

An Exploratory Study of the Experiences of Social Workers who are employed in Nurse
Practitioner-Led Clinics in the Province of Ontario

by

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Abstract

This study explored social workers' experiences working in primary health care—specifically, those employed in Nurse Practitioner-Led Clinics (NPLC). This qualitative study utilized a sample of nine social workers employed in Ontario. Data were analyzed using a thematic analysis. Results revealed two thematic clusters pertaining to the social work role and the organizational/structural aspects of the role. Subthemes of the first cluster identified (1) the social work role as multi-faceted and hard to define, (2) issues of poverty and (3) the lack of understanding of the social work role by other professionals, including the importance of positive collegial relationships. Subthemes of the second cluster identified (1) a lack of supervision and the importance to self-care, (2) working in isolation as a challenge, and (3) conflicting models including subthemes on professional hierarchy and pay disparities. Results may help to define the role of social workers who are employed in NPLCs as well as the challenges they may encounter. This research offers a vision of how social work can make a difference within the new era of primary health care aimed at developing health care systems more suited to the needs of individuals, families and communities.

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Chapter 1: Introduction

In the last decade, Canada has experienced a climate for change in the organization and management of health services. Economic trends and federal budget deficits place tremendous pressure on provincial and territorial governments to economize on health spending. This has generated widespread cost containment measures where hospital units and entire facilities have been closed, community services have been shuffled, and health care staff have been moved around or dismissed at an extraordinary rate. To a significant extent, cost containment has trumped the quality and accessibility of health care (Bolaria & Dickinson, 2002).

Most recently, studies have been undertaken outlining the need for restructuring in the Canadian health care system. The Romanow Commission (2002) discussed a major change regarding the delivery of health care services in Canada. A major component of this report describes the development and implementation of a primary care model. Health Canada's (2004) review of the health care system identified the need for primary care reform that centres on the development of inter professional teams for a more effective delivery of collaborative patient centered care. Health Canada's report entitled *A 10-Year Plan to Strengthen Health Care* (2004) outlined the importance of recognizing that public health efforts should include enhanced health promotion including chronic disease and illness management, timely access to care, and continuity of care encompassing integrated care within the community. This supports the strategy of the Ministry of Health and Long Term Care (2002) that would see the creation of a new primary health care delivery model which would involve the expansion and transformation of existing primary health care centers into inter professional health teams. Reviewing the action plan of the Ministry of Health and Long Term Care (2015) highlights the next phase of building on the progress of providing care that is coordinated and integrated. This model marks a

transition from the traditional model of physician based care to a team approach that includes physicians, nurses, pharmacists, social workers and other health care professionals working collaboratively to ensure that care can be coordinated and delivered in a seamless fashion.

The Ministry of Health and Long Term Care (MOHLTC), Health Human Resources Strategy Division (2007) announced funding for the creation of twenty five Nurse Practitioner-Led Clinics (NPLC's) throughout the Province of Ontario to be fully operational by 2012. The MOHLTC (2007) indicated that Nurse Practitioner-Led Clinics would differ from Family Health Teams and Community Health Clinics as Nurse Practitioners are the lead providers of primary health care as opposed to physician-led providers in Family Health Teams and Community Health Clinics. The MOHLTC (2007) stated that Nurse Practitioner-Led Clinics would provide comprehensive, accessible and coordinated family health care through a collaborative approach including nurses, social workers and dieticians to populations that have difficulty accessing a primary care provider. The MOHLTC (2007) estimated the twenty five Nurse Practitioner-Led Clinics would provide health care to over "40,000 unattached patients" (p. 2). The first Nurse Practitioner-Led Clinic opened in Canada in Sudbury, Ontario in 2007. To date, across Ontario twenty five communities have established Nurse Practitioner-Led Clinics all employing social workers on a fulltime and part-time basis (MOHLTC, 2007).

The transition to a primary health care model has far-reaching implications for the profession of social work. Lymbery & Milward (2009) believe it is inevitable that increasing numbers of social workers will be employed within primary health care settings, therefore, a need for more research to inform the policy agenda is increasingly important. Allen (2012) supports this notion in her discussion of the future of medical social work whereby the author notes that social workers must actively engage at every level of the reorganization of health care

not only for the opportunities it will afford the profession in terms of expanded employment but also because of the “value oriented perspective that fully complements the effort of achieving ideal health reform” (p. 186). Giles et al. (2007) challenge social workers to expand the literature that supports social work practice in health. In their study of professional competencies of social workers in primary health care, authors Horevitz and Manoleas (2013) indicate that “little of a systemic nature is known about core competencies utilized by social workers in primary care settings” (p. 759). The authors indicate that additional research examining core competencies of social workers in primary care settings is required.

The 2003 report of the Canadian Association of Social Workers (CASW) on Social Work in Primary Health Care indicated that the profession will be challenged to incorporate “a deeper understanding of the challenges and opportunities facing the social work profession as a result of the move to a primary health care model” (p. 4). In addition, the CASW (2003) reinforced the view that much of the research about primary health care comes from other countries and other professions.

Purpose of the Study

With respect to the current project, the purpose of this research was to conduct a qualitative study that explored the experiences of social workers who are employed in primary health care, more specifically to understand the experiences, from social workers’ perspectives, amongst people who were employed in Nurse Practitioner-Led Clinics in the Province of Ontario. A review of the literature was conducted in order to gain a better understanding of what was available on this topic and what were the deficiencies in the literature. Following this review of the literature, it was identified that few published studies explored the experiences of social workers that were employed in primary health care, more specifically Nurse Practitioner-Led

Clinics from the perspective of social workers. The gap in knowledge indicated the need for more research into the role of social workers in primary health care models. The information was collected using telephone recorded interviews and electronic questionnaires with social workers who were employed in Nurse Practitioner-Led Clinics in the Province of Ontario. The literature was analyzed using a thematic analysis.

Chapter 2: Literature Review

In this chapter, some of the existing research related to the topic of social work in primary health care will be reviewed. The resulting literature review relates to published studies about the various perspectives of primary health care and social work. In order to gather relevant literature, I reviewed numerous online databases and websites related to this research topic. The articles reviewed were mostly obtained from, but not limited to, the Desmarais Library, Laurentian University online multidisciplinary databases EBSCO host and ProQuest as well as the social work database where I retrieved articles from the *Social Work in Health Care Journal*, *Social Science & Medicine*, *British Journal of Social Work*, *Primary Health Care Research & Development* and *Health & Social Work*. The literature search included key words such as primary health care and social work, community health care and social work, inter-disciplinary teams in health care, inter-professional teams and health care, family health teams and social work, and nurse practitioner and social work.

It is important to note that there were a limited number of published studies of primary health care and social work, more specifically, there was limited research pertaining to Nurse Practitioner Community Health Clinics and social work. Additionally there was limited information on primary health care and social work from the perspective of social workers themselves. In this search I sought out to retrieve both quantitative and qualitative research papers, study reviews and policy-oriented papers. Some of the studies included a review and evaluation of primary health care and others focused on interdisciplinary teams in primary health care from the perspective of other professions such as Nurses, Occupational Therapists and Physicians. The articles gathered for this literature review ranged from the years 1970 to 2016.

The following literature review highlights 46 years of research that has contributed to the depth of knowledge in the field of primary health care and social work.

A thematic analysis focused on six main themes including three sub-themes which were divided into two groupings that represented the experiences of social workers employed in these settings. There are five main components to this literature review that will support the need for further research in the area of social work in primary health care. The first section provides an overview of primary health care. The second section examines the role of social work in primary health care. The third section discusses social work challenges in primary health care. The fourth section explores the experiences of social workers in primary health care. The fifth section looks at interprofessional teams and social work in primary health care.

An Overview of Primary Health Care

Primary health care refers to an approach to health including an array of services which extends beyond the traditional health care system. Primary health care focusses on health care services that include health promotion, illness and injury prevention and responsiveness to community needs. In 1978, the World Health Organization (WHO) embraced a primary health care approach as the preferred and most effective delivery of health services as outlined in the Declaration of the Alma-Ata (WHO, 1978). The report defines primary health care as a “philosophy of health care and a model for providing services that support health” (p. 8). The declaration emphasized effective primary health care as community-based, promoting healthy lifestyles by providing continuing care of chronic illness and recognizing the importance of the broader determinants of health. In addition, the report stresses effective primary health care as embracing a wide range of services and involving a range of health-care providers (WHO, 1978).

Primary health care has also been defined in terms of three core characteristics, including its scope, the character of care, and the integration of services (Ashery, 2008). Five essential attributes to practice in this area include accessibility, comprehensive care, continuity, coordination, and accountability (Ashery, 2008). Primary health care can be defined as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Donaldson, Yordy, Lohr, & Vanselow, 1996, as cited in Ashery, 2008, p. 405). This definition reaffirms the view that primary health care is care that is integrated (Ashery, 2008). A key component of this definition is that it also acknowledges the importance of both family and community in understanding the patient’s individual situation, health, living conditions, and cultural background (Ashery, 2008). As part of the provision of integrated care, a variety of health professionals should be involved, including various medical professionals and support staff, along with social workers serving as critical team members (Ashery, 2008).

In support of this, Mable & Marriott (2002) further explain that quality primary health care recognizes the broader determinants of health that includes “coordinating, integrating and expanding systems to provide more population health, sickness prevention, health promotion, not necessarily just by doctors [that] it encourages the best use of all health providers to maximize the potential of all health resources” (p. 3). Others have suggested that primary health care is a “service at the entrance to the health care system that addresses diagnosis, ongoing treatment of health conditions, health promotion and disease and injury prevention” (Kingston-Riechers, Ospina, Jonsson, et al., 2010, p. 6). The researchers further indicate that primary health care is responsible for coordinating the care of patients and integrating their care with the rest of the

health care system by providing access to other healthcare providers and services. The Health Council of Canada (2005) supports the idea that primary health care is often the first point of contact that people have with the health care system. The report concludes that primary health care includes treatment of chronic health conditions, health promotion and supportive care; that services are accessible to all individuals and provided by “health care professionals with the right skills to meet the needs of individuals and the communities being served” (p 24).

Greater understanding of the role of primary health care in addressing systemic health inequalities has led to widespread efforts to promote more integrated care services, especially for vulnerable populations in need. It is noted that globalization especially has created a strong push for integrated primary health care (Williams & Des Marais, 2016). The authors reaffirm that researchers and professionals in different fields have increasingly recognized the many linkages between human, environmental, and animal health demand intervention strategies designed to address these connections, as well as systemic and fundamental inequalities (Williams & Des Marais, 2016). The researchers put forth the argument that “a stronger focus on developing prevention and intervention strategies to address health in disenfranchised communities within the United States and developing countries can have a significant impact on health, longevity, and well-being” (Williams & Des Marais, 2016, p. 5). This perspective has led to the development of policy designed to integrate behavioural health sciences into primary health care settings (Horevitz & Manoleas, 2013). The rationale given is that integration of services in a primary health care setting can ensure the provision of health and social services in a way that better meets a range of client needs (Horevitz & Manoleas, 2013).

At present, primary health care services in Canada are delivered mostly by family physicians and focus on the diagnosis and treatment of illness and injury. In recent years, the

ways in which primary health care is organized and delivered has been the focus of much debate. In a discussion of the health care system, Allen (2012) describes the system as “fragmented” whereby clients attend one location after another for various medical appointments. The author concludes that fragmentation has led to “lapses in communication among providers which can be costly in dollars and patient outcomes” (p. 183). In particular Allen (2012) highlights negative outcomes when diagnosis fails to take mental health into account. The author stresses the need for health care reform that reorients health care around primary care.

Several studies discuss the increasing complexity of patient care as well as rising health care costs highlighting a need to shift the way health care is delivered. The literature contends that a more collaborative, primary care model can deliver a more appropriate model of care. A review of interdisciplinary teamwork in Canadian primary health care settings provided background information outlining the transition from a traditional model of physician based health care to a team based approach in which “physicians, nurses, social workers and other health care providers will work collaboratively to ensure a more coordinated system of care and delivered in a seamless manner” (Oandasan, Gotlib Conn, Lingard et al., 2009, p. 152). A discussion by Livingston (1998) providing an update on health care in Canada suggests that a more effective health system would address primary and preventative care rather than focusing much of the resources on the treatment of disease. In addition, the discussion highlights the use of nurse practitioners as “a new point of entry into the system” and further suggests that services of “non-physician providers” are well received and cost the system less (p. 275).

From this perspective, Ashery (2008) concludes that it is clear that social workers are operating in a context in which their opportunities to work as part of an integrated primary health care team are increasing. In countries like Canada and the United States, primary health care

occurs in community hospitals, outpatient clinics, government-funded health centres, sole-practitioner and group practices, and in health maintenance organizations (Ashery, 2008). The interprofessional health care teams tasked with providing health care services to patients in these contexts are made up of nurses, primary care physicians, nurse practitioners, and doctor's assistants (Ashery, 2008). When behavioural health and primary health care are integrated through a single model for care, social workers also serve on these teams (Ashery, 2008).

Social Work and Primary Health Care

Primary health care fundamentally promotes partnership in all aspects of health care (MacIntosh & McCormack, 2001). The United Kingdom has been at the forefront of integrating social work services in primary health care, as part of the broader efforts to create one-stop care service centres for patients and communities (McLeod, 2002). This strategy has been rooted in the understanding that access to social work services is vital for improving the chances of maintaining physical health, as well as long-term well-being and the prevention of chronic health issues (McLeod, 2002). The potential for certain populations, including underserved populations like the elderly or those living in poverty, has prompted a range of efforts to strongly integrate social work into primary health care settings (McLeod, 2002). Indeed, populations of elderly patients have enjoyed improved access to social services due to more social workers being staffed in primary health care centres (Cumella & Le Mesurier, 1999). Specifically, this population has benefitted from improved access to home and respite care, along with improved access to information, advice on health matters, and some of the elements of counselling (Cumella & Le Mesurier, 1999). These are all critically important resources for maintaining long-term health and well-being, especially among the aged population (Cumella & Le Mesurier, 1999).

It should also be noted that there is much research to support claims that social workers have an important role to play in primary health care settings. According to Craig, Frankford, Allan, Williams, Schwartz, Yaworski, & Malek-Saniee (2016), the research shows that both depression and anxiety tend to be under-diagnosed and under-treated in the context of primary health care settings. This is in spite of the fact that there is much evidence to show that depression and anxiety play an important role in an individual's overall experience of health and well-being (Craig et al., 2016). In one study, it was reported that nearly 80 per cent of patients in a primary health care clinic showed signs of depression or anxiety (Craig et al., 2016). Moreover, the data indicated that depression and anxiety were associated with a lack of quality social relationships, as well as a lack of problem solving skills and poor health (Craig et al., 2016). These findings show that social workers have a particularly important role to play insofar as these professionals are best equipped to help patients address a knowledge and skill deficits to improve their resources in these areas (Craig et al., 2016).

Thus, social workers in the context of primary health care are equipped with specific sets of tools and knowledges to help them address some of the key challenges and barriers facing clients in their attempts to maintain and manage their overall health and well-being (Craig et al., 2016). As part of primary health care teams, social workers can help clients such as these develop the skills and understanding needed to improve their social relationships, improve their problem solving skills, and ultimately address key issues contributing to their depression and anxiety (Craig et al., 2016). With better knowledge and understanding in these important areas, clients can take on more of the work required to maintain their own health and well-being, and ensure an improved overall quality of life.

In examining health care settings in Great Britain, Lymbery & Milward (2001) highlighted the recognition that closer working between social work and primary health is needed to ensure that community care needs can be met effectively. The authors indicate that this has led to the establishment of a “number of clinics” that have established social work positions within a primary health care setting (p. 242). The authors evaluated three primary care clinics (The Nottinghamshire Projects) in Great Britain. They conclude that the location of a social worker within the clinics brought about improvements in patient care “due to a more holistic preventative approach” (p. 246).

Much of the literature proposes a model that offers a biopsychosocial perspective that considers the whole person in the context of the larger environment. Allen (2010) contends that interdisciplinary teams including social workers “can bring this lens” (p. 183). Additionally the researcher stresses that social workers have a unique opportunity to ensure that health care models truly improve outcomes for the communities that they serve. Researchers Horevitz and Manoleas (2013) conducted a study of professional competencies of social workers in integrated primary health care supports. Similarly Allen (2012) posited that a team based model of care attempts to fully address the biopsychosocial spectrum of clients. A review of Zittel, Lawrence and Wodarski’s (2002) discussion of the biopsychosocial model of health and implications for health social work practice identified that a biopsychosocial perspective most often used in multi professional teams is the “model of choice for researching and addressing health related illnesses conjunctive to social work practice” (p. 19).

In their discussion of the bio-psychosocial model and implications for social work authors Zittel, Lawrence & Wodarski (2002) indicate a greater recognition of the importance of recognizing the relationship between health and psychological functioning. The authors outline

the importance of this recognition for the social work profession as active members of interdisciplinary teams. Additionally, they highlight the increased employment of social workers as active participants in primary care clinics. Allen's (2012) discussion of the future of medical social work indicates that social workers are well qualified in patient-engagement techniques as well as an understanding of social and environmental barriers to health. This bodes well for the social work profession as social work principles recognize the relationship between the individual and greater social context.

The implementation of new health care models has created opportunities for new roles for social workers in primary health care. A study by Rushton & Briscoe (1981) examining social work as an aspect of primary health care indicates that although social workers' roles in primary health care are difficult to define, a major area of expertise of social workers in a primary health care setting is the exploration of emotional factors. Lymbery & Milward's (2009) study indicates that the location of social workers in primary health care clinics may provide an opportunity to practice a form of social work which has the "potential to be more imaginative and creative than oriented practice within case management" (p. 253).

Reviewing the effectiveness of integrating social work psychosocial services into primary care practice, authors Badger, Ackerson, Buttell & Rand (1997) surveyed 299 physicians who had used social work services in primary care settings. Results of the study indicated that physicians expressed positive attitudes toward exploring psychosocial issues and referred to social workers. The authors contend that patient health outcomes are more beneficial when psychosocial issues are addressed.

To ensure that social workers are able to provide clients with these important benefits, there needs to be more emphasis on improving the education and training that social workers

receive in preparation for their practicing in integrated environments. The research notes that ongoing changes at the policy level are increasing the opportunities for social workers to practice in primary health care settings and other integrated environments (Davis, Guada, Reno, Peck, Evans, Sigal & Swenson, 2015). If social workers are to rise to the challenges associated with integrated care and the provision of services in primary health care settings, there need to be concerted efforts on the part of educators and leaders in the social work field to prepare future social workers to take on diverse and challenging roles in integrated primary health care environments (Davis et al., 2015). Models for the provision of culturally relevant care may be especially important for helping prepare these professionals to work in these environments, and with diverse populations with varying health needs (Davis et al., 2015). This review now turns to some of the specific challenges affecting social workers in the context of primary health care settings.

Social Work Challenges in Primary Health Care

While social workers have an important role to play in primary health care, their work and success in this field is problematized by a range of issues. According to Cowles (2009), some of the major challenges affecting social workers in primary health care settings and environments include a lack of understanding among interdisciplinary team members regarding the role and skills of the social worker. Ambiguity regarding the roles of social workers can impact on the concept of collaborative care within a primary care setting. Rushton & Briscoe (1981) indicate a potential area of difficulty in collaboration among multi-disciplinary teams is the fact that social workers' outlook and training differs considerably from that of doctors and nursing staff which creates ambiguity among primary team members. Badger, Ackerson, Buttell

& Rand, (1997) found that the role of the social worker in medical settings has not always been clear potentially leading to the de-valuation of social work services.

Gaboury et al. (2009) studied the key components of interdisciplinary collaboration within Canadian Integrative Health Clinics. The authors recruited 22 participants from various Canadian Integrated Health Clinics within varying positions including physicians, nurses, nurse practitioners and dieticians. The study identified the oppressive stance of the biomedical professionals with other disciplines which impacted collaboration amongst team members ultimately affecting patient outcomes. Lymbery & Milward (2009) noted that disparities in professional status between various groups may be a significant problem in interdisciplinary work, more specifically the authors indicate that social workers may “lose a sense of the specific contribution of the social work discipline due to the dominant ideological force [as] medical” (p. 243). Researchers Oandasan, Gotlib, Conn et al. (2009) studied staff in three Canadian family health centers in urban locations. Findings from the study revealed significant barriers to interprofessional team building which was associated with “lack of role understanding and lack of existing processes to teach collaboration” (p. 152).

Suggestions for increasing collaboration amongst teams included issues discussed by Gaboury et al. (2009) regarding the importance of awareness of one’s clinical paradigm and dual education and training, and understanding and knowledge of colleague’s roles and differing paradigms. This supports Giles, Gould, Hart & Swancott’s (2007) study of 36 social workers in New South Wales health clinics that found support for their hypothesis that “the greater the shared understanding of differing roles in multi professional teams, the greater the teams effectiveness” (p. 151).

In order to overcome the challenge of role ambiguity the research suggests that social workers take an active stance defining their roles. A study by Giles et al. (2007) of 36 social workers in New South Wales health clinics was to gain social worker's understandings of their practice in health and to develop common priorities for social workers to apply across a variety of health settings. The authors contend that traditional practices of health care are being questioned and it is essential for social work as a profession to clarify its role central to individual, family and community health status. Zittel et al. (2002) indicate that social workers must take an active role in further developing their roles in multi professional teams in order to further develop a bio-psychosocial model of health care. Allen (2012) stresses that "social workers need to articulate the unique qualifications and skill set they bring to the table" (p. 184). Badger et al. (1997) indicate that social workers can challenge the dominant medical ideology and "aspire to collaborative arrangements in primary care, they need to identify and educate the medical community about social work services and functions" (p. 22).

Brown, Lewis, Ellis et al. (2011) noted that both health care workers and social workers routinely experience conflict as part of their work on interprofessional teams in primary health care settings. For social workers, especially, the authors indicate that conflict is a routine and regular aspect of work associated with working as part of a collaborative team in primary health care. Major sources of conflict identified in the primary health care context included accountability, issues related to the role boundaries of different team members, and questions related to individual scope of practice (Brown et al., 2011). The authors specified that, when different team members do not fully understand the role of other team members, conflict can easily arise (Brown et al., 2011). Social workers have emphasized the belief that other team members may not fully understand what role they serve, or their importance to the work of the

interdisciplinary team overall (Brown et al., 2011). Doctors, conversely, have emphasized a need to understand who has authority to do what, and who should not be taking certain actions (Brown et al., 2011). It is noted, however, that over time, more experienced teams may encounter these problems with less frequency, as individual team members better understand others' roles, and there is less clear division in terms of who is responsible for different aspects of care (Brown et al., 2011).

Conflict can also arise when there are questions surrounding the scope of practice as experienced by other professionals (Brown et al., 2011). When a new professional is added to an interprofessional or interdisciplinary team, there may be confusion about the role and the specific responsibilities associated with the role (Brown et al., 2011). Established professionals have noted that the introduction of new team members can cause confusion; conversely, new team members can similarly experience confusion if there is not enough sharing or collaboration to facilitate the new professional's integration into the team (Brown et al., 2011). Other research shows that role conflict and role ambiguity are significant factors related to burnout and stress as perceived by social workers working in mental health care settings (Coyle, Edwards, Hannigan et al., 2005). This makes clear the notion that role conflict and confusion can not only contribute to conflict among members of the interdisciplinary care team, but lead to stress and burnout for the individual social worker.

Burnout in social workers has been found to be associated with the workload, the degree to which the worker is involved with patients receiving care, a perceived lack of support, and role conflict (Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2005). Burnout can also be linked to the effectiveness of caring (Cheung & Chow, 2011). This shows that challenges associated with interdisciplinary work have clear implications not only for the team as a

functioning unit, but for the individual professionals working on the team as well. Moreover, the research also shows that social workers are more likely to experience higher levels of stress when compared with other occupational groups that are comparable (Lloyd, King, & Chenoweth, 2002). This means that, among all the members of an interdisciplinary team, social workers may be the most vulnerable to experiencing stress-related burnout due to conflict and other problems in both the provision of care services, as well as the coordination of care. The challenge for social workers, then, is understanding how best to manage this stress in an environment where a lack of support and role confusion may be significant issues.

Research in this area may provide some helpful resources for social workers battling stress. While it has often been theorized that burnout is a phenomenon mostly related to the organization, the research by Egan (1993) indicates that the workers' views of themselves, as well as their world view can have a major impact on burnout. Additionally, workers who have high self-esteem and who perceive a sense of mastery over their work are less likely to become stressed and affected by burnout (Egan, 1993). It should also be noted that social workers may lack the education to be prepared to enter roles in primary health care thus making them vulnerable to burnout (Cowles, 2009). Researchers have argued that these findings provide evidence to support claims that primary health care organizations, along with social work educators, should do more to nurture and cultivate these feelings and attributes among social workers and other professionals working in primary health care settings (Egan, 1993). Such efforts could be critical for ensuring that individual social workers have more individual resources to help them safeguard against many of the challenges and problems associated with their work in primary health care. Moreover, because caring effectiveness has been shown to be linked to burnout, enhancing professional competencies through various training and learning

strategies can potentially protect the social worker from experiencing burnout (Cheung & Chow, 2011).

A discussion by Solberg (2016) shows that for their part, health professionals in primary health care settings are frequently stressed, overworked, and feel discouraged about their ability to be successful in these roles. Indeed, it is not just social workers who experience the stress and difficulty of working in these complex and often stressful environments while providing care. According to da Silva, Peres, de Souza Lopes, Schraiber, Susser, & Menezes, (2015), the research shows that all members of primary health care teams may face the risk of violence in the workplace. In addition, the research shows that exposure to different types of violence is associated with the development of depressive symptoms in the individual worker (da Silva et al., 2015). The most common type of workplace violence reported among interdisciplinary health care teams in primary care settings is insults, which represents 44.9 per cent of all incidents of workplace violence (da Silva et al., 2015).

In addition, social workers and other health care workers may be at risk for experiencing other types of violence at work, including threats, and acts of physical aggression (da Silva et al., 2015). Exposure to these types of violence was found to be linked to depressive symptoms (da Silva et al., 2015). Moreover, this research also uncovered, within this particular population of workers, levels of depression were already high, at 36.3 per cent (da Silva et al., 2015). Among workers in this category, 16 per cent were identified as potentially having major depression (da Silva et al., 2015). These findings show that for all workers in primary health care teams, the nature of the work, as well as the context in which work takes place poses significant risks for health and well-being. Moreover, exposure to violence can potentially heighten the negative

effects of conflict and other problems these workers already face due to the interdisciplinary nature of teams in the primary health care setting.

Social Workers' Experiences in Primary Health Care

For social workers, the experience of working in primary health care settings can be fraught with an array of complex challenges and other issues. While conflict and stress have been shown to be routine and commonplace within these different interdisciplinary teams, the literature also notes that social workers and community health professionals can be an important source of support, and that collaboration and working together can help to address challenges associated with providing care in coordinated fashion (Brownstein, Hirsch, Rosenthal, & Rush, 2011). From this perspective, both social workers and other types of professionals involved in the provision of primary health care services can be a source of strength and support for their fellow professional. In order for such support to be realized, however, team members must be able to communicate effectively and have strong knowledge and understanding of their own role in primary health care, as well as the roles of their fellow professionals.

The research also shows that issues like role confusion and scope of practice may be compounded by the fact that social workers may be expected to take on different roles at different times as part of their work on primary care teams (Craig & Muskat, 2013). Researchers investigating the work of social workers on primary health care teams found that social workers were expected to play diverse roles in the course of their day-to-day work (Craig & Muskat, 2013). The specific roles identified by researchers in this case included those of the bouncer, the janitor, the glue, the broker, the firefighter, the juggler, and the challenger (Craig & Muskat, 2013). Besides the fact that these roles all include different duties and responsibilities, the researchers found that there were different levels of status associated with these differing roles

(Craig & Muskat, 2013). The multiple roles played by social workers no doubt contribute to the problem of role confusion on interdisciplinary teams. Social workers have noted the challenges they encounter in promoting understanding among doctors and other professionals regarding their role and purpose within the context of the care team (Cowles, 2009). Other professionals need to understand that the particular role adopted by a social worker in a given situation depends upon not only the client's needs, but the needs of the care team and other factors associated with the situation.

The role of the bouncer involves the social worker forcefully taking control of a situation (Craig & Muskat, 2013). The authors highlighted that social workers noted their being called upon frequently to take on the role of the bouncer in primary care settings (Craig & Muskat, 2013). While this is not a role that typically occurs in most health care settings, social workers reported being made to feel like they were put in a position where they had to adopt the role of the bouncer in order ensure a successful outcome (Craig & Muskat, 2013). While this role can be likened in some ways to that of an arbitrator, it requires a higher level of assertiveness (Craig & Muskat, 2013). Moreover, the use of force, rather than diplomacy is often required by this role (Craig & Muskat, 2013). One of the main challenges for social workers associated with this experience is that they are largely unprepared to take on this role; when expected to do so, social workers can experience stress and discomfort in determining how best to take charge of a situation and resolve any problems (Craig & Muskat, 2013). When these and other challenges are further compounded by problems such as role confusion, conflict can easily arise between different team members.

Social workers are also frequently expected to take on the role of the janitor (Craig & Muskat, 2013). Social workers noted they were often expected to carry out clean-up or janitorial

type services by other members of the team, and that other members of the team often failed to recognize the importance of these tasks (Craig & Muskat, 2013). In this study, the majority of social workers surveyed indicated that while they did not enjoy performing these tasks, they recognized their overall importance to the success of the care team and for the provision of services (Craig & Muskat, 2013). Playing this role often involves the social worker attempting to fill the gaps left by others on the team or clean up messes created by others (Craig & Muskat, 2013). Conversely, when adopting the role of glue, the social worker functions to hold the family, the treatment plan, and even the interdisciplinary care team together (Craig & Muskat, 2013). Playing this role can add an additional burden to social workers, as they are often expected to provide support to both staff and patients (Craig & Muskat, 2013). Because social workers are already at an increased risk for experiencing burnout due to their work (Lloyd, King, & Chenoweth, 2002), fulfilling this role may be especially challenging.

Social workers are also expected to take on the role of the broker, which requires them to facilitate and coordinate communication and understanding between patients, their families, and members of the medical team (Craig & Muskat, 2013). During the period of transition, it is social workers who take the role of leading the transition and brokering the coordination of services for the client, as well as communication among the different stakeholders involved (Craig & Muskat, 2013). Unlike the role of glue, which simply involves providing support, the role of the broker involves the social worker actively negotiating and brokering the provision of services, and coordinating the various aspects of care (Craig & Muskat, 2013).

In the role of the firefighter, the social worker strives to resolve crises or otherwise drop what they were doing to address an immediate problem or other issue (Craig & Muskat, 2013). Due to the prevalence of conflict in interdisciplinary care teams in primary health care settings,

social workers may be frequently called upon to take on this role (Craig & Muskat, 2013). It is also noted that in primary health care settings like urban hospitals, other professionals working as members of the interdisciplinary care team are likely to turn to social workers to adopt this role (Craig & Muskat, 2013). Other professionals on the care team tend to look to social workers to address crises that emerge in the provision of care services and have noted the skills that social workers bring to these situations in their attempts to successfully resolve them (Craig & Muskat, 2013).

The role of the juggler involves the social worker managing multiple roles at once, including many of the roles discussed here (Craig & Muskat, 2013). Social workers have indicated that as part of their work, they must not only manage these different roles, but also manage the expectations associated with the primary care setting, as well as their various cases (Craig & Muskat, 2013). Finally, the role of the challenger involves the social worker adopting the role of advocate for the individual client (Craig & Muskat, 2013). Frequently, social workers have to act as advocates for the client among other members of the care team, as well as advocate in the broader context of the hospital itself (Craig & Muskat, 2013). Social workers have reported a strong desire to challenge the traditional medical model, as well as ensure that the total spectrum of patient needs were addressed by the care team as a whole (Craig & Muskat, 2013). The need for social workers to adopt multiple roles exists regardless of the practice context (Lucio, 2015). It is clear, however, that for social workers in primary care settings, there is a need to transition seamlessly between different roles in order to meet the needs of the client, as well as those of other team members.

A final issue to note regarding social workers' experiences in primary health care settings relates to their serving historically marginalized and underserved populations. The literature

notes that social workers may face challenges in their attempts to provide services to these marginalized populations due to their socio-economic insecurity, the lack of trust for the health care and social service system, and a lack of understanding about the nature of treatment (Treloar, Gray, Brener, Jackson, Saunders, Johnson, & Newman, 2014). For example, research by Treloar et al. (2014) on Aboriginal populations with cancer has shown that these three issues present as key challenges for all workers involved in primary health care. These specific issues create particular challenges for successful service provision in the traditional context of service delivery (Treloar et al., 2014). A more inclusive approach rooted in an understanding of how the community has historically been maligned by government can help social workers to potentially address and overcome issues of mistrust and other challenges (Treloar et al., 2014)

Interdisciplinary Teams and Social Work

Historically, the research on interdisciplinary and inter-professional teams in the context of primary health care currently has suffered from some significant shortcomings (Schofield & Amodeo, 1999). In the past, researchers have noted significant weaknesses in the terminology used in interdisciplinary team research, as well as the actual content of the research (Schofield & Amodeo, 1999). Given the need for improved understanding in this area to help social workers and other professionals address the multiple challenges they face in their work as part of these teams, efforts to address these shortcomings have been theorized as being critical. Over time, however, much progress has been made by way of generating improved understanding of social work in the context of interdisciplinary primary health care teams (Maramaldi, Sobran, Scheck, Cusato, Lee, White, & Cadet, 2014). For example, researchers have now developed a universal basis of interdisciplinary social work competencies (Maramaldi et al., 2014). This represents an

important step toward helping social workers identify and assess key competencies relevant to their success in working as part of integrated care teams (Maramaldi et al., 2014).

It should also be noted that Hudson (2002) emphasizes how inter-professional team work has often been cited in the literature as a “lofty goal” and potentially unworkable in reality due to differences in perspectives between differing professions. In the U.K., much of the focus in the fields of health care and social work have involved emphasis on organizational partnerships and cooperation, rather than inter-professional team work (Hudson, 2002). It should be noted that community nurses and social workers in this context have challenged this longstanding idea by developing a model for working together in primary health care (Hudson, 2002). A key challenge in this area relates to the fact that historically, it has been seen as impossible to develop inter-professional partnerships and collaborative teams involving members of different professions. Overcoming this stereotype has represented a challenge for both health care and social workers in the health setting. Research by Lymberry (2006) also shows that an additional challenge in this area relates to the ways that concepts like ‘partnership’ and ‘collaboration’ have been poorly defined. Despite these ideas being identified as critically important at the policy level, a lack of clear definitions means that professionals, including both social workers and doctors and nurses, have historically faced many challenges in their efforts to live up to these ideals.

Some authors have noted that the differing nature of social work and the health care professions also tends to problematize collaboration in primary health care settings (Lymberry, 2006). It is noted that there are major power differentials, as well as cultural differences between social workers and doctors and nurses (Lymberry, 2006). The literature indicates that disparity in professional status exists, more specifically, Dingwall (1982) cited in Lymberry (2011) discuss the tendency for the differing professional groups to struggle to maintain control of their work.

The author concludes that physicians are most likely to impose their characterization of the problems onto others on the team due to their structurally more powerful position. Ultimately, in the majority of primary health care settings, the contributions social workers can make are limited to those approved of by the doctor (Lymberry, 2006). This means that social workers may face a range of significant constraints due to their having less power than doctors in the context of primary health care. This can also be intensified when the social worker adopts different roles (Craig & Muskat, 2013). This can directly impact on inter-professional work by creating conflict around team goals and objectives. It is noted that, in primary health care settings, team goals should always be developed in consultation with all team members having the opportunity to contribute their thoughts (Xyrichis & Lowton, 2008). Research points out that there is a tendency, however, for medical staff to adopt more of a leadership role in this regard, thanks in part to their higher levels of power (Xyrichis & Lowton, 2008). Moreover, these imbalances may be institutionalized in some settings; in the UK, general practitioners are tasked with running the primary care groups responsible for the commission of primary health care services (Rummary & Coleman, 2003).

In their research, Xyrichis et al. (2008) highlight two main factors that tend to have an impact on the ability of interdisciplinary teams to work together successfully in primary care settings, including the structure of the team and the processes used by the team. The researchers also identified six specific issues related to these factors, including team premises, team size and composition, the support available from the organization, the meetings held by the team, the presence of clearly articulated goals, and finally, team audits (Xyrichis & Lowton, 2008). The nature of the professionals involved in these teams means that an understanding of the various barriers preventing effective teamwork is required for smooth collaboration (Xyrichis & Lowton,

2008). In other words, while teams may provide inherent advantages for those working in other settings, the differences between the professionals involved in interdisciplinary teams in primary health care settings means that teams themselves are not inherently favourable to greater success (Xyrichis & Lowton, 2008).

The authors highlight some of the barriers that limit team effectiveness beyond the control of individual nurses and social workers (Xyrichis & Lowton, 2008). For example, individual workers can often do little to affect the overall size of the team, or its knowledge base (Xyrichis & Lowton, 2008). Other barriers and challenges are more open to change and the potential for change (Xyrichis & Lowton, 2008). As noted, the power imbalance between professions is a significant issue that tends to affect a range of issues related to effective team work. The researchers argue that where funding exists for such resources, the introduction of skilled facilitators could be useful in resolving conflicts in these team-based settings (Xyrichis & Lowton, 2008). Facilitators can potentially help the different sides involved resolve conflicts and come together to meet patient goals (Xyrichis & Lowton, 2008). At the same time, greater funding and support for inter-professional education can better prepare both social workers and nurses and doctors to participate in these important health care teams (Xyrichis & Lowton, 2008). Allowing professionals the opportunity to learn more about each other and each other's role in primary health care can lead to greater understanding, as well as more mutual respect, which can improve collaboration overall (Xyrichis & Lowton, 2008).

Other research shows that there may be additional opportunities for social workers to make valuable contributions as members of primary care teams. Translational science involves attempts to streamline the latest findings from research into clinical practice, and has been made a top priority by the National Institute of Mental Health (Brekke, Ell, & Palinkas, 2007).

Translational science is seen as having the potential to help introduce findings from research into care settings in faster and more expeditious ways (Brekke, Ell, & Palinkas, 2007). Social workers may have a strong role to play in facilitating this work (Brekke, Ell, & Palinkas, 2007). The authors argue that social work is the best-positioned profession to take on this role and improve the quality of mental health care services that patients receive (Brekke, Ell, & Palinkas, 2007). If social workers are to become leaders in translational research, there needs to be additional efforts put forth at ensuring that the field can develop the kinds of leaders needed to participate in this difficult work (Brekke, Ell, & Palinkas, 2007). Striving to achieve this outcome will no doubt require additional resources and create challenges for social workers; adopting more of a leadership role in translational science and research could potentially address some of the power imbalance issues affecting interdisciplinary teams, especially those tasked with addressing mental health dimensions of community need (Brekke, Ell, & Palinkas, 2007).

Summary

It is clear that social work is currently in the midst of a broader paradigm shift with regard to the provision of health care and social services in the western world. Policy initiatives in recent years have focused on the integration of care services and primary health care to address a diverse convergence of patient needs related to various systemic and individual health issues. As a result of this changing practice context, social workers are increasingly being tasked to adopt diverse roles in their work, as well as rise to the many challenges associated with integrated primary health care. While these issues have certainly complicated the work of social workers and exposed them to a range of risks that can affect their physical, emotional, and psychological well-being, the drive toward the integration of care represents a positive step for both individual clients, as well as the field of social work overall.

The need for professionals to communicate and collaborate effectively in primary health care settings demands that social work education respond with efforts to better prepare social workers to operate in interdisciplinary contexts. Moreover, their work with clients in this context demands improved cultural education and training to help ensure that social workers are mindful of challenges that can arise due to differing perspectives, values, and ideas. In this sense, social workers are being asked, more than ever before to manage a complex range of patient needs, while also managing the needs of other professionals. This not only requires the adoption of multiple roles, but also the development of a range of competencies, and individual characteristics. Educators and leaders in the field should focus on how best to empower social workers in these challenging contexts, as well as ensure they have the access to the resources needed to facilitate their success. Only when the education and training resources available to social workers better reflect their occupational challenges in primary care settings will future generations of professionals be well-equipped to manage the needs of clients, as well as their fellow professionals. By the same token, enhanced training for doctors and nurses is needed to help them understand the complex nature of social work, as well as the need for social workers to adopt multiple roles and address competing issues.

The literature has been beneficial in identifying health care reform as well as challenges the social work profession has encountered with a shift to a more collaborative care model. Studies have been conducted that have sought the perspective of “team members” which have often inferred this to be the social workers perspective. Few Canadian studies have been done that explore the experience from the perspective of social workers. In particular, this writer was unable to find any literature exploring the experiences of social workers employed in Nurse Practitioner-Led Clinics (NPLCs). This reinforces Liamputtong (2007) suggestion that more

research is required from the viewpoint of the lived experience; research on the perspectives of social workers in NPLCs can provide valuable insights into their experiences.

Chapter 3: Research Design and Methods

The purpose of this qualitative study was to understand the experiences of social workers who are employed in primary health care, more specifically Nurse Practitioner-Led Clinics. Another rationale for doing this research is to gain a better understanding of social workers experiences, from their perspective, based on their experiences of being employed in this setting. An interdisciplinary collaborative approach is a systems perspective for the provision of essential health care for all which has been associated with effective health care delivery. A team based approach is a useful way to deliver primary health care, however a gap in understanding the very nature of interdisciplinary teamwork can be illustrated by the lack of research on social workers' role in the delivery of a primary health care model.

The research questions to be addressed in this study were based on a review of the literature and my own experiences as a social worker employed in a primary health care model. A series of twenty-one questions divided into four sections including environment, education and orientation, mentorship, rewards and future were asked of the participants (Appendix A). The methodology section below will highlight how this research study was conducted.

Methodology

Using a qualitative research method, the purpose of this study was to explore the experiences of social workers who are employed in the new era of primary health care, more specifically, to explore the experiences of social workers who are employed in Nurse Practitioner-Led Clinics. Creswell (2009) defines qualitative research as “a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem” (p. 4). Authors Fossey, Harvey, McDermott and Davidson (2002) suggest that qualitative research “needs to draw on different perspectives, methodologies and techniques to generate breadth of

knowledge and depth of understanding” (p. 717). Qualitative research does not suggest a single truth about the experiences of subjects in a study; rather, it describes the experiences of all participants and acknowledges that their experiences are rooted in multiple contexts (Creswell, 2007). Qualitative research is well suited to this study as it allows the research participants to develop and create their own meaning regarding how they experience being employed in a primary health care setting. As such, I interviewed nine social workers who are employed in Nurse Practitioner-Led Clinics throughout Ontario in order to gain a better understanding of their experiences when employed in primary health care settings, from their own perspectives.

Theoretical Perspective

The purpose of this study was to understand the experiences of social workers who are employed in Nurse Practitioner-Led Clinics. The research questions were best answered by a phenomenological approach because it enabled the search for the meaning and nature of social workers direct experiences through their own accounts.

It is not enough to refer to phenomenology as a research approach. A key feature of phenomenological research, as defined by Creswell (2007), is the strong philosophical component. It is important to clarify how the philosophical principles of phenomenology are implemented in a particular study as it provides direction for the overall structure of data analysis and procedures (Moustakas, 1994 as cited in Creswell, 2007, p 78). The rationale for this study is from a social constructivist/critical theory worldview. Social constructivism is an interpretive framework where individuals seek to understand their world and attach their own meanings to their experiences (Creswell, 2013). In addition, Creswell (2013) identifies the social constructivist view as a concept whereby multiple realities exist and are constructed through interactions with others; it takes the view that “individuals seek understanding of the world in which they live and work” as well as axiological beliefs of the importance of researcher’s values

that can influence research (p. 24). From a social constructivist perspective, people create meaning out of their experiences through interactions with others within a changing social and historical context (Creswell, 2007; Schwandt, 2003). These meanings are formed through interactions with others rather than being distinctive within each individual (Creswell, 2013). Applying a social constructivist framework was the most useful approach in obtaining the views and distinctions that influenced the individual worldview of the research participants. It allowed the participants to fully and freely describe their own interpretations of their experiences.

This worldview dovetails nicely with critical theory which acknowledges the conception that many peoples' realities are based on inequalities in societal power and privilege. Freeman & Vasconcelos (2010) describe critical theory as being concerned with enabling disenfranchised members to overcome domination and is based on the premise that certain groups in society are in a subordinated position. The controlling group has greater prestige, power and status than the oppressed group. In critical social theory, power is extra-personal, which means that an increase in power is compensated by someone else surrendering part of their power. From this perspective, empowerment is equated with liberation and involves a struggle because powerful people are not likely to readily hand over resources, information or responsibility unless they see an advantage to doing so. According to Kincheloe and McLaren (1994), the common purpose of researchers who approach investigation through critical theory therefore is to come to know about human experience to promote social change (Cited in DePoy et al., 1999, p. 561).

Collaboration can be defined as working with another person or group in order to achieve a goal. There is much research to show that inter-professional collaboration has become an important factor in health care delivery. A study of collaboration in Canadian integrative healthcare clinics discusses a collaborated practice as "a combination of biomedical practice with

alternative holistic medicine therapies and practitioners” (Gaboury, Bujold, Boon, & Maher, 2009, p. 707). Additionally, the authors highlight the view that health care professionals working in interdisciplinary health care clinics often enter the collaboration with very different paradigms of healthcare and visions of health and illness (Gaboury et al., 2009). Findings that emerged from this study highlighted the interpersonal relationships within some of the clinics showed “some signs of a hierarchy imposed on the nonmedical practitioners by their biomedical peers” (p. 713). The authors found that “the implicit hierarchical rapport either affects complimentary alternative practitioners differently based on their professions or is enacted differently by the biomedical practitioners based on their complimentary alternative peers’ profession” (p. 713).

A critical theory framework can uncover existing power differentials which can potentially lead to findings about the creation of a more egalitarian rapport between practitioners. The positive aspect of this could assist in the development of more efficient health care teams whereby an optimal working environment where practitioners are encouraged to exchange and where conflicts are minimal would positively impact patient outcomes (Gaboury et al, 2009).

Setting

In consideration of the setting, Creswell (2009) indicates that qualitative researchers tend to collect data at the site where participants are more likely to experience the issue or problem being studied. In this study, the Nurse Practitioner-Led Clinics were an appropriate place for the population group that was interviewed. More specifically, the setting for this research was the multiple sites of Nurse Practitioner-Led Clinics located within the Province of Ontario (Appendix B, Map of Clinic Locations in Ontario). The characteristics of the 25 clinics are urban and rural locations within the Province of Ontario. All clinics are led by nurse practitioners and employ social workers. The use of multiple sites required careful consideration in terms of

geographical location as this had the potential to be time consuming and costly, consideration was given to geographic location in the discussion regarding data collection. No further detailed setting descriptors will be provided due to the potential of being a possible participant identifier and in order to preserve the confidentiality of participant data. Further discussion of this will be provided in ethical considerations.

Sampling

In qualitative research Patton (2002) associates the sampling strategy of purposeful sampling as most well suited for qualitative inquiry. The author describes the objective of purposeful sampling as “selecting information-rich cases strategically and purposefully; specific type and number of cases selected depend on study purpose and resources” (p. 243). This notion is supported by Polkinghorne (2005) who outlines the goal of qualitative research as “enriching the understanding of an experience” as such, the selection of participants is purposeful and should not be random or left to chance (p. 140). Additionally, Patton (2002) identifies several types of purposeful sampling including criterion sampling which the author describes as the involvement of selecting participants who meet some predetermined criteria.

Since the intention of this research was explore the experiences of social workers employed in Nurse Practitioner-Led Clinics in the Province of Ontario the purposeful sampling strategy used was criterion sampling as all participants met the predetermined criteria of a primary health care social worker employed in a specific setting. In terms of sample size Higginbottom (2004) noted that “sample size is not determined by the need to ensure generalizability, but by a desire to investigate fully the chosen topic and provide information rich data” (p. 14). This research sought to investigate the topic by providing all 24 social workers employed in the Nurse Practitioner-Led Clinics the opportunity to participate.

Recruitment

In terms of recruitment of participants Polkinghorne (2005) stresses the importance of seeking participants that can provide important perspectives about the phenomenon under investigation as opposed to those who are conveniently available. The author suggests reaching out to social networks can be helpful for securing basic information. The recruitment method to obtain the nine participants for this study was done by mailing an invitation to participants (Appendix C) along with a consent to participate (Appendix D) to all Nurse Practitioner-Led Clinics in the Province of Ontario to the attention of the social worker. The invitation to potential participants outlined the intent and purpose of the research study, the approval of the Research Ethics Committee of Laurentian University, the approximate time involved and the contact information of both the researcher and thesis supervisor. The consent to participate outlined that this was a voluntary study and participants were free to withdraw at any time. If interested in participating, participants were asked to sign the consent form and mail it back to the researcher in the self- addressed stamped envelope that was provided. Participants were asked to include their preferred method of contact highlighting the importance of personal contact information.

Ethical Considerations

Of particular concern with regard to selecting and recruiting participants are the ethical considerations. The Tri-Council Policy Statement (2010) outlines ethical considerations for concern of the participants welfare; factors include “physical, mental and spiritual health” (p. 9). All participants were provided consent forms authorizing their voluntary participation in the study. The consent form highlighted that participants have the right to withdraw from the research at any time. In keeping with the principles of ethical conduct and respect for human dignity, confidentiality and privacy is very important considering the situational influences of my

sample population such as being interviewed at and speaking of their occupation within Nurse Practitioner-Led Clinics. Consideration for participant safety must be given in terms of participant's level within the organizational hierarchy. The consent form requested preferred method of contact be personal contact information including phone numbers and/or personal electronic mail accounts. Furthermore, it stated that, as the total sample size is relatively small consisting of 24 social workers, no participant or setting demographics will be provided as a way to further maintain the privacy and confidentiality of the participants.

Data Collection

In order to begin data collection, a 25-page research proposal had to be developed and reviewed by Laurentian University's School of Social Work for a period of ten days, as a requirement by the Masters of Social Work (MSW) Program committee. After approval was received from the committee, the next step was to get approval from the Laurentian University Research Ethics Board; approval was granted on April 15, 2015.

Careful reflection was given in terms of the data collection process as geographic locations and resources did not permit face to face interviews with the nine participants. All participants requested their initial preferred method of contact via personal electronic mail which was provided on their consent forms. After initial contact was made with the nine participants via electronic mail, seven of the participants requested receipt of the questionnaire via personal electronic mail and two of the participants requested telephone recorded interviews.

With respect to the research instrument, Creswell (2007) discusses data collection in phenomenological research as consisting typically of "two broad general questions...other open ended questions may also be asked" (p. 81). For the purpose of this research study, the primary research question for this study was the following: what are the experiences of social workers

who are employed in Nurse Practitioner-Led Clinics? A semi-structured questionnaire included several sub questions. The full instrument is included in this report as Appendix A.

A limitation of the data collection process in this study is the inability to conduct face to face interviews with the participants due to geographic location as well as several participants citing time constraints. Data collection consisted of electronic mail correspondence and telephone recorded interviews therefore limiting my ability to observe facial/body expression and physical location as well as hearing tone of voice.

For this study, there were two telephone interviews which were recorded and took approximately 90 minutes to complete. The seven other participants returned their responses to the questions to this researcher's personal electronic mail. All participants had returned the signed consent via Canada Post to this researcher prior to conducting the interviews. Ongoing electronic communication ensured the participants felt comfortable with the consent form as well as being provided the opportunity to ask any questions. Upon completion of the two telephone recorded interviews, I transcribed each interview verbatim and offered the participants with a copy of the transcript. A follow-up discussion with the nine participants via electronic mail took place after the initial coding of the data for the purpose of reviewing and providing the opportunity for feedback.

Researcher's Role

A defining methodological feature of phenomenology emphasized by Creswell (2007) is the notion of "bracketing" (p. 78). Creswell (2007) describes this process as "identifying and discussing the researcher's personal experiences with the phenomenon" (p. 78). The assumption is that this process will allow the researcher to set them aside and focus purely on the experiences of the participants.

As the student researcher, I took the lead role in collecting and analyzing the data from the interviews with the participants. I have a particular interest in hearing social workers personal opinions about their experiences working in Nurse Practitioner-Led Clinics. I have been working in the field of primary health care as a social worker within a Nurse Practitioner-Led Clinic for six years. I have noticed from the literature that social workers do not have much of a voice when it comes to demonstrating the value of social work practice in the lives of individuals, families, communities and the on-going development of the systems that deliver health care services. Also, there is limited information from a social worker's perspective related to their experiences. I have a strong belief that if we understood more about social workers experiences in Nurse Practitioner-Led Clinics we could provide a better understanding of social workers competencies which can strengthen and focus the role of social work in primary health as well as health care reform.

As a researcher and a social worker employed in a Nurse Practitioner-Led Clinic it is vital that I am aware of the issues that may arise when studying colleagues. Creswell (2013) discusses potential issues that may arise from studying "one's own backyard" (p. 151). The author describes this type of knowledge as "dangerous knowledge" outlining risks that may include raising questions about the quality of data collected (p. 151). Throughout the process I was aware that I needed to be reflexive and mindful throughout the research study about my role as a researcher. I continuously kept in mind that my role is as a researcher and not a social worker employed in a Nurse Practitioner-Led Clinic. I believe this piece of reflexive practice was needed at every interview and throughout every step of the data analysis process. I recognize that my employment in the field of primary health care is a factor that I needed to continuously reflect upon when listening to participants as they shared their experiences.

Strategies for Validating Findings

In order to validate my research findings, I will begin by clarifying my research bias at the onset of the research process. According to Creswell (2007), “clarifying research bias from the onset of the study is important so that the reader understands the researcher’s position and any biases or assumptions that impact the inquiry” (p. 208). I have made it clear in the section on *Researcher Role* that a large part of the reason for doing this research is due to my personal interest in the topic of my research study. I have also been open and honest in this research paper about my current work in the field of primary health care, particularly as a social worker employed in a Nurse Practitioner-Led Clinic and the biases that could potentially impact the analysis. These biases could involve the way that my questions are worded. I already have the assumption that some social workers employed in primary health care are devalued; however, I need to remain objective and open to the viewpoints that are being presented to me. Due to the above noted reason, I need to be continuously self-aware of my role as a researcher versus my role as a social worker in a Nurse Practitioner-Led Clinic. I will remain conscious of this distinction by maintaining a reflexive journal. This writer’s openness and self-reflection with regard to contemplation of my professional location contributes not only to the validation of this study but to ethical validation as well.

Member checking is considered by Lincoln and Guba (1985) to be one of the most critical techniques to establish credibility (Creswell, 2007). In this study, the two initial telephone interviews were 90 minutes in length. Once I completed the interviews and transcribed the data, I provided the two participants with a copy of their transcript and gave time to review it. The seven participant responses which were received electronically were reviewed by this researcher. Subsequent individual electronic communications with the nine participants was

conducted to review their feedback about the transcript that they have read as well as the responses to questionnaires they submitted. Participants were asked to share anything that they wanted to add to the information that had already been gathered or whether there was something that was misunderstood. Once coding the data was complete and themes extracted, the participants were provided with an overview of the themes via electronic mail. The purpose of this was to ensure that the participants felt like they were part of the process and also to provide them with the opportunity to share additional information that they may not have thought about during the initial interview. According to Creswell (2007) “seeking the participants perspectives of the results/findings” is another form of validation (p. 252).

Another form of validation outlined by Creswell (2007) describes the characteristics of the data collection process as consisting of in-depth interviews with participants that provide deep, rich understanding of the lived experience of the participants. The use of open ended questions in the data collection process of this study does not limit participant information which according to Creswell (2007) speaks to the validity and trustworthiness of the study by way of transferability.

Other validation strategies discussed by Creswell (2007) state that “prolonged engagement and persistent observation in the field include building trust with participants, learning the culture” (p. 250). Furthermore, Fetterman (2010) contends that “participant observation requires close, long-term contact with the participants” (Creswell, 2013, p. 251); Lincoln and Guba (1995) contend that trustworthiness of a study incorporates creditability and transferability which is “operationalized by prolonged engagement in the field as well as thick description to ensure the findings are transferable between the researcher and those being studied” (Creswell 2007, p. 246). It is the intent of this study to conclude that the data established

credibility and transferability due to the “thick descriptions” provided by the participants. To further enhance the reliability of the study field notes, journals and descriptions of data collecting methodologies were maintained.

Data Analysis

The data was analyzed inductively utilizing interpretive thematic analysis. According to Braun and Clark (2006) an inductive approach means that the themes extracted from the data are strongly linked to the data themselves rather than picking out data that fits the belief of the researcher or a theory. Thematic analysis is a method for identifying, analyzing and reporting themes within data that is collected through research. According to Braun and Clark (2006) thematic analysis gives the data analysis process credibility and clarity about how certain themes and patterns came from the particular data being analyzed in addition, the authors discuss how this approach complements the features of flexibility in qualitative research. This method has six phases to the analysis, and I used the step-by-step guide provided by Braun and Clarke (2006).

In step one of the model the authors outline how the researcher has to be familiarized with the information collected. She does so by reading and re-reading the data that was transcribed. In my analysis of the data collected, the process of thematic analysis began immediately after I received the first questionnaire response. In step one of the model I became familiar with the data by reading and re-reading the responses. Additionally, I choose to transcribe the two audio-recorded interviews and read through them several times. In step two, the researcher must generate initial codes and begin building the analysis which is a summary of parts of the data. I began to generate codes by highlighting in different colors important information with what I thought was relevant to the research question as well as making notes on the transcript. The third step is about searching for themes from the codes identified. The themes

will capture important information about the data as it embraces the codes to form a theme. In step three, I began searching for themes by creating a color code theme and extracted segments of the data according to the color coding. I continued decontextualizing the data further into sub categories by copying and pasted the colored highlighted sections on a separate document. I began searching for themes by reviewing the data codes over and over again. As I was reviewing the codes, themes came forward and I was able to make associations with commonalities from each participant. Step four is reviewing potential themes and making sure that it tells a story about the gathered data and codes. In doing so, the researcher is “quality checking” the themes, according to Braun & Clarke (2006, p. 82). In step four I continued to review the themes in relation to relevance to the research question. In step five, the researcher is defining and naming the themes to be able to give a clear definition to each of the given themes, which is also known as “define and refine” (Braun & Clarke, 2006, p. 92). In this phase, I was able to explain what all of the themes and sub-themes signify and how they are related to the research topic. A diagram was created outlining the interconnectedness of the concepts. Step six is producing the written report. The purpose of this phase was to provide a story of the data.

Summary

This chapter included a summary of the procedure taken to conduct the research in order to gather the necessary data from the participants. The steps outlined to conduct this study were carefully chosen in the hope that it best represents the experiences of social workers who are employed in Nurse Practitioner-Led Clinics. In the next chapter, I utilize the results from this study and explore the interpretation of each theme based on the social worker’s perspective using quotes from the participants. Additionally, linking the main themes to existing literature highlights the importance of this information that could facilitate expanding on the current study

results. The perspective of the social constructivist/critical theory worldview was used to gain an understanding of the participants experiences of the world in which they work and the meanings they attach to their experiences. A social constructivist framework was the most useful approach in obtaining the views and distinctions that influenced the individual worldview of the research participants. It allowed the participants to describe their own interpretations of their experiences. Moreover, critical theory acknowledges the concept that many peoples' realities are based on inequalities in societal power and privilege. From this perspective, a critical theory framework can uncover existing power differentials which can lead to the creation of a more egalitarian rapport between practitioners.

Chapter 4: Results and Discussion

This chapter provides a description of the results of a qualitative study designed to explore the experiences of social workers who are employed in Nurse Practitioner-Led Clinics. It includes three main sections: a summary of the study, a discussion of the findings of the study and a discussion of literature related to the findings.

Themes and Subthemes Emerging from the Analysis

My initial codes were comprised of eight main themes. In phase five, I was able to refine my eight main themes into two groupings with six final themes and three subthemes that are representative of the overall story of the data and true to the research question (see Figure 1).

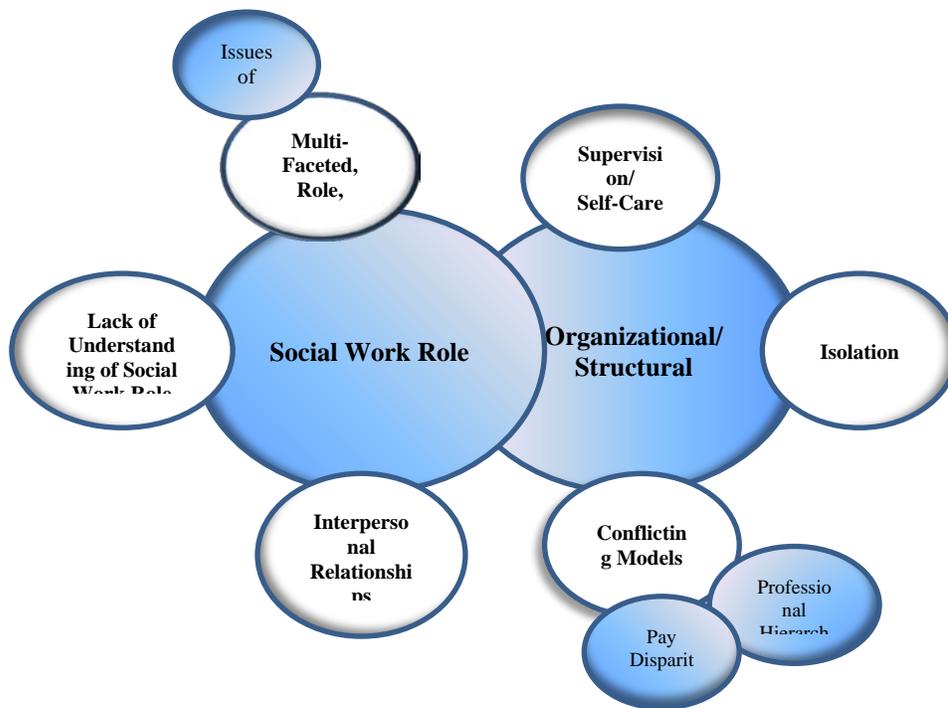


Figure 1: Themes and subthemes emerging from the analysis

Figure 1 shows the themes and subthemes that emerged from the analysis. The themes are organized into groupings of six themes and three subthemes that show the participants'

perspectives (see Figure 1). In-depth exploration of the experiences of social workers employed in Nurse Practitioner-Led Clinics requires an understanding of the inter-relationship of the two main groupings; group one is shown in Figure 2 pertaining to the social work role and group three is shown in Figure 3 relating to organizational and structural issues.

The first grouping represents the social work role within Nurse Practitioner-Led Clinics (See Figure 2 for Social Work Role). The first theme identified the social work role as multi-faceted and hard to define, a subtheme included issues of poverty as all of the participants identified working from the broader social determinants of health in terms of poverty. The second theme highlighted the lack of understanding the social work role in terms of competencies by other professionals. The third theme in this grouping identifies the importance of positive collegial relationships as discussed by the participants.

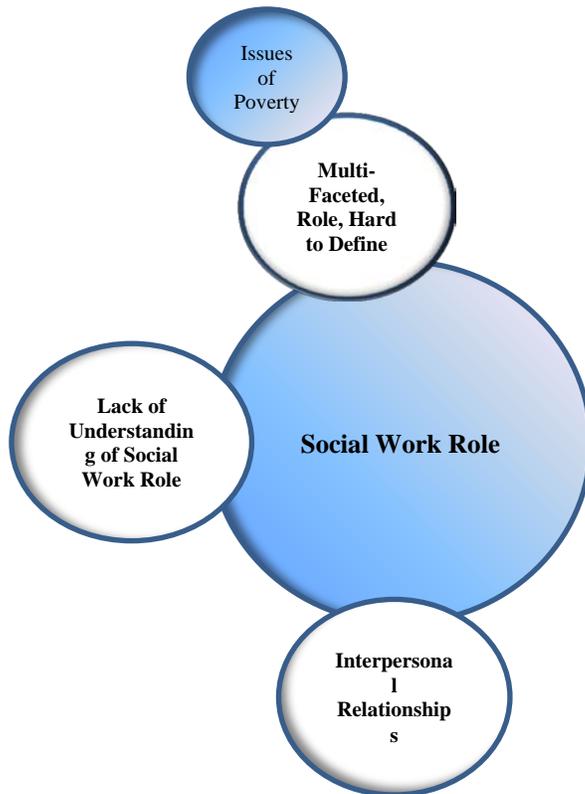


Figure 2: Social work role

The second grouping represents the organizational/structural aspects of the social work role within Nurse Practitioner-Led Clinics (See Figure 3, Organizational/Structural). The first theme in this grouping identified lack of supervision and the importance to self-care. The second theme identified working in isolation as challenging for the participants. The third theme established was conflicting models including two subthemes comprising of professional hierarchy and pay disparity.



Figure 3: Organizational/Structural

The themes that emerged provide a summary of the positive aspects of social worker's experiences but also highlighted some of the challenges and limitations associated with the social work role in Nurse Practitioner-Led Clinics.

Interviews conducted with social workers revealed much about their individual experiences, as well as some of the common themes and issues affecting their work. Themes were divided into two main groups, including those related to the role of social worker, as well as those related to the organizational and structural aspects of the social work role in the context of Nurse Practitioner-Led clinics. In terms of those themes related to the role of social worker, three main themes were identified. The first of these is the role of social worker as being difficult to define. An important subtheme related to this theme is issues of poverty, as participants noted their need to focus on social determinants of health with respect to clients' experience of poverty. The second theme identified was the lack of understanding among other professionals regarding the specific competencies held by social workers. The third theme relates to the need for positive collegial relationships among participants. In terms of themes related to the organizational and structural aspects of the social work role within Nurse Practitioner-Led clinics (NPLC's), themes included lack of supervision and its importance related to self-care, the challenges of working in isolation, and finally, conflicting models, which included the two subthemes of professional hierarchy and pay disparity in the organizational context. In this section the results are presented, with a particular focus on how participants perceived these different issues related to their work.

The Social Work Role

Social work as multi-faceted and hard to define.

The first theme identified related to the multi-faceted nature of social work as a profession, as well as the difficulty defining the overall scope and nature of the work itself. All nine of the participants indicated that their role as a social worker was multi-faceted in nature, which added to the complexity of work. One participant explained, "my role is to be part of a health care team, providing mental health counselling, system navigation and case management."

This quote captures the need for social workers to adopt multiple areas of focus in their work as part of an interdisciplinary health care team. In this context, social workers do not have a singular focus, and instead, attempt to navigate a challenging environment where they are often required to take on multiple roles. To illustrate, one participant indicated that being successful in this role and environment requires the social worker to adopt “many roles within the clinic, i.e. therapist, case manager, health promotion, etc.” These respondents all reflected on their need to consider multiple and often competing priorities, as well as spread their focus over a range of responsibilities with respect to patient care.

The different specific aspects of individual roles vary depending on the individual worker and the environment in which they work. For example, one participant explained that the work involved conducting "individual, couples and family psychotherapy to those struggling with a mental health diagnosis or other psychosocial concerns." In addition, this participant noted that the role required work in a case management capacity, as well as to facilitate groups at different work sites. The multi-faceted nature of the role is related to both the diversity inherent in individual client needs, as well as the complex nature of the work environment. Another participant noted, “I believe that the role of a social worker in an NPLC is to fundamentally work with the client where they're at and to support them accordingly, so I believe that a social work role does need to be somewhat multi-faceted and does need to be able to meet people where they're at”. This shows that beyond the complex nature of the social work role, the NPLC environment creates issues and challenges which further stretches the capacities of these professionals.

Issues of poverty.

Beyond the complex and multi-faceted nature of their individual roles in NPLCs, the social workers interviewed all reported routinely having to deal with issues of poverty as part of their work. Poverty functions as an overarching issue in the context of social work, and particularly in the context of providing service delivery in an interdisciplinary clinic setting. Participants noted that many of the clients being served through the clinic struggle with the problem of low income and poverty, as well as the broad range of related issues and challenges. Poverty functions as an insidious issue that works to affect clients' health in a number of different ways. Social workers in these practice settings thus have to consider poverty as a key issue affecting clients' health and their ability to access resources to support their overall well-being. One participant explained, "Every aspect when we're working with clients is related to their... you know, what we would define as the social determinates of health, and poverty being one of them. I think the majority of our clients do live in poverty". This statement helps to make clear that despite the broad spectrum of client needs these professionals encounter, poverty functions as a kind of unifying force affecting patients' overall health and well-being. The unique challenges posed by poverty have required these social workers to be creative in their attempts to address different issues and provide clients the help they need.

Lack of understanding of the competencies of social workers.

The second major theme identified related to the role of social worker was the lack of understanding regarding the specific competencies held by social workers in the NPLC environment. Interviews revealed that the majority of participants (seven of nine) indicated their belief that a lack of understanding regarding their role, as well as the specific competencies they hold, worked to create specific challenges related to their work. One participant explained, "I

really experienced a lack of support for my role and a lack of understanding for my role, you know, um, and various interpretations of what my role should be”. This statement highlights the potential challenges related to a lack of understanding and the presence of differing interpretations regarding the social work role. It should be noted, however, that some participants identified the potential positive implications of this reality of their practice environment. One respondent suggested that a lack of clear understanding could be empowering insofar as it allowed the professional to take greater control over shaping their own work in the clinic. One participant stated, "I have the ability to define my role more, as opposed to other settings, where it was already defined". For this respondent, a lack of understanding did create challenges, but also offered opportunities for improved practice.

It was also noted that the specific organizational environment impacted on the degree to which social workers could navigate these challenges. During an extended discussion in response to questions about challenges with respect to coworkers in the NPLC, one participant explained that “they’re very open to learning about the social work role and, and, and, um, I’m thrilled to be working with people who are like minded. I would like to change something at the organizational level right, and I think the model really does the social workers that they hire a disservice”. Social workers recognized how their own capacity to define their own role, or navigate the challenges related to a lack of understanding regarding their competencies, was directly mediated by factors related to the practice environment itself. This helps to account for the different experiences of some participants with respect to defining the social work role.

Critical importance of collegial relationships.

An additional theme to emerge from the interviews was the critical importance of positive collegial relationships for the professionals working in these environments. Collegial

relationships, including mentor and mentee relationships, helped social workers to not only find their footing in early employment situations, but promote their professional growth over time. One interviewee explained that aside from the positive personal relationships developed among members of the care team, the participant benefitted from being exposed to the different perspectives offered by the different professionals working in her firm. The participant remarked, “I feel enjoyment in working as a team and consulting with others in their roles, gaining and sharing different knowledge and perspective.” Another respondent described their experiences working with others using terms like “Positive, supportive, collaborative, open.” In addition, the participant explained, “I have no need to change things with my relationships at work as we have a strong, collaborative, cohesive team in which the social worker is a respected member of the clinical team.” For this respondent, working as part of a team provided support and a sense of camaraderie in what can often be challenging conditions.

Other respondents echoed these sentiments. One interviewee explained that the relationships with others helped the participant to know that the work was valued, and that team members worked together to facilitate the best possible health outcomes for clients. One participant stated, “I am blessed to work on a team that values the profession of social work and sees it as an integral component of health care. My relationships at work are collaborative and respectful and I know I am both appreciated and valued by my co-workers.” This sense of recognition and value was seen as being particularly important for not only effective collaboration, but for dealing with the constant challenges that arise in the context of routine service delivery. Responses reflected the nature of participants' experiences in working with others as part of an interdisciplinary care team, as well as the benefits of this approach for patient outcomes and the work experience itself. Responses largely framed collegial relationships as a

key source of support, as well as a means to facilitate understanding regarding their own contributions to client care.

Organizational and Structural

Lack of supervision and implications for self-care.

Organizational and structural themes are themes more directly related to the NPLC practice environment. Seven of nine participants indicated their belief in the importance of a lack of supervision; furthermore, five of nine respondents made direct connections between individual self-care practices and overall supervision. Personal supports and resources outside the workplace were cited as especially important for promoting effective self-care in the face of different work-related challenges. For example, several participants explicitly mentioned the importance of self-care for effectively navigating the unique challenges related to the work. In the words of one participant, “when you face clients who have had to undergo some serious hardships our level of compassion at times can cause emotional distress within our own life.” This participant also reflected on the potential for many professionals to internalize feelings of guilt over the suboptimal client outcomes they do witness at work. The participant explained, “we as social workers place so much emphasis on problem-solving skills and sometimes there are no solutions to clients’ problems. When it is the system that fails them we can at times view that as our own failures.”

Another respondent offered their insights: “obviously, the nature of clinical work is emotionally exhausting. Dealing with heavy issues and the client’s emotionality can have a wear and tear effect, making self-care for any therapist a must.” For this participant, the nature of social work itself creates particular challenges related to the nature of the work, as well as the different issues that clients may be experiencing. Frontline care workers, including social

workers and other health professionals, are tasked with the challenging work of creating and maintaining appropriate boundaries in the context of their duties at work. In the words of one participant, “when you face clients who have had to undergo some serious hardships our level of compassion at times can cause emotional distress within our own life.” For these reasons, paying appropriate attention to one's own health and well-being, as well as the degree to which problems at work are being internalized, is critically important for long-term success.

Five of the nine respondents also linked supervision and self-care. One participant noted, “I do think that I would not have done well in this role as a new grad, due to the autonomy and lack of supervision.” Another participant explained “it’s important that social workers have access to uh, other social workers for supervision so that we can maintain a level of quality um, and um growth in our work and also that we can have a way of um, maintaining our own resiliency in our work.” The need to maintain quality, as well as ensure appropriate levels of support were cited as key reasons for greater supervision and support. The capacity for such support to provide meaningful benefits to clients and their health outcomes suggests such efforts are vital for strengthening the capacity of social workers to benefit clients in the context of interdisciplinary health care settings.

The challenges of working in isolation.

Another major theme to emerge from the findings relates to the different challenges created because of the isolated nature of the work. All nine of the participants interviewed specifically referenced the isolated nature of the work, as well as how this creates particular challenges for the individual social worker. One participant remarked, “In the NPLC, there is some professional isolation, due to being the only social worker there.” Another explained that, “sometimes you face isolation being the only one on the team from a different entity.” For social

workers especially, working in the context of the NPLC can be professional isolating. In contrast to the other members of the care team, the social worker brings a decidedly unique perspective, thanks to their training and their focus when working with individual clients. In response to a question regarding support systems at work, one interviewee remarked, “being the only social worker on the team um, like sometimes you feel like your point of view or your perspective is kind of unique, um, in the environment your working with so that can be challenging.” Another participant suggested that additional social workers in the NPLC could potentially help address this problem.

Conflicting models.

The theme of conflicting models was also emphasized by respondents, with eight of nine interviewees suggesting this was a potential problem. For these respondents, their training and backgrounds as social workers created the potential for conflict in the context of working in the NPLC care team. Different approaches, different ethical considerations, and different priorities could all create the potential for increased conflict and other challenges between the different members of the care team. One participant explained that from her/his perspective, “social work ethics require sometimes different approaches than my medically-trained colleagues to issues related to confidentiality, conflict of interest, and dual relationships.” Frequently, conflict related to differing perspectives and approaches may arise. Strategies for navigating these challenges and other problems related to differences in perspective were cited as particularly important for addressing these issues. One participant noted, “allied health professionals all define social determinants of health differently and view a client’s needs differently... I believe my role is also to support the NP’s in better understanding the needs of clients with mental health diagnoses.”

Depending on their specific context, social workers navigated these challenges with different approaches and strategies.

Professional hierarchy.

Five of nine participants noted the impact of professional hierarchy in terms of their experience of the different challenges related to conflicting models. It was noted that more recognition for the importance of social work could help to mitigate some of the potential challenges created by a perceived professional hierarchy. One interviewee indicated that from her/his perspective, “the biggest downfall within this type of role, is not being able to move up within the organization.” The inability to advance to a management position was directly related to status as a social worker. In the context of an NPLC, only Nurse Practitioners would be eligible to move into a position of leadership. This effectively results in the dominance of one perspective over others in the clinic.

Pay disparity.

Another sub-theme to emerge from the findings, pay disparity was noted by two of the nine participants. One respondent explained, “another reason why we have had turnover is because—and this is something I’ve specifically wanted to come out in this research— is the pay disparities.” For this participant, disparity in pay between the different professionals added a further layer of challenges to the already significant difficulties created by conflicting models. This respondent was made acutely aware of their perceived lesser value as a social worker in relation to other members of the care team. Compensation provided an objective measure of value relative to others on the care team with nursing training.

Discussion

A review of the findings related to the relevant literature reveals some important connections between the experiences of these respondents, and the findings obtained in past research in this field. Nurse Practitioner-Led Clinics can be understood as a reaction to the problem of fragmentation within the health care system (Allen, 2012). The research shows that practice settings such as those like NPLCs will likely continue to increase in the future, as part of the trend toward integrated care (Ashery, 2008). Social workers represent a critically important stakeholder in the context of these care teams, which ultimately require the effective integration of behavioral health, primary health, and social work perspectives (Ashery, 2008). Indeed, past research shows that social workers possess unique tools and abilities to provide care in these contexts (Craig et al., 2016), and their presence in these environments can contribute to improved health outcomes for individual patients (Lymbery & Milward, 2001). The interdisciplinary teams on which these social workers serve reflect the broad understanding and acceptance of how a team-based model of care works to meet the full spectrum of patient needs, including all of their biopsychosocial needs (Horevitz & Manoleas, 2013; Allen 2010). The NPLC environment also reflects policy changes which make more integrated care an important option for health care systems to provide (Davis, Guada, Reno, Peck, Evans, Sigal & Swenson, 2015).

Role ambiguity and understanding the social work perspective.

An important challenge noted by the respondents related to the difficulty others had in understanding the specific competencies and functions associated with the role of social worker. This reflects a challenge long-observed in the literature, specifically with respect to role ambiguity in social work (Rushton & Briscoe, 1981). In integrated care settings, other

professionals may struggle to understand the specific role played by the social worker, as well as how the social worker fits in the care team with respect to the other members. The findings presented here show that role ambiguity continues to be a significant challenge for social workers in integrated care settings. While the degree to which these challenges affect individual social workers varies, depending on different factors, including the practice environment, the majority of respondents (seven of nine) interviewed indicated that they experienced some degree of challenges related to the lack of understanding regarding the social work role in the context of the NPLC. For some respondents, their experience with respect to role ambiguity involved their own work being devalued, which is supported in literature showing how ambiguity can lead to the devaluing of social work in an integrated health care context (Badger, Ackerson, Buttell & Rand, 1997). For other respondents, role ambiguity created the potential for more positive opportunities for enhancing understanding.

One participant explained that the different members of the care team understood the social work role in different terms and in different ways. This created the potential for barriers in achieving care goals, particularly when the social work role was misunderstood. In the context of integrated care settings, the research shows that the most significant barriers to successful interdisciplinary care work is the different professionals understanding the roles of others, including that of the social worker (Oandasan et al., 2009). A lack of understanding regarding the nature of the role and the different areas of focus related to social work can create a number of different types of difficulties. Indeed, the answers obtained from respondents here show how role ambiguity and differences in understanding can problematize the social worker's role in the context of integrated care. Because the social worker's function may be seen in different ways by different stakeholders, the potential for conflict is high. This confusion makes it more difficult

for the social worker to make valuable contributions with respect to the patient's health outcomes.

The research also shows that, traditionally, social workers have struggled to promote understanding regarding their role among the other professionals serving on the care team (Cowles, 2009). In this research, while role ambiguity was noted as a potential challenge for social workers in interdisciplinary care settings, the respondents interviewed here experienced this issue to varying degrees. For some of these respondents, a lack of understanding was explicitly cited as a problem that impeded their ability to provide effective care. For others, the issue was framed more in terms of a challenge related to the unique interdisciplinary nature of the care setting, particularly when compared to traditional settings, where all professionals have the same training, backgrounds, and professional perspectives. In some cases, ambiguity over the social worker role led to the individual's perspective being devalued, while in others, it led to important teaching and education opportunities. This helps to make clear the diversity in experience with respect to role ambiguity for social workers in the context of interdisciplinary care settings. While role ambiguity certainly created the potential for conflict, whether or not conflict arose depended on other factors related to how the social worker and organizational context responded to this ambiguity.

The potential for role ambiguity to lead to negative outcomes for the social worker was highlighted in the findings. The research, however, also suggests that role ambiguity could also lead to a number of other potential problems for the team. This supports past research showing that the degree to which team members understand each other's role and perspective, influences to overall effectiveness of the team in providing care (Giles, Gould, Hart & Swancott, 2007). Solving the problem of role ambiguity through positive steps to help promote greater awareness

and understanding among different team members was shown here to have the potential for reducing this ambiguity and providing greater clarity. At the same time, it should also be noted that the findings show the potential for staffing turnover and role changes to sustain and even exacerbate these challenges. One respondent recounted an experience in working with an array of different professionals due to dysfunctional turnover. As a result, the participant worked with several different professionals, each of whom had a somewhat unique understanding and conceptualization of the social work role. The potential for such differing conceptualizations and understandings has led to an enhanced potential for conflict in the context of interdisciplinary care environments (Brown et al., 2011).

The research shows that social workers can help to address these challenges by articulating their own perspective, as well as their appropriate role and function with respect to a particular client's needs (Allen, 2012). The findings obtained in this research show that social workers employed this strategy to varying degrees, and experienced varying levels of success in terms of reducing the impact of the problem of role ambiguity. It has also been argued in the published research that social workers need to take on a more active role with respect to developing their occupation in the context of interdisciplinary health care teams (Zittel et al., 2002). In this case, the findings show that greater efforts toward the education of others and the development of the social work role can potentially help social workers avoid the trap of having their roles externally defined. In cases where there exists role ambiguity and a poor understanding of the social work role, this can greatly impede the social worker's meaningful contributions. Taking a more active role in this regard could potentially help social workers promote greater understanding and deference for their unique perspectives.

Social work as multi-faceted work.

The findings also highlight the multi-faceted nature of the social work role. According to the literature, social work is by its very nature multi-faceted; however, in the context of an integrated care environment, social workers can be expected to take on a variety of different roles at different times, depending on the particular needs of a given client (Craig & Muskat, 2013). Moreover, the different roles needed to be adopted by social workers may be associated with differing levels of status (Craig & Muskat, 2013). These respondents indicated their recognition of social work as multi-faceted work, as well as the many challenges that could arise from their work as requiring them to adopt multiple roles in the context of the primary care setting. The respondents interviewed for this research provided answers in support of these findings, explaining that their success in their work ultimately depended on their ability to adopt different roles at different times, depending on the individual client's needs and any potential risk factors or other relevant information. For example, one respondent explained:

“While my title is Clinical Social Worker, the work I do at the clinic goes far beyond that of direct one-on-one counselling. Advocacy work is a large part of my role, either working with or on behalf of my clients to access supports and services in regard to the social determinants of health such as income, employment, housing, etc. As such, I engage in a lot of systems navigation and connect with many outside community agencies. I do a lot of referrals to other resources.”

The experiences of respondents thus reflect past research showing that social workers in primary care settings must work to respond to the various challenges that arise related to the individual client and their particular circumstances. This necessitates work that is multi-faceted in nature, and requires the professional to change their particular focus, depending on the relevant circumstantial and individual factors related to client needs. In this case, the findings suggest that this requires the social worker to develop the skills needed to fulfill each of the most common roles they will be asked to play in the context of care delivery. At the same time, social

workers also need to be prepared to navigate the various other challenges related to their taking on various different roles.

An important subtheme related to the multi-faceted nature of social work relates to the pervasive impact of poverty on many of the patients receiving care. Indeed, it should be noted that poverty was identified as an important issue affecting the majority of clients receiving services through integrated care settings. Prior research has shown that poverty is a particularly important factor in promoting efforts to advance integrated care (McLeod, 2002). The potential for poverty to affect multiple facets of the individual client's health and well-being suggests a need for approaches designed to provide a holistic and broad-based approach to addressing all relevant social determinants of health. For those patients trapped in poverty, integrated care provides the potential for such a holistic approach. Social workers need to be prepared to help manage the many health challenges that can arise from the experience of poverty, especially severe poverty experienced over an extended period of time.

Isolation, supervision, and self-care.

In this research, isolation was identified by respondents as an important factor related to the nature of their work. While this does not reflect specific findings reviewed in the research, the literature does show that in the context of interdisciplinary care settings, social workers can be challenged by conflict which emerges in these settings (Brown et al., 2011). Social workers can also be threatened by stress and other problems related to their frontline role and interactions with different patients. Past research has shown that, for social workers, burnout and job stress are particularly important concerns, because these issues can contribute to reduced effectiveness of caring (Cheung & Chow, 2011). Managing the potential risks associated with job stress is fundamental for ensuring one's continued effectiveness in a social work role. The findings

obtained in the current study suggest that individualized self-care resources and practices are especially important in this regard. Self-care helps to protect social workers against the harmful effects of conflict, stress, and other negative emotional and psychological problems related to their work.

The findings help to reinforce the importance for effective self-care for health care workers, especially those in frontline contexts. One respondent noted that she/he sought advice and professional support on a private, paid basis. The participant stated, “I regularly see a social work counsellor on a regular basis for both my own personal counselling and supervision, it's not paid for, it's private.” For this participant, going out of pocket was deemed necessary to ensure access to a professional support system for guidance, advice, and the overall support they felt was lacking in the interdisciplinary care environment. Past research has shown that among all of the different members of the interdisciplinary care team, social workers are the most at-risk for experiencing job-related stress and burnout (Lloyd, King, & Chenoweth, 2002). The findings of the current study suggest that social workers who recognize the importance of self-care may be better equipped to safeguard against these potential challenges, regardless of the particular approach they may take to meet their individual needs.

The published research also shows that social workers are often stressed and have internalized negative feelings about their capacity to make a positive difference in their role (Solberg, 2016). Moreover, the research shows that social workers face an elevated level of risk for experiencing burnout due to their work (Lloyd, King, & Chenoweth, 2002). In the current study, a majority of the respondents (five of nine) linked self-care to supervision, and emphasized their own struggles with internalizing negative feelings. One respondent shared her/his experience in dealing with emotional exhaustion related to work, while another noted the

potential for structural problems to be related to their experience of stress and anxiety. For the respondents, self-care was cited as particularly important for protecting oneself against the barrage of emotional and psychological challenges that come with the work, which for many, appear to be exacerbated by the lack of supervision.

The research on job burnout has shown that among social workers acting in frontline care settings, factors like role ambiguity and role conflict can have a significant impact on their experience of burnout and stress (Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2005). The findings from the current study do not specifically discuss role ambiguity in relation to burnout, but it is noted that role ambiguity for at least one participant led to the perception of decreased support for their work overall. These findings suggest that for already vulnerable social workers, problems like stress and burnout can be mediated by the degree to which the social workers feels like a valued member of the team, and that their perspective and contributions to care are understood and valued by the other members of the health care team. Communication to facilitate clear understanding of the social worker role may be especially important for creating positive conditions in this respect.

Conflicting models.

The findings from this research also suggest that the unique practice environments in which social workers find themselves working alongside primary health professionals can create unique challenges, due to the presence of conflicting and often competing models of care. Such challenges arise as a reflection of the differing perspectives and approaches of the different professionals involved in the interdisciplinary care team. For example, the findings showed that the conflicts between the different models and approaches held by different members of the care team created unique challenges for proceeding with the patient's care. Rushton & Briscoe (1981)

explain that, because social workers and primary health care workers have such different training and backgrounds, their different perspectives can create unique practice challenges. These respondents experienced a range of difficulties and challenges related to the unique backgrounds and perspectives of different members of the care team. In the current research, it was found that for some respondents, advancing their perspectives relative to primary care professionals was difficult. This supports findings related to the potential for some professionals adopting the biomedical perspective to adopt oppressive attitudes and practices which limit the potential for integrated care to succeed (Gaboury et al., 2009).

Related to the problem of differing models and perspectives is the problem of differences in professional status among the different members of the care team. The findings presented here also mirror those in the published literature showing differences in status can lead to conflict (Lymbery & Milward, 2009). The research shows that in such an integrated primary health context, social workers may be challenged, resulting in their losing perspective in relation to the perspectives of others on the care team (Lymbery & Milward, 2009). In this case, while no single participant reported the sense of a loss of perspective, the majority of respondents (eight of nine) indicated that conflict between the different members of the care team, expressly due to the adherence to differing models for care, was an important issue shaping their work in the NPLC. These findings suggest that integrated care settings may be negatively impacted in terms of the overall level of care service that can be provided unless there are steps taken at the organizational level to account for the very different perspectives of the various professionals that are working as part of the care team.

Collegial relationships and peer support.

The findings obtained in the current study with respect to the importance of collegial relationships and peer support for social workers in NPLCs is also reflected in the literature on social workers and professional support. Past research has shown that social workers and community health professionals can be an important source of support, and that collaboration and working together can help to address challenges associated with providing care in coordinated fashion (Brownstein, Hirsch, Rosenthal, & Rush, 2011). In this case, the social workers drew support from their positive relationships with peers. Respondents indicated the benefits provided by collegial relationships, including their capacity for insulating professionals against the harsh effects of navigating the various challenges involved in providing disciplinary care. The findings show that interpersonal relationships provide individual support and give meaning to interdisciplinary work. While the majority of respondents indicated their positive experiences in this regard, one respondent in particular expressed appreciation for the fact that other care professionals saw the social work as fundamental to the team's overall success. In other cases, the majority of respondents noted their experiencing some type of benefit related to the support they drew from their peers in the NPLC.

It should also be noted that findings show that social workers can potentially choose which aspects of the workplace social environment to devote resources to, allowing them to avoid conflict and develop more supportive relationships. One respondent indicated that she/he stayed away from workplace politics, instead choosing to pursue positive and supportive relationships. Another respondent noted the positive experience working with team members who understood social work and recognized their particularly important contributions to the overall care provided to the patient. These two experiences show that social workers' ability to

access positive and supportive relationships may vary greatly, depending on the nature of their practice environment. At the same time, it is clear that professionals have a degree of choice over which types of relationships they seek to cultivate, as well as which aspects of workplace social life they participate in.

The research also shows that in the context of primary care settings, such as NPLCs, processes and the team's structure are two important factors that help to determine the team's chances of success (Xyrichis & Lowton, 2008). In the present study, the findings obtained show that it was the types of relationships emphasized by respondents, rather than any particular structural factors, that were critical in explaining the effectiveness of teams or the overall level of support perceived by respondents. This may be a helpful point for informing future inquiries. The findings presented here, however, show that for social workers stationed in interdisciplinary care, clear communication, strong networks of allies, and efforts to promote professional support are particularly important for ensuring client success.

Chapter 5: Conclusion

This chapter is a discussion of a qualitative study designed to explore the experiences of social workers who are employed in Nurse Practitioner-Led Clinics. It includes four main sections: a summary of the study, implications for social work practice, limitations of the study and suggestions for future research.

Summary of the Study

This study focused on social workers experiences working in primary health care, more specifically, social workers who are employed in Nurse Practitioner-Led Clinics. This qualitative study utilized a sample of nine social workers who are employed full and part time within Nurse Practitioner-Led Clinics throughout the Province of Ontario. Data was collected using recorded telephone interviews which were transcribed verbatim as well as electronic survey questions. A series of twenty one questions divided into four sections including environment, education and orientation, mentorship, rewards and future were asked of the participants.

The questionnaires and transcripts were analyzed using an inductive approach to thematic analysis. Thematic analysis is a method for identifying, analyzing and reporting themes within data. According to Braun and Clark (2006) an inductive approach means that the themes extracted from the data are strongly linked to the data rather than data that has been selected to fit a theory or belief of the researcher. The six phases to the analysis as outlined by Braun and Clark (2006) were used to analyze the data resulting with six final themes and three subthemes divided into two groupings that are representative of the overall story of the data.

The perspective of the social constructivist/critical theory worldview was used to gain an understanding of the participants experiences of the world in which they work and the meanings they attach to their experiences. A social constructivist framework was the most useful approach

in obtaining the views and distinctions that influenced the individual worldview of the research participants. It allowed the participants to fully and freely describe their own interpretations of their experiences. Moreover, critical theory acknowledges the concept that many peoples' realities are based on inequalities in societal power and privilege. From this perspective, a critical theory framework can uncover existing power differentials which can lead to the creation of a more egalitarian rapport between practitioners.

Interviews conducted with social workers revealed much about their individual experiences, as well as some of the common themes and issues affecting their work. Themes were divided into two main groups, including those related to the role of social worker, as well as those related to the organizational and structural aspects of the social work role in the context of Nurse Practitioner-Led clinics. In terms of those themes related to the role of social worker, three main themes were identified. The first of these is the role of social worker as being difficult to define. An important sub-theme related to this theme is issues of poverty, as participants noted their need to focus on social determinants of health with respect to clients' experience of poverty. The second theme identified was the lack of understanding among other professionals regarding the specific competencies held by social workers. The third theme relates to the need for positive collegial relationships among participants. In terms of themes related to the organizational and structural aspects of the social work role within Nurse Practitioner-Led clinics, themes included lack of supervision and its importance related to self-care, the challenges of working in isolation, and finally, conflicting models, which included the two subthemes of professional hierarchy and pay disparity in the organizational context. The next section will discuss implications of this research for social work practice.

Implications for Social Work Practice

Explaining the need for a multi-faceted approach.

The findings have some important implications for social work practice. Findings from the interviews reinforce the notion that social work is multi-faceted by nature, and characterized by a great deal of role ambiguity, particularly in the context of interdisciplinary care settings. The respondents in this research who navigated these challenges most successfully were those who were able to transform experiences of confusion and poor understanding to those allowing for the education of others on the care team, specifically with respect to the role of the social worker, or their particular perspective related to a given client or health issue. Because social work is multi-faceted, social workers should be prepared to account for this complex reality in the context of an interdisciplinary care setting. In other words, social workers need to help educate others on the care team regarding their need to take different roles at different times. Furthermore, social workers entering these settings should consider the potential for different specialized training resources to improve their potential to succeed. In light of the different demands associated with the different types of roles that social workers are expected to play, training may have a variety of benefits.

Social workers can help communicate important ideas about their own perspective and ideas with respect to patient care, particularly through a discussion of their need to advance a multi-faceted approach in their work. Being explicit with other members of the care team regarding the different roles that will be adopted can help prepare other staff for knowing what to expect and how to support the social worker through their own efforts. At a basic level, this can also help to reduce role ambiguity, lessening the chance for conflict and creating greater potential for mutual understanding and ultimately improved interdisciplinary care. Because role

ambiguity is clearly identified in this research as a significant challenge for social workers in interdisciplinary care settings, any efforts to create better role clarity should be considered important for improving the ability of the social worker to serve the client.

Addressing poverty.

The findings also show that social workers have a particularly important role to play with regard to addressing poverty and its complex and interrelated consequences. Poverty is clearly a key social determinant of health that touches the lives of so many receiving care in the interdisciplinary context. Developing special strategies and approaches for not only managing the health issues related to poverty, but communicating the need for this focus among other professionals on the care team may be helpful for acceptance of important efforts on the part of the social worker. If those adopting the biomedical perspective have better understanding of what the social worker is focused on and why, the potential barriers limiting improvements in care can be addressed over time. Because poverty can relate to so many dimensions of health and shape an individual's experience of different health issues, addressing these issues supports the work of other care team members. If social workers can play a role in creating better understanding in this area, there may potentially be more broad-based efforts to address poverty as part of promoting public health.

Resolve conflicts in models.

The fundamental nature of interdisciplinary care means that there will always be professionals from different backgrounds who advocate different perspectives and approaches with regard to client care. Rather than contribute to more conflict, however, differences in perspective can be rationalized to promote better care for the patient. Some basic training measures may be important for helping the different members of an interdisciplinary care team

understand the perspectives of others on the team, as well as why they prioritize particular approaches and perspectives with respect to patient care. If team members understand the underlying reasons for conflict, as well as take steps to prevent it from harming the care process, they can transform these opportunities to generate a range of outcomes for patients, as well as the care environment as well. Individual education initiatives covering different medical models and the social determinants of health could potentially be sufficient to make a positive change in terms of helping professionals recognize the value in their having differing perspectives on health issues.

Provide greater supervision and professional support.

The research also provides some potentially important insights with regard to supervision and support for social workers. The findings show that a lack of supervision and professional support was potentially a problem for many social workers in interdisciplinary care settings. In the context of an NPLC, a social worker stands in contrast to the many other members of the care team, particularly in terms of perspective, training, and areas of focus for care. These conditions necessitate support systems which allow social workers to draw upon the professional support and guidance needed to ensure their own effectiveness. Measures to provide different types of professional support and assistance may not only work to benefit social workers, but also benefit the organization. If social workers perceive greater professional support and superior supervision measures, they may take on a more active role in terms of their advocating for their perspectives on the clients' best interest. It should not be left to individual social workers to establish their own professional systems, but in cases where no institutional supports are available, such efforts may be critical.

As a related point, the isolating nature of the work required of social workers in these contexts further adds to the challenges associated with a lack of supervision. If those leading these organizations listen to the needs and perspectives of social workers, building greater systems of support should be prioritized as part of efforts to enhance care. For their part, social workers themselves should be empowered and take steps to ensure their connectivity to others, especially in their personal lives. While all professionals should be provided help in accessing the appropriate professional support, maintaining personal networks of support falls on the individual. When a social worker accepts a position in a care environment such as an NPLC, they may need to recognize their significant vulnerability, particularly relative to the other professionals they are working alongside. For these reasons, it is critical for social workers to take steps to protect themselves, especially from the taxing effects of stress and isolation.

Build positive social networks.

Finally, the importance of positive, collegial relationships in the context of interdisciplinary care settings cannot be overlooked. The findings presented here suggest that social workers can cultivate and draw upon positive, collegial relationships with their peers in these settings to reduce their vulnerability and strengthen their support. This, however, requires social workers to specifically focus on developing the types of positive relationships conducive to support, and avoiding those aspects of work-social life that may potentially lead to additional forms of conflict. In light of challenges like stress, burnout, and other work-related difficulties, positive friendships at work can offer a variety of benefits for not just social workers, but all members of the care team. It should be noted, however, that due to their particular vulnerability, social workers should emphasize the development of friendships and other positive relationships even more than others. Social workers have much to benefit from building strong alliances with

their peers, which may enhance their ability to teach others, as well as provide an alternative, but still credible perspective on a patient's particular health issue or problem.

Study Limitations

Although there are strengths to this study, there are some limitations to consider. In consideration of the data collection process, a limitation was the inability to conduct face to face interviews with the participants due to geographic location as well as several participants citing time constraints. Data collection consisted of electronic mail correspondence and telephone recorded interviews therefore limiting my ability to observe facial/body expression and physical location as well as hearing tone of voice. Additionally, the interviews conducted by electronic mail correspondence did not allow for further probing of participant responses.

A second limitation of the study was that only social workers employed in NPLC's were interviewed. In order to get a better understanding of the experiences of social workers who are employed in primary health care, social workers who are employed in Family Health Teams and Community Health Clinics should have been interviewed as well.

Suggestions for Future Research

Qualitative research has a potentially powerful role to play in evidence based practice and systematic reviews. In their study Long and Godfrey (2004) contend that "it may enhance understanding or provide different insight into a problem" (p. 182). This is a crucial point as Giles et al. (2007) highlight the lack of research of the profession of social work in primary health care settings. Thus, the authors conclude that "analysis from the perspective of social workers is warranted in order to strengthen and focus the role of social work in primary health care" (p. 150).

The ever changing social, economic and political climates guarantee us that health care reform will continue for years to come. Within the health care reform climate, primary health care symbolizes an attempt by the health care system to align its structures and practices with a broader determinant of health perspectives. The 2003 report of the Canadian Association of Social Workers on social work in primary health care identifies that “the determinants of health have been embedded within social work theory and practice for a century” (p. 8). The report concludes that the meaning of this is that the social work profession has a significant contribution to make in primary health care.

In order for the contribution to be recognized it is vital that the profession have a clear vision outlining the difference the profession can make. By providing a better understanding of their competencies social workers can demonstrate that they are qualified to provide a wide array of services that could possibly affect the health of clients. An essential component will be that social workers clarify their roles, functions and contributions to primary health care. Herod and Lymberry (2001) assert that “the value of social work needs to be evidenced and asserted and social workers must be actively involved in the process” (p. 25). In their study of multi professional teams in primary health care, Herod and Lymberry (2009) point out that social work is “at a crossroads and that practitioners should play an active role in seeking to define the way forward for social work rather than adopt a passive approach that makes the occupation particularly vulnerable to government or managerial definitions” (p. 18).

This is an important concept because the establishment of the social work profession in primary health care can provide opportunities to inform policy agendas for the creation of new policies more relevant to people’s needs by addressing health disparities.

Implications for the future

The emergence of social workers in primary health care represents an important development in the approach to addressing both individual and collective health issues and problems. The integrated care teams operating in primary health care settings are challenged to address the complexities of patient needs that can affect overall health and well-being. To be successful in this dynamic and complex context, social workers need access to training and education that is designed to support their success in an integrated environment.

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Appendices

Appendix A: Interview Guide

ENVIRONMENT

- What attracted you to work in a Nurse Practitioner-Led Clinic?
- Can you describe your role being employed as a social worker in a Nurse Practitioner-Led Clinic?
- Can you describe your experiences of being employed as a social worker in a Nurse Practitioner-Led Clinic?
- Can you tell me how you perceive your experience to be thus far in your work as a social worker in a Nurse Practitioner-Led Clinic?
- Can you describe your views on the social work role within a Nurse Practitioner-Led Clinic?
- Would you please describe challenges in your role?
- Can you describe some emotional experiences linked to your work, if any?
- Can you tell me about some stressful times?
- What did you think work in this setting would be like?
- Can you describe why you think your role is different (or the same) as other social work settings?
- Are there any changes you would like to implement?
- Are there any barriers to the profession representing itself as a health discipline? If yes, please describe them.
- How can social workers become more clear and effective at articulating their roles and functions within interdisciplinary teams?
- What support do you think social workers need so they can be explicit about their skills and contributions within interdisciplinary teams?

- Are social workers in this role assisting around people's needs of poverty? If so, how?

EDUCATION AND ORIENTATION

- How do you feel your education has prepared you for this type of work?
- How do you feel your orientation program has prepared you?

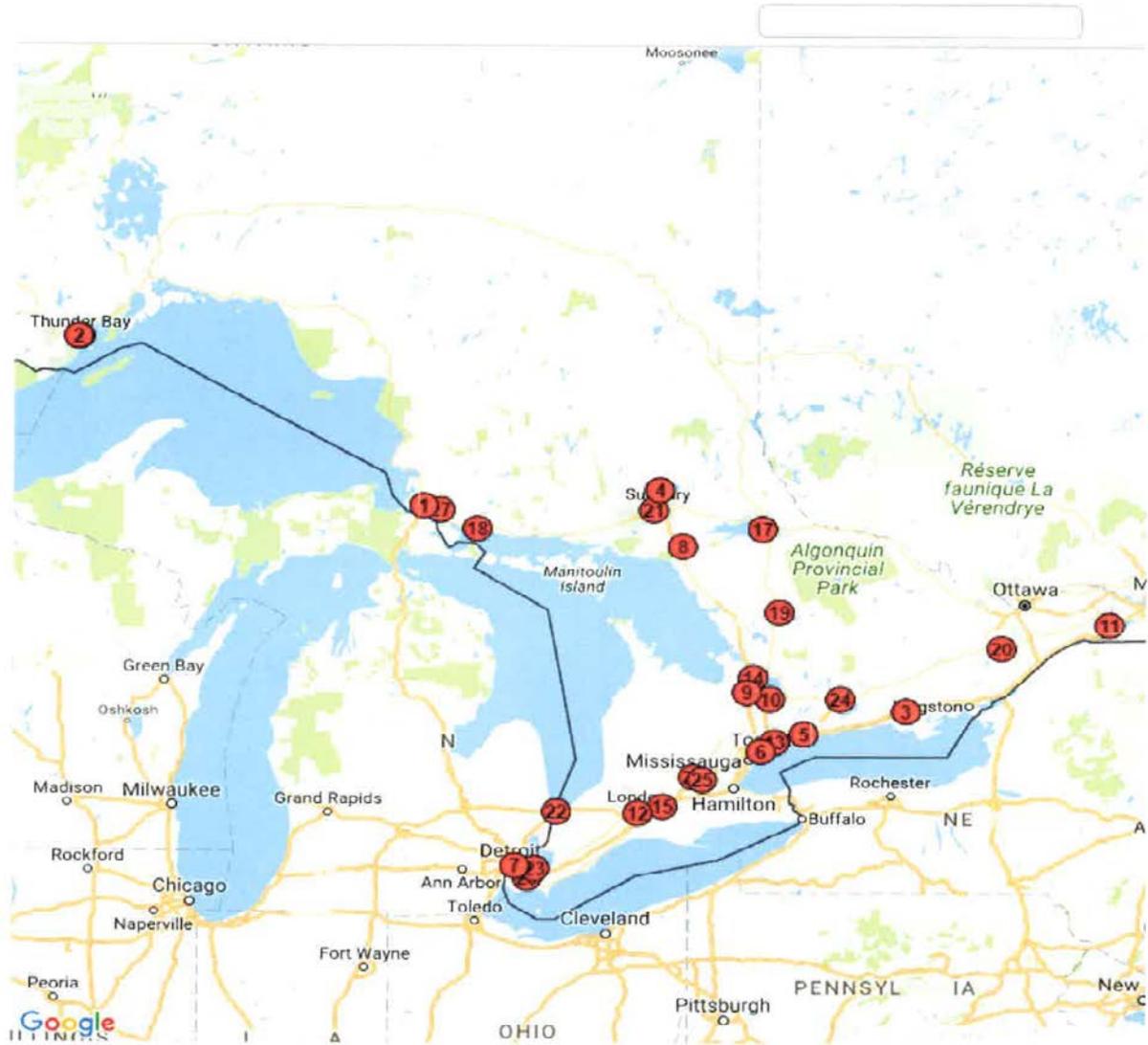
MENTORSHIP AND SUPPORTIVE RELATIONSHIPS

- Can you tell me about your mentor relationship?
- What do you think you could say or do to change things within your relationships at work?
- Would you please describe your support systems in your work and home life?

REWARDS AND FUTURE

- What are the rewards in your role, (if any)?

Appendix B: Map of Nurse Practitioner-Led Clinics in the Province of Ontario



Appendix C: Invitation for Study Participation



INFORMATION FOR PROSPECTIVE PARTICIPANTS

HELP WANTED FOR MSW RESEARCH PROJECT ON SOCIAL WORKERS IN NURSE PRACTICIONER-LED CLINICS

If you are presently employed as a social worker in a Nurse Practitioner-Led Clinic within the Province of Ontario, you are invited to participate in a research study conducted by Joanne Kohtakangas, RSW, Laurentian University School of Social Work Master's Candidate. Prospective participants are social workers currently employed full- or part-time in a Nurse Practitioner-Led Clinic within the Province of Ontario.

The purpose of this study is to better understand the lived experiences of social workers employed within Nurse Practitioner-Led Clinics. The information gathered may strengthen and focus the role of social work in primary health care, more specifically Nurse Practitioner-Led Clinics, which could enhance the important contribution of the social work profession within primary health care.

The time required for participation in the study is approximately one hour for each one-on-one, face-to-face or telephone audio-recorded interview at a time convenient for you. You will also be invited to participate in a second interview as a follow up discussion to review results.

The information you provide will be kept strictly confidential. Your participation is strictly voluntary, and you may withdraw at any time. Your employment will not be affected by this study as your identity will not be revealed. You may gain personal reward knowing that your information can help to strengthen the role of the social work profession within primary health care. If you are interested in participating in this study, please contact:

Joanne Kohtakangas RSW
(705) XXX-XXXX x222

Thank you in advance for your consideration of this matter.

Regards,
Joanne Kohtakangas RSW

Appendix D: Consent Form



CONSENT

Study: Exploring the Experiences of Social Workers who are employed in Nurse Practitioner-Led Clinics in Ontario.

Investigator: Joanne Kohtakangas MSW student: jkohtakangas@capreolnplc.com or joannek@personainternet.com

Supervisors: Dr. Carol Kauppi and Dr. Suzanne Lemieux, Laurentian University School of Social Work.

I am an MSW student at Laurentian University in Sudbury, Ontario. I am interested in learning about the experiences of social workers who are employed in Nurse Practitioner-Led Clinics in Ontario. This study may provide information that can help to strengthen and focus the role of social work in primary health care, more specifically Nurse Practitioner-Led Clinics which may enhance the important contribution of the social work profession within primary health care. By sharing your ideas with me, it is possible that the information you provide will help in gaining a better understanding of the importance of the social work profession within primary health care. The results of my MSW thesis may provide opportunities to inform policy agendas for the creation of new policies more relevant to people's needs by addressing health disparities.

There is a chance that you might experience some stress during our discussion. If this happens please note that we can stop the interview anytime you may wish. Participation in the study is strictly voluntary; you can decide to withdraw from the study at any time without any penalty or consequence. Please note your future employment will not in any way be affected by participating or not participating in the study as your identity will not be revealed.

If you agree to be part of this project, you are asked to participate in two interviews. Our first interview will take approximately 60 minutes and will be audio-recorded and transcribed verbatim by this researcher, a copy will be provided to you. Depending on location, individual interviews will take place face to face or via telephone at a time convenient to you. You will be invited to participate in a follow up discussion which will take approximately 30 minutes. The purpose of the second interview is to review the transcript with you and provide the opportunity for feedback. The information you share will be kept confidential which means that only I and my thesis supervisor at Laurentian University see it. You will never be identified by name or by any other identifying information in the thesis or when the results are shared with others.

Once this research project has been complete, your contact information/consent form will be kept for one year and then this information will be shredded. Our interview from the digital recorder and my personal computer will be permanently erased when the thesis has been completed. Should you have any questions about the project, you may call or email my supervisor: Dr. Carol Kauppi, Ph.D. Professor of social work, ckauppi@laurentian.ca, 705-675-1151 x5058, If you have questions about the research ethics, you may email the ethics officer at ethics@laurentian.ca, 1-800-461-4030 My contact details are: Joanne Kohtakangas, joannek@personainternet.com

By signing this form, you voluntarily agree to take part in this project and you are letting us know that you understand everything on this form. You will get a copy of this form that you can keep.

Participant Name: _____

Participant Signature: _____ Date: _____