ESSENTIALS OF SOCIAL WORK PRACTICE
IN PUBLIC HEALTH PROGRAMS
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Introduction

Social workers entering public health resemble newcomers in a country with a seemingly similar language and culture. At the surface, much is comfortably familiar, but one is surprised by some peculiar differences in history and traditions, in deeply held beliefs, and in the inner workings of important institutions. It becomes apparent to the newcomer that it helps to reflect on observed similarities and differences in order to use one's talents to good advantage, and to contribute the best from one's own values and folkways.

The analogy suggests the plan for this presentation. The first part will be devoted to a bird's-eye view of some major characteristics of public health, formulated in terms of their significance to the social worker entering a public health agency, project, program, or institution related to public health. These characteristics are orientation to prevention, orientation to populations, specificity in defining dynamics of health and disease in populations, and orientation to long-range strategies. The sketch of each of these characteristics includes social work perspectives on similarities, differences, and implications for practice. With this as a foundation, the second part of this paper will review major elements of social work practice in public health.

MAJOR CHARACTERISTICS OF PUBLIC HEALTH

1. Orientation to Prevention

Modern public health was born as an institutional means and science to cope with the scourge of communicable diseases. Powerful health departments developed with the broad range of "protection for health and life of the people," and with a built-in ideology and technology focused on prevention. Juridical lines between prevention and treatment seemed clear; public health was concerned with prevention, private medicine with treatment. As public health concerns expanded beyond communicable disease, first to maternal and child health and then to an ever-increasing range of non-communicable conditions affecting all age groups, the original dichotomy between prevention and treatment became conceptually untenable. It became apparent that, when absolute prevention is not feasible, there is, nevertheless, preventive payoff in early discovery of disease processes and prompt intervention. Even when disease processes are advanced there are many opportunities for preventive deterioration or enhancing functioning. This conceptualization as primary, secondary, and tertiary prevention has important institutional and ideological significance. Beyond the institutional boundaries of public health agencies, public health, a social movement engaged in a continuing struggle to infuse preventive practices into other social institutions and into the healing professions. The true believers dream and think in terms of prevention wherever they find themselves.

In contrast, the commitment of the social work profession to prevention is ambivalent. This observation is not due to unproductive self-flagellation, but it is susceptible to orderly analysis and rational plans for self-correction. At the turn of the century there were both preventive and treatment elements in social work—the former reflected primarily in the settlement house movement, the latter in the charity organization societies. In the reformist climate of that era leaders of both groups were actively involved in creating programs to prevent infant mortality, tuberculosis, etc., and helped to lay the groundwork for the public health movement. Prevention and improvement of social conditions were synonymous. This necessitated the creation of many types of social institutions to improve working conditions, public education, housing, and outdoor recreation, to mention but a few. Because of the wide range of social institutions to be developed or improved, social work, unlike public health, did not establish a single central, powerful institution concerned with prevention, an institution which could socialize and energize us to think an institutional prevention as the central professional purpose. Social work has been sustained and nurtured more by the treatment tradition stemming from the charity organization societies. Thus, if we want to elevate prevention to a higher priority in our scheme of things, we cannot simply add it to our existing ways of thinking and doing. We must rethink both the conscious use-of-self in everything we do and the institutional arrangements of which we are a part.
This is not to say that we are starting at zero point. For many years substantial numbers of social workers have engaged in preventive work in public health, and in other areas, such as public schools and rural social work, thereby contributing significantly to the development of public health methodology. Furthermore, embedded or latent in social work practice are important preventive elements which either have not been conceptualized or labeled as such, or have not been pulled together into comprehensive strategies. In casework, for example, many strands of casework theory and practice suggest that the focus is not only on helping to solve an immediate problem, but on increasing the client's long-term coping capacity. How conscious is the social work profession of this as a preventive concept, to be made explicit, researched, and promoted?

2. Orientation to Populations

Focus on prevention means that public health is concerned with those persons "at risk" of developing a disease, and not just with those who already have a disease and seek help with it. Reliance on the traditional "complaint-response" system of curative medical practice is incompatible with concepts of prevention. Studies indicate, for example, that young teenagers tend not to seek prenatal care. Thus, public health must identify high-risk populations and find ways to protect them. The sense of obligation to populations is as strong among public health practitioners as the sense of obligation to individuals is among many social workers.

This emphasis has important consequences for the determination of priorities in the allocation of resources. Risk merely indicates a degree of possibility or probability that any one individual in a high-risk population will actually develop the disease, or already has a disease. For example, a pap smear screening procedure may be administered to a woman who may not have a genital tract malignancy. Extrapolating this to large populations, the question arises as to what proportion of total available resources should be devoted to preventive programs focused on populations of whom sizeable numbers may not develop a problem, as against the proportion of resources to be devoted to curative programs dealing with cases of individuals who have been diagnosed as having a disease.

Public health philosophy would suggest that prevention should have the first claim on resources, a notion ultimately attributable to a utilitarian ethical view that seeks to maximize "the greatest good of the greatest number." This philosophy has a persuasive rationale for developing countries, but it is often not reflected in public policy in the United States. Our values about the importance of each individual are linked to expectations that the latest achievement in medical technology will be made available to each known victim of disease. It follows, therefore, that the body politic, and often the professions, allocate less resources for the development of preventive programs which serve apparently anonymous populations-at-risk. Compare, for example, the vast sums expended for individuals with congenital abnormalities with the much smaller amounts devoted to preventive strategies, despite public health struggles to counteract this tendency.

As a consequence of the previously mentioned historical developments, we in social work have tended to split our concerns with individuals and populations. First came specialization in methodologies—casework, groupwork, and community organization, and later the division between macro and micro tracks. The exception arose in social work in the health field, particularly in public health. It is inspiring to review historical statements in which the description of multiple social work functions or roles reflects a simultaneous perspective on individuals and populations. For example, in 1947 the Medical Social Work Unit of the Children's Bureau issued a statement on functions of medical social work consultants. Along with direct casework service and case consultation were stated several population-oriented functions—liaison and coordinating activities; and participation in formulating policy for the overall program, in community organization to help meet gaps in services, and in educational programs for other professional personnel. A similar perspective is reflected in the 1949 statement of Standards to be Met by Medical Social Service Departments in Hospitals and Clinics, approved by the American Hospital Association and issued by the American Association of Medical Social Workers.

This model, of which there were several subsequent versions, confronts public health social workers with a difficult value dilemma faced by public health: how much of our most precious resources, time and energy, do we take away from the insistently accumulating service needs of known patients in order to improve the well-being of anonymous present or future populations in the hospital or in the community? With our tradition of accountability to individuals, can we give at least equal weight to accountability to populations? This may be the toughest question regarding conscious-use-of-self for social workers entering public health, or promoting public health concepts, to answer.
3. Specificity in the Mapping of Characteristics of Disease in Populations

Intervention by all healing and helping professions requires a knowledge base with a double focus: the unique aspect of each person and his or her problem, and commonalities among people and their problems. A random review of articles in professional journals dramatically illustrates that social work emphasizes the former, public health the latter. The cornerstone of public health knowledge is the science of epidemiology which is concerned with mapping the distribution of disease in populations in the light of various population and environmental characteristics. It includes the delineation of the attributes of a condition, its prevalence and incidence, and typical causative and contributory factors.

It is important to note that epidemiology has evolved in ways sometimes not immediately perceived by social workers. We are inclined to contrast the richness of multiple causative factors identified by social workers in individual cases with what we believe to be the epidemiologist's narrow concern with single causes. It is true that, in the initial epidemiologic investigations of a disease, focus frequently is on what appears to be a key causative factor, whether the presence of a microorganism, or a genetic characteristic, or a traffic hazard. However, epidemiology progresses by seeking to understand why, in two populations exposed to the same factor, the incidence of disease is greater in one population than in the other. As a result, additional factors are isolated so that the movement in development of knowledge is from single to multiple cause explanations, with increasing specificity in differentiating between predisposing, precipitating, and perpetuating factors, in what Terris calls the "web of causation." Epidemiologists reared in the earlier communicable disease era have sometimes been slow to consider and investigate social and psychological factors, but the leaders and visionaries in the field have been alert to these all the way along.

Since this conference is being held in North Carolina, it seems especially appropriate to mention a national leader, Dr. John Cassel, who, before his untimely death a few years ago, chaired the Department of Epidemiology at the School of Public Health, University of North Carolina at Chapel Hill. Cassel searched for an explanation of epidemiologic data that suggested that certain populations were at risk not just of one disease but of a wide range of communicable and non-communicable conditions. He formulated the theory that susceptibility to all manner of disease is increased by certain psychosocial stress factors, notably stresses arising from people's inability to obtain meaningful evidence that their actions are leading to desired consequences. Such circumstances, which in social work we tend to call coping difficulties, would pertain, in situations of role conflict, blocked aspirations, or cultural ambiguity, as for example, in cases of immigrants confronted with requirements for cultural readjustment, or elderly persons confronted with rapid changes in their neighborhoods. But why, in the presence of such stresses, are some populations and some individuals more susceptible to disease than others? A possible answer to this, according to Cassel's theoretical formulation, lies in the relative presence or absence of social supports which may act as a cushioning factor in minimizing the effects of social stress.

This theory seems plausible to social workers since it focuses on aspects of human behavior familiar to us. It makes epidemiology seem less distant and forbidding, and some might even shrug their shoulders and say that we have known about social stress and social support systems for a long time. The epidemiologist would answer that we don't really know it yet; that it has taken hundreds of studies to suggest this theory, and it will take hundreds more to refine it and prove it.

What is needed is a combination of epidemiological and clinical research to advance knowledge. The clinical practitioner/researcher, whether in social work, medicine, or any other field, supplies essential insights which otherwise might elude the epidemiologist, and it is likely, that, in the aggregate, social work has contributed to public health knowledge in this manner. To be fully effective in this arena, however, we need to attend to specification of commonalities of events in populations, and we need to learn more about the language of numbers.

An example illustrating the possible use of epidemiology for reform of the services delivery system is offered in order to underline its possible utility for social work. Experience suggests that the sequence of predisposing, precipitating, and perpetuating psychosocial processes or events frequently does not coincide with the time sequence of corresponding stages in the somatic sphere. For example, the kind of psychosocial stresses discussed by Cassel are rooted in circumstances antedating onset of the disease; on the other hand, somatic disease may be a contributory or precipitating factor in a new psychosocial problem. However, as social workers know all too well, the health care system has been constructed primarily around the sequence of somatically required interventive episodes, including hospitalization, without taking cognizance of the natural history of psychosocial processes. As I have pointed out elsewhere, it is tempting to put this in the form of a "law": the greater the import of social and psychological
factors in particular diseases, the more dysfunctional are the institutional boundaries for psychosocial intervention when defined by the episodes of medical care such as hospitalization, and the more disjointed are provisions by overall systems for continuity through various phases of care. If we had a substantial body of social epidemiologic data to document all this, it might take us for a giant step toward the human service system we are wishing for!

4. Orientation to Long-Range Strategies

Prevention of disease in populations involves grand strategies, each employing many different techniques. As mentioned previously, the most generally useful classification of the strategies is that of primary, secondary, and tertiary prevention. Primary prevention may attempt the eradication or significant reduction of a causative agent in the environment, as through burial of radioactive materials; or the reduction of exposure of a susceptible population to a particular agent, such as the provision of medicine bottle tops which cannot be opened by small children. Primary prevention may also seek to achieve changes in the individuals in susceptible populations to make them resistant to causative factors, by providing immunizations or administering silver nitrate prophylaxis of newborn to protect against gonorrhea ophthalmia, for instance. These examples illustrate conceptions of primary prevention focused on protection against single diseases or health hazards. A broader view of primary prevention, stimulated by sophistication with regard to multiple etiologic factors, includes the creation of conditions conducive to positive health and to prevention of clusters of diseases. Examples are the lessening of stressful social conditions impacting on people, or preventive counseling to prepare for pregnancy, delivery, and parenthood.

Secondary prevention involves a strategy of curing or arresting a disease in its incipient phases through prompt diagnosis and treatment. The objective is to prevent complications or prolonged disability in the individual, or to limit the effect of the disease on others. Many techniques are utilized to bring patients promptly to diagnosis and treatment. This includes promotion of community attitudes to encourage people to undergo prompt diagnosis and treatment, and the application of a wide range of screening and casefinding techniques. These are applied for general or high-risk populations on a mass basis, or in periodic health examinations. They may also be applied in the direct service practice of professional practitioners who see individuals for a particular complaint and at the same time check the possibility of other incipient problems. The strategy of tertiary prevention aims to counteract consequences of conditions in individuals which were not discovered in their earlier phases, and to prevent chronic disability through rehabilitation.

An important feature of these strategies, not easily seen by the novice in public health, and not always made explicit in the literature, is the movement from tertiary to secondary to primary prevention, which takes place over long periods of time. In the field of public health dentistry, for example, early efforts were concentrated on tertiary prevention—making corrective services more widely available. This in turn, led to an emphasis on secondary prevention through prompt detection of serious malocclusion, and later, to effort to achieve primary prevention through fluoridation and improve dietary habits. Another example, in the area of heart disease, cancer and stroke, was the creation of a network for tertiary and secondary prevention through the regional medical program in 1965, followed by a currently expanding movement toward various kinds of primary prevention efforts. An example of immediate relevance to this conference are developments in perinatal care. Early definitions were linked to tertiary prevention through neonatal intensive care units; expanded newer definitions emphasize secondary and, where possible, primary prevention which starts prior to conception through networks of community-based programs.

This kind of movement can be viewed as a response to the aforementioned value and related social policy dilemmas, since it fans out from an initial major concern with victims of disease to a concern with populations at risk. Furthermore, it is made possible by knowledge-building leading from the tertiary toward the secondary and primary levels. For example, once a condition is understood, research questions arise: what can be done to arrest it in its initial stages, and how can it be prevented altogether? It is important to recognize that new preventive strategies require not only added knowledge and changes in technology, but also changes of comp systems in many institutions. There is no public health dictator and no ready-made public policy prescribing such change. It takes mobilization of progressive public health-oriented focus to clarify new directions and to overcome vested interests of doing things.

A final point in this section is a reminder that the concept of levels of prevention is sometimes confused with the concept of levels of care. The latter is related to efforts to regionalize services with a profession in relative need for access, frequency of need for services, and technical complexity. At one extreme is primary care, to be readily available close to people's residences and less complex technically;
at the other extreme is complex tertiary care, to be available for regions covering much larger populations. It is helpful to understand the conceptual and operational differences between levels of prevention and levels of care, as well as the relationship between them. For example, primary care is a major locus for many aspects of primary and secondary prevention.

MAJOR ELEMENTS OF SOCIAL WORK PRACTICE IN PUBLIC HEALTH

Having visited public health country and being familiar with culture and language, we are now ready to become residents there as public health social workers, perhaps feeling initially awkward and continuing to make interesting discoveries and embarrassing mistakes. We have, of course, memorized the major chapters of the guidebook-orientation to prevention, orientation to populations, specificity in the mapping of characteristics of disease in populations, and orientation to long-range strategies. We are aware that these features of our new home will necessitate that we transcend our immediate past education or experience in casework city, or group work county, or community organization state, and that we may have to learn as soon as possible to draw on the considerable social work heritage in direct and indirect services, with interventive repertoire quite similar to that included in the previously mentioned historical standards statements.

The key to our effectiveness in public health is sound planning of social work activities. We need to clarify which one of the direct and indirect roles is desirable in a particular program at a particular point in time, and learn how to prioritize our activities.

To reflect on this, it is useful to follow the same general problem-solving model we use in all social work activities: assessment, planning, intervention, and evaluation. Just as an individual treatment case the planning of appropriate interventions depends on clinical assessment, so the planning of a cluster of roles in a whole public health program flows best from assessment of the overall program from a social work perspective. As in individual cases, these phases may overlap.

1. Assessing a Public Health Program from a Social Work Perspective

Several related clusters of questions might be explored: what are the objectives and scope of the program viewed in a community context? What is the access to the program? What are the provisions to assure comprehensiveness and continuity of service? How are psychosocial factors perceived, recognized, or dealt with in service encounters with the program's clientele. Let us briefly review these questions.

---What are the objectives and scope of the program in the context of community-wide prevention strategies?

Is this a comprehensive program with defined accountability to a population in a substantial geographic area, potentially concerned with an open-ended spectrum of health problems and with intervention at appropriate levels? If so, to what extent are psychosocial considerations applied in selection or priorities? For example, in a public maternal and child health program, how much attention is given to adolescent health?

On the other hand, the scope of the program may be more limited. It may be comprehensive and oriented to prevention, yet without clearly defined population accountability, as in the case of some community clinics. Or a program may be focused on a particular aspect of prevention with a particular population, such as family planning services. Or it may be primarily a treatment program with preventive opportunities confined to primary prevention. In these various kinds of limited-scope programs, the application of psychosocial considerations in the selection of program priorities should be assessed.

A related important question is whether and how a limited-scope program sees itself as part of a community-wide prevention effort. For example, both Hospital A and Hospital B may treat possible child abuse victims and deal with them similarly, but Hospital A extends its responsibility by actively relating its services to the development of a community-wide, prevention-oriented child abuse network, while Hospital B is concerned only with treating its own patients. Stated another way, viewing our public health program as a subsystem, how does it fit into an existing or potential community-wide system which can accommodate to long-range preventive strategies, including positive changes in levels of prevention? Fragmentation of effort is "Public Enemy Number One" in the health and human services arena, incompatible both with public health and social work objectives.
Another cluster of questions has to do with sources of policy determining the program, fiscal resources, nature of administrative structure and processes, and power alignments. These questions deserve to be presented in greater detail but will have to await another paper.

2. The Range of Roles of Public Health Social Workers

At part of our planning, we need to visualize the repertoire of roles of public health social workers, which involve collaboration with other disciplines. With some variations in terminology, the major roles have been described in standards statements and in the literature for many years, as mentioned earlier in this paper. In the following brief descriptions, an attempt is made to make explicit how each role is related to the levels of prevention.

Program Planning and Policy Development. There are two major aspects of program planning, interrelated, but with different objectives. One has to do with our work contributions to the planning of any or all aspects of the program to assure that psychosocial aspects of prevention and treatment are understood, considered, and appropriately incorporated. This involves communication of our values, knowledge, and ideas through participation in internal committees, supply of data, or consultation. The other aspect of program planning already mentioned, has to do with developing an appropriate mix of social work roles and techniques in accordance with the circumstances and needs of the program.

Community Organization and Social Planning. Both community organization and social planning may be applicable at all levels of prevention. Community organization tends to be utilized especially in primary and secondary prevention, with the objectives to motivate, mobilize, and organize citizen groups to participate in preventive health activities, as for example in outreach for purposes of casefinding.

Social planning is related to interagency efforts to develop or alter policies or services especially with respect to issues mentioned in the previous section, i.e., program scope, community-wide prevention strategies, access, continuity, and comprehensiveness.

An example of social planning on the primary prevention level is the creation of improved linkages between maternal and child health programs and family-life education activities in public schools. On the secondary level, an example would be the development of improved information and referral services.
he secondary level, an example would be the development of information and referral services. On the tertiary level, an example would be the creation of an effective and psychosocially sensitive transportation system between general obstetrical services in outlying areas and central intensive care facilities. An example transcending all levels of prevention is the development of a State-based system of maternal and child health care.

Direct Services. A wide range of direct social work service interventions are applicable in public health. These include family life education; development of self-help groups; advocacy; crisis intervention; and group, family, or individual treatment. Direct social work services can contribute to primary prevention by enabling groups, families, and individuals in high-risk populations to anticipate and abort behaviors or social functioning problems which may predispose to, or precipitate health problems. Examples are parent education, family planning, and genetic counseling. In secondary prevention, direct social services contribute through early assessment of social risk factors and intervention with behaviors or problems which may exacerbate existing health problems or complicate treatment. As a means to this end, social workers in health settings are increasingly experimenting with social screening instruments. In tertiary prevention, direct social work service attempts to impact behaviors or problems which may exacerbate disease or complicate treatment.

Consultation and Education. Consultation and education have the common objectives of sharing social work knowledge and expertise in order to extend the understanding of and effective incorporation of psychosocial elements in the preventive and treatment efforts undertaken by other disciplines. Usually consultation has as a starting point an immediate question presented by an individual or small group of consultees, while education tends to provide general information to larger numbers. In consultation, a differentiation is usually made between case consultation and program consultation. Case consultation is utilized mainly with respect to secondary and tertiary prevention strategies, where diagnosis and treatment of individual case situations may require understanding of psychosocial factors by other personnel. Program consultation and education of other disciplines have potential for all levels of prevention.

Research. The research role of social workers has two objectives roughly paralleling those mentioned with respect to program planning. One is to enhance the effectiveness of social work activities, and, as such, should be an integral part of anything we undertake. The second objective is to contribute to research in the larger program, directly or through consultation. It is well to recall that reliance on empirical data in program development and evaluation. Our capacity to draw on empirical data is a significant aspect of being recognized and valued in public health. Even if we are not engaged in sophisticated research, the appropriate citation and utilization of findings in the literature can be potent tools in program planning, consultation, and education. Simple empirical studies have long-range utility. For example, the importance of classification and counting of selected characteristics of a population served in an outreach program over a specified period of time may help substantially in a primary prevention effort. Beyond this, for the field as a whole, a high priority in enhancing our contribution to public health is the reorientation of social work research to develop a substantial body of knowledge based on epidemiologic investigation.

3. Planning the Public Health Social Work Program

Having assessed the health program and having reviewed the potential range of social work roles in our mind's eye, what guides our planning? The following ideas may help.

Considering Values: Choices in Levels of Prevention. As indicated earlier in this paper, the movement from tertiary to secondary to primary prevention involves value dilemmas. For example, social workers in hospitals have attempted to use screening for high-risk social factors shortly upon admission as a substitute for the vagaries of late or ill-conceived medical referrals, which in effect is a movement toward secondary prevention. In some hospitals, this has failed, because, with inevitably limited resources, it shifted time away from manifest problems to incipient problems. There are some technical aspects to this, but the value aspect is large and requires serious reflection.

Other examples of value dilemmas include: what relative priority should be given to the investment of social work time and energy in developing preventive pre-hospital orientation sessions with patients versus developing post-hospitalization mutual support groups? Or, how much time should be taken away from direct services in a developmental disability program in order to participate in the planning of community genic counseling program versus the planning of improvements in institutional programs for the severely disabled? Should we permit such questions to be decided by circumstances or chance, or should we seek to extend our opportunity for making conscion
choices in disposing of our time and energy, and to suffer the pain that goes with it.

There are no prescriptions for the difficult process of reflecting on priorities in terms of levels of prevention, but it may be helpful to be alert to some pitfalls. One of these is to view the value issues as being relevant only on the larger urban or national scene where major policies regarding resource allocation are made, and to overlook the importance of the kind of value choices suggested above which are at the level of the individual worker or social work department.

Another pitfall, recently noticeable in social work, is an abrupt shift of attention from treatment to primary prevention, with concomitant undervaluation of secondary prevention in improving well-being, in restructuring of the fragmented human services delivery system, and in expanding our knowledge base. A related pitfall is the equating of primary prevention strategies with behavioral-change approaches designed to help people assume more responsibility for their own health. While this should be a significant component in primary and secondary prevention strategies, it cannot compensate for improvement in social and environmental conditions. In all of this, it helps to view needs and services from epidemiologic, ecologic, and systems perspectives.

Using a Multiplier Effect: Fanning out from Small to Large Systems. When social work was introduced into public health many years ago, the key role was considered to be that of consultant, reflected in the titles of public health social workers in official agencies. While all other roles were included in various forms, this conception confirmed that through use of consultation we would multiply our individual effort by influencing others to include social and psychological understandings in their work. There is a natural sequence in this process which can be consciously considered in our planning and which is applicable in different settings. The sequence moves from small to larger systems, from direct service to case consultation with other disciplines, to informal or formal educational sessions with them, to program and community planning. At each stage we contribute psychosocial understandings; concurrently we learn more about the problems and the people we work with and seek ways to extend our influence.

Using a Multiplier Effect: Packaging Teamwork. There are many ways of packaging teamwork so as to stretch ourselves and to use our time where it counts most. In the realm of secondary prevention, for example, instead of doing our own psychosocial screening, we may be able to develop screening criteria to be applied by others. This has been done, in cooperation with community workers, or volunteers, admission clerks, public health nurses, physicians, baccalaureate social workers, or through self-screening by patients. Similarly, assessment, treatment, and follow-up can be packaged in different forms of teamwork and we need to plan systematically at what point in the process direct service skills of a social worker are best utilized. One model provides for social worker's direct contact to focus on assessment, with all treatment dealt with through consultation with others or referral. In a second model, the social worker is engaged in assessment, treatment, and follow-up with cases selected on specified criteria, while all other cases are dealt with by other personnel, with social work consultation. The range of possibilities in primary preventive efforts is even greater. What needs to be understood is that the multiplier effect through systematic packaging of many kinds of teamwork within and between agencies is characteristic of all of public health practice.

Using a Multiplier Effect: Demonstration for Replicability. In any setting, demonstration of some element of practice or of a new approach should be made explicit to those decision-makers and collaborators who need to understand what is to be demonstrated. They should know not only what is to be accomplished, but also why, and when. They should be invited to participate in every stage of the process. In public health, in particular, in demonstration of a new procedure, there is frequently a criterion of replicability so as to benefit the total population. My prized first lesson about this concept came many years ago in a State Health Department when I proposed to demonstrate the use of casework services in nursing homes. My superior, sympathetic, but a realist, asked me how many hundreds of social workers we would need in the State if the demonstration were successful? Was I prepared to battle for this program in the light of other priorities? Instead, as an alternative, would I want to demonstrate having a social worker to provide consultation, staff education, and social resource mobilization to a cluster of nursing homes? This, if successful, might have realistic possibilities for statewide replication, and would not preclude more intensive direct service approaches under specified circumstances.

Constructing a base for sanction and accountability. In order to give rein to our professional imagination and creativity, comments on sanction and accountability have been deferred to the end of this presentation. As professionals in bureaucracies social workers are not free agents. We are responsible to our agencies, our clients, and to the professio
This three-fold obligation is never easily managed in social work because we may have professional reservations about some agency values, policies, or programs. An added complexity arises in public health when we adopt the perspective that we are concerned not only with a known clientele but with a range purposes and strategies necessary to enhance the well-being of anonymous populations. It becomes all the more important to consider sanction and accountability in our planning.

We might find ourselves in a situation in which the inherited program statement or job description does not match our concepts regarding our objectives and roles. What can we do? One possible answer is to attempt to renegotiate the program statement or job description before planning further. In attempting this, it is important to utilize official standards statements, such as those contained in the Program Guidance Manual for the Office of Maternal and Child Health22 and the forthcoming statement on Standards for Public Health Social Work, currently being developed by the Social Work Section of the American Public Health Association and the National Association of Social Workers. Also, as mentioned, there is strong historical sanction for a broad configuration of social work roles, reflected most recently in the otherwise obsolete 1962 APHA standards document for public health social work23 and in the 1976 NASW Standards for Hospital Social Services.24

Whether or not an attempt is made to renegotiate a program statement at the outset, it is useful to involve administrative superiors in the phases of the problem-solving process which guides our overall effort. While in this paper the focus has been on assessment and planning, the process includes the actual interventions, i.e., the putting into practice the mix of roles and activities being planned, and the evaluation of these interventions, which feeds back into planning on a continuing cycle. To obtain sanction and support, we might propose a demonstration strategy pertaining to our overall roles and activities, including a series of successive "contracts." The first might involve a sanction for a psychosocial program assessment, with results to be shared after a specified period of time, to be followed by contracts regarding specified roles, interventions, and evaluations. If this step-by-step process is carried out rigorously, reliably, with well-formulated written documentation, it can go a long way on obtaining sanction and demonstrating accountability. It is a powerful way to clarify what we stand for and what we can do, and it helps to overcome resistances. I have seen this process even melt hearts of stone!

A FINAL NOTE: LINKING THE PAST AND THE FUTURE

As we make our way in public health country, it is well to know of the social work pioneers and leaders who helped, or are helping, to pave our way to the future. Their ideas can help guide us and their unflagging determination against many odds can be a source of inspiration at those inevitable times when we feel frustrated, burnt-out, and alone. From a galaxy, let me name but a few who helped to lay the foundations for public health social work. There was Edward T. Devine, General Secretary of the New York Charity Organization Society around the turn of the century, who authored one of the earliest comprehensive studies in social epidemiology, and who helped to persuade President Theodore Roosevelt to organize the first White House Conference on Children and Youth. The list includes Julia Lathrop, the first chief of the United States Children's Bureau, and Edith Baker, for many years the head of the Medical Social Work Unit of this unique agency, both of whom profoundly influenced the philosophy and substance of services to children and families.

Among the more recent leaders there have been professors in schools of social work and schools of public health, such as Harriet Bartlett, Eleanor Cockerill and Elizabeth Rice, who as national leaders had the vision to perceive, enunciate and promote a broad mission of social work in the health field, including public health. William Hall, at the University of Pittsburgh School of Public Health; Elizabeth Watkins, at the University of North Carolina School of Public Health; and Robert Jackson, formerly at the School of Public Health, University of California at Berkeley and currently with the Public Health Service, are all thinkers and teachers, extending and adapting what we know to changing circumstances and needs, and providing impetus for new ventures in practice, education, and national social work organizations. Finally, there is Virginia Insley, who has just retired as Chief, and Juanita Evans, who has recently been appointed Chief, Medical Social Work, Office for Maternal and Child Health. They are great public servants to whom I am dedicating this paper, and who symbolize the public health social work tradition spawned in the United States Children's Bureau, fighters of a thousand battles to help us carry it forward from the past to the future.
REFERENCES


