HEALTH CARE SOCIAL WORKERS' EXPERIENCES WITH INTERPROFESSIONAL COLLABORATION

by

April Coffin

B.A. Health Sciences, Simon Fraser University 2012

MAJOR PAPER SUBMITTED IN PARTIAL

FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

In the

School of Social Work and Human Services

UNIVERSITY OF THE FRASER VALLEY

Spring 2022

Approval

Name: **April Coffin**

Degree: **Master of Social Work**

Title: **Health Care Social Workers Roles and Experiences with Interprofessional Collaboration**

Examining Committee:

Lisa Moy, BA, BSW, MSW, PhD, RSW
First Reader
Associate Professor, School of Social Work & Human Services

Jeff Wood BSW, MSW, RSW
Second Reader
LTA Instructor, School of Social Work & Human Services

Curtis Magnuson, BA, BSW, MSW, RSW
Graduate Program Committee Chair
Associate Professor, School of Social Work & Human Services

Approved: April 2022

Abstract

There is an increasing trend towards interprofessional collaborative care models in Canadian health care systems. Social workers bring a unique perspective to the interprofessional team as their purpose, values, and scope of practice substantially differ from other health care professionals. As such, differences in patient care approaches can create barriers to interprofessional team collaboration (Reid, Greaves, & Kirby, 2017). This thematic literature review explores the challenges facing social workers as interprofessional healthcare team members. Using feminist theory as a theoretical framework, themes were identified as barriers to collaboration: lack of role clarity, influence of the medical model environment, education, and organizational structures. The history of neoliberalism and its impact on Canada's health care system was examined to understand how neoliberal ideologies have shaped social work. Further, literature gaps and limitations were highlighted to support future research. Lastly, implications to future social work practice and policy are discussed to strengthen the social work profession and aid in the future success of the interprofessional team approaches to health care delivery.

Table of Contents

HEALTH CARE SOCIAL WORKERS' EXPERIENCES WITH INTERPROFESSIONAL COLLABORATION

Introduction

Substantial evidence supports interprofessional collaboration as the new standard for best practice patient-centred care in health care (Ambrose & Ashcroft, 2016; Ashcroft et al., 2020; Craig et al., 2020; Fraser et al., 2018; Glaser & Suter, 2016; Held et al., 2019; Zerden et al., 2020). As such, there is an increasing trend toward interprofessional collaborative models of care in Canada's health care systems (Ambrose-Miller & Ashcroft, 2016; Ashcroft et al., 2020; Craig et al., 2020). Interprofessional collaborative care involves various health care professionals from different specialties working together to provide care for patients and their families to improve patient health outcomes (Ambrose-Miller & Ashcroft, 2016). Most interprofessional health teams are made up of professionals whose practice aligns with the medical paradigm, which prioritizes physical health outcomes (Braedley, 2012). Social workers, however, play a critical role in supporting patients outside of their physical health needs.

According to the British Columbia College of Social Workers (BCCSW) (2022), social work scope of practice focuses on "assessment, diagnosis, treatment and evaluation of individual, interpersonal and societal issues through the use of social work knowledge, skills, interventions and strategies, to assist individuals, couples, families, groups, organizations and communities to achieve optimum psychological and social functioning." (para 1). In other words, social workers prioritize the relationship between individuals and their environment outside of their medical issues to help restore wellness. According to Canadian Association of Social Workers (CASW), social work values patients' right to autonomy and self-determination and helps people make informed choices (2005). As a result of this scope of practice, social workers' values and approaches to patient care may substantially differ from the interprofessional team.

As collaborative care models become more prevalent, it is more critical to understand the complexities of interdisciplinary collaboration so that social workers can become even more skillful and effective collaborators (Abramson & Mizrahi, 2008). Therefore, this literature review identifies the functions of social workers on interprofessional teams and examines the following research question: given social workers' purpose, values, and scope of practice differ from other health professionals, what are the roles and challenges that social workers face when collaborating with interprofessional health care teams? With a better understanding of the interprofessional team dynamics, social workers can optimize opportunities for interprofessional collaboration.

My Social Positioning

Positionality refers to one's social location and worldview, and our positionality influences how one responds to power differentials in various environments (Warf, 2010). It is important to acknowledge that my positionality affects how I approach, analyze, and interpret the research in this literature review. I also recognize that my positionality is fluid and subjective to my interpretation of my social identity and sense of self. From a feminist theory standpoint, social positioning refers to how one occupies societal groups such as class, gender, race, ethnicity, age, and sexual orientation within the context of oppressive power relations (Harding, 2009). I am a white, English-speaking, cisgender female born and raised in Canada. I position myself within identities of privilege and marginalization. My whiteness, citizenship and dominant language have granted me privileges that have helped me pursue and succeed in higher-level education.

I am a Master of Social Work Student. As a student, my confidence in my professional identity is still developing. I rely on other health professionals with whom I have significant

experience and strong opinions when collaborating on patient care. When disagreements arise, I am quick to question my professional judgement. I also feel silenced and, at times, powerless as a woman in a patriarchal society. My ability to speak up, participate as an equal, and advocate among an interdisciplinary team is met with expected sex-role norms and oppressive social structures that suppress my voice. I find myself fighting against my inner voice that tells me to be 'agreeable' among interdisciplinary teams; I second guess my clinical impression if it does not align with hospital objectives or teams' recommendations. I acknowledge that these thoughts are perpetuated by my upbringing and societal gender norms, which I am working on undoing every day. I also acknowledge that my identity as a social worker aligns me within a Canadian history where social workers took part in the racism and discrimination experienced by Indigenous peoples of Canada. I carry this identity and recognize this history can influence how others engage with me, particularly Indigenous people.

Due to the history of discrimination faced by the health care system, I am particularly attentive to patients who identify as Indigenous. I consciously hold more space and time for Indigenous patients to promote more equity in health care and further steps towards reconciliation. With that said, I acknowledge that I am cautious that I may be met with mistrust when working with Indigenous patients. This assumption is derived from the history of social workers' involvement in cultural assimilation that has led to the overrepresentation of children in the foster care system. I acknowledge that the health care system continues to be systemically racist towards Indigenous individuals and other marginalized groups, and I feel strongly that the most appropriate response is to restructure the entire system. My biases are entrenched in how I interpret the literature and are reflected in my implications for policy change.

Methodology

The theoretical framework of feminism was used to understand the lens through which I interpreted the literature. A brief overview of feminist theory was chosen to acknowledge how neoliberalism has aided the emerging literature themes. Research methods are also outlined to demonstrate the focal point of the literature within a Canadian context.

Theoretical Framework

Although there is no universal feminist theory, historically and currently, feminist theory has been critiqued for downplaying women's experiences who face multiple forms of oppression. It is no surprise that women dominate the social worker field in most societies, both as clients of a social worker and social work professionals (Payne, 2014). It is not in the scope of this paper to review or critique the different traditions of feminist theory. Instead, I intend to give a broad overview of my understanding of feminist theory and its response to neoliberalism.

Though feminist theories have evolved, they are united by believing that all "women should have equal access to all forms of power" (Turner & Maschi, 2015, p.152). Feminists believe that political, economic, and social power relations have made women inferior (Turner & Maschi, 2015). More specifically, my perspective of feminism favours principles of radical feminism, which characterizes society as patriarchal (Saulnier, 2000). Patriarchy is described as a system of organizations, institutions, and daily practices that "privileges men through political manipulation of individual identity, social interactions, and organizational structural systems of power" (Saulnier, 2000, p.20). Radical feminism believes women's injustice experiences are political issues grounded in an imbalance of power between men, adopting the term "the personal is political" (Saulnier, 2000).

Regarding foundational principles of feminist theory, Teater (2010) suggested four shared commonalities in feminist social work practice that examine the link between gender and power. This included ending patriarchy, raising consciousness about how social structures establish gender inequities, empowering women, and understanding people in their environment. Campbell (2014) coined the term ‘neo-patriarchy’ to demonstrate how patriarchy is entangled with neoliberalism. In other words, the inequality between genders was fueled by the expansion of the global market economy when the government shifted their responsibility from the welfare state to individual responsibility of health. Campbell states that neoliberalism created a new form of institutional gender hierarchy through the “gendered division of labour, the allocation of unpaid care work to women, and the application of both structural and physical violence” (as cited in Gregor, 2018, para 1). As men continue to hold and maintain a majority of the power, social inequalities are reinforced and maintained by a capitalist society.

Feminist theory reveals the influences of neoliberalism and political structures embedded in the literature themes by drawing attention to the detrimental effects on gender equality (Elomäki & Kantola, 2018). I hope to draw attention to how power dynamics reinforce social roles and demonstrate how patriarchal structures perpetuate social workers' challenges to interprofessional collaboration. Using feminist theory to promote consciousness-raising encourages readers to reframe the idea that the ‘personal is political.’ Only when these relationships are identified and understood can steps be taken to make transformational changes.

Research Methods

This thematic review was developed by utilizing the University of Fraser Valley's EBSCO database. Key terms that were entered include "social worker in health care," "interprofessional team," "neoliberalism," "medical model," "interprofessional education,"

"barriers to practice," "hospital social work," "collaborative care," "health care policy," "social work leadership," "role of a social worker," "social work conflicting values," "social workers in health care," "feminist theory in social work," "Canadian health care" and "history of social work."

The literature reviewed predominantly accessed Canadian research conducted during 2012- 2021. In order to complete a thorough review of the literature, a 10-year timeline was chosen as the majority of the research fell within this timeframe. Some studies in Britain, Australia, and the United States were included as they demonstrated similar Canadian trends of interdisciplinary health care and the role of social workers (Ashcroft et al., 2018). It is, however, essential to note that these countries have different social, political and policy differences than Canada. The research was filtered by the relevance of the topic and publication dates. While the majority of the research authors reviewed had a disciplinary background in social work, additional authors included were situated within the disciplines of public policy and education.

Of the articles available, sixty-four articles were reviewed in depth. Articles' research methods were varied, including qualitative, quantitative, literature reviews, and mixed qualitative and quantitative research methods. In order to capture more research about the ways that social work has developed over the past two decades, I then expanded the search to include a broader timeline between 2000- 2009.

The literature that was selected is peer-reviewed and was retrieved from a range of journal databases, including *International Health Care System Profiles:* Canada, *Health and Social Work, Canadian Medical Association Journal, Social Work in Health Care, The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, Canadian Woman Studies, Canadian Association of Social Workers, Soundings, Journal of Interprofessional Education and*

Practice, Research on Social Work Practice, International Journal of Arts & Sciences, Social Work Master's Clinical Research Papers, Healthcare (Basel, Switzerland), Journal of the Society for Social Work and Research, British Journal of Social Work, The Journal of Contemporary Social Services, Hypatia, Journal of Social Work Education, Social Work Education, Journal of Interprofessional Care, Social Service Review, International Journal of Consumer Studies, Health & Social Work, JAMA internal medicine, American Journal of Public Health, Journal of Economic Issues, Journal of Interprofessional Education & Practice, Social Work, Healthcare Policy | Politiques De Santé, Journal of Social Work Practice, BMC Palliative Care, Health Sociology Review.

Academic peer-reviewed articles were used as they are accepted by most researchers as credible, evidence-based and valid. Social work theory and research books were used to guide my theoretical understanding and methodological approach. Historical books in social work, neoliberalism, feminism, and health care were also used to provide background context.

Context and Background

To understand the themes identified in this literature review, a contextual overview of influential historical factors must first be explored. More specifically, this section focuses on broader ideological, political and policy contexts related to the topic of healthcare social work roles.

The Influence of Neoliberalism

Canada's health care system has been shaped by neoliberal world views (Spolander et al., 2014). Neoliberalism encompasses two ideas: 'neo,' meaning new and 'liberal', meaning free from government involvement (McGregor, 2000). Neoliberal ideology began gaining acceptance

in Canada during the economic crisis of the mid-1970s, which Mullaly and Dupre (2019) describe as a shift to ‘welfare capitalism’ with the “belief that a welfare state could exist within capitalism” (p. 31). However, the dominant discourse in capitalism reflects “individualism, a minimal welfare state, and meeting corporate interests” (Mullaly & Dupre, 2019, p.33). This shift prioritized debt reduction through increasing deregulation and promoting private enterprises, reducing the government's accountability for the welfare state and human wellbeing (Donnan, 2014; Harvey, 2010). As such, Canada became a wealthier country but at the expense of the wellbeing of its people (Christianto, 2018). Mullaly and Dupre (2019) argue that capitalism, which upholds neoliberal ideologies, re-emphasizes the “historically disadvantaged groups such as women, and racialized individuals” (p.29). The three principles of neoliberal ideologies are individualism, privatization and deregulation, and decentralization.

Neoliberal Individualism

The individualistic philosophy of neoliberalism believes that “human beings will always favour themselves” and individualism trumps collective concern for others (McGregor, 2001, p.83). Within this, there is no need for government interference to ensure fair distribution of wealth or resources (McGregor, 2001). Individualist values promote health as a personal responsibility that blames the individual for ill health (Strier, 2019). Individualist views those who need to access health care as a "drain on the system" (Power & Polzer, 2016). As such, social work is seen as a profession of lesser value, as the "poorest people in society should find their own solutions" to their problems (McGregor, 2001).

Neoliberal Privatization and Deregulation

Neoliberal ideology believes that health care must be deregulated and privatized (Harvey, 2005). Privatization involves removing government-controlled services and shifting responsibility to for-profit businesses. Deregulation involves removing or reforming laws that previously enabled government control.

Privatization and deregulation shift power from government to for-profit corporations and private entities. Healy and Meagler (2004) note a universal trend in Canada of deregulation in the social service sector, having less control over standardizing areas of wellbeing such as wages, working conditions, and health benefits. This can be problematic for social workers as most social services are government-controlled and funded (Healy & Meagler, 2004). Whiteside (2011) points out that between 1980 and 1990—the years that marked a significant shift to neoliberalism—Canada cut spending on health care despite the total health care costs rising by forty billion dollars. As a result, the health care system compromised the quality of care, including staff shortage and overcrowded hospitals.

Neoliberal Decentralization

Decentralization is defined as the "transfer of power arrangements and accountability system from one level of government to another" (McGregor, 2001, p. 86). The principle behind decentralization is distributing power, responsibility, and accountability from federal and provincial levels to municipal or regional local governments to improve efficiency. According to the World Bank, however, decentralization is shown to have little success in areas related to health care as smaller governments do not have the money or ability to offer the same quality of health care service (1997). Canada is no exception, as the federal government has progressively decreased its funding to provinces. The impact of budget cuts has resulted in an increasingly

unstainable health care system. Quality of care suffers as the costs of the hospitals continue to rise (Strier, 2019). As a result, the government responded by laying off staff, increasing overcrowding and wait times in hospitals. (McBride, 2005; Strier, 2019). Therefore, private health care becomes suddenly more appealing and supported by those who can afford it, thereby reinforcing neoliberal ideologies within society. However, a two-tier health care system goes against the principle of the Canada Health Act and the enshrined concept of what constitutes "universal" (Lee, 2021).

The rise of neoliberalism has had a profound impact on social workers through organizational structural demands in health care and the promotion of individualism. As such, the influence of neoliberalism has made it challenging for social workers to practice, particularly in health care. I hope that by drawing attention to neoliberalism, its influence among the literature themes will be more apparent, thus providing a more profound illustration of its systemic impact.

Health Care in Canada

Canada's publicly funded health care system called "Medicare" was passed in federal legislation in 1957 and 1966 (Government of Canada, 2019). In 1984, the *Canada Health Act* replaced and strengthened the two previous acts and "set national standards for medically necessary hospital, diagnostic, and physician services" *(*Allin et al., 2020, para 2). The Canada Health Act is an important document that has helped shape the consensus about health care as a universal right rather than a privilege in Canada and has protected against privatization (Spithoven, 2011).

Each province and territory delivers health care through funding that is transferred from the federal government. To receive the funding, provinces and territories' health insurance plans must

meet five criteria established in the Canada Health Act (Government of Canada, 2019). This method of service delivery has heavily relied on the federal government for adequate and equal distribution. According to the Government of Canada (2019), the five criteria include:

> Non-profit public administration of provincial and territorial plans; comprehensiveness in the delivery of all medically necessary services; uniform coverage of all insured persons under the rubric of universality; the guarantee of accessibility to necessary hospital and physician services without financial or other barriers; and portability of insurance across provinces and territories, with some limits on services provided outside the country.

Since the late 1970s, the Canadian government has shifted its priorities towards neoliberal principles of individualism, privatization and deregulation, and decentralization, while hoping that a globalized free market would boost Canada's economy (McGregor, 2001). Compared to other high-income countries, Canada scores relatively low on health care delivery (Schneider, 2021). The Commonwealth Fund report card on health in 2021 revealed that Canada scored 10th out of 11, just in front of the United Stated when comparing access to "care, care process, administrative efficiency, equity, and health care outcomes" (Schneider, 2021, p. 2). This statistic reveals that neoliberalism affects not only social workers' but everyone working and accessing the health care system.

Medical Model in Canada

The American Psychology Association (2022) defined the medical model as "the concept that mental and emotional problems are analogous to biological problems—that is, they have detectable, specific, physiological causes and are amenable to cure or improvement by specific treatment." (para. 1). Canada's health care system operational values strategically align with concepts of the medical model. The medical model guides most health care professionals in their

practice as their primary focus is on correcting disease and restoring patients' functioning. In the hospital, patients' health is led by physicians with a focus on disease management. As previously mentioned, social workers' scope of practice focuses more holistically on patient health; therefore, they are faced with working in a medically driven system that does not prioritize their scope of practice.

The medical model still carries much weight despite long-term criticisms. For example, Engel (1977) critiqued the medical model because it "leaves no room within its framework for the social, psychological, and behavioural dimensions of illness" (Farre & Rapley, 2017, p. 2). Engel (1977) states:

> the existing biomedical model does not suffice. To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he [sic] lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model (p. 132, as cited from Farre & Rapley, 2017).

Although Canada's health care system traditionally operates within the principles of the medical model, there has been a shift in the last decade towards a more collaborative approach to health care delivery (Zimmerman & Dabelko, 2007). The government recognizes the need for a more holistic approach to health care to address complex patients who are overutilizing the 'system' through readmission or extended hospital stays. This new approach involves interprofessional health care teams.

Interprofessional Teams

Interprofessional collaboration is essential for effective patient care and organization survival (Mizrahi & Abramson, 2000). The Canadian Interprofessional Health Collaborative [CIHC] (2010) defines interprofessional collaboration as "a partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues" (p. 11). The terms interdisciplinary and interprofessional were frequently throughout the literature when discussing health care collaboration. As such, I will use the term interchangeably throughout this paper. Interdisciplinary or interprofessional teams can be made up of various health professionals, but most commonly include nurses, physicians, pharmacists, dieticians, psychiatrists, psychologists, occupational therapists, physiotherapists, and social workers (Zerden et al., 2019). These health professionals work alongside patients, families and communities in reciprocity, equality, coordination, and shared decision towards a common goal (Ambrose-Miller & Ashcroft, 2016). Interprofessional teams come together in coordinated efforts such as in daily rounds and case conferences to provide an opportunity for professionals to support one another and share their individual expertise to solve problems (Glaser & Suter, 2016). The purpose of interprofessional collaboration is to demonstrate patient-centred care and improve the patient's health outcomes more efficiently and comprehensively (CIHC, 2010; Glaser & Suter, 2016). According to Held et al. (2019), effective interprofessional collaboration requires strong communication skills and a solid working relationship built on trust and mutual respect.

The Evolution of Social Work in Canada

The social work profession originated from Christian charity work over a decade ago (Bryson & Bosma, 2018). Early on, charity organizations focused on helping primarily on

helping people at an individual level (Jennissen & Lundy, 2012). The demand for social work increased with the emergence of urban-industrial capitalism and immigration (Jennissen & Lundy, 2012). As poverty, social dislocation, and population health issues rose, social workers began to recognize the need for more extensive societal changes beyond the individual (Jennissen & Lundy, 2012).

Social workers first appeared in hospitals in America in the 1920s to focus on the social side of illness, such as family coping, maternal and child health, and poverty (Ruth et al., 2017). Physicians and nurses who controlled the hospitals were initially resistant to the need for social workers until the positive impact of social services became more apparent (Ruth et al., 2017). It is reasonable to assume the Canadian history of hospital social work is similar as the evolution of social work was heavily influenced by American philosophy (Bryson & Bosma, 2018; Mullay, 2019).

In the early 1920s, social work curricula were taught throughout Canadian Universities and relied on American social work influence to build the profession (Bryson & Bosma, 2018; Jennissen & Lundy, 2012). The profession separated from American social work in 1926 when the first Canadian social worker organization, the Canadian Association of Social Workers (CASW), was formed. The purpose of CASW is to promote social work and advance social justice, specifically within a Canadian context (CASW, 2014). The core CASW social work values and principles include: “respect for the inherent dignity and worth of persons, pursuit of social justice, service to humanity, integrity, confidentiality, and competence in professional practice” (CASW, 2005, para. 7).

Social work in Canada evolved with the rise of capitalism and was heavily influenced by American ideology that promoted neoliberalism (Mullaly & Dupre, 2019). The continued push to

adopt neoliberal ideologies has strained Canada's health care and social welfare system (Mullaly & Dupre, 2019). Mullaly and Dupre (2019) argue that:

> rather than challenging inequality or the capitalist system, which is based on inequality, social work in Canada has historically favoured large-scale government programs to compensate for the chronic and acute ills of an industrial liberal society and to ameliorate the reluctant suffering (p.116).

Therefore, social workers in Canada are forced into prioritizing inefficiency to meet the demands of health care and social services organizations structured after management models and institutional values (Mullaly & Dupre, 2019). As evident in the literature review findings, health care social workers continue to practice in a system and a team with differing health management priorities. As the following section explores, research demonstrates that social workers face organizational structural barriers and conflicting values, making it more challenging for interprofessional collaboration.

Findings

Roles of social workers on collaborative interprofessional teams

The literature argues that a social worker's role in the hospital is challenging to define (Ambrose-Millet & Ashcroft, 2016; Ashcroft et al., 2018; Hennan & Birrell, 2019). Hennan & Birrell (2019) broadly defined health care social workers as those who assess patients' health and social care needs and support the patients' families. Praglin (2007) describes the purpose of social workers in health: "[social workers] work collaboratively as part of interprofessional teams to support recovery, to promote quality of life in the context of chronic illness and disability, and to advocate for societal change to address social disadvantages" (as cited in Craig & Muskat, 2013, p.7). However, the specific roles social workers have on interprofessional

teams vary depending on the area of employment and specialty. Unfortunately, social workers' multifaceted and varying functions have contributed to barriers experienced by social workers on interprofessional teams. These barriers are grouped into four themes: role clarity, medical model environment, education, and organizational structure.

The literature describes social work functions as multifaceted, fulfilling many roles across the fields of health (Muskat, Craig, & Mathai, 2017; Stanhope et al., 2015). For example, Craig and Muskat (2013) interviewed hospital social workers who described their roles as bouncers, janitors, glue, brokers, firefighters, jugglers, and challengers. The authors used these themes to describe the multifaceted role social workers have in health care settings. The authors' analogy aligns with other studies identifying social workers' role as a balancing act, with no template or one-size-fits-all approach (Glaser & Suter, 2016; Hennan & Birrell, 2019).

Marsh and Bunn (2018) point out that the distinctive contribution made by social workers is their commitment to social justice and focus on the person-in-environment. Glaser and Suter (2016) note that unlike the medical model, which focuses on physical illness, social workers assess the whole person's needs in their environment using a bio-psycho-social approach. Therefore, patients may have several barriers which require social work engagement across multiple disciplines. Unlike nurses and physicians, social workers support patients beyond their physical or mental ailment by examining social barriers within their environment that impact their wellbeing. Rocco (2017) noted that social workers are unique in "that they focus on relationships as the basis of their interventions and are experts in providing services not only to the client, but also to their families" (para. 8). Jennissen and Lundy (2012) also point out that social work is the only profession in which human rights and social and economic justice are integral to its code of ethics and practice.

Fraser and colleagues (2018) found that social workers have three main functions or specializations within an interdisciplinary team, which include "behavioural health intervention, care management, and community engagement or patient referral" (p. 193). Behavioural health specialists typically focus on the "assessment and treatment of mental health and substance use problems" (p.194). Fraser et al. (2018) also found that “behavioural health specialists used standardized assessment tools and assisted in initial diagnostic evaluations" (p.194). Tadic et al. (2020) also highlighted the significant contribution social workers have on mental health services finding that 84.7 % of social workers delivered or supported mental healthcare services in Ontario.

Social workers are placed in care manager roles when social determinants of health play a significant role in the care plan of a patient. The Government of Canada (2022) defines social determinants of health as:

> A specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians (para. 4).

The main determinants of health include “income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviours, access to health services, biology and genetic endowment, gender, culture and race" (Government of Canada, 2020, para. 3).

Fraser et al. (2018) found that several studies highlighted social workers using standardized and functional assessments in care manager roles to evaluate patients' engagement,

barriers with SDH and treatment adherence. Craig et al. (2016) also connected care manager roles with the social determinates of health (SDH), noting that addressing SDH leads to improved treatment compliance and better health outcomes. Similarly, Andermann (2016) found that a social worker's role in addressing SDH was vital for patient recovery.

Social workers are also system navigation experts, including service linkage and coordination of community supports for patients who need community-based services (Teater, 2014). Fraser et al. (2018) found that social workers connected patients to resources outside the medical system to help address SDH barriers. Similarly, Ashcroft et al. (2018) surveyed 154 social workers working in primary care among interdisciplinary teams and found that 84% frequently complete community referrals. Many other studies had similar findings noting that social workers have in-depth knowledge of community resources that support patients navigating the welfare system, housing, mental health and addictions resources, and treatment options (Béland et al., 2006, Geron et al., 2005; Heenan & Birrell, 2019;). By educating and connecting patients to community services, social workers equip patients with the knowledge and support needed to reduce the rate of readmissions (Pannick et al., 2015).

Lastly, many studies cited crisis intervention and managing complex family dynamics as critical for social workers (Hennan & Birrell, 2019; Rizzo et al., 2000). Often, social workers support patients and their families by communicating and advocating their needs to the rest of the health care team. Hennan and Birrell (2019) found that "older patients were frightened by the decision-making process and were frequently given conflicting information and advice" (p.1747). They found that social workers ensured that patients were “fully informed and empowered to make decisions” (Hennan & Birrell. 2019, p.1747). Social workers also coordinated family meetings, supported advanced care and discharge planning, and provided

ongoing supportive counselling (Chong-Wen Wang et al., 2018). By ensuring the patient's wishes are clarified and respected, services can be consistent with the patient's priorities and aid interdisciplinary team functioning and efficiency.

Collaboration Challenges Faced by Social Workers on Interprofessional Teams

This section examines the literature on health care social workers' experiences with interprofessional collaboration within a Canadian context. I identified four themes that were common barriers for social workers to participate in interprofessional collaboration. These themes were broken into four sections: role clarity, medical model environment, interprofessional training, and an organizational structure.

Theme One: Role Clarity

The first social worker interprofessional collaboration barrier theme that emerged in the literature was role clarity. Confusion about a social worker's role among an interprofessional team was the most prevalent challenge social workers identified (Ambrose-Miller & Ashcroft; 2016; Gregorian, 2005; Zerden et al., 2019). Ambrose-Miller and Ashcroft (2016) found that "challenges arise when social workers take part in interprofessional teams without a clear understanding of their role and the roles of their interprofessional colleagues" (p.107). Glaser and Suter (2016) also found that only one of nine social workers felt that other interprofessional team members understood their role. Zerden et al. (2019) also noted that role ambiguity among social workers increased the difficulty for other interprofessional team members to understand the boundaries of the social work role. Several studies have found that physicians and nurses were most often identified as the professions which do not fully understand the roles of social workers (Glaser & Suter, 2016; Mizrahi & Abramson, 2008; Netting & Williams, 2000). More

specifically, Auerbach et al. (2008) found that members of the interprofessional team could not distinguish the difference between the scope of social workers and that of nurses.

Unclear roles can create conflict and inefficiencies among the interprofessional team. Social workers can find themselves duplicating services with other health professionals and are given "tasks without consideration," such as administrative paperwork, which are outside their duties and obligations (Glaser & Suter, 2016; Zerden et al., 2019).

Judd and Sheffield (2010) found that the lack of clear roles can create tension and competition among social workers and nurses when addressing psychosocial barriers for patients. However, not all research uncovered conflict between disciplines. Keefe et al. (2009) interviewed nurses, physicians, and social workers and found no role confusion or overlap concerns. However, within this study, social workers were seen as separate from the medical team and labelled as 'gap-fillers,' meaning their primary role was to support nurses and physicians and enhance the ability of these other professions to provide care. It appears that other health professionals perceive less conflict and overlap only when social workers' are not viewed as equal members of the interprofessional team.

Role Clarity: Role Negotiation

Ambrose-Miller and Ashcroft (2016) and Fraser et al. (2018) found that if social workers do not have a firm grasp of their roles, their roles will be dictated by other interprofessional health care team members. Social workers also face pressures to adapt their roles to align with the agency's goals (Hugman, 2009). For example, Craig et al. (2020) interviewed social workers who were given additional administrative duties, fixed communication breakdowns and filled the gaps within the team.

Similarly, Ashcroft et al. (2018) surveyed social workers and found that 24% of respondents were asked to “perform duties beyond their scope of practice” (p.113). Some examples include "relaying medical results," "dispensing medication," and "providing specialized therapeutic modalities" (p.112). Taking on additional tasks can be problematic for both workloads and the profession itself. For example, Zerden et al. (2019) found that "44% of social workers felt that their caseloads were too large to carry with their expanded roles" (p.5). With inappropriate tasks added to their workload, social workers have even less chance to perform the duties within their scope of practice. Therefore, role confusion can contribute to inefficient practices and suboptimal functioning within the interprofessional team (Zerden et al., 2019). Also, performing duties outside one's expertise can put patient care at risk and jeopardize the professional of social work. Social workers who practice outside of their scope are at risk of losing their job and licence and may be subject to an investigation under the Social Work College for their professional conduct (British Columbia College of Social Workers, 2021).

Social workers are expected to transition between the multifaced roles seamlessly. This balancing act in some studies is viewed as an asset, improving productivity and providing a holistic approach to care; despite the challenge that role ambiguity causes, Zerden et al. (2019) found that social workers enjoy having flexibility in their role. Ambrose-Miller and Ashcroft (2016) also acknowledged that social workers identified that flexibility was essential to adapt to the changing context and meet the team's needs. Heenan and Birrell (2019) described flexibility and creativity as crucial skills identified by social workers. Therefore, it appears that it is not the flexibility of the role that causes challenges but the lack of knowledge regarding boundaries that pertain to the role. Hendrix et al. (2021), Oliver (2013) and Heenan and Birrell (2019) qualitative

interviews among social workers all acknowledged that boundaries were beneficial for social workers but challenging to maintain due to the nature of their work.

Role Clarity: Professional Identity

Social workers feel like an 'outsider' within the interprofessional team and believe that their professional approach is not always respected (Craig et al., 2013; Glaser & Suter, 2016). Glaser and Suter (2016) found that health care professionals held disrespectful attitudes against social workers, which is linked to a lack of understanding of the role. The authors report that social works bring a unique perspective to the role that may not be valued compared to other health professionals with similar professional lenses. Apart from social workers' professional duties, social workers feel they must constantly 'prove' themselves that they belong on the interprofessional team (Glaser & Suter, 2016). Oliver (2013) cautioned that social workers' professional identity is at risk if they do not demonstrate competence and confidence in contributing to the team. Gregorian (2005) suggests that social workers need to "seize opportunities to demonstrate their value and versatility by taking on difficult situations, be they individual cases or systems issues" (p.9). No literature was found that reports other health professionals (such as nurses or physicians) having to 'prove' their skillset. Gregorian (2005) encouraged social workers to focus on creating meaningful and positive relationships with other health professionals as these relationships "often determine the status and scope of social work practice within the institution" (p.9). It appears that social workers within these studies felt a preconceived assumption that their coworkers viewed them as less valuable.

The research also suggested that social workers "market" themselves around their role to demonstrate their value. There is a clear consensus that social workers work 'outside' of the system dominated by medically focused health professionals. Another contributing factor that

influences the risk of social workers' professional identity is the ‘invisible nature’ of social work practices. Weich (2000) was one of the few studies that recognized gender as a factor. The author links the invisibility of the role to the history of the suppression of women's voices, stating that "it has been difficult for social work to assert itself in full, robust, uncompromising ways about what it knows and what it can do." (p.396). Wiech (2000) also notes that the assertive view of male-dominated professions constantly questing the validity of social workers' voice suppresses the identity of social workers, a profession predominantly held by women.

Role Clarity: Scope of Practice

The lack of role clarity among social workers also impacts the ability of social workers to demonstrate their full scope of practice. Research has shown that health professionals with differing values and theoretical bases can be a barrier to collaboration (Keefe et al., 2009; Ramgard et al., 2015). For example, Glaser and Ester (2016) found that 75% of social workers felt that their knowledge, skills, and abilities were not fully utilized within a health care team. Social workers report that this was due to limited resources, lack of time, and many tasks that other team members did not fully recognize. Many other researchers have linked underutilization to role clarity issues (Hepp et al.; Shor, 2010;2014; Zerden et al., 2019). Shor (2010) indicates that other team members may indirectly underutilize social workers' contributions as they are unaware of their full scope of practice and knowledge base. Oliver (2013) agreed that social workers often feel like their healthcare team contributions go unrecognized. Unlike social workers, other health professionals' primary function is to improve or monitor a patient's physical health. Biological health indicators are significantly more measurable and 'visible' than the social workers' priorities, such as counselling and addressing specific SDHs. As well, social

work practice often happens out of sight from most of society, which reinforces the lack of understanding of their role among other health professionals (Gordon, 2018).

Social workers' roles as advocates can also create tension among the interprofessional team. Ambrose-Miller and Ashcroft (2016) found that social workers faced criticism from other health care professionals when their advocacy skills brought attention to systemic issues within the health care system. For example, one participant stated, "[What] do hospitals expect when they discharge a client that needs rehabilitation but isn't eligible to receive it, what is our job with advocating for this care when they don't have any funding? When you stand your ground, they often say that's not your job" (p.104). Craig et al. (2020) found that social workers felt that they were put in uncomfortable situations, needing to negotiate the needs of the patients with the needs of the rest of the team. Social workers felt that they had to remind the team that patients and their families were also part of the team, not just those who hold hospital badges (Craig et al., 2020).

Role Clarity: Leadership

Some studies connected a lack of leadership and supervision opportunities for social workers as a barrier to interprofessional collaboration (Ashcroft et al., 2018; Ambrose-Miller & Ashcroft, 2016; Globerman, 2002; Gregorian, 2008, Stadick, 2020; Zerden et al. 2021). In many studies, social workers worked as the sole social worker for their unit or department and expressed a lack of connection with other social workers. Similarly, in their study of social work leadership, Globerman et al. (2002) found that only one out of twelve hospitals had a director of social work. Out of the eleven other hospitals, there were no organizational support systems specifically for social workers to use as guidance or consultation. The author found that the lack

of social work leadership influenced a weak organizational commitment to the profession and reinforced social workers' blurred roles and responsibilities.

In contrast, Bejan et al.'s (2014) interview with social workers across nine provinces found that, on average, 65% of social workers had access to regular clinical supervision. The authors also found that social workers considered their colleagues essential in supporting each other with challenging work environments. It is unknown if this is due to the lack of upper-level leadership opportunities or a testament to building supportive relationships with colleagues.

Theme Two: Medical Model Environment

The second social worker interprofessional collaboration barrier theme that emerged was practice challenges within a medical model environment (Ambrose-Miller and Ashcroft, 2016; Ashcroft et al., 2018; Craig & Muskat, 2013; Gordon, 2018; Oliver, 2013). Social workers found it challenging to collaborate with health care professionals whose educational background is dominated by the ideologies of the medical model; related, social workers also argued that existing hierarchical structures that centre around physicians overtly undermine the social work profession (Belrhiti et al., 2021; Craig & Muskat, 2013; Mizrahi & Abramson, 2008). Despite social workers' advocacy efforts, they have limited power to direct patient care, as physicians make the final decisions regarding patient care plans and discharges.

Craig and Muskat (2013) determined that social workers had to challenge the medical model within the interprofessional team in order to identify and advocate on behalf the patient's needs. One participant described themselves as a 'challenger champion' stating:

> It goes to a point where you have to get into a community action, like social action, because people are not listening, people don't see what you see, or what should be seen, in a way that should be dealt in safe planning, so you have different levels of advocacy, at

> some point you really have to take a stand and say "this is what needs to be done and this is how it needs to be done, and, if it is not, it will be a very unsafe situation for our patients (p.13).

Social workers are faced with finding a balance between the patients' rights to self-determination and respecting the organizational principles to maintain successful collaboration. For example. Ambrose-Miller and Ashcroft (2016) found that if collaborative culture is neglected or met with disagreements, interprofessional teams revert to the traditional medical model as a 'default setting.' Their study revealed that a collaborative culture requires time and a supportive environment to be successful. One participant shared that "it takes the dedicated people to keep it going or else it does backslide . . . if you don't have someone embracing that, it does go back" (p.14). Despite such challenges, Fraser et al.'s (2018) systematic review found that across the 26 studies, 19 studies favoured interprofessional care involving social workers over the traditional medical model.

Medical Model Environment: Physician Centrality

The delivery of health care has been traditionally organized around the expertise of physicians (Ponte et al., 2003, as cited in Hall, 2005). Although the interprofessional team process challenges the authority of a physician's hierarchy, the literature demonstrates that a hierarchy still exists (Ambrose-Miller & Ashcroft, 2016; Craig & Muskat, 2013; Zimmerman & Holly, 2007). Social workers cited in Belrhiti et al. (2021) and Zimmerman and Holly (2007) affirmed that physicians are both at the top of the hierarchy and the primary decision-makers among interprofessional teams. Whitehead (2007) found that the process of health care collaboration reinforces the idea of physician's centrality. For example, Ambrose-Miller and Ashcroft (2016) noted that meetings among team members or families occur around the

physician's schedule. Social workers organize and facilitate these meetings; however, physicians typically direct care decisions. Under the traditional medical model, Zimmerman and Holly (2007) found that patients and their families felt that their opinions were ignored by physicians and felt that physicians directed their health decisions. Social workers are expected to balance the role of an advocate while maintaining a respectful relationship with the interprofessional team.

Research demonstrated that professional hierarchy could significantly impact interdisciplinary team dynamics when patient care perspectives differ. For example, Ambrose-Miller and Ashcroft (2016) found that social workers felt physicians ignored their views related to patient care. Keffe et al. (2009) found that physicians felt reluctant to have social workers among the integrated health care team. Physicians felt that social workers took too much time from their schedule and stated that referrals were made to social work to allow them to move on to the next patient, implying that direct collaboration was not necessary. In contrast, Abramson and Mizrahi's (2003) study found that one-third of physicians expressed an "interdependent orientation to interdisciplinary practice" (p.4), meaning that patient care and decision-making are shared responsibilities within the interprofessional team. In this study, Abramson and Mizrahi (2003) found that physicians' behaviour and attitudes appear to shift paradigms that recognize the benefits of a more professional collaborative environment.

Medical Model Environment: Power Dynamics

In the research, social workers explained that power dynamics perpetrated by a medical model were a primary barrier to interprofessional collaboration (Ambrose-Miller & Ashcroft, 2016; Belrhiti et al., 2021; Heenan & Birrell, 2019; Whitehead, 2007). Whitehead (2007) found that power issues determine the degree to which collaboration occurs within an interdisciplinary

team. Power has been described according to Hardy & Phillips (1998) as those who have “formal authority to make decisions and who controls the resources; and who has less tangible aspects of symbolic power or the ability to control ideas and meaning” (as cited in McDonald et al., 2012, p.2). Hardy and Phillips assert that the distribution of resources determines power dynamics. In health care, tangible and intangible resources are directed through policy processes that the government creates. Martin-Rodriguez et al. (2005) argue that power differentials are also influenced and reinforced by broader social, cultural, and professional systems (as cited in McDonald et al., 2012). Power dynamics stem from the medical model, which embraces professional hierarchies within the health care system (Hendriz & Gringeri, 2021). Historically, among a health care team, physicians are on top of the professional hierarchy of power (McDonald et al., 2012).

Whitehead (2007) also found that power dynamics particularly impacted social workers because they felt that hospital policies valued medical professionals more than social workers. Similarly, Belrhiti et al. (2021) and Nugus et al. (2010) found that social workers experienced power dynamics among daily interprofessional collaboration, which created tension among the health care team, and negatively affected patients' care quality (Belrhiti et al.,2021). Therefore, power dynamics should be considered when implementing collaborative care models, as ignoring power differentials can hinder interprofessional collaboration (Baker et al., 2011).

Power dynamics also negatively impact social workers' communication ability (Ambrose-Miller & Ashcroft, 2016; Heenan & Birrell, 2019). Ambrose-Miller and Ashcroft's (2016) interviews among social workers found that power inequity was demonstrated through the actions and behaviours of their coworkers. For example, social workers explained that physicians would take over meetings, leaving social workers feeling lost and disempowered. As a result,

social workers expressed the need to be "even more diligent with demonstrating worth" within the interprofessional team due to the existing power inequalities (p.107). Similarly, Heenan and Birrell (2019) recognized that power and control were demonstrated by physicians, which inhibited social workers' ability to find and use their voices. Hall (2005) found that physicians are trained to make decisions and take on leadership roles in team settings. Therefore, other interprofessional team members may assume that physicians will take charge and may be reluctant to challenge the pre-existing hierarchy.

Whitehead (2007) found that there are many barriers to engaging physicians in the collaborative processes, including "specific powers, status, professional socialization and decision-making responsibility" (p.1010). Similarly, Reese and Sontag (2001) noted that historically, physicians tend to be authoritarian and focus more on the action and outcome than on relationships. This differs from social work, where value is placed more on patient self-determination and relationship building with patients and their families. Physicians also tend to rely on objective data in the decision-making process instead of social workers who are more likely to work from the patient's story (Hall, 2005).

The impact of power imbalance interferes with competing perspectives on professional values and patient care issues (Abramson & Mizrahi, 2008; Oliver, 2013). Mizrahi and Abramson (2008) found that physicians were less likely than social work to identify patient or family dynamic issues related to illness. More specifically, social workers are more likely than physicians to identify interpersonal and system components of psychosocial factors such as adjustment to illness, hospital system issues, and community resource issues.

Social workers can also internalize these differences in professional values, as Heenan and Birrell (2019) and Stadick (2020) found that social workers are reluctant to speak out against

physicians. Hall (2005) also found that these invisible barriers hinder interprofessional collaboration as unacknowledged tension exists. Therefore, the authors argued that it is important for social workers to feel comfortable sharing their professional perspectives to aid the patient's quality of care.

Research further demonstrates that successful collaboration must also have an environment that values interprofessional reciprocation (Stadick, 2020). Stadick (2020) interviewed various health care professionals who explained that feeling valued stems from mutual trust, respect, and validation regarding one's contributions to the team (Stadick, 2020). Craig et al. (2020) found that these critical factors to successful collaboration take time and must be fostered through relationship building. Many studies, however, note that health care professionals feel like they have less time now than ever to spend with patients and rely on the necessary information from the team (Ambrose-Miller & Ashcroft, 2016, Crag et al., 2020; Glaser & Suter, 2016; Hall; 2005; Heenan & Birrell, 2019).

Theme Three: Interprofessional Training

The third social worker interprofessional collaboration barrier theme that emerged was the educational backgrounds of health care professionals (Hall, 2005; Mizrahi & Abramson, 2008). The Canadian government has recognized the need for improvements in collaboration and has implemented interprofessional training programs in the last decade (Whitehead, 2007). Interprofessional training programmes "bring together students from different health professions to work and learn together, either in a classroom or a clinical setting" (Hall, 2001, as cited in Whitehead, 2007). The goal of interprofessional training is to enhance collaboration between health care professionals" (Whitehead, 2007).

However, the research identifies a gap between educational systems and curriculum and what is expected in practice. Many studies have acknowledged the lack of interprofessional education that health care professionals receive during their formal education (Glaser & Suter, 2016; Hall, 2009; Stadick, 2020; Zerden et al., 2021). Dauphinee and Martin (2000) acknowledge that health care academics are separated into specializations. Current education models for health care professionals are based on separate specialized training that inadequately prepares students for collaboration (Heenan & Birrell, 2019). Zerden et al. (2021), Heenan and Birrell (2019) and Hall (2009) describe academic specialties as 'silos' which limit the opportunities for collaboration outside of one's own profession. Although establishing professional identity and competencies is fundamental, Ramgard et al. (2015) found that solely focusing on "one's own profession in isolation can be problematic, as the perception that professionals have toward the identities of other disciplines can impact whether they are viewed as rivals or as complementary resources" (as cited in Glaser & Suter, 2016, p.405). Hall (2005) points out that "profession-specific worldviews merely prepare individuals to work within their own profession, not to communicate with individuals from another profession" (p.193).

Health care professionals must rely on other skill sets outside of their education to collaborate successfully with other health care professionals. Leipzig et al. (2002) interviewed medical students, nursing students, and Master of Social Work students and found that they have varying ideas on the construct of collaboration. Their study found 80% of medical students believed they had the final word on team decisions and had the right to change a patient’s care plan without consent from the rest of the team. In comparison, only 35-40% of social workers and nursing students agreed with the physicians’ viewpoint within the same study. This study uncovers a need for more interprofessional training for health care students. The authors also

point out the hierarchical and disciplinary model embedded in physicians' education as are key factors to the difference in viewpoints on team cohesion and attitudes in decision-making.

Hall and Weaver (2001) found that conflict resolution skills are not routinely taught in professional schools. Communication skills are also tailored to focus on interacting with patients and families from the perspective of their profession, not amongst other health care employees (Hall, 2005). Social workers specifically found it challenging to communicate with medical professionals due to unfamiliar vocabulary (Hall, 2005; Zerden et al., 2019). Zerden et al. (2019) found that 24% of social workers reported that terminology differences between medical professions made it more challenging to integrate among the team. As a result, social workers felt less confident speaking up in meetings, asking questions, or advocating for patients in team meetings.

There is also a difference between the ways that social workers and medical professionals assess and collaborate. Mizrahi and Abramson (2008) surveyed social workers and physicians on collaboration and found that social workers were much less satisfied than physicians when assessing the success of team collaboration. They found that social workers identified significantly more areas in which collaboration could have improved. Mizrahi and Abramson's (2008) study also revealed that social workers perceived more disagreements with physicians when there are differences in patient care approaches. At the same time, when compared with social workers, physicians were significantly less likely to be critical of themselves when evaluating their contributions to interprofessional collaborations (Mizrahi & Abramson, 2008).

Despite the lack of interprofessional education, research demonstrates that health care professionals believe that such education is beneficial for successful collaboration. Leipzig et al. (2002) surveyed students in medical school, nurses, and social workers and found that

respondents strongly supported an interprofessional approach. Despite disagreements on approaches to collaboration, it is believed to be the best method to optimize patient care (2002). Way et al. (2000) also found that health care professionals found the benefits of sharing knowledge and creative problem solving as a team to influence patient outcomes positively. Zerden et al. (2019) found that interprofessional education and training help better prepare professionals for the realities of team-based care and help meet the holistic needs of patients. Despite there being a consensus that interprofessional collaboration can be helpful for patient care, the research reveals that there is disagreement about the delivery and value of cooperation, particularly among physicians. The research associated this disagreement with two things: the professional hierarchy that places physicians in power; and the lack of attention paid to interprofessional training during the education of health care professionals.

Theme Four: Organizational Structure

The fourth and final barrier to interprofessional collaboration for social workers that emerged was with regards to organizational structures (Ambrose-Miller & Ashcroft, 2016; Auerbach et al., 2007; Craig et al., 2020; Craig & Muskat, 2013; Fraser et al., 2018; Glaser & Esther, 2016; Stadick, 2020; Zerden et al., 2019). Organizational structures are “clinical and administrative systems that guide cooperative practice, as well as the characteristics of the health care facility structure” (Kvarnström, 2008, as cited in Amerbrose-Miller & Ashcroft, 2016). Political processes, such as the government’s influence on neoliberalism, have shaped how health organizations are structured through resource and funding allocations (Hyslop, 2016). Specifically, for social workers, restructuring has led to funding cuts, reduced staff and departments in hospitals (Gou & Company, 2007). As a result, and as discussed in earlier sections, "neoliberal reengineering of social work has transformed the core of the social work

profession and forced it to confront the flared gap between its values and the realities of practice" (Streir, 2019 p.340). Apart from restructuring, social workers are often physically situated apart from the rest of the interdisciplinary team. Organizational structural barriers that were identified in the literature include communication, social work remuneration and resources, and competing values.

Organizational Structure: Communication

Many studies found that communication was a key component to effective collaboration (Ambrose-Miller & Ashcroft, 2016; Auerbach et al., 2007; Craig et al., 2020; Craig & Muskat, 2013; Fraser et al., 2018; Glaser & Esther, 2016; Stadick, 2020). Craig et al. (2020) found that social workers viewed themselves as gatekeepers of information, critical in facilitating patient flow. Social workers obtain information such as family functioning, psychosocial issues and community services and are relied on to share relevant information with the team. The research identified two main structural barriers to communication: the lack of colocation and inaccessible electronic medical records (EMR).

Communication: Colocation

Colocation refers to "various professionals working within the same organizational facility, and likely under the same roof" (Ambrose-Miller & Ashcroft, 2016, p.102). For example, nurses and doctors work closely together in hospitals, having their workplace on the same floor and often the same room. Other interprofessional health care professionals, such as social workers and psychiatrists' offices, are in a different area of the hospital, a different building, or in the community.

Studies found that social workers identified the lack of colocation as a barrier to collaboration (Ambrose-Miller & Ashcroft, 2016); Ashcroft et al., 2018; Zerden et al., 2019).

More specifically, Ashcroft et al. (2018) found social workers reported that a lack of colocation limited their ability to consult team members regarding patient care. Ambrose-Miller and Ashcroft (2016) also found that social workers who were located off-site from the rest of the team experienced challenges with communication. The authors also found that the lack of colocation contributed to inappropriate referrals and lack of knowledge of the social work profession.

Colocation allows health professionals to work closely and increase the opportunity for interprofessional collaboration. Haggarty et al. (2012) specifically found that colocation decreases wait times for patients when healthcare professionals work in a shared site. Ambrose-Miller and Ashcroft (2016) found that colocation allowed nurses and physicians to learn about the daily tasks held by social work, which reduced role clarity barriers. Similarly, Kates et al. (2011) found it is beneficial for social workers to be visible among the team to help promote communication. Keefe (2009) noted,

> for social workers, the need to be visible within the practice, available for consultation, and ability to articulate their potential contribution to the patients' well being at all times, may be necessary for physician and nurse providers to truly understand their roles, and ultimately forming a cohesive collaboration (p.592).

Colocation, however, may not always be feasible due to the lack of office space. Zerden et al. (2019) found that more than 25% of social workers reported that they do not have a designated office. The author also points out that social workers work in both hospital and community settings; therefore, a set location may not be possible.

Communication: Electronic Medical Records

Research demonstrates that sharing electronic medical records (EMR) is essential for clinical integration (Fraser et al., 2018; Zerden et al., 2019). However, social workers identified that EMR could also be a barrier to communication when EMR is not accessible to all healthcare professionals (Zerden et al., 2019). Social workers identified that not all relevant information is reflected in the patient chart and that not all interdisciplinary team members have the same level of access to information. As such, social workers felt that EMR charts were not always a reciprocal form of communication (Ambrose-Miller & Ashcroft, 2016). Social workers reported that other team members did not read social work chart notes. Some health professionals also did not have access to the same EMR databased as social workers.

Zerden et al. (2019) interviewed 395 social workers from different healthcare settings who work on interprofessional teams. The authors found an overreliance on charting in electronic health records, reporting that only 53% of participants had access to the same EMR system, while 15% reported that they never used the same EMR record. EMR records were more likely to be unified across hospitals versus community settings. Less than two-thirds of social workers reported that they routinely entered information into patients' EMR systems for other interdisciplinary team members to review. This study did not uncover the reasoning behind the lack of data entry but suggested that the shortage of office computers and social workers' large caseloads were factors. Nonetheless, social workers identified that both formal and informal forms of communication are vital for transparent communication and to optimize patient care (Zerden et al., 2019).

Organizational Structure: Remuneration and Resources

Compared to other health care professionals, social workers are underpaid, lack job security, and have limited access to resources (Bajan et al., 2014; Gregorian, 2008). Hyslop (2016) and Hendrix (2021) found that the neoliberal ideology that resulted in the erosion of social services is a driving factor to social workers' lack of funding, increased workload and being unpaid. As such, remuneration and organizational resources affect social workers' ability to provide high-quality services.

Hospital social workers typically have the lowest salary on an interprofessional team (Bejan et al., 2014). For example, Grant and Curry (2013) argued that social workers have a significantly lower salary than their professional colleagues with an equivalent educational level. More specifically, Weick (2000) and Lewis (2018) found a connection between gender inequity and the large pay discrepancy among social workers compared to other health care professionals. The authors connected the status of women in society to the status of social work as a women's progression. Lewis (2018) discovered “that social workers earn less than comparable employees in other college-majority occupations, and the pay gap has widened since 1980” (p.294). Zerden et al. (2019) found that 25% of social workers reported that a hierarchal salary system harmed equitable team interactions. Ambrose-Miller and Ashcroft (2016) also described that social worker salaries were one way to reinforce power inequities, making them feel less valuable both within themselves and how they were perceived among the interprofessional team.

In addition to remuneration challenges, Bejan et al. (2014) interviewed 389 social workers across Canada and discovered social workers felt understaffed, financially under-compensated, and worked in precarious occupational positions. As well, 60% of social workers said that their caseloads have increased and they feel rushed in their day-to-day work (2014).

Similarly, Zerden et al. (2019) found that 44% of social workers agreed that their caseloads were too high to meet the needs of the interprofessional team. Moreover, Ashcroft et al. (2018) found that increased social worker service demands led to time constraints, decreasing collaboration opportunities. Lower job security and the first department to be eliminated during organizational cost-cutting were also reported by social workers (Auerbach et al., 2007; Barth, 2003). Despite all this, Bejan et al. (2014) and Grant and Curry (2013) report social workers have a high career satisfaction rate. It appears that social workers do not undertake the profession for the salary but factors external to the working environment.

Organizational Structure: Competing Values

Research demonstrates that social workers experience operational pressures of discharge planning, which interferes with their professional values. While the pressure of discharge is prevalent among all disciplines, most other health care professional values are more aligned with operational priorities. When faced with operational or interprofessional pressures to discharge patients, social workers reported conflict and tension among the team when advocating for longer patient stay (Glaser & Suter, 2016; Heenan & Birrell, 2019).

The role of social workers in discharge planning is to support patients' stability once back in the community, reducing the probability of readmissions (Glaser & Suter, 2016). Craig et al. (2020), and Hennan and Birrell (2019) found that social workers were often the last checkpoint before discharge. Heenan and Birrell (2019) point out that "hospital discharge is not a single or isolated event but is rather a complex series of linked incremental steps that involve a wide range of groups and networks sharing knowledge and making decisions" (p.1743). Judd and Sheffield (2010) and Glaser and Suter (2016) found that social workers spent over 60 percent of their time on discharge planning. McLaughlin (2016) points out that the time social workers spend on

paperwork aids to the lack of understanding and perceived value among interprofessional team members.

Social workers also faced competing values between the health care system's operational priorities and their professional code of ethics. Hyslop (2016) found that social workers reported that they feel pressured by the demands of 'the system' over the needs of the patients. Moody (2004) points out that the hospital's goals of reducing patients' length of stay create ethical dilemmas for social workers. Similarly, Glaser and Suter (2016) found that social workers felt that patient discharges were at times unethical as they perceived patients returning to unsafe living environments without proper supports in place. Social workers felt that they could not apply their skills and professional knowledge due to an "overemphasis on rushed discharge and filling beds" (p. 399). As a result, Houston et al. (2013) found that social workers experienced the highest rate of moral stress surrounding discharge planning compared to other health care professionals.

There is conflicting research on how team members perceive social workers regarding discharge planning. Craig et al. (2020) found that social workers felt the team valued them as vital components to safe discharge planning. As well, Globeman et al. (2002) and Mizrahi and Berger (2001) found that social workers were viewed as crucial in expediting discharge plans. Glasby (2004) found that their colleagues highly valued hospital social workers when coordinating patient discharges. However, where perception shifted was when operations pressures of discharge planning heightened (Glasby, 2004). Hennan and Birrell's (2019) and Glasby (2004) found that tension among the interprofessional team was reported when social workers advocated to prolong discharge or spent 'too much time' on discharge planning. When holding to their professional values, Glaser and Suter (2016) found that social workers were

perceived as 'bed blockers' by other health care professionals, notably when they advocated for a patient's more extended stay. Colleagues viewed social workers as problematic to the integrative team setting due to their conflicting professional views on patient care. As such, Barth (2003) reported that social workers were more likely to be removed from discharging patients if they were viewed as uncooperative in 'speedy discharge' planning.

Implications

I have reviewed the literature that explores the experiences of social workers when collaborating with interprofessional health care teams. Although social workers on interprofessional care teams are vital to optimize patient care, several barriers to effective team practice were identified. As such, the literature has many implications for future social work practice, policy and interprofessional education; such implications may be employed to optimize social work interprofessional collaboration.

Implications for Social Work Practice

The literature identifies that social workers' have a flexible role and undertake many different tasks in an interprofessional team. However, the multifaceted nature of social workers contributes to the role confusion and ambiguity among the rest of the team. Lack of role clarity leads social workers to negotiate their roles on the team, threatens their professional identity, and questions their value to the team. Role confusion contributes to inefficient practices such as duplicate services, underutilization of social workers' skill set and tension among the team. Therefore, there is a strong need for social workers' roles to be clarified within the interprofessional team.

The literature suggests that it is up to social workers to teach the interprofessional team about their scope of practice. Craig et al. (2020) found social workers who are reluctant to share

their professional perspectives and experiences to the team "hinders social workers from working to their full scope of practice and diminish their contribution to patient care." (Craig et al., 2020, p.7). It seems redundant that the social work profession, a licensed profession, is compelled to prove their skills to colleagues to gain understanding and acceptance. I assume this is because the scope of practice substantially differs from other health care professionals.

Nonetheless, the research indicates that role clarity must be established to collaborate effectively. Therefore, it would be helpful for the team to understand each professional's role and skillset. That way, professional boundaries can be established, and each professional has their designated tasks and responsibilities known to the team. It is important for colleagues in other disciplines to have a clear understanding of social workers' roles as this may improve the negative attitudes held by other team members. When roles are clearly outlined, colleagues will be able to work within each other's scope of practice and rely on social workers more appropriately. Members of the interprofessional team would also have increased awareness of social workers' scope of practice, leading to more appropriate referrals and better utilization of their skillset. Thereby, social workers would feel more respected and valued, promoting the team's overall cohesiveness and mutual understanding.

Lastly, the literature demonstrates the need for social workers to have a firm grasp of their professional identity to maintain professional integrity. Research indicates that power dynamics reflected in professional hierarchies diminished social workers' voice and confidence. Given social workers are the only profession within the health care team that explicitly examines social justice, social workers need to be able to navigate team conflict. Social workers should be encouraged to translate their advocacy skillset towards their professional practice to help assert

themselves as equal team members. In addition, social workers can advocate towards changing organizational structural demands that impose ethical conflicts and impede patients' wellbeing.

Implications for Social Work Policy

The literature indicated that social workers found that organizational aspects (e.g. income, job security, workload) were influential factors in successful interprofessional collaboration. The research found that social workers are consistently underpaid compared to their colleges with similar education levels. Inequity and measurements of self-perceived 'fair treatment' were presented through social workers' perception of themselves and the team's perception of social workers. Therefore, equalizing social workers' pay would likely reduce existing power hierarchies and support social work professionalization. As well, reducing social workers' workload by increasing the ratio of social workers per department or organization would allow more time for collaboration and flexibility in a social worker's role to adapt to the teams' specific teams.

The lack of social worker leadership and opportunities for mentorship was identified as a challenge in solidifying a professional identity. Therefore, policies should include more supervision, mentorship, and leadership opportunities to strengthen the social work profession. As well, managerial and director roles who are responsible for social workers should be occupied by social workers. This way, social workers can accurately advocate on behalf of the team and promote social work within the organization.

The literature also indicates several barriers to communication, including colocation and the lack of a unified EMR system. A shared EMR system would allow for a better opportunity for interprofessional team members to understand social workers' contributions to patient care. Therefore, ensuring that health care professionals operate under one EMR system is vital for

effective communication. Placing social worker offices in the same location as other interprofessional team members would allow for more informal daily communication between health care professionals.

Implications for Interprofessional Education

Many studies identified that healthcare professionals who participated in interprofessional education or training were more successful with interprofessional collaboration (Brennan et al., 2020; Delavega, 2019; Hovlan et al., 2019; Millstein, 2020; Zerden, 2021). The literature indicates that effective interprofessional collaboration enhances patients' quality of care, improves patient outcomes, lowers costs, and improves organizational efficiency (Institute of Medicine, 2015). Therefore, it would be helpful, both in educational systems and workplaces, to mandate interprofessional training as part of the employment's curriculum or onboarding process. For social workers, interprofessional training for all health care professionals may aid in the barrier found to practicing in a medical model environment and help flatten the hierarchy between professionals. There would also be an opportunity to communicate and learn from each other without the pressures from organizational structures.

Interprofessional education, however, is not the complete solution to the challenges faced with interprofessional collaboration. Zerden et al. (2021) found that social workers who received formal interprofessional training as students reported similar barriers, such as medical terminology and "not being perceived as a true health profession in a medical context" (p.764). Lutfiya et al. (2016) similarly found social workers who completed interprofessional education as students felt they could not keep up with the rapidly evolving health care system in practice. Therefore, social workers need to be taught basic medical terminology and an overview of illnesses and the skillset to navigate the complex health care system. After all, it is a social

worker's role to help patients and their families cope with illness and provide education about their resources.

Lastly, I believe this literature revealed a diametrically oppressed awareness of the impact of neoliberalism among social workers. I intentionally chose to highlight neoliberalism to create awareness and emphasize the need to incorporate the effects of political ideology in social work education. Neoliberalism has significantly impacted social work practice by restricting and reducing public sector funding and shifting society's ideology to favour individualism. As a result, there has been a negative effect on working conditions, available resources, and professional autonomy for social workers. For social work education, Macias (2015) and George et al. (2013) report that school curricula are delivered through market-driven discourses, which has refrained students from participating in social activism (as cited in Strier, 2019). Consequently, students are taught to focus on their academic grades and are unconscious of society's social and political stakes.

Limitations and Gaps in the Research

In following a feminist framework, it is important that I acknowledge that all research is subjected to its own biases. When reflecting on my own biases, I have become aware that my previous degree in Health Sciences and work experience in research caused initial barriers in how I structured and viewed this topic. Having a background in science has made me unconsciously favour quantitative research articles. I was taught that quantitative research is more reliable, objective, and valuable than qualitative research. It was not until my pursuit in the Master of Social Work that I grasped the value of qualitative research by exploring the 'why' in people's thoughts and behaviours.

Based on the literature reviewed, several limitations and gaps are notable. A majority of the authors were also social workers, but they rarely identified their positionality and biases. Therefore, the lens of this literature review revolves around a single scope of practice that limits insight from interactive focuses such as patients, other health professionals, and policy analyses.

Second, in some articles, details about social workers' employment settings were limited. Most of the research gathered were qualitative interviews with social workers in a hospital setting. However, some studies did not specify the employment setting or describe the setting as general, such as 'primary care.' With the growing number of social workers working among interprofessional teams in community settings, it would be beneficial to compare if similar challenges existed.

Third, most literature did not examine the demographics of research participants. A majority of the studies focused on social workers who identified as white, demonstrating a diversity gap in the research. Therefore, it is likely that other research in similar settings would also produce varying results.

Fourth, this review lacked literature from the perspectives of other health care professionals. Therefore, the lens of this literature review revolves around a single scope of practice and lacks comprehensively challenging social worker self-reports.

Lastly, much of the literature did not clarify if interviewees completed interprofessional education courses within their employment or education background. It would have been helpful to understand if collaboration differed among those trained in interprofessional education. Although interprofessional education was seen as beneficial across various professions, little research demonstrates that it prevents or mitigates social workers' experiences with

collaborations. Therefore, there is a risk of casual inference about the effectiveness of interprofessional education for social workers.

Given what I have found to be the various impacts of neoliberalism on the work of social workers in healthcare settings, there is an absence of literature that directly connects neoliberalism with interprofessional collaboration. It was evident that the barriers identified by social workers were due to the consequence of neoliberal policies. Most articles, however, did not go beyond the surface and explore the 'why' factor among research participants or authors. Therefore, patterns connected to neoliberalism in the literature primarily relied on my lens instead of researchers' interpretations.

Conclusion

The literature demonstrated that social workers face many challenges to interprofessional collaboration. My hope is that this paper aids future discussions for strategies to optimize opportunities for interprofessional collaboration. Given social workers' unique role in health care, it is essential to address these barriers to maximize their capacity to respond to patient and population needs. With a stronger understanding of the interprofessional team dynamics, social workers can also optimize opportunities for interprofessional collaboration.

The literature also highlighted the influence of ideological, political and policy contexts on social workers' roles. My hope is this paper acts as a catalyst in promoting awareness and developing strategies to deal with the impact of neoliberal reform as it has consequences for the social work profession, social policy, health care and population health. Lastly, the challenges identified in this paper calls for changes in future social work policy, practice, and education. My hope is that readers are inspired and utilize these recommendations as opportunities to engage in advocacy for policy reform.

References

Allin, S., Marchildon, G., Peckham A., (5, June, 2020). *International Health Care System Profiles: Canada*. North American Observatory on Health Systems and Policies, University of Toronto. https://www.commonwealthfund.org/international-health-policy-center/countries/canada

American Psychological Association. (2022). *Apa dictionary of psychology*. https://dictionary.apa.org/medical-model

Ambrose-Miller, W., & Ashcroft, R. (2016). Challenges faced by social workers as members of interprofessional collaborative health care teams. *Health and Social Work*, *41*(2), 101–109. https://doi.org/10.1093/hsw/hlw006

Andermann, A. (2016). Taking action on the social determinants of health in clinical practice: A framework for health professionals. *Canadian Medical Association Journal*, *188*(17-18). https://doi.org/10.1503/cmaj.160177

Ashcroft, R., McMillan, C., Ambrose-Miller, W., McKee, R., & Brown, J. B. (2018). The emerging role of social work in primary health care: A survey of social workers in Ontario family health teams. *Health and Social Work*, *43*(2), 109–117. https://doi.org/10.1093/hsw/hly003

Auerbach, C., Mason, S., & Laporte, H. (2008). Evidence that supports the value of social work in hospitals. *Social Work in Health Care*, 44(4), 17–32. doi:10.1300/J010v44n04_02

Béland, F., Bergman, H., Lebel, P., Clarfield, A. M., Tousignant, P., Contandriopoulos, A. P., & Dallaire, L. (2006). A system of integrated care for older persons with disabilities in Canada: Results from a randomized controlled trial. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 61, 367–373. doi:10.1093/gerona/61.4.367

Braedley, S. (2012). The masculinization effect: Neoliberalism, the medical paradigm and Ontario's health care policy. *Canadian Woman Studies*, *29*(3), 71-83.

British Columbia College of Social Workers. (2021). *Complaint information.* https://bccsw.ca/public/complaint-information/

Bryson, S. A., & Bosma, H. (2018). Health social work in Canada: Five trends worth noting. *Social Work in Health Care*, *57*(8), 1–26. https://doi.org/10.1080/00981389.2018.1474161

Bejan, R., Craig, S., & Saini, M. (2014). "I love my job but..." A portrait of Canadian social workers' occupational conditions. *Canadian Association of Social Workers*, *16*(1), 21- 45.

Campbell, B. (2014). After neoliberalism: The need for a gender revolution. *Soundings*. 56 (17). 10-26.

Canadian Interprofessional Health Collaborative (CIHC). (2010). *A national interprofessional competency framework*. http://www.cihc.ca/files/CIHC_IPCompetencies_ Feb1210.pdf

CASW. (2014). *About CASW*. https://www.casw-acts.ca/en/about-casw/about-casw

CASW. (2005). *Code of ethics core social work values and principles*. https://www.casw-acts.ca/files/attachements/code_of_ethics_values_principles_0.pdf

Christianto, H. (2018, August, 10) *Neoliberalism: past, present…future?* Canadian international council. https://thecic.org/neoliberalism-past-present-future/#_edn5

Craig, S. L., Eaton, A. D., Belitzky, M., Kates, L. E., Dimitropoulos, G., & Tobin, J. (2020). Empowering the team: A social work model of interprofessional collaboration in hospitals. *Journal of Interprofessional Education and Practice*, *19*(1), 1–9. https://doi.org/10.1016/j.xjep.2020.100327

Craig, S., Frankford, R., Allan, K., Williams, C., Schwartz, C., Yaworski, A., … Malek-Saniee, S. (2016). Self-reported patient psychosocial needs in integrated primary health care: A role for social work in interdisciplinary teams. *Social Work in Health Care*, 55(1), 41–60. doi:10.1080/00981389.2015.1085483

Craig, S. L., & Muskat, B. (2013). Bouncers, brokers, and glue: The self-described roles of social workers in urban hospitals. *Health and Social Work*, *38*(1), 7–16. https://doi.org/10.1093/hsw/hls064

Delavega, E., Neely-Barnes, S. L., Elswick, S. E., Taylor, L. C., Pettet, F. L., & Landry, M. A. (2019). Preparing social work students for interprofessional team practice in healthcare settings. *Research on Social Work Practice*, *29*(5), 555–561. https://doi.org/10.1177/1049731518804880

Donnan, M. E. (2014). Life after neoliberalism in Canada: How policy creates homelessness and how citizenship models fail to provide solutions. *International Journal of Arts & Sciences, 7*(5), 585-596.

Elomäki, A., & Kantola, J. (2018). Theorizing feminist struggles in the triangle of neoliberalism, conservatism, and Nationalism. *Social Politics: International Studies in Gender, State & Society*, *25*(3), 337–360. https://doi.org/10.1093/sp/jxy013

Enge, J. (2013). Social workers' feminist perspectives: Implications for practice". *Social Work Master's Clinical Research Papers*. https://ir.stthomas.edu/ssw_mstrp/173

Farre, A., & Rapley, T. (2017). The new old (and old new) medical model: Four decades navigating the biomedical and psychosocial understandings of health and illness. *Healthcare (Basel, Switzerland)*, *5*(4), 88. https://doi.org/10.3390/healthcare5040088

Fraser, M. W., Lombardi, B. M., Wu, S., Zerden, L. de S., Richman, E. L., & Fraher, E. P. (2018). Integrated primary care and social work: A systematic review. *Journal of the Society for Social Work and Research*, *9*(2), 175–215. https://doi.org/10.1086/697567

Glaser, B., & Suter, E. (2016). Interprofessional collaboration and integration as experienced by social workers in health care. *Social work in health care*, *55*(5), 395–408. https://doi.org/10.1080/00981389.2015.1116483

Gordon, J. (2018). The voice of the social worker: A narrative literature review. *British Journal of Social Work*, *48*(5), 1333–1350. https://doi.org/10.1093/bjsw/bcx108

Government of Canada. (2019). *Canada's health care system.* https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html

Government of Canada. (2020). *Social determinants of health and health inequalities*. https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Geron, S.M., Andrews, C., & Kuhn, K. (2005). Infusing aging skills into the social work practice community: A new look at strategies for continuing professional education, families in society. *The Journal of Contemporary Social Services*, 86(3), 431–440.

Gregor, A. (2018). *Lecture on reflections of 'neoliberal neo-patriarchy' in the situation of Hungarian women*. Personal collection of A. Gregor. Central European University, Budapest, Hungary.

Globerman, J., White, J., & McDonald, G. (2002). Social work in restructuring hospitals: Program management five years later. Health and Social Work, 27(4), 274-284.

Gregorian, C. (2005). A career in hospital social work. *Social Work in Health Care*, *40*(3), 1–14. https://doi.org/10.1300/j010v40n03_01

Harding, S. (2009). Standpoint theories: Productively controversial. *Hypatia*, *24*(4), 192–200. http://www.jstor.org/stable/20618189

Harvey, D. (2010). *A brief history of neoliberalism*. Oxford University Press.

Healy, K., & Meagher, G. (2004). The reprofessionalization of social work: Collaborative approaches for achieving professional recognition. *British Journal of Social Work*, *34*(2), 243–260. https://doi.org/10.1093/bjsw/bch024

Heenan, D., & Birrell, D. (2019). Hospital-based social worker: challenges at the interface between health and social care. *British Journal of Social Work*, *49*, 1741–1758. https://doi.org/10.1093/bjsw/bcy114

Held. M., Black, D. R., Chaffin, K. M., Mallory K. C., Diehl A. M. & Cummings. S. (2019). Training the future workforce: Social workers in integrated health care settings, *Journal of Social Work Education*, 55(1), 50-63, https://10.1080/10437797.2018.1526728

Hendrix, E., Barusch, A., & Gringeri, C. (2021). Eats me alive!: Social workers reflect on practice in neoliberal contexts. *Social Work Education*, *40*(2), 161–173. https://doi.org/10.1080/02615479.2020.1718635

Hepp, S. L., Suter, E., Jackson, K., Deutschlander, S., Makwarimba, E., Jennings, J., & Birmingham, L. (2014). Using an interprofessional competency framework to examine collaborative practice. *Journal of Interprofessional Care*, 29(2), 131–137. doi:10.3109/13561820.2014.955910

Hugman, R. (2008). But is it social work? Some reflections on mistaken identities. *British Journal of Social Work*, *39*(6), 1138–1153. https://doi.org/10.1093/bjsw/bcm158

Institute of Medicine. (2015). *Measuring the impact of interprofessional education on collaborative practice and patient outcomes*. http://www.nationalacademies.org/hmd/Reports/2015/Impact-of-IPE.aspx

Jennissen, T., & Lundy, C. (2012). One Hundred Years of Social Work: A history of the profession in English Canada, 1900-2000. W. Ross MacDonald School Resource Services Library.

Judd, R., & Sheffield, S. (2010). Hospital social work: Contemporary roles and professional activities. *Social Work in Health Care,* 49, 856–871. doi:10.1080/00981389.2010.499825

Keefe, B., Geron, S. M., & Enguidanos, S. (2009). Integrating social workers into primary care: Physician and nurse perceptions of roles, benefits, and challenges. *Social Work in Health Care*, *48*(6), 579–596. https://doi.org/10.1080/00981380902765592

Lee, S., Rowe, B., & Mahl, S. (2021). Increased private healthcare for canada: Is that the right solution? *Healthcare Policy | Politiques De Santé*, *16*(3), 30–42. https://doi.org/10.12927/hcpol.2021.26435

Marsh, J. C., & Bunn, M. (2018). Social Work's contribution to direct practice with individuals, families, and groups: An institutionalist perspective. *Social Service Review*, *92*(4), 647–692. https://doi.org/10.1086/701639

McBride, S. (2005). Paradigm shift: Globalization and the Canadian state (2nd ed.). Fernwood.

McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies*, *25*(2), 82–89. https://doi.org/10.1111/j.1470-6431.2001.00183.x

Mizrahi, T., & Abramson, J. S. (2000). Collaboration between social workers and physicians: Perspectives on a shared case. *Social Work in Health Care, 31*(3), 1–24. https://doi.org/10.1300/J010v31n03_01

Mullaly, R. P., & Dupre, M. (2019). *The new structural social work: Ideology, theory, and Practice* (fourth). Oxford University Press.

Muskat, B., Craig, S. L., & Mathai, B. (2017). Complex families, the social determinants of health and psychosocial interventions: Deconstruction of a day in the life of hospital social workers. *Social Work in Health Care,* 56(8), 765–778. doi:10.1080/00981389.2017.1339761

Netting, F.E., & Williams, F.G. (2000). Expanding the boundaries of primary care for elderly people. *Health & Social Work*, 25(4), 233–242

Oliver, C. (2013). Social workers as boundary spanners: Reframing our professional identity for interprofessional practice. *Social Work Education*, 32(6), 773-784, https://dio.org/10.1080/02615479.2013.765401

Pannick, S., Davis, R., Ashrafian, H., Byrne, B. E., Beveridge, I., Athanasiou, T., Wachter, R. M., & Sevdalis, N. (2015). Effects of interdisciplinary team care interventions on general medical wards: A systematic review. *JAMA internal medicine, 175*(8), 1288–1298. https://doi.org/10.1001/jamainternmed.2015.2421

Payne, M. (2014). *Modern social work theory*. Palgrave Macmillan.

Power, E. M., & Polzer, J. (2016). *Neoliberal governance and health: Duties, risks, and vulnerabilities*. McGill Queen's University Press.

Praglin, L. J. (2007). Ida Cannon, Ethel Cohen, and early medical social work in Boston: The foundations of a model of culturally competent social service. *Social Service Review*, *81*(1), 27–45. https://doi.org/10.1086/511013

Rämgård, M., Blomqvist, K., & Petersson, P. (2015). Developing health and social care planning in collaboration. *Journal of Interprofessional Care*, 29(4), 354–358. 10.3109/ dio:13561820.2014.1003635

Reid, C., Greaves, L., & Kirby, S. (2017). *Experience, research, social change: Critical methods* (3rd ed.). University of Toronto Press.

Rizzo, Victoria, M., & Abrams, A. (2000). Utilization review social work.Pdf. *Health and Social Work*, *25*(4), 264–269.

Rocco, C. (2017, October 16). *Occupational therapy, social work, both or neither?* https://www.solutionsforliving.ca/2017/10/occupational-therapy-social-work-both-or-neither/

Ruth, B. J., Wachman, M. K., Marshall, J. W., Backman, A. R., Harrington, C. B., Schultz, N. S., & Ouimet, K. J. (2017). Health in all social work programs: Findings from a US national analysis. *American Journal of Public Health*, 107 (S3), S267–S273. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304034

Saulnier, C. F. (2000). Incorporating feminist theory into Social Work Practice: Group Work examples. *Social Work With Groups*, *23*(1), 5–29. https://doi.org/10.1300/j009v23n01_02

Schneider, E. C., Shah, A., Doty, M. M., Tikkanen, R., Fields, K., & Williams II, R. D. (2021, August 4). *Mirror, mirror 2021: Reflecting poorly - health care in the U.S. compared to*

other high-income countries. https://search.issuelab.org/resource/mirror-mirror-2021-reflecting-poorly-health-care-in-the-u-s-compared-to-other-high-income-countries.html

Schrecker, T. (2016). Neoliberalism and health: The linkages and the dangers. *Sociology Compass*, *10*(10), 952–971. https://doi.org/10.1111/soc4.12408

Shor, R. (2010). Interdisciplinary collaboration between social workers and dieticians in nutrition education programs for children-at-risk. *Social Work in Health Care*, 49(4), 345–361. https://doi.org/10.1080/00981380903364775

Spithoven, A. (2011). It's the institutions, stupid! Why U.S. health care expenditure is so different from Canada's. *Journal of Economic Issues*, *45*(1), 75–96. https://doi.org/10.2753/jei0021-3624450105

Stadick, J. L. (2020). Understanding health care professionals' attitudes towards working in teams and Interprofessional Collaborative Competencies: A mixed methods analysis. *Journal of Interprofessional Education & Practice*, *21*, 100370. https://doi.org/10.1016/j.xjep.2020.100370

Strier, R. (2019). Resisting neoliberal social work fragmentation: The wall-to-wall alliance. *Social Work*, *64*(4), 339–345. https://doi.org/10.1093/sw/swz036

Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated health: An opportunity for social work. *Social Work in Health Care*, *54*(5), 383–407. https://doi.org/10.1080/00981389.2015.1025122

Tadic, V., Ashcroft, R., Brown, J., & Dahrouge, S. (2020). The role of social workers in interprofessional primary healthcare teams. *Healthcare Policy | Politiques De Santé*, *16*(1), 27–42. https://doi.org/10.12927/hcpol.2020.26292

Teater, B. (2010) An introduction to applying social work theories and methods. Maidenhead: Open University Press.

Turner, S. G., & Maschi, T.M. (2015). Feminist and empowerment theory and social work practice. *Journal of Social Work Practice*, *29*(2), 151-162. https://doi:10.1080/02650533.2014.941282

Wang, C.-W., Chan, C. L., & Chow, A. Y. (2018). Social workers' involvement in advance care planning: A systematic narrative review. *BMC Palliative Care*, *17*(5). https://doi.org/10.1186/s12904-017-0218-8

Warf, B. (Ed.). (2010). *Positionality*. Encyclopedia of Geography (5th ed.). Thousand Oaks: Sage.

Weick, A. (2000). Hidden voices. *Social Work*, *45*(5), 395–402. https://doi.org/10.1093/sw/45.5.395

Whiteside, H. (2011). Unhealthy policy: The political economy of Canadian public-private partnership hospitals. *Health Sociology Review*, *20*(3), 258–268. https://doi.org/10.5172/hesr.2011.20.3.258

World Bank. (1997) *Decentralization and health care.* http://www.worldbank.org/publicsector/decentralization/ healthcare.htm

World Health Organization. (2022). *Social determinants of health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Zerden, L. de, Jones, A., Day, S., & Lombardi, B. M. (2021). Interprofessional collaboration: An evaluation of social work students' skills and experiences in Integrated Health Care. *Journal of Social Work Education*, *57*(4), 758–770. https://doi.org/10.1080/10437797.2020.1743219

Zerden, L. D., Lombardi, B. M., & Richman, E. L. (2019). Social workers on the interprofessional integrated team: Elements of team integration and barriers to practice. *Journal of Interprofessional Education and Practice*, *17*(April), 1–7. https://doi.org/10.1016/j.xjep.2019.100286

Zerden, L. de, Lombardi, B. M., & Jones, A. (2019). Social workers in integrated health care: Improving care throughout the life course. *Social Work in Health Care*, *58*(1), 142–149. https://doi.org/10.1080/00981389.2019.1553934

Zimmerman, J., & Dabelko, H. I. (2007). Collaborative models of patient care: New opportunities for hospital social workers. *Social Work in Health Care*, *44*(4), 33–47. https://doi.org/10.1300/J010v44n04_03