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***THE TRANSITION FROM MULTI-DISCIPLINARY TEAM TO INTER-  
DISCIPLINARY TEAM: THE IMPACT OF INTEGRATED HEALTHCARE ON THE  
NATURE AND IDENTITY OF HEALTH SOCIAL WORK PRACTICE IN AOTEAROA  
NEW ZEALAND***

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## ABSTRACT

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Integrated healthcare aims to transform the health system and improve health outcomes, while managing national health spending, by providing a more co-ordinated, collaborative and cohesive response to patient-centred care. Inter-disciplinary teams (IDT) have become synonymous with integrated healthcare, as it provides a framework for conceptualising an alternative approach to patient-centred care, within the District Health Board (DHB). This study explored how the transition from a multi-disciplinary team (MDT) to an IDT structure, within the DHB, influences the nature and identity of health social work practice. The subjective experiences of the twelve registered health social workers, who participated in this study, reflect the unique Aotearoa New Zealand context at different stages of the transition from an MDT to an IDT.

Critical theory and a constructivist theoretical framework guided this qualitative research study, in which health social work is conceptualised within the broader context of competing and inter-related socio-political, cultural and economic demands. Semi-structured interviews were conducted with each of the participants, from across Aotearoa New Zealand. The data from these interviews was collated, according to emerging themes and patterns and analysed in relation to relevant national and international literature.

The participants in this study were unanimous in their support of the transition to an IDT, citing the correlation between increased professional collaboration and improved patient outcomes. The findings from this study reveal that while the nature and identity of health social work practice remains unchanged, the transition to an IDT affords further opportunities for practitioners to demonstrate competence and to gain credibility. Findings highlight that exposing other disciplines to the unique knowledge and skills that social work brings to patient-care, positions the profession as integral to the functioning of the IDT.

The significance of this study and the recommendations that have emerged, highlight the need for DHBs to be more transparent about the rationale for change and to involve health social work at every stage of the transition to an IDT. This study concludes that distinguishing between the MDT and the IDT, and providing professionals with ongoing education and support around working collaboratively as an IDT, creates sustainable change. The bicultural nature of health social work in Aotearoa New Zealand offers opportunities to strengthen integrated healthcare, by drawing on Whakawhanaungatanga, the practice of appreciating and growing relationships and kotahitanga, which involves bringing people together. These serve as unifying concepts within the IDT.

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***Ehara taku toa, he takitahi, he toa takitini***

***My success should not be bestowed onto me alone, as it was not individual success but  
success of a collective***

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# CHAPTER ONE

## INTRODUCTION

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### 1.1 INTRODUCTION

Reforms have been a major feature of the New Zealand health system since the late 1930's, when the Social Security Act 1938 aimed to provide free healthcare to all New Zealanders (Ahuriri-Driscoll, 2016; Davis & Ashton, 2001; Gauld, 2001; New Zealand Parliament, 2017; Schofield, 2001; Stanley-Clarke, 2016). The last three decades in particular, has seen radical and continuous efforts to align healthcare with the global market economy (Barnett & Barnett, 2005; Brook, 2016; Kearns & Joseph, 1997; Maidment & Beddoe, 2016). Widespread health sector restructuring, referred to as New Public Management Reforms<sup>1</sup>, which was implemented in New Zealand in the 1980s and 1990s in response to neoliberal economic policies, fundamentally led to the re-definition of healthcare as a commercial entity, informed by business principles (Barnett & Barnett, 2005; Duncan, 2007; Le Heron & Pawson, 1996). Ongoing efforts to restructure healthcare, have sought to ensure greater efficiencies in service delivery, equity and access to quality healthcare for all New Zealanders, while managing economic constraints (Ahuriri-Driscoll, 2016; Barnett & Barnett, 2005; Lunt, O'Brien & Stephens, 2008).

In parallel to health reforms, health social work<sup>2</sup> has also evolved over the course of its long history within the health system (Auslander, 2001; Beddoe, 2011; Nash, 2001; Schofield, 2001). The profession has gained significant traction in terms of its credibility and status, albeit to varying degrees, as an integral part of the health system both nationally and globally (Ambrose-Miller & Ashcroft, 2016; Beddoe, 2010; Beddoe, 2011; Beddoe & Deeney, 2012; Boyce, 2006; Carey, 2015; Carey, 2016; Giles, 2013; Giles, 2016; Glaser & Suter, 2016).

According to Beddoe (2011, p.24), the “distinctive” nature and identity of health social work has been inextricably connected to the profession’s “claim” over “expertise in the psychosocial aspects of health and illness”. Health social work asserts that its unique knowledge and skills can be used to support patients, their family and whānau, to adjust to a

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<sup>1</sup> New Public Management Reforms are aimed at managing national health spending, while aiming to provide high standards of service provision within healthcare.

<sup>2</sup> Health social work refers to the field of practice undertaken by social workers who are employed within a healthcare service.

life-changing health event while navigating the complexities of the health system. This sets health social work apart from other health professionals<sup>3</sup>. The history and evolution of health social work with Aotearoa New Zealand will be discussed in more depth in Chapter two of this thesis.

The promise of further restructuring and the growing trend towards integrated healthcare, which is more efficient and responsive to patient needs, supports the Ministry's Health Strategy (Ministry of Health, 2016). At the same time, the drive towards integrated healthcare which signals a directional shift in relation to patient-centred care, highlights the potential for traditional domains of health social work practice to be challenged by other disciplines within the health system (Beddoe, 2010; Beddoe, 2011; Beddoe & Deeney, 2012; Carey, 2015; Hughes & Wearing, 2013; O'Donoghue, 2015; Opie, 2006). The current study posits that despite the challenges that are brought about by inevitable change, there are opportunities for health social work to identify gaps in service delivery which other disciplines are unable to meet. This will not only ensure positive outcomes for patients, their family and whānau, but will also position the profession as a key player within the health system (Beddoe, 2011).

The current research study conceptualises the trend towards integrated healthcare, through the transition from a multi-disciplinary team (MDT) to an inter-disciplinary team (IDT), in order to explore the impact that changes in the structure and approach to patient-care might have on the nature and identity of health social work practice within the context of the District Health Board (DHB)<sup>4</sup>. While some of the literature continues to use the terms MDT and IDT interchangeably, the current study defines these as two discrete teams (Hughes & Wearing, 2013; Jessup, 2007). In doing so, the dualism within their different structures and underlying philosophies towards patient-centred care is acknowledged.

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<sup>3</sup> Health professionals, in the context of this research study, refer to specific disciplines who have engaged in formal academic training and are qualified and registered with a discipline-specific professional body. These disciplines include, but are not limited to doctors, nurses, social workers, psychologists, physiotherapists, occupational therapists and speech-language therapists.

<sup>4</sup> District Health Boards (DHBs) were established in January 2001, after the New Zealand Public Health and Disability Act was passed in 2000. There are twenty DHBs throughout Aotearoa New Zealand, each tasked with funding, planning and providing healthcare services within a defined geographical location (<https://www.health.govt.nz/new-zealand-health-system/my-dhb>).

MDTs have long typified traditional healthcare. This research study defines an MDT as a group of health professionals based in discipline-specific siloes, that respond independent of one another to patient-care, according to their unique skills, knowledge and expertise (Hughes & Wearing, 2013; Jessup, 2007). In contrast, this study defines an IDT as an integrated, co-located<sup>5</sup> team of health professionals, from different disciplines, who actively collaborate and consult with one another (D'Amour & Oandasan, 2005; Hughes & Wearing, 2013; Jessup, 2007). Through a shared understanding of the patient's needs, the IDT develops a collective, co-ordinated and cohesive response to patient-centred care (D'Amour & Oandasan, 2005; Hughes & Wearing, 2013; Jessup, 2007).

The process by which health professionals work co-operatively and in partnership with one another, to achieve collective decision-making, refers to as interprofessional collaboration (Ambrose-Miller & Ashcroft, 2016; Giles, 2016; Glaser & Suter, 2016). This study concludes that interprofessional collaboration maximises efficiencies and quality health outcomes for patients, their family and whānau.

This study suggests that the transition towards integrated healthcare needs to be conceptualised in direct relation to the distinctive history of Aotearoa New Zealand, in which the Te Tiriti o Waitangi<sup>6</sup> recognises the fundamental position of Māori culture and customs and their sovereignty as Tangata Whenua<sup>7</sup> of Aotearoa New Zealand (Ahuriri-Driscoll, 2016; Bartley, 2016; Ruwhiu, Te Hira, Eruera & Elkington, 2016). This study concludes that an IDT approach which integrates health social work practice and is informed by both the philosophy of Whakawhanaungatanga, which is the importance of relationships and the provisions of Te Tiriti o Waitangi, supports and is integral to patient-centred care. Health social work brings a unique perspective to interprofessional collaboration and demonstrates a commitment towards collaborative and co-ordinated decision-making, in order to ensure positive outcomes for patients, their family and whānau (Ambrose-Miller & Ashcroft, 2016; D'Amour & Oandasan, 2005; Hughes & Wearing, 2013; Jessup, 2007).

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<sup>5</sup> Co-location is a key feature of an inter-disciplinary team, in which different disciplines practice in close physical proximity to one another.

<sup>6</sup> Te Tiriti o Waitangi is the Māori translation for the Treaty of Waitangi, which is the founding document of Aotearoa New Zealand. The Treaty was signed between Māori and the British Crown in 1840.

<sup>7</sup> Tangata Whenua refers to Māori as the founding/indigenous people of Aotearoa New Zealand.

## 1.2 RESEARCH AIMS AND OBJECTIVES

It is against the backdrop of social work as an evolving profession, and its position within the context of a health system that is both paradoxical and contested in nature that this research study has emerged. This study aims to contribute to the growing body of literature within Aotearoa New Zealand, which explores how changes within the health system influence social work practice. The significance of this research study is in the way in which it highlights the value of health social work within the IDT and the contribution the profession is able to make to ensure patient-centred outcomes, from the perspective of registered health social workers, by exploring the transition from an MDT to an IDT in the context of the DHB.

The aims and objectives of this study were directed by the research topic:

*The transition from multi-disciplinary team to inter-disciplinary team: The impact of integrated healthcare on the nature and identity of health social work practice in Aotearoa New Zealand.*

### **The Aims of this Research Study were:**

- To examine the experiences of registered health social workers who have practiced in an MDT and an IDT, within a DHB in Aotearoa New Zealand.
- To examine the nature and identity of health social work practice within the MDT and the IDT in the context of the DHB.

### **The Objectives of this Research Study were:**

- To explore the ways in which health social workers conceptualise the differences between an MDT and an IDT.
- To explore how health social workers experienced change following the transition from an MDT to an IDT.
- To determine the rationale for the transition to an IDT approach.
- To establish whether health social work roles and responsibilities changed following the transition to an IDT.
- To explore the opportunities that have presented because of the transition to an IDT and the impact these have had on health social work practice within the DHB.

- To explore the challenges that health social workers have experienced following the transition to an IDT and ways in which these have been addressed, within the DHB.
- To provide recommendations on how to effectively transition health social workers from an MDT to an IDT.

The aims and objectives of this study, along with a comprehensive literature review, created a number of key research questions, which in turn guided the semi-structured interview process (Appendix VIII).

### **1.3 THE RESEARCHER'S INTEREST IN THIS AREA OF STUDY**

Rubin and Babbie (2010, p.52) suggest that one of the factors which can guide a research topic is the “researcher’s intellectual curiosity and personal interest” in the area under investigation. The ideological lens that connects me to this research study draws on notions of social justice and human rights. I have always been interested in the notion of change and in ways in which people respond to change. My cultural position, in relation to this study can be traced back to my undergraduate social work degree, which began the year after Nelson Mandela became South Africa’s first democratically-elected President. This event in our history had a profound impact on my family and I who, prior to April 1994 had been subjected to the regime’s oppressive Apartheid laws.

From the outset, I connected with the values of social justice, self-determination and human rights, which underpin social work. My undergraduate studies allowed me to develop a deep understanding of the ideological and philosophical underpinnings that drive change and the profound capacity of individuals and communities to mobilise for change in ways that can redirect the course of history. The inextricable connections between my personal and professional values and the philosophical lens through which I view the world, have allowed me to be receptive to personal change and to recognise the potential for remarkable change in those I work with. It is within this cultural context that I have developed an interest in, and a respect for, bicultural social work practice.

Nowhere have I found the notion of change and the potential to adjust to change more apparent than when individuals, their family and whānau are confronted with a life-changing health-related event. My social work practice experience has been in the areas of crisis intervention, emergency management, trauma and oncology where my roles have involved

providing emotional, psychological and practical support to individuals and their family and whānau, as they deal with the impact of a chronic and/or critical health-related diagnosis.

I have always practiced alongside and collaborated with a diverse range of professional disciplines, in both the Government sector and in Non-Government Organisations (NGO) respectively. Having supervised both social workers and professionals from other disciplines, I have gained an understanding of the conceptual frameworks that guide professional practices and ways in which these can both facilitate and undermine interprofessional collaboration within healthcare. What distinguishes health social work from other disciplines within the health system remains the profession's broad scope of practice and its expertise in psychosocial assessment.

My interest in integrated healthcare and in interprofessional collaboration began approximately nine years ago, during my role as the Clinical Supervisor of an adult social work trauma team, in an acute tertiary hospital in Aotearoa New Zealand. While health social workers maintained strong professional alliances across the spectrum of health service areas, structural demarcations and siloes both within social work and across disciplines existed. These included separate team structures between in-patient services vs. out-patient/community services and between physical health vs. mental health services. Within each of these services, further delineations existed according to adult, women and paediatric services.

Despite the DHB introducing an integrated Allied Health<sup>8</sup> structure, the Social Work Department continued to support an MDT approach, in order to retain the profession's identity and autonomy. During my seven-year tenure at the DHB, changes in the wider political economy resulted in organisational restructuring. Towards the latter part of 2010/2011, the decision to assimilate the Social Work Department, within in-patient services, into an IDT structure was realised. Each IDT included varying combinations of health social workers, physiotherapists, occupational therapists, therapy assistants and/or speech-language therapists.

The transition from an MDT to a fully integrated IDT structure received mixed responses from health social workers, ranging from those who were ambivalent and adopted a "wait-

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<sup>8</sup> Health social workers and other support services, including physiotherapists, occupational therapists, speech and language therapists, therapy assistants, psychologists and dieticians are collectively referred to as part of Allied Health services.

and-see” approach, to those who were resistant to the change. These responses were largely driven by the lack of clarity regarding the differences between the MDT and IDT structures and the benefits of the IDT approach in terms of social work practice. At the same time, existing relationships, which had been established between social workers and other disciplines in the MDT prior to integration, did create a sense of familiarity and connection.

Those who had always advocated for separation from Allied Health Services experienced a profound sense of disconnection from social work colleagues. For some, the transition to an IDT was an alienating and disempowering experience, as they perceived other disciplines attempting to colonise areas of expertise that had traditionally been the domain of health social workers. Priorities around budget cuts, managing patient volumes, discharge planning and funding allocations appeared to overshadow social work values and principles, creating further dis-ease.

My rationale for supporting this transition was based on the opportunities integration presented for increased interprofessional collaboration and the potential to highlight unique health social work knowledge and skills. This process highlighted the importance of identifying strategies that support social work buy-in and create sustainable change. This reaffirms the need for further research in this area.

## **1.4 STRUCTURE OF THE THESIS**

Brief summaries of each of the subsequent chapters are presented in order to provide an outline of the thesis structure:

### **Chapter One**

This first chapter has introduced the research study, by locating health social work within the broader context of healthcare. Key terms and concepts that have been used throughout this thesis have been identified and explained in this chapter. These terms will be discussed in further detail in subsequent chapters. The research topic, as well as the aims and objectives, which informed this study, have been presented in this chapter. The rationale for undertaking research in this particular area, which has been based on both personal interest and experience as a senior social worker, has been discussed. This chapter concludes with an outline of the structure of the thesis, including brief summaries of each of the subsequent chapters.

## **Chapter Two**

This background chapter locates the current study within an historical and cultural context, by drawing on existing literature and research. Western and Māori conceptualisations of health and wellbeing, including the broad theoretical frameworks that underpin these notions, are presented in this chapter. Health social work is defined and its extensive history within Aotearoa New Zealand is presented in this chapter, in order to highlight the evolution of the profession. This provides the backdrop for understanding the professions' preparedness for the transition to a new era of integrated healthcare.

## **Chapter Three**

This third chapter provides a comprehensive review of the key themes that were identified in the plethora of international literature and New Zealand research, and which are relevant to an understanding of the transition from an MDT to an IDT. Key elements, which support an integrated healthcare framework are discussed and critiqued, according to both the opportunities and challenges they pose for health social workers, following the transition to an IDT. This chapter emphasises the importance of interprofessional collaboration in addressing health inefficiencies and ensuring positive patient-centred outcomes. Changes within healthcare are conceptualised, in this chapter, as an opportunity for health social work to identify gaps in service provision, which benefit the health system as a whole.

## **Chapter Four**

This chapter provides an explanation of the research design and methodology, which informed this study. Critical theory and the constructivist theoretical framework that guided this qualitative research study are discussed in this chapter. This chapter presents Systems Theory as a way of conceptualising the notion of change and the transition from an MDT to an integrated IDT structure. The method used to interview participants and the ways in which the data from these interviews was collated and analysed is discussed. An account of the formal ethics application, including the ethical issues, which were carefully considered at the outset, is presented in this chapter. The limitations as well as the significance of this research study are also presented.

## **Chapter Five**

This chapter presents the significant findings that emerged during the course of the data collection process. The chapter commences with an overview of the key findings, including the demographics of the participants. The four key areas which were addressed during each of the interviews and which relate directly to both the research topic and the literature review are discussed. Key features, including the opportunities and challenges within each of these



team approaches, are presented. The voices of the twelve registered health social workers who participated in this research study are evident throughout this chapter, by way of direct quotes that emphasise their experiences, thoughts and opinions.

### **Chapter Six**

The significance of each of the key findings that emerged from the research study are discussed and analysed in relation to supporting literature, to substantiate their relevance to the current study. The outcomes of this research study directly related to the research topic and to a deeper understanding of the broader research area.

### **Chapter Seven**

This chapter provides a conclusion to the thesis. The significance of the study, as well as its limitations are presented in this chapter. Participants' reflections of the research process are included in this chapter. This thesis concludes by providing recommendations for further research.

## **1.5 CONCLUSION**

The purpose of this chapter was to introduce the research topic, including key terms and concepts that are discussed throughout this thesis. The aims and objectives which informed this research study, and which guided the research topic, have also been outlined in this chapter. The background to this research study has been presented, including the researcher's personal interest and practice experience as a health social worker in Aotearoa New Zealand. The following chapter contextualises health social work and provides an historical overview of the profession, as a field of practice within Aotearoa New Zealand's health system.

## CHAPTER TWO

### BACKGROUND: AN HISTORICAL CONTEXT

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#### 2.1 INTRODUCTION

*Kia whakatōmuri te haere whakamua:*

*'I walk backwards into the future with my eyes fixed on my past'*

This whakataukī acknowledges the significance of our social work history and the meaning that it gives to our understanding of the present context, which in turn informs the vision that we have for our future as a profession. This chapter locates the current study within the context of Aotearoa New Zealand. Notions of health and wellbeing are conceptualised from both Western and Māori perspectives. This chapter provides an overview of the ways in which the principles that underpin biculturalism are able to strengthen an integrated IDT approach. An historical overview of the extent to which health social work, as a field of practice, has evolved within Aotearoa New Zealand, highlights the evolution of the profession. This provides the backdrop for the current study, which contends that the profession has demonstrated preparedness and willingness to embrace the transition from a tradition MDT approach to an integrated IDT.

#### 2.2 CONCEPTUALISATIONS OF HEALTH

##### 2.2.1 Western Conceptualisations of Health

According to Howden-Chapman (2005, p.51), the promotion of health and wellbeing is a distinguishing feature of any sustainable democracy. Innovations in medical science have provided patients with more treatment modalities today than ever before, resulting in marked reductions in mortality and morbidity rates across the developed world (Fouché, 2014). Our efforts to remain healthy are an ever-important focus of our existence as human beings, and enable us to live purposeful lives and to make meaningful contributions to our world.

Hospitals remain the primary domain of doctors and nurses who are accorded elevated status. By extension, Western conceptualisations of health and wellbeing, which are individualistic and monocultural, ascribe value to the traditional medical model, which prioritises the assessment, diagnosis and treatment of medical conditions (Ambrose-Miller &

Ashcroft, 2016, p.104; Giles, 2013). At the same time, as healthcare standards across the first world and developing countries improve, traditional conceptualisations of medicine have begun to erode (Fouché, 2014). The dogma of traditional medicine has become a contestable arena and the dominance previously commanded by an exclusive and prestigious medical paradigm has shifted towards integrated healthcare. This highlights the constant evolution and paradoxical and dynamic nature of the health system, which reflects the complexities and ongoing tensions that exist within the wider milieu (Baum, 2015).

The demands of our diverse population, together with a growing aging demographic who have increasingly complex health needs, arising from multiple comorbidities and other chronic conditions, has placed renewed emphasis on the importance of improving access to quality healthcare (Barnett & Barnett, 2005; Fouché, 2014; Ministry of Health, 2016). This, together with the global trend towards increased public scrutiny and expectations concerning service provision, has begun to highlight the need for greater levels of accountability and transparency within the health system (Fouché, 2014, p.219).

A functionalist perspective of health and illness considers the way in which different facets of social functioning at the micro, meso and macro levels co-exist to establish social order and stability (Ryan, 2005). Ryan (2005) suggests that for individuals, families and whānau to maintain health and wellbeing and to contribute to the market economy as productive members of society, they need to have access to an efficient and responsive health system.

The International Federation of Social Workers (2008), which conceives the wider policy implications of health, proposes that:

all people have an equal right to enjoy the basic conditions which underpin human health. These conditions include a minimum standard of living to support health and a sustainable and health-promoting environment. All people have an equal right to access resources and services that promote health and address illness, injury and impairment, including social services.

According to The World Health Organization (1948), health is “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”. While this definition considers health and wellbeing holistically, it presupposes health as an “ideal”, and does not account for the subjectivities inherent in the individual’s experience of their own health and wellbeing (Dew & Davis, 2005). Significant health-related issues including obesity, diabetes, heart disease, chronic illness, mental health and premature deaths

are directly associated with the inability to access the necessities of life, including access to quality health services (McLeod & Bywaters, 2000; Baum, 2015).

There is a significant amount of national and international literature, which draws consistent links between disproportionate access to healthcare and increased health inequalities (Ajwani, Blakely, Robson, Tobias & Bonne, 2003; Howden-Chapman, 2005; Ministry of Health, 2015; Stronks, van de Mheen, Looman & Mackenbach, 1996; Syme, 1996). A Structuralist paradigm challenges notions of equality and consensus and posits that the social divisions and power disparities that exist within society inextricably influence the individual, family and whānua's ability to access healthcare (Ryan, 2005; Baum, 2015). Baum's (2015, p.535) assertion that "political and economic power" are interwoven and stacked in favour of capitalism therefore highlights the inherent and ongoing disconnections between medicine and patients.

In reality, tensions exist between the pressure to respond to escalating patient numbers and the growing demand for cost-effective, high quality healthcare (Fouché, 2014; Ministry of Health, 2016). Ryan (2005, p.8) concurs and advances that the health context perpetuates inequities based on "gender, race, class and ethnicity". This supports a Marxist approach, which embraces the notion of a "class consciousness" in which those who "own the means of production" are able to access quality healthcare, thereby reinforcing disparities in mortality and morbidity rates across class, race and gender (Baum, 2015; Gray & Webb, 2009; Ryan, 2005).

Two schools of thought exist in relation to the provision of healthcare within Aotearoa New Zealand: (1) proponents of universal healthcare provision based on need and (2) advocates of targeted provision of healthcare in which services are directed towards high-risk communities (Ahuriri-Driscoll, 2016; Cheyne, O'Brien & Belgrave, 1997; Durie, 2005). Cunningham and Kiro (2001) draw attention to risk of "stigmatisation" inherent within targeted healthcare provision and the imperative to demonstrate responsiveness to Māori. Durie (2005) contextualises this by highlighting obligations to Te Tiriti o Waitangi. Howden-Chapman (2005, p.52) challenges the perpetuation of inequalities in healthcare distribution and proposes a broad-spectrum approach which extends beyond micro-level interventions that addresses "individual risk factors", to those which target under-resourced and marginalised communities. This highlights the need for renewed focus on healthcare delivery, directed at addressing the social determinants of ill health and disease management, in which policies at the macro level more realistically reflect individual experiences, at both the micro and meso levels (Dew & Davis, 2005).

### 2.2.2 Māori Conceptualisations of Health and Wellbeing

Consideration of Māori notions of health and wellbeing cannot proceed without first acknowledging the profound and protracted impact which colonisation has had on Māori inequalities and health disparities (Ahuriri-Driscoll, 2016; Dew & Davis, 2005; Ruwhiu, Te Hira, Eruera & Elkington, 2016). In contrast to Western conceptualisations, Māori constructs of health and wellbeing are inextricably connected to whakapapa<sup>9</sup> and the sense of belonging to the collective (Mooney, 2009). A Māori worldview conceives health and wellbeing as extending beyond the physical and biological, to the emotional, psychological, cultural and spiritual realms. Health and wellbeing are therefore conceptualised holistically and emphasise connections and relationships with family, whānau and the land (Ahuriri-Driscoll, 2016; Anglem, 2014; Cunningham & Durie, 2005; Durie, 1994).

Durie's (2003) Te Whare Tapa Whā framework is seminal and identifies four key dimensions for conceptualising Māori health and wellbeing:

- Taha Wairua, the spiritual element
- Taha Whānau, the importance of extended family
- Taha Tinana, the physical element
- Taha Hinengaro, thoughts and emotions

According to this framework, the balance between each of these four dimensions is essential to maintaining good health and a sense of wellbeing. For Māori, physical health is inextricably connected to the individual's spiritual, emotional and whānau wellbeing. Māoridom reflects a collective culture, which extends beyond the individual and/or their immediate/nuclear whānau, to the wider community (Ruwhiu, 2013). According to Ruwhiu (2013), it is within the whānau that collective decision-making occurs and where Māori cultural values and beliefs are instilled. Spirituality extends beyond religion to include deeper connections with people, the physical environment and whakapapa.

A Māori worldview embraces notions of Whakawhanaungatanga, the practice of appreciating and growing relationships and kotahitanga, which involves bringing people together (Hollis-English, 2012; Mooney, 2009). Mooney (2012), in her research on "Māori social work views and practices of rapport building with rangatahi Māori", found that a therapeutic rapport with young people and their whānau was very important, as it affected

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<sup>9</sup> Māori refer to genealogy as *whakapapa*

access and engagement with services. Mooney (2009) argues further that there is a relationship between the rapport, which is established between the health social worker and the client at the beginning of the relationship, and positive patient outcomes. Hollis-English (2012) concurs and identifies a strong correlation between practitioners' ability to foster positive relationships and improved Māori wellbeing.

## **2.3 BICULTURALISM: A FRAMEWORK FOR STRENGTHENING INTEGRATED HEALTHCARE**

Biculturalism refers to the “co-existence” of both Māori and Pākehā/tauiwi<sup>10</sup> “values and traditions” within Aotearoa New Zealand (Kee, Martin & Ow, 2014, p.17). Bicultural discourse is inextricably connected to the sovereignty of Tangata Whenua and to our collective responsibilities to Te Tiriti o Waitangi, in which the principles of partnership, participation and protection are integral. Roberts (2016, p.208; Anglem, 2014) suggests that bicultural discourse has initiated a “paradigm shift” away from a “deficit ideology” towards an emphasis on “locating cultural understanding at the centre of practice”.

Biculturalism is integral to social work practice within Aotearoa New Zealand (Social Workers Registration Board, 2018; Aotearoa New Zealand Association of Social Workers, 2013). The Social Work Registration Board (2018) clearly outlines the expectations that are placed on practitioners to demonstrate “respect for the status of Māori as Tangata Whenua” of Aotearoa New Zealand, in its Code of Conduct (Principle 2):

2.1 work in partnership with Māori clients and their family/whānau 2.2 work in a culturally appropriate manner while recognising the diversity within the Māori population 2.3 have an understanding of Te Ao Māori and be able to state and use bicultural practice models 2.4 promote the rights of Māori to use Māori social work and/or bicultural models of practice to protect the integrity of Māori as Tangata Whenua 2.5 promote access to services that meet the needs of Māori clients 2.6 as a supervisor, endeavour to ensure supervision is culturally relevant if the supervisee is Māori 2.7 as a supervisor, endeavour to ensure supervision is culturally relevant, safe, and responsive to Māori clients.

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<sup>10</sup> *Tauwi* refers to people who have come to live in Aotearoa New Zealand, other than Māori/*tangata whenua*.

The current study recognises the implicit benefits of drawing on a bicultural framework, in order to both strengthen and sustain integrated healthcare within Aotearoa New Zealand. This study advances that consideration, and inclusion, of a bicultural framework sets research within Aotearoa New Zealand apart from international studies that have been undertaken. While there is a relative paucity in the literature that connects a bicultural framework specifically to the transition from a multi-disciplinary team (MDT) to an integrated inter-disciplinary team (IDT) approach, biculturalism and Māori models of practice are not new to interprofessional collaboration within Aotearoa New Zealand.

Notions of Whakawhanaungatanga, which relates to the practice of appreciating and growing relationships and kotahitanga, which involves bringing people together, are integral to a bicultural framework (Hollis-English, 2012; Mooney, 2009). Similarly, an integrated IDT approach draws on notions of inclusiveness, collaboration and interconnectedness to harness the collective efforts of different disciplines, in order to facilitate a cohesive response to patient-care (D'Amour & Oandasan, 2005; Giles, 2013, p.191; Hughes & Wearing, 2013; Jessup, 2007).

Durie, Fitzgerald, Kingi, McKinley and Stevenson (2002, p.12) advocate for “Māori development”, based on a Māori worldview in order to redress ongoing inequities for Māori. According to Ruwhiu (2013) and Anglem (2014), a bicultural approach to social work practice reaffirms the ability of whānau to exercise their right to self-determination and to generate solutions at the individual, whānau, iwi and hapū levels, which are infused by Māori cultural values and beliefs. Whānau Ora reflects this philosophy and represents an integrated model of care, which is informed by notions of Māori cultural identity and collectivist approaches to health and wellbeing (Giles, 2013; Roberts, 2016). A Whānau Ora approach locates the family and whānau as a collective, rather than the individual, at the centre of the “transformation” process, and utilises “intersectoral collaboration” to achieve the goals, which have been identified by the family and whānau (Giles, 2013, p.192; Roberts, 2016).

Key authors submit that health policy within Aotearoa New Zealand has moved some way from its previous Eurocentric orientation, towards a kaupapa Māori approach, where a “by Māori, for Māori” approach acknowledges the centrality of Māori culture, customs, knowledge and wisdoms in addressing ongoing disparities for Māori (Ahuriri-Driscoll, 2016, p.139; Durie, 2005; Cunningham & Kiro, 2001; Stanley-Clarke, 2016, p.59). The New Zealand Public Health and Disability Act 2000 recognises the principles of the Treaty of Waitangi and aims to “improve health outcomes for Māori” by ensuring Māori participation

at all levels of “decision-making and in the delivery of health and disability services”. From this, the Māori Health Strategy - He Korowai Oranga has emerged, to provide the framework for “Māori health development” in Aotearoa New Zealand (Ministry of Health, 2014). He Korowai Oranga outlines the importance of intersectoral collaboration, between Māori, the Government and the health and disability sectors, to ensure that health service provisions to Māori whānau are targeted at maximising “health and wellbeing” and reducing “disparities with other New Zealanders” (Ministry of Health, 2014). Ruwhiu, Te Hira, Eruera and Elkington (2016, p.83) concur and emphasise that recognition and inclusion of the provisions of Te Tiriti o Waitangi within policy, yields benefits for all New Zealanders. They contend that “Māori knowledge, wisdom, pedagogies, principles and practices” are essential components of “best practices” and imperative to engagement with Māori as Tangata Whenua of Aotearoa New Zealand (Ruwhiu, Te Hira, Eruera & Elkington, 2016, p.83).

## **2.4 WHAT IS HEALTH SOCIAL WORK?**

The International Federation of Social Workers’ (IFSW, 2014) global definition of social work states that:

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.

Social workers, who are employed within a healthcare service such as a DHB or a Primary Health Organisation (PHO) in Aotearoa New Zealand, are required to: (1) have a recognised social work qualification from a tertiary education provider, as set out by the New Zealand Social Workers Registration Board (SWRB)<sup>11</sup>; (2) be registered with the SWRB and (3) hold a current Annual Practicing Certificate (APC). To fulfil the requirements needed to gain an

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<sup>11</sup> The “Social Workers Registration Board (SWRB) is the regulatory authority for social workers” in Aotearoa New Zealand “and was established under the Social Workers Registration Act 2003 (Social Workers Registration Board, 2018).



APC, social workers need to hold a valid competence certificate and provide evidence of attending regular supervision (Social Workers Registration Board, 2018).

Although the largest percentage of registered social workers in Aotearoa New Zealand are employed in the health system, health remains the primary domain of doctors and nurses and is therefore a secondary setting for practitioners (ANZASW, 2017; Beddoe, 2011; Boyce, 2006; Giles, 2013). The key role of health social work is to support and empower individuals and their family and whānau, as they adjust to the impact of a life-changing diagnosis and the cumulative effects of treatment. In doing so, health social work seeks to mediate between patients, their family and whānau on the one hand and the complexities which are inherent within the health system, on the other hand (Beddoe, 2011; Auslander, 2001).

Dziegielewski (2004) defines health social work as:

A form of social work practice that takes place in a hospital and other setting and that facilitates good health and prevention of illness, as well as helps physically ill clients and their families to resolve the social and psychological problems related to disease and illness.

In contrast, medical science highlights the power imbalance within the doctor-patient relationship, by emphasising medical expertise in diagnosing, treating and rehabilitating “patients” (Armstrong, 2000; Healy 2005; Rees & Rodley, 1995). Traditional conceptualisations of medicine repudiate the impact of social determinants of health and undermine notions of inclusiveness and patient-centredness (Opie<sup>12</sup>, 1997; Giles, 2016). Authors including Ambrose-Miller and Ashcroft (2016), Good (1994) and Opie (1997) recognise the inherent limitations in exclusively and single-mindedly applying the traditional medical model to the complex milieu within which patients co-exist.

Asquith, Clarke and Waterhouse (2005, p.10) suggest that a number of “competing and contradictory discourses” converge to frame the nature and identity of social work practice. According to Sheppard (2006), social work is “socially constructed”, which presupposes the potential for external forces to exert subjective influence over the nature and focus of the profession. Health social work embraces a “social response to ill-health” by acknowledging the complex and dynamic interplay between the individual’s health and the influences exerted by the wider ecological system (Auslander, 2001; Beddoe, 2011; Giles, 2013). In

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<sup>12</sup> Opie’s (1997) research focused on “issues of discourse and representation in multi-disciplinary teams within New Zealand’s healthcare services.

addition, Baum (2015) advances that both “health” and “social work” is influenced by the broader social-political, cultural and economic contexts within which they are located, resulting in a fluid and paradoxical milieu. By challenging structures that perpetuate inequalities, social work ensures that those who are marginalised are able to exercise their right to self-determination and access quality healthcare (Giles, 2009; Giles, 2013; McLeod & Bywaters, 2000).

Despite the constraints that have been placed on the profession by the dominant medical paradigm, the scope of health social work practice has become expansive overtime (Beddoe, 2011). Practitioners now practice across diverse and complex service areas/wards, relating to specific diagnoses (Giles, 2013; Rubin & Babbie, 2010). Issues relating to mental health, domestic violence, child protection and substance abuse are key facets of health social work practice, which require practical, emotional, psychological, cultural and spiritual support for patients and their families (Harms, 2013; Giles, 2013; Schofield, 2001). Key theoretical frameworks that guide practice include systems theory, cognitive behavioural theory, psychodynamic theory, grief and loss, anti-oppressive practice and strengths-based practice (Giles, 2013).

Giles (2013) highlights the pressures that are placed on social workers within the New Zealand health system, where the volume of patients far exceeds the number of hospital beds that are available. O’Brien (2014, p.11-12) acknowledges the changing nature of social work practice in Aotearoa New Zealand and suggests that the profession has shifted from “the broad context of practice”, towards a “narrow focus on more immediate practice issues and on what frames the day-to-day activities and demands of undertaking practice”.

Given the pressure to respond in a timely and efficient way, discharge planning, which requires skills in psychosocial assessment, risk management and safety planning, has become a critical focus of the health social worker’s role (Maramaldi, Sobran, Scheck, Cusato, Lee, White & Cadet, 2014). Beddoe (2011), Giles (2016) and Pollack (2010) assert that the challenge for practitioners, who are tasked with managing risk and safety at the coalface and which results in copious documentation audits and case reviews, is to resist the urge to practice defensively and reactively. Instead, they suggest that a “critical and reflective” engagement in “ethical”, patient-centred practices supports clinical decisions which are based on sound assessments (Beddoe, 2011; Giles, 2016; Pollack, 2010).

The duality within the health social worker’s role highlights the profession’s responsibilities to individuals, families and communities, in the first instance (Giles, 2013). In raising the

consciousness of other disciplines, through education and coaching, about the symbiotic relationship that exists between health (medicine) and wellbeing (psychosocial), practitioners are able to position themselves, in what Beddoe (2011, p.25) refers to as a “distinctive space”. Thereby, allowing the profession to play a key role in reducing re-admissions and contributing to successful health outcomes (Beddoe, 2011; Giles, 2016).

## **2.5 THE HISTORY OF HEALTH SOCIAL WORK**

Nash (2001, p.42) highlights the importance of our history, as health social workers, by suggesting that:

Perhaps social work, as we move into a new century, is caught in a paradoxical situation. The history of social work reflects the social, political, cultural, and economic circumstances in which it is practiced. This is why the balance between the social justice and social control elements in social work changes from time to time. This is also why it is so useful to know one’s history in order to interpret what is happening and keep it in perspective.

In order to locate social work within the current trend towards integrated healthcare, it is important to review the history of health social work, as a field of practice, since its inception in the nineteenth century (Auslander, 2001; Beddoe, 2011; Nash, 2001; Schofield, 2001). According to Beddoe and Deeney (2012), the history of health social work has been characterised by blurred boundaries and role confusion between practitioners and medical professionals. According to Beddoe (2011, p.25), health social work has had a tumultuous history involving “a complex struggle to define itself” in relation to “other powerful players” within the health system. Bywaters (1986) asserts that the history of health social work is a history marked by “interprofessional conflict” and “the widespread emasculation” of the profession. Given this backdrop, it seems unsurprising that the nature and identity of the health social work remains contested over eight decades later (Beddoe, 2011). However, despite changes over time, the profession has remained true to its core values of social justice, human rights and self-determination.

Social work has evolved since its early involvement in British charity organisations in the mid-1800s (Auslander, 2001; Beddoe, 2011; Giles, 2013; Hughes & Wearing, 2013; O’Donoghue, 2015; Pierson, 2011; Schofield, 2001). In Aotearoa New Zealand, the early

history of social work can be traced back prior to the signing of Te Tiriti o Waitangi in 1840, where it was deeply rooted in the social structure of Māori society (Nash, 2001, p.33). Notions of welfare were conceptualised within the context of kinships and relationships to family and the broader community (Nash, 2001).

Early immigrants introduced British models of welfare to New Zealand society, which involved charitable trusts allocating aid to those who were deemed “deserving” (Nash, 2001; Pierson, 2011, Schofield, 2001). By 1875, the increase in hospital services, which provided both medical care and support services, led to the centralisation of healthcare (Schofield, 2001, p.147). According to Nash (2001, p.34) these “early systems of social welfare”, which were monocultural, effectively forged the way for social work.

The association between health social work and District Nursing Services, within Aotearoa New Zealand, can be traced back to the 1930s, where the “role of the nurse as a medical social worker” was regarded as integral to patient-care (Beddoe & Deeney, 2012; Nash, 2001; Schofield, 2001; Spensley, 1953). According to Nash (2001, p.32), the focus on the professionalisation of social work in the late 1940s resulted in tensions between “the state and the profession” for control “over the definition of social work”. While the first health social worker was appointed in Auckland in 1939, it was not until 1954 that health social work became independent of District Nursing Services (Johnstone, 1969; Schofield, 2001).

The economic buoyancy after World War II and into the 1950s saw a reduction in the demand for social work services in Aotearoa New Zealand (Nash, 2001; Schofield, 2001). In contrast, the economic downturn in the 1960s resulted in efforts to address social and economic inequities within Aotearoa New Zealand. The passing of the Māori Welfare Act of 1962 aimed to assimilate Tangata Whenua into Aotearoa New Zealand society (Nash, 2001, p.35). These “assimilationist policies” were later challenged in the Pūao-te-āta-Tū Report which was commissioned by the Department of Social Welfare in 1986, for creating “dependence” and undermining Māori rights to self-determination (Nash, 2001, p.39). According to Healy (2005), the social justice responsibilities of social work are targeted at challenging the impact of structural oppression on the micro and meso-levels of society.

In 1964, the New Zealand Association of Social Workers (NZASW) was formed with the intention of ensuring that social workers received access to education and training (Schofield, 2001). The later inclusion of *Aotearoa* to the New Zealand Association of Social Workers (ANZASW) reflected the NZASW’s bicultural commitment (Nash, 2001; Schofield, 2001). The NZASW joined the International Federation of Social Workers

(IFSW) in 1964, resulting in Aotearoa New Zealand social workers being subject to international professional standards of practice (Nash, 2001, p.32). By 1964, there were 53 health social workers across twenty-five hospitals in Aotearoa New Zealand (Nash, 2001; Schofield, 2001).

The 1970s and early 1980s were characterised by significant political tensions in New Zealand, most notably the Māori Land March in 1975<sup>13</sup>, the evictions on Bastion Point in 1978<sup>14</sup> and the 1981<sup>15</sup> Springbok Tour (Nash, 2001). These events galvanised social work around the profession's core values of social justice and human rights and created a resurgence in calls to reclaim professional identity through increased professionalisation (Nash, 2001). By 1971, the title of "social work" was formalised and became a "recognisable public service occupation" under the State Services Occupational Classification (Nash, 2001, p.36).

Unsurprisingly, Schofield (2001, p.149) defines the period between 1972 to 1988, as a "watershed period" characterised by increased "bureaucratic change" and "consolidation" of health social work in Aotearoa New Zealand. The appointment of the first social work advisor, as well as efforts to ensure that social workers became qualified and upskilled, significantly improved the status of health social workers in Aotearoa New Zealand (Schofield, 2001, p.149). In 1972, mental health services were incorporated into hospital boards (Schofield, 2001, p.148). By 1974, the number of social workers in Aotearoa New Zealand increased to approximately 857, with 405 social workers employed within the Department of Social Welfare and 186 social workers employed within hospital boards across the country (Nash, 2001, p.37). Seventeen percent of these social workers had a formal qualification (Nash, 2001). By 1988, there were 27 Māori social workers in health

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<sup>13</sup> The historic 29 day Māori Land March (hīkoi) started in Te Hāpua, in the Far North on the 14<sup>th</sup> September 1975, with 50 marchers and ended in Wellington on the 13<sup>th</sup> October 1975, when 5000 marchers arrived at parliament with a petition which was signed by 60 000 people (Ministry for Culture and Heritage, 2018). The hīkoi, which was led by Whina Cooper, was in protest against ongoing Government claims to Māori land (Ministry for Culture and Heritage, 2018).

<sup>14</sup> On the 25<sup>th</sup> May 1978, 222 people were evicted from Bastion Point, on Auckland's Waitematā Harbour (Ministry for Culture and Heritage, 2017). The occupation, which lasted 506 days, was in response to the Government's decision to create a housing development on former Ngāti Whātua reserve land (Ministry for Culture and Heritage, 2017).

<sup>15</sup> The 1981 Springbok Tour to New Zealand, from July to September, marked 56 days of unrest (Ministry for Culture and Heritage, 2014). The protests, which involved over 150 000 people in over 200 demonstrations, across New Zealand, were in response to the apartheid regime in South Africa at the time (Watters, 2014).

and one in five health social workers held a senior position (Daniels, 1989; Schofield, 2001, p.149). Today, twenty-three percent of registered social workers, in Aotearoa New Zealand, are employed within the DHB (ANZASW, 2017).

The debate around social work registration within Aotearoa New Zealand, which began in the 1970, signals that the profession is again in the midst of landmark change (Nash, 2001, p.37; SWRB, 2018). The Social Workers Registration Act 2003 provides the “framework for the registration of social workers in Aotearoa New Zealand” and explicitly outlines the importance of “professionalism”, accountability and competence to practice social work. This, together with the emphasis the Act places on ensuring “the safety of members of the public” remains a crucial focus in the drive towards mandatory social work registration today (The Social Workers Registration Act 2003).

## **2.6 CONCLUSION**

This chapter has located the current research study within the Aotearoa New Zealand context. Notions of health and wellbeing have been defined, from both Western and Māori perspectives. Biculturalism, as a framework for strengthening integrated healthcare has been discussed, as it relates directly to the findings of the current study. This distinguishes the current study from international research in this area and locates this research within the cultural context of Aotearoa New Zealand. The discussion around health social work practice and its history within Aotearoa New Zealand highlights the evolution of the profession. It is against this backdrop that we are able to conceptualise the professions’ preparedness and, as the current study concludes, willingness to engage in the transition towards integrated healthcare. The following chapter identifies key themes which were identified in the literature review and which are relevant to an understanding of the transition from an MDT to an IDT.

## CHAPTER THREE

### LITERATURE REVIEW

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#### 3.1 INTRODUCTION

Davidson and Tolich (1999, p.88) refer to the literature review “as an academic whakapapa”. The process of reviewing existing literature provides the researcher with an opportunity to both contextualise and determine the significance of the study currently under investigation (Davidson & Tolich, 1999; O’Leary, 2014; Rubin & Babbie, 2010). O’Leary (2014, p.99) states that the purpose of the literature review is to “inform readers of developments in the field” and to “establish the researcher’s credibility”.

Current New Zealand literature highlights the importance of evidence-based social work practice, higher tertiary qualifications for social workers and the need to foster a stronger research culture within the profession (O’Donoghue, 2015; Beddoe, 2011). This research study explored *the transition from multi-disciplinary team to inter-disciplinary team*, in order to ascertain *the impact of integrated healthcare on the nature and identity of health social work practice within Aotearoa New Zealand*.

This chapter is the culmination of a comprehensive review of both national and international contemporary literature, which was undertaken prior to embarking on the data collection (Rubin & Babbie, 2010). Key terms that were used to inform the search included - *integrated healthcare, inter-disciplinary teams, multi-disciplinary teams, health social work, change, healthcare and interprofessional collaboration*. The key themes that emerged from the abundance of literature supports the relevance of the current study and locates it within the context of a broader socio-political and cultural context, which is complex, dynamic and changeable (Davidson & Tolich, 1999; van Gool, Theunissen, Bierbooms & Bongers, 2016). These themes include the transition from a multi-disciplinary team (MDT) to an inter-disciplinary team (IDT) from a social work perspective, understanding integrated healthcare and its key elements and the process of interprofessional collaboration, which informs an IDT approach.

### **3.2 THE TRANSITION FROM A MULTI-DISCIPLINARY TEAM TO AN INTER-DISCIPLINARY TEAM**

The need to do more with less has become the mantra of health boards, policymakers, politicians and managers alike. The growing pressures on healthcare services, created by an increasing aging population, coupled with more people living with chronic conditions and complex health needs, sits in disproportion to the resources which are available (Cooper, 2011; Fouché, 2014). Dew and Davis (2005) contend that health reforms have served a purpose far beyond managing health deficits, by re-organising the health system, which in turn has had an inevitable impact on the re-shaping and development of health professionals. Traditional constructions of healthcare, in which discipline-specific health professionals practice independently and/or within silo-oriented teams, has been replaced by an integrated healthcare approach, which requires greater interprofessional collaboration in clinical decision-making (Cooper, 2011).

The trend towards integrated healthcare is reflected in the expansive international, and growing body of comparative New Zealand, research, which has been conducted over recent years (Abramson & Mizrahi, 1996; Ambrose-Miller & Ashcroft, 2016; Barrett, Sellman & Thomas, 2005; Beddoe, 2010; Beddoe, 2011; Beddoe & Deeney, 2012; Carey, 2015; Carey, 2016; Giles, 2013; Giles, 2016; Glaser & Suter, 2016; Mizrahi & Abramson, 2000; O'Connor, Fisher & Guilfoyle, 2006; O'Donoghue, 2015; Parker-Oliver, Bronstein & Kurzejeski, 2005; van Gool, Theunissen, Bierbooms & Bongers, 2016; Winkelmann, 2013; WHO, 1988). At the same time, there is a paucity of research, which identifies a single, comprehensive conceptual framework for integrated healthcare (Cooper, 2011). Cooper (2011) acknowledges this gap and suggests that this reflects the need for further research in order to develop a model(s) of integrated healthcare.

Heralded as “best practice”, an integrated approach to patient-centred care aligns with the New Zealand Health Strategy, and seeks to address duplication and fragmentation by providing a targeted, deliberate and co-ordinated response to healthcare, which is transparent, equitable and accessible (Barrett, Sellman & Thomas, 2005; Ministry of Health, 2016; World Health Organization, 1988). Cooper (2011) conceptualises integrated healthcare as “an organising principle” which is aimed at managing patient volumes and improving the patient journey throughout the continuum of care. In line with current health social work discourse, the current study posits that the transition from an MDT to an IDT reflects a broader political agenda, which seeks to address increasing patient volumes while managing



health expenditure within Aotearoa New Zealand (Ambrose-Miller & Ashcroft, 2016; Beddoe, 2010; Beddoe, 2011; Carey, 2015; Carey, 2016).

Traditional notions of the MDT have made way for the transition towards an IDT, which represents an integrated, coherent, systematic and collaborative approach to patient-centred care. While the literature reflects the tendency among professionals to refer to the MDT and the IDT interchangeably, there is a rich body of emerging literature, both nationally and internationally, that suggests that there is merit in conceptualising these as two discrete healthcare teams, with opposing philosophies and differing political ideologies (Hughes & Wearing, 2013; Jessup, 2007; Korner, 2010).

MDTs are made up of different health professionals who bring their own discipline-specific roles, responsibilities, skills and knowledge to the team to ensure safe, effective patient-care (Hughes & Wearing, 2013, p.93; Jessup, 2007). In contrast, IDTs involve collaboration between different health disciplines, “who take on board each other’s perspectives and adapt their roles” in order to “provide an integrated and cohesive” response to patient-care (Hughes & Wearing, 2013, p.93; D’Amour & Oandasan, 2005, p.9). Giles (2016), who identifies a direct link between effective professional integration and the provision of “quality patient-care”, supports this view.

Carey (2016) asserts that a key advantage of the MDT is the professional autonomy that it provides to each discipline. At the same time, the MDT is time-consuming and creates duplication of services, as each discipline assesses patients according to their discipline-specific criteria (Carey, 2016). In contrast, IDTs necessitate the ability of a wide range of health professionals, from different modalities, to communicate, co-operate and collaborate effectively with one another, in order to establish clinical pathways that address complexities in patient-care (Carey, 2016; Matthews, Pockett, Nisbet, Thistlethwaite, Dunston, Lee & White, 2011, p.136). This highlights the potential of the IDT to be responsive to service-related inefficiencies and to reduce fragmentation in healthcare provision.

A significant proportion of the literature identifies co-location as a key factor in ensuring the successful transition towards an integrated IDT structure (Ambrose-Miller & Ashcroft, 2016; Goldman, Meuser, Rogers, Lawrie & Reeves, 2010; Howard, Brazil, Akhtar-Danesh & Agarwal, 2011; Kates, Mazowita, Lemire, Jayabarathan, Bland, Selby & Audet., 2011). Co-location refers to the close physical proximity within which IDT members are located in relation to one another. While interprofessional co-location has the potential to create seamless integration and closer professional relationships within the IDT, the literature

cautions against the risks of diluting the social work role and isolating the profession (Ambrose-Miller & Ashcroft, 2016; Goldman, Meuser, Rogers, Lawrie & Reeves, 2010; Howard, Brazil, Akhtar-Danesh & Agarwal, 2011; Kates, Mazowita, Lemire, Jayabarathan, Bland, Selby & Audet, 2011; Oliver, 2013). Carey (2015; 2016) speaking from a British perspective, concurs and asserts that the trend towards integrating health social work into the IDT has the potential to create “fragmentation”, “uncertainty, loss of belonging and fractured identities” for the profession. Others agree and advance that there is limited “empirical evidence” to suggest that integration provides “more effective care” (Ambrose-Miller, 2016; Carey, 2016, p.6; O’Connor, Fisher & Guilfoyle, 2006; Parker-Oliver, Bronstein & Kurzejeski, 2005).

In addition, Holscher and Sewpaul (2006) suggest that integrated healthcare is underpinned by the notion of managerialism, which defines problems according to economic imperatives. According to managerialism discourse, solutions are targeted towards managing a burgeoning health deficit, while ensuring the long-term sustainability of the health system (Holscher & Sewpaul, 2006). Dominelli (2010, p.602-604) conceptualises managerialism in terms of the “commodification of goods and services” which “restricts the social worker’s access to resources that match their assessment of need”. This aligns with the neoliberal policies and New Public Management Reforms, which were introduced in the 1980s and 1990s to ensure structural oversight of the state sector (Schofield, 2001). Separations between policies, funding, service outcomes and service provision create competition between service providers to deliver quality healthcare (Nash, 2001; Schofield, 2001). These reforms have placed significant responsibility on health services to secure funding streams, by achieving key performance indicators that highlight accountability and efficiencies in healthcare provision (Cheyne, O’Brien, & Belgrave, 2000; Nash, 2001; Schofield, 2001).

In their study, Glaser and Suter (2016) established that effective integration was hindered by the lack of understanding around the roles and responsibilities implicit within the health social work role. These findings were similar to those of Reese and Sontag (2001) who identified that a major barrier to integration related to the lack of understanding health professionals had about the range of knowledge and skills each discipline brought to patient-care. What these findings highlight, are unique opportunities for health social workers to utilise their communication skills, in order to promote effective professional collaboration and teamwork (Matthews, Pockett, Nisbet, Thistlethwaite, Dunston, Lee & White, 2011; Giles, 2013). Opportunities exist for social workers to mitigate these challenges by taking on educative, leadership and mentoring roles and by clearly and competently articulating their role and the unique contribution the profession is able to make within the IDT, and

ultimately to patient-care (Ambrose-Miller & Ashcroft's, 2016; Beddoe, 2011).

### **3.3 INTEGRATED HEALTHCARE: KEY ELEMENTS**

There is consensus within the literature about the focus of integrated healthcare and the wide-ranging elements which constitute such a framework (Ambrose-Miller & Ashcroft, 2016; Beddoe, 2010; Beddoe, 2011; Beddoe & Deeney, 2012; Cooper, 2011; Gabrielova & Veleminsky, 2014; Maramaldi, Sobran, Scheck, Cusato, Lee, White & Cadet, 2014; Parker-Oliver, Bronstein & Kurzejeski, 2005). Each element poses both challenges and opportunities for practitioners to highlight their unique skills and knowledge. The following themes provide an understanding of the context within which health social work operates when collaborating across disciplines namely: professional identity; interprofessional culture; role clarification; power dynamics and interprofessional communication (Ambrose-Miller & Ashcroft, 2016; Belanger & Rodriguez, 2008; Canadian Interprofessional Health Collaborative, 2010; Gagne, 2005; Giles, 2016; Glaser & Suter, 2016; Goldman, Meuser, Rogers, Lawrie & Reeves, 2010; Hansson, Friberg, Segesten, Gedda & Mattson, 2008; Interprofessional Education Collaborative, 2011<sup>16</sup>).

#### **Professional Identity**

Notwithstanding its history of social action and anti-oppressive practices, the professional identity of social work remains paradoxical, contested and debated, as it mediates between the client's individual and wider social contexts (Hugman, 2009; Oliver, 2013; Sheppard, 2006). Sheppard (2006) contends that the ongoing challenge for social work is in the way the profession ensures that the rights of the individual are upheld in direct proportion to the rights and obligations of the profession in relation to the state and to society as a whole.

Beddoe's (2011) study highlights the complex connections between the professional identity of health social workers, practitioners' access to continuing professional education (CPE) and the profession's status within healthcare services in Aotearoa New Zealand. Beddoe's (2011) study is invaluable in identifying ongoing and persistent disparities between the traditional medical model and the psychosocial approach, because it challenges health social workers to be proactive and competent in the way they articulate their professional identity to other health professionals, within the context of an integrated IDT.

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<sup>16</sup> IPEC (2011) is the United States' Interprofessional Education Collaborative, which outlines core competencies for interprofessional collaborative practice.

What distinguishes health social work from other professional disciplines is its capacity to conceptualise the way in which the patient's wider socio-cultural, political and economic context affects their ability to cope with, and adjust to, a sudden and traumatic life-changing health event (Ambrose-Miller & Ashcroft, 2016; Beddoe, 2011). This psychosocial approach, which is an intrinsic part of the professional identity of health social work practice, is underpinned by the values of social justice, human rights and self-determination. Crucially, these values form the bedrock of the profession's global identity.

### **Integrated Team Culture**

Ambrose-Miller and Ashcroft (2016) propose that interprofessional collaboration enables professionals to engage in collective clinical decision-making, which requires both a cohesive team culture and a shared understanding of the patient's needs. In a Canadian study, which was undertaken with social workers, educators and students, Ambrose-Miller and Ashcroft<sup>17</sup>(2016) identified that the notion of egalitarianism was important to health social workers. According to this study, a collaborative team culture was fostered when health social workers felt that their knowledge and skills were valued, respected and encouraged by other disciplines within the team (Ambrose-Miller & Ashcroft, 2016).

Similarly, in Aotearoa New Zealand, Giles' (2016) small-scale study revealed that when health social workers' knowledge about the patient's wider context was recognised and valued by other health professionals, it not only yielded quality outcomes for the patient, their family and whānau, but it also created effective interprofessional collaboration. An American study by Liepzig, Hyer, Wallenstein, Vezina, Fairchild, Cassel and Howe (2002) explored the "attitudes of professional disciplines" in relation to the IDT and found that social workers not only valued interprofessional collaboration highly, but they also brought a depth of knowledge, skills and experiences of collaboration and teamwork to the process. Ambrose-Miller and Ashcroft (2016) conclude that organisations which demonstrate a commitment to a culture of collaboration, through its ethos, values and governance models, have a higher probability of creating effective, sustainable and successful interprofessional team collaboration.

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<sup>17</sup> Ambrose-Miller and Ashcroft's (2016) Canadian study entitled: "*Challenges faced by Social Workers as Members of Interprofessional Collaborative Health Care Teams*", identified the facilitators and barriers to collaboration, from the perspective of social workers.

## **Role Clarification**

Given the complex nature of the health system, social workers are required to mediate between specialist and generalist practice frameworks. The multi-faceted nature of health social work has allowed practitioners, for the most part, to remain steadfast in their commitment towards a generalist paradigm, by drawing on the breadth of skills and knowledge derived from diverse fields of practice. Although social workers are located to specific service areas/wards, their role in relation to a patient's admission and subsequent discharge, is wide-ranging and diverse. The variability and flexibility with which social workers are able to practice within the health system, allows them to adapt and respond to the specific needs of the patient, their family and the service area/ward, simultaneously. This view is echoed by Ambrose-Miller and Ashcroft's (2016, p.104) study which found that health social workers were able to establish themselves as integral to the team, by identifying gaps in service delivery and addressing areas of "clinical complexity", which other disciplines were unable to meet.

The role of the health social worker is to navigate the gamut of emotional, psychological, social, practical, financial, spiritual/religious and cultural complexities experienced by the patient and their family and whānau, in relation to a sudden, life-changing and/or chronic health-related event. In addition, the practitioner's skill in effective communication enables them to advocate for the patient and to mediate between the individual, their family and whānau and other members of the IDT (Giles, 2016).

While the health system provides scope for innovation and resourcefulness, inevitable constraints that are dictated by specific service areas/wards, demand that practitioners are competent and able to articulate their role and the values they bring to patient-centred care (Ambrose-Miller & Ashcroft, 2016; Beddoe, 2011; Giles, 2013; Hugman, 2009; Oliver, 2013). Beddoe's (2011, p.37) findings which highlight health social workers' "lack of confidence and autonomous decision-making", are consistent with those of Ambrose-Miller and Ashcroft (2016, p.104) who suggest that the "fluid and ambiguous" role of social work serves as a significant barrier to the practitioner's ability to make decisions and to engage in effective interprofessional collaboration. Ambrose-Miller and Ashcroft (2016, p.107) found that social workers who were clear about their role and the benefits in terms of patient-care, were more confident about engaging in integrated healthcare. Role clarification therefore provides significant opportunities for practitioners to educate the IDT about the scope of social work practice, and the substantive impact their involvement can have on ensuring

quality patient outcomes (Ambrose-Miller & Ashcroft, 2016). In doing so, health social workers are able to promote the integrity of the profession while gaining credibility.

### **Power Dynamics**

Health social work embraces a radical emancipatory social work practice framework, in which notions of power, control, equity, oppression and social justice give rise to discourse around the right to access healthcare, commensurate with the need of the individual (Giles, 2013). A number of authors contend that the notion of power, which is widely recognised as a key feature of integrated healthcare, has the potential to hinder successful interprofessional collaboration (Ambrose-Miller & Ashcroft, 2016; Baker, Egan-Lee, Martimianakis & Reeves, 2011; Nugus, Greenfield, Travaglia, Westbrook & Braithwaite, 2010; Whitehead, 2007). Carey (2016) asserts that while interprofessional collaboration requires teamwork in order to ensure positive patient outcomes, health social workers are vulnerable to the challenges of power relations, different value orientations and alternative lines of accountability.

Foucault's (1978) work on the "influence of discursive power in institutional settings" remains seminal and is as relevant to our contemporary understanding of power and control within healthcare, as it was nearly four decades ago. Contemporary health research continues to draw on the framework created by Foucault, in order to conceptualise the way in which dominant discourses, which operate "within institutional spaces", influence power dynamics (Atwal & Caldwell, 2005; Giles, 2016, p.28; Opie, 1997, p.261). Ascribing "privilege" to particular disciplines and their "discursive practices", defines perceptions of "reality" and dictates "expected standards of performance", within integrated healthcare teams (Atwal & Caldwell, 2005; Giles, 2016, p.28; Opie, 1997, p.261).

Ambrose-Miller and Ashcroft (2016) highlight ways in which "overt power" and "covert power" are expressed within healthcare teams. Overt power, which is sanctioned at a structural-governance level, elevates the status of one discipline above that of another discipline(s) (Ambrose-Miller & Ashcroft, 2016, p.102; Whitehead, 2007<sup>18</sup>). Covert power, on the other hand, includes actions and/or behaviours that appear less obvious and more surreptitious, yet nonetheless equally subversive (Ambrose-Miller & Ashcroft, 2016; Whitehead, 2007).

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<sup>18</sup> Whitehead (2007) refers to "communication regarding patients which takes place around the doctor's schedule and which reinforces the doctor's centrality", as an example of overt power.

Efforts to reduce the power imbalance and maximise interprofessional collaboration, requires that teams demonstrate both competence and a collective commitment towards patient-centred care (Ambrose-Miller & Ashcroft, 2016; Beddoe, 2011; Giles, 2013). According to Jones and Jones (2011, p.180) “trust and unanimity of purpose can moderate conflict within a team”. Given the profession’s intrinsic knowledge, expertise and skills in human behaviour, group work and conflict management, practitioners are well-placed to manage power dynamics, and to lead efforts that facilitate collaborative, professional relationships within the IDT (Ambrose-Miller & Ashcroft, 2016; Giles, 2013).

### **Interprofessional Communication**

Developing, enhancing and facilitating effective interpersonal and intrapersonal communication is integral to all social work practice. Effective and articulate communication denotes both direct communication and indirect communication (Ambrose-Miller & Ashcroft, 2016). A number of studies, both national and international, highlight the importance of effective communication within the context of an integrated team approach, and suggest a direct correlation between the way in which professionals communicate and the potential for power dynamics to emerge (Atwal & Caldwell, 2005; Giles, 2016; Opie, 1997). The distinctive way in which specific disciplines use language and terminology, serves as both a powerful exclusionary mechanism and a means by which professionalism and status are accentuated. The literature advances that health professionals’ ability to communicate confidently and exercise influence in clinical decision-making, is in direct proportion to both their professional competence and their position in relation to the dominant discourse (Atwal & Caldwell, 2005; Giles, 2016; Opie, 1997).

At the same time, Giles’<sup>19</sup>(2016) New Zealand study provides insights into the potential for miscommunication and asserts that ineffectual, unco-ordinated and disorganised communication between health professionals undermines the “team’s effectiveness”, causing “distress”, and “confusion”. This, in turn, holds direct implications for patient safety and discharge planning. Encouraging “effective communication” across disciplines and demonstrating a commitment towards interprofessional collaboration therefore yields benefits for both health professionals and patients alike (Ambrose-Miller & Ashcroft, 2016; Giles, 2016). Health social work can play a crucial role in this regard.

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<sup>19</sup> Giles’ (2016) New Zealand study was entitled: “How do social workers perceive the functioning of multi-disciplinary teams in the hospital context?”

### 3.4 INTERPROFESSIONAL COLLABORATION

Research relating to interprofessional collaboration and its implications for social work practice within healthcare, has gained momentum, both internationally and within Aotearoa New Zealand (Ambrose-Miller & Ashcroft, 2016; Barrett, Sellman & Thomas, 2005; Beddoe, 2010; Beddoe, 2011; Carey, 2016; D'Amour & Oandasan, 2005; Gabrielova & Veleminsky, 2014; Giles, 2016; Glaser & Suter, 2016; Goldman, Meuser, Rogers, Lawrie & Reeves, 2010). The abundance of literature in this field, highlight both the benefits of effective interprofessional collaboration on the one hand, and the challenges which health social workers experience when collaborating with disciplines who ascribe to the traditional medical-scientific paradigm on the other hand (Giles, 2016; Glaser & Suter, 2016).

Interprofessional collaboration refers to the “process” by which members of an integrated IDT work in partnership with one another and engage in “shared decision-making” in order to achieve positive health outcomes (Craven & Bland, 2013; Giles, 2016; Glaser & Suter, 2016). Unlike traditional medical discourse, interprofessional collaboration heralds a paradigmatic shift, which alters the way in which health professionals engage with one another, in order to create “a system of co-operating independents” that function as a unit (Ambrose-Miller & Ashcroft, 2016, p.102; Glaser & Suter, 2016). Interprofessional collaboration therefore demands that health professionals are both competent and articulate in their roles (Ambrose-Miller & Ashcroft, 2016; Glaser & Suter, 2016).

The Canadian Interprofessional Health Collaborative [CIHC<sup>20</sup>] (2010) provides a framework for conceptualising interprofessional collaboration, which refutes a hierarchical approach to patient-care. The Canadian Interprofessional Health Collaborative (2010) appeals instead for inclusiveness and collectivism in order to ensure greater accountability and transparency. This framework aligns strongly with social work practice, as it recognises that patients and their families, who are confronted with a life-changing health event, can only feel empowered to make informed decisions about their health, if they are an integral part of the IDT and its decision-making processes (CIHC, 2010). Authors concur and suggest further that collaboration across professional disciplines results in the streamlining of clinical pathways, which in turn provides patients and their families with ease of access to quality

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<sup>20</sup> The Canadian Interprofessional Health Collaborative (2010) comprises health organisations, health educators, researchers, health professionals and students, and provides a National Interprofessional Competency Framework that outlines best practices for interprofessional education and collaborative patient-centred care.



healthcare (Goldman, Meuser, Rogers, Lawrie & Reeves, 2010; Ambrose-Miller & Ashcroft, 2016).

### **3.5 ORGANISATIONAL CHANGE**

The current study is grounded in an understanding that organisational change cannot simply be conceptualised at an abstract, theoretical level. According to van Gool, Theunissen, Bierbooms and Bongers (2016), organisations are in a constant state of flux as they manage inevitable and rapid change. Changes within the political arena are driven by the wider global market economy, which in turn directs policy. These changes are reflected at an organisational level through strategic planning and governance pathways and implemented at an operational level, where health professionals are tasked with delivering safe, competent and efficient services, which reflects policy directives.

Organisational change has warranted significant debate and has long been associated with negative connotations associated with ongoing, organised, systematic “planned and rational change” aimed at reducing inefficiencies and improving health service provision (Ambrose-Miller & Ashcroft, 2016; Glaser & Suter, 2016; Mizrahi & Abramson, 2000; Reed, 1999). As patient volumes are projected to increase, placing further strain on already inflated health systems across the globe, managing costs by minimising duplication and fragmentation has become a prerequisite for sustainable healthcare. Changes within healthcare have therefore become as much about adapting to a rapidly changing global environment, as it has about organisational survival (van Gool, Theunissen, Bierbooms & Bongers, 2016).

Hughes and Wearing (2013) highlight the interconnected, complex and transactional nature of organisations. Traditional constructions of organisational change which separate what occurs at the broader socio-political and cultural level, from the organisation’s ability to implement strategic planning, have been challenged (Bourgeois, 1980; Hasenfeld, 1983; Hughes & Wearing, 2013; Jones & May, 1992; Schmid, 2004). To understand organisational changes, at both a structural and an operational/process level, we need to engage in what Hughes and Wearing (2013) and Wolin (2004) refer to as “organisational analysis”, which refers to the influence of policy initiatives and the application of fiscal indicators to measure social service outcomes within healthcare.

Hughes and Wearing (2013, p.59) propose the reframing of organisational change, as both an

opportunity and a “proactive strategy” aimed at redressing inequities and discrepancies within healthcare. van Gool, Theunissen, Bierbooms & Bongers (2016) concur and assert that “permanent flexibility” and a “pro-active attitude” at all levels of the organisation are essential ingredients in the ongoing evolution and survival of health systems. A systems approach to organisational change therefore recognises the interconnected and multi-faceted nature of healthcare, in which professionals, patients, family and whānau, managers, policymakers, community and government stakeholders alike, are actively involved in the change process (van Gool, Theunissen, Bierbooms & Bongers, 2016, p.184).

### **3.6 CONCLUSION**

This chapter has explored a number of themes which are integral to a deeper understanding of the transition from an MDT to an IDT, and which have been identified in both the international literature and in New Zealand research. Drawing on contemporary research, this chapter has signalled the way in which integrated healthcare has gained momentum. Key elements, which constitute an integrated healthcare framework, have been discussed and critiqued according to both the opportunities and challenges they pose for health social workers, following the transition to an IDT. The emphasis on interprofessional collaboration within an integrated approach is regarded as essential to addressing health inefficiencies and to ensuring positive patient-centred outcomes. Changes within healthcare are conceptualised as an opportunity for health social work to identify gaps in service provision, which benefit the health system as a whole. The following chapter presents the research design and methodology that was used to achieve the aims and objectives of the current study. The chapter also provides an outline of the sample selection and data collection processes, which were employed.

## CHAPTER FOUR

### RESEARCH DESIGN AND METHODOLOGY

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#### 4.1 INTRODUCTION

Research can be defined as a “legitimate, creative and strategic process”, which involves the repeated use of objective, rigorous and systematic procedures to test what we think about reality against what we observe, and conversely, to examine what we observe in the light of what is known, in order to generate “credible conclusions” (Grinnell, 1988, p.14; O’Leary, 2014, p.9). Gibbs (2005, p.136) states that social work research involves: exploring, describing and analysing social work practice, theories, knowledge, interactions, interventions and systems”. Proponents of social work research, assert that the capacity to promote “social justice and social inclusion”, in order to instigate constructive, transformative change, by locating the research process within a wider socio-political and cultural context, highlights the enduring and distinguishing nature of this type of research (Dominelli, 2005; Gibbs & Stirling, 2013; McDermott, 1996; McLaughlin, 2007, Shaw, 2007; Smith 2009).

This chapter reveals the way in which each of the interconnected parts of the research process were instrumental in systematically structuring and guiding this qualitative study. This research study is located within a critical constructivist paradigm, which assumes that multiple realities (ontology) are constructed within the broader socio-political, economic and cultural context. This chapter discusses the critical constructivist paradigm in detail and provides an account of the rationale for using this approach. Systems theory provides a theoretical framework for conceptualising the change process, which, in the context of the current study explores the impact which integrated healthcare has on the transition from a multi-disciplinary team (MDT) to an inter-disciplinary team (IDT).

The way in which semi-structured interviews were used to gather the volume of data capturing the participants’ voices, is also discussed in direct relation to the research methodology. The formal ethics application and subsequent ethics approval process, which was undertaken prior to embarking on the data collection, is reflected on in this chapter. The limitations of this research study are also carefully considered.

## **4.2 RESEARCH TOPIC**

*The transition from multi-disciplinary team to inter-disciplinary team: The impact of integrated healthcare on the nature and identity of health social work practice in Aotearoa New Zealand.*

O’Leary (2014) emphasises the importance of ensuring that the research topic is clearly outlined in order to define the area of research under investigation and to establish the parameters within which a topic can be studied. This not only provides direction in relation to the research design and methodology, but it also guides decision-making processes. Similarly, Rubin and Babbie (2010, p.61) suggest that a research topic needs to be “narrow and specific” and presented “in a way that can be answered by observable evidence”.

Research is a formalised, systematic “and rigorous process, of gathering data to answer a particular question and this question will generally involve epistemological assumptions about the need for knowledge, which in turn can facilitate problem solving” (O’Leary 2014, p.2-3; Scotland, 2012). Knowledge and the ways in which we go about trying to achieve knowledge, are subjectively constructed.

In attempting to explore the topic under investigation, the current study considered that both healthcare and social work practice sit within a wider social, political, economic and cultural milieu. The study recognises an increasing trend towards an integrated approach to patient-centred care within Aotearoa New Zealand. This reflects a global movement. This research topic therefore examined the impact that such a transition might have on the nature and identity of health social work practice, within the DHB specifically.

## **4.3 RESEARCH AIMS AND OBJECTIVES**

The primary aim of this research study was to explore the subjective experiences of registered health social workers, who were employed within District Health Boards (DHBs) in Aotearoa New Zealand and who had transitioned from an MDT to an IDT. The study also aimed to examine the nature and identity of the professions’ core roles and responsibility within the MDT and the IDT, in the context of the DHB.

The objectives of this research study, which were informed by these aims included:

- To explore the ways in which health social workers conceptualise the differences

between an MDT and an IDT.

- To explore how health social workers experienced change following the transition from an MDT to an IDT.
- To determine the rationale for the transition to an IDT approach.
- To establish whether health social work roles and responsibilities changed following the transition to an IDT.
- To explore the opportunities that have presented because of the transition to an IDT and the impact these have had on health social work practice within the DHB.
- To explore the challenges that health social workers have experienced following the transition to an IDT and ways in which these have been addressed within the DHB.
- To provide recommendations on how to effectively transition health social workers from an MDT to an IDT.

These aims and objectives were fundamental in formulating the research topic and in guiding the semi-structured interviews. While some of the literature referred to the terms MDT and IDT interchangeably, the current research study deliberately distinguished between the MDT and the IDT, by defining these as two discrete teams within healthcare, each with a different structure and approach to patient-care. This research study conceptualised an MDT as a group of health professionals who are based within discipline-specific siloes and who bring their unique professional skills, knowledge and expertise to patient-care (Hughes & Wearing, 2013; Jessup, 2007). In contrast, the current study defined an IDT as an integrated, co-located team of health professionals, from different disciplines, who actively collaborate and consult with one another, in order to develop a shared understanding of the patient's needs, which results in a collective, co-ordinated and cohesive response to patient-centred care (D'Amour & Oandasan, 2005; Hughes & Wearing, 2013; Jessup, 2007).

A significant, yet unexpected finding which emerged from the current research study, and which will be discussed in detail in the subsequent chapters, is the way in which some health social workers were unaware of the distinctions between these two teams. To accommodate for this unexpected outcome, the study categorised participants according to distinct groups, which added depth to the overall research topic. Based on the outcomes which have been generated, it is anticipated that this study will contribute to the body of emerging research within Aotearoa New Zealand that explores the position of social work within the health system and its role in relation to interprofessional collaboration. It is also hoped that this research area will gain further exposure and that social work research, which examines the notion of integrated healthcare and the implications for social work practice, will begin to

gather momentum within Aotearoa New Zealand. These recommendations will be discussed in further detail in the final chapter of this thesis.

#### **4.4 RESEARCH METHODOLOGY**

This research study investigated the way in which the transition from an MDT to an IDT occurred, and how this process influenced the roles and scope of health social work practice within the DHB. By employing a qualitative methodology, this study was able to explore the complexities, which are inherent in the transition process, through the multiple realities and lived experiences of registered health social workers (O’Leary, 2014; Carey 2012; Baum, 2015; Rubin & Babbie, 2010). Qualitative research aligns with social work discourse, as it seeks to capture the depth and meaning that participants attribute to their experiences (Rubin & Babbie, 2010). By providing the conduit for participants to reflect on the transition process, their thoughts, experiences and opinions became integral to a deeper and more meaningful understanding of the research topic. A postmodern epistemology enabled value to be ascribed to the many ways in which these registered health social workers contributed to the construction of knowledge, relative to their subjective practice experiences within the context of the DHB (O’Leary, 2014).

According to Scotland (2012, p.13), a critical paradigm recognises the way language, which is imbued with dimensions of power and control, both reflects and “shapes reality”. The language used in each of the participants’ narratives reflects their subjective experiences of change and the implicit meanings that they attribute to these experiences. Their perceptions of reality and their recollections of the transition process are bound by time and informed by their position in relation to the dominant medical paradigm. Scotland (2012) asserts that critical theory attempts to challenge social injustices and “marginalism”.

This study therefore proposed that the experiences of health social workers are socially constructed in response to the complex and dynamic interplay that occurs between systems at different levels, both within and external to the DHB. Both healthcare and health social work practice are presented as paradoxical and contested in nature. Guba and Lincoln (1994, p.110) suggest that perceptions of what constitutes reality are constructed within the “social political, cultural and economic” context, which is in a constant state of flux. In turn, the power dynamics which are an inextricable part of this context, influence the way in which individuals construct knowledge (Scotland, 2012, p.13).

#### 4.5 CONCEPTUALISING CHANGE FROM A SOCIAL WORK PERSPECTIVE: SYSTEMS THEORY

Change does not occur in a vacuum and cannot be conceptualised as detached from its wider context. In asserting that “restructuring not only takes place in places but also takes place in the lives of individuals”, Kearns and Joseph (1997, p.19) emphasise the impact of change not only at the organisational level, but also at the subjective individual and team levels respectively. Ecological system theory<sup>21</sup> provides the framework within which social workers conceptualise the dynamic and multifaceted nature of change (Connolly & Healy, 2013; Hughes & Wearing, 2013).

This research study has utilised a systems perspective to conceptualise *the transition from multi-disciplinary team to inter-disciplinary team and the impact of integrated healthcare on the nature and identity of health social work practice within Aotearoa New Zealand*. This study is therefore located within a broader interconnected system, where changes in one part inevitably result in changes in other parts of the system. Change discourse, therefore, frames understandings about ways in which health social workers not only adjust to this transition but ways in which they are simultaneously accommodated by the reconfiguration of a new integrated IDT system, which comprises of different professional disciplines. This new system, in turn poses opportunities and challenges for health social workers to grow and develop, while it presents the profession with opportunities to continue its evolution.

Change has become a constant facet of the healthcare landscape. By their very nature, social workers are change agents, striving to promote social change within a broader socio-cultural and political context, at the individual/intrapersonal, family and whānau, community, organisational and governmental levels (Aotearoa New Zealand Association of Social Workers, 2017; van Gool, Theunissen, Bierbooms & Bongers, 2016).

Patients, who are diagnosed with an acute and/or chronic medical condition, are confronted by the physiological, psychological, cultural, spiritual/existential and social trauma caused by such a significant life-changing event. At the same time, they together with their family and whānau are often overwhelmed by the practical and logistical implications related to navigating the health system and managing treatment. The complex interplay between these

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<sup>21</sup> Ecological systems perspective, also referred to as social ecological perspective, is rooted in system theory.

dimensions of patient health and wellbeing enables changes to occur at the individual, group and community levels, through a dynamic process of adaptation.

Simultaneously, the patient's capacity to manage their own medical condition exists in juxtaposition to their ability to manage the impact on family and significant others. Harms and Connolly (2013) assert that patients are not passive recipients in this change process and by exercising their human agency, through decision-making, they attempt to garner control over a process that is often perceived as both complex and inevitable.

Drawing on this conceptual framework, social workers recognise the capacity of individuals, families, groups and communities respond to significant life-changing events and adapt to systemic change, in order to ensure positive outcomes (Connolly & Healy, 2013). Social workers are trained to support individuals, families and communities to develop coping strategies, which enable them to cope with normative responses to change, in order to engage in a process of accommodation and adjustment to a potentially new status quo, over time.

#### **4.6 SAMPLING: SELECTION OF PARTICIPANTS**

The purpose of this research study was to understand the subjective experiences, thoughts and opinions of registered health social workers, who have been part of an organisational change process, which had resulted in their transition to an IDT approach to patient-care, within a DHB.

All social workers who are employed within a DHB in Aotearoa New Zealand are required to be registered with the Social Workers Registration Board (SWRB) and to hold a current Annual Practicing Certificate (APC) (SWRB, 2018). Membership of the Aotearoa New Zealand Association of Social Workers (ANZASW) as a whole however, is considered optional and is not a requirement of employment, as a health social worker. All the respondents who participated in this research study were either registered with the SWRB or were registered and members of the ANZASW.

O'Leary (2014, p.183) refers to the selection of a research sample, as a strategic process which enables the researcher to undertake purposeful analysis. Baum (2015, p.216) suggests that qualitative research sampling provides depth of meaning and aims to ensure that the findings are representative of the wider population. The use of purposive sampling was to ensure that participants had basic practice knowledge of both an MDT and an IDT within a



DHB (Carey, 2012, p.39). For the purposes of this research study, two formal applications were made to the ANZASW, to attract registered participants from their membership (Appendix III). They sent an advertisement out, by email, to members to invite them to participate, if they met the research criteria.

The following criteria guided the selection of research participants for this study:

- 5+ years as a practicing social worker;
- Current or previous experience as a registered health social worker within a DHB;
- Previous experience as a member of an MDT within a DHB;
- Currently or previously a member of an IDT within a DHB.

In total, twelve participants were interviewed for this research study. Six potential participants were not interviewed because of identified conflicts of interest, where the researcher had worked with them in previous social work roles. A further two respondents were not interviewed after they withdrew.

The sample group for this research study included twelve participants from across both the North Island (N=8) and South Island (N=4) of Aotearoa New Zealand. According to Baum (2015), the size of this sample group provides the researcher with the opportunity to identify variations across the findings. O’Leary (2014, p.121) suggests that a qualitative research methodology supports the selection of a “small number of in-depth cases”. The length of practice experience of the twelve respondents who participated in this research study ranged from five to twenty-seven years, with the average length of practice experience being 11½years.

The majority of the participants in this research study were New Zealand European/Pākehā (N=8), while N=3 participants identified as Māori and N=1 participant identified as Chinese. N=10 female and N=2 male health social workers interviewed. N=10 of the research participants were employed within a DHB at the time they were interviewed for this study. The remaining N=2 participants who were employed within a hospice and a Primary Healthcare Organisation (PHO) respectively at the time, also had previous experience as health social workers within a community-based service, within a DHB in Aotearoa New Zealand.

The majority of the sample group (N=10) were employed in adult services, compared to N=2 participants who were employed in paediatric services. Participants were employed in both

part-time and full-time social work roles within the health sector. N=3 of the participants stated that they were either semi-retired or in the process of retiring from their positions as health social workers within a DHB or another health sector. All of the participants in this study had current or previous experience within a DHB.

The findings of this study indicate a distinction between in-patient and community-based services within the DHB and identifies where participants were based at the time of this study. N=5 of the participants in this study were based in a community service. N=3 of these participants were based in physical health and the N=2 remaining participants were based in mental health services. N=3 of the participants were based in an in-patient service, within physical health. N=2 participants, in physical health and mental health services respectively, held dual responsibilities across both in-patient and community-based services within their respective DHBs.

#### **4.7 DATA COLLECTION**

The research methods, which were employed in this study, were directly informed by a critical paradigm. Scotland (2012, p.14) contends that critical methods explore the individual's construction of reality "from a cultural, historical and political stance".

Prior to conducting the semi-structured interviews, each participant was sent a copy of the Information Sheet (Appendix IV) which provided them with the researcher's details, a detailed description of the research study and an overview of the interview process. Participants were advised of the data management systems, which would be used to store all data gathered from each of the interviews, until the research study had been concluded and examined, after which time these files would be destroyed (O'Leary, 2014). These systems included the use of password protected electronic files and a lockable filing cabinet (O'Leary, 2014). Participants were also advised that they would be provided with a summary of the research findings following its conclusion and that an e-copy of the final research study would be held at the library at Massey University, Palmerston North.

The research topic, the aims and objectives of the study, and a comprehensive literature review, supported the construction of a number of key research questions (Appendix VIII). These research questions included both general and specific questions and guided each of the thirteen semi-structured interviews. General questions broadly related to the changes, which health social workers had experienced within the context of the DHB, while more specific

questions were targeted at the changes health social workers had experienced at the local team level. Specific questions provided opportunities for health social workers to draw comparisons between their practice experiences within the MDT and the IDT.

The descriptive nature of the qualitative methodological design, which underpinned this research study, encouraged the use of semi-structured interviews. Semi-structured interviews are often used in qualitative social work research to provide greater flexibility and discretion to participants to express themselves more freely and for the researcher to pursue unexpected themes and lines of information (O’Leary, 2014; Carey, 2012).

Participants were asked to sign a Participant Consent Form (Appendix V), indicating that they had read the Information Sheet (Appendix IV) and agreed to the interview being recorded. In total, thirteen semi-structured interviews were conducted with twelve registered health social workers, including one participant who was interviewed twice to accommodate for time constraints. These interviews were conducted over an eight-week period, from October to December 2017. Interviews were conducted by prior arrangement, via Skype and/or telephone. All interviews were voice-recorded and took between 60 - 90 minutes. Each interview was transcribed, and then sent to participants for them to review, and to make any changes. All the data generated from these interviews was solely directed at achieving the aims and objectives of the research study and to develop a deeper understanding of the topic under investigation (O’Leary, 2014).

#### **4.8 DATA ANALYSIS**

O’Leary (2014, p.300) refers to qualitative data analysis as “an organic process”, which involves the dynamic interplay between “searching for meaning” in themes and patterns, “interpreting” these meanings and finally, drawing “conclusions”. Similarly, Patton (2015, p.630) suggests that analysing qualitative data requires the researcher to identify “significant patterns” and to construct “a framework for communicating the essence of what the data reveals”. According to Babbie (2010, p.391), it is important that researchers are able to “recognise meaningful patterns among variables”.

The process of analysing the data for this research study was consistent with those used in similar national and international qualitative and empirical studies. Following on from each of the interviews, the voice recordings were transcribed by the researcher. Initial observations and key themes which consistently emerged across the data and which related

directly to the research topic, were identified and recorded (Braun & Clarke, 2006). The exploratory and descriptive nature of this research study supported the use of both an interpretivist paradigm and a collaborative research approach, in order to encourage participants to reflect on the meanings and philosophies, which underpinned their subjective experiences, as health social workers within the MDT and the IDT (Baum, 2015, p.219).

Participants were given the opportunity to review and amend their respective transcript. To enhance the credibility of this proposed research study, and to ensure transparency, Carey (2012) suggests that research participants could view the themes which have been identified, to ascertain whether they agree with them. Each transcript was collated and systematically analysed according to key themes and patterns that emerged from the data (Corbin & Strauss, 2007). This qualitative research approach, referred to as grounded theory, utilised a combination of inductive and deductive reasoning (O’Leary, 2014; Babbie, 2010; Rubin & Babbie, 2010).

Themes, which emerged from the data collection, were compared with those which had been identified in the literature review and which were reflected in the research topic. Beddoe (2011) proposes that data analysis should include ongoing review of relevant literature, to identify commonalities with other research and to reduce the likelihood of researcher bias. These themes are analysed in detail in Chapter Four and discussed in depth in Chapter Five of this thesis.

## **4.9 ETHICAL CONSIDERATIONS**

Prior to the commencement of the data collection, a formal application was made to Massey University’s Human Ethics Committee, for full ethics approval. The ethics application was duly reviewed and approved by Massey University’s Human Ethics Committee (Appendix I). The Ethics Committee Statement was included in the Participant Information Sheet (Appendix IV) advising participants about whom they could contact if they had any concerns about the research. This study embraces the principles of ethical, credible and responsible research practices. These principles align with those outlined in Te Tiriti o Waitangi, the Social Workers Registration Board’s (SWRB) Code of Conduct and Aotearoa New Zealand Association of Social Workers’ (ANZASW) Code of Ethics.

Respondents were also informed that participation in the study was voluntary and that they were under no obligation and had the right to decline any question during the interview

and/or withdraw from the research study at any stage, without providing a reason. Participants were advised that every effort would be made to protect their confidentiality, including identifying details and information relating to individuals' thoughts, opinions and experiences, which could be traced back to specific health social workers and/or DHBs. They were also informed that absolute anonymity could not be guaranteed (O'Leary, 2014; Babbie, 2010).

Before participating in this research study, each participant was asked to sign a Participant Consent Form (Appendix V), stating that they had read the Information Sheet (Appendix IV) and had the details of the study explained to them to their satisfaction. Participants were also informed that they could ask further questions at any time during the research process. Participants were asked to indicate on the Participant Consent Form (Appendix V) whether they agreed to have the interview recorded. They were also given the option of having their recording(s) returned to them.

Following on from each interview, recordings were transcribed and sent to respective participant, for them to review their own transcript. An Authority for the Release of Transcripts form (Appendix VII) was signed by each participant, confirming that they had been given an opportunity to amend the transcript of their interview and that they agreed to the researcher using extracts from the edited transcript in reports and publications that arose from the research.

The researcher acknowledges her own subjective experiences, having been part of an organisational change management process, which involved the transition from an MDT to an IDT structure, in a large tertiary hospital, within Aotearoa New Zealand. To ensure that the researcher remained objective and to enhance the integrity and credibility of this research study, the researcher ensured that every stage of the research process, including the ethics application, research methodology, data collection and research findings were discussed with and overseen by her thesis supervisors.

#### **4.10 LIMITATIONS OF THE RESEARCH STUDY**

Given the researcher's practice experience, as a health social worker, importance was placed on remaining objective and conscious of any preconceived biases. While the use of semi-structured interviews created opportunities to capture rich and meaningful data, by way of

health social workers' reflecting on their subjective/lived experiences within the DHB, there were limitations to this research study:

- While the size of the sample group was considered to be appropriate for this study, limitations in terms of ethnicity, gender, age and the size of the DHB ie. tertiary vs. regional DHB, preclude the findings of this research study from being representative of, or generalised to, the larger health social work community within Aotearoa New Zealand.
- Not all the participants in this research study understood the theoretical distinctions between an MDT and an IDT. Some of the participants in this study therefore did not conceptualise change and the transitional process from a theoretical perspective. Consequently, not all the participants in this research study had experiences of transitioning from an MDT to an IDT. However, the decision to include this small sample in the research study was based on the remarkable insights these practitioners provided in terms of the role of health social work, the challenges and the opportunities inherent within an IDT and the support required to sustain change.

#### **4.11 CONCLUSION**

This chapter has presented the research design and methodology that underpinned this study. The way in which a formal ethics application, and subsequent ethics approval, informed the data collection process, has been examined here. The sampling procedures, which were used in the selection of participants, have been outlined in this chapter. This chapter has discussed in detail the systematic and organised process of data collection, which ensured that participants were able to make an informed decision about participating in this study. A thematic analysis of the data enabled significant themes and patterns to emerge from the data. These themes are discussed and analysed in depth in the following chapter.

## CHAPTER FIVE

### PRESENTATION OF RESEARCH FINDINGS

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#### 5.1 INTRODUCTION

This research study aimed to explore the:

*The transition from multi-disciplinary team to inter-disciplinary team: The impact of integrated healthcare on the nature and identity of health social work practice in Aotearoa New Zealand.*

The study drew on the subjective experiences of registered social workers, who were employed within District Health Boards (DHBs) in Aotearoa New Zealand and who had transitioned from a multi-disciplinary team (MDT) to an inter-disciplinary team (IDT). Two key aims informed this research study from the outset:

- To examine the experiences of registered health social workers who have practiced in an MDT and an IDT, within a DHB in Aotearoa New Zealand.
- To examine the nature and identity of health social work practice within the MDT and the IDT in the context of the DHB.

The following chapter presents the findings, which emerged during the course of thirteen in-depth interviews, with twelve registered health social workers from DHBs across Aotearoa New Zealand, over a two-month period from October to December 2017. Participants' voices have been threaded throughout this chapter, using direct quotes from each interview. Where possible, quotes have been edited for accuracy and clarity.

The chapter has been structured according to four key areas, which were addressed during each of the interviews and which correlate directly to the research topic and to themes identified within the plethora of literature that was reviewed prior to commencing the data collection. These areas focus on participants' experiences of:

- The multi-disciplinary team
- The inter-disciplinary team
- Change and the transition towards an integrated IDT structure and approaches to

patient-centred care

- The nature and identity of health social work practice within the inter-disciplinary team

## 5.2 AN OVERVIEW OF KEY FINDINGS

In order to identify the opportunities and the challenges present within both MDT and IDT approaches, participants were asked to reflect on their experiences, as health social workers within a DHB in Aotearoa New Zealand. There was no requirement in this study in relation to the length of time participants needed to have been part of either the MDT and/or the IDT. Key themes and patterns emerged as similarities and differences in participants' thoughts, experiences and opinions became more evident. These findings provided invaluable insights into ways in which integrated patient-centred care impact the nature and identity, including the roles and responsibilities, of health social workers within the DHB.

Notwithstanding that change is a core facet of social work practice, findings from this study revealed that participants supported the transition from an MDT to an integrated IDT approach. Participants valued opportunities to work alongside other professional disciplines, in order to contribute to positive patient outcomes. Some participants in this study disclosed that their personal values and philosophies enabled them to remain receptive to change processes. At the same time, participants acknowledged that their approach to change was not representative of all health social workers within the DHB.

A significant, albeit unexpected finding which emerged during the course of the data gathering process, was the way that some of the participants in this study used the terms "*multi-disciplinary team*" and "*inter-disciplinary team*" interchangeably. It therefore emerged that, while the majority of the participants in this study had practiced in both an MDT and an IDT, not all the participants in this study had in fact transitioned from an MDT to an IDT.

While some participants were able to articulate the distinctions between these two discrete team approaches clearly, other participants either did not know what an IDT was and/or were unable to articulate the differences between them. This was evidenced by three participants who referred to their respective teams as an MDT, despite the descriptions which they provided resembling key features of an IDT approach. These are reflected in Table 1 below.



Table 5.1: Participant Demographics

| Characteristics                                  | Health Social Workers |    |
|--|-----------------------|----|
|  | No.                   | %  |
| Experienced the Transition from an MDT to an IDT | 6                     | 50 |
| Always been in an IDT                            | 4                     | 33 |
| Members of an MDT/No experience in an IDT        | 2                     | 17 |

While not all participants had transitioned from an MDT to an IDT, the cross-section of participants in each of these groups revealed significant insights into health social workers' experiences at different stages of the transition process, thereby providing depth to the research topic. To accommodate for this research outcome, participants were categorised according to three distinct, albeit overlapping groups:

- Those who had transitioned from an MDT to an IDT within a DHB;
- Those who had always been part of the IDT and
- Those who were part of an MDT at the time this study was undertaken. The two participants in this category were at different stages of the transition process, within their respective DHB. For one participant, the notion of an IDT has been suggested. For the other participant, a review of their service had been completed pre-empting a possible transition to an integrated IDT structure.

Two further unexpected findings which emerged from this study, included:

- the strong alignment between a community-based service and an IDT approach and
- the role of biculturalism in strengthening health social work practice within the IDT.

A further finding from the data collection revealed the need for managers, and organisations as a whole, to provide greater transparency about the rationale for change. Clarity about the differences between these respective team structures and the implications of an integrated IDT approach for health social work practice, were regarded as crucial to the transition process and to sustained change within the DHB. These finding revealed opportunities for further research and development in this area.

The findings from this research study revealed that the nature and identity of the health

social work role within the DHB did not change significantly, following the transition to an IDT structure. Participants reflected on the opportunities that they had been able to seize, within this new integrated IDT structure, which allowed them to position themselves ideally to:

- (1) respond more effectively and efficiently to identified patient needs, which were not able to be met by other disciplines within the IDT
- (2) educate other IDT members about the scope of health social work practice and the benefits in terms of patient outcomes and
- (3) support and mentor other health professionals within the IDT.

These opportunities not only positioned health social workers as integral to the IDT's functioning, but they also enhanced effective professional relationships with other disciplines. Participants reflected on aspects of their social work role, which gave them the most job satisfaction and fulfilment. This allowed them to acknowledge the invaluable contributions they were making to team functioning and patient outcomes, in an environment where the medical paradigm continues to take precedence. The following sections of this chapter present the results of this research study in detail, according to significant themes that emerged.

### **5.3 THE MULTI-DISCIPLINARY TEAM**

Multi-disciplinary teams have been an integral part of the health system landscape. A key focus of this research study was the emphasis it placed on health social workers' experiences within two fundamental teams in the DHB, namely: multi-disciplinary teams (MDT) and inter-disciplinary teams (IDT). While these team structures and approaches to practice tend to be used interchangeably, the current study defines these as two discrete teams, each with their own mandate, albeit still focused on ensuring high standards of service provision and positive patient outcomes.

Participants were asked the following questions concerning their MDT experiences within the DHB:

- What is your understanding of a Multi-disciplinary Team (MDT) within the District Health Board (DHB)?
- Who are/were the other members of your MDT?

- Describe your role as a health social worker in the MDT
- What did the other members of the MDT understand your role to be?
- What is/ was your experience as a health social worker within the MDT?

All the participants in this study were familiar with the notion of an MDT. Their descriptions of an MDT, within the DHB, reflected a traditional approach to practice and to achieving patient-centred outcomes. Participants indicated that health professionals within the MDT operated relatively independently and assessments of patients occurred through the professionals' own discipline-specific lens. This was evident in the way in which these participants articulated their understanding of an MDT:

*...a multi-disciplinary team is when you have lots of different disciplines that...work... within their own discipline...but there's not a lot of overlap and...consultation between disciplines...[or]...reliance on each other to inform patient-care...it's quite separate. (Participant 1)*

*An MDT is where people from various areas come together...under different managerial structures...and...[discuss]a patient and then go away...An MDT...[is]less co-ordinated...[and]MDT workers generally have other responsibilities[and]...other obligations... (Participant 9)*

These statements highlight the distinctive nature of the MDT, where clear separations between health professionals are created, due to the distinctive discipline-specific silos within which health professionals practice. Consequently, participants referred to the way in which this increased the potential for duplication and overlapping of assessments and resources:

*...We all do assessments as those are generic roles...and they will all be done...in a...uniform way...so it's a very medical model...The only difference...is that certain disciplines will have certain strengths in...certain areas and that will be...evident in the way the...assessment flows...We're collecting the same...data... (Participant 3)*

Other disadvantages of the MDT noted by participants included the time-consuming, bureaucratic and repetitive nature of this structure. They also noted that professionals were not always able to foster close and effective working relationships, which would allow them to develop a deeper understanding of others' roles and responsibilities, given that they were only intermittently based on the ward or service area. One participant reflected on this in the following way, highlighting the incongruence with social work:

*...We worked in separate rooms...from other disciplinary teams...Only when we have...meetings, people will sit in one big room...So sometimes...it's really hard to know*

*your colleagues...in other teams... [and] to meet people...So my understanding is in your work as a social worker, you need to work together...with other...professionals...(Participant 4)*

This social worker reflected on the way in which the lack of clear processes and lines of accountability within the MDT reduced the potential for health professionals to collaborate with one another in ways that allowed them to develop insight into the social worker's roles:

*...I would always struggle...because my natural instincts...[are to]...work collaboratively... So, for me there was always that...[missing] feedback loop.(Participant 6)*

In spite of these disadvantages, participants also highlighted the capacity of the MDT to provide a measure of safety for health professionals. Participants suggested that the MDT provided them with opportunities for greater flexibility in the way they chose to manage their workloads across service areas. They noted that they were able to disperse themselves across a number of service areas, rather than being bound to a particular ward/service area. Some participants regarded this as important where health social workers did not feel valued within their respective service area and/or where there were challenging professional relationships within the team:

*Within the MDT my experience is that...people write their notes and wander off and do what they...need to do...You're not always in the...frame together...To be honest... you ...hope that you get on well with people but...there's a reasonable chance that your management structure means that you can go elsewhere...There's less of that connection. (Participant 9)*

One of the distinct advantages of the MDT included the way in which this structure afforded health social workers within the DHB, greater opportunities to retain their professional identity, which was not the perception some participants held of the IDT. While participants reiterated the lack of connection with other disciplines in the MDT, they highlighted the way in which the structure of this team provided them with a greater level of independence and autonomy. This was largely facilitated through the separate and individualistic nature of practice in the MDT.

### **5.3.1 FEATURES OF A MULTI-DISCIPLINARY TEAM**

#### **Referral-Based**

Participants in this study cited the referral-based nature of the MDT as one of its key

features. Due to the siloed-nature of the MDT, a referral-based system was regarded as most effective. While this system allowed the service area/ward to decide which disciplines needed to be involved in a patient's care, it also enabled health social workers, and other disciplines, to triage their own workload. Participants cited the relationship they had with the referrer, as well as the referrer's own motivation and their understanding of the scope of the health social worker's role, as key factors that resulted in fluctuating referral rates. At the same time, some participants did acknowledge that their ability to demonstrate skill and practice competence helped to establish trusting, professional working relationships with other members of the MDT. This participant articulated it clearly:

*...Work really relied on your relationships with the MDT and whether or not...they trusted you...with that clinical judgement [and] clinical reasoning...I had a number of...people on the ward...that...I had a really positive relationship with...But there were others who I...[had] to negotiate...[with]...more diplomatically...There wasn't...a clear pathway of how to work with other people. It was more around a relationship...And you had to earn your stripes, rather than there just being a set way of working...in some ways it was quite disempowering. (Participant 1)*

Within the MDT structure, specific and discrete tasks were ascribed to each discipline. At times, participants noted that these tasks appeared to be commensurate with what other disciplines considered to be within the health social worker's range of knowledge and skills. Other disciplines often conceptualised the health social work role as primarily involving practical tasks:

*...So...some...people...will say: "we need to come up with a discharge plan for this person on the ward" and I will...go and see them. And... we'll have a discussion...Staff...who still adhere to the previous model [medical model] will say: "Mrs...is going to be discharged this week. She's going to need home showering. She's going to need...housework. I've put the referral through"... "You call a family meeting"...So it's very prescriptive. (Participant 2)*

## **Hierarchies**

Hierarchies were identified by N=5 of the twelve participants in this study, as another key feature of the MDT. Participants referred to the inequities and clearly defined hierarchies that appeared to exist within the MDT. The perceived lack of patient involvement and inclusiveness within the MDT's decision-making processes further reinforced traditional notions, which located the health professional in the position of "the expert":

*...Some...people...will say: "we need to come up with a discharge plan for this person on the ward"...Staff...who still adhere to the...[medical model] will say: "Mrs...is going to be discharged this week. She's going to need home showering. She's going to need...housework. I've put the referral through"... "You call a family meeting"...So it's very*

*prescriptive. And [there's] ...no sense that it's client-centred and that the client would drive choice around those things. (Participant 2)*

*...there was one time that I did a joint visit with...a midwife in the community. But that was only because we had to go to a meeting afterwards together...So the midwife was like "ok... you can come into this home...But it wasn't..."we're going together as a team"...if I was... good enough I could...be part of it... In that sense,...the MDT...was...a hierarchy...As a social worker I was...rarely...someone that did a referral to someone else in the MDT...So if there was a patient on the ward...and I identified something, I'd always have to go back to the midwife, who would then decide if a referral was needed... (Participant 1)*

References to the influence of the medical model featured highly among participants in this study and notions of power and control were regarded as significant. Four of the participants in this study referred explicitly to the position of health social workers within an MDT as being at the "bottom" of the hierarchical structure. These participants regarded the role of the doctor, and the impact of the medical paradigm, in determining both clinical outcomes and attitudes towards others, as particularly noteworthy:

*...Right the way up the chain of command...you...have the doctors on one side...and then you've...got this trickle down effect...to your...MDT...at the bottom...Obviously there is that...recognised...hierarchy...The care plan should be organised with the doctor...There is [a]...joint discussion about what needs to happen...but...it still sits strongly in the medical model...The...doctor...does...seem to claim...more of the...right. (Participant 3)*

*...You've got the doctor and then you've got the nurse and then you've got the physio [and] the OT. It...goes in order to the social worker... You're in a marginalised group and maybe that's because of the area that the social workers work in ...You can become...sucked-up into that medical model where the social worker...sits at the bottom of the...chain of command...If you look to this [as]...an inverted pyramid, I think social workers are...at the bottom...of a...medical model. (Participant 6)*

*...there were some doctors who just referred all the time because they got it...and...they looked at the person [as] more than just [their] presenting medical problem. But there were others...who never seemed to see their patients as anything other than the medical problem ...and they didn't want to, for whatever reason, look at the whole person and so we would never...be referred to, even though there might be glaring needs and concerns that were probably impacting on the person's health... (Participant 11)*

References to notions of the "patient" were significant as they inadvertently emphasised the expertise of the medical professional, thereby reinforcing disproportionate power relations within medical discourse. In contrast, social work references to the "client" denoted the profession's deliberate attempts to reduce the power imbalance and to restore within the client an awareness of their right to self-determination. This was reiterated by this participant, who stated that:

*“...in an...MDT model...you’re...stifled [by]...how much you can contribute...and how much you valued within that framework...it is a medical model in the DHBs...and it is driven by...the...patient as opposed to a client (Participant 7).*

Participants reflected on the deliberate and proactive strategies, which they employed in order to garner control and to overcome the lack of inclusiveness and consultation that they considered to be part of the MDT structure. One of these strategies included establishing a unique base of professional expertise, in which the health social worker would:

*...retain... power by not sharing information...and there’s the sense of expertise...That value comes from holding...power and that knowledge because if you do, people will come to you because they can’t go anywhere else. And...therefore, you become relied on...but I think that idea supports a learnt helplessness...It’s not an empowering process. (Participant 6)*

Particular areas of expertise included the health social workers’ vast knowledge and experience in relation to appropriate external/community resources. Participants acknowledged the value they added in knowing where and how to refer patients and their family and whānau in a safe and timely way, given the extreme pressures related to discharge planning within the DHB. Participants’ also recognised the level of skill they brought to the MDT in terms of bridging the gaps between the patient, the family, the MDT and the health system in general. These attempts at creating a niche position for the profession, which other disciplines were unable to deliver, allowed participants to become integral to the team’s functioning.

## **5.4 THE INTER-DISCIPLINARY TEAM**

To examine participants’ experiences of being part of an IDT within the DHB, the following questions were posed:

1. What is your understanding of an Inter-Disciplinary Team (IDT) within the DHB?
2. In your experience, what were the benefits and/or challenges of the transition to an IDT?
3. Who are/were the other members of your IDT?
4. How was your role as a health social worker similar in the IDT compared to your role within the MDT?
5. How was your role as a health social worker different in the IDT compared to your role within the MDT?
6. What do the other members of the IDT understand your role to be?

An overwhelming N=9 participants in this research study were supportive of an integrated team approach and referred to the benefits of health social work being part of the IDT structure. Participants in this research study reported slight variations in the combinations of professional disciplines, which made-up their respective IDT. These included: doctors; nurses; occupational therapists; physiotherapists; palliative care nurses and doctors; midwives; art therapists; counsellors; pharmacists; health coaches, paediatricians; health support workers; psychiatric nurses; mental health clinicians; kaumatua; kuia; mataora therapists and/or; dieticians. These combinations of professionals also reflected the specific service areas within which the health social worker was located i.e.: in-patient services; out-patient/community services; mental health services and/or whether the patient population included adults, women or children.

While all the participants in this study were familiar with the concept of an MDT, just over half of the sample group N=7 indicated that they knew what an IDT was and how it differed from that of an MDT structure. N=5 participants in this study either used the terms MDT and IDT interchangeably or were unaware of what an IDT was and associated the notion of an IDT with hospital “jargon”:

*...bizarrely...all the other disciplines talk about it, and particularly the nurses. It's an MDT to them. It's not an IDT. And I'm saying to them but we're still...visiting families together, gathering the same information together. Using that information to inform our assessments but collaborating to...establish the needs of the family. But yet everyone...[is] still calling it an MDT. (Participant 1)*

*...I'm actually not sure what...an inter-disciplinary team is and...I wouldn't have heard that term used. It's all about the MDT...I'm aware that there's all sorts of things that are bandied about...and people are wanting to be innovative... within health. (Participant 11)*

N=3 participants in this study referred to their team as an MDT, despite each of them resembling key features that are consistent with that of an IDT structure. These findings do highlight the need for ongoing research and education in this area. As discussed later in this chapter, this conceptualisation of an IDT contradicts a key feature of the IDT, in which members of the IDT are co-located within close physical proximity to one another.

Here the participants attempted to describe an IDT using key features of an MDT:

*...I don't actually know the difference between an inter-disciplinary and a multi-disciplinary. We...[refer to them as]...the same thing...If you're looking at inter-disciplinary then...you're thinking about locating all your social workers in one place. Locating all your occupational therapists in another place and...working in separate siloes and being called on...to work together [on] one particular case where needed. (Participant 3)*



*...[the] nurses and...[the] medical team and [the] social care team work...under one roof...in the one big office...as a team...I think that's better described as [a] multi-disciplinary team because we are one team working in one...geographical location... our organisation [referred to it as] a multi-disciplinary team. (Participant 4)*

These participants' accounts highlighted the interchangeable use of the MDT-IDT approaches and that the apparent lack of clarity around these two teams was not isolated to health social work specifically, but was more widespread and extended to other disciplines, including medical professionals. In some instances, participants revealed that this lack of clarity about the distinctions between these two teams was evident at the broader organisational level, which in turn manifested in confusion at the individual and team levels respectively.

Participant 4 articulated their endorsement of the IDT approach most clearly by emphasising the importance of demonstrating 'the intention to be a team member', by being "more integrative" and by creating opportunities where disciplines are able to "work collaboratively". It is noteworthy that participants in this study referred more consistently to the IDT as a "team", compared to the MDT. Participants regarded the way in which professional disciplines within the IDT functioned as a unit and engaged in dialogue, as instrumental in helping the team to develop the shared sense of purpose required to deliver patient-centred care:

*...[An] inter-disciplinary [team] is when there's real...discussion and collaboration... around [the]...patient, as opposed to "this is what I'm doing as a social worker for this patient. What are you doing?"... [An] inter-disciplinary [team] would go "how can we deal with this...together [as] a team..." (Participant 12)*

*...the IDT is a team that works together under [one]...umbrella...[It's]...more centralised...and more organised...The IDT... has a more personalised component...to it. So people are more personally connected to each other I believe...An IDT...actually...requires a different...thought process...[With] an IDT...there's the opportunity of developing...good interpersonal working relations...in a co-ordinated way [to] bring multiple...specialities to the family, which I've seen, can be a very powerful weapon. (Participant 9)*

References to "good colleagues" who are "supportive", "willing to learn" from one another and who have "mutual respect" for "one another's strengths" highlighted key attributes which they suggested created a cohesive team culture and enabled health social workers to feel valued and included within the IDT. Participants were unanimous about the benefits a positive team culture brought to their practice and ultimately to patient outcomes:

*...one of the senior doctors said... "it's like...a rugby game and...when somebody's been*

*binned for ten minutes, “the rest of the team pulls together and you just get on with it” ...and “...when the social work’s not there...we just pull together and get on with it” ... “and when they come back, they’re...a valued member of the team” “ (Participant 12)*

One of the participants in this study used the example of a diagram most eloquently, to illustrate the point at which different professional disciplines’ knowledge and skills overlap, as the point at which the IDT functions at its most optimal level:

*...collaborating with...other disciplines...to...come up with solutions and care plans and... using the knowledge that each discipline brings...I had this...diagram of three circles...One circle for social work and...the second circle...overlaps that and that might be physio and then another circle might overlap that and that might be an OT. And so it’s...the space in between the overlapping bits... (Participant 1)*

#### **5.4.1 FEATURES OF AN INTER-DISCIPLINARY TEAM**

Participants identified three key features of an IDT approach, which distinguished this team from that of the MDT:

- *Co-location* centralises all members of the IDT within the same physical location. This is in contrast to the MDT structure, where health professionals are located in discipline-specific departments/siloes that are removed from the service area(s) or wards.
- *Patient-centred care* involves the patient, their family and whānau actively collaborating with one another in order to develop a joint care plan, which is informed by a shared understanding of the patient’s needs. The patient is regarded as an active member of the team and is involved at all levels of decision-making, regarding their treatment.
- *Joint assessments* are conducted between health social workers and other health professionals, in consultation with the patient and their family, compared to the MDT where discipline-specific assessments are conducted individually.

While not exhaustive, a number of the participants in this study consistently referred to the significance of these features as being more pronounced within their respective IDTs. Participants indicated that these features characterised a new norm, following the transition from an MDT.

## Co-location

Co-location emerged as a significant theme within this research study, with N=8 of the participants co-located within an integrated IDT. This characteristically involved different health professionals relocating from discipline-specific departments, to sharing the same physical space with other professional disciplines. The physical proximity that co-location provided to members of the IDT, afforded them multiple opportunities to develop effective, trusting relationships, based on mutual respect and a sense of inter-connectedness:

*...If you spend time with people...and you show them what you do...then they will understand much clearer what you do... (Participant 9)*

*...But definitely, with [the] MDT...I felt like because you weren't naturally...working alongside each other doing visits... together...you had to make more of an effort to...build those relationships. Whereas...within an IDT, because you doing a lot together and you're in each other's company, you...build that relationship naturally. (Participant 1)*

*...the previous [Charge Nurse]...was very much that we were a team and...[was] very respectful of our position and encouraged the nurses to...consider social work...Some of the nurses are brilliant and...they totally get it and...we've a great relationship...in a collegial manner...It's a lot to do with the attitudes of the staff...towards what social work does...and part of that will be understanding what social work does. (Participant 12)*

With greater visibility and access to one another, came opportunities for IDT members to develop much deeper understandings of the health social worker's roles and the scope of their practice:

*...overtime, you [develop]...working relationships with people and...they come to know you as reliable...We all know each other, and so you begin to understand people's working patterns...I think that...the quality of the relationship and the capacity for inter-dependency and reciprocity...really needs to be developed. [To] me that's the difference between an MDT and an IDT. (Participant 2)*

*So...within a...IDT, you have got more...sharing...There's more...equality in terms of...how you work...There's...less hierarchy [and] there's more respectfulness. (Participant 6)*

Three participants stated that co-location created stronger “interpersonal connections” between health social workers and other disciplines within the IDT. Ease of access to other IDT members, by way of “corridor conversations”, which facilitated the timely “sharing of information”, was regarded as a key factor in helping the IDT to reduce the delays in patient-care:

*We work in the same...service location and that helps...to connect...and form...relationships with each other...[With the]...inter-disciplinary[team] there's more focus on*

*building really good trusting relationships...That to me seems to be the real key to... connect as a team. Really respectful of each other's...professional opinions...I think that's really important (Participant 6)*

*...So...you have the opportunity of people triaging earlier...You are more likely to pool your resources into... areas... [and]...you...have greater...access to people..because they're in your office...And...if it works well... you...have more...collegial...support with different people...So...you...get a...healthier workforce.(Participant 9)*

The nature of practice and the physical proximity within which working relationships occurred required professionals to demonstrate a “real investment”, “a level of engagement” and a “willingness to participate” in the IDT:

*...The openness to...learn and...share your vulnerabilities... where [as]...they can be hidden in a multi-disciplinary [team]...because you're...working...within your own little group...Connecting but not...sharing. (Participant 6)*

The symbiotic nature of relationships within the IDT was particularly profound for some participants, who highlighted the acute sense of safety they experienced within the IDT overtime. This is contrary to the perceived tenuous and sometimes unpredictable nature of the relationships they had experienced in the MDT:

*...we worked so hard to try and build trusting relationships with...other disciplines [in the MDT]... [In the MDT]...you had to just...constantly (be) working on those relationships. And constantly aware that those relationships could...slip...In an IDT that didn't happen...I don't know if it's just about team culture or if it's...the difference in the IDT...way of working...but...once I realised that I...didn't have to watch my back so much and I didn't have to...put so much effort into relationship-building...I knew that it just happened naturally and it was sustainable. (Participant 1)*

## **Patient-Centred Care**

While participants acknowledged that both the MDT and the IDT position the patient “centrally”, and neither “sees the patient better than the other”, the way in which “patient-centred care” was defined and the process by which each team achieved this objective, was identified as being markedly different. These participants provided a depth of insight into the different ways in which the MDT and the IDT impact patient-care, based on their experiences in both teams:

*...I think it's more...client-centred definitely, because...you're...looking at who's doing what, when [and] how can we work best for this client...by working together rather than in isolated little pockets”...We had situations where...services...would only work with children...up to a certain age...And all of a sudden, when that child turned 5, they would get*

*handed over to another social worker, who worked in a more generic service...But the needs didn't change...The family had established a relationship. So it...allows the family to have an established relationship with someone that they can connect with...throughout... (Participant 6)*

*...in terms of...the MDT, I don't see...any long-term change [for]...the patient... It...only looked at the presenting issues and focused on...short-term outcomes. But in the IDT...there [are] opportunities to...link...to...long-term meaningful, sustainable outcomes...We're only in that [patient's] life for 6 weeks...and...if we have done enough work in that time to...influence...meaningful change [and] build relationships for that [patient] and [their] whānau...the chances of change, I think are significantly greater. (Participant 7)*

The siloed approach of the MDT was regarded by participants as fragmented, because of the way in which this team approach positioned the medical professionals as the experts in the diagnosis and treatment of the patient. In contrast, participants experienced the IDT approach as collaborative and co-ordinated in its efforts towards joint care of the patient. Participants referred to ways in which the IDT's emphasis on "patient engagement with health outcomes" produced long-term, sustainable outcomes for patients, resulting in them remaining "totally engaged" in their own health planning:

*...It's lovely to be part of that team where it functions well and...you feel that you're all on the side of the patient trying to effect the best possible...discharge planning for them and set them up well to succeed. (Participant 11)*

*...this new model...is...driven by the...patient. So it...takes the focus off...the medical professional being the expert and places it on...the patient being empowered to participate in their own planning. So it becomes more patient-centred....Mum...consents to the meetings happening and...is... involved...in her own care planning...[With] the multi-disciplinary framework ...mum was not...consulted...and the whole...focus shifted...to the...direction that the services or the health professionals...were proposing...It [is] a real change in thinking ...from safety to support...and empowered mum to...have a say in what she wants... (Participant 7)*

The relationship between the patient and the IDT, served as a further determinant in promoting the patient-centred nature of the IDT. While participants were not definitive about who co-ordinated the IDT process, they did identify the professional's relationship with the patient, as a key factor in determining who might be in the best position to lead the care plan and promote positive patient-centred care. This participant also highlighted the involvement of the patient in such decision-making, which in turn created further buy-in:

*...they...will lead the...plan...because [they have] the best relationship and [they] want to manage [their] client's...plan at [their]...patient's request...We're all accountable for the tasks that we do...and then...everybody...decides...when do you want this reviewed? And so ...we have to come back and then look at what we've...achieved... (Participant 7)*

## Joint Assessments

There were N=5 participants in this study who noted that the transition from an MDT to an IDT correlated with the introduction of joint assessments with other health professionals. For N=1 participant, the introduction of a “compulsory initial joint assessment”, which they considered to be “positive”, marked the only change they could identify when the integrated IDT structure was introduced. Other participants reported that they had observed marked “attitudinal shifts”, as a direct result of conducting joint assessments. They attributed this to the opportunities, provided by the joint assessment process, for other disciplines to develop a deeper understanding of the health social worker’s role and their competence and skill:

*...from the very beginning I didn't think I was...valued. But...after sometime, especially when we did our joint visits, I picked up some questions or signals, which were ignored by [the] nurse and then...they really valued me and appreciated [that]...I was there...At triage meetings, if we discuss [a] family...they will ask “...do you have something to add?” So I can see the attitude changed. ...Whereas, previously there wasn't that ... (Participant 4)*

Participants achieved significant recognition and endorsement within the team through their ability to identify and address gaps in service provision, which could not be met by other professional disciplines within the team. There were N=4 participants in this study who referred specifically to health social work’s unique “psychosocial approach”, which recognises “the total person in their whole context” and the dynamic and cumulative impact which multiple spheres of the patient’s wider context can have on their ability to “transition” or adjust to a potentially life-changing health-related event. For the following participant, joint home visits created prime opportunities for them to utilise their skills and knowledge to address the impact of the patient’s wider context on their health and wellbeing. This area of skill and knowledge was regarded as unique to health social work practice:

*...You can hear about poverty in the hospital, but once you go into somebody's home and you see it, it's really evident...People are really willing to...understand those social issues...or acknowledge it. Whereas in the hospital...you're... constantly trying to...advocate for a family...or for a person. Their home life is really invisible to the MDT in a hospital...And I think possibly it's...the fact that the IDT get exposed to a whole lot more information...I think...because we do joint assessments... you ...see each other's practice straight away and you spend that time debriefing after your assessments...(Participant 1)*

*...it's not always easy to articulate what we do...but I do think the team understands that what we do is effective and...contributes well...in terms of working with our clients. (Participant 3)*

Participants were emphatic that joint visits enabled them to clarify their role, educate other disciplines about their scope of practice and build effective team relationships. This allowed

health social workers not only to demonstrate competence and professionalism, but also to garner support and credibility within the IDT. Conversely, participants remarked about the potential joint visits gave them to learn about other disciplines' roles as well. The benefits inherent in this lay in the reduction of duplication and fragmentation:

*... I can go to a visit and I...just love the fact that I have the opportunity to observe how the occupational therapist works or a physio [works] and [I] really get an understanding about...what they do. And that in turn...informs me...where...I...can fit in...and where the gaps are... that's...really helpful... (Participant 6)*

#### **5.4.2 THE CHALLENGES OF AN INTER-DISCIPLINARY TEAM**

While an overwhelming number (N=9) of participants in this research study were supportive of integrating health social work into an IDT structure, they also deliberated the challenges presented by an IDT approach. Some participants expressed concern about the risk of other disciplines within the IDT, encroaching on roles, which have traditionally been the domain of health social workers. Participants also referred to the way in which the IDT posed more "risk" because of the emphasis it placed on the "team", as opposed to the MDT, which presented as less "risky", due its focus on the "group". For this participant, the influence of austerity measures and a neoliberal paradigm, heralds the potential for roles and responsibilities to be blurred and signals a significant risk to the unique professional identity of health social work within the DHB:

*...I think that... if you're not careful in an IDT...there is always the risk that you will take on roles that you shouldn't take on...There is a greatest risk of loss of identity in the IDT... because there's...greater risk that management will ask us to do generic roles...[because] ...we're all in this together and we're all needing to...do the same thing so that we can get this job done quicker... The IDT runs the risk of actually having one narrative...one set of paperwork...one viewpoint...one direction...one plan....The IDT...arguably forces you into other roles that[are]...placed...onto you by others.(Participant 9)*

A further significant finding of this study revealed that some participants experienced a sense of isolation from their health social work colleagues. Although one participant stated that their team included more than one health social worker, which gave them with a "sense of connection with others from [their] own discipline" (Participant 3), this was not representative of other IDTs. Most of the participants were the sole health social worker in their IDT, compared to the MDT, which was made up of larger discipline-specific teams of health social workers. Participants also reflected on the sense of "vulnerability" and scrutiny they felt accompanied co-location:

*...with a MDT team...if you don't do something, no one...knows... [In an] inter-disciplinary [team] I think... [there's]...more...expectation that...there are things that you need to do. And if you don't, then that becomes very clear...but also...if you do get stuck, you can't...hide behind that...and actually bringing that to the table and going "...how can the team help and...how can we do this?" (Participant 6)*

At the same time, participants remarked that the sense of disconnection they experienced did not represent a significant deterrent, and did not outweigh the significance of the positive, supportive and collaborative working relationships that they were able to form with other members of the IDT:

*...there's times when...you've had a really hard...draining, emotional case....I would often go...and there'd be [another social worker] there to...de-brief with...I really struggled with getting quite isolated...and disconnected from the social work team at the start...for quite a while...So it's an interesting thing in that on one level I think "...I could do without them" and then on another level there really is...a benefit to having that... social work team and the understanding around... it... (Participant 12)*

Participants reflected on their proactive efforts to maintain contact with social workers across the DHB and other health sectors. This allowed them to retain their sense of professional identity, with social workers who spoke the same language and shared the same conceptual frameworks around patient-centred care. Maintaining regular professional supervision, which is a requirement to practice as a registered health social worker within an Aotearoa New Zealand DHB, also helped to ensure connections to social work:

*...As a social worker, I'm far more isolated in an IDT. That kind of checking-in, getting support...from...people who understand the work that we do and the values that we work with... We're far more reliant on support from the...IDT...I've been thinking about...how I create...a network of social workers...to...challenge my practice and make sure that I'm not...slipping into a... paraprofessional role or...coming from a...medical...focus too much. Actually the...role of the social worker is...quite unique and it's really important. (Participant 1)*

Other participants in this study drew attention to the potential for interprofessional dynamics and conflict to occur, when they were absorbed into an IDT that had an established team culture. This participant compared their experience of merging with an existing IDT, to that of a blended family:

*...The biggest thing...that would have supported it...would have been...around forming...a new team...What happened was the social workers were included into an existing team and...that's probably...the reason why...there is still a level of tension within...that team...If you're looking at a family system, it's basically a blended family, with an existing home,*



*family rules and all of a sudden you're bringing in these stepchildren who have been brought up quite differently...In terms of working...as a team...social workers moving into a different...team, and trying to...establish themselves within...an already formed culture...[can be]...challenging...if there's a...cohort of disciplines that are already working in the inter-disciplinary way...That's where the point of tension can occur...[when] you invite another a group of clinicians in who have quite a different philosophy and you have to work together . (Participant 6)*

*...An IDT...that has fractions and...splitting and...nastiness in it, I would...get rid of that immediately...[With].....a bad MDT...there [are]...opportunities for people to move away and think [about]...their work and...then come back again....A bad IDT...is a pitiful thing...and a very...dangerous move. (Participant 9)*

Although participants were confident that their knowledge of, and skills in, conflict management allowed them to manage interprofessional dynamics within the IDT, they did highlight responsibility of the organisation, and managers, to create structures which supported effective teamwork and a positive team culture.

## **5.5 THE TRANSITION PROCESS**

### **5.5.1 THE DIFFERENT STAGES OF THE TRANSITION PROCESS**

Due to the interchangeable way in which the participants in this study conceptualised notions of the MDT and IDT, and which was also reflected in the literature, which was reviewed prior to collecting the data for this study, not all participants had transitioned from an MDT to an IDT. However, this unexpected finding revealed significant insights into health social workers' experiences at different stages of the transition process, which in turn provided depth to this research topic. To accommodate for this, the twelve respondents who participated in this research study were categorised according to three distinct groups, each signifying a different stage in the transition process. These include participants who:

1. *Transitioned from an MDT to an IDT:* N=6 of the twelve participants in this research study transitioned from an MDT to an IDT. N=4 of these five participants were part of an in-patient service within a DHB at the time of their transition. The remaining N=2 participants had been part of community-based services within the DHB. N=1 of these participants later practices in a hospice service, which also transitioned from an MDT to an IDT.
2. *Were members of an IDT:* N=4 participants in this research study had always been members of an IDT and reported that changes within their respective teams were

aimed at creating more effective clinical pathways for patients and their families and whānau.

3. *Were members of an MDT:* N=2 of the remaining participants both reported to a social work Team Leader/manager within a Social Work Department and were based in in-patient services within their respective DHBs. At the time of this study, one of these members reported that the notion of an integrated team had been suggested and the other member reported that their team was in the process of responding to a review, which had been undertaken, to initiate the transition from an MDT to an IDT.

Participants' perceptions and experiences of the transition process were reflective of the stage within which they were located at the time of this research study. Whilst it had not been anticipated that participants would be at different stages of the transitional process, their thoughts and subjective experiences provided invaluable insights and made a profound contribution to understanding ways in which health social workers experience change. Locating participants at different stages of the transition process suggests a trend towards an integrated IDT approach within the DHB, with N=10 of the twelve participants having experience of an integrated IDT structure. The remaining N=2 participants in this study, who were part of an MDT, reported a possible and/or imminent transition to an IDT. This represents a significant finding in this research study.

### **5.5.2 THE RATIONALE FOR CHANGE TO AN INTER-DISCIPLINARY TEAM**

Regardless of where they were positioned in the transition process, participants were overwhelmingly in support of an integrated team approach. Participants identified that there were significant benefits to an integrated IDT model. These included:

- (1) seizing opportunities to collaborate with other disciplines in order to achieve positive health outcomes for patients and their family and whānau,
- (2) educating professionals about the health social work role and the contributions the profession could make to patient-centred care and
- (3) learning about other disciplines' roles, which in turn allowed health social workers to identify gaps in service provision and support their colleagues in patient-care.

N=3 of the participants, who had transitioned from an MDT to an IDT, reported that the

decision to transition had not been negotiable and had not been presented to them as optional. N=3 participants in this study also reported that the decision had been made prior to them joining the DHB and had been presented to them when they were interviewed for their respective roles. Only N=1 participant in this study reported being actively involved in the development and implementation of an IDT structure, thereby reflecting their role and seniority within their specific DHB.

Participants' recollections of the length of time it took from when the notion of IDT had been mooted to its implementation, were varied and ranged from a number of months to others who stated that they were "still transitioning...to[a] fully integrated service" a year after implementation. Notably, those participants who had transitioned to an IDT a number of years ago, found it challenging at times to recall exact timeframes. This participant could not recall whether a timeframe had been given and suggested that it had felt that the transition had taken place with immediate effect:

*...I don't think...they gave the timeframe. We [were] just...told...there's no more MDT. We are [an] IDT now... (Participant 4)*

Participants' experiences of the transition process were directly affected by the way in which the change had been managed at a structural level, and implemented by middle management, within their respective DHB. Some participants experienced the impact of this top-down managerial approach as imposing and disempowering. One participant suggested that middle managers had been "forced to put the change in motion" (Participant 4).

*...[There was]...not...any consultation around...what resources would be required and...there were...other...areas who...were a...little alarmed that there was none of that sort of feedback. And when they tried to raise those topics...they were...rebuffed. So it was...a managerial concept rather than...a roots-up...concept. (Participant 2)*

*...it felt like some kind of thing that was happening that...you weren't sort of involved with. It was just sort of being done to you...by management. (Participant 3)*

When asked what they had understood were the reasons for the change from an MDT to an IDT at the time, some participants recalled that they had not been entirely aware of why the structure needed to change. Where there had been a lack of consultation and collaboration, and where opportunities to involve staff in the decision-making process had been neglected, participants reported an acute sense of "worry" and "confusion". Uncertainty about what the change meant was exacerbated by the lack of clarity provided around "exactly what an interdisciplinary" was and the likely implications it would have for health social workers. This

highlighted the need for ongoing professional development around the IDT's structure and its practice approach. These participants reflected the experiences of others in this study:

*Personally, I found at the beginning nobody knows...what's the meaning of the...change...and what will happen to everybody...[or]...what it will look like...[and]what's the difference...The word's changing (referring to the concepts of MDT and IDT). What [does] that mean...in practice? (Participant 4)*

*...I think at the time I didn't...have a great understanding of why it was happening. I...see the benefit now...that I've been working in an IDT. But...I can't remember what my...understanding was at the time...I think there was a lot of talk about not working in siloes and...that shared care and sharing information...I certainly didn't get any impression and...still don't of the idea that it's [a] cost-saving strategy...It certainly wasn't something that I thought of at the time. (Participant 1)*

In contrast, other participants experienced the transition from an MDT to an IDT as a gradual, transparent and inclusive process. The team's involvement in the decision-making processes empowered them, resulting in a sense of ownership and control over the transition process. This had a causal effect in terms of the team's responsiveness to the change and in their ability to recognise the benefits of an IDT approach. Participants reported that clinical pathways created by an IDT approach, had facilitated continuity of care, which ensured that limited resources within the DHB were utilised more effectively. This participant's recollection of the process highlighted the way in which health social workers were able to reframe the change, in order to garner control:

*...initially it was an approach...we chose...before it became: "this is how we need to work"...Consultation...from management...working groups...[and] people...being asked to contribute...So [while]this was very much driven by management...it was very inclusive of everyone as well...So it was "ok, this is what we...want to do", the rationale [and]...a lot [of] information shared [including] a lot of journal articles. A lot of understanding about why we want to move more to an integrated service [and] what this looks like...So the rationale was really sound...It was...looking at... "how can we work better ...with...other disciplines"...[for a] more client-centred practice really... (Participant 6)*

Implicit here are critical features and key strategies required for effective change, including consultation, inclusiveness, working groups and the sharing of information from a range of sources. This suggests that where there is clarity around the rationale for the proposed change, and where there is an understanding of the potential impact on practice and on service provision, then there is greater probability of staff buy-in and receptiveness to the transition process.

### 5.5.3 THE INFLUENCE OF NEW PUBLIC MANAGEMENT REFORM

Participants stated that they had begun to see “a shift” towards “reforms” that were geared towards “making systems work better for people to put the patient at the centre of the equation”. Efforts to involve patients and their families and whānau in decision-making processes regarding their diagnosis, treatment and care, were perceived as more pronounced within the IDT. In addition to risk-management and safety planning, the transition from an MDT to an IDT approach, was regarded by some participants, as having an increasing focus on connecting the patient and their family and whānau with relevant and appropriate resources.

N=9 of the participants in this study reported having little or no understanding of New Public Management Reform. For some participants, the notion of New Public Management Reform suggested “*another form of jargon*” (Participant 1). Whilst some participants did not specifically mention the term “New Public Management Reform”, they either made references to related concepts, or were able to recognise the impact of “*...the systems that you’ve got to activate in order to do robust discharge planning and to understand what the pathways are...in an...acute hospital...*” (Participant 11)

*...every week we get the CEO update. So you’re kept really well informed about where the DHB is going [and] what they’re hoping to achieve. There’s a very clear...plan about what...drives the organisation. There are opportunities [for]...training around LEAN thinking and...systems’ improvements...We’re... aware of the...things that... improve patient flow...The patient is at the centre...of service provision...The health system I think encourages and inspires innovative practice...It’s open to ideas. (Participant 11)*

Those participants who had an understanding of New Public Management Reform referred to the hospital as “a political environment” where the emphasis seemed to be on meeting targets and on achieving “measurable outcomes”. These participants discussed the impact recent reforms have had on both staff and on service provision within their respective DHBs:

*...[It’s]really a follow-on from the...early reforms...in the nineties where service outcomes were separated out from service provision...So...new management is...focused on...meeting those outcomes and is less involved in managing how that service is provided...We...don’t have...much flexibility...I do associate them with the...neoliberalism...model...There is less investment...[and]meeting the outcomes is really difficult and the funding is really rare... There’s...significant gaps linked to...services we can offer clients...and...It sounds good on paper...But...[there are] constraints around people’s capacity and...constraints around targets...(Participant 2)*

*...I’ve heard of...New Public Reform...in relation to...the public service and...within the Health Ministry of Health...Lean thinking... That...changing philosophy...We became*

*aware...that surgeons were being put together...with...systems' experts and were being asked...[about] the breakdowns...[to] make...systemic changes. Patients were consulted [about]... "how could...your life be made better?"...And then...they were all brought together...and...that's created...very good opportunities for change...It's become much more a business... (Participant 11)*

A key finding in this study revealed the way in which some participants associated the IDTs emphasis on improving service provision and health outcomes, with an increase in workload and a subsequent reduction in access to resources within the health system. Some participants reflected on the impact this had on other facets of their role:

*...there...seemed to be more pressure to get through numbers and manage situations...And ...on the back of that...seeing a lot of people working really hard...but writing...minimalist notes...So that was...[at]...a time of transition where the organisation was trying to...have everyone work to the peak of their...performance... (Participant 3)*

*...there's been fiscal changes and...a tightening of... FTE...That's had an impact on the ground floor because...we're unable to...fill FTE...because...of management... decisions... and so we're under greater pressure...That [has] impacted me...because...things have actually just got tighter...[and] the resources...[are]...thinner. (Participant 9)*

Participants were generally positive about the impact reforms have had on their practice and on streamlining and supporting service provision within the DHB. "Changes in practice", "better management" and "a safer way of practicing", which resulted in health social workers "identifying issues earlier" and being "more...responsive" to patient needs, were regarded by all participants as important positive outcomes of such reforms. Participants also highlighted ways in which clearer clinical pathways had created greater efficiencies in terms of resourcing and patient-centred care:

*...there was a whole pathway in terms of how clients come into our service...Where that was...centralised...we formed clusters based on geographical locations...We had representatives from each of the Allied Health...services...It was about ...sharing resources [and] sharing information...It was really keeping the [client] at the centre [and]... "how can we make this...better for the family"...It's...strengthening those gaps...[and]connect[ing] people rather than [them]going through...convoluted [systems]...You can... advocate for them...and...it's also an opportunity to identify...clients that may have disengaged with services and [are] missing appointments...and developing plans to address that...(Participant 6)*

Even participants, who had not transitioned from an MDT to an IDT, were able to provide significant insights into the way in which new clinical pathways could result in more effective assessment, triage and co-ordination of services:

*...rather than having all those... functions happening in...a chaotic way...the whole thing*

*[is] integrated in the one unit... And...rather than having...people scattered all over the place, you [are]...getting...tasks happening in one centre with one group of people that are specialised to do that kind of work...and...transitioning people through from...a level of critical care...back to recovery and...ongoing routine care...after a crisis. So...you've actually... taken the...crisis energy out of the team. (Participant 3)*

#### **5.5.4 RESPONSES TO CHANGE**

While the participants in this study were receptive to the transition process, they reflected on the range of responses they had observed from health social work colleagues, which had included both overt and covert forms of resistance. Those health social work colleagues who appeared to resist the transition from an MDT to an IDT expressed themselves by remaining “entrenched in the old style system” by putting “it in the too hard basket” or deciding “that they were too busy to do anything differently”. Consequently, they “went back to the way they [had been] working” prior to the transition:

*...I think with anything...there are some people that struggle more with change than others. And that is always a challenge and...you can see a real sense of loss and grief around that...It's that adjustment that...can be really...hard...and...that...is an ongoing issue...It's that...loss of “actually, we like it how it is”...The...loss of...collegiality that...existed and all of a sudden you bringing people in that actually don't share our vision...And there's a new vision here that we need to adapt to...That's...really challenging...That sense of loss...was magnified. (Participant 6)*

*...The resistance [involved]...not turning up to the...meetings...To be honest...their reason changed all the time...Not loading anything into the computer files, refusing to learn the system...Everything has changed so much in terms of what we have to do...(Participant 8)*

In contrast, a key finding that emerged during the course of this study was the way in which those who supported the transition to an IDT acknowledged the influence their personal philosophies and attitudes towards change had had in allowing them to embrace the transition process:

*...I could see the benefits from the patient's point of view...and so I was willing to...give it a go...And I'm always interested in trying new things and trying to...give that a go...And so...my own...personal thoughts and feelings about the transition probably helped and supported that. I don't know if that was the case for everyone though. (Participant 1)*

*...I'm very open to other people's...professions and...what strengths they bring to a situation that are different from mine...I love working in a team. (Participant 12)*

*...change doesn't just affect you in one area, but if you know you've been...called...to now operate in a new system [and] in a new way...it is going to impact you may be physically*

*because you've got to go somewhere else...[and] emotionally having to get your head around the fact that...your role might be changing... Change...impacts us in different ways, in different times and [in] different areas of our life and...it's a really...healthy way to acknowledge...how that is impacting you... (Participant 11)*

Some participants, also identified the tenure staff had practiced in the organisation, as a determining factor in relation to way health social workers responded to the change process. This participant revealed remarkable insights into responses exhibited by health social workers who had been part of the team for a long time, compared to newer staff members:

*...the resistance to change, the anger about change for some of them, where they've been there a long time. The newer ones...are...more open...because...they not so...tainted by what they perceive as injustice...I don't think that social workers always manage change well. Maybe they [are]...so involved in other people's...change processes...that [it's]...pretty overwhelming... The...more aggrieved teams are more resistant to change, because...they've lost too much and...if they accept any more change, then something else might be eroded ... So [they]...stand strong against change...Where social workers feel...embattled...they... try to withstand change...Some of the new grads and younger ones...are there with energy [and] vision...(Participant 11)*

### **5.5.5 SUPPORTING THE TRANSITION PROCESS**

Opportunities to work alongside other disciplines in an integrated IDT structure appealed to the participants in this study because it contributed to their sense of interprofessional collegiality and professionalism. For some participants, the transition to an IDT was marked by a Pōwhiri, a formal Māori welcoming, which had allowed staff across different professional disciplines to meet one another, signifying a new era within the service. For others, “large scale presentations”, “workshops”, “meetings” and “documents” provided information and education. Participants stated that these had helped them “to develop a deeper shared understanding of what it meant to be in an IDT” and had served as forerunners to the transition from an MDT to an IDT:

*...I think some of the stuff that happened did make it easier...Actually being introduced and knowing who the other...disciplines were...I [had]...no idea when we were working in (the) MDT who... was in {which} team So there was a lot of...real basic stuff around introductions and... understanding what the other disciplines did and what...referrals they accepted and didn't accept...I think it went some way to help. (Participant 1)*

*...As the model started to pick-up there [were]...community meetings and...a lot of...graphics, which were pasted in the Health Centre and in the hallways and...foyer of the hospital...There...was consultation around what the new building would look like and how things would be reconfigured... (Participant 2)*



Participants reiterated that conceptualisations of the integrated structure and its practice framework, which had been created through presentations and workshops, were difficult to translate into practice and did not always, reflect reality. Participants stated that they had received information about what an IDT looked like “*at a conceptual level, not an actual level*”, emphasising the disconnection between the information which had been provided at a theoretical level and the challenges which emerged in practice. These participants’ descriptions captured what others had experienced as well:

*...There were numerous meetings...explaining...the... approach...Numerous times to... either feedback or share your concerns or...participate in whatever hui was going...Since...[the change]...there have been lots of [other]changes which...have not been...collaborative, cohesive and congruent...There were no supports for any good and proper training for the whole system. Though I said we had numerous meetings what was said, is now not what is happening (Participant 8).*

*...We...all shifted offices. So...that we would sit with people of other disciplines....But I don’t think that...made a huge difference because...we...didn’t actually spend that much time in the office together...So...while there was this...idea that we would work collaboratively with each other, there was no structure to do that...What would have helped...more...was...a... structure...Something practical to...help us...work together... on a regular basis...We did all this training. We got moved offices...and then all of a sudden we were meant to be functioning as an IDT...It was more about this ideal, rather than actually knowing how to put it into practice, or it being meaningful in our practice... (Participant 1)*

One participant who was in an MDT at the time of this study, and who was in the initial stages of the transition to an IDT following a review of their structure, reflected on what they considered to be supportive:

*...[There are] things we feel concerned about that...we would like to highlight before anything goes any further...As a social worker...you’ve got to have the ability to...think things can change...We have to talk about it...to make it a...good process...The ability to...communicate concerns...and to feel that you’ve been heard...is huge...I would hope that...they are wanting to do the best [and]that they would listen to us, if we had a good reason to question something...(Participant 12)*

This reflection was commensurate with the views and concerns held by those participants, who had already transitioned to an IDT, prior to their transition process. This highlights the juxtaposition between participants’ acknowledgement of the inevitability of change within the DHB, and the need to ensure that the process was inclusive and transparent. At an organisational and structural level, this also emphasises the importance of managers acknowledging, validating and normalising staff’ concern, in order to create greater buy-in from staff and sustainability of the change process.

## 5.6 HEALTH SOCIAL WORK

Participants' subjective experiences of change within a DHB, and the ways in which the nature and identity of their role, as health social workers shifted in response to the transition from an MDT to an IDT, remained a key focus of this research study. A significant finding of this study revealed that while the team approach had changed to an IDT, there were no marked shifts in their substantive role and responsibilities as health social workers. Overall, participants were clear about the parameters and professional boundaries of their role within the new IDT structure:

*...the core function of...health social work...is still...looking at the social determinants of health and...social inequities...[and] access to health care... It's still...my core... function... My core business hasn't changed. (Participant 1)*

*... if you're clear about your role, you can adapt that...to any environment...So it...might be different actual...tasks that you do... I'm quite clear what my...role is... (Participant 5)*

Participants in this study regarded the multifaceted and dynamic nature of the health social work role, as the reason they were able to make an invaluable contribution to patient-centred care, regardless of the team structure and/or the service areas/wards within the DHB. Participants identified the following key roles and responsibilities within the scope of their practice within the DHB:

- loss and grief
- trauma
- resourcing and practical supports
- risk assessment and safety planning
- assessing the patient's ability to cope and adjust following a health-related event
- assessing family and other social support systems
- alcohol and drug issues
- mental health issues
- child protection and domestic violence

Other roles within the scope of health social work practice, which were identified by participants, included “advocating” for patients and/or their family and whānau, “problem-solving” and “assessing and addressing needs.

*...it can be...explaining what the doctor said [because] they're using language that is so far above [the patient's] head...It could be...locating a whānau member or...getting...hold of a lawyer... WINZ, getting documents...getting hold of the...courts or the police...helping them*

*...[with the] ACC process and...the MSD historic claims process. So...my role is...vast. (Participant 8)*

Other participants identified the role of the health social worker as critical in managing the tension that exists between ensuring clinical accountability on the one hand, and empowering the client to exercise their right to self-determination on the other hand:

*...I think...that social work supports the person to make their own decisions...if it's done well...and engages the client, the family [and] the services...and informs them of what you think the risks are...it...enables the...risk to be better managed.... (Participant 3)*

While participants highlighted the practical and task-related aspects of the health social work role, they were emphatic that their role superseded these and included unique skills, which distinguished them from other disciplines within the IDT. Participants highlighted the key differences between the psychosocial approach used by health social workers and the conceptual and philosophical frameworks that underpin the medical model. These participants captured the experiences and views of others in this study:

*...So often...in my experience health people go off on what needs to happen, without any real thought of... "is it what the client actually wants?" Whereas, my starting point would always be...what the client's stated goal is and then how does that link to... preferred outcomes for health. (Participant 2)*

*...[The] social work...identity is that we...look...a lot...further...into that...which... other professions don't want to go[into]...because it's out of their scope... We find other...options and...other ways of looking at something...and...[use] different worldviews ...You...can use different models...Whereas, the medical model is...set...You...don't have much choice...That's what...should stand out as [the] social work...identity. (Participant 5)*

These findings reveal that unlike the narrow focus of the medical model, the health social work role considers the broader context and the complex way in which social, psychological, physical, spiritual, economic and political determinants influence the patient's health and wellbeing.

*We...[consider]...[the] social and environmental factors in relation to the family dynamics...and... "how realistic are [the] medical goals in...relation to what...this family is...currently dealing with?"... (Participant 6)*

*...We...focus on the person in their environment...It's not making them better [or] doing things to them. It's listening to that person and... [it's about]...advocacy, privacy, consent...[and] empowerment...They are key things to our Code of Ethics and...our practice...that's...one of the biggest differences. (Participant 12)*

The capacity of the health social worker to bridge the gap and "link [the] patient with the

medical team” by “interpreting medical jargon” and improving communication, were also identified as key facets of the health social worker’s role. Participants highlighted the way in which they were able to raise consciousness within the DHB, around the important role which stakeholders, external to the hospital environment play in ensuring positive health outcomes. The wealth of knowledge participants held in relation to key community resources, and the impact this had on safe and timely discharges within the DHB, set social work apart from other professions within the IDT:

*Social workers...are the key to making...a lot of things happen within health...because they're the ones that...do all the relational connecting...whether it be with the medical staff, with the whānau, with the extended whānau. They're the ones that have the knowledge of what's out there in the community. The medical staff only know...from a medical perspective, not necessarily what is going to help that whānau or that... patient... in the community...For a social worker, it's also about building the bridges or recreating safe spaces between [the] patient/ client/whānau and the staff... (Participant 8)*

*...we add that...holistic care...There's the...ability to care for more than just the body. (Participant 12)*

As the structure of the IDT allowed health social workers to demonstrate their immense and unique practice skills and knowledge, and as this allowed them to forge closer professional relationships within the IDT, opportunities for participants to support other disciplines through interprofessional mentoring and coaching presented. One participant described this as a “*niche role*” in the following way:

*...other disciplines...rely on us when...we're not necessarily needed for the patient...And it's...helping the other disciplines...work effectively with the family and have the family able to be confident in working with those disciplines...Once the family realises that the ...IDT are aware and have that sense of empathy...it's easier for them to engage with some of the other disciplines...[It's]bridging both the family's understanding [and] the IDT's ability to work with...[them]...and there's...a sense of being [the]...glue that connects and holds people...Rather than having a direct role with the family...it's actually...trying to form a cohesive plan...and mentoring other disciplines... (Participant 1)*

### **5.6.1 POSITIVE ASPECTS OF HEALTH SOCIAL WORK PRACTICE**

The majority (N=8) of the participants in this study stated that they felt “valued” and “acknowledged for their experience and expertise” by the other members of the IDT. They reflected on the sense of satisfaction they derived when their role within the team was understood and acknowledged:

*...there [were]...some real tricky cases here...and...then one of them said “...we’re going [to]...see [name of social worker]. She’ll know what to do”...I thought that was actually quite powerful... (Participant 5)*

*...I go to one ward meeting [where]...the Charge Nurse...knows every patient...and can speak to their condition...and that flows onto her respect for...her team...We all feel valued. And she’ll say... ‘I think social work will be needed there because’... “he seems to be getting frail and I don’t think he’s got any supports” and...so...I feel really valued...It’s...about leadership...When you’ve got a...good, strong, respected leader who acts professionally, has got good basic communication skills...that... sets the scene...for some very good work. (Participant 11)*

When participants were asked which aspects of health social work gave them the most enjoyment and job-satisfaction within the DHB, two key themes emerged:

1. The diversity of roles and responsibilities involved in supporting patients and their families and whānau, following a significant health-related event and
2. Being part of a positive, supportive and professional team culture

These themes are evident in the following responses, which have been presented here to acknowledge and respect the wisdoms, insights and vast experiences that give meaning to those who participated in this research study:

*...working with vulnerable families that have limited...ability to access healthcare and support [and]...the stimulation...[provided by]other team members...(Participant 1)*

*...working...with people [to] address issues and moving through their challenges [to] make positive change...Facilitating groups...and having a supportive team environment around me, which makes things so much easier... (Participant 3)*

*...the diversity of the...patients...It’s not one particular...field of expertise required...It...covers...the whole...spectrum...and also...pulls on all areas of knowledge...from...financial to advocacy to...old age to decision-making... (Participant 5)*

*...I enjoy connecting with the...whānau...I love just being able to...build that rapport and relationship and...hearing their story...I also love seeing the results...I get a lot of...validation from the whānau and clients... (Participant 8)*

*...it’s always felt like you’ve got the potential to do more linking up within the community...The...health system feels more positive to me...I find the health system [has] ...got more potential for innovation and...the potential for systemic change. (Participant 11)*

These accounts demonstrate the multifaceted identity and versatile nature of the health social work role. The establishment of respectful, trusting professional relationships between health social workers, patients and their families and whānau also reflects the interprofessional relationships and collegiality between the participants in this study and members of the IDT.

### 5.6.2 THE ROLE OF EDUCATION IN HEALTH SOCIAL WORK PRACTICE

Education, within the IDT context, denotes opportunities for health social workers to both:

- teach other health professionals about the scope of their practice, including the role and responsibilities of the health social worker and
- learn about other disciplines' roles and responsibilities within healthcare.

*usually people will know...what doctors and nurses [do].But usually they will ask"... what's [the social worker's]...role?"...Everybody understands social work through a different lens. (Participant 4)*

Participants identified a direct correlation between their ability to educate other IDT members about their social work role, and effective team functioning. Participants emphasised the importance of articulating and demonstrating their role clearly, in order to ensure that other members of the IDT understand the contribution health social work is able to make to collaborative patient-centred care:

*...I think that we would grow...as a profession. We...would be seen as more useful and...understood. We'd move away from being...just one step better than a really good friend...That would be valuable...To be honest, we would more likely be asked more difficult questions in our area...and be held to account more about our answers. (Participant 9)*

*...I had a role to educate the doctors [about]...what I could offer. And it was a dialogue and conversation that we needed to have and...they needed to feel that they could run stuff by me. I would tell them whether or not that was something I could pick up on or not. And if I couldn't, then who might be able to...I think as a professional, we've got a role to do part of the educating...of other professionals as to exactly how we fit in and what we can do... (Participant 11)*

While the health social workers in this study recognised that educating IDT members was an ongoing responsibility, they admitted the sense of achievement and satisfaction they experienced when other disciplines developed an understanding of their role:

*...I find probably the most frustrating is the ongoing education needed...of the other professionals that I work with, around what a social worker does... We're out of those main two professions of nursing and...doctors and...trying to educate...them...to be thinking how I would think...But ones I've trained...go "I've got [name of social worker] sitting on my shoulder" And I'm like "great, that's exactly it" (Participant 12)*

Health social workers acknowledged that they utilised every opportunity to have informal discussions with, and to mentor and coach, members of the IDT purposefully, in order to influence quality service provision to patients, their family and whānau. Opportunities to position themselves strategically within the team, by being proactive and developing strong professional relationships within the IDT, allowed some of the health social workers in this study to gain greater visibility and to establish their professional profile within the team:

*I think...education is potentially the only thing...I've... used...and...I'll say... "you need to be thinking about social work..."...I keep my profile up...and I...always...take hold of ...opportunities... (Participant 12)*

Participants identified documentation and recording of clinical notes as a key area where health social workers were able to demonstrate clinical accountability and educate other IDT professionals about their practice skills and professional.

### **Documentation and Clinical Notes**

Participants identified documentation in the patient's clinical notes as an important tool that they could use to educate members of the IDT about their role and demonstrate the contribution health social workers made to patient-care. Information regarding diagnosis, assessment outcomes and treatment plans were documented in the patient's clinical notes. In some instances, participants reported writing their clinical notes in a way that enhanced engagement with other health professionals. For this participant, this implied orientating their clinical notes in a way which appealed to medical professionals:

*I think...[I have]...become much more clinically orientated, in terms of...thorough note-writing...doing the assessments very much in the medical style of assessment... Although...a lot of what I write is [still]...socially...focused...I'm...upskilled ...and...attuned... to the person's presentation...I'm thinking more...medically...in terms of the assessment [but] I'm still working with the person in their social context. (Participant 3)*

The emphasis that this participant placed on engaging the medical team, reflects continued tensions that exist between the medical and the social domains of healthcare, and the deliberate efforts, and skill, of the health social workers to the bridge these gaps. For this

participant balancing adherence to the frameworks prescribed by the medical team, while remaining cognisant of the nature and identity of health social work practice, created an acute sense of awareness of their own professional development and competence.

Similarly, this participant reflected on the depth of awareness and level of insight required to document “what it is that health social workers do”, in order to demonstrate clinical competence. This account highlights the subjective nature of social work practice and the challenges health social workers experience when attempting to measure sustainable outcomes, in order to demonstrate clinical competence:

*...There's some real challenges with...trying to educate other disciplines in terms of what social workers do. I think that sometimes the role can be quite...ambiguous...because it's not...particularly tangible sometimes. I think...there's the challenge of how do I write this up? How do I make sense of what I'm doing so I can continue to make sure...I know when I've done it. (Participant 6)*

Similarly, this participant reflected on the way in which health social workers assert a measure of control, by way of documentation. In this way, participants were able to position themselves strategically to engage in discourse with the medical team, around the unique role health social work in patient-centred care:

*...I used to...write quite comprehensive clinical notes...into the clinical summary...so the doctors would read it. So...if I had... noted...some clinical issues that I found when...talking to a patient...I [would]...frame my role around how I would support mum and dad...Like...I positioned myself, as opposed to being positioned by them [the medical team]. (Participant 7)*

This key finding reveals opportunities to bridge the gap between the medical team and the patient, their family and whānau. By contributing to the medical teams' knowledge and understanding of the patient, in terms of information which is relevant to their health and diagnosis, participants in this study were able to influence clinical decision-making. Significantly, this served to increase both the profile and credibility of the health social worker.

### **5.6.3 CHALLENGES WITHIN HEALTH SOCIAL WORK PRACTICE**

Participants identified the difficulties inherent in navigating and managing relationships within the IDT. They highlighted key strategies that they used, and which were synonymous



with social work practice, in order to mediate these challenges and maintain cohesiveness within the team:

*...you have some disciplines that go “that’s social work, I’m not doing that” when it’s actually something that they could easily just have a conversation with the family about... You don’t get the opportunity to have that narrative to start with....It is hard because...on one hand you’re wanting to establish really strong positive working relationships with people...And then on the other hand, you need to challenge them too. And...that can be...difficult, particularly if you form strong alliances with your colleagues...I have to be really careful...and...tactful...I think the key is diplomacy really... (Participant 6)*

*...the...team I’m in have no understanding of...health social work and they don’t want to know...I believe they do not value...what a social worker brings...[and] they absolutely don’t value any cultural input...Their actions don’t show it. I don’t think it’s the social workers’ that need to change...That change of perspective needs to come from those...that I work alongside...(Participant 8)*

Participants in this study did acknowledge that the broad scope of social work practice often accentuated the ambiguous nature of the profession, thereby perpetuating confusion among other disciplines about the roles and responsibilities of the health social worker. For some participants, the over-emphasis, which other disciplines placed, on the practical and task-related aspects of the health social work role, undermined the expansive nature of the profession:

*...One of [the] biggest problems with social work...is that...we lack clarity ourselves...around our identity...To be honest, we don’t advertise very strongly what our values [are]...Often we are given tasks...and...we’re seen as useful in doing those tasks. But...based on our identity, why do we do it? And that’s the bit that we don’t tell people... We don’t tell people that the reason...is because we believe in social justice. Or we believe...that if we...improve their...situation...that that will have a contextual impact on...their wellbeing and health... We do the deed, but never tell people why we behave the way that we behave. (Participant 9)*

*...So...there...is a...misunderstanding from...professionals about what a social worker... does...and often the role...was...construed to be more around [the] practical... needs...of the patient.....often...people question... “why do you think that... “you’re a social worker”... “Ok, I’m a social worker, but I’m also a counsellor. I can...do an assessment. I...have a...wide range of skills that could...feed into your planning...” I think that... [you]...continually trying to validate yourself...And so that can become cumbersome and tiring.. (Participant 7)*

At the same time, participants reflected on the way in which social workers themselves undermined the value of the profession, referring to themselves as “just a social worker”, rather than highlighting their “role in this patient’s life”. Consequently, as this participant remarked, this created opportunities for other professionals to dictate the parameters of the health social worker’s remit, by assigning practitioners roles and responsibilities:

*...and a lot of the...teams...in the hospital system, don't understand...social work and what it can contribute...It's seen as... "...we need somebody to get them to this appointment"...You [are]...questioned or asked to do things that aren't in your role because of those other professionals who...don't understand the role....So it's...people's understanding in those other professions and their expectations of what they believe a social worker does... (Participant 5)*

Participants therefore expressed awareness about maintaining clear professional boundaries and managing the expectations IDT members. Where roles between health social work and other disciplines did overlap, participants were cognisant of the balance between maintaining professional boundaries and ensuring ongoing effective professional relationships within the IDT:

*...it...makes you aware about being really mindful of [your] boundaries...I'm constantly reminding myself [of] what's my role...Or having...the conversations and going... "...this is...your role, but is there anything you would like me to do while I'm here?"... (Participant 6)*

In considering the challenges confronting health social workers in the DHB, some participants also referred to the way in which social workers' training and experiences in other fields of practice, influenced the way they practiced in healthcare. Similarities and differences in the way different health social workers approached the same issue, were highlighted. For some participants, mediating these variations in social work approaches to practice not only perpetuated the ambiguity within the role, but also created points of tension within the IDT:

*...I came from...a...DHB...My colleague's from [a] community organisation...So...we...had different understanding[s] of...the...role of social work...and...we have a different understanding of what we should do [and] what we could do [and] what we do not do... After [a] few years...[they] learnt...through the work...[but they are]...still reluctant to... advocate. I think advocacy is part of [the] social work role...I think [their] training is [different]... (Participant 4)*

*...We had two different...social workers with quite different views...The approach might be quite different...so you have other Allied Health professionals getting used to this kind of...approach and all of a sudden these other social workers come in. It's...been quite a point of tension...around the expectations of the members of the team...I think it's just different philosophies...and that can be quite challenging. (Participant 6)*

## **5.7 IN-PATIENT vs. COMMUNITY SERVICES ALIGNMENT**

An unexpected finding that emerged over the course of this research study, among participants from both in-patient and out-patient/community-based services, were the distinct

correlations they drew between:

1. An in-patient service and an MDT approach and
2. An out-patient/community-based service and an IDT approach

*...I came into a new team thinking that we were going to be working in a IDT way, similar to how I'd experienced...in...an in-patient [service] and because my first experience of working in an IDT probably wasn't really an IDT way, we just called it IDT...I then started doing these...joint assessments with nurses and...with occupational therapists [in the community team]...It was quite new but [I] felt quite comfortable...I was...waiting for...there to be some sort of issue...like...with the (previous) IDT. So I was waiting for the hierarchies...I was trying to work out...who was...the head of the...IDT and...how that worked. And because it didn't... happen and there was this...mutual respect for each other's roles straight away, it was...refreshing...I feel like we've got a whole raft of different disciplines and we work far more in an inter-disciplinary way. (Participant 1)*

One participant, who had transitioned from an MDT to an IDT, and who covered both in-patient and out-patient services, referred to in-patient as “hospital-based” services which were “largely health-led”. In this participant’s experience, in-patient services embraced a traditional medical model, which was MDT-focused, compared to the “community-care model”, which they strongly associated with an IDT or “integrated team”. Another participant echoed a similar perspective:

*...the culture of in-patient to community is quite different...[in community]There's...more planning [and a]collaborative, communicative approach...Within an in-patient setting... there might be a referral...left [for]...the social workers to deal with...It's written in the notes...I don't think...from my experience...the IDT approach has been used within an in-patient [service]...But certainly community...absolutely...fits...[it's] much easier to make connections with other health professionals who are working [with] that family... Working in a MDT seems to be more in-patient[focused]... (Participant 6)*

Participants suggested that the IDT structure appeared to be unique and restricted to Allied Health services. This posed challenges to them when they worked with members of the medical team, including doctors and midwives, who were seemingly not required to practice in an inter-disciplinary way. This was most notably articulated by this participant who had transitioned from an MDT to an IDT within an in-patient service, and then later moved to an IDT in a community-based service within the same DHB:

*...in the hospital, IDT was considered [to be] an Allied Health way of working. The other disciplines we worked with quite closely were midwives and they weren't...Allied Health professions. So they still worked very much in siloes and we were constantly trying to work alongside them and develop that...way of practicing...it was hard because they didn't... and hadn't been trained in that way. (Participant 1)*

This reflection resonated with other participants who cited a strong alignment between community-based services and an integrated IDT approach to patient-care:

*...As [a] person who's come from a community-care model...and...who thinks that wellness is much...wider than just identifying a pathology, I was excited about that notion...that...you would be able to work with people in their own communities around managing their own health without with this...notion of being sick and going to a healthcare facility...I have always been...conceptually on board with that... notion of working. So I didn't really unpack it too much...I thought this will be an exciting transition and (it) sits with me philosophically. (Participant 2)*

*...the positives are that you can reframe peoples' idea of their health and offer them more autonomy....and we can do that in the community...I think conceptually that's a huge shift for people's own health literacy...So I think overall, the integrated model is a really positive one and I think the community model is a really positive one and I see that they link beautifully together...I believe that it offers social workers a real opportunity to be strengths-based practitioners, because the health model is not always strengths-based and it's pretty largely pathology-based...(Participant 2)*

Reflections from these participants' highlighted distinctive differences between the individualistic nature of the in-patient/MDT structure, compared to the inclusive, and collaborative approach of a community-based IDT structure. Participants here also drew direct correlations between the IDT's capacity to encourage and empower patients to define their own concept of health and wellbeing, by living independently within the community.

## **5.8 BICULTURALISM**

N=4 participants in this research study made direct references to the importance of bicultural social work practices within the Aotearoa New Zealand health system. This outcome is significant in that it locates this research study in the context of Aotearoa New Zealand. Three of these four participants in this study identified as Māori and referred to themselves as “bicultural social work practitioners”:

*...So...[in] my email...I put my iwi and...I put my...name...and...it has value for me...it's important for me to practice in a way that I feel safe...I give value to things Māori and so therefore I would place a lot of currency on the way I worked with Māori...I feel validated to be able to practice the way that I think...best works for me, without compromising any of my social work standards or any of my practice. (Participant 7)*

One participant referred to the importance of speaking Te Reo Māori, using Māori models of practice and the importance of establishing a strong sense of rapport between the health social worker and the Tangata Whenua -client:

*...So, if I'm meeting with a Māori whānau...I don't even say the words social worker because they'll cut me off straight away because of...past experiences...So I say I'm a... Māori support person...that comes alongside you, that offers awahi, manaaki...tautoko... And then I say "social work is much like...Taha Māori", where you give of yourself and...I use a lot of Māori models. Like I say "it's like a Powhiri, you engage, you welcome"...you still connecting and having that kōrero... (Participant 8)*

However, according to this bicultural health social worker's experiences, this was not always supported by the organisation:

*...a lot of the clients ...needed Māori input...and when you spoke the language...and you recorded it...it wasn't accepted...You...had to put the English meaning to whatever you wrote ...in Māori...When you working with Māori clients, they want a bit of Māori...If you have a look at the statistics today, we feature very high in the negative areas...I'm a Māori social worker. And...so when you...have a mental disability and you even say a couple of words in Māori, it makes them feel a little better...Rather than feel stigmatised. (Participant 10)*

This participant highlighted that with persistence, social workers could assist other professionals to change their practice, in order to ensure better outcomes for their Tangata Whenua clients:

*...People sense...the way that the relationship is building...I've been working with midwives to do Whakawhanaungatanga. And...the benefit that they saw is that if they took more time, they would build the relationship... which would mean that they would get less DNAs...And I guess what...they got out of it was "yeh, sometimes I do rush [because] I've got to see eight patients and I don't build that relationship, but maybe I just need to make that time". (Participant 7)*

*...It is...that approach that looks beyond the...single issue and the single medical problem, that puts people within the context of their family, of their mental and emotional health and their physical health...Good emotional health is at [the] top...of the pyramid...and so I think that for the Europeans or Pākehā getting...an understanding of Māori models of viewing health...is...to our benefit really. And where we do that well, I think we see much better outcomes, and that's my experience in health, welfare, justice...Where we integrated and used Māori models of...practice, I think we did a far better job by not only Māori clients, all clients. (Participant 11)*

Participants acknowledged that the alignment between biculturalism and an IDT approach created opportunities for them to "feel culturally safe" within their social work practice. This highlights opportunities to engage in discourse which allows professionals to learn from, and develop insights about, one another, within the context of a safe and respectful space:

*...In terms of the IDT...it sits with my bicultural nature and my understanding of things Māori. I feel comfortable. I feel valued...I feel like I can learn as well...It's when other people come in and their worldview or their view of how things are [is different] you can...look at it and go... "...I didn't see it that way" And so you...feel safe... it's robust at times...it's not offensive...But people's experiences are different. (Participant 7)*

*...I believe I actually work from a mono-cultural model which is Māori...I believe that if it's going to work for the marginalised in our society which is Māori, it will work for anyone. (Participant 8)*

Comparisons between the MDT and IDT approaches, further illuminates the weight participants placed on their right to practice as bicultural social workers:

*...as a bicultural practitioner, in the multi-disciplinary setting, there was not a lot of opportunity to influence...the bicultural agenda for the patient...because it was based on a medical model [which]...didn't...have a lot of room for...biculturalism within its framework...[Whereas]...in the...IDT, it's heavily entrenched in the way we work with...the community, the professionals, the family and whānau...and the patient...and it has value...We are doing our assessments...in a bicultural framework...based on...academically approved models of...working...with whānau...And...you don't have the...resistance from the... medical model... because...how you're working with the patient is working....And...so it...frees you up to... work in...a culturally safe way with the patient...It means that I can feel safe...(Participant 7)*

Participants referred to the holistic and inclusive nature of healthcare from a Māori worldview. By applying Māori models of practice to the transition process, participants were able to conceptualise the impact that change has on health social work practice and on their capacity to be responsive to such change, within the context of healthcare in Aotearoa New Zealand. This was most eloquently articulated by this participant:

*...our philosophy is underpinned by [the] need to look at...people holistically, there are Māori models of care that...help us [to] understand what that looks like...[and] how it might influence what we need to be doing...You've got to be thinking about all four quadrants of the person...and that change doesn't just affect you in one area, but if you know you've been...called...to now operate in a new system [and] in a new way...it is going to impact you may be physically because you've got to go somewhere else...[and] emotionally having to get your head around the fact that...your role might be changing... Change...impacts us in different ways, in different times and [in] different areas of our life and...it's a really balanced, healthy way to acknowledge...how that is impacting you... (Participant 11)*

## **5.9 CONCLUSION**

The findings which have been presented in this chapter have identified four key areas which relate directly to the research topic and to key themes cited in the literature review. Findings from this research study indicate that both the MDT and IDT approach are focused on service provision and on achieving positive outcomes for patients and their family and whānau. Participants in this study were overwhelmingly responsive to change within the health system and supportive of the transition from an MDT to an IDT. Participants

recognised the unique skills which health social work brings to patient-centred care, through an integrated team approach. Key findings from this research study also suggest a strong alignment between an IDT approach and (1) a community-based service and (2) a bicultural framework. The following chapter provides a detailed discussion and analysis of the key findings which emerged from this research study.

## CHAPTER SIX

### DISCUSSION OF RESEARCH FINDINGS

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#### 6.1 INTRODUCTION

This research study sought to investigate registered social workers' experiences of *the transition from multi-disciplinary team to inter-disciplinary team* in order to examine the *impact of integrated healthcare on the nature and identity of health social work practice within Aotearoa New Zealand*.

This study recognises an emerging trend towards integrated patient-centred care, within the DHB, and proposes that the global market economy, combined with the political and cultural context of Aotearoa New Zealand, have been influential in this transition process. A key objective of this research study has been to investigate the way in which an IDT structure both supports and challenges health social work practice, within the context of the DHB, by drawing on the subjective experiences of registered health practitioners. Ways in which health social workers have conceptualised the differences between an MDT and an IDT respectively, have highlighted significant findings. However, the outcomes of this study have signalled the need for yet further research and development in this area, in order to create sustainability in the ongoing trend towards integrated patient-centred care, within the DHB.

This chapter provides a detailed discussion and analysis of the key findings which were outlined in the preceding chapter. The core themes which were presented in both the previous chapter and in the literature review, and which are reflected in the research topic, have been retained in this chapter. The significance of each of the findings from this study have been extrapolated, using supporting literature to substantiate relevance to the research topic.

#### 6.2 DEFINING THE MULTI-DISCIPLINARY TEAM (MDT)

Participants' understandings and experiences of the MDT overwhelmingly reflected the way in which this team approach has become synonymous with the global landscape of healthcare. While no single definition of an MDT emerged from this research study, all the participants were able to describe an MDT, including the way this team is structured, how it operates and what its key features are. Drawing on these descriptions, and the subjective



experiences of the MDT, distinct similarities in terms of the key features and characteristics of the MDT began to emerge. Participants agreed that an MDT comprised of:

- Different professional disciplines which are located within discipline-specific siloes
- Patient assessments are conducted separately, by each discipline, according to their discipline-specific orientation

These findings are supported by Jessup (2007), Korner (2010), Giles (2016) and Hughes and Wearing (2013), who define the MDT as a group of health professionals, who are based within discipline-specific siloes and who bring unique skills, knowledge and expertise to patient-care. MDT members practice independently of, and in parallel to, one another around specific roles and tasks relating to the patient's care (Jessup, 2007; Korner, 2010; Giles, 2016; Hughes & Wearing, 2013). For some of the participants in the current study, the siloed-nature of the MDT revealed inconsistencies between the way in which health social workers were regarded as being part of the team involved in a patient's care, yet they, together with other disciplines, practiced independently of one another. Participants highlighted this as a significant deficit in the MDT approach. In addition, Jessup (2007) and Korner (2010) differ in their references to the regularity of MDT meetings. While Jessup (2007) suggests that MDT meetings are regular and focused on reviewing the patient's care-plan, Korner's (2010) study identified that MDT meetings were limited and /or infrequent and focused specifically on patient with complex needs. The experiences of the participants in this study were consistent with those articulated by Jessup (2007).

Participants identified that doctors and nurses were consistent features across all MDTs. However, the inclusion of other professional disciplines, within the MDT, differed according to the needs and diagnosis of the patient and the specialisation of the service area/ward, where the participant was located. This finding highlights the variability in the MDT configuration and its lack of uniformity. Giles (2016), D'Amour, Ferrada-Videla, San Martin-Rodriguez and Beaulieu (2005) and Kvarnstrom (2008) suggest that collaboration between different professional disciplines can be wide-ranging and diverse.

This study found a strong alignment between the MDT and the traditional medical model. Participants identified a distinctive hierarchical structure within the MDT, where notions of the "patient", "diagnosis", "disease" and "treatment", underpinned medical discourse and reinforced the expertise of the medical team. According to the participants in this study, doctors and nurses were responsible for directing and overseeing the activities and tasks of MDT members, including determining referrals to health social work services. Whitehead

(2007), Lynch (2011), Nugus, Greenfield, Travaglia, Westbrook and Braithwaite (2010) assert that doctors have held a central position, and yielded significant power, and within the health system. Ambrose-Miller and Ashcroft (2016), in their Canadian study, identified the presence of hierarchy as a significant barrier to interprofessional collaboration.

Similarly, seminal studies conducted in Aotearoa New Zealand, including those of Opie (1997) and Beddoe (2010; 2011) have identified power imbalances, which are consistent with the hierarchical nature of the MDT. Beddoe's (2010; 2011) further highlight the MDT as a contested space, in which social workers struggle to achieve status that is comparable to that of doctors and nurses. According to Giles (2016, p.26) the existence of "the prevailing discursive regime" has a profound influence on where social work is "positioned" in relation to other professional disciplines within the DHB. For some of the participants in this study, this often manifested in the medical team over-emphasising the practical, task-related aspects of the health social work role, at the exclusion of the vast range of core social work knowledge and skills. According to Beddoe (2011), the scope of health social work practice has become more expansive and has diversified over time, despite the constraints that have been placed on the profession by the dominant medical paradigm.

Participants were unanimous about the importance that social work practice places on effective connections, professional relationships and engagement with others. The value that these participants placed on interprofessional collaboration is consistent with the findings of an American study by Liepzig, Hyer, Wallenstein, Vezina, Fairchild, Cassel and Howe (2002), which concluded that social workers are experienced and skilled in teamwork and therefore recognise its significance, compared to other disciplines. Haultain (2013) draws a direct correlation between developing and maintaining effective professional relationships within the MDT, and positive impact this has on patient outcomes.

Participants emphasised a distinctive paradox between the individualistic and siloed-nature of the MDT, compared to nature and identity of social work practice, which promotes inclusiveness and collaboration. They revealed that referrals to their service depended on the relationship they had developed with the referrer and the medical team. The findings of this study however revealed that because health social workers were intermittently present on the ward and dispersed across a number of service areas, they were less likely to establish strong professional relationships with members of the MDT. By extension, this study also found that the practitioner's ability to develop trusting, professional relationships with potential referrers/members of the MDT, was directly contingent on their ability to demonstrate competence in their social work practice. In addition, this allowed members of the MDT to

learn about the role of the health social worker. These findings align with those of Ambrose-Miller and Ashcroft's (2016) study, which established that when social workers were present on the ward, other disciplines were more likely to develop an understanding of their role, which in turn increased the probability of referrals to the social work service.

While the participants in this study did not identify wide-ranging benefits within the MDT, compared to those they identified in the IDT, some participants did indicate that the MDT required less "investment" in professional relationships, and therefore "less risk", because of the perceived level of detachment between different disciplines. Opportunities to retain their autonomy and professional identity were regarded by some participants as a key advantage of the MDT. In a German study, Korner (2010) identified that the MDT offered a higher level of professional autonomy. The MDT, more than the IDT, provided participants with opportunities to consult, and debrief, with other health social workers, with whom they shared common values and philosophical understandings in relation to patient-care.

### **6.3     DEFINING THE INTER-DISCIPLINARY TEAM (IDT)**

A significant outcome that emerged from this study was that while registered health social workers were unanimous in their understanding of an MDT, there was greater variability in their level of understanding regarding the IDT. Crucially, this study found that those participants who had transitioned from an MDT to an IDT (N=6), had the greatest level of understanding about the differences between an MDT and an IDT. In comparison, those participants who had not transitioned from an MDT to an IDT, and who had always been part of the IDT (N=4), had the least understanding about the differences between these two teams (See Table 5.1). These participants tended to use the terms MDT and IDT interchangeably and indicated that they had not been aware of these distinctions, prior to this research study. Jessup (2007), who asserts that professionals are inclined to use these terms interchangeably and/or to defer to the MDT, supports this finding. Importantly, this finding reveals that health social workers' lived experiences of the transition from an MDT to an IDT, is pivotal to their understanding of the differences between these respective teams.

The rationale for including those participants who had not transitioned from an MDT to an IDT, in the findings of this study, was based on their ability to add value and a deeper understanding to the research topic. These health social workers, whose combined experience accounted for more than seventy years of social work practice, brought significant insight and depth to the study through their ability to speak with conviction about

their roles within an IDT and the benefits this team approach presented to the profession. They were also able to provide recommendations and further insight into what support health social workers might need to integrate into the IDT.

Those participants who had transitioned from an MDT to an IDT (N=6) revealed that, prior to the transition process, they had also been unaware of, and/or unclear about, the differences between these two discrete teams and how they differed in their approaches to patient-centred care. However, participants revealed that this lack of clarity was not isolated to health social workers. They identified that some medical professionals, including managers tasked with implementing the transition process, were also unaware and/or unclear about these distinctions. Where medical professionals continued to operate according to an MDT approach, health social workers, who had transitioned to an IDT, were left to navigate these challenges. For the latter, where managers had not articulated the rationale for the change and/or where the potential benefits of an IDT structure remained unclear, participants identified that staff responses ranged from ambivalence to resistance.

Consequently, participants were resolute that clarity and transparency at both the structural/organisational and management levels respectively, regarding the differences between these two teams and the benefits an IDT held for health social work practice and crucially, for patient outcomes, was paramount. Participants suggested that in addition, ongoing training, review and monitoring of the IDT, after the transition process, would result in higher levels of staff buy-in and culminate in long-term, sustainable change. This finding has revealed significant opportunities for further research and education in this area.

From the outset, this research study conceptualised an IDT as an integrated, co-located team of health professionals, from different disciplines, who actively collaborate and consult with one another, in order to develop a shared understanding of the patient's needs, which results in a co-ordinated and cohesive response to patient-centred care. While no single definition of the IDT emerged from this research study, there were distinct similarities in the way participants described this team structure and its approach to patient-centred care.

Overwhelmingly, this study found that participants across all three categories of the transition process, ie: those who had transitioned from an MDT to an IDT within a DHB; those who had always been part of the IDT and those who were part of an MDT, supported the transition to an integrated IDT approach. Notably, the latter group (N=2) were at different stages of the transition process. These marked significant findings in this research study.

Participants in this study referred to the IDT as a team that functions as a collective, by utilising the knowledge and skills of each discipline, to identify solutions that influence positive patient outcomes. These findings are consistent with the conceptual framework that underpinned this study from the beginning. Unlike the MDT, in which traditional conceptualisations of healthcare and service provision are perpetuated, the IDT signals a paradigmatic shift, which alters the way in which health professionals engage with one another, in order to create “a system of co-operating independents” that function as a unit (Ambrose-Miller & Ashcroft, 2016, p.102; Glaser & Suter, 2016). The findings of this study strongly align with those of Korner’s (2010) study, which identified higher levels of teamwork and team effectiveness within the IDT, compared to the MDT. Participants were unanimous that the IDT aligned with the ethos and philosophical base of social work, by emphasising inclusiveness and providing increased opportunities for them to work collaboratively, and to engage and make connections with other health professionals. According to Korner (2010, p.755), the IDT offers opportunities for professionals to engage in ongoing dialogue with one another, which in turn fosters greater “collaboration, co-operation and integration”.

While the participants in this study did not specifically emphasise the economic benefits of the transition to an integrated approach, some participants did suggest that the utilisation of resources, which facilitated timelier responses, did translate into greater efficiencies and improved service provision within the DHB. Ultimately, this resulted in increased patient engagement, which manifested in long-term, sustainable change for patients, their family and whānau. In contrast, Giles’ (2016) study identified that ineffective team functioning, which was characterised by a lack of structure and co-ordination, resulted in fragmentation and duplication of healthcare services, which in turn held poor outcomes for patients.

For the participants in this study, the co-location of the IDT, in which different professional disciplines are situated in the same physical space, was a key contributing factor in establishing an effective and cohesive team culture. A significant proportion of the literature identifies co-location as a key factor in ensuring the successful transition towards an integrated IDT structure (Ambrose-Miller & Ashcroft, 2016; Howard, Brazil, Akhtar-Danesh & Agarwal, 2011; Goldman, Meuser, Rogers, Lawrie & Reeves, 2010; Kates, Mazowita, Lemire, Jayabarathan, Bland, Selby et al., 2011). According to the participants in this study, the close physical proximity within which the IDT was located created opportunities for professionals, across different disciplines, to respectful, supportive, interdependent and reciprocal relationships. This increased the ability of the team to communicate and to function more effectively, thereby resulting in improved services to patients, their family and

whānau. According to Ambrose-Miller and Ashcroft's (2016) study, co-location also facilitated greater social work visibility, which allowed other disciplines to develop an understanding of the scope of social work practice, thereby heightening interprofessional collaboration within the IDT.

This study found that some participants employed deliberate strategies to address the sense of isolation and separation from other health social work colleagues, created by co-location. While participants acknowledged the supportive and collaborative working relationships they had established within the IDT, they emphasised the importance of maintaining contact with other practitioners. This allowed them to retain their sense of professional identity with health social workers who spoke the same language and shared a common conceptual framework around patient-centred care. This finding is supported by others who highlight that while co-location creates closer professional relationships within the IDT, there are implicit risks of diluting the health social work role and isolating the profession (Ambrose-Miller & Ashcroft, 2016; Goldman, Meuser, Rogers, Lawrie & Reeves, 2010; Howard, Brazil, Akhtar-Danesh & Agarwal, 2011; Kates, Mazowita, Lemire, Jayabarathan, Bland, Selby et al., 2011; Oliver, 2013). For these participants, regular professional supervision, which is a requirement to practice as a registered health social worker within Aotearoa New Zealand DHBs, also allowed them to retain their connections to social work.

At the same time, this study found greater levels of scrutiny and oversight of professionals' practices because of the IDT's focus on the collective and on the emphasis co-location placed on increasing levels of access to, and visibility of, professionals. The participants in this study highlighted the level of "risk" this posed, particularly to practitioners who were not as experienced and/or competent in their practice. These findings are strongly supported by studies undertaken by Beddoe (2010, p.106; 2011, p.24), who identified that comparisons between health social workers and medical professionals highlighted the "weak" "knowledge-claim of social work". Beddoe (2011), Ambrose-Miller and Ashcroft (2016) and Glaser and Suter (2016), assert that health social workers can mitigate these challenges, by clearly and competently articulating their role and the unique contribution they make to patient-centred care.

According to the participants in this study, the IDT allowed health social workers to identify gaps in service delivery, and to seize opportunities which other disciplines were not able to meet. This included bringing a vast range of unique knowledge and skills that maximised positive patient outcomes. Joint assessments between professionals, a key characteristic of the IDT, also facilitated stronger relationships, as professionals developed an understanding

of the valuable contribution health social work made to patient-care. At the same time, participants identified opportunities to provide support and mentoring to other IDT members. According to Hughes and Wearing (2013) and van Gool, Theunissen, Bierbooms and Bongers (2016), professionals need to respond strategically to organisational change, by pre-empting opportunities and identifying gaps in service delivery. This study found that the duality in the health social worker's role, allowed the profession to position itself as an integral member of the IDT and to make an invaluable contribution to the team's functioning. These findings align strongly with those of Ambrose-Miller and Ashcroft's (2016) study, which identified that where practitioners were more accessible to other disciplines, and where they utilised their skills to support other IDT members, there was greater potential for the IDT to develop insight into the health social work role and the value the profession brings to the IDT.

While participants identified closer working relationships within the IDT as a key feature, they highlighted the potential for other disciplines to encroach on roles, which have traditionally been the domain of health social workers, within the DHB. Schofield (2001, p.151) cautions social workers about the "lessening of professional autonomy" and suggests that "boundaries between health professionals have become blurred and contestable". Carey (2016, p.5) echoes this sentiment and advances that the problem with integration, for health social work, is that the profession is "vulnerable" to having its role "usurped" by other disciplines within the IDT. Carey (2015; 2016) asserts the importance of autonomy and professional identity and highlights the impact this has on improved service delivery and positive outcomes for individuals, families and communities.

In addition, this study found that the IDT, compared to the MDT, created more opportunities for participants to have difficult conversations and/or to resolve conflict more effectively, because of the close proximity within which working relationships occurred. Participants were able to leverage off the sense of collegiality fostered within the IDT, by drawing on the profession's knowledge and skills in human behaviour, group work and conflict management, to facilitate these discussions (Ambrose-Miller & Ashcroft, 2016; Giles, 2013). Jones and Jones (2011, p.180) also suggest that trust plays an important role in managing conflict within the IDT.

#### **6.4 HEALTH SOCIAL WORK**

In responding to the topic, this research study found that the transition from an MDT to an

IDT did not significantly impact the nature and identity of health social work practice in Aotearoa New Zealand. Asquith, Clarke and Waterhouse (2005, p.10) assert that a number of “competing and contradictory discourses” converge to frame the nature and identity of social work practice. According to the findings from this study, the strengths implicit within the scope of health social work practice, together with the profession’s unique and encompassing skills and knowledge base, persisted and were sustained, within the new integrated IDT structure.

Where this research study found significant shifts and improvements was in the manner in which the IDT structure and approach created opportunities for health social workers to be more visible and to develop stronger, more effective, collaborative professional relationships with other disciplines. This integrated approach, allowed for a more cohesive team, in which other professionals were able to develop an understanding of the health social work role. In turn, this resulted in a more co-ordinated healthcare response, which was patient, family and whānau-centred. Goldman, Meuser, Rogers, Lawrie and Reeves (2010), Ambrose-Miller and Ashcroft (2016) concur and suggest that collaboration across professional disciplines results in the streamlining of clinical pathways, which in turn provides ease of access to quality care for patients and their families. According to Hughes and Wearing (2013), D’Amour and Oandasan (2005) and Giles (2016), the integrated-nature and cohesiveness of the IDT has a direct impact on the provision of quality patient-centred care.

This study confirmed that the expanse of practical, emotional, psychological, financial/economic, spiritual and cultural knowledge and skills, implicit within the health social worker’s role and responsibilities, was transferable regardless of the service areas and/or team approach. Participants in this study had vast experience in a range of areas including loss, grief and trauma, discharge planning, risk assessment and safety planning, psychosocial assessments, alcohol and drug issues, mental health, child protection and domestic violence. Health social workers’ knowledge of community resources and services remained a crucial strength within the IDT.

Opportunities to educate other professionals were also significantly more pronounced within the IDT. This study revealed the crucial role that joint patient visits and combined assessments, key features of the IDT, served in terms of educating both health social workers and their IDT colleagues about one another’s respective roles. The close physical proximity within which the IDT operated, coupled with opportunities to conduct joint assessments, allowed for more consistent and sustained learning. Joint assessments therefore served a crucial role in enabling practitioners to demonstrate competence in their practice and to gain



credibility within the IDT. In addition, this research found that health social workers also used clinical documentation, where all patient assessments and care plans were recorded, strategically to educate other IDT disciplines about the depth and clinical competence of their assessments and the valuable contribution the profession made to patient-care. In an attempt to educate other disciplines about their role, health social workers from this study disclosed that their documentation style had evolved and that they intentionally structured their clinical notes to reflect a biopsychosocial approach. This finding is consistent with Beddoe's (2010) claim that while social workers and other health professionals share a common goal and a commitment towards achieving positive client outcomes, health social work brings a distinctiveness to patient-care which is highlighted in the profession's expertise in psychosocial assessment.

While health social workers were able to draw on the wide-ranging and multifaceted aspects of their role, they were also able to identify gaps in service provision, which other disciplines were unable to meet. This finding is supported by Ambrose-Miller and Ashcroft's (2016, p.104) study which found that health social workers were able to establish themselves as integral to the team, by identifying gaps in service delivery and addressing areas of "clinical complexity", which other disciplines were unable to meet. This represents a significant outcome in this study and highlights the capacity of health social work to contribute to the IDT's functioning and its ability to respond more efficiently and effectively to patient needs.

Practitioners were also able to use their professional knowledge, skills and experiences to support and mentor members of the IDT, thereby further enhancing effective professional relationships. This finding highlights both the duality of the health social work role and the important role it holds in terms of the IDT's functioning. Giles (2013) supports this and highlights the importance of supporting, educating and coaching health professionals. By raising the consciousness of health professionals about the symbiotic relationship that exists between health (medicine) and wellbeing (psychosocial), health social workers are able to position themselves in what Beddoe (2011, p.25) refers to as a "distinctive space", thereby enabling the profession to play a key role in reducing re-admissions and contributing to successful patient outcomes (Giles, 2016). According to Schofield (2001), the rapidly changing health environment poses significant challenges for health social workers as they attempt to respond to changes and deliberate the implications for future practice.

These findings capture the position of health social work, within the DHB, as distinctive. Practitioners have been able to practice *within* the context of a medical paradigm, while remaining relevant and adapting to this rapidly evolving system. By conceptualising health

and wellness holistically, health social workers have succeeded in bridging the gap between medicine and diagnosis and the wider socio-economic, political, cultural and spiritual determinants of health. Baum (2015), Auslander (2001), Beddoe (2011) and Giles (2013), who assert that health social work, recognises the complex and dynamic interplay between the individual's health and the influences exerted on them by the broader social-political, cultural and economic contexts within which they are located to create a fluid and paradoxical milieu, supports these findings. By challenging structures that perpetuate inequalities, social work therefore ensures that those who are marginalised are able to exercise their right to self-determination and access healthcare services (Giles, 2009; Giles, 2013; McLeod & Bywaters, 2000).

The findings of this study highlight health social work as playing a critical role in supporting both the medical/health professional on the one hand, and the patient, their family and whānau on the other hand. These findings are supported by Sheppard (2006), Beddoe (2015; 2016), O'Brien (2014) and O'Donoghue (2015) who assert that it is imperative for health social workers to apply a critical lens, which allows them to be both responsive and transformative in their practice. Giles (2013) acknowledges the depth of insight that health social workers bring, in terms of understanding the connections between patients and the health system. Adams, Dominelli and Payne (2009 p.24) agree and suggest that social workers need to reflect on the "complexities imposed on their work and reduce structural inequalities" by using "a critical reflexive lens".

This study revealed that health social workers derived immense job satisfaction and fulfilment from their role within the DHB. This included enjoying the diversity of roles and responsibilities involved in supporting patients and their families and whānau, following a significant health-related event. Being part of a positive, supportive and professional team culture, where they felt valued and acknowledged for their experience and expertise by the other members of the IDT, provided health social workers with a deep sense satisfaction. This enabled practitioners to embrace the challenges in this paradoxical and highly contested environment, where the medical model continues to take precedence.

The challenge for health social workers, which has been highlighted by this new integrated IDT environment, has been to articulate their role more clearly, in order to reduce ambiguity. Ambrose-Miller and Ashcroft (2016), Glaser and Suter (2016) and Beddoe (2011) support this finding and assert that social workers need to clearly and competently articulate their role and the unique contribution they make within the IDT, and ultimately to patient-care. In the current climate, where fiscal constraints dictate service provision, social workers need to

become more proficient in the way they articulate their contribution to patient-care. This remains a challenge for health social work, given both the multifaceted nature of the role and the variety with which individual practitioners approach their practice. In addition, this is compounded by the propensity of other health professionals who measure sustainable outcomes and clinical competence according to their own discipline-orientation.

## **6.5 CHANGE AND THE TRANSITION PROCESS**

This research study revealed that health social workers were supportive of the transition to an IDT because of the opportunities this approach presented for them to collaborate with other disciplines, in order to achieve positive health outcomes for patients and their family and whānau. In turn, this highlighted an apparent disconnection between the individualist and siloed approach of the MDT and the ethos and philosophical framework, which informs social work practice. Cooper (2011) suggests that traditional constructions of healthcare, in which discipline-specific health professionals practice within silo-oriented teams, have been replaced by an integrated healthcare approach, which requires greater interprofessional collaboration.

The findings from this research study, which are consistent with that of van Gool, Theunissen, Bierbooms and Bongers (2016), reveal the extent to which health social workers are aware of the rapid and continuous changes, that have become the hallmark of the health system, and the challenges that accompany such transitional processes. A key characteristic of all the participants in this research study was their resilience and steadfast commitment to maintaining positive outcomes for patients, their family and whānau, regardless of the changes that occurred at a structural/organisational level. Hughes and Wearing (2013) and Wolin (2004) emphasise the importance of health social workers developing an awareness of organisational changes, at both a structural and operational/process level, in order to understand the influence that policy initiatives and fiscal indicators have on social service outcomes within healthcare.

While health social workers were generally unfamiliar with the concept of New Public Management Reform, they were aware of the ways in which changes in the wider political context, affected their practice and their ability to support patients, their families and whānau and to ensure safe discharges. According to Giles (2013 p.185) “pressure to radically reduce a patient’s length of stay, have created concerns for social workers in relation to increased distress levels and quality of life”. Similarly, Schofield (2001), Beddoe (1993), Opie (1993)

and Stewart (1998) remark that clear demarcations between management and frontline staff have resulted in a redefinition of the boundaries between health professionals, and a greater emphasis on discharge planning. Participants in this study emphasised the way in which achieving measurable outcomes had become key drivers in ensuring systems improvements and service provision. Notably, this study did not identify opportunities to manage increasing patient volumes and/or to reduce spiralling health costs, as significant benefits of the IDT. At the same time, centralised clinical pathways created by the IDT, ensured greater efficiencies in terms of resourcing and patient-centred care. Key authors including Sheppard (2006), O'Brien (2014) and O'Donoghue (2015) highlight the impact that neoliberalism, with its focus on funding streams, achieving measurable targets and managerialism, has had on the delivery of social work services. O'Donoghue (2015) advances that neoliberalism, which emphasises "economic productivity, efficiency and outcomes", is the antithesis of the traditionally socialist and philanthropic ideology that underpins social work practice.

This study found significant inconsistencies in the level of involvement health social workers had in the decision-making processes, regarding the transition to an IDT structure. Overall, decisions to implement change within the DHB, were made at a structural level and implemented by middle managers at an operational level. This highlights a significant paradox, which is inconsistent with the inclusive and collaborative ethos that underpins both integrated healthcare and social work practice.

Where there had been consultation from management, and where the rationale for the transition to an IDT had been clearly presented, this study found that social workers were more receptive and responsive to the transition process. Presentations, workshops, meetings and current research in the area of integrated healthcare, assisted health social workers to develop an understanding of the IDT structure, and served as important forerunners to the implementation process. However, this study found inconsistencies between DHBs, both in the extent to which these strategies were applied prior to the implementation of the IDT, and in the extent to which health social workers were supported to continue developing an understanding of the IDT structure and its practice approach, after implementation occurred. The need for greater clarity at the outset from management, regarding the rationale for the transition, ways in which the IDT structure and approach to patient-care differs from that of an MDT, and the likely practice implications for health social workers, have been highlighted by these findings. This study further identified the importance of implementing ongoing supports for health social workers, through professional development, following the transition to an IDT. Findings suggest that this would bridge the gap between a theoretical/conceptual understanding of integrated healthcare and the actual practical

implementation of the IDT, and create long-term sustainability of the transition to an IDT. This marks a significant finding in this study and highlights considerable scope for further research.

## **6.6 ALIGNMENT BETWEEN THE INTER-DISCIPLINARY TEAM AND A COMMUNITY-BASED APPROACH**

The findings of this study highlight a strong alignment between participants' experiences of a community-based/out-patient approach and that of an integrated IDT approach. The majority of the participants in this study (N=10) had either current or previous community-based social work experience. Some of the participants were also employed in both in-patient and outpatient services. In contrast, some participants identified parallels between the individualistic nature of the MDT and in-patient services.

Participants made strong connections between in-patient services and hospital-based services, which they associated with the traditional, health-led MDT approach. Participants suggested that this emphasised the expertise of medical professionals, rather than the collaborative efforts of the IDT, and encouraged health social workers and other professionals to practice in discipline-specific siloes.

In contrast, this study found that the community-based approach mirrored that of an IDT approach to patient-care, in the way in which both emphasised inclusiveness and collaboration. This study also found that IDT's capacity to encourage and empower patients to define their own concept of health and wellbeing, while living independently in the community, more pronounced. Health social workers in this study regarded the efforts to combine and co-ordinate the collective knowledge and skills of the IDT, with those of the patient and their family and whānau, as more pronounced in the IDT–community model, compared to the MDT-in-patient model. According to van Gool, Theunissen, Bierbooms and Bongers (2016), a systems' approach recognises the interconnected and multi-faceted nature of healthcare, in which professionals, patients, family and whānau, community and stakeholders alike are actively involved.

This study found that despite the trend towards integrated patient-care, nurses and doctors have not necessarily been trained in an IDT approach and/or are aware of the differences between the two team approaches. This study found that this posed challenges for health social workers, as it served to undermine the sustainability of the IDT structure and the

integrity of integrated patient-centred care within the DHB. This finding, together with the dearth of available literature, reinforces the need for more research and education in this area, in order to highlight the benefits of integrated care across all healthcare services. According to van Gool, Theunissen, Bierbooms and Bongers (2016), “flexibility” and a “pro-active attitude”, at all levels of the organisation, are essential to the ongoing evolution and survival of health systems globally”.

## **6.7 BICULTURALISM: OPPORTUNITIES TO STRENGTHEN AN IDT**

Biculturalism is an important part of social work practice in Aotearoa New Zealand. Health social workers are expected to demonstrate knowledge of Te Tiriti o Waitangi and competency in applying the principles of the Treaty to practice with Māori (Aotearoa New Zealand Association of Social Workers, 2013; Social Workers Registration Board, 2017). This research study acknowledges the primacy of Tangata Whenua and the important place that Te Tiriti o Waitangi holds within Aotearoa New Zealand society. Ruwhiu, Te Hira, Eruera and Elkington (2016, p.83) concur and emphasise that recognition and inclusion of the provisions of Te Tiriti o Waitangi within policy, yields benefits for all New Zealanders. They contend that “Māori knowledge, wisdom, pedagogies, principles and practices” are essential to “best practices” and imperative to engagement with Māori as Tangata Whenua of Aotearoa New Zealand (Ruwhiu, Te Hira, Eruera and Elkington, 2016, p.83).

The current study recognises that there is much to be garnered from a bicultural model of practice, given its potential to both strengthen and sustain integrated healthcare within Aotearoa New Zealand. This study advances that consideration, and inclusion, of a bicultural framework sets research within Aotearoa New Zealand apart from studies undertaken in other parts of the world.

Building relationships with patients, their family and whānau, and finding meaningful connections through engagement, dialogue and kōrero, formed an integral part of the health social worker’s kete. This finding is supported by Mooney’s (2012) study, which highlighted the impact therapeutic rapport with young people and their whānau had on their ability to access and engage with services. Similarly, Hollis-English (2012) asserts that for Maori social workers, the significance of establishing connections with clients takes precedence. Mooney (2009) argues that there was a relationship between the rapport, which is established between the health social worker and the client at the beginning of the relationship, and positive patient outcomes.

This study found incongruencies between the collective approach of biculturalism and the individualistic nature of the MDT, which aligned strongly with the traditional medical paradigm. However, a significant finding that emerged from this research study was the way in which participants, both Māori and non-Māori health social workers drew distinct parallels between an IDT approach, and that of a bicultural model of social work practice. Notions of the collective, inclusiveness, whanaungatanga, whānau, manaakitanga and kotahitanga are central to both biculturalism and integrated healthcare. Mooney (2009) cites the important role that whanaungatanga holds in guiding and establishing a collaborative and respectful relationship. Authors including D'Amour and Oandasan (2005), Giles (2013), Hughes and Wearing (2013) and Jessup (2007) highlight the way in which the collective and collaborative efforts of different professional disciplines, within the IDT facilitate a cohesive response to patient-care.

For Māori health social workers, the similarities between the philosophies underpinning both the IDT and bicultural social work practice provided a safety about engaging in discourse, which challenged other IDT members about their values and beliefs. Similarly, Hollis-English's (2012) study identified the way in which Māori social workers were able to educate non-Māori staff, in order to address cultural barriers. Crucially, the current study identified significant opportunities for health social workers, and others involved in the transition to integrated healthcare, to draw on the principles implicit within a bicultural framework in order to strengthen practice within the IDT, in order to create sustainable change. This outcome distinguishes this study from international studies and locates the transition to an IDT firmly within the cultural milieu of Aotearoa New Zealand.

Both Māori and non-Māori health social workers in this research study, highlighted the importance of applying a bicultural framework to health social work practice, within the DHB. Māori health social workers in this study, emphasised the currency they placed on their ability to work with Tangata Whenua patients and their whānau. Mooney's (2009) study supports this finding and identifies the duality in the core competency of Māori health social workers. According to Mooney (2009), this competence is evident in the social worker's ability to integrate a Māori cultural lens into clinical practice. According to Ruwhiu (2013) and Anglem (2014), a bicultural approach to social work practice reaffirms the ability of whānau to exercise their right to self-determination and to generate solutions, at the individual, whānau, iwi and hapū levels, which are infused by Māori cultural values and beliefs.

This study found inconsistencies in Māori health social workers' experiences of feeling supported to practice in a bicultural way, within their respective DHB. Hollis-English's (2012) reported similar findings where some Māori social workers admitted to feeling isolated and unsupported within their respective organisations. In addition, these practitioners referred to the lack of understanding about their role as Māori social workers (Hollis-English, 2012). This finding highlights a significant deficit within the health system and a lack of consistency relating to culturally responsive healthcare. Roberts (2016) and Anglem (2014) agree and highlight the way in which bicultural discourse emphasises the importance of developing culturally responsive practices.

Where Māori health social workers were supported, they experienced higher levels of satisfaction and a sense meaning in their role. Social workers reported feeling validated in their ability to practice in a culturally safe way. This emerged as a significant finding in this research study and reinforced the importance of authentic social work practice and of ensuring that Tangata Whenua social workers are supported to practice in a way that enables them to engage in meaningful professional relationship. This in turn demonstrates culturally responsive healthcare, which in turn translates into positive outcomes for all New Zealanders.

## **6.8 CONCLUSION**

The six core themes, which have been discussed and analysed in detail in this chapter, provide depth of insight into the ways in which registered health social workers experience *the transition from multi-disciplinary team to inter-disciplinary team and the impact of integrated healthcare on the nature and identity of health social work practice in Aotearoa New Zealand*. These core themes, which have been extrapolated using supporting literature to substantiate relevance to the research topic, identify similarities between health social workers' experiences in Aotearoa New Zealand and those of health social workers worldwide. For the participants in this study, the traditional MDT approach provided opportunities for social workers to retain their autonomy and professional identity. However, this study found a groundswell of support, among registered health social workers, who identified a strong alignment between the IDT and the ethos and philosophical frameworks that underpin social work practice. Notions of inclusiveness, collaboration, connections and relationships were consistent across both the IDT approach and social work practice. What distinguishes this study from international studies is the cultural context within which it is located. The bicultural nature of health social work in Aotearoa New Zealand, and the



responsibility of professionals to Te Tiriti o Waitangi, offer unique opportunities to strengthen the IDT, by drawing on Whakawhanaungatanga, the practice of appreciating and growing relationships and kotahitanga, which involves bringing people together. These serve as unifying concepts within the IDT. The following chapter concludes this study and provides recommendations for further research. Participants' reflections have been included in the following chapter to highlight the willingness of health social workers to engage with this discourse, and to collaborate in research that values their lived experiences of change.

## CHAPTER SEVEN

### CONCLUSION AND RECOMMENDATIONS

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#### 7.1 INTRODUCTION

This research study has sought to understand: *the transition from multi-disciplinary team to inter-disciplinary team and the impact of integrated healthcare on the nature and identity of health social work practice in Aotearoa New Zealand*. This concluding chapter sets out by identifying the significance of this study, while acknowledging the desire to see further research undertaken in this field. The limitations of this study are also presented in this chapter. A number of recommendations that have emerged during the course of this research study are discussed in this chapter.

#### 7.2 SUMMARY OF RESEARCH AIMS

This study sought to explore how the transition to an integrated IDT structure influences health social work practice, within the context of a DHB. The aim of this research study was to examine the experiences of registered health social workers who had practiced in an MDT and an IDT, within a DHB, in Aotearoa New Zealand. This study also aimed to examine the nature and identity of health social work practice within these two discrete team approaches, in the context of the DHB.

These aims were guided by a number of key objectives which sought:

- To explore the ways in which health social workers conceptualise the differences between an MDT and an IDT.
- To explore how health social workers experienced change following the transition from an MDT to an IDT.
- To determine the rationale for the transition to an IDT approach.
- To establish whether health social work roles and responsibilities changed following the transition to an IDT.
- To explore the opportunities that have presented because of the transition to an IDT and the impact these have had on health social work practice within the DHB.

- To explore the challenges that health social workers have experienced following the transition to an IDT and ways in which these have been addressed within the DHB.
- To provide recommendations on how to effectively transition health social workers from an MDT to an IDT.

### **7.3 SIGNIFICANCE OF THE STUDY**

The significance of this research study is in the way in which it highlights the value of health social work within the IDT and the contribution the profession is able to make to ensure patient-centred outcomes, from the perspective of registered health social workers, by exploring the transition from an MDT to an IDT in the context of the DHB. This research study has recognised an inevitable trend towards integrated healthcare and has highlighted the profession's responsiveness to, and support of, such a transition. The ethical responsibility to provide quality healthcare to a growing patient population, whilst managing a financial deficit, remains a key focus for both the government and health professionals alike. While this study has sought to contribute, in part, to the growing body of emerging literature within Aotearoa New Zealand, by examining health social workers' subjective experiences of integrated healthcare, it acknowledges that significant research in this area is needed to ensure sustainable change.

### **7.4 LIMITATIONS OF THE RESEARCH STUDY**

While semi-structured interviews created opportunities for health social workers to reflect on their subjective experiences within the DHB, there were limitations to this research study:

- While the size of the sample group was considered to be appropriate for this study, limitations in terms of ethnicity, gender, age and the size of the DHB ie. tertiary vs. regional DHB indicate that the findings of this research study cannot be representative of, or generalised to, the larger health social work community within Aotearoa New Zealand.
- Some participants in this study were unaware of the distinctions between an MDT and an IDT. This was reflective of the way in which professionals tend to use these terms interchangeably. For some of the participants in this study, this also reflected the wider lack of awareness, about the differences between these two team structures,

among medical professionals and managers within the DHB. The decision to include this small sample in the research study was based on the remarkable insights these practitioners provided in terms of the role of health social, the challenges and the opportunities inherent within an IDT and the support required to sustain change. This finding highlights the importance of further research and professional development in this area.

## **7.5 PARTICIPANT REFLECTIONS**

The health social workers who participated in this research study commented on the value they had derived from participating in this study and on the opportunity it had provided them to reflect on the process. Health social workers confirmed that by participating in this research study, they were able to finally reflect on, and acknowledge, the significance of the transition from an MDT to an IDT. Given that this research study aimed to explore the subjective experiences of registered health social workers who had transitioned from an MDT to an IDT, within a DHB in Aotearoa New Zealand, it is appropriate to include the voices of the participants who contributed a depth of insight to this research topic and made this study possible:

*One participant referred to this in this way: No it's...been interesting kind of reflection because (pause) Yeh. I think that...I've got to be really grateful for where I am and the kind of team culture but also the way that management support(ed) the IDT process and that sort of thing. It's a really valuable kind of topic to be looking at. (Participant 1)*

*...It's...clarified (smiling) an awful lot just by you asking those questions. It's really been interesting...that's all good. I do appreciate that. I've...actually found it really useful in terms of being able to talk...I hope it's just going to really...bring things together...in terms of...helping the profession...that's an important part of what you're doing.(Participant 3)*

*...actually... I'd like to say...During...my interview, I feel...your question made me think a lot of...the things I[hadn't]...thought about before...Thank you.. (Participant 4)*

*...it's actually been really valuable for me to...reflect on this whole process, because I haven't really had the opportunity to...this [has] ...actually really...highlighted some...areas for me that I think...I haven't thought about... I mean it's great when you...can be involved in something that's actually practical as well.... It's great...I've really enjoyed the questions.*

*I think...that it really...opened up a lot of discussion for me as well...I'm grateful for the opportunity...it's been good to...process it all really. It's been really helpful (Participant 6)*

*I'd like to see some more research from it actually. I think that would be important...I think what you're doing is really good...the [research] you're doing. (Participant 7)*

*...I feel...it's been good. It's been really interesting. (Participant 12)*

## **7.6 RECOMMENDATIONS AND FUTURE RESEARCH OPPORTUNITIES**

This research study has reflected ongoing changes within the health system and attempts by health social workers to contribute to quality patient outcomes, through integrated healthcare. While this reflects a global trend in healthcare, it is also reflective of health social work's responsiveness to change.

Based on the subjective experiences of registered health social workers, this research study identified overwhelming support for the transition to an IDT approach, within the DHB. Participants in this study identified that there were significant opportunities for health social work to demonstrate the profession's unique knowledge-base and skills. This study identified that the IDT created opportunities for health social workers to develop strong, collaborative and supportive professional relationships with different disciplines. This created the context for health social workers to educate other professionals about their role, while identifying gaps in service provision, which the profession is unequivocally able to meet. In turn, these presented significant benefits for both IDT members and for patients, their family and whānau. This study further concludes that the nature and identity of health social work is strengthened by the transition to an integrated IDT approach. While the team structure changed, participants identified that the unique roles and responsibilities implicit within health social work practice had not shifted and were transferable to the IDT structure. This signals opportunities for the profession to demonstrate competence and to make a valuable contribution to integrated healthcare, as it progresses into the next phase of its ongoing evolution.

Based on the outcomes that have been generated from this study, it is hoped that further social work research, which examines the notion of integrated healthcare and the

implications for health social work practice, will gather further momentum within Aotearoa New Zealand. A number of recommendations have been identified from this research:

- The ways in which health social workers have conceptualised the differences between an MDT and IDT respectively, have emerged as a significant finding in this research study. This has signalled the need for further research and professional development that supports health social workers to gain a clearer understanding of these distinct team approaches and the impact they have on health social work.
- Further research is also required to support other health professionals and managers within the DHB to understand the differences between the MDT and the IDT. This will provide clarity and transparency in the transition process, which in turn has the potential to create long-term sustainable change.
- Further research is required to explore the long-term benefits of integrated healthcare in Aotearoa New Zealand in order to create further service improvements.
- The development of an integrated healthcare framework, within Aotearoa New Zealand, that includes guidelines for monitoring and evaluating the IDT.
- Further research which investigates ways in which a bicultural framework can support an IDT.
- Examining the experiences of Tangata Whenua health social workers within an IDT.
- Comparative research which examines the IDT structure within in-patient services vs. out-patient/community services.

## **7.7 CONCLUSION**

Social work has proven yet again its capacity to evolve and adjust to an ever-changing context. This study concludes that health social work is both prepared and willing to engage in the transition towards integrated healthcare, by highlighting the value that the profession brings both to the functioning of the IDT and to ensuring positive patient-centred outcomes. The IDT provides opportunities for practitioners to utilise their unique skills and knowledge to support patients, their family and whānau, as well as the other members of the IDT. Notions of inclusiveness and collectivism, which are reflected within an IDT approach, demonstrate a strong alignment with health social work, where Whakawhanaungatanga, the importance of relationships, kotahitanga, the importance of bringing people together, and the provisions of Te Tiriti o Waitangi, are integral to patient-centred care within Aotearoa New Zealand.

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## APPENDICES

### APPENDIX I: ETHICS APPROVAL



Date: 21 August 2017

Dear Karlin Austin

Re: Ethics Notification - SOB 17/13 - The impact of New Public Management reform on health social work practice: What influence does organisational change have on the nature and identity of health social work practice within an interdisciplinary team?

Thank you for the above application that was considered by the Massey University Human Ethics

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Brian Finch  
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)



## APPENDIX II: AMENDMENT TO RESEARCH TITLE

**SOB 17/13**      The impact of new public management reform on health social work practice: What influence does organisational change have on the nature and identity of health social work practice within an interdisciplinary team?

Karlin Austin (HEC: Southern B Application SOB 17/13)

Department: School of Social Work

Supervisor: Dr Lareen Cooper & Dr Hannah Mooney

Thank you for your letter dated 28 March 2018 outlining the change you wish to make to the above application.

The change to the title has been approved and noted to now read as follows:

*The transition from multi-disciplinary team to inter-disciplinary team: The impact of integrated healthcare on the nature and identity of health social work practice in Aotearoa New Zealand.*

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee. If over time, more than one request to change the application is received, the Chair may request a new application.

Regards

Patsy

*Patsy Broad*

*Team Leader, Research Ethics*

*Research Ethics Office*

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### APPENDIX III: REQUEST TO ANZASW – RECRUITMENT OF PARTICIPANTS



**MASSEY UNIVERSITY**  
COLLEGE OF HEALTH  
TE KURA HAUORA TANGATA

Aotearoa New Zealand Association of Social Workers (ANZASW)  
National Office  
P. O Box WX33484  
Christchurch

To Whom It May Concern

**Re: Request for recruitment of ANZASW members to participate in a Master of Social Work research study.**

My name is Karlin Austin and I am writing to inquire whether Aotearoa New Zealand Association of Social Workers would please consider inviting its members across New Zealand to participate in a research study which I am currently undertaking, as part of the Master of Social Work programme, at Massey University, Manawatu, Palmerston North.

The title of my research study is: ***The impact of New Public Management Reform on health social work practice: What influence does organisational change have on the nature and identity of health social work practice within an interdisciplinary team?***

The purpose of this research study is to understand the subjective experiences, thoughts and opinions of registered social workers, who have been part of an organisational change process which resulted in their transition to an inter-disciplinary team (IDT), aimed at supporting integrated patient-care, within a District Health Board (DHB) in Aotearoa New Zealand.

This research study views the experiences and insights gained from registered social workers as invaluable in contributing to a deeper and more meaningful understanding of the impact integrated healthcare has on the nature and identity of health social work practice, within inter-disciplinary teams. All participation in this study is voluntary and there is no obligation for members to participate. Participants can withdraw from the research study at any stage during the process, if they wish to do so.

Criteria for participation in this research study include:

- 5+ years as a practicing social worker;
- Current or previous experience as a registered social worker within a District Health Board;
- Previous experience in an multi-disciplinary team (MDT) within a District Health Board;

- Currently or previously a member of an inter-disciplinary team (IDT) within a District Health Board.

If you have any questions about this research study, or require further details, please do not hesitate to contact myself, Karlin Austin (Master of Social Work research student) on [Karlin.Austin.1@uni.massey.ac.nz](mailto:Karlin.Austin.1@uni.massey.ac.nz) and/or my supervisors: Lareen Cooper ([L.Cooper@massey.ac.nz](mailto:L.Cooper@massey.ac.nz)) and Hannah Mooney ([H.A.Mooney@massey.ac.nz](mailto:H.A.Mooney@massey.ac.nz)).

Yours sincerely,  
Karlin Austin

## APPENDIX IV: INFORMATION SHEET



**MASSEY UNIVERSITY**  
COLLEGE OF HEALTH  
TE KURA HAUORA TANGATA

*The impact of New Public Management Reform on health social work practice: What influence does organisational change have on the nature and identity of health social work practice within an interdisciplinary team?*

### INFORMATION SHEET

#### Researcher Introduction

My name is Karlin Austin. I am in the process of completing the Master of Social Work programme, at Massey University, Manawatu, Palmerston North.

I am currently undertaking research in the area of health social work practice, within Aotearoa New Zealand. The purpose of this research project is to understand the subjective experiences, thoughts and opinions of registered social workers, who have been part of an organisational change process which resulted in their transition to an interdisciplinary team (IDT), aimed at supporting integrated patient-care within a District Health Board (DHB).

#### Project Description and Invitation

As a registered social worker, who is currently practicing or who has previously practiced within a DHB in Aotearoa New Zealand, you are invited to participate in this research project.

Criteria for selection in this research project include:

- 5+ years as a practicing social worker;
- Current or previous experience as a registered social worker within a DHB;
- Previous experience as a member of an MDT within a DHB;
- Currently or previously a member of an IDT within a DHB.

This project recognizes that the increasing global trend towards an integrated model of patient-care, within healthcare services, is an attempt at managing national health spending, while aiming to achieve positive health outcomes for patients and their whanau.

The aim of this research project is to contribute to a deeper and more meaningful understanding of the impact organisational change has on the nature and identity of health social work practice within interdisciplinary teams. This project seeks to explore the ways in which New Public Management reform, which is informed by neoliberalism, impacts the way in which registered social workers practice within an IDT, in Aotearoa New Zealand.

### **Participant Identification and Recruitment**

This research project views the experiences and insights gained from registered social workers, who have been through an organisational change process, aimed at supporting integrated patient-care within an IDT in a DHB, as invaluable.

Your participation in this study is voluntary and there is no obligation for you to participate. As a participant in this research study, you are entitled to decline to respond to any question at any stage during the interview process.

If you wish to participate in this research study, you will be invited to discuss the scope of your social work role prior to the organisational change process taking place, and the extent to which you believe your role has shifted and/or changed overtime, as a result of such an organisational change process. You will also be asked to comment on what you perceive the benefits and/or challenges are for registered social workers, who have transitioned to and been integrated into an IDT within a DHB, in Aotearoa New Zealand. As a participant in this study, you will be given the opportunity to identify any supports which you believe would benefit other registered social workers who are undergoing an organisational change process, while at the same time providing competent, professional social work practice to patients and whanau within a DHB.

The findings of this research will be presented in partial fulfilment of the requirements of the Master of Social Work degree at Massey University. The findings may also be published in peer-reviewed journals and/or presented at conferences.

### **Project Procedures**

If you volunteer to take part in this research project, you will be interviewed in order to learn more about your experiences within an IDT. These semi-structured interviews will be voice

recorded and will take between 60 - 90 minutes. Interviews may be conducted by prior arrangement via Skype and/or telephone.

There may also be instances in which I may request a follow-up interview, following the initial interview, in order to clarify and/or gain deeper understandings. You are under no obligation to agree to follow-up interviews and you can decline such a request, without providing a reason.

### **Data Management**

All interviews will be voice recorded and transcribed. You will be given the opportunity to review and edit your transcript. All data gathered from these interviews will be stored securely in password protected electronic files or locked in a filing cabinet until the research project has been concluded and examined, after which time these files will be destroyed. You will be given a summary of the project findings when it is concluded. A copy of the final research project will also be held in the Library at Massey University.

All data gathered from these interviews will be used for the sole purposes of this research project. Data will be analysed and collated according to themes and patterns. At no stage will any identifying details be disclosed, in order to protect your identity as a participant in this research project. While every attempt will be made to protect your confidentiality, absolute anonymity cannot be guaranteed.

### **Participant's Rights**

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

### **Project Contacts**

If you wish to participate in this research study and/or you have any questions or concerns about the project, please do not hesitate to contact myself, Karlin Austin (Master of Social

Work research student) at [Karlin.Austin.1@uni.massey.ac.nz](mailto:Karlin.Austin.1@uni.massey.ac.nz) and/or my supervisors: Lareen Cooper at [L.Cooper@massey.ac.nz](mailto:L.Cooper@massey.ac.nz) and Hannah Mooney at [H.A.Mooney@massey.ac.nz](mailto:H.A.Mooney@massey.ac.nz)

#### Committee Approval Statement

*This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 17/13. If you have any concerns about the conduct of this research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email [humanethicsouthb@massey.ac.nz](mailto:humanethicsouthb@massey.ac.nz)*

Yours sincerely,

Karlin Austin

## APPENDIX V: PARTICIPANT CONSENT FORM



**MASSEY UNIVERSITY**  
COLLEGE OF HEALTH  
TE KURA HAUORA TANGATA

*The impact of New Public Management Reform on health social work practice: What influence does organisational change have on the nature and identity of health social work practice within an interdisciplinary team?*

### PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name – printed**

.....



## APPENDIX VII: AUTHORITY FOR THE RELEASE OF TRANSCRIPTS



**MASSEY UNIVERSITY**

COLLEGE OF HEALTH  
TE KURA HAUORA TANGATA

*The impact of New Public Management reform on health social work practice: What influence does organisational change have on the nature and identity of health social work practice within an interdisciplinary team?*

### AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

## APPENDIX VIII: RESEARCH QUESTIONNAIRE



**MASSEY UNIVERSITY**  
COLLEGE OF HEALTH  
TE KURA HAUORA TANGATA

*The impact of New Public Management Reform on health social work practice: What influence does organisational change have on the nature and identity of health social work practice within an interdisciplinary team?*

### RESEARCH QUESTIONNAIRE

1. How long have you been a registered social worker?
2. How long have you been working/did you work as a health social worker in the District Health Board (DHB)?
3. What aspects of health social work do/did you enjoy the most in the DHB?
4. What aspects of health social work do/did you find the most challenging while working in the DHB?
5. What is your understanding of a Multi-disciplinary Team (MDT) within the District Health Board (DHB)?
6. What is your understanding of an Inter-Disciplinary Team (IDT) within the DHB?
7. What is your understanding of New Public Management?
8. As a registered health social worker within the DHB, what are some of the significant changes you have seen that have impacted on your practice with patients and their whānau?

9. What was your understanding of the reasons/rationale given for the change from an MDT to an IDT? In your experience, what support was provided to assist you in the change from an MDT to an IDT?
10. How long were you part of the MDT before the structure changed to an IDT?
11. In your experience, what made the transition from an MDT to an IDT manageable/supportive?
12. In your experience, what made the transition from a MDT to an IDT more challenging/difficult?
13. In your experience, what were the benefits and/or challenges of the transition to an IDT?
14. Who are/were the other members of your MDT?
15. Who are/were the other members of your IDT?
16. Describe your role as a health social worker in the MDT?
17. What did the other members of the MDT understand your role to be?
18. What is/ was your experience as a health social worker within the MDT?
19. How was your role as a health social worker similar in the IDT compared to your role within the MDT?
20. How was your role as a health social worker different in the IDT compared to your role within the MDT?
21. What do the other members of the IDT understand your role to be?
22. Is there anything further you would like to add?