

Social Work clients shared with other agencies

A study of a total Social Services population and inter-agency shared care populations

Very little information about these populations.

Study examines a total Social Services adult care population, excluding residential care homes (N = 19,461) in the context of its general coterminous Health Authority population (N = 646,239).

*** Nearly two thirds (61%) of the Social Services population were women, (compared to the Health Authority population of 51%)**

*** 62% were over 65 years (compared to 23% of the Health Authority)**

The study then examines care populations shared between Social Services and other agencies, identifying the amount of shared care and the characteristics of specific shared care sub-groups.

*** 42% of the Social Services population were shared with the Community Health Trust and 19% with the Mental Health Trust.**

*** The proportion of the Social Services population in contact with Criminal Justice and A&E was nearly twice that in the overall Health Authority population.**

Introduction

In order to plan and provide appropriate social care services it is necessary for social work and social care commissioners, managers and practitioners to have an understanding of the characteristics of their total care populations and how these relate to service use.

It is possible to gain a clearer picture of the Social Services care population through comparison with the total population characteristics for the area that the Local Authority Social Services serves (here these are provided by utilising a total Health Authority dataset covering 98% of the population.)

In order to develop inter-agency and multi-professional care for shared populations, it is equally necessary to have an understanding of the extent of shared care and the characteristics and service use of shared care populations.

This study provides for the first time a clear picture of a Social Services “care population,” (ie. all Social Services clients for one county as a whole) and of its social care populations that are shared with other agencies.

Groups of clients who attended more than one agency were seen as "dual agency" or "multiple agency" populations and were defined for the purposes of this study as inter-agency "shared care populations".

Although it was unclear whether this "shared care" was co-ordinated, as agencies had no information about shared populations prior to this study.

Background

Much has been written about the need for partnership between Social Services and other agencies (Kelly et al. 2003, Greig and Poxton 2001) and many recent initiatives have attempted to bridge the divide and encourage inter-professional working and inter-agency collaboration.

Research linking total social care and other agency populations for any one geographical area is very limited. Godden and Pollock (1998, 2002) found that Social Services input was provided mainly to the over-65s, who were three times more likely to receive a social service than a community health service. 11% of individuals receiving a social care package also received community health on one day.

Data and Methods

The method used combined information about total agency populations by anonymizing individual records with a software encryption package. The format of data collected was uniform and computer compatible. Software was used by agency staff to anonymise data at source, prior to research access, thereby retaining anonymity of individuals, yet using the same anonymisation codes.

Information about populations as a whole was then fed back to the agencies, individual data was not available. This software was distributed to all participating agencies and IT support offered to instruct agency staff in its use and devise means for each agency to extract and anonymise data for transfer in a useable form. Ethical approval was obtained from all relevant Ethics Committees.

Results

Total population data for the statutory social care service over a period of three years.

Placed in the context of the population of the Health Authority to give an overview of the characteristics of the social care population compared to the wider Health Authority population.

These data are then placed alongside data from other agencies to show how far the social care population is shared with other agencies and the characteristics of those shared care populations.

**TABLE 1. Age and gender differences
Social Care population.**

As expected, older people made substantial use of Social Services.

Almost two-thirds (61.8%) Social Services were over 65 years.

(in HA less than a quarter (22.9%) over 65)

**Almost two-thirds of clients were women in the Social Services population (60.5%),
(In HA half (51.3%) were women).**

**TABLE 2. Age and gender combined in a
Social Services.**

**When age and gender are taken together older females outnumbered older males.
Older women made up two-thirds or more of the older people using Social Services.**

In summary, the older population (over 65 years) made greater demands on services as might be expected and older females substantially outnumbered older males.

TABLES 3/4 Service use and assessed need.

Table 3: for the social services population
18.6% had mental health problems
25% had a physical disability
2.1 % physical illness
1.2% drug/alcohol misuse

Males had more mental health problems, substance misuse and physical disability.

In Table 4 When age and gender are combined, older females outnumbered those under 65 by two to one, but the disparity was smaller between young and old males.

Whilst there were many more older women (7,836) than older men (4,105) in the care population as a whole, a larger percentage of these women received elder care services, where 6,219 (79.1%) women of 65 received elder care services only 2,871 (69.9%) of men over 65 did so. However it can be seen that physical disability services were more often used by older men (1,004, 24.5%) than older women (1,366, 17.4%).

B) Shared Care Populations

Having analysed the single Social Services population, Tables 5 and 6 now show the extent to which sub-populations of Social Services are shared with other agencies. The amount of shared care is identified by calculating the extent to which agency populations overlap

Table 5 Social services shared care clients

The largest shared population group is with Community Health, here 42% of the Social Services population were shared with the Community Health Trust.

A fifth (18.6%) of social services population was shared with mental health services.

The Social Services population in contact with the Criminal Justice agencies (4.73%) was nearly twice as high as for the overall Health Authority population (2.86%).

Attendance at A+E is also nearly twice as high among the Social Services population (21% as compared to 11% of the Health Authority population as a whole.)

Table 6 Age and gender of shared populations (these can be compared to the Social Services population in the top row)

There were differences between the service use of different age groups, younger Social Services clients were more likely to attend mental health (39.85% compared to 18.63% of the total Social Services population), A&E, drug, housing and criminal justice.

In contrast, middle-aged Social Services clients were more likely to attend Alcohol services, and older clients were more likely to attend Community Health.

Few gender differences for the shared care population of Social Services + A&E (21% for both males and females) and for Social Services + Mental Health.

However men were more likely to have contact with Social Services + substance misuse and Social Services + Criminal Justice agencies. In contrast women in Social Services populations were more likely to attend Community Health services.

TABLE 7 extent to which particular Social Services care groups were shared with other agencies

Those receiving elderly care (53.61%), the physically ill (39.75) and those with a learning disability (49.91%) were more likely to contact Community Health services

whereas those with mental health problems and substance misuse problems were more likely to contact A&E (29.84% and 42.55% respectively).

When one small care group, such as Social Services clients with drug and alcohol problems, is examined in detail it can be seen that although 147 of those assessed as having drug or alcohol problems attended specialist services, 88 clients did not. It is also interesting that 41% of Social Services clients with substance misuse problems also attended mental health services (indicating that these are clients with “dual diagnosis.”)

Discussion

Usefulness of information about Social Services populations and shared care (dual agency) populations.

Social Work practitioners at all levels could find it useful to have information about their own client populations and similarly to have information about those client populations that they share with other agencies and professionals

To develop integrated care and care packages or to tailor services for particular target groups with multiple social and health care needs.

To develop inter-professional working.

Health care agencies are developing public health studies of health care populations, it may also be useful for social work as a discipline to develop similar studies of social care populations in order to develop an information base based on social work population needs.

Limitations of the study method

This is a descriptive account of patterns of service, as it is difficult to interpret their meaning with any confidence.

It does not monitor problems relating to administrative, resource and organisational factors which influence utilisation of services.

It is only useful for population studies, not individual casework or clinical purposes, as it identifies group rather than individual characteristics.

It does not, (in common with other record linkage methods), monitor actual need as opposed to assessed need.

To develop a practically useful tool at a local level, it would be necessary to expand the scope and examine:-

*** details for particular sub-groups of shared clients, such as; reasons for referral, assessed needs, particularly short term or long term needs, high or low risk etc.**

*** information concerning resources and costs would need to include type and cost of care for different groups. (resource issues may be different for different agencies. Eg. the proportion of shared clients is similar for the Social Services Department and the Mental Health Trust, as the 3,626 shared clients formed 18.6% of Social Services population, and these same shared clients formed 19.06% of the Mental Health Trust population. But this shared population forms a very small proportion of the total Health Authority population as a whole (0.5%). Therefore, local resource issues and individual agency budgets may influence inter-agency collaborations with shared client groups**

References

- Acheson, E.D. and Baldwin, G. (1978). *Textbook of Medical Record Linkage*, Oxford, Oxford University Press.
- Braveman, P. and Tarimo, E. (2003) 'The social inequalities in health within countries; not only an issue for affluent nations', *Social Science and Medicine*, 54 (11), pp.1621-1635.
- Bywaters, P. and McLeod, E. (2001) 'The impact of New Labour health policy on Social Services: A new deal for service users health?', *British Journal of Social Work*, 31 (4), pp. 597-594.
- Cotgrove, A. J. and Gowers, S.G. (2003) 'The future of in-patient child and adolescent mental health services', *British Journal of Psychiatry*, 183, pp. 479-480.
- Department of Health (2000). *National Service Framework for Older People*, London.
- Dhar, H.L. (2001) 'Gender, aging, health and society', *Journal of the Association of Physicians of India*, 49, pp.1012-20.
- Frohlich, N., Carriere, K.C., Potvin, L. and Black, C. (2003) 'Assessing socio-economic effects on different sized populations. To weight or not to weight', *Journal of Epidemiology and Community Health*, 55 (12), pp.913-920.
- Ford, T., Goodman, R., Meltzer, H. and Vostanis, P. (2003) 'Service utilisation by children with conduct disorders: findings from the GB National Study', *European Child and Adolescent Psychiatry*. 12 (5), pp.231-238.
- Ginn, J. Arber, S. and Cooper, H. (1997) 'Researching older people's health needs and health promotion issues', London, Health Education Authority .
- Godden, S. and Pollock, A.M. (1998) 'How to profile the population's use of health care and social care in one district', *Journal of Public Health Medicine*, 20 (2), pp.175-9.
- Godden, S, Pollock, A. and Pheby, D. (2002) 'Editorial', *British Medical Journal*, 320, 265.
- Goldacre, M., Kurina, L., Yeates, D., Seagroatte, V. and Gill, L. (2000) 'Use of large medical databases to study associations between diseases', *Quarterly Journal of Medicine* 93,10, 669-75.
- Gomez, E.G. (2002) 'Gender, equity and access to health services: an empirical approximation', *Pan American Journal of Public Health*, 11 (5-6), pp.327-334.
- Gregory, J., Hodgetts, A. and McBrien, J. (2003) 'Offending and risky behaviour in community services for people with

- intellectual disabilities in one Local Authority', *Journal of Forensic Psychiatry and Psychology*; 14 (2), pp. 280-297.
- Greig, R. and Poxton, R. (2001) 'From Joint Commissioning to Partnership working: will the new policy framework make a difference?' *Managing Community Care*, 9 Aug, 32-38.
- Hellman, E.A. and Stewart, C. (1996) 'Social support and the elderly client', *Home Healthcare Nurse*, 12 (5), pp.51-60.
- Horner, N. (2003) *What is social work ? Context and Perspectives*, Exeter, Learning Matters.
- Keene, J., Bailey, S.E., Swift, L. and Janacek, G. (2000) 'The Tracking Project: a collaborative multi-agency database to inform inter-professional policy with shared clients/patients', *Journal of Interprofessional Care*, 14 (4), pp.325- 336.
- Keene, J. (2001) *Clients with Complex Needs: Interprofessional Practice*, Oxford, Blackwell Science.
- Keene, J., Swift, L., Bailey, S. and Janacek, G. (2001) 'Shared patients: multiple social and health care contact', *Health and Social Care*, 9 (4), pp. 205-214.
- Kelly, D., McCulloch, A. and Willis, M. (2003) 'Take your partners', *Community Care*, 1490 (24), pp.42-43.
- Levin, E., Davey, B., Iliffe, S. and Kharicha, K. (2002) 'Research across the social and primary health care interface: methodological issues and problems' *Research Policy and Planning* 20(3), 17-29
- McLeod, E. and Bywaters, P. (2000a) *Social Work, Health and Equality*, London, Routledge.
- McLeod, E. and Bywaters, P. (2000b) 'Tackling inequalities in physical health: a new objective for social work', *British Journal of Social Work*, 29 (4), pp. 547-566.
- McLeod, E., Bywaters, P. and Cooke, M. (2003) 'Social Work in Accident and Emergency Departments: A Better Deal for Older Patients' Health?', *British Journal of Social Work*, 33 (6) 787-802.
- Salari, N. (2003) 'Partnership boards and generic care workers at centre of services reform', *Community Care*, 1494 (22), 20-21.
- Smith J., and Baltes, M.M. (1998) ' The role of gender in very older age: profiles of functioning and everyday life patterns', *Psychology and Aging*, 13 (4), pp.676-95.
- Standing H. (1997) 'Gender, vulnerability and equality in health sector reform programmes a review', *Health Policy and Planning*, 12 (1), pp.1-18.

Table 1: Age and gender profiles for total Social Services population within a Health Authority area.

	Female	Male	16-24yrs	25-65yrs	>65
Health Authority N= 646,239	331,585 51.3%	312,941 48.4%	78,982 12.2%	418,984 64.8%	148,273 22.9%
Social Services N = 19,461	11,767 60.5%	7,605 39.1%	710 3.6%	6,726 34.6%	12,025 61.8%

The Social Services population was co-terminus with the Health Authority. This enables comparison of the two care populations.

Table 2: Combined Age and Gender profiles.

	Female 16-24	Female 25-65	Female >65	Male 16-24	Male 25-65	Male >65
Health Authority N= 46,239	38,963 6.0%	208,452 32.3%	84,170 13%	39,843 6.2%	209,605 32.4%	63,493 9.8%
Social Services N = 19,461	353 1.8%	3,551 18.2%	7,863 40.4%	356 1.8%	3,144 16.2%	4,105 21.1%

In some instances the overall figures including gender are lower, because, while there were no missing cases for age, there were some missing cases for gender.

Table 3: Age and gender difference in type of problem

	Total	Mental health	Drug Alc.	Physic ill	Physic disab.	learnin g disab.	Elder Care
Total	19,461	3,623 18.6%	235 1.2%	405 2.12%	4,871 25.0%	531 2.7%	9,402 48.3%
Femal	11,767	2,063 17.5%	57 0.5%	230 2.0%	2,695 22.9%	238 2.0%	6,369 54.1%
Male	7,605	1,549 20.4%	176 2.3%	173 2.3%	2,151 28.3%	291 3.8%	2,987 39.3%
16-24	710	387 54.5%	46 6.5%	15 2.1%	81 11.4%	124 17.5%	6 0.8%
25-65	6,726	2,778 41.3%	182 2.7%	291 4.3%	2,408 35.8%	384 5.7%	262 3.9%
>65	12,025	458 3.8%	7 0.1%	99 0.8%	2,382 19.8%	23 0.2%	9,134 76.0%

Table 4: Combined age and gender profiles for type of problem

	Total	menta l health	Drug / alcoh ol	Physic ally ill	Physic al disabil ity	Lear ning disab ility	Elderl y Care
Total	19,461	3,623 18.6%	235 1.2%	405 2.12%	4,871 25.0%	531 2.7%	9,402 48.3%
Fema 16-24	353	205 58.1%	17 4.8%	9 2.5%	35 9.9%	531 2.7%	4 1.1%
Fema 25-65	3,551	1,541 43.4%	39 1.1%	156 4.4%	1,294 36.4%	238 2.0%	141 4.1%
Fema >65	7,863	317 4.0%	1 0.0%	65 0.8%	1,366 17.4%	291 3.8%	6,219 79.1%
Male 16-24	356	182 51.1%	29 8.1%	6 1.7%	45 12.6%	124 17.5 %	2 0.6%
Male 25-65	3,144	1,226 39.0%	141 4.5%	134 4.3%	1,102 35.1%	384 5.7%	114 3.6%
Male > 65	4,105	141 3.4%	6 0.1%	33 0.8%	1,004 24.5%	23 0.2%	2,871 69.9%

NB. it can be seen that there is a small amount of error in the dataset as 6 young people are recorded as receiving elderly care.

Table 5: Shared populations with other agencies

	Social services	mental health	Comm Health	A&E	Drug agency	Alc agency	Housing	NS	CJS
% tage of Health Authority	19,461 3.01%	19,029 2.94%	82,751 12.8%	69,651 10.78 %	1,206 0.19 %	1,476 0.23 %	9,833 1.52 %	121 0.02 %	18,461 2.86 %
% tage of Social Services		3,626 18.63 %	8,179 42.03 %	4,162 21.39 %	193 0.99 %	254 1.31 %	604 3.10 %	48 0.25 %	921 4.73 %

Table 6. Shared populations: Age and gender.

	Social Services	Mental Health	Comm Health	A&E	Drug ag	Alc ag	Housing	NS	CJS
Social Services	19,461	3,626 18.63 %	8,179 42.03 %	4,162 21.39 %	193 0.99 %	254 1.31 %	604 3.10 %	48 0.25 %	921 4.73%
16-24yrs	710	283 39.85 %	171 24.08 %	222 31.27 %	56 7.89 %	16 2.25 %	84 11.83 %	9 1.27 %	187 26.34 %
25-64yrs	6,726	2,223 33.05 %	2,079 30.91 %	1,501 22.32 %	136 2.02 %	231 3.43 %	394 5.86 %	39 0.58 %	702 10.44 %
65 +	12,025	1,120 9.31%	5,929 49.31 %	2,439 20.28 %	1 0.01 %	7 0.06 %	126 1.05 %	0 0.00 %	32 0.27%
Male	7,605	1,492 19.62 %	2,758 36.27 %	1,634 21.49 %	143 1.88 %	159 2.09 %	310 4.08 %	40 0.53 %	697 9.17%
Femal	11,767	2,115 17.97 %	5,359 45.54 %	2,500 21.25 %	48 0.41 %	95 0.81 %	283 2.41 %	7 0.06 %	220 1.87%

Table 7. Shared populations: Assessed need.

	Social Services	Mental Health	Comm Health	A&E	Drug agency	Alc agency	Housing	NS	CJS
Social Services	19,461	3,626 18.63 %	8,179 42.03 %	4,162 21.39 %	193 0.99 %	254 1.31 %	604 3.10%	48 0.25 %	921 4.73 %
Mental Health	3,623	2,376 65.58 %	916 25.28 %	1,081 29.84 %	107 2.95 %	182 5.02 %	308 8.50%	28 0.77 %	601 16.6 %
Drug/ Alcohol	235	96 40.85 %	29 12.34 %	100 42.55 %	93 39.6 %	54 23.0 %	57 24.26 %	24 10.2 %	168 71.5 %
Physical Illness	405	64 15.80 %	161 39.75 %	126 31.11 %	3 0.74 %	16 3.95 %	19 4.69%	4 0.99 %	37 9.14 %
Learning disability	531	18 3.39%	265 49.91 %	71 13.37 %	1 0.19 %	1 0.19 %	19 3.58%	0 0%	17 3.20 %
Physical Disability	4,871	256 5.26%	1,832 37.61 %	713 14.64 %	6 0.12 %	15 0.31 %	83 1.70%	2 0.04 %	74 1.52 %
Elderly Care	9,402	932 9.91%	5,040 53.61 %	2,150 22.87 %	1 0.01 %	9 0.01 %	132 1.4%	1 0.01 %	34 0.36 %