An analysis of referrals to social services in state primary care in Malta

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ABSTRACT

Background

Involvement of the social worker in patient management leads to better holistic care. A better understanding of the service offered is needed.

Objectives

The aim is to review the referrals made to the social worker in Primary HealthCare in Malta since the introduction of the service. Other objectives include increasing the awareness of this service, and improving community care.

Method

A retrospective analysis of the data obtained by the social worker was carried out by examining all the referrals to the social worker between the 17th August 2015 and the 30th September 2018. Data collection included the total number of referrals, age, nationality, locality, source of referral, time from referral to first contact, reason for referral and co-morbidities.

Results

The majority of subjects (n=52) were 65 years or older. There were 56.4%, 16.8% and 25.7% of cases from the North, Central and South catchment areas respectively. The majority of patients (n=69) were referred by GPs (67.6%). The others were referred by other healthcare professionals or they were self-referred. The average waiting time from the date of referral to the initial contact with the social worker was 18 days. Most referrals were due to social problems (52%) whilst 38 clients (37%) suffered from mental health illness and 37 clients (36%) suffered from cardiac diseases mainly hypertension and ischaemic heart disease.

Conclusion

Recommendations for increasing awareness which will lead to better community care were put forward in the discussion, including implications for policy making and making good use of the service.

Keywords

Social work, general practice, general practitioners, primary care, holistic health

INTRODUCTION

The social work profession aims to "promote or restore a mutually beneficial interaction between individuals as well as between individuals and society in order to improve the quality of life, by aiding persons in receipt of such services to understand, resolve and prevent personal, interpersonal, family or social problems" (Social Work Profession Act, 2003). The International Federation of Social Work favours the WHO principles as they closely relate primary health care (PHC) and 'population health' by addressing the social determinants of health, which include the unjust inequalities in global health as a result of social, environmental, political and economic factors (International Federation of Social Workers (IFSW), 2008).

The introduction of the social worker at the level of PHC in Malta started in August 2015 (Ministry of Health, 2019a). This was set up because many general practitioners (GPs) were unaware how they can be of help to patients, when faced with several social circumstances during a consultation. In primary care, it is not only the GP who encounters difficult social situations, but also other healthcare professionals (HCPs) such as nurses, occupational therapists, podologists and speech therapists. From the 15th of December 2015, referrals to the social worker were accepted from any HCP working within the PHC. Referrals to the social Worker are made using the typical referral ticket (Mater Dei Hospital (MDH), 2011).

Provision of service

To date, there is only one social worker providing this service in PHC. Initial appointments take place in Cospicua or in Birkirkara Health Centre. Patients residing in Mosta, Birkirkara, Rabat and Gzira catchment areas are referred to Birkirkara Health Centre and those from Cospicua, Paola, Floriana and Qormi catchment area to Cospicua Health Centre. This is an optional service and therefore patients need to accept referral to the social worker clinic. Home visits are available depending on the needs of the client. 'There's a growing shift towards providing care in people's homes and new intensive care roles, rather than residential care' (Batty, 2004). It is of paramount importance that social workers and GPs work hand in hand for better patient management.

It should be noted that the service offered at Social Worker's Office situated in Qormi Health Centre was not taken into consideration in this study. The social workers there are employed by Social Services and not by PHC.

Objectives

The aim of this study is to review the referrals made to the social worker in health centres in Malta since the introduction of the service. Other objectives include increasing the awareness of the service available in PHC and to improve community care.

METHOD

A retrospective analysis was carried out by examining all the referrals to the social worker between the 17th August 2015 and the 30th September 2018. All referrals from all the health centres in Malta were included. In this study, referrals from Victoria Health Centre were excluded. Data were obtained from the database held by the social worker herself. Data was given without any traceability; no identification of patients was possible. Data collection included the total number of referrals, age, nationality, locality, source of referral, time from referral to first contact, reason for referral and co-morbidities either from what the GP had listed or else from the case assessment performed by the social worker. These were further subdivided into sections for better data analysis. These sections included domestic violence, learning disability, mental health and addiction, physical disability, relationship/family problems and social support. Comorbidities were divided into cardiac, mental health and endocrine.

This study was approved by the Department of PHC and also by the Data Protection Officer in the Department. Ethical approval was not needed for this audit, as patients' details were not identifiable. Confidentiality was ensured.

The data was inputted and analysed using Microsoft Excel 2007.

RESULTS

The total number of referrals was 102. Around 95% of patients were Maltese. Other participants came from Ethiopia, Ivory Coast, Somalia, Sweden and Tunisia. The majority of subjects (n=52) were 65 years or older (Figure 1).

There were 56.4% (n=57), 16.8% (n = 17) and 25.7% (n=26) of cases from the North catchment area, Central catchment area and South catchment area respectively (Figure 2). Overall the Birkirkara area was the one from which most referrals originated (n=37) (Figure 3).

The majority of referrals (n=69) were done by GPs (67.6%). The others were referred by clinicians attending the Adult Down Syndrome clinic (14.7%), Mental Health Clinics (2.9%), and other clinics (11.8%) as shown in Table 1. These included the Diabetes Clinic, Ophthalmic Clinic,

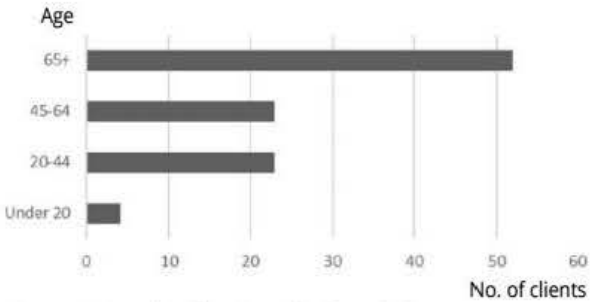

Figure 1: Age distribution of referred clients

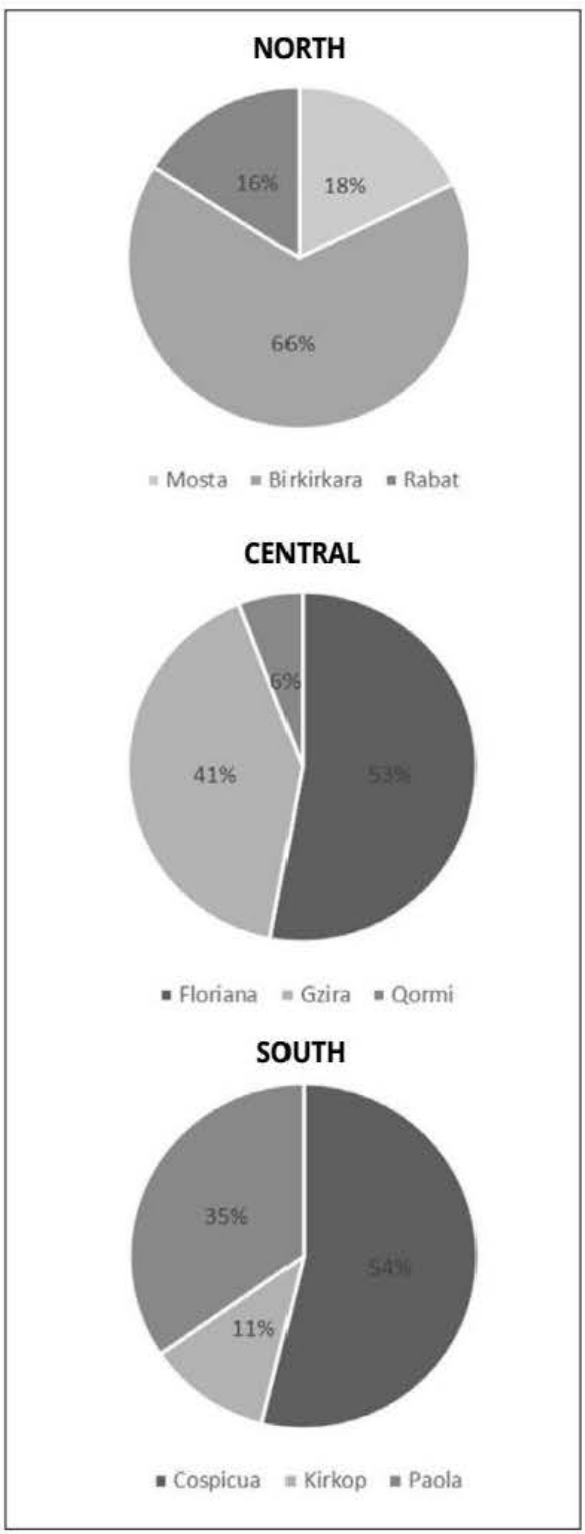

Figure 2: Referrals by catchment area and further subdivided by health centre

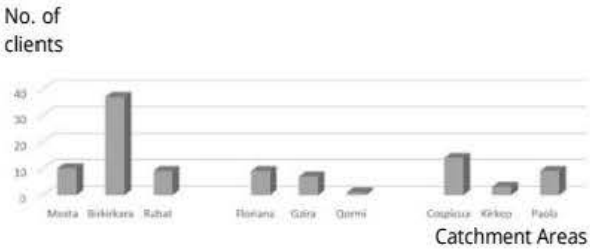

Figure 3: Referrals by different health centres

Physiotherapy Clinic, Prescription Clinic, Speech and Language Clinic, Treatment Room and Lifestyle Clinic. Interestingly, 2.9% of cases were self-referred.

The average waiting time from the date of referral to initial contact with the social worker was 18 days (range: 0-171).

Reasons for referral were further divided into categories shown in Table 2. Most referrals were due to social support problems (52%). Social support included people living on their own and primary care givers in need of additional support for the people they are taking care of, including physical disability and dementia. Also included were those clients who needed financial assistance and housing. About 15.7% of the referrals (16 referrals) were made in view of either mental health problems or addictions. Others are listed in Table 2.

This study showed that 38 clients (37%) suffered from mental health illness, mainly depression and anxiety whilst 36% (37 referrals) of those referred to the social worker suffered from cardiac diseases mainly hypertension (HT) and ischaemic heart disease (IHD). The third most common comorbidity in these clients was illnesses related to Diabetes Mellitus Type 2 (Figure 4).

Source of referral	No. of referrals
General Practitioners	69
Mental Clinics	3
Adult Down Syndrome Clinics	15
Other Clinics	12
Self-Referred	3

Table 1: Source of referral

Reason for referral	Number of referrals
Social support (including financial problems)	53
Mental health + addiction	16
Learning disability	15
Physical disability	8
Domestic violence	7
Relationship/family problems	3

Table 2: Reason for referral

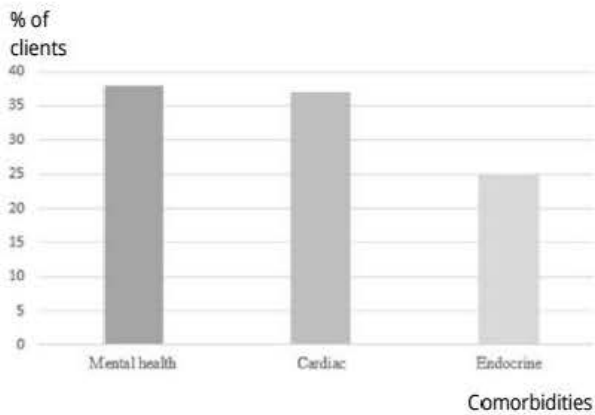

Figure 4: Comorbidities present

DISCUSSION

Analysing the referrals, one can see that referrals to the social worker from the non-Maltese population was small compared to what was expected, considering the large number of migrants (National Statistics Office, 2014). These people might be benefitting from good projects that are already set up by LEAP (Ministry of Social Welfare, 2019a). The LEAP Project, which was set up in 2013, aims to 'combat social exclusion and poverty through employment, capacity building, social integration and social mobility' (LEAP's mission statement) (Ministry of Social Welfare, 2019a). It was founded to provide opportunities for employment for vulnerable groups such as single mothers, ex-offenders and also migrants. Another reason for the low turnout of non-Maltese is that they might experience a language barrier when attending health centres resulting in suboptimal consultations or else lack of awareness that such services exist. This patient population might be experiencing unmet needs or demands.

Good communication is the basis of good quality medical care. The language preferences of patients should be noted and interpreter services provided to facilitate the consultation process. A patient-centred approach that must be taken in consultations involves gathering information using the ICE framework – Ideas; Concerns; and Expectations (Silverman and Kinnersley, 2012). This approach will not be properly adhered to if a language barrier is present and thus social problems may go unnoticed. Other probable reasons for low turnout of migrants may be either the lack of awareness of the social worker service within health centres or else because they are already making use of other services offered by the Jesuit Refugee Service in Malta. The aim of this organisation is 'to assist with immediate needs while encouraging and enabling the longer term goal of self-sufficiency' by helping them psychosocially and also legally (Jesuit Refugee Services, 2019).

The majority of patients resided in Birkirkara (37 referrals). This was followed by Cospicua (14 referrals). This might have occurred because the social worker clinics are situated in these localities, making them more accessible to these residents. Moreover, the GPs and allied HCPs might be more aware of the service being provided. The HSE Health Inequalities Framework 2010-2012 recognises that 'the health of individuals, groups and communities is affected not only by the level of health and social-care services provision, but equally by the degree of access to them' (Health Service Executive, 2008).

There might be other reasons for this observation. People with lower socioeconomic status generally live in areas with poorer quality housing. This is evidenced by the Census of Population and Housing 2011 issued by National Statistics Office (National Statistics Office, 2014) whereby people living in the Southern Harbour district have the highest illiteracy rates (National Statistics Office, 2014, p.146), the lowest tertiary education rates (National Statistics Office, 2014, p.158), and the highest unemployment rates (National Statistics Office, 2014, p.165). Additionally, this district had the cheapest rent (National Statistics Office, 2014, p.258) and the worst state of dwellings, indicating poorer quality

housing. This may subsequently give rise to an increased risk of contracting specific diseases and may even affect mental health (An, et al., 2016). One would assume that in these areas, social requirements would be the highest.

However, our present study does not support this. This might have occurred because in the current study, only the public service was analysed. It could be that clients in that area prefer using the private service or else they are making use of other social support services available such as Haven (Ministry of Health, 2019b) in Paola. This can be explained by the presence of a LEAP centre in Birgu (Ministry of Social Welfare, 2019a). Furthermore, people from this district might not even feel the need to attend the health centre at all. As Fuchs (1978) states, education may lead to positive social, psychological and economical skills and positive attitudes about health access to preventative health centres. Due to low education attainments in this district as shown in the Census of Population and Housing (2011) , this could also explain the low turnout (National Statistics Office, 2014, p.161). Considering that many non-Maltese reside in Buġibba, only 6 referrals were brought forward (NSO, 2014). This can also be attributed to another LEAP centre in Buġibba (Ministry of Social Welfare, 2019a).

One needs to be aware of another service situated in Qormi Health Centre as mentioned in the introduction. This service was not included in this study as the social workers are not employed by the PHC department and referrals are made solely by psychiatrists. The service offered focuses mainly on psycho-social issues of those at high risk of mental health disorders (Ministry of Social Welfare, 2019b). In this study, one can note that the turnout from Qormi was very low. One can stipulate that having a mental health clinic in Qormi with subsequent referral to this service (Qormi Social Service) would result in less people consulting the GP about mental health issues and hence less referrals to social workers employed by the PHC department.

People of lower social classes were found to have increased prevalence rates of coronary heart diseases with higher associated mortality rates than those of higher social classes because of raised prevalence of risk factors including smoking, high blood pressure, obesity, increased blood glucose and elevated cholesterol (Rose and Marmot, 1981). Furthermore, socioeconomic status had a greater impact on cardiovascular morbidity when compared to other risk factors including hyperlipidaemia, hypertension and smoking (Pincus, et al., 1998). In addition, people in lower social classes were found to have higher blood pressures, impaired glucose tolerance, smoked more and exercised less (Rose and Marmot, 1981). Similarly, in this study, around one-third of patients referred to the social worker suffered from cardiac diseases. Therefore, the role of the social worker is essential as the social problems might be masked by the plethora of physical complaints. By tackling social challenges, the risk of disease might be lowered. Awareness of such service would help GPs to identify vulnerable cases and refer appropriately.

The United Nations state 'the inevitable increase in the share of older persons that results from the decline in fertility and improvement in survival that characterize the demographic transition— is occurring throughout the world' (United Nations, Department of Economic and Social Affairs, Population Division, 2017). Therefore, this might explain why 52% of the referrals were made for people aged 65 or more. With regards to the population of the Maltese Islands attending health centres, Baldacchino, et al., (2017) found that there was a 'highly significant correlation ($p<0.001$) between increasing age and number of comorbidities' and also noted that elderly patients tend to bring up more issues during a consultation process. Therefore, from this study discussed by Baldacchino, et al., (2017), one can conclude that more elderly patients attending the health centre (due to the phenomenon of ageing population (United Nations, Department of Economic and Social Affairs, Population Division, 2017)) are more likely to have chronic conditions and accompanying co-morbidities. This is associated with increased social needs and adjustments and so the need of the social worker on board is highly evaluated. An American (lower Manhattan) study showed that if social problems are not dealt with properly, they can increase the risk of physical diseases (Kellogg

and Brickner, 2000). Elderly who are homebound due to their comorbidities have higher disease burden associated with worse prognosis and limited functionality (Kellogg and Brickner, 2000). This might impact their mental health, and apart from the medico-social care offered to them, their psychological needs need to be addressed (Kellogg and Brickner, 2000). It is therefore useful to refer to the social worker earlier on, to involve the necessary health care professionals so as to improve patients' physical abilities and hence prevent or delay their becoming dependant through prior anticipation.

As stated by NICE, 80% of chronic illness and 90% of mental health problems are managed in primary care (National Collaborating Centre for Mental Health (Great Britain), National Institute for Health, Clinical Excellence (Great Britain), British Psychological Society and Royal College of Psychiatrists, 2011). In this study, most of the patients referred suffered mainly from mental health and endocrine illnesses. Many chronic illnesses such as diabetes mellitus, which can be physically disabling in the later stages, and mental health diseases, including dementia, will inevitably lead to social problems. Given that 15% of the referrals were due to mental health and addiction problems, and 37% of patients had a co-existing mental health disease, it shows the importance of managing mental illness and its associated comorbidities and how these affect patients.

Mental health prevalence has increased over the past few years internationally (Andrade, et al., 2013). People suffering from mental health illness might need primary care services, either because of a deterioration in view of psychosocial stressors or because of treatment compliance. Primary care is usually their first point of contact and therefore good liaison between the primary care physician and the social worker is important for better patient outcomes. Social worker led mental health services in patients' homes were found to significantly reduce symptoms of chronically ill depressed elderly, thereby improving their health status (Reckrey, et al., 2013). This continues to re-establish their importance in tackling mental health issues in the community. Furthermore, their role is essential when assisting palliative patients, whose psychosocial needs need to be thoroughly addressed at end-of-life care (Reckrey, et al., 2014).

The current study showed that the waiting times were not long with a mean of 18 days. The implications of this can be twofold: on one hand this might imply that the service that is being offered is a good one, as the waiting time is short. However, on the other hand it might also imply that there is a lack of referrals, in-keeping with lack of awareness of the service provided. By delving into social struggles during a consultation, the time might increase but will eventually lead to a decrease in ineffective consultations, by exploring the hidden agenda (Silverman, 2005). Social problems might recur, leading to other presentations such as physical symptoms which might mask the original social problem.

Similar to the current study, a London-based study conducted in 1980, found that the majority of referrals came from GPs (67.6% versus 63.4%) (Corney and Bowen, 1980). The rest are from other HCPs, which is reflective of the impact these professionals have in primary care. This also validates the use of social services by other HCPs. It is paramount that social workers and GPs work hand in hand for better patient outcome. Ideally there is a continuous rapport between the two parties so that even after the referral is done, the social worker and the GP can re-discuss further, ensuring a holistic approach to health management. In 1968 the Seebohm committee had stated that 'survey after survey has shown that many family doctors do not seek help from social workers nor use social services that are available: they often do not know about them, or do not understand or value them' (The Seebohm Report, 1968). As a consequence, it led to analysis of the family doctors' perception of social worker involvement in primary care (Williams and Clare, 1979). Data in this study shows that the referrals to the social worker did not correlate with the age or experience of the GP. The majority of GPs also emphasized the importance of face-to face meetings with the social workers instead of just a ticket of referral (Mater Dei Hospital, 2011). Given the size of Malta, such informal discussions

might be more feasible and might result in better assessment and management of the situation in question. Also, such discussions should be held at more localities, and not solely in Birkirkara and Cospicua, where initial meetings occur. This might be made available when this service is led by more than one social worker.

Interestingly, the present study showed that domestic violence was not an infrequent reason for referral. It is known that people who have themselves been brought up in an environment of abuse, domestic violence, illicit substance use and mental health disease are "12 times more likely to have attempted suicide, 7 more times to be alcoholic and 10 times more likely to have injected street drugs" (Van Niel, et al., 2014). Hence, the role of the social worker is of utmost importance not only to tackle the issues of domestic violence, but also to rule out illicit substance use and mental health diseases in family members. An adequate support network must also be provided to prevent them from ending up victims of mental health disease or illicit substance use.

The GP can influence the social determinants of health by observing and asking about the patient's social status, financial and household problems and therefore facilitate referrals to the primary social worker as soon as possible. A study showed that more than 40% of patients reported that the GP was oblivious to the challenges the patients were facing (Iezzoni, et al., 2015). When identified, social struggles should be documented in the medical file at health centres, given that different doctors might encounter the patient, ensuring continuity of care due to the absence of patient registration. It is not merely our duty to the patient, but also towards achieving sustainability in health services. National Health Systems Strategies (NHSS) 2020 for Malta has stated that 'better use of the resources available to us' is needed 'to deliver the maximum benefit for our continued investment in the health sector' (Ministry for Energy and Health, 2014). Also mentioned in NHSS 2020, is the need to upgrade all settings providing health services (Ministry for Energy and Health, 2014). From this, one can conclude that there is an increasing need of social workers working hand in hand with GPs from health centres to keep up with the increasing social demands our population requires and that the social worker in the primary care is a step forward in the right direction.

One must also discuss the impact of the service on the social worker. The questions which arise include whether the social worker can turn to another professional when the burden is too much to handle and whether the amount of referrals is overwhelming. A study conducted in 2016 investigated the effect of burnout on a group of social workers. Burnout is a very common recognised negative factor that affects performance in health care workers. The study showed that the longer their career is, the higher the risk of burnout. However, apart from the period worked, there are multiple factors which affect performance, including gender, marital status and personalities. Therefore, a support system must be developed in order to tailor the specific needs that are required by each social worker (Lachytová and Kalanin, 2016).

Strengths of this study

All referrals since the beginning of the service in 2015 were included in this study. The importance of recording comorbidities enabled the authors to analyse in-detail the reason for referral. Hence, this helped the identification of vulnerable groups and their needs which will enable to facilitate better and earlier referral in the future.

A comparison to the study carried out by Corney and Bowen, in London in 1980, helped identify that even though the majority of referrals are made by GPs, a significant number were made by other HCPs. This validates the extension of the service to other HCPs and increases the awareness of all HCPs.

Limitations of study

One limitation of the study was the subjective nature of the mode of classification of the referrals done. The social worker's classification was used rather than the ticket of referral. This was due to various reasons for referral, and that the presenting complaint could have been just the tip of the iceberg. Patients referred to the social work service have a multitude of

problems and this can lead to misinterpretation of data. For example, a wife whose husband (who is the family's bread winner) suffers from Alzheimer's Disease and is physically dependent will have a number of problems. She would require financial support, or practical help to take care of her husband. Due to time and resource constraints, each referral was put under one category but in reality there was more than one reason for the referral because of significant overlap in adherence with the LEAP statement. Furthermore, the total number of GPs who referred to such service is unknown. The referrals could have been from the same GP or from different ones. Subsequently one cannot extrapolate any data on the awareness amongst GPs and HCPs.

Further implications

As stated by Volland (1996), 'People who seek medical treatment still need guidance beyond the actual identification and treatment of a medical problem' (Volland, 1996). This highlights the need of social workers in primary care, where patients repeatedly attend health centres steering away from their medical problem and give clues about poor social status. Doctors need to be more aware of these services in order to aid patients. A study by Matalon, et al. (2002) showed that GP satisfaction increased from 4 to 8 on a scale from 1-10 following intervention by the social worker (Matalon, et al., 2002).

Keeping in mind that the social determinants of health lead to more equitable health outcomes for everyone, training medical staff and other healthcare workers would be necessary (Canadian Medical Association, 2013). Such training will undoubtedly lead to more adequate referrals and will increase the pool of social workers in primary care, leading to better holistic community care addressing the biological, psychological and social aspects and this is in keeping with the vision proposed by NHSS 2020.

CONCLUSION

In this study, all referrals made to the social worker since the introduction of the service in Malta were analysed. Traits in patients' demographics and co-morbidities present were noted and their effect on the biopsychosocial well-being was studied with respect to the need for social worker input in their holistic care. Certain trends with regards to the geographical residency of the patient and how they influence referral to this service were also noted.

The authors propose an amendment to the normal ticket of referral whereby the referrer can tick the option, making the referral system more standardised. An electronic ticket of referral will eliminate misplaced or illegible referrals. This will also facilitate the job of the social worker and help to guide her in the right direction to better tackle the issues being presented to her. As mentioned in the discussion, continuous rapport between the GP and the social worker is essential, after initial assessment by the social worker.

A repeat analysis of the service after certain policies are set in place (increasing awareness, abiding by NHSS 2020 by increasing the pool social workers), will be of benefit to all GPs. One should also include Gozo in the next analysis and whether their social needs differ. Furthermore, more statistics regarding the Qormi Social worker office will be of assistance to the primary care sector and shed light on the impact the service has on the community.

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