Challenges Faced by Social Workers as Members of Interprofessional Collaborative Health Care Teams

Wayne Ambrose-Miller and Rachelle Ashcroft

Interprofessional collaboration is increasingly being seen as an important factor in the work of social workers. A focus group was conducted with Canadian social work educators, practitioners, and students to identify barriers and facilitators to collaboration from the perspective of social work. Participants identified six themes that can act as barriers and facilitators to collaboration: culture, self-identity, role clarification, decision making, communication, and power dynamics. These findings carry important implications for interprofessional collaboration with social workers in health practice.

KEY WORDS: *collaboration; interprofessional care; mental health; power dynamics; role clarification*

There is an increasing trend toward greater inclusion of interprofessional collaborative care models in the health care system (Goldman, Meuser, Rogers, Lawrie, & Reeves, 2010). Collaborative models bring various health care providers together—such as physicians, nurses, social workers, psychologists, pharmacists, dietitians, and others—to provide team-based care. Key factors can help influence or deter successful collaboration. Social work has historical experience in team-based care and brings a unique perspective to health care environments. The purpose of this qualitative study was to explore social work's experiences of interprofessional collaboration.

INTERPROFESSIONAL COLLABORATION

Interprofessional collaboration can assume various forms and be defined in diverse ways (D'Amour, Ferrada-Videla, San Martin-Rodriguez, & Beaulieu, 2005; Kvarnström, 2008). Collaborative care involves providers from different specialties working together to provide care for individuals and their families in the most appropriate and efficient manner (Craven & Bland, 2013). The goal of interprofessional collaborative practice is to help improve health outcomes for those using the health care system (Canadian Interprofessional Health Collaborative [CIHC], 2010). Interprofessional collaboration happens when practitioners, patients, clients, families, and communities develop and sustain interprofessional working relationships that facilitate optimal health outcomes (CIHC, 2010). Primary health care provides one example in which we see increasing shifts from care provided by an independent physician to care provided by interprofessional teams (Goldman et al., 2010; Hutchison, Levesque, Strumpf, & Coyle, 2011).

A number of factors facilitate and enhance collaborative care. In the United States, the Interprofessional Education Collaborative (IPEC) (2011) outlines four core competency domains for interprofessional collaborative practice: (1) adopting values/ethics for interprofessional practice; (2) understanding interprofessional roles/responsibilities; (3) enhancing interprofessional communication; and (4) facilitating teams and teamwork. Similarly, the Canadian Collaborative Mental Health Initiative (CCMHI) (Gagne, 2005) also described four key elements of collaborative mental health care that are consistent with IPEC's four core competencies. According to CCMHI, the four key elements guiding collaborative mental health care are (1) increasing accessibility to mental health services; (2) consumer centeredness; (3) the need for systems and structures to support collaboration; and (4) enhancing the richness of collaboration (Gagne, 2005). IPEC and CCMHI (Gagne, 2005) have suggested that achieving quality collaborative mental health care requires inclusion of these competencies. Additional factors that support successful interprofessional team collaboration are organizational structure, professional identity, scope of practice, and understanding and

doi: 10.1093/hsw/hlw006

addressing problematic power differentials (Belanger & Rodriguez, 2008; CIHC, 2010; Goldman et al., 2010; Hansson, Friberg, Segesten, Gedda, & Mattson, 2008).

Organizational Structure

Organizational structure influences interprofessional collaboration and includes clinical and administrative systems that guide cooperative practice, as well as the characteristics of the health care facility structure (Kvarnström, 2008). Structural factors that facilitate collaborative care include collaborative leadership, organizational culture that supports collaboration, effective methods of communication, and colocation (Goldman et al., 2010; Howard, Brazil, Akhtar-Danesh, & Agarwal, 2011; Kates et al., 2011). Kates et al. (2011) emphasized the importance of colocation of team members in working collaboratively. *Colocation* refers to various professionals working within the same organizational facility, and likely under the same roof. Communication between team members can be affected when there is more than one site, or even when team members are housed on different floors in the same building (Goldman et al., 2010; Kates et al., 2011).

Professional Identity and Scope of Practice

Interdisciplinary teams require clarity of roles and responsibilities to ensure optimum team function (CIHC, 2010). Individual members come to the team with varying degrees of understanding concerning the capabilities of other professions (Goldman et al., 2010, Lynch, 2011). Statements about scope of practice from professional associations (College of Nurses of Ontario, 2014; International Federation of Social Workers, 2012) provide a cursory overview of one's professional role.

Social workers who work as the sole social worker on a health care team must often negotiate their role on an interdisciplinary team without consultation with other members of their profession (Oliver, 2013). Hugman (2009) acknowledged that the role of social work is often directed by the goals of the agency. Social workers are in a position of having to carve out roles and demonstrate how this assists the team in a unique way. "If social work cannot show that it can do certain things, then its authority will be challenged" (Hugman, 2009, p. 1143). Competence in a particular task may direct practice more than professional scope (Oliver, 2013). Oliver (2013) stated that the professional identity of social workers is weakened by conflicting messages within the profession itself. Ongoing debates concerning micro or macro practice models, and philosophical debates between medical model and anti-oppressive paradigms, may cause new practitioners to struggle in their attempts to determine the nature of their role within an interdisciplinary team (Hugman, 2009; Oliver, 2013).

Power Differentials

Interprofessional collaboration can be facilitated or hindered by overt and covert power differentials; power dynamics must be considered when developing and implementing collaborative models (Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010; Whitehead, 2007). Overt power differentials are revealed in structural ways such as with existing governance models that place one profession in decision-making positions over other professions, and compensation practices that reward some professions more lucratively than others. Covert power differentials require a level of critical reflection as they are often more subverted. Whitehead (2007) provided the example of interdisciplinary teams in which communication regarding patients takes place around the doctor's schedule, reinforcing the doctor's "centrality." Issues of power determine to what degree collaboration occurs. Interdisciplinary care seeks to change the dynamic of interactions between health professionals to form a system of cooperating independents. The flattening of hierarchies inevitably affects the role of the physician, who traditionally held a privileged position of power (Lynch, 2011; Nugus et al., 2010; Whitehead, 2007).

SOCIAL WORK IN INTERPROFESSIONAL COLLABORATIVE HEALTH CARE TEAMS

For many years social workers have provided mental health counseling to individuals, families, and groups within the social services context (Canadian Association of Social Workers [CASW], n.d.). As models of health care delivery are expanded to include interprofessional health care teams, social workers have the opportunity to play an important role in providing collaborative health care. This study engaged social workers in an exploration of barriers and facilitators of interprofessional collaboration in health environments. It was conducted during a two-day joint national conference of the

Canadian Association for Social Work Education (CASWE) and CASW.

METHOD

An exploratory qualitative design guided a semi-structured focus group and analysis of data. The sample population for this study was social work faculty members of Canadian universities, other social work educators, practitioners, researchers, and students attending the CASWE and CASW joint annual conference held at Brock University in St. Catharines, Canada, on May 26–29, 2014. The focus group was advertised in the conference program using the conference program terminology of "think tank" and clearly described as a research study. For the purpose of this article, and because our approach to conducting the think tank is consistent with a focus group, we are using the term "focus group" to describe our study. Research ethics board approval was obtained for this study through the University of Waterloo located in Waterloo, Canada.

At the beginning of the session, an information letter describing the study—the purpose of the session being to collect research data, the focus group process, and how to receive a copy of the results of the study—was provided to each participant. The session began with the first author (Wayne Ambrose-Miller) stating that the purpose of the focus group was to gather data that would be used to prepare a journal article. A process of informed consent was used and was described in the information letter and the verbal statement given at the beginning of the session. Participants were informed verbally and in writing of their right to opt out of having their comments included in the written record. Participants were informed verbally of their right to attend the session without verbally participating and that they were welcome to leave the session at any time.

A semistructured interview format was used to conduct the focus group interview. Both authors co-facilitated the focus group interview. Although the focus group was not audio recorded, a research assistant acted as a notetaker throughout the entire focus group session and recorded comments directly into a word processing file. The research assistant was given the directions to take notes verbatim as much as possible and to exclude identifying information such as participant names, institute and organizational names, and other identifying information. Instead, each participant was assigned a code (P1 through P11). Immediately following the conclusion of the focus group, both authors and the research assistant met to do an initial review of the notes compiled during the focus group. The focus group session, including a brief introduction of the study and short introduction on interprofessional collaboration, was 90 minutes in length.

Thematic content analysis with some elements of grounded theory was used to analyze the data (Braun & Clarke, 2006; Charmaz, 2006). We used a modified version of coding similar to the three phases of initial coding, focused coding, and axial coding (Charmaz, 2006). Coding and analysis were interrelated processes that involved both authors equally throughout. The initial coding and focused coding processes occurred with both authors simultaneously. Both authors cross-checked their coding structures and, in cases where mismatches occurred, conducted detailed discussions to achieve consensus. A preliminary coding scheme was developed after identifying major themes.

FINDINGS

Eleven individuals participated in the focus group and agreed to have their data included in the study. Specific demographic information was not collected from the participants at the outset of the focus group. However, from the data we ascertained that there was a range of representation of social workers, including baccalaureate- and master's-level social work students, clinical social workers (BSW and MSW educated), social workers in managerial positions, and academics with doctoral degrees in social work. Although we did not collect specific data on the length of experience of each participant, it ranged from early-career to later-career social workers.

Six main themes emerged in the data: (1) collaborative culture, (2) self-identity, (3) role clarification, (4) decision making, (5) power dynamics, and (6) communication (see Table 1). The themes were similar to the interprofessional competencies identified by IPEC (2011) in the United States and two of the four key elements of collaborative mental health care described by the CCMHI (Gagne, 2005).

Collaborative Culture

Participants spoke of the importance of a culture of collaboration in their organization. This theme is consistent with IPEC's (2011) core competencies of interprofessional communication and teams and teamwork and appears consistent with CCMHI's (Gagne, 2005) elements of collaborative structures

Table 1: Thematic Framework of the Results

Theme	Subthemes
Collaborative culture	Individual attitudes and beliefs
	Nurturance
	Leadership
Self-identity	Awareness of social work contributions, role
	Diversity of social work
	Organizational resistance
Role clarification	Formal educational opportunities
	Educating through demonstrating
	Professional bodies
	Colocation
Decision making	Professional differences
Communication	Communicating through action
	Client care chart
	Time
Power dynamics	Power differentials acting as barrier

and richness of collaboration. Having an organizational culture that supports, values, and encourages collaboration was described as being important for successful collaboration. Participants stated that attitudes and beliefs of individuals within the working environment, leadership, and nurturance shaped the organizational culture. Participants indicated that it was important to attract individuals who encourage collaboration and stated that there are individuals who seek out collaborative environments in which to work. For example, one participant stated, "Different nurses voted to be under my unit in the cooperative instead of elsewhere because of the approach. Ours is very egalitarian overall" (P8).

Leadership was also identified as an important contributor to how well collaboration occurs, because formal and informal leadership reinforce collaborative ideas to the rest of the team. One participant described the importance of her informal influence: "I think I'm a good role model" (P3). Yet participants described the minimal presence of social work in formal health care leadership roles as problematic.

A collaborative organizational culture also requires nurturance: "It takes the dedicated people to keep it going or else it does backslide . . . if you don't have someone embracing that, it does go back" (P5). A collaborative culture helps to address challenges, "especially at moments when there are slip-ups" (P5). Participants described the traditional medical model as a "default setting" in health care that interprofessional teams may revert back to if nurturing of the collaborative culture is neglected. The broader work environment contributes to or challenges the collaborative experience. For example, one participant stated, "Something that's missing is looking at the broader structure and the environment that we're working in. Collaboration takes time. There's a large push right now in my work where there's a lot of number counting that doesn't necessarily look at quality care" (P3). This participant suggested that collaboration takes time and the environment needs to support that to be successful.

Self-Identity

Participants discussed the role of self-identity in the following three ways: (1) awareness of social work contributions, (2) diversity within social work, and (3) resistance in response to the social work identity. This theme was related to the IPEC (2011) core competency roles/responsibilities and the CCMHI (Gagne, 2005) elements of collaborative structures and richness of collaboration. Collaboration starts with an awareness of one's own individual contributions as a social worker. Participants stated that social work enriches interprofessional collaboration by adding a different conceptualization and approach to health within a team that is broader than the traditional medical model: "We look at the human aspect, both individual and in the society" (P6). Another participant stated, "Humanizing in practice is my role" (P4). What both participants suggested is that the social work role helps to give greater context and relational understanding of the individual.

Participants indicated that social workers have to proactively carve out their role within health settings in a way that is self-directed. Participants emphasized the need for social workers to be competent in their role and confident in their identity. Social work's role fluidity was identified as an asset because it helps fill in service gaps and address clinical complexity: "I think we pride ourselves in ambiguity so that there's still a place for complexity" (P5). However, having an unclear social work role can lead to challenges in collaboration: "[The] lack of clarity in social work roles is extremely challenging. . . . It makes me think, what is the professional identity that we want to portray?" (P6).

Participants indicated that social worker's role as client advocate can create tension between the worker and the rest of the collaborative team. Social worker as advocate was seen as an inherent part of the social work identity, yet participants described having other colleagues tell them not to act in the

advocacy role: "[What] do hospitals expect when they discharge a client that needs rehabilitation but isn't eligible to receive it, what is our job with advocating for this care when they don't have any funding? When you stand your ground, they often say that's not your job" (P6).

Role Clarification

Role clarification and having an awareness of one's interprofessional colleagues were described as important to collaboration. Awareness of others was described in three ways: (1) interprofessional educational opportunities, (2) educating colleagues, and (3) the influence of colocation. This theme was related to the IPEC (2011) core competency roles/responsibilities and the CCMHI (Gagne, 2005) elements of collaborative structures and richness of collaboration. Participants emphasized the importance of various professions learning from each other and valued some of the opportunities for collaborative learning provided at the university level. For example, one participant stated, "In [university] right now, there's about five different courses that include doc's, nurses . . . that you're placed with an interdisciplinary team with various different professionals to gain information and experience" (P4). Another participant stated, "interdisciplinary training is mandatory at [university]" (P7). As well, "In my schooling there's a two-week medical rotation where medical residents spend time with social workers" (P8). However, participants indicated that opportunities that exist for formal interprofessional learning are sparse: "In my training in my MSW there was no training with the medical faculty" (P2).

Educating colleagues occurred in various formal and informal manners: "Once a month we'll have an education session on something. Changes on care, social work month, little workshops make other people engage in it . . . we have been able to teach each other and share in what everyone does" (P2). Participants also described how learning about one another happened organically: "I learned a lot from the nurses, and I like to think that they learned something from me as well" (P5).

Participants emphasized the importance of educating through demonstrating: "When you do specifics and show specifics things become much better identified" (P5). "It's not just the standards, it's not just collaborations, it's what we can do and what we do, do in work" (P2). Participants also described how educating colleagues could also occur at the broader macro level. For example, one participant recommended that social work's professional bodies engage with medical professional bodies so as to help dynamics that occur within clinical collaborative settings:

> I'd love to see our body talk more with the medical body. As social workers we need to have this conversation so often. Medical doctors don't need to do that so I think we need to show how we, as social workers, need to communicate this. If we did this in the education then things would change drastically. If we didn't have to keep tap[ping them] on their shoulders to keep telling them why we're so important, then services would be different. We need to push for more. (P6)

Colocation with other interprofessional colleagues was considered important for social work. Participants indicated that colocation was an important means for physicians and nurses to learn about social work in daily encounters. These types of encounters facilitated by colocation can help demonstrate the social work role, which in turn assists in better utilization of social work services. For example, one participant stated,

> Colocation sure can help or hinder work. We provide services to our member clinic. . . . The doctor and nurse were taking on that role. We now have automatic referrals for traumatic accidents, cancer . . . because they now identify it is the social worker's role. (P2)

Here the participant suggested that challenges existed in social work referrals in the clinic where the social worker was located off-site. Interestingly, participants also spoke about how knowing oneself and knowing the roles of others helped to foster role fluidity that was described as an asset for enhancing collaboration: "If someone needed something, the professional in the room would complete that" (P5).

Decision Making

Decision-making processes were identified as important for collaboration. This theme was related to the IPEC (2011) core competency teams and teamwork and the CCMHI (Gagne, 2005) elements of collaborative structures and richness of collaboration. Participants emphasized how existing decision-making

processes had often been problematic for interprofessional collaboration. Ultimately, participants advocated for a collaborative method of decision making. For example, "Most informed decisions should include the team. If it's their liability then I should be looking at the whole team" (P3). Decision-making processes were identified as a barrier when differences emerged across professions as to the decision-making process and outcomes that participants experienced. For example, "Individual doctors are also . . . risk adverse. . . . I don't know how that is all framed but 'I'm making the decision' is how most doctors make these choices" (P2). Along with differences across professions, this participant also suggested that there could be concerns with the heterogeneity that exists within professions: "[A] suicidal patient was approached completely different by one than by another doctor on our team" (P2).

Communication

Participants spent a great deal of time talking about the importance of communication in collaboration. Effective communication was described as necessary for interprofessional collaboration, whereby poor communication was considered a barrier to collaboration. This theme was related to the IPEC (2011) core competency interprofessional communication and the CCMHI (Gagne, 2005) elements of collaborative structures and richness of collaboration. Participations spoke about various forms of communication that were an asset to collaboration. For example, communicating through one's action was one way that the various team members could learn about one another's roles. One participant described how a social work colleague offered clinical consultation to the team as a way to support the team as well as demonstrate the role of social work: "One thing that a coworker has done to define his own role in the team is by recognizing his strengths to them. Every other Thursday, the nurses and doctors are offered time with him. Support and value have increased since then" (P4). What this participant suggests is that by having regular access to the social worker, physicians and nurses in that team have been able to grasp a better understanding and value of what social work offers.

Participants described documenting in client charts as a vehicle to demonstrate one's own contributions to the collaborative. For example, one participant stated, "I'm trying to make my charting for clinical impressions and personal insights, 'what was going on there?' Charting has [provided] critical reflection opportunities and this is where I'm starting to find my voice" (P4). Patient care notes were also described as a vehicle for acknowledging colleagues: "In my notes, I need to identify the good work of others" (P1). Another participant stated, "These are the important things to chart! We need to note these" (P2). Participants also stressed the importance of face-to-face dialogue to help colleagues understand a different approach than what they are familiar with. For example, one participant stated, "Harm reduction . . . if we don't have a conversation with the doctor then no one will know we're talking about it" (P4).

Participants also spoke about the method of communication being problematic for collaboration. Several participants described the use of electronic medical records (EMR) for charting as problematic for collaborative communication. Participants described that other team members did not read social work–specific chart entries in the EMR and felt that the EMR itself eroded the potential for reciprocal communication. One participant explained that some providers' notes were being kept from other providers for reasons of confidentiality: "Some problems include locked files for social workers, which then spread to be all locked files. Balance between confidentiality and care is definitely a challenge" (P8). Another participant agreed and stated, "When we ha[d] the paper files it was different" (P2).

Power Dynamics

Power inequities and dynamics emerged in the data as a barrier to collaboration: "Power differentials are there" (P3). This theme was related to the IPEC (2011) core competency interprofessional communication and the CCMHI (Gagne, 2005) element collaborative structures. Power inequities affected social work's voice and contributions: "Physicians come in with power. . . . We as social workers in general are pretty awful at doing this. If doctors come in and take that power, we get talked over and lost" (P6). Participants indicated that salaries was one way that power inequities were demonstrated: "Power inequalities and with that, we're pushing for a change in salary, [which] could be influential too because of the inherent worth portrayed in the dollar amounts in salary" (P8). Power inequities were considered particularly problematic for collaborative care when acted out through the actions and behaviors of colleagues. For example, one participant described an

incident in which a colleague did not interact in a way that was considered respectful and suggested that she was not an equal among her collaborative peers: "I was doing work as a multidisciplinary team . . . he asked if I wanted anything to drink and said, 'Get this little girl some tea'. . . to his secretary" (P3). Because of existing power inequities, participants believed that social work had to be even more diligent with demonstrating worth to the collaborative team. One participant stated, "There's something so satisfying with having to prove yourself but then prove your worth when no one else believed it to be possible" (P3).

DISCUSSION

Interprofessional collaboration is increasingly being viewed as a necessary component in the delivery of health care (Gocan, Laplante, & Woodend, 2014). Social workers seem ideally situated to be important contributors to health care teams (Beddoe, 2011; Oliver, 2013). Social workers in this study have found collaborative care to involve both challenges and rewards. Challenges arise when social workers take part in interprofessional teams without a clear understanding of their role and the roles of their interprofessional colleagues. Social workers have also identified how power differentials have been exposed when opportunities arise for team decision making.

There remains a need for clarity in the roles of social workers on interprofessional teams while still maintaining a sense of flexibility to look at team-specific needs. Social workers who have a strong sense of what social work can provide to the team have the ability to communicate that vision in the work that they do. Bell and Allain (2011) advocated for a dynamic core social work identity that is adaptive to changing contexts. Participants seemed to agree that there were benefits to having fluidity in one's role to meet the needs of the team. To maintain the profession's integrity and traditional values such as advocacy for one's client, however, it was necessary to have a firm grasp on the unique perspective that social workers often brought to the team. This was particularly important when the perspective of the social worker was in conflict with the perspectives of the rest of the team. Advocacy for patients and calling attention to social justice issues was one role that participants identified as having the potential to cause conflict among team members.

Participants highlighted a possible link between clear interprofessional roles and experience with interprofessional education. Both formal and informal methods of interprofessional education seem to be effective ways to strengthen teamwork (Jones & Jones, 2011; Kenward & Stiles, 2009; Nisbet, Lincoln, & Dunn, 2013). Interprofessional education programs within formal professional training (Kenward & Stiles, 2009), teamwork-training programs for pre-existing teams (Jones & Jones, 2011), and informal interprofessional learning (Nisbet et al., 2013) all have the capability to provide familiarity and comfort with the various professions that make up interprofessional teams in health care.

Collaborative care in interprofessional health teams requires leadership, mentoring, and the ability to guide decision making within the team (Sims, 2011; Whitehead, 2007). Participants of this study expressed the view that decision making in collaborative teams sometimes exposed old power dynamics in which professions that had traditionally held the most power in decision-making situations expected to continue to be in that role. Participants remained hopeful that greater inclusion of interdisciplinary education and collaborative opportunities would produce an increase in decision making that demonstrated a sharing of power within the team. Jones and Jones (2011) reported that interdisciplinary education opportunity often results in the development of common goal setting and trust building. This in turn leads to other by-products such as conflict management: "Intra-team trust and unanimity of purpose can moderate conflict within a team" (Jones & Jones, 2011, p. 180).

There has been ample attention on the reform of health care systems in Canada, the United States, and elsewhere (Deber & Mah, 2014; Forest & Denis, 2012). Aims to improve interprofessional team-based collaborative care include, but increasingly extend beyond, physicians and encourage intersectoral collaborations across health and social sector domains (Bickerstaffe, 2013; Danaher, 2011; Groszkruger, 2011; Hutchison et al., 2011). The shift away from the traditional physician-centered model of care presents challenges to assumptions embedded in the traditional health care system (Hutchison et al., 2011; Romanow, 2002; World Health Organization, 2008). We believe that this is an opportunity for social work to shape collaborative mental health care, and assist the transition to greater collaboration, by enacting our leadership abilities in practice and policy.

CONCLUSION

Interprofessional collaboration in health care offers many rewards and challenges. Social workers have

the ability to bring to the team a unique perspective concerning the patients to whom we provide care. This study highlights several areas of concern for social workers in interprofessional teams, including the tension between a clearly defined social work role and the necessity for fluidity of roles in interprofessional teams. A continued discussion about the role of social work in interprofessional health care is necessary to build a stronger sense of our potential role and to improve ways to better meet the needs of our clients. HSW

REFERENCES

Baker, L., Egan-Lee, E., Martimianakis, M. A., & Reeves, S. (2011). Power in health care organizations: Contemplations from the first-line management perspective. *Journal of Interprofessional Care, 25*, 98–104.

Beddoe, L. (2011). Health social work: Professional identity and knowledge. *Qualitative Social Work, 12*(1), 24–40.

Belanger, E., & Rodriguez, C. (2008). More than the sum of its parts? A qualitative research synthesis on multidisciplinary primary care teams. *Journal of Interprofessional Care, 22*, 587–597.

Bell, L., & Allain, L. (2011). Exploring professional stereotypes and learning for inter-professional practice: An example from UK qualifying level social work education. *Social Work Education, 30*, 266–280.

Bickerstaffe, S. (2013). *Towards whole person care*. London: Institute for Public Policy Research.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

Canadian Association of Social Workers. (n.d.). *Social work practice in mental health*. Retrieved from http://www.casw-acts.ca/en/social-work-practice-mental-health

Canadian Interprofessional Health Collaborative. (2010). *A national interprofessional competency framework*. Retrieved from http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications.

College of Nurses of Ontario. (2014). *Legislation and regulation—RHPA: Scope of practice, controlled acts model*. Toronto: Author.

Craven, M., & Bland, R. (2013). Depression in primary care: Current and future challenges. *Canadian Journal of Psychiatry, 58*, 442–448.

D'Amour, D., Ferrada-Videla, M., San Martin-Rodriguez, L., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, 19*(Suppl. 1), 116–131.

Danaher, A. (2011). *Reducing health inequities: Enablers and barriers to intersectoral collaboration*. Toronto: Wellesley Institute.

Deber, R., & Mah, C. (Eds.). (2014). *Case studies in Canadian health policy and management*. Toronto: University of Toronto Press.

Forest, P. G., & Denis, J. L. (2012). Real reform in health systems: An introduction. *Journal of Health Politics, Policy and Law, 37*, 575–586.

Gagne, M.-A. (2005). *What is collaborative mental health care? An introduction to the collaborative mental health care framework*. Mississauga, Ontario: Canadian Collaborative Mental Health Initiative. Retrieved from http://www.ccmhi.ca

Gocan, S., Laplante, M. A., & Woodend, A. K. (2014). Interprofessional collaboration in Ontario's Family Health Teams: A review of the literature. *Journal of Interprofessional Practice and Education, 3*(3), 1–19.

Goldman, J., Meuser, J., Rogers, J., Lawrie, L., & Reeves, S. (2010). Interprofessional collaboration in family health teams: An Ontario-based study. *Canadian Family Physician, 56*, e368–e374.

Groszkruger, D. (2011). Perspectives on healthcare reform: A year later, what more do we know? *Journal of Healthcare Risk Management, 31*(1), 24–30.

Hansson, A., Friberg, F., Segesten, K., Gedda, B., & Mattson, B. (2008). Two sides of the coin: General practitioners' experience of working in multidisciplinary teams. *Journal of Interprofessional Care, 22*(1), 5–16.

Howard, M., Brazil, K., Akhtar-Danesh, N., & Agarwal, G. (2011). Self-reported teamwork in family health team practices in Ontario: Organizational and cultural predictors of team climate. *Canadian Family Physician, 57*, e185–e191.

Hugman, R. (2009). But is it social work? Some reflections on mistaken identities. *British Journal of Social Work, 39*, 1138–1153.

Hutchison, B., Levesque, J. F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: Systems in motion. *Milbank Quarterly, 89*, 256–288.

International Federation of Social Workers. (2012). *International policy on health*. Retrieved from http://ifsw.org/policies/health/

Interprofessional Education Collaborative. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Retrieved from https://www.aamc.org/download/186750/data/core_competencies.pdf

Jones, A., & Jones, D. (2011). Improving teamwork, trust, and safety: An ethnographic study of an interprofessional initiative. *Journal of Interprofessional Care, 25*(3), 175–181.

Kates, N., Mazowita, G., Lemire, F., Jayabarathan, A., Bland, R., Selby, P., et al. (2011). The evolution of collaborative mental health care in Canada: A shared vision for the future. *Canadian Journal of Psychiatry, 56*(5), 1–10.

Kenward, L., & Stiles, M. (2009). Intermediate care: An interprofessional education opportunity in primary care. *Journal of Interprofessional Care, 23*, 668–671.

Kvarnström, S. (2008). Difficulties in collaboration: A critical incident of interprofessional healthcare teamwork. *Journal of Interprofessional Care, 22*(2), 191–203.

Lynch, S. (2011). Health system factors affecting communication with pediatricians: Gendered work culture in primary care. *Social Work in Public Health, 26*, 672–694.

Nisbet, G., Lincoln, M., & Dunn, S. (2013). Informal interprofessional learning: An untapped opportunity for learning and change within the workplace. *Journal of Interprofessional Care, 27*, 469–475.

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J., & Braithwaite, J. (2010). How and where clinicians exercise power: Interprofessional relations in health care. *Social Science and Medicine, 71*, 898–909.

Oliver, C. (2013). Social workers as boundary spanners: Reframing our professional identity for interprofessional practice. *Social Work Education, 32*, 773–784.

Romanow, R. J. (2002, February). *Shape the future of health care* [Interim report]. Ottawa: Commission on the Future of Health Care in Canada.

Sims, D. (2011). Achieving collaborative competence through interprofessional education: Lessons learned from joint training in learning disability nursing and social work. *Social Work Education, 30*(1), 98–112.
Whitehead, C. (2007). The doctor dilemma in interprofessional education and care: How and why will physicians collaborate? *Medical Education, 41*, 1010–1016.
World Health Organization. (2008). *The world health report 2008—Primary health care: Now more than ever.* Geneva: Author.

Wayne Ambrose-Miller, PhD, *is a social worker, Garden City Family Health Team, 145 Carlton Street, St. Catharines, Ontario L2R 1R5, Canada; e-mail: wmiller7@cogeco.ca.* ***Rachelle Ashcroft, PhD,*** *is assistant professor, School of Social Work, Renison University College, University of Waterloo, Ontario, Canada.*

Original manuscript received October 15, 2014
Final revision received February 26, 2015
Accepted February 27, 2015
Advance Access Publication February 29, 2016