issues that patients may not share otherwise. GPs agree that having access to Social Workers for their patients expands the range of services available and increases the likelihood of patients engaging in recommended care.

Adding expertise and capacity for specialist or targeted programs

Many practices offer specialised early intervention and prevention programs. These programs include parenting groups, smoking cessation programs, and healthy ageing programs. Social workers were often involved in supporting or facilitating support groups and working within these programs. This had the advantage of bringing in additional funding for a practice and expanding services for their patients. Since these programs were funded by third parties and grants, this evaluation did not examine the involvement of other practice staff or the impact of collaboration with Social Workers.

Providing specialist advice and education to general practice staff

The Social Workers give specialised advice and education to general practice staff. They provide information on health and welfare service system issues like NDIS or Aged Care policy. One of them also shares knowledge on elder abuse and Aged Care policy reforms. This helps practice staff support patients better.

Providing wellbeing support for general practice staff

An earlier section of this report (Role development, **page 16**) outlined that Social Workers also provide support to general practice staff by offering education and debriefing. This is not as common for GPs and practice staff, but Social Workers have the expertise in this area. Their contribution helps foster a workplace culture that prioritises staff wellbeing.

Some practices involve Social Workers in workplace wellbeing programs, while others provide less formal team support and brief counselling. However, there is concern that this might take away from clinical time with patients. It is important for Social Workers to focus on their role in supporting patients and consider the scope of practice in the primary healthcare setting.

Engaging with the wider community to enhance service delivery

Social Workers have found that their professional connections and relationships have had a positive impact on the wider community. By working closely with external agencies and organisations, Social Workers can provide more appropriate and streamlined referrals to various community services. This ensures that their patients have a successful transition to the services. These relationships provide an opportunity for Social Workers to contribute their expertise to policy and program discussions addressing community needs and service gaps. As a result, they believe their role helps alleviate strain on community and government services, including hospitals.

Social Workers also believe that they provide cost-effective services and save government funds by being a point of contact upstream, potentially preventing unnecessary emergency department visits and hospitalisations.

GPs also recognise the benefits of effective primary health care planning, such as the use of programs like MAC, in reducing hospital stays. This suggests that community-based care can lead to a more efficient utilisation of hospital resources and improved patient outcomes.

> **"If someone had a My Aged Care plan in place, a package that was already done and then unfortunately they got admitted to hospital, they wouldn't have to sit in a hospital bed waiting for the aged care assessment to happen and then waiting to get a package to facilitate safe discharge planning. That can be done in the community, and then if someone does, for example, break their hip and end up in hospital, their hospital stay will only be as long as the hip takes to heal."**
> *GP*

PROGRAM ENABLERS AND CHALLENGES

Interviews with Social Workers and GPs revealed a range of enabling factors and implementation of the program.

Essential Social Worker attributes

Social Workers in general practice play a complex and challenging role, working autonomously to meet the diverse needs of patients. They employ various approaches such as counselling, casework, advocacy, and group facilitation. They believe that a high level of knowledge, skills, and experience are necessary for this role, making it better suited for those with several years of clinical experience.

They emphasise the importance of having a well-established social worker identity and practice framework to navigate relationships and make ethical decisions in dynamic and complex settings. Autonomy, confidence, networking skills, and the ability to handle ethical dilemmas are key traits. Flexibility is also crucial in addressing patient needs within the constraints and challenges of the healthcare system.

The success of the model is contingent upon "placing the right Social Worker in the right general practice, at the right time."

Communication and relationship building

Effective connections and relationships among primary health care teams and external service providers, e.g. RACH staff, have been crucial for Social Workers to provide effective social work services. It was important to build trust and rapport with the multidisciplinary team during the early stages of implementation.

Social Workers felt connected when there was good communication and support from other staff. They used various strategies, such as adapting referral processes, attending meetings, and providing feedback, to help team members understand their role.

> **"I've got a very open line of communication with our doctors."**
> *Social Worker*
>
> **"There was not much understanding from the GPs initially about what a Social Worker does...So for me, it was educating them... I wrote a bio on where I'd been, and what my key interests are."**
> *Social Worker*

Case load management

The demand for social work services varies across practices. Patient needs determine their scope of practice, although target groups are prioritised.

> **"I had a caseload of 68 active patients (a few months ago), and there was just too much work. I asked if we could stop the referrals for 3 or 4 weeks. Management was very receptive of that."**
> *Social Worker*

Social workers acknowledge that the high demand for services can be overwhelming and increase their stress, so they have to find ways to manage it. The number of days per week that practitioners are engaged with the practice affects case load management and clinical capacity.

Both part-time and full-time Social Workers practitioners face challenges in managing their caseload and increasing demand for services. Regardless of hours worked, patient needs and demands always exceed available time. They utilise a high level of expertise in needs assessment and triage to manage their case load effectively.

> **"One of the first things I do is look at the internal emails, then open my calendar. I'll sometimes have up to 6 (referrals) and triage most urgent ones."**
> *Social Worker*

Co-location of services

The success of the SWiGP program and the engagement of patients and carers relied heavily on its co-location within general practice, according to GPs and Social Workers.

Co-location in general practices decreased barriers to accessing social work services, allowing patients to be seen in a timely, easy, and affordable manner. It normalised the services and helped reduce stigma for those who may be reluctant to access support associated with "not coping" or being "mentally unwell."

With the SWiGP program, establishing trust and rapport with patients happened easily. GPs had difficulty referring patients to social work services in the community prior to this.

> **"Referring to an external Social Worker. I've tried once or twice, and it's never gotten anywhere. I've sent a referral to the public system, and they've just never been seen. So, we can't even get access to a Social Worker if we wanted to."**
> *GP*

Social workers and GPs also found that the ability to pay for services often prevented patients from pursuing external referrals, even though these are the individuals who most require psychosocial support services that complement physical health services. Hence, the co-location of free social worker services worked very well. The report further explores program sustainability and funding models in subsequent sections.

Flexibility of service delivery and Social Worker autonomy

It is important for the Social Workers to work autonomously and flexibly within their scope of practice, allowing them to provide outreach services to homes and RACHs. This flexibility allows easier access for patients and caregivers, particularly those facing increased complexity such as being homebound, dealing with mental health issues, and lacking family support.

Social Workers could attend a patient's home, assess their living situation, aid with utilities, and provide practical supports. This made a difference to patients' overall wellbeing and prevented them from "falling through the cracks." GPs agreed that Social Workers' professional opinion and assessment improved their ability to provide appropriate medical care and services.

The SWiGP program removed limitations in consultation times, space, and financial outlay for patients, allowing them to receive the care they needed in the safe space of the general practice. This created an environment where patients felt more comfortable being open about their circumstances or concerns.

> **"The capacity of the Social Worker to spend that additional time with patients almost allows the patients to feel less burdensome on you as the GP. They feel that the Social Worker has set aside the one hour or 45 minutes, so there is that safe space, not rushed, the phones not ringing. People are not knocking on the door asking for things. This gives them a safe space to be able to think 'OK, perhaps I can share this with somebody, because I'm not taking up the doctor's time, she's got another patient, I do not want to hold up people'. Certainly, the fact that time can be spent maybe helps the patients talk about what the real issues are."**
> *GP*

Access to the Social Worker

All Social Workers reported that patients experienced quick and easy access to their services. Patients and carers expressed that greater access to the social work service would be advantageous, especially when the Social Worker worked part-time.

The need for increased availability of the Social Worker would be measured at practice level taking into account the patient population, needs identification, scope of service, and service model at the practice.

Table 4 shows that referrals were accepted, and the service was highly accessible. There were no instances where patients could not access the service when they needed it. Social Workers indicated in this report that there were occasions when the number of referrals surpassed their ability to provide services. GPs also mentioned that when Social Workers worked part-time, there were occasional challenges in the timeliness of follow-up or feedback on referred cases.

> **"This is such a great program/pilot, it would be excellent if it continued and was scaled up. The Social Worker has been fantastic, it is wonderful that the service extends to family members."**
> *SWiGP participant*

PROGRAM SUSTAINABILITY

Sustainability considers the viability of the SWiGP program for broader implementation and factors influencing long-term considerations for the inclusion of Social Workers in a multidisciplinary general practice model.

Funding models for the ongoing support and financial viability of the program

Social Workers stated the sustainability and success of the SWiGP model was contingent on the development of an appropriate and secure funding model that meets the needs of the Social Worker, the general practice and their patients.

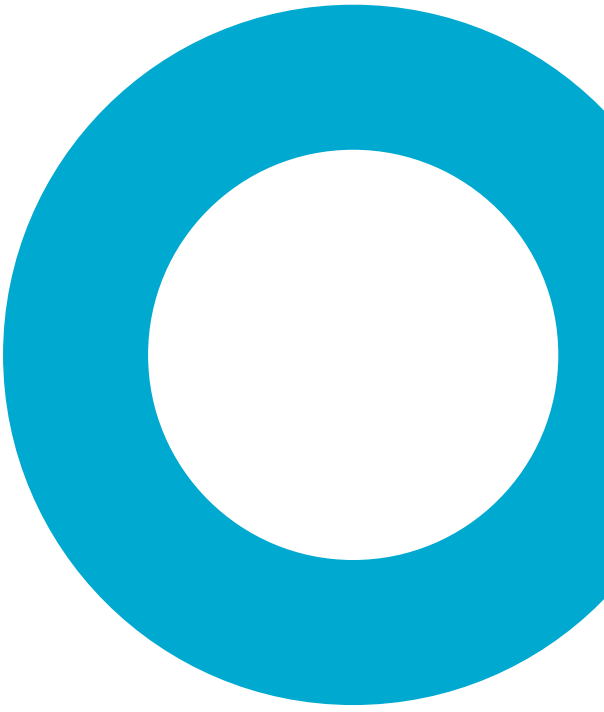
They stressed the SWiGP model needs to be funded appropriately to ensure:

- employment of Social Workers is financially viable for general practices
- social work services operate with no out-of-pocket expenses for patients and carers
- social workers receive commensurate payment for the work they need to do.

GPs expressed that they could not see a way in the current MBS funding scheme for primary health care to fund a service such as this from a general practice business model perspective. GPs reflected that the current Medicare model did not work well for social medicine, noting that the amount of work required to meet billing criteria in some cases meant that it was not profitable for the practice to pursue items such as case conferences for patients.

GPs felt that GP Management Plans (GPMP) and Team Care Arrangements (TCA) had potential for the inclusion of Social Workers and noted that it would be a funding option if Social Workers were included as a health professional on these.

GPs recognised that many services provided by Social Workers in the SWiGP program did not require a mental health care plan. Generalist Social Worker roles were seen as valuable for those in social disadvantage, experiencing isolation, or needing assistance with service navigation. They suggested the inclusion of social work services in health assessments for patients over 75 or those with chronic diseases. They agreed that integrating Social Workers into multidisciplinary care in general practices would be beneficial and hoped for future government funding to support this.



DISCUSSION

The findings of the evaluation of the SWiGP pilot program are discussed in relation to the evaluation questions associated with **program implementation**, **program experiences**, **program benefits** and **potential sustainability**.

PROGRAM IMPLEMENTATION

Was the SWiGP pilot program implemented as intended across the practices?

The SWiGP pilot program was implemented in 4 general practices according to their specific needs. The program followed the guidelines set by CHN in service agreements. Each practice decided on their own criteria for hiring Social Workers and the focus of their services. They also shared their experiences and updates at CHN-coordinated stakeholder meetings held quarterly. These meetings provided a chance for interprofessional learning and discussions about trends, challenges, and new concepts being tested in the practices.

Practices report activity to CHN every quarter as required by the contract. The SWiGP pilot program has shown that including Social Workers in primary health care teams:

- enhances the level of psychosocial support that general practices provide to patients and carers
- increased capacity of GPs to help patients access community and government support service
- built capacity for general practices to address patients' unmet needs in various areas such as finance, housing, relationships, isolation, life transitions, family conflict, and abuse.

Including Social Workers in general practice provides comprehensive psychosocial and practical assistance for patients from different backgrounds. They play a crucial role in coordinating care for patients with complex presentations and chronic disease. It is important to fully utilise Social Workers' skills and time to meet the needs of patients who can benefit from their services. When hiring a Social Worker, practices should determine if the role meets their patients' needs and if an AMHSW is necessary or a generalist Social Worker would suffice (see discussion regarding MBS item numbers in **Sustainability**, **page 46**).

In other programs, Social Workers have operated as 'Link Workers' and facilitated social prescribing.[10] However, this approach may limit the skills and value that they can offer in a general practice. Social prescribing is just one component of the wider range of services provided by Social Workers in this setting.

A targeted role for effective social prescription enables GPs to offer improved support to patients dealing with complex chronic diseases, mental health concerns, and social isolation.

At practice level, service models should be developed to define intended outcomes, episode parameters, cessation of care, and service capacity for social work. This will ensure optimal utilisation of Social Workers as skilled health professionals.

Was the pilot successful in identifying and reaching the intended population in each pilot practice?

Across 12 months of data collection, the SWiGP program received 533 referrals. Out of these, 513 referrals were accepted across all participating practices. The majority of SWiGP participants were female, aged between 46 and 79 years old, and from an English-speaking background. About 5% of participants identified as Aboriginal and/or Torres Strait Islander, and approximately 7% indicated that English was not their primary language spoken at home.

Looking at the trends, the aggregated findings show why people were referred to the program. The most common reason was to get help with accessing government services like MAC, NDIS, Housing, DSP, and domestic assistance. These reasons accounted for more than 50% of referrals. They were also among the top 10 secondary reasons for referral. In 3 of the 4 practices (A, C, and D), the focus was on helping people over 65 stay in their homes and get more services.

Practice B, on the other hand, focused on supporting patients facing socio-economic disadvantage and vulnerability. Their referrals were more about mental health, DSP access, and family violence. This aligns with the target population for their practice. (Refer to **page 55** for individual practice referral data for Practice B.)

As set out in the program aims, the SWiGP pilot sought to:

- build capacity for greater support for the general practice workforce through interdisciplinary collaboration
- improve individual patient capacity for system navigation
- increase the efficiency and effectiveness of primary health care services for patients, particularly where they were at risk of poor health outcomes.

Referral trends show that Social Workers played a crucial role in achieving these aims. They responded to practice needs and adapted their skills and approach as necessary. They used their experience to deliver flexible care.

GPs were better equipped to help patients and carers with social health issues. Patients and carers found value in having a skilled health professional in a trusted, safe setting to assist them with challenging problems. Those facing social isolation or family violence had access to care with reduced barriers.

Has the pilot program identified aspects of implementation which are important considerations for future iterations of programs such as this?

The SWiGP program and implementation approaches taken by each of the 4 general practices improved the capacity of these practices to provide low level psychosocial support and increase opportunities for patients to access social and community services. Key factors that were important in implementation success include:

Social Workers having the support to:

- establish themselves as an integrated and valued member of the health care team
- develop relationships with GPs and other general practice staff that facilitates referrals and builds trust
- develop an interprofessional network between themselves that supported their practice, despite independently operating in different practice settings
- develop service models that fit the needs of the practice
- operate autonomously and with flexible service delivery
- establish referral pathways and connections with local service providers and government agencies
- effectively manage caseloads and demonstrate operational competence
- provide educational opportunities and upskill other primary health care professionals about the social work role
- access appropriate professional supervision.

Positive feedback shared by GPs, patient and carer service users has supported the contributions of the Social Worker role within a general practice setting. Program stakeholders widely shared similar feedback.

Findings around referral types, professional practice and complexity of presentations seen in the SWiGP pilot program demonstrate that Social Workers in general practice settings are working across the full range of their scope of practice.

The evaluation found that they mainly focused on essential clinical and patient-related tasks, which were classified as administrative. Social Workers expressed concerns about workload and how mismatched expectations affected their clinical work time, including data collection for the evaluation. This issue was more prominent in part-time roles.

The evaluation did not include a detailed time-in-motion study to allocate tasks to activity categories. Developing a definition or coding for role elements and recording this information through detailed activity diaries would be helpful in better understanding the actual time required for a Social Worker to work effectively with patients and measure outcomes.

Fraser et al. identified Social Worker tasks in a systematic review of studies on integrating social work in primary health care. They found that, besides providing team-based care and contributing to care plans, Social Workers performed various activities within their roles:[1]

- conducted standardised assessments
- consulted with care providers
- managed care plans
- provided patient education and psychoeducation (i.e. leading self-care training groups for patients with chronic health problems)
- facilitated communication among team members
- linked patients with community resources
- advocacy
- conducted functional assessments in the context of addressing social determinants of health.

This aligns with the research findings presented by Zuchowski et al. around the characteristics and social work practice undertaken by Social Workers in the SWiGP pilot program.[16] Capturing data around specific role components would allow for improved service planning, capacity management and inform costing around a Social Worker role. The trade off on clinical time and value of this to the practice would need consideration if implemented.

The time breakdown of Social Worker activity is a key factor in understanding capacity and strategically planning services. For future evaluations, it is important to capture in-depth activity information and clearly define the role elements that contribute to patient outcomes. Social workers in primary health care must possess strong self-management skills and be confident in their ability to assess cases. Assessment, triage, and establishment of systems are important for implementing the SWiGP model and managing referrals and case load.

Opportunities to strengthen future implementation include:

- consideration of program design at the practice level prior to engagement of a Social Worker
- clear role definition and scope of practice aligned with patient outcomes
- development of intake assessment and triage systems at a practice level that include decision tools for GPs to assess patient needs prior to referral
- service model development at practice level that ensures definition of episodes of care, service contacts and clinical governance
- development of professional networking groups
- improved data quality including patient-related outcome measures and use of validated tools to monitor patient and program level improvement
- development of internal monitoring, evaluation, and risk management frameworks for social work in general practice at the general practice level with integrated reporting and monitoring by PHNs.

PROGRAM EXPERIENCE

Does integration of Social Workers into General Practice improve how primary health care supports patients who have additional needs around complex presentations or social determinants of health?

The evaluation showed that having a Social Worker in general practices improved the practice's ability to support patients and carers with additional needs. These needs included complex presentations, vulnerability, and concerns about social determinants of health. GPs and Social Workers agreed that having a Social Worker in the practice helped facilitate access to the right support. GPs felt empowered by having a health professional who was an expert in social supports and psychological wellbeing. They had increased access to support services and an expert's knowledge.

The presence of the Social Worker also helped GPs better understand patients' external circumstances that could affect their ability to follow health recommendations and care plans. Sometimes, the Social Worker's involvement allowed GPs to learn more about patients that they may have missed during consultations.

The findings showed that having a Social Worker as part of a primary health care team improved patients' and carers' access to psychosocial and practical support. This integration reduced stigma and barriers for patients, especially when dealing with complex issues related to social determinants of health. The SWiGP program made it easier for patients to access psychosocial support, which is important for primary prevention.

According to de Saxe Zerden et al., integrated care in primary health care settings has less stigma than specialised mental health clinics, making it more accessible for patients. Additionally, early intervention allows the treatment of behavioural health problems when they are less complicated and more responsive to brief interventions.[2]

Referrals to Social Workers in the 4 practices mostly involved accessing support services and providing psychological support. Around 70% of referrals were for accessing government services and getting assistance with service navigation. Between 30% to 40% of referrals included psychological support. Primary reasons for referral included managing complex issues, chronic conditions, advanced care planning, transitions of life, grief and loss, and social connection support.

Data from the Australian Institute of Health and Welfare (AIHW) shows that up to 91% of Australians have chronic conditions, with mental health and behavioural conditions being the top 10 most common.[25] Data from the Australian Bureau of Statistics (ABS) indicate that chronic conditions account for a significant proportion of general practice activity, in 2022–23, 60% of people who visited a GP in the previous 12 months had a long-term health condition. Social determinants of health, including aspects of social cohesion and inclusion, loneliness, socioeconomic factors, health behaviours, psychosocial and safety factors, workforce participation, ability to earn income and access social support all have an influence on a person's health and wellbeing.[26] The SWiGP pilot program demonstrated that including a Social Worker in the primary health care team improved general practice's ability to address social determinants of health. It also allowed for early intervention.

Does the SWIGP program improve the capacity for general practice to assist patients with navigating non-medical issues which otherwise impact on their health?

The evaluation highlights the important role of Social Workers in facilitating access to services and system navigation, ranging from care coordination to social prescription or signposting. The capacity for Social Workers to provide continuity of care in complex presentations enhances healthcare delivery across the bio-psychosocial spectrum. The complexity of patient and carer circumstances necessitates qualified Social Workers rather than diploma-level qualifications in case management or welfare. Role delineation and desired outcomes should be carefully considered when engaging the services of a Social Worker. Having a Social Worker in the practice increases the likelihood of patients engaging with psychosocial supports. Initial hesitation is often overcome once the nature of the Social Worker's role is explained, as patients appreciate not having to seek help from external providers. The ability to provide warm referrals and have in-person conversations with Social Workers gives GPs a sense of wrap around care that they often feel is lacking when referring to external service providers.

The SWiGP program had an unintended outcome — some Social Workers in practices also supported the wellbeing of the general practice staff. This additional role should be recognised as part of the Social Worker's function in the program. When creating the role description, practices should consider if this is within the scope of the Social Worker's role. While it may seem logical to have team wellbeing and emotional support from a professional in the practice, it could also add strain to the Social Worker's main role of working with patients and carers. This is something to explore in future versions of SWiGP.

The program has shown that the role can include targeted social prescription and other complex aspects of social work. There are opportunities to explore how targeted involvement on GP Chronic Disease Management Plans and targeted social prescription by Social Workers in general practice may contribute to:

- reduced hospital admissions, burden on GP services and costs for people with chronic conditions
- deepened integration between clinical care interprofessional teams and social support
- improvement in social isolation and loneliness
- enhanced community connection.

Having Social Workers as part of a multidisciplinary general practice team ensures there is a skilled professional to facilitate effective social prescribing. More broadly, social prescription and increased multidisciplinary capability enhance the capacity for general practice to provide a holistic approach to care.[27]

Future programs should integrate validated measurement tools at regular intervals to measure and monitor the effectiveness of social work services. Access to patient level change in wellbeing or mental health outcome measures, and the ability to attribute these changes to Social Worker support, would provide a quantitative assessment of program outcomes and demonstrate the effectiveness of improving patient outcomes.

Patient Reported Outcome Measures (PROMs) such as PROMIS or SF-36 are commonly used to assess outcomes like symptoms, daily functioning, and quality of life. Ideally, Social Workers would administer these tools to all patients at least twice during their engagement. This is aligned with the recommendations made by the MBS schedule review taskforce to, 'Introduce standardised health outcome and patient reported outcome measures to enhance patient level decision making and resource planning and allocation' and contribute to improved quality and safety in health care delivery.[28]

PROGRAM BENEFITS

Do patients and carers who are referred to a Social Worker feel that the service is beneficial; they feel supported, see the Social Worker as a trusted health professional, and feel that a Social Worker improves their experience of care in the general practice?

Patients and caregivers had positive encounters with Social Workers who assisted them in accessing services and finding support. This complemented the care provided by the GP. They trusted that the Social Worker followed up and advocated for them with agencies.

The Social Worker helped them navigate the MAC system, reducing anxiety and improving their understanding of service eligibility. The presence of the Social Worker improved their overall care experience with their GP and provided support not previously received. Patients and carers found the Social Worker helpful for their emotional well-being and relieving stress.

Positive outcomes were achieved in various areas such as navigating services, meeting psychosocial needs, housing, family violence, welfare checks, and increasing social participation. The willingness of the Social Worker to provide help, even in unexpected or minor situations, was greatly appreciated and made patients and carers feel cared for. Trust in the social work service developed when tangible outcomes improved their personal situation.

The SWiGP program can offer services to carers and engage with patients' family members in their homes. This was a valued aspect of the program. However, there is a need to consider risk management strategies when a Social Worker attends a patient outside of the practice setting.

The practice that worked with RACHs highlighted the importance of Social Workers providing emotional and practical support to carers. It was noted that RACHs often lack social work services, putting additional pressure on carers to navigate systems and services. It is difficult to determine how services to carers and family members would progress in future programs or funding models for Social Workers in general practice. The current billing requirements only allow Social Workers to deliver services to people other than the patient if they are an AMHSW (see **Table A6**, **Appendix 7**). This could be considered when developing guidance or frameworks for Social Workers in general practice. While it is the nature of social work practice to extend care to family members and carers, billing constraints may create ethical conflicts.

Program participants valued the increased capacity of Social Workers to provide support and connect them with required services, especially in times of health concerns or significant life challenges, e.g. deteriorating health concerns, significant life challenges or changes (such as job and housing insecurity, financial problems, relationship breakdown, conflict or violence).

Social Workers emphasised that many patients in the SWiGP program would not have accessed social work services in a timely manner, if at all. Previous research has identified the social work role as crucial in reducing power imbalances in healthcare settings and creating a safe space for patients to share their concerns.[19] The qualitative findings of this pilot program align with these research findings.

Patients and carers frequently described the social workers as calming, helpful, friendly, kind, understanding, and supportive. Social workers themselves stressed the importance of meeting patients where they are. Patients' reflections on feeling unhurried highlight the social nature of the profession and the importance of therapeutic relationships.

Previous research has identified similar findings, Kam (2020) noting that, 'Going beyond individual support, they [patients] wanted Social Workers who would assist them to express their views and make requests to government, work with them as allies and protect and fight for their rights'.[26] The SWiGP program highlighted the important role of Social Workers in providing advocacy and support to patients and carers struggling with accessing services.

In what ways does the inclusion of a Social Worker as part of a multidisciplinary general practice team benefit health professionals in general practice?

Social Workers developed strong relationships with other professionals and community services. This built trust in the SWiGP program for the healthcare team and patients. As SWiGP gained momentum, the team recognised the value of Social Workers in primary healthcare. GPs started identifying situations where a Social Worker could help patients.

A systematic review by Zuchowski et al. found that including Social Workers improved team effectiveness and communication.[16] GPs saw Social Workers as a trusted resource for social sector services. Qualitative feedback from GPs showed that having a Social Worker reduced their workload and provided a specialist for patient referrals. Working with a Social Worker on issues related to social medicine relieved the burden on GPs to spend time — often unpaid — to complete paperwork or research services for patients. This reduced burnout in GPs and gave them a sense of control.

A study by Parajuli et al. in 2022 found that factors like working in an urban area and unrealistic patient expectations contributed to low internal locus of control (LoC) in GPs, leading to increased depression and burnout.[29] The findings of this evaluation indicated that the presence of a Social Worker in the practice led GPs to feel that they had increased agency and support around managing some of these issues — such as demands on time, ability to manage patient expectations and to feel supported in their practice.

The evaluation findings repeatedly highlighted the importance of increasing capacity in general practice to address unmet social and emotional needs. While mental health care and counselling are part of the Social Worker role, it is not the only aspect. GPs reported that having a Social Worker available to handle paperwork and follow up with external agencies allowed them to focus on the medical needs of patients and reduced the pressure to complete these tasks within consultation times. This also reduced the workload for GPs and the out-of-pocket costs for patients.

Social Workers also played a role in interprofessional education and knowledge sharing within the multidisciplinary team. They provided both formal and informal education, which was well-received by GPs. Some GPs initially had a limited understanding of the Social Worker role, and these opportunities for learning helped build trust and connections within the team. There is literature supporting the importance of provider education for successful integration of Social Workers in primary health care.[2] Social Workers improved GPs' and team members' ability to support patients' psychosocial well-being and practical needs with their professional skills and knowledge.

Does the SWIGP program improve how general practice connects with the broader health and community services sector?

The SWiGP pilot program found that integrating Social Workers into general practice teams increased their ability to help patients access psychosocial support and navigate the community services sector. Data from the program showed that the primary reason for referral to Social Workers was to assist patients in accessing broader health and community services.

General practitioners (GPs) felt that Social Workers were able to effectively communicate with the social services sector, resulting in more efficient access to services for patients. GPs also valued the specialised knowledge that Social Workers brought to the practice, improving collaboration and team effectiveness, and providing additional referral and support options.

In practices focusing on the over 65 years old group, the addition of wrap around psychosocial services was seen as crucial in reducing hospitalisations and aiding in-home care. General practices with a high proportion of elderly patients saw the SWiGP program as a potential way to reduce unnecessary hospitalisations and emergency department visits. Having a Social Worker in primary healthcare settings may also help reduce hospital stays for patients eligible for MAC packages.

The AIHW 2024 report shows that older Australians (aged 65 and over) have higher rates of potentially preventable hospitalisations (PPH) compared to those under 65. The rates are approximately 6900 per 100,000 people for older Australians and 1700 per 100,000 people for younger Australians (under 65 years).[30] The AIHW report identifies acute conditions such as perforated/bleeding ulcers, cellulitis and urinary tract infections, and chronic conditions such as diabetes mellitus, hypertension, nutritional deficiencies and iron deficiency anaemia are among 22 identified conditions where hospitalisation may be prevented through primary and community care early intervention.[30] These are conditions frequently seen among the 65 years and over population. The aspects of implementation described throughout this report relating to this population may indicate that a multidisciplinary team approach has a role in aiding primary health care providers to identify and manage chronic conditions in the community more effectively.

The integration of Social Workers in primary care and their role in reducing PPH through early intervention and identification of specific conditions is worth considering in future evaluations. A cost benefit analysis could provide insight into their integration's system level impacts particularly in reducing hospital bed days.

The SWiGP program identified mental health support, brief intervention, social connection support, and mental or family stress as the 3 most common secondary reasons for referral. Transitions of life and grief and loss support were also common reasons for referral. According to the Royal Australian College of General Practitioners (RACGP) Health of the Nation Survey (2023), mental health concerns were the main issue for GPs, with a 11% increase in patients presenting with psychological issues since 2017.[27] GPs take on a significant proportion of the workload associated with mental health, as they are often the first point of contact for people experiencing mental health concerns.[25]

The skill set and scope of practice of Social Workers and their co-location in general practice, demonstrated by the findings of the program, make their inclusion in a primary health care team well placed to address low to moderate intensity primary mental health concerns. The evaluation highlighted several examples of how Social Workers in the pilot program provided brief interventions and low intensity mental health care to de-escalate stress and increase engagement with medical advice.

Psychosocial services have been shown to improve personal recovery, reduce the number and length of hospital admissions, and improve housing, health, social inclusion, and employment outcomes as well as outcomes for carers.[10] Investigating the cost effectiveness of Social Workers in delivering Low Intensity Mental Health Services could pave the way for funding primary healthcare programs like SWiGP in the future.

What are the program enablers and challenges identified as considerations for future iterations of SWiGP programs?

Enabling factors for the SWiGP pilot program included:

- flexibility of role development to meet practice needs
- willingness of health professionals in the general practice to accept and learn about the Social Worker role and apply this to their practice
- co-location of service delivery, making social work service accessible and inclusive with open lines of communication
- established referral and communication pathways within the practice, including patient record access for all members of the primary health care team
- engagement of experienced and skilled Social Workers who were a good fit for the needs of the role in each practice
- practice level capacity to provide appropriate space and infrastructure support, and leadership support for the pilot program (GP Champions)
- development of professional networks and trust with patients, carers, external service providers, and agencies
- having additional time available to see patients
- capacity to provide in-reach services into RACHs and patients homes
- inclusion of carers and family members in service delivery
- support from CHN in the overarching provision of governance, collegiate relationship development, opportunities for shared learning, and support for clinical supervision to Social Workers
- supported funding for the service by CHN.

Challenges in the implementation of the SWiGP program included:

- clarity of role delineation and scope of practice in the establishment phase
- GP and health professional understanding of the scope of the social work role
- case load management and service demands placing excessive strain on sole practitioners
- establishment of intake criteria, systems and processes for triage to ensure that those accessing the service are maximising the skill set of Social Workers based on identified needs
- establishment of role and interface with other social services in community
- lengthy recruitment times for Social Workers at some practices
- Social Workers felt overwhelmed and burnout at times resulting in reduced clinical capacity
- no foreseeable funding mechanism to engage Social Workers to ensure financial viability for practices or to provide social work services with low or no out-of-pocket expenses for patients outside of specific funded programs
- lack of data collection that reflected patient-related outcome measures at individual and program level.

PROGRAM SUSTAINABILITY

What are the considerations needed to create longer term sustainability for the pilot program?

Experience level of Social Workers in general practice

Social Workers employed by practices in the SWiGP pilot program were all experienced, with 83.3% (5/6 Social Workers) having 7- 10 years of social work experience (individually), 50% having postgraduate qualifications and all having pursued further education to reinforce areas of core interest, such as working with older people, elder abuse and pastoral care. There are clear arguments for the necessity of Social Workers in a general practice setting having a baseline level of postgraduate experience, much of which relates to the autonomous nature of the role, the need to be able to undertake assessment of sometimes complex social work cases and the skills to manage a caseload that covers a wide range of social work skills.

Financially, it may be a challenge for general practices to hire Social Workers with 5 or more years of experience without dedicated funding. The level of experience and education required for a Social Worker role in a practice depends on the practice's needs.

Zuchowski et al. investigated the placement of student Social Workers in general practice settings. While this study highlighted considerations around engagement of less experienced Social Workers, it also demonstrated they can assist with patient issues surrounding assistance with service navigation, social prescription, and applications for NDIS, MAC, DSP, and other services.[15] This points back to careful consideration of the needs of a general practice in engaging a Social Worker as part of a multidisciplinary team.

Service model development that considers the core needs of the practice and what they need from a Social Worker role may assist in determining the level of experience required for the person undertaking the role and provide an option where a general practice can benefit from a social work service with a limited scope of practice, but at a lower cost to the practice.

Clinical supervision and professional collaboration

Social Workers in general practice operate independently, without the support systems of community or hospital-based settings. It is important to establish formal and informal support mechanisms to facilitate professional and role development in the SWiGP model.

The SWiGP program introduced GP Champions to provide internal professional support and clinical governance, although the level of support varied across practices. The nature of providing psychosocial support can be emotionally burdensome, and operating as a sole practitioner increases the risk of burnout.[25]

CHN included clinical supervision to provide external professional support for Social Workers in the SWiGP program. It was widely acknowledged that including formal clinical supervision, in accordance with AASW professional standards, would support Social Worker practice. Participation in clinical supervision is also a condition of professional practice as a Social Worker who is a member of the AASW.

When employing a social worker, general practices need to ensure that this is factored in and ensure adequate support mechanisms are in place to promote ethical practice and prevent burnout.

Funding models for the ongoing support and financial viability of the program

The SWiGP program received funding for an initial 18 months through CHN. It was later extended for another 12 months. The main concern for the long-term sustainability is to find a secure funding model. This model should consider the following factors:

- operating the service at an appropriate clinical capacity
- providing appropriate remuneration to attract qualified social workers
- finding viable options for billing through the MBS
- minimising out-of-pocket expenses for service users.

At present, there are limitations on billing for social work services in under the MBS. Although tsome item numbers allow billing for social work services in general practice through telehealth and phone, they do not sustain the employment of a social worker. **Table A6** in **Appendix 7** provides a breakdown of billable MBS item numbers for these services.

The current MBS schedule permits AMHSW to bill for services. They can provide focused psychological strategies in person or through video/phone conference. Social workers who are AMHSWs can also bill for providing pregnancy support and eating disorder services under Medicare.

WAPHA has examined the feasibility of including AMHSW in general practice teams. However, they found that recruiting and maintaining the credentialing for AMHSWs may be challenging due to the more generalist nature of work in general practice settings.

The Multidisciplinary Team Care Review (MDTR MBS — Item 872) involves Social Workers. However, GPs have expressed concerns about the practical requirements of having all team members and the patient present during a consultation, which makes coordinating the MDTR difficult.

GPs have also raised limitations with the MBS funding for Team Care Arrangements (TCA) and GP management plans (GPMP), as they do not include Social Workers.

Starting 1 November 2024, the Australian Government will replace GPMP and TCA with a single GP Chronic Condition Management Plan, which may affect the billing for social workers in general practice. It was suggested that those who are accredited with the AASW could potentially receive additional funding for the SWiGP model, but this would still limit their role in general practice. Only patients referred under a Mental Health Care Plan would be eligible for billing under specific MBS item numbers.

Many patients referred to Social Workers in the SWiGP program did not require care for mental health, pregnancy, or eating disorder as covered by these plans. In the current MBS funding arrangements, there are limited options for billing social work services of a more generalist nature, which were the most common cases seen in the SWiGP program.

A systematic review of social work in general practice by Zuchowski and McLennan (2023), which explored programs internationally, noted that "18 of the 26 studies stated that social work practice in primary health care was made possible because of changes to funding and legislation".[16]

Sustainable funding options for social work in general practice is a major challenge to be overcome in the broader implementation of SWiGP models. By developing a more robust evidence-base on cost effectiveness and outcome measures, there is greater potential to advocate for changes and investment in primary health care teams at a system level.

EVALUATION LIMITATIONS

There were several limitations identified by the evaluation team than should be taken into consideration in interpretation of the findings. These included:

Data collection

- Data collection at each of the practices was variable, with Social Workers managing their own data collection methods. There was no baseline data collection or agreed standardised methods prior to program commencement. While Social Workers were given guidance around monthly qualitative data collection, individual interpretation varied, resulting in variable data collection across practices.
- Data collection did not incorporate validated patient level outcome measures such as Quality of Life because the Social Workers were not willing to administer these measures. They highlighted issues with the use of more formalised validated tools in the evaluation citing concerns around developing rapport, tensions around administration of validated tools and client vulnerability, and demands on patient and Social Worker administrative time in undertaking validated tools.
- The evaluation used a mixed methods approach, but most of the data collected was qualitative. The evaluation mainly focused on themes extracted from the qualitative data, incorporating quantitative data when possible.
- Qualitative data collection did not include the perspectives of broader stakeholders such as external service providers (e.g. RACH staff, other service provider organisations, Carers ACT), nor did it capture qualitative insights from patients and carers in a structured focus group.
- Qualitative data from patients and carers was obtained through open-ended questions on the patient feedback survey.

Bias

- As patient feedback surveys were administered directly to patients and carers by the Social Workers themselves, there is the potential for social desirability bias in responses to patient and carer feedback surveys.
- Sampling bias was present in selection of patients and carers who completed participant feedback surveys. At the beginning of the evaluation, recommendations were made to allow all patient participants of the SWiGP program to contribute to the evaluation via direct mail out or electronic distribution of a participant feedback survey. However, Social Workers were worried that patients and carers might find it difficult to complete these surveys because of the characteristics of the patient population and their digital literacy. Concerns were also raised about direct distribution of these surveys potentially impacting patients' willingness to engage in the SWiGP program or creating confusion around what was being asked of patients and carers, when receiving a survey from an external source.

Comparability

- The SWiGP pilot program only included 4 general practices, all located in metropolitan areas.
- The practice selection process for the pilot was based on expression of interest, which restricted the ability to compare practices with similar demographics and patient populations. Therefore, the findings of this evaluation cannot be generalised.

Evaluation approach

- While the evaluation framework was co-designed with the stakeholder group, this occurred after Social Workers had been engaged by practices and had already commenced in the role. This limited the development of an evaluation framework that incorporated the collection of baseline data and pre-intervention qualitative data from practices and GPs, removing the capacity of the evaluation to compare beliefs and experiences of stakeholders pre and post SWiGP implementation. This also resulted in limitations of the co-design process as Social Workers were not engaged in the development of program level outcome measures and described the feeling of the evaluation being an extra layer of administration that detracted from clinical time.
- The evaluation did not consider economic evaluation due to the program's nature and MBS limitations for billing social work services in primary health care. More information would have been beneficial, such as utilising daily activity diaries for more efficient tracking of billable hours for Social Workers.
- Due to limitations in data collection, small participant numbers, and survey response and sampling bias, the evaluation study has limited generalisability.

FUTURE CONSIDERATIONS AND RECOMMENDATIONS

1.

General practices considering to establish social work services should develop service models for operation of the program at a capacity that can cope with service demand, allowing for appropriate use of Social Worker skill set to avoid burn out. This is especially critical in a practice setting where there is only one Social Worker engaged in service delivery. This should include outcome measurement (PROMIS, SF-36) and key performance indicators linked to patient outcomes such as self-identified goals, and respond to areas of unmet needs, quantitative and qualitative data collection and measurement of program level engagement.

2.

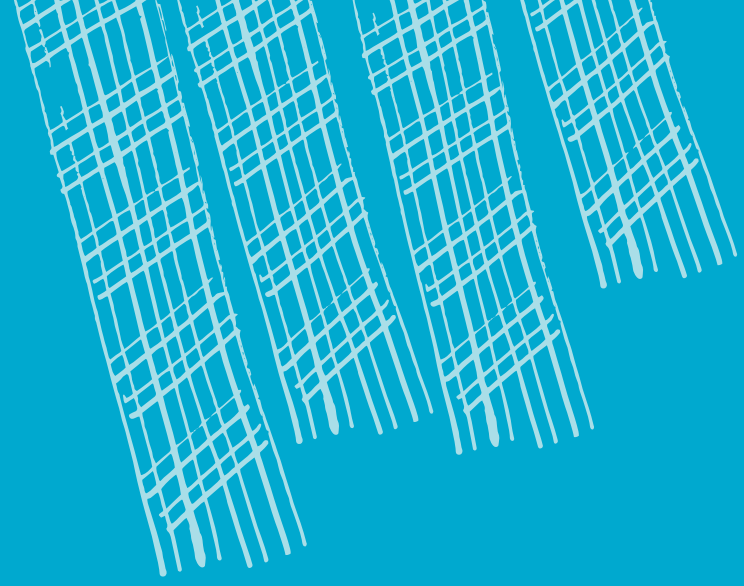
PHN implementation should consider development of program level data collection to strengthen the capture of data insights around episodes of care, service engagement, mental health specific assessments and brief intervention and the use of initial assessment and referral decision support tools. Use validated survey tools such as Your Experience of Service (YES) and collection of baseline data to measure improvement in overall wellbeing as a result of service engagement.

3.

PHN and AASW should jointly provide support to practices in future implementation of SWiGP, especially in the development of needs assessment, social work models of care, and establishment of practice and program level outcome measures to create a collective, comparable evidence base to establish the effectiveness of Social Workers in general practice.

4.

Develop a position paper or working group with AASW to provide guidance around the establishment of a Social Worker in a general practice role, to ensure that Social Workers skills are being maximised and patient needs are being met in a way that optimises capacity for service delivery.



5.

PHN must consider an economic analysis of future SWiGP funded projects to inform the evidence base around value for funding Social Workers in general practice through federal funding mechanisms.

6.

PHN and general practice should communicate success stories and positive outcomes of SWiGP to encourage development of similar models and build the evidence-base for Social Workers as a valued member of a multidisciplinary general practice team.

7.

Future implementation of SWiGP should consider the inclusion of service users in engagement around service planning, implementation and decision making from a continuous quality improvement and consumer participation perspective.

8.

PHN must continue to explore opportunities to increase primary health care access to social work services and develop guidance for General Practice in the ACT on integration of Social Workers into general practice settings based on the outcomes of this pilot program.

9.

PHN should consider the capacity of the SWiGP program to sit within the scope of a Low Intensity Mental Health intervention and encourage the collection of Primary Mental Health Care Minimum Data Set (PMH-MDS) details for patients accessing social work services in general practice who access the service for primary presentations associated with mental health concerns, or those that would fit within the scope of a low intensity mental health presentation. Consideration of inclusion of a standardised needs assessment tool such as CANSAS would also provide an opportunity for ongoing qualitative data collection that is comparable across practices.

REFERENCES

1. Fraser, MW., Lombardi, BM., Wu, S., de Saxe Zerden, L., Richman, EI., Fraher, EP. (2018) Integrated primary care and social work: A systematic review. Journal of the Society for Social Work and Research, 9(2); 175–214 DOI: https://doi.org/10.1086/697567
2. de Saxe Zerden, L., Lombardi, BM., Fraser, MW., Jones, A., Garcia Rico, Y. (2018) Social work: Integral to interprofessional education and integrated practice. Journal of Interprofessional Education & Practice. 10: 67–75, DOI: https://doi.org/10.1016/j.xjep.2017.12.011
3. Capital Health Network (2021) Capital Health Network (ACTPHN) 2021–2024 Needs Assessment. Capital Health Network (ACT PHN). Available from https://www.chnact.org.au/wp-content/uploads/2022/03/Capital-Health-Network-ACT-PHN-2021-24-Needs-Assessment.pdf
4. Australian Government (2022) Future focused primary health care: Australia's Primary Health care 10-year plan 2022–32. Australian Government, Department of Health. Available from https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en
5. Keefe, B., Miyake-Geron, S., Enguidanos, S. (2009) Integrating Social Workers into primary care: Physician and nurse perceptions of roles, benefits and challenges. *Social Work in Health Care*. 48:6.
6. Waddington, C., & Egger, D. (2008). Integrated health services: What and why? (Technical Brief 1). Geneva, Switzerland: World Health Organization. Retrieved from http://www.who.int/healthsystems/service_delivery_techbrief1.pdf
7. Australian Association of Social Workers [Website] How Social Workers work. Accessed May 22nd 2024 from https://www.aasw.asn.au/social-work/about-social-work/how-social-Workers-work/
8. Australian Association of Social Workers (April 2021). Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law Submission 6. Accessed May 22nd 2024 from https://www.aph.gov.au/DocumentStore.ashx?id=71f212f3-df97-4638-b7ae-a1f550ee5a59&subId=706677
9. McGregor, J., Stewart, W.M., Harris, F, M. (2018) Health benefits of primary care social work for adults with complex health and social needs: a systematic review. *Health and Social Care in the Community*. 26(1):1–13.
10. NHS England (2020) Social prescribing and community-based support: Summary guide. NHS England and NSH Improvement. Sourced from https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/
11. Gibbons, AR., Howarth, M., Lythgoe, A. (2019) Social Prescribing in Greater Manchester. University of Salford, Manchester. Sourced from https://www.gmcvo.org.uk/system/files/GM%20Social%20Prescribing%20Research%20-%20Exec%20Summary.pdf
12. COORDINAIRE. South Eastern NSW Primary Health Network [Website] Social RX: Social Prescribing Service. Accessed from https://coordinare.org.au/community/service-summary/social-rx on 29 August 2024.
13. Wenworth Healthcare. Nepean Blue Mountains Primary Health Network [Website] Social Connections Project. Accessed from https://www.nbmphn.com.au/Community/Services/Older-Persons-Health/Social-connectedness-project on 29 August 2024.
14. Hunter New England Primary Health Network [Website] Care Navigation Program. Accessed from https://thephn.com.au/care-navigation on 29 August 2024.
15. Zuchowski, I., McLennan, S., Sen Gupta, T. (2023) Evaluation of social work student placements in general practice. British Journal of Social Work. 53: 2762–2783.
16. Zuchowski, I., McLennan, S. (2023) A systematic review of social work in general practice: opportunities and challenges. Journal of Evidence- Based Social Work, 20:5, 686-726. Retrieved from https://DOI.org/10.1080/26408066.2023.2202665
17. Australian Social Prescribing Institute of Research and Education (2024). Accelerating social prescribing in Australia: An innovative frontier in the provision of healthcare.
18. Jayasekara, RS. (2012). Focus groups in nursing research: Methodological perspectives. Nursing Outlook, 60: 411–416.
19. Pope, C., van Royen, P., Baker, R. (2002). Qualitative methods in research on healthcare quality, Quality & Safety in Health Care, 11: 148–152.

20. Moen. J., Antonov, K., Nullson, L.G. et al. (2010). Interaction between participants in focus groups with older patients and general practitioners. Qualitative Health Research, 20: 607–616.

21. Willis, K., Green, J., Daly, J., et al. (2009). Perils and possibilities: Achieving best evidence from focus groups in public health research, Australian and New Zealand Journal of Public Health, 33: 131–136.

22. Braun, V., & Clarke, V. (2013). Successful qualitative research: A practical guide for beginners. London: Sage Publications.

23. Jackson, K., & Bazeley, P. (2019). Qualitative Data Analysis with NVivo, 3rd ed. London, United Kingdom: SAGE Publications.

24. Thomas, DR (2006) A general inductive approach for analysis of qualitative evaluation data. American Journal of Evaluation, 27(2): 237–246. Accessed May 5th 2024 from https://doi.org/10.1177/1098214005283748

25. Nielsen, M. B., Johannessen, H. A., Christensen, J. O., & Finne, L. B. (2023). Emotional dissonance and burnout among child welfare Workers: The moderating role of social support from colleagues, supervisors, and organization. Journal of Social Work, 23(4), 615-635. Retrieved from https://doi.org/10.1177/14680173221143649.

26. Kam, PK. ((2019) 'Social work is not just a job': The qualities of Social Workers from the perspective of service users. Journal of Social work, 20(6):775-796. Retrieved from https://doi.org/10.1177/1468017319848109

27. Royal Australian College of General Practitioners (2024) Health of the Nation 2023: An annual insight into the state of general practice. Web Report. Accessed on 18/08/2024 from https://www.racgp.org.au/general-practice-health-of-the-nation-2023

28. Australian Government Department of Health. (2020) An MBS for the 21st Century — Recommendations, learnings and ideas for the 21st century. Medicare Benefits Schedule review taskforce final report to the minister for health. Accessed on 18/08/2024 from https://www.health.gov.au/sites/default/files/documents/2020/12/medicare-benefits-schedule-review-taskforce-final-report-an-mbs-for-the-21st-century-recommendations-learnings-and-ideas-for-the-future.pdf

29. Parajuli, DR.,Ullah, S., McGrail M., McLachlan, C.S., Isaac, V. (2022) Work-related, socio-cultural, and personal factors associated with locus of control among Australian general practitioners. Journal of Psychiatric Research. 155: 589-595.

30. Australian Institute of Health and Welfare. (2024) Potentially preventable hospitalisations in Australia by small geographic areas, 2020–21 to 2021-22. Web Report. Accessed on 18/08/2024 from https://www.aihw.gov.au/getmedia/808b885e-0532-4732-8b79-8b9b82e3b1ba/potentially-preventable-hospitalisations-in-australia-by-small-geographic-areas-2020-21-to-2021-22.pdf?v=20240813075538&inline=true


HEALTHCARE

APPENDICES

APPENDIX 1. SWIGP PRACTICE CHARACTERISTICS

TABLE A1. SWIGP PRACTICE CHARACTERISTICS

PRACTICE	SOCIAL WORKER	PRACTICE FOCUS
A	0.4 FTE (19 hours)	• *Practice A* is a suburban general practice. • The practice has a large patient population of long-term clientele. • The patient demographic is mostly over 65 years. • The focus of the Social Worker role is to aid people over 65 years and facilitate access to systems and services which allows them to stay living in their homes for longer, with life transitions associated with ageing. While this was the primary focus, the Social Worker in this practice also engaged with patients practice who were not part of this demographic and who were identified as potentially benefiting from working with a Social Worker. • The Social Worker provides outreach services in other locations, where need was indicated.
B	0.8 FTE (32 hours)	• *Practice B* is located in an outer suburban area with a moderate to high level of socio-economic disadvantage. • The practice has a core demographic of people who are able to access primary health care services that are bulk billed (no out-of-pocket cost to the patient). • The practice sees patients from across the age spectrum, with a lean towards a lower average age of between 40 and 50 years, with a focus on patients who are marginalised, have complex care needs, and are often in need of care involving primary health care and social support. • The Social Worker role at this practice is focused on working broadly across the identified needs of the population group. Referrals are made as patients are identified who may gain some benefit to their physical, emotional, or psychological wellbeing from a social work service, including provision of support to GPs in the management of applications to the Nationals Disability Insurance Scheme (NDIS) and My Aged Care (MAC). • The Social Worker provides outreach services where the need is indicated.
C	1.0 FTE (38 hours)	• *Practice C* is situated in a suburban setting. • The practice takes an innovative approach to patient care, offering a broad range of medical and allied health services within the one space. This includes a geriatrician, outreach doctor, clinical psychologist, and pharmacist onsite. • The practice provides primary health care outreach services to residential aged care homes (RACH) both in the local area as well as in the broader Canberra region. • The Social Worker role works primarily with patients of the practice who reside in RACH, however, where indicated also provides support and assistance to clientele who visit the practice. The nature of the social work role being focused on working with patients in RACH's sees the core patient volume for the Social Worker (95%) being with these patients and the other 5%. • The Social Worker provides outreach services where the need is indicated.
D	0.4 FTE (19 Hours)	• *Practice D* is in a suburban setting. • The practice has a patient demographic across a wide age range and socio-economic status. • The Social Worker role at this practice focuses on working broadly across the identified needs of the population group. Referrals are made as patients are identified as potentially gaining some benefit to their physical, emotional, or psychological wellbeing from a social work service, including provision of support to GPs in the management of applications to the NDIS and MAC. • The Social Worker provides outreach services where the need is indicated. • *Practice D* initially engaged a Social Worker with a Mental Health accreditation skill set who resigned from the position in July 2023 (3 months into the data collection period). The Social Worker role remained vacant until mid-December 2023. As a result, there is no data for this practice from August 2023 – January 2024.

APPENDIX 2. DATA COLLECTION

TABLE A2. SOCIAL WORKER QUALTRICS DATA COLLECTION

SOCIAL WORKER STATISTICAL DATA COLLECTION	MEASURE	COLLECTION METHOD
REFERRAL INFORMATION		
Number of new referrals received in the month (1st day of the month — last day of the month inclusive)	Number	• Individual Social Workers use a method of tracking statistics that works for them. • Collate numbers weekly and input into spreadsheet/reporting template monthly.
Current total case load — (total number of patients active + holding)	Number	
Number of referrals accepted (how many were referred to SW vs how many followed through with referral or who were deemed unsuitable)	Number	
Number of referrals that involved a carer	Number	
Number of GPs at the practice who made a referral	Number	
Sources of referral (GP, Practice Nurse, Administrative staff, External, Other (i.e. Self)	Number	
Reason for referral • Primary • Secondary	Number per category	
DEMOGRAPHIC INFORMATION (TOTAL CASE LOAD OF PATIENTS (ACTIVE + INACTIVE) ACROSS THE MONTH)		
Patient gender	M/F/Not specified	• Individual Social Workers use a method of tracking statistics that works for them. • Collate numbers weekly and input into spreadsheet/reporting template monthly.
Average patient age	In years	
Patients age range	(youngest – oldest)	
Patients who identify as Aboriginal or Torres Strait Islander	Number	
Patients where English is not the primary language spoken in the home	Number	
SW Activities Approximate hours across: • Admin, Clinical, Professional Development, Multi-disciplinary liaison, Travel, Other (Specified)	Hours spent across the month	• Social Workers track how they use their time across activity categories.
Option to provide a written case study of patient story or activity for the month		

APPENDIX 3. FINDINGS DATA TABLES

TABLE A3. CHARACTERISTICS OF SOCIAL WORKERS EMPLOYED IN THE SWIGP PILOT PROGRAM

CATEGORY	CHARACTERISTIC	N OF RESPONDENTS (%)
Gender	Male	1
	Female	5
Age (years)	50–59	4
	60–69	2
Tertiary qualification[+]	Bachelor's degree	6
	Postgraduate qualification (SW)	3
	Accredited MH Social Worker	1
Experience (years)	1–3	-
	4–6	-
	7–9	1
	10+	5
Other skill sets	Other skill sets that complement SW practice	• Working with older people • Working with complex health systems • Elder abuse • Understanding of the complexities with ageing for LGBTI people • Pastoral care

[+]Some Social Workers had more than one qualification. Note: 6 Social Workers participated in the data collection over the 12 months, Due to recruitment challenges, there is missing data from one practice for 6 months of data collection.

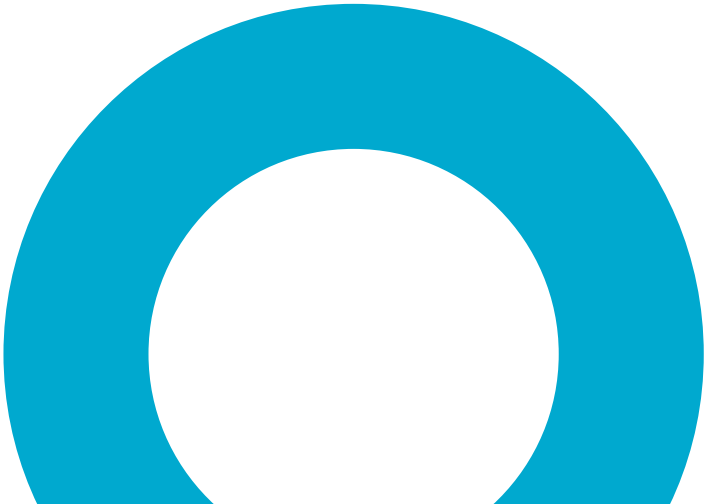


TABLE A4. SWIGP PATIENT AND CARER SURVEY RESPONDENT CHARACTERISTICS

CATEGORY	PERCENTAGE OF RESPONSES (%)
AGE RANGE	
u/15yr	0 (n=0)
15–24yr	2.1 (n=1)
25–34yr	2.1 (n=1)
35–44yr	4.2 (n=2)
45–54yr	8.5 (n=4)
55–64yr	14.9 (n=7)
65–74yr	12.8 (n=6)
74–84yr	34 9 (n=16)
Over 85yr	21.3 (n=10)
GENDER	
Male	19.1 (n=9)
Female	80.9 (n=38)
Not specified	0
PERSON COMPLETING SURVEY	
Patient	66.6 (n=30)
Sibling	6.7 (n=3)
Parent	2.2 (n=1)
Partner	11.1 (n=5)
Child	6.7 (n=3)
Other (carer)	6.7 (n=3)

TABLE A5. PATIENT AND CARER RECALLED REFERRAL INFORMATION

CATEGORY	PERCENTAGE OF RESPONSES (%)
SOURCE OF REFERRAL	
GP	84.8 (n=39)
Practice nurse	2.2 (n=1)
Administration staff	4.4 (n=2)
Other health professional	4.4 (n=2)
Cannot recall	4.4 (n=2)
UNDERSTANDING OF REASON FOR REFERRAL	
Yes	91.1 (n=41)
No	0
Partially (not 100% sure what they would be able to help with)	9.9 (n=4)

APPENDIX 4. QUALITATIVE DATA OVERVIEW – FOCUS GROUPS AND INTERVIEW GUIDES

4.1 SOCIAL WORKER INTERVIEW GUIDE 1

SWiGP Interview Guide 1

August 2023

Thank you for taking time out of your busy schedules to meet with me. I understand you have allocated an hour to this interview – so we will aim to finish at 11am.

The evaluation team at UC are interested in your insights and experiences of the SWiGP program so far and how you feel it is working for you, the GP's, other practitioners, patients, and carers at your general practice.

I have been told that you have provided consent to be here, and with your permission I will record the interview, and then the recording will be transcribed, so I can conduct an analysis and provide a report back to the UC team – which they will use as one of their main data sources to inform their evaluation. Within these constraints your confidentiality and privacy will be respected.

Today I have been asked to cover 4 main topics, including:

1. Your Role and Purpose (and others' perception and acceptance of this)
2. Your Relationships, Processes and Practices
   a. With staff; and
   b. With patients (and their carers)
3. Your understanding of the Benefits and Limitations of having Social Workers in GP clinics
4. Sustainability of the practice model

I want this to be an open discussion where you can discuss anything you think is relevant – you are obviously the experts and know a lot more than me – so please feel free to prompt and ask questions of each other as we work our way through the discussion and the topics or questions I have been asked to cover.

Let us start by you introducing yourself, and stating:

- the GP clinic you are working in
- when you started in the role; and
- how you would describe your role in the clinic

1. Understanding, suitability and acceptance of role and purpose

I want to start the interview by gaining a good understanding of your role and purpose within the GP clinic and how others have perceived this role.

- How would you describe your role in the GP Clinic?
- What are you trying to achieve for the GP clinic and their patients, or even the community more broadly (if your purpose extends this far)?
- Does your current role differ to what you imagined it would be before you had commenced?
  - How so? Why?
- When you started was there any mismatch in the expectation of others (GPs, other staff, patients) of your intended role and purpose?
- So, thinking back, how much has your role been adapted over time or has it remained consistent? Why?
- Do you now think you are acting as an integrated part of the general practice?
- So, in view of that, how closely would you say your job role now aligns with the overall intended role and purpose of the SWiGP program?

2a. Working within the general practice: your relationships, processes and practices with other staff

OK, now that I have a good understanding of your role, and how others perceived it, let's drill down into how this is actually working within your daily practice.

Firstly, I want to explore your relationships, processes and practices with other staff at the clinic (including any challenges with this and the things that have worked well).

- How quickly and warmly were you (and your role) embraced by other staff?
- What were the main challenges to your successful integration into the practice?
  - What helped you overcome these challenges?
  - Which obstacles, if any, still remain?
    - Can these be overcome?
- Tell me a bit about how any administrative or system issues (like booking systems, patient records/management systems) were established and how these are working for you?

- How have referral processes been working?
  - Are the referrals you receive suitable?
  - Do you feel you have been able to manage the demand for your services and patient load effectively?
    - Do you get appropriate support to manage this?
  - Has there been any changes to the types of referrals you receive and how you receive them over time?
- What main lessons have you learnt about how to successfully work with others within a GP clinic?

2b. Working within the general practice: your relationships, processes and practices with patients (and their carers)

Now I want to focus on your relationships, processes and practices with your patients.

- What has been your experience of introducing your services to patients?
  - Has this differed across patient demographics?
    - e.g. Either by age, gender, culture, socio-economic status or any other factors?
- Are people with complex social and health needs your main patient group?
- What factors have affected or enabled your capacity to engage with patients OR their willingness to engage with you?
  - How have you overcome any of these challenges?
- Can you characterise the typical duration and intensity of support/care you provide to patients?
- How satisfied do you think your patients feel about the level of care/support they receive from you?
- And how satisfied do you feel about the level of care you are able to provide to your patients?

3. Benefits and limitations of SWiGP practices

Now I want to turn to identifying the benefits, outcomes (and if appropriate the limitations) of the SWiGP Program.

- Can you outline what the main benefits have been of having a Social Worker embedded within a GP Clinic to the following people:
- Firstly, GPs and other practice staff:
  - Do you think the SWiGP program has been effective in improving multidisciplinary team care at the practice?
- Patients (and their carers):
  - Has it helped patients to get "the right care in the right place at the right time"?
  - Has it been beneficial in helping patients (and their carers) to navigate service systems or appropriately access govt/community services?
- Yourself:
  - How has being embedded within a general practice been beneficial to you and your practice as a Social Worker?
- Do you think there is scope for the SWiGP or your role to be doing more to benefit patients and the community as a whole?
- Can you identify any gaps or limitations of the status quo?
  - If so, what are they?
  - And do you have any suggestions of how these can be addressed or closed?

4. Sustainability

To finish up I want to quickly explore some of your thoughts on the sustainability of the program.

- Would you advocate for a continuation or expansion of the SWiGP model?
- What are the main things you would like to see improved or changed before it is continued or expanded?
- If you had the chance to 'dot point' the 3 main strengths, weaknesses, opportunities and threats of the SWiGP program model what would they be?
- Has clinical supervision and Community of Practice meetings been helpful and working well?
  - How could you be better supported in your role?

TO FINISH – Thank you, and what other important things have you not had the chance to say?

4.2 SOCIAL WORKER INTERVIEW GUIDE 2

SWiGP Interview Guide 2

March 2024

Thank you for taking time out of your busy schedules to meet with me. I understand you have allocated an hour to this interview — so we will aim to finish at 11am.

The evaluation team at UC are interested in your insights and experiences of the SWiGP program so far and how you feel it is working for you, the GP's, other practitioners, patients, and carers at your general practice.

I have been told that you have provided consent to be here, and with your permission I will record the interview, and then the recording will be transcribed, so I can conduct an analysis and provide a report back to the UC team — which they will use as one of their main data sources to inform their evaluation. Within these constraints your confidentiality and privacy will be respected.

As this is following on from the first round of focus groups done in August last year, today will cover similar topics to the first focus groups and build upon your experiences over the past 6 months. I tried to ask open-ended questions the first time around and took a very exploratory approach.

This time, because it is your final opportunity to contribute directly to evaluation data, I might try and pin you down a bit more particularly in the hope of gaining some consensus from you all about the factors that have been the most significant in determining the success or otherwise of the Pilot Program and that are the most important in underpinning a SWiGP model into the future. The main areas we covered in August (and that we will again base the interview around today) were:

1. Your Role and Purpose (and others' perception and acceptance of this)
2. Your Relationships, Processes and Practices
   a. with staff; and
   b. with patients (and their carers and broader community)
3. Your understanding of the Benefits and Limitations of having Social Workers in GP clinics
4. Sustainability of the practice model

I want this to be an open discussion where you can discuss anything you think is relevant — you are obviously the experts and know a lot more than me so please feel free to prompt and ask questions of each other as we work our way through the discussion and the topics or questions I have been asked to cover.

Let's start maybe with — SW A introducing herself, with providing a quick overview of:

- When you started in your role; and
- How you would describe your role in the clinic
- How has your role evolved in the past 6 months/since our last discussion?
- And who or what is the impetus for these changes?

1. Understanding, suitability and acceptance of role and purpose

- What would you say is your role in the general practice — what unique contribution do you bring?
- What do you think have been the major learnings of others in the practice about Social Workers and the role they can play?
- Likewise, what surprising or new things have you learnt about yourself, social work, and the nature of Primary Health Care by being embedded in a general practice?
- Is it essential that the role, purpose and intended outcomes of the Social Worker role be clearly defined early on in your tenure? By whom and how?
- How should your role be measured or evaluated?

2a. Working within the general practice: your relationships, processes, and practices with other staff

OK, let's now explore your relationships, processes, and practices at the Practice (including any challenges with this and the things that have worked well).

- Give me some examples of how the Social Worker role has become an integrated part of the general practice?
  - And what are the most important factors that enable, promote or support this integration (or lack thereof)?
- How would you now describe the nature of your relationships with the GPs and other staff in the practice?
  - What are the most important factors that contribute to positive relationships and appropriate referrals?
- How would you describe the level of demand for your service?
- Have you needed to develop or refine referral systems?
- Have you been able to adequately manage your caseload?
  - What has helped you to do this?

2b. Working within the general practice: your relationships, processes and practices with patients (and their carers)

Now I want to focus on your relationships, processes and practices with your patients.

- **SW A** – can you describe the core demographic of your patient group (if you have one) and the work that you do with and for them?
- **SW B** – has the core demographic of your patient group, and the work you do with and for them, remained the same?
- Has the duration and intensity of support/care you provide to patients remained similar across the time you have been working on the program?
- Do you get the sense that all of your patients are satisfied with the level of care/support they receive from you?
- What are some examples of what you have achieved for the patients, the GP clinic, or even the community more broadly (if your purpose extends this far)?

3. Benefits and limitations of SWiGP practices

- What would you say are the clear and main benefits of having a Social Worker embedded within a GP Clinic? For patient, for the Practice and as a Social Worker.
  - How has having a Social Worker in house helped general practices to better meet the needs of their patients?
- Do you think you have actively addressed levels of unmet need that were present in the community?
- Do you think you are supporting, or have reduced the burden on, other community services or agencies? How so?
- Do you feel like you have any barriers or limits on your **scope of practice** – can you practice in the way you think is most appropriate/helpful? Why/Why not?
- What process should be used, including who should be involved, in defining the scope of practice for Social Workers in general practice?
- Do you think there is scope for the SWiGP or your role to be doing more to benefit patients and the community as a whole?
  - What are the main limitations on your role?
  - What are the main barriers that get in the way of you being about to do more?

4. Sustainability

To finish up I want to quickly explore some of your thoughts on the sustainability of the program.

- Do you value the inclusion of structured clinical supervision in the program?
  - Is this necessary? and
  - What model of supervision would best meet the needs of Social Workers in general practices?
- Is there anything else that could be done to make you feel more supported in your role?
- Would you advocate for a continuation or expansion of the SWiGP model in your Practice and beyond?
- Is there anything you would like to see improved or changed before it is continued or expanded?
- If you had the chance to 'dot point' the 3 main strengths, weaknesses, opportunities, and threats of the SWiGP program model what would they be?

TO FINISH – Thank you, and what other important things have you not had the chance to say?

4.3 INTERVIEW GUIDE

GP — SWiGP Interview Guide

November 2023

Thank you for taking time out of your busy schedules to meet with me. I appreciate your giving up of clinical time to provide feedback for the SWiGP evaluation. The interview today should only take 15–20 minutes.

The evaluation team at UC are interested in your insights and experiences of the SWiGP program so far and how you feel it is working for you as a GP in a practice where the SWiGP program has been operating, as well as for the patients and carers at your general practice.

Thank you for providing consent to be here — with your permission I will record the interview, and then the recording will be transcribed. These transcripts will then be analysed provide a valuable qualitative data that will contribute to the broader evaluation of the SWiGP program. Within these constraints your confidentiality and privacy will be respected.

Today I will cover 4 main topics, including:

1. Your understanding of the Social Worker role and purpose
2. Your Relationships, processes and practices
   a. With SW themselves
   b. In relation to how SW role has allowed patients to benefit (and their carers)
3. Your understanding of the Benefits and Limitations of having Social Workers in GP clinics
4. Sustainability of the practice model

I want this to be an open discussion where you can discuss anything you think is relevant — you are obviously the experts and know a lot more than me — so please feel free to prompt and ask questions of each other as we work our way through the discussion.

Let's start by you introducing yourself, and stating:

- the GP clinic you are working in;
- when you started in the role; and
- how you would describe your role in the clinic

1. Understanding, Suitability and Acceptance of Role and Purpose

I want to start the interview by discussing your understanding of the Social Worker role and purpose within the GP clinic — clarify whether or not the GP has made a referral to the Social Worker.

- Prior to having the Social Worker role within the practice, what was your understanding of the scope of practice of a Social Worker and how if at all has that changed since having a Social Worker within the practice team?
- How would you describe the Social Worker role in this practice?
- How has having the Social Worker at the practice, helped to achieve for the practice broadly, your patients, and — if relevant — the community more broadly (if your purpose extends this far)?
- Do you now think the Social Worker role has become integrated into the general practice? What does having a Social Worker in the practice allow for you to achieve for your patients that was previously difficult or not possible?

2a. Working within the general practice: your relationships, processes and practices with other staff

The next few questions aim to look at how the SWiGP program is actually working within the practice and impacting your practice as a GP.

- Do you feel like you have been able to develop a good working relationship with the Social Worker?
- Did you experience any challenges to working with the Social Worker?
  - What helped you overcome these challenges?
- Do you feel that the Social Worker has been integrated within the practice now?
- Do you think there are any major obstacles that still remain (in terms of integration)? Can these be overcome?

2b. Working within the general practice: your relationships, processes and practices with patients (and their carers)

Now I want to focus on your relationships, processes and practices with your patients.

- Can you describe how referral processes been working from the GP perspective?
  - Do you feel like you have a good grasp on where a Social Worker may be able to help a patient who is experiencing non-medical issues that are impacting on their lives?
  - Describe how you would typically approach a Social Worker referral with a patient?
- What has been your experience of introducing social work services to patients?
  - How do they normally respond to this suggestion — positive/negative/ hesitant?
  - Has this differed across patient demographics? e.g. Either by age, gender, culture, socio-economic status, or any other factors?
- What has the feedback you have received from your patients been in relation to the Social Worker / their Social Worker interactions?

3. Benefits and limitations of SWiGP practices

Now I want to turn to identifying the benefits, outcomes (and if appropriate the limitations) of the SWiGP Program.

- In your opinion what do you see as the main benefits of having a Social Worker embedded within the GP Clinic?
- Do you think the SWiGP program has been effective in improving multidisciplinary team care at the practice?
- In relation to patients (and their carers):
  - Has it helped patients to get "the right care in the right place at the right time"?
  - Has it been beneficial in helping patients (and their carers) to navigate service systems or appropriately access govt/community services?

4. Sustainability

To finish up I want to quickly explore some of your thoughts on the sustainability of the program.

- Would you advocate for a continuation or expansion of the SWiGP model?
- Is there anything you would like to see improved or changed before it is continued or expanded?
  - Thinking more in relation to the broader scope of the SWiGP pilot program…
- If you had the chance to 'dot point' the 3 main strengths, weaknesses, opportunities and threats of the SWiGP program model what would they be?

APPENDIX 5. CONSUMER AND CARER FEEDBACK SURVEY

UNIVERSITY OF CANBERRA

Social Workers in General Practice

PARTICIPANT FEEDBACK SURVEY

The purpose of this survey is to get your feedback on your experience as a patient or carer working with the Social Worker from Wakefield Gardens.

This survey will ask you about your experience with the Social Worker in General Practice Program and will take about **10 minutes** to complete.

This survey will ask you a range of questions including:

- some details about you
- your experience seeing a Social Worker at your General Practice
- questions relating to access to services and assistance with service access

Your participation in the survey is voluntary. You can choose not to participate. You may also withdraw your participation at any time without any impact on your appointments with the Social Worker now or in the future.

Your information will be confidential. All responses are confidential and will not contain any information that can identify you. The results from this evaluation may be presented and published in reports or scientific journals. No data published will identify individuals participating in the evaluation.

☐ Yes. I agree to take part in the patient feedback survey.

HOW TO COMPLETE THIS SURVEY

1. **Provide your consent to participate in the survey.**
   To do this tick the box above to indicate you are happy to provide your information.
2. **There are two parts to compete in this survey:**
   Part A: Asks questions about you — This section asks some questions about your age, gender and how you usually see your GP.
   Part B: Asks questions about your experience of seeing a Social Worker — your experiences over working with the Social Worker in person at your general practice, as well as any other areas the Social Worker may have assisted you.
3. **Return the survey**
   How do I return the survey?
   A reply-paid envelope has been included with this pack — you can simply mail the survey back to the address provided. You may also drop the completed survey back to your general practice in the envelope provided.
   When does it need to be returned?
   Completed surveys should be returned by ...

Please continue to the next page to start the survey.

UNIVERSITY OF CANBERRA

PART A: ABOUT YOU

This section asks some questions about your age, gender and how often you usually see your GP.

Q1. What is your age? (Indicate your age by placing a tick in the space under the appropriate age range)

AGE RANGE	UNDER 15YRS	15–24 YR	25–34 YR	35–44 YR	45–54 YR	55–64 YR	65–74 YR	75–84 YR	85YRS +
Answer	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q2. How do you describe your gender? (Please circle the response that you identify with)

☐ Woman ☐ Man ☐ Non-binary/third gender ☐ Prefer not to say

Q3. If you are a family member or carer completing this form on behalf of a participant, what is your relationship to the participant? (Please circle)

☐ Sibling ☐ Mother ☐ Father ☐ Partner ☐ Child ☐ Other: _____

Q4. How often do you see or have contact with your GP — either in the practice, via telehealth or by the GP coming to you?

☐ Once a week or more ☐ Once a month ☐ Once every two — three months

☐ Other frequency, please specify _____

PART 2: ABOUT YOUR EXPERIENCE SEEING A SOCIAL WORKER

When completing part 2, please include your experiences of working with the Social Worker in person at your general practice, as well as any other areas the Social Worker may have assisted you (such as completion of paperwork, applications etc).

Q1. How did you find out about the Social Worker?

☐ GP ☐ Practice Nurse ☐ Administrative Staff ☐ Not Sure/Can't recall

☐ Other Health Professional at this practice (Please specify) _____

Q2. Did you understand the reason for your referral to the Social Worker?

☐ Yes ☐ No ☐ Partly — I was not 100% sure what they would be able to help me with

Continues over the page...

UNIVERSITY OF CANBERRA

Q3. The following questions talk about your experience working with the Social Worker. Please indicate your answer on the scale provided.

	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER	N/A
THE LEVEL OF SUPPORT AND ASSISTANCE YOU RECEIVED FROM THE SOCIAL WORKER						
The Social Worker understood what support I needed to help improve my health and wellbeing	☐	☐	☐	☐	☐	☐
The Social Worker helped me to find support services in the community that may help my health and wellbeing	☐	☐	☐	☐	☐	☐
The Social Worker helped me to access appropriate services that I needed	☐	☐	☐	☐	☐	☐
The Social Worker made sure that I was able to access the supports I needed & followed up with me	☐	☐	☐	☐	☐	☐
The Social Worker helped me with the forms and letters that I needed to complete to access the suggested services	☐	☐	☐	☐	☐	☐
YOUR EXPERIENCE OF CARE WHEN WORKING WITH THE SOCIAL WORKER						
I feel that having access to a Social Worker (at my GP) has improved my experience of health care at my general practice	☐	☐	☐	☐	☐	☐
The Social Worker provided emotional support and/or counselling	☐	☐	☐	☐	☐	☐
The support or care I received from the Social Worker met my needs	☐	☐	☐	☐	☐	☐
YOUR EXPERIENCE OF DEVELOPING TRUST IN THE SOCIAL WORKER AND SOCIAL WORK SERVICE						
I felt safe and welcome using the service	☐	☐	☐	☐	☐	☐
I had access to the Social Worker when I needed them	☐	☐	☐	☐	☐	☐
I was able to include my family & friends in care I needed	☐	☐	☐	☐	☐	☐
My individuality and values were respected (such as your culture, faith, gender identity, etc.)	☐	☐	☐	☐	☐	☐

Q4. Is there anything else you would like to share about your/your family member's experience with the Social Worker? (Open ended question)

Continues over the page...

UNIVERSITY OF CANBERRA

QUESTIONS YOU MIGHT HAVE ABOUT THIS SURVEY

Do I have to complete the survey?

You may choose not to complete this survey. If you choose to complete the survey, you can skip any questions you do not want to answer.

You may also withdraw from having your feedback included in the evaluation at any time without having to give a reason. You can do this by informing the evaluation team either by email or phone — contact details are provided at the bottom of this form.

If you decide not to participate or withdraw, this will not affect the care or support you receive from your general practice now or in the future.

Are there any benefits?

This project is designed to help improve overall service delivery at your general practice, as such you may benefit from participating in this survey.

Are there any risks?

Talking about your experiences can sometimes lead to feelings of discomfort or distress.

If you do not wish to answer a question, you may:

- skip any questions, or
- choose to stop participating completely

Should you experience any concerns or distress, please speak directly with your general practice, with your Social Worker or seek other appropriate support. You may wish to contact Lifeline on 13 11 14 for immediate counselling support.

What about confidentiality?

Only approved members of the University of Canberra, Health Research Institute evaluation team will have access to the information you provide.

Your responses will be de-identified and stored securely on a password protected computer at the University of Canberra. Once the evaluation is complete, information will be shared only in a de-identified form with the funders of the project — the ACT Primary health Network (ACTPHN). All information collected is required to be stored by the university for a 7-year period. After 7 years, information will be destroyed according to university protocols.

The overall Social Worker in General Practice evaluation outcomes may be presented at conferences and written up for publication. Project reports or publications from this project will not contain information that can identify any individual participant.

Future research

The information collected for this evaluation may inform future projects on related areas. Any future use of your data will meet with any conditions set by the Human Research Ethics Committee of the University of Canberra.

Information about ethical data collection

The evaluation has been approved by the Human Research Ethics Committee of the University of Canberra in accordance with the guidelines of the Ethics Committee and the NHMRC (National Health and Medical Research Council) (HREC — 12037).

Participants can discuss their involvement in the evaluation with the chief investigator, Professor Rachel Davey (02 6201 5359) or you may like to e-mail the evaluation project officer — Andrea.Gledhill@canberra.edu.au.

If any participant would like to speak to an officer of the University not involved in the evaluation you may contact the Research Ethics & Integrity Advisor on 02 6206 3916 and quote the project number (HREC — 12037).

Questions and concerns

Questions or concerns about the research can be directed to the researcher and/or supervisor.

Contact details for the research team are provided below:

Chief Investigator

Rachel Davey
Faculty: Health
Phone: 02 6201 5359
Email: Rachel.Davey@canberra.edu.au

Research Officer

Andrea Gledhill
Faculty: Health
Phone: 02 6201 5380
Email: Andrea.Gledhill@canberra.edu.au

If you have any complaints or concerns about the ethical conduct of this research, you may contact the University of Canberra's Research Ethics & Integrity Unit team via telephone 02 6206 3916 or email humanethicscommittee@canberra.edu.au or researchethicsandintegrity@canberra.edu.au

If you would like some guidance on the questions you could ask about your participation, please refer to the Participants' Guide located at https://www.canberra.edu.au/research/graduate-research/current-research-students/integrity-and-ethics/ethics/accordion/human-ethics/human-ethics-documents/Agreeing-to-participate-in-research.pdf

APPENDIX 6. PRACTICE LEVEL REASONS FOR REFERRAL

PRACTICE A

Figure A1 shows primary and secondary reasons for referral at practice A. The target population for social work services at practice A were patients aged over 65 years. The Social Worker received referrals for patients outside of this age group as clinically indicated. Assistance with accessing My Aged Care (n=111) and domestic assistance (n=104) were indicated as the most common reasons for referral to the Social Worker at Practice A. This is aligned with having a Social Worker as part of a multidisciplinary team supporting patients in this older age bracket.

Other reasons for referral associated with an ageing population included advanced care planning (n=71), grief or loss (n=68), social connections support (n=43) and transitions of life (n=39).

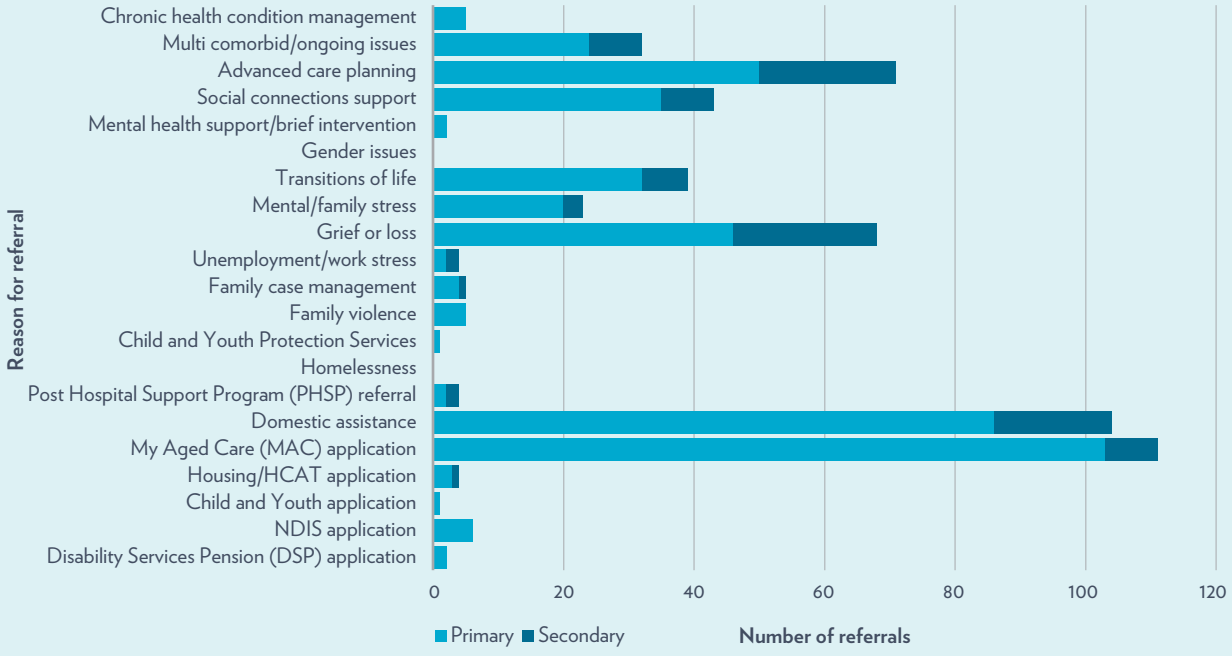


FIGURE A1. PRIMARY AND SECONDARY REASONS FOR REFERRAL TO SWIGP PROGRAM AT PRACTICE A

PRACTICE B

Practice B (Figure A2) has a greater focus on supporting vulnerable persons and those with socio-economic disadvantage and complex life issues. A clear difference can be seen in the types of referrals to the Social Worker at this practice. Areas such as Disability Services Pension (n=92), NDIS (n=86), Housing/HCAT applications (n=86) and mental health support (n=83) were seen more frequently. This practice also had a greater proportion of patients with multi-comorbid and complex issues (n=54).

While social connection support (n=42) and transitions of life (n=47) made a up a large portion of referrals, reasons for referral were more evenly distributed across other areas which covered a broader scope of practice including family violence (n=28), unemployment or work stress (n=25), mental/family stress (n=21) and some MAC application support (n=30).

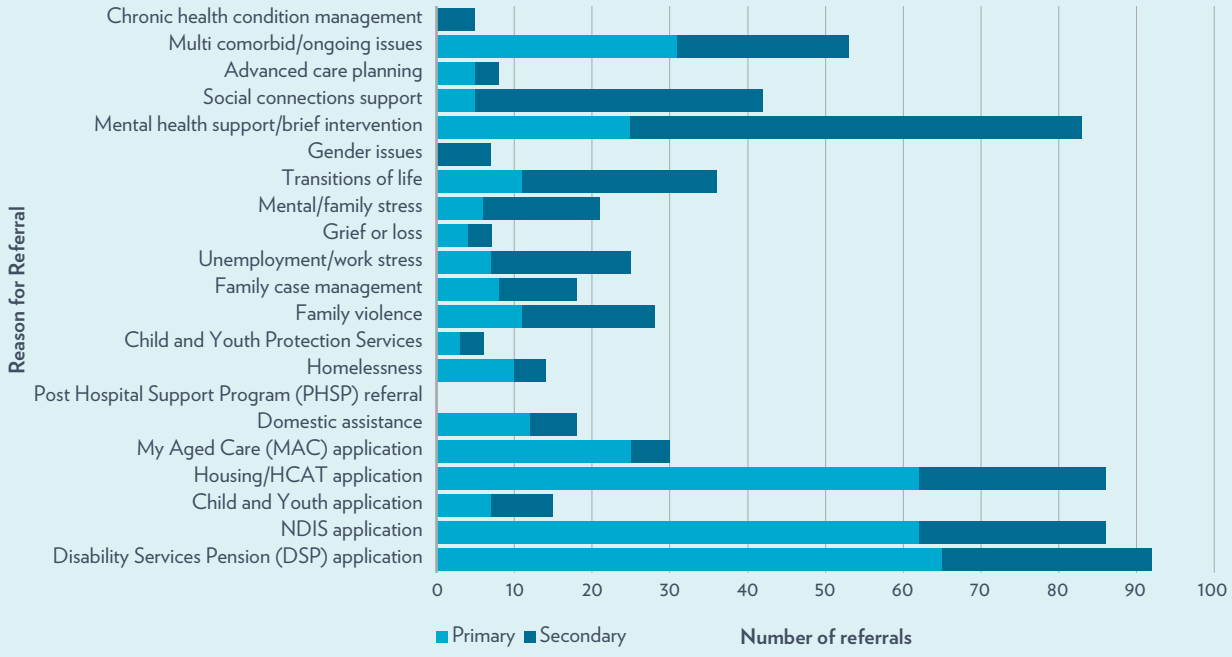


FIGURE A2. PRIMARY AND SECONDARY REASONS FOR REFERRAL TO SWIGP PROGRAM AT PRACTICE B

PRACTICE C

The Social Worker at practice C (Figure A3) had a large proportion of referred patients who were residents or carers at RACHs. This practice provides outreach GP services to several RACHs in the Canberra region. This accounts for the lower number of MAC applications and domestic assistance support referrals at the practice, despite the average age of patients at being similar to practice A — 76.5 years at practice C compared to 79 years at Practice A.

The distribution of referrals at practice C was biased towards mental/family stress (n=43), grief or loss (n=32), advanced care planning (n=26), transitions of life (n=26) and chronic health condition management (n=13). While practice C maintained the largest overall number of total referrals (n=183) and the number of primary and secondary reasons for referrals appears low in relation to this, referrals at this practice may be general support or the Social Worker allocated reasons differently to other practices.

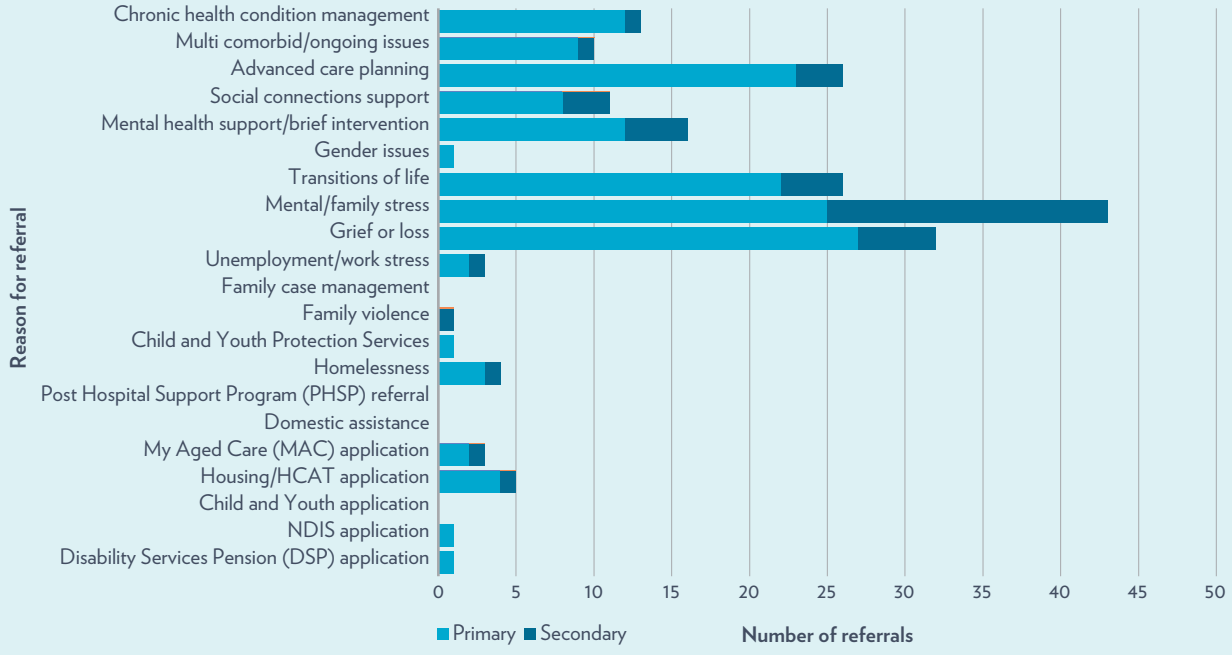


FIGURE A3. PRIMARY AND SECONDARY REASONS FOR REFERRAL TO SWIGP PROGRAM AT PRACTICE C

PRACTICE D

Practice D did not offer SWiGP services for 5 months of the evaluation period, during their recruitment of a suitable Social Worker. This accounts for overall lower numbers for this practice.

Practice D has a mixed patient demographic. The mean age of the patient group seen by the Social Worker is 69 years old. Figure A4 shows MAC application assistance (n=37) as the most frequent reason for referral. Domestic assistance (n=23), social connections support (n=23), mental health support and brief intervention (n=20), mental/family stress (n=22), chronic health condition management (n=20) and family case management (n=17) were all given as reoccurring reasons for referral for Social Worker support.

It is worth noting that the Social Worker engaged at practice D during the first part of the data collection period (April 2023 – July 2023) was an Accredited Mental Health Social Worker. This may have influenced the number of referrals made at this practice related to mental health support and brief interventions.

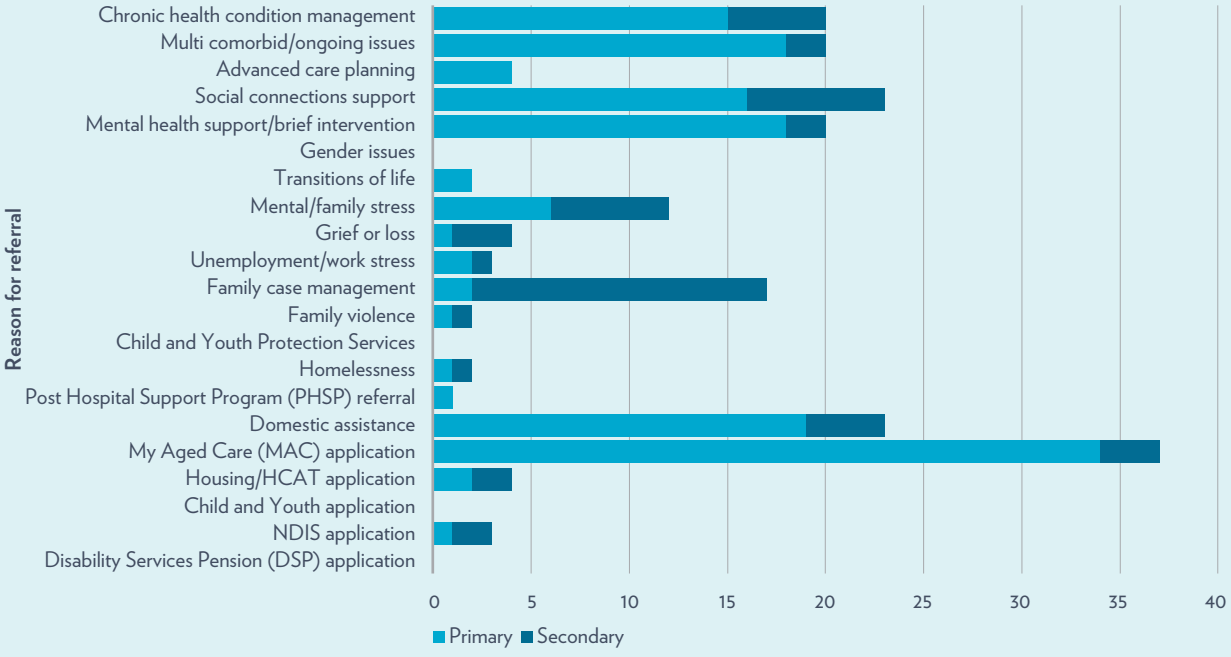


FIGURE A4. PRIMARY AND SECONDARY REASONS FOR REFERRAL TO SWIGP PROGRAM AT PRACTICE D

APPENDIX 7. SUMMARY OF MEDICARE ITEM NUMBERS FOR SOCIAL WORKERS

TABLE A6. MEDICARE ITEM NUMBERS ASSOCIATED WITH SOCIAL WORKERS

ITEM NUMBER	DESCRIPTION	FEE
FOCUSED PSYCHOLOGICAL STRATEGIES BY SOCIAL WORKERS		
80150	Focused psychological strategies (FPS) health service provided to a patient in consulting rooms by an eligible Social Worker (AMHSW) if: (a) the patient is referred by a referring practitioner (a medical practitioner who has referred the patient as part of a GP Mental Health Treatment Plan or psychiatrist assessment and management plan); and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible Social Worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration Patients with an assessed mental disorder (dementia, delirium, tobacco use disorder and intellectual disability are not regarded as mental disorders for the purposes of these items) a patient is eligible for up to 10 individual allied mental health services per calendar year	70.95
80154	FPS health service provided in consulting rooms by an eligible Social Worker (AMHSW) *to a person other than the patient*, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible Social Worker by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes	70.95
80155	Professional attendance for FPS provided to a patient at a place other than consulting rooms + requirements for item 80150	99.95
80156	FPS health service provided at a place other than consulting rooms by an eligible Social Worker (AMHSW) *to a person other than the patient*, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible Social Worker by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes	99.95
80160	As per item 80150; where the service is at least 50 min duration	100.20
80162	FPS health service provided in consulting rooms by an eligible Social Worker (AMHSW) *to a person other than the patient*, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible Social Worker by a referring practitioner; and (c) the service lasts at least 50 minutes	100.20
80165	Professional attendance for FPS provided to a patient at a place other than consulting rooms + requirements for item 80150; where the service is at least 50 min duration	129.10
80166	FPS strategies health service provided at a place other than consulting rooms by an eligible Social Worker (AMHSW) *to a person other than the patient*, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible Social Worker by a referring practitioner; and (c) the service lasts at least 50 minutes	129.10

Medicare item numbers associated with billing for social work services — current at 20/08/2024

APPENDIX 7. **SUMMARY OF MEDICARE ITEM NUMBERS FOR SOCIAL WORKERS** *cont.*

ITEM NUMBER	DESCRIPTION	FEE
80170	FPS health service provided to a patient as part of a group of 4 to 10 patients eligible Social Worker (AMHSW). (a) the patient is referred by referring practitioner; and (b) the service is provided in person; and (c) the service is at least 60 minutes duration Patients can access up to a further 10 sessions in for group FPS of at least 60 min duration in addition to 10 individual sessions.	25.40
80171	FPS health service provided to a patient as part of a group of 4 to 10 patients by an eligible Social Worker (AMHSW) if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the Social Worker; and (e) the service is at least 60 minutes duration	25.40
80172	As per item 80170; where the patient is not an admitted patient and service is up to 90 min in duration	34.55
80173	As per item 80171; where the service is up to 90 min in duration	34.55
80174	As per item 80170; where the service is up to 120 min in duration	47.10
80175	As per item 80171; where the service is at least 120 min in duration	47.10
PHONE ATTENDANCE		
91187	FPS health service provided by phone attendance by an eligible Social Worker (AMHSW) if: (a) the person is referred by: i. a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or ii. a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or iii. a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and (b) the service is provided to the person individually; and (c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible Social Worker gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration Patients with an assessed mental disorder (dementia, delirium, tobacco use disorder and intellectual disability are not regarded as mental disorders for the purposes of these items) a patient is eligible for up to 10 individual allied mental health services per calendar year	70.95
91188	As per item 91187; where the service is at least 50 minutes in duration	100.20
91204	Phone attendance for a FPS health service provided by an eligible Social Worker (AMHSW) *to a person other than the patient*, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible Social Worker by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes	70.95
91205	As per item 91204; where the service is at least 50 minutes in duration	100.20

Medicare item numbers associated with billing for social work services — current at 20/08/2024

ITEM NUMBER	DESCRIPTION	FEE
TELEHEALTH ATTENDANCE		
91175	FPS health service provided by telehealth attendance by an eligible Social Worker (AMHSW) if: (a) the person is referred by: i. a medical practitioner, either as part of a GP Mental Health Treatment Plan or as part of a psychiatrist assessment and management plan; or ii. a specialist or consultant physician specialising in the practice of his or her field of psychiatry; or iii. a specialist or consultant physician specialising in the practice of his or her field of paediatrics; and (b) the service is provided to the person individually; and (c) at the completion of a course of treatment, the referring medical practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible Social Worker gives a written report to the referring medical practitioner on assessments carried out, treatment provided and recommendations on future management of the person's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration	70.95
91176	As per item 91175; where the service is at least 50 minutes in duration	100.20
91196	Telehealth attendance for a FPS health service provided by an eligible Social Worker (AMHSW) *to a person other than the patient*, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible Social Worker by a referring practitioner and (c) the service lasts at least 20 minutes but less than 50 minutes	70.95
91197	As per item 91196; where the service is provided to *a person other than the patient*, and is at least 50 mins in duration	100.20
PREGNANCY SUPPORT COUNSELLING		
81005	Nondirective pregnancy support counselling health service provided to a patient, who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible Social Worker (AMHSW) if: (a) the patient is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the patient is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the eligible Social Worker does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (d) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005 or 81010, items 792 or 4001 in the general medical services table, or items 92136, 92138, 93026, 93029, 92137 or 92139 in the Telehealth and Telephone Determination apply) for each pregnancy This service may not be provided by a Social Worker who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.	83.30

Medicare item numbers associated with billing for social work services — current at 20/08/2024

APPENDIX 7. **SUMMARY OF MEDICARE ITEM NUMBERS FOR SOCIAL WORKERS** *cont.*

ITEM NUMBER	DESCRIPTION	FEE
93026	Non directive pregnancy support counselling health service provided to a person who is currently pregnant or who has been pregnant in the preceding 12 months by an eligible psychologist, eligible Social Worker or eligible mental health nurse as a telehealth attendance if: (a) the person is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the person is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the service is provided to the person individually; and (d) the eligible psychologist, eligible Social Worker or eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (e) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005, 81010 in the Allied Health Determination, item 4001 of the general medical services table and items 93029, 92136 and 92138 apply) for each pregnancy. The service may be used to address any pregnancy related issues for which non directive counselling is appropriate	83.30
93029	Non directive pregnancy support counselling health service provided to a person, who is currently pregnant or who has been pregnant in the preceding 12 months by an eligible psychologist, eligible Social Worker or eligible mental health nurse as a phone attendance if: (a) the person is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the person is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the service is provided to the person individually; and (d) the eligible psychologist, eligible Social Worker or eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (e) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005, 81010 in the Allied Health Determination, item 4001 of the general medical services table and items 93026, 92136 and 92138 apply) for each pregnancy. The service may be used to address any pregnancy related issues for which non directive counselling is appropriate	83.30

Medicare item numbers associated with billing for social work services — current at 20/08/2024

ITEM NUMBER	DESCRIPTION	FEE
MULTIDISCIPLINARY CASE CONFERENCE TEAM PARTICIPATION AND CHRONIC CONDITION MANAGEMENT		
10955	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which another item in this Group applies) For the purpose of these items, eligible health professionals must meet the eligibility requirements as set out in the *Health Insurance (Section 3C General Medical Services — Allied Health Services) Determination 2024)* This includes AMHSW. The case conference must be organised by the GP/prescribed medical practitioner. The multidisciplinary case conference team must include a GP/prescribed medical practitioner and at least 2 other members providing different kinds of care to the patient. The multidisciplinary case conference team requirements include: • each member must provide a different kind of care or service to the patient; and • each member must not be an unpaid carer of the patient; and • one member may be another GP/prescribed medical practitioner The allied health professional does not need all participants to be MBS-eligible to be able to claim payment for their participation. Members can include allied health professionals, home and community service providers and care organisers. See associated notes in schedule for comprehensive list. Specific Guidance is provided for allied health participation in a case conference — see notes relating to item number in schedule.	55.65
10956	Mental health service provided to a patient by an eligible mental health worker (AMHSW) if: (a) the service is provided to a patient who has: i. a chronic condition; and ii. complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth and Telephone Determination applies) in a calendar year	70.95
10957	As per item 10955; for case conferences lasting between 20 and 39 minutes	95.45
10959	As per item 10955; for case conferences lasting 40 minutes or longer	158.80
80176	Attendance by an eligible allied health practitioner (AMHSW), as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes	55.65
80177	As per item 80176; for case conferences lasting between 20 and 39 minutes	95.45
80178	As per item 80176; for case conferences lasting 40 minutes or longer	158.80

Medicare item numbers associated with billing for social work services — current at 20/08/2024

APPENDIX 7. **SUMMARY OF MEDICARE ITEM NUMBERS FOR SOCIAL WORKERS** *cont.*

ITEM NUMBER	DESCRIPTION	FEE
ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH AND CHRONIC DISEASE MANAGEMENT		
81325	Mental health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible mental health worker (AMHSW) if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has: i. a chronic condition; ii. complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and iii. the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth and Telephone Determination applies) in a calendar year	70.95
93048	Telehealth attendance provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible allied health practitioner if: (a) a medical practitioner has undertaken a health assessment and identified a need for followup allied health services; or (b) the patient has: i. a chronic condition; and ii. complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and iii. the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and (c) the person is referred to the eligible allied health practitioner by a medical practitioner using a referral form issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the service is provided to the person individually; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b): i. if the service is the only service under the referral—in relation to that service; or ii. if the service is the first or the last service under the referral—in relation to that service; or iii. if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters; to a maximum of 10 services (including any services to which this item or 93000, 93013 or 93061 or any item in Subgroup 1 of Group M3 or any item in Group M11 of the Allied Health Determination applies) in a calendar year	70.95

Medicare item numbers associated with billing for social work services — current at 20/08/2024

ITEM NUMBER	DESCRIPTION	FEE
93061	Phone attendance provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible allied health practitioner if: (a) a medical practitioner has undertaken a health assessment and identified a need for followup allied health services; or (b) the patient has i. a chronic condition; and ii. complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the patient is a resident of an aged care facility, the patient's medical practitioner has contributed to a multidisciplinary care plan; and iii. the service is recommended in the patient's Team Care Arrangements or multidisciplinary care plan as part of the management of the patient's chronic condition and complex care needs; and (c) the person is referred to the eligible allied health practitioner by a medical practitioner using a referral form issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the service is provided to the person individually; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible allied health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b): i. if the service is the only service under the referral—in relation to that service; or ii. if the service is the first or the last service under the referral—in relation to that service; or iii. if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters; to a maximum of 10 services (including any services to which this item or item 93000, 93013, 93048 or any item in Subgroup 1 of Group M3 or any item in Group M11 of the Allied Health Determination applies) in a calendar year	70.95
EATING DISORDERS		
82376	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible Social Worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration	70.95
82378	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible Social Worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration	70.95
82379	As per item 82376, where the duration is at least 50 min	99.95
82381	As per item 82378, where the duration is at least 50 min	129.10

Medicare item numbers associated with billing for social work services — current at 20/08/2024

APPENDIX 7. **SUMMARY OF MEDICARE ITEM NUMBERS FOR SOCIAL WORKERS** *cont.*

ITEM NUMBER	DESCRIPTION	FEE
82382	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided in person; and (c) the service is at least 60 minutes in duration	25.40
82383	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible Social Worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 60 minutes in duration	25.40
93100	Eating disorder psychological treatment service provided by telehealth attendance to an eligible patient by an eligible Social Worker (AMHSW) if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration.	70.95
93103	As per 93100; where the service is at least 50 minutes	100.20
93134	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible Social Worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration.	70.95
93137	As per 93134; where the service is at least 50 minutes	100.20

Medicare item numbers associated with billing for social work services — current at 20/08/2024

UNIVERSITY OF CANBERRA

Canberra ACT 2601 Australia
T +61 2 6201 5111
canberra.edu.au