

Episode 99 - Dr. Shelley Craig and Dr. Barbara Muskat: "Bouncers and Jugglers and Firefighters ... Oh My!": A Qualitative Investigation of Social Work Roles in Health

[00:00:08] Welcome to living proof a podcast series of the University at Buffalo School of Social Work at www.socialwork.buffalo.edu. We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to address you our regular listeners. We know you have enjoyed our podcasts as evidenced by the more than 200000 downloads to date thanks to you all. We'd like to know what value you may have found in the podcast. We'd like to hear from all of you practitioners researchers students but especially our listeners who are social work educators. How are you using the podcast in your classrooms. Just go to our Web site at www.socialwork.buffalo.edu forward slash podcast and click on the contact us tab. Again thanks for listening. And we look forward to hearing from you. Before we begin I'd like to send a special shout out to Felicity our biggest fans in Dublin Ireland. Thanks for listening. Social work roles in medical settings are shifting with changes in the provision of health care in North America. In addition to organizational changes and changes in financing social workers face encroachment upon our traditional roles in hospital settings from allied health professionals nurses counselors and even physical therapists can perform some of the traditional social work functions. But can they replace us. Or is there something special about social workers.

[00:02:05] Dr. Shelley Craig is an assistant professor at factor in when ToJ faculty of social work at the University of Toronto. Dr. Craig is a registered and licensed clinical social worker with over 16 years of practice experience. Also in Toronto Dr. Barbara Muskat is a Director of Social Work at the hospital for sick children a child and adolescent therapist at the Redpath center and a faculty affiliate at the factor in When Tosh Faculty of Social Work Dr. Muskat has over 30 years experience as a clinician clinical supervisor and program director in a variety of settings doctors Craig and Muskat conducted a qualitative study to better understand the changing roles of social workers in urban hospital settings. Seven major roles emerged. They were a bouncer juggler janitor broker firefighter glue and challenger doctors Craig and Muskat discuss implications of their research for social work education and for the professions contribution to understanding and addressing the social determinants of health. Dr. Joan Doris assistant professor at the University at Buffalo. Department of pediatric and community dentistry spoke with doctors Craig and Muskat by telephone this is Joan Doris and I'm here today interviewing Doctors Shelley Craig and Barbara Muskat about their work regarding social work roles in health care and the like. Tell us and we both people. Could you tell me a little bit about what your current research in the series about. Certainly thank you for the opportunity. Joan this is Shelley Craig. We can give you a little bit of the back. This research project that we're going to talk about today really emerged from a couple of different situations but it really emerged from some discrepancies that I was seeing in the classroom.

[00:04:17] So I teach software practice in health a variety of classes here at the factory and when Tosh Faculty of Social Work at the University of Toronto and what I noted that quite a few evolve are MSW students were actually doing their practice comes in their internships and hospital settings and there was quite a discrepancy between what they are articulated as their experiences and roles as well as those of their colleagues that were working there full time and what the textbook said the role of any experiences should be so that essentially led me to go out to the community which is where I sort of connected with Dr. Muskat. And now we've essentially become inseparable. But because I thought we're missing something in our education in terms of being able to prepare students and so Barban I thought we would go out to those doing the work. The social workers in

frontlines particularly those in urban hospitals and really get a sense of how they described their role and their experiences as what they felt. The value added was a social work in that context. So we tend to both approach research from a practice based perspective and a lot of the literature around social works was actually written by non social workers. So that indicated to us that this is something that perhaps we could learn more about. And then in social work we can empower those that are actually doing the work. And so we went through the process of we sort of conceptualize just a small.

[00:05:51] At that point qualitative study using focus groups in which we would interview current practicing social workers particularly those on the frontlines in urban hospitals and ask them essentially what I articulated what their roles were they thought how they conceptualize their roles and what their experiences were. And we have found them to sort of get into this but with the social workers were very engaged. And again we have an unfunded study so far brought the chocolate home but we were actually a little bit surprised by the number of women who had to do much recruitment by the number of hospitals that had sort of brought their social workers together and said we think this is a great opportunity. And so we actually have now eight list of hospitals and health care settings that want to participate in this study and sort of the next phase of the study that's sort of where it came from is essentially the lack of research in this area as well as student experiences in both Barban and I come from Barb is currently. Someone who's on the frontlines. I was in emergency room social worker and the rehab social worker in Florida for many years. So we both come at it also from our experiences as well. So a little bit of the backstory. Can I just want to add Mrs. Barbara Muskat speaking that I'm the director of social work here at the hospital for sick children in Toronto and what I was hearing from the social workers on Martine's was an uncertainty about what their role had become if they had come into the roles at a time when psychosocial support and helping people cope with illness seemed to be the way they conceptualize their role.

[00:07:37] But with the rapid changes in the medical system with the impact of social determinants of health being larger than ever in our Canadian medical system they found that the rules were changing dramatically and they didn't quite know what to do with that and how to incorporate that into their identity as social workers and medical social workers. So I think what's kind of quite unique about this study is it came from the different directions it came from researchers brains it came from students discretion and it came from practitioners concerned. What's striking to me about what both of you said is it sounds like we're in a period of flux in terms of medical social work. That's the research that's out there really doesn't describe what we're doing and that's what's happening is sales is shifting. And what I was wondering is before we move forward with Conal tell me a little bit about what historically that role has been and how it's described in the research so that we can have that as a basis we're looking for that what you're seeing in your work with where it actually works for people. Well this is Barb's speaking. I think that what you read about is roles of more clinical direct work where social workers would be working one on one with patients or their families or running groups or providing more counseling or psychosocial support to adapt to medical situations. And maybe a little bit would be said about advocacy on behalf of patients and families in terms of rights and benefits. But I know that in Toronto Harpe population has shifted.

[00:09:25] We have many many many newcomers people who have no benefit no health coverage no finances no home and because we have a system of medical care that everyone is invited in to be part of the medical system when patients are in the hospital and they have no money to pay for drugs and no place to go when they get out and no money to buy food for the family. It all shifts down to the social workers. We are really again that safety and that was once written about in the literature for such words. But we have become a huge safety net with some fear of role encroachment by other professions on the traditional work that we did. So lots of other people in hospitals would like to do the counseling. Very few people want to go and find medication coverage. So that's from the practitioner point of view. I don't know Shelley if you want to add to

that. No I would tend to agree. So the literature address some of the roles that social workers are continuing to fulfill. For example assessment in some cases advocacy. But I think there's a shift in the approach and the amount of time that social workers are able to spend on those. And Barbara it indicates the fact that issues of counseling in particular we noted that some of our study participants that had worked in hospital settings for a significant time felt like there was a significant shift. They used to be able to provide counseling and they really shifted to crisis management. And I think one of the other things that has really changed the nature of social work delivery here. And I also believe in cross North America is this sort of real shift into professional are into collaborative care as well. Essentially there are very few standalone social work departments and so everything is sort of merged into these into professional teams.

[00:11:28] And that in and of itself even if social work rules were clear in a departmental framework they are no longer nearly as clear in interprofessional care framework. And so sometimes the group of practice in the delivery of services relate more to the relationships between team members and sometimes in terms of what social work delivers and sometimes a little about the specific occupation or upbringing. So I think that those and then that then has opened up I think this idea of role creep that Barb addressed in a really interesting way for social work as well particularly for some of them higher status roles that social work can fulfill in healthcare settings. Addressing some of those roles one of things that I find interesting for a lot of people might like to do some people from other disciplines. You hear a social workers saying this. Those other professions are as can do them as well. Are they as prepared for those roles in the medical setting. I can say this. I can say that there is a belief out in the world that anybody can lead a group and are social workers fight this all the time that how we believe one facilitates a group and empowers people to group is different have other allied professionals think about leading groups which is often really educating people in a room. But there is a real belief that anybody and everybody. You really don't need preparation to lead a group and therefore other people can lead. So that's one example. And also kind of counseling. I mean how people consider counseling is another piece where other groups are feel that they can do it.

[00:13:18] And finally we're beginning to see that a group that you wouldn't expect occupational therapists for instance are very interested in learning CBT for instance because they believe that that should be part of their role. So yeah we're seeing it across the hospital from a number of different groups but nobody else wants to like help people with the very practical day to day things. Very few people are wanting to do that. Right. There are only certain role that other professions seem to want to take that social work is always doing. And I think that the nature of a sort of delivering social work services in essentially a medical model which is a host organization isn't always necessarily understand the delivery of psychosocial services then sometimes create the situation where social workers have to clearly articulate what their roles are and what their skill sets are because it isn't necessarily a perfect fit or even feel like the best fit. You know it's certainly important to have Siglo social services and health care settings but still sometimes for the social workers that are actually physicians it's a little challenging because you have to negotiate a system that doesn't quite understand in many cases what you do or what you can bring to the table. That sounds like some of the important steps this work is just helping us to articulate what it is that we can do. You mentioned health settings so one of the things that was curious about is citius social workers talk about in the States at least we're seeing some shift more towards integrated services not in a huge way yet but it seems to be the trend. And I wondered if you are seeing that.

[00:15:05] And if so is that changing a sense of post setting to become one of the hosts or is it not there yet. This multidisciplinary versus integrated at this point. Well we're starting a move to community based health of mental health. Combination programs called Community Care Access Centres. There are some functioning. I wouldn't say they're fully functioning. The move is to move as many people out of acute care settings and into the communities because of cost savings. And I

don't think we have enough information yet about how they're going although one of the groups that does on our waiting list is one of those groups to go and speak with. They're very interested in speaking with us about their roles. So we don't have anything yet but maybe in a year we might have some more information about that you've both mentioned the way will the Kenyans tell me a little bit more about that. Are these social workers who want to meet with you. Are these actually institutions that are saying we need the information you're getting from this work in order to do our work better. This Shelley essentially it's both. Right now it is I would say weighted more heavily in the direction of social workers wanting to share which is great actually what their what their rules and experiences are. And we tend to believe that the practice implications and certainly that any policy implications should emerge from the people that are doing the work which are the frontline social workers as opposed to some of the university setting per se so that those kind of partnerships are really what we're looking at I think.

[00:16:59] And I just had a comment about the previous discussion about integrated care. I agree that I think that here in Canada we're not necessarily there I know in the States there's quite a bit of discussion of integrated care in sort of theory but in practice it still feels like it's very much still the medical model that's dominating it. So in many cases the social workers although mental health and psychosocial issues are important they're not nearly as important as the sort of strict medical diagnostic approach. So I think on paper it looks fantastic. I think in practice it's not quite there yet. Don't know quite what that will look like so social workers in those kind of models are still having to sort of assert in many cases why it's important or why the social determinants of health for a particular patient need to be factored in to the integrated plan. So I feel like there's definitely a ways to go with regard to that model. Oh yeah I think that's certainly what I see and hopefully this work that will move us in that direction. Can you tell me a little bit more about the specifics of the study. You mentioned you did focus groups. It was a convenient sample. Did you have a theoretical underpinning that was driving this or is this more practice driven. It was really practice based research used the community based participatory research model and keeping it open for such an exploratory study.

[00:18:35] As we move forward we'll certainly be using I think some stricter approaches and the majority of our participants were just the kind of briefly describe them about 85 per cent their highest degree with an MSW and then followed by a DSW and about 2 or 3 percent had a Ph.D. or so highly educated and we went to seven urban hospital settings participants Ingrid 65 participants total but these are also health social workers that had worked in healthcare services an average of almost 12 years. So that certainly indicates I think a group of individuals that are specialists and incredibly knowledgeable but also probably have seen a shift in some ways in the approach to healthcare services as well. So in terms of our sort of general hospital here in the Greater Toronto Area. So that was sort of our focus. We wanted to essentially keep it manageable because we weren't entirely sure how interested some of our participants would even be in chatting with us despite the fact that Barbara is a very nice chocolate. But I think the other pieces been interesting barbs being that we with their hospital settings that are affiliated with a University of Toronto. So we have colleagues in these teaching hospital settings and it took very little effort to sort of go to one and then others would hear about it. And so it really is a bit of snowballing in a way. But other hospitals and we tried to kind of be varied between different things like the hospital sometimes have different slightly different focuses. So we tried to get some variation in there but the quote waiting list is really other hospitals that have heard about it and said We'd like to speak with you as well.

[00:20:34] So and we had one very interesting experience which isn't contained in our findings but we have a colleague who's in a hospital in Halifax which is quite a distance and we did an online focus group where we were in Toronto and their group was in Halifax and we did a focus group with him over conferencing software. So it sounds like one of the things he brought up rolling on was the idea that that research shouldn't just be coming out of universities and it's interesting here

that you have so many practitioners who are saying we want to contribute to this knowledge base and we have an interesting and important thing to say to help widen the knowledge base and it sort of sounds like Gee I wonder if more if this were happening what we would be learning from it again they know best. So that's very much a vitamin averages talking about this the other day this is Sheli and it's really I think we think of very social work as approach to research go to where the client is for the purposes of this research that is our expert is the person the frontline social workers actually doing the work and I want to mention that when I was talking about sort of the basic demographics that the social workers that we spoke to were in all different units and settings within the hospital. So ranging from the emergency room to rehab units and so the themes that we found about the particular rules really were applied across the different hospital units which was actually something that surprised us a little bit. For example we thought the theme of one of the themes was social work role as challenger which isn't particularly surprising perhaps that would be something that we would see more frequently in emergency room social workers and that was not the case. It wasn't.

[00:22:26] It certainly was for emergency room social workers but we also felt we also found that the social workers that were working in long term care for example also felt like they had the challenge to make sure that the patient needs and their psychosocial issues were actually factored into the overall case plan and some discharge plan. So that was a little surprising. Can you tell us a little bit more about the major things that you found in your research so I can start those. But Barb certainly jump in. So we actually had there were seven major roles that were discussed by the social workers and hospital settings. And I want to be clear that the language that they use so the names of the roles actually emerged from the social workers. Now anyone that's worked with the hospital social worker knows how creative and innovative they are. So it wasn't us. So the title of the role actually were and let me just quickly list them and then we can talk a little bit about what we found. The most surprising or interesting but the role of bouncer the role of janitor the role of glue broker firefighter juggler and Challenger which I addressed before and with regard to the first one. We were a little surprised that the participants again in all the settings used the language of bouncer's because that is not I would argue something that we really teach social work students at least in my class a bit about how to be bouncer's in some ways this could be similar to perhaps what have been described as mediators or arbitrator's in some cases in the other social work role literature.

[00:24:11] But the role the bouncer particularly for these urban social workers was really much more. It was like having to forcibly control the setting. So it was essentially taking people out of families out for example. Certainly in times of a health crisis families come to quote unquote support their family member that's in crisis. However they're under so much stress that I would say some of those perhaps negative patterns emerge and so families can get hostile families and start fighting things can't happen because of the stress of the situation. And so quite a few the social workers talked about having to really work with families and work with individuals to quickly and assertively control a setting. And so that was one that I think we found a little interesting and again made me rethink some of the ways that I was discussing social work rules in my classes. That next one was janitor you know janitors kind of work is very important in organizations but they usually have to clean up the mess without getting a lot of thanks. And we like to talk about my favorite quote which is that social workers have to get the pants. And we weren't sure if that man initially but there were lots of people especially an adult hospital settings to come in and they've been living in shelters or on the street. And when they come in people get rid of their clothes. So it's the social workers who have to come and get them. And they have closets full of clothes. Now to get to their patients and literally I mean this stuff it's sort of less pleasant less clean less clinical the leftover problems.

[00:25:56] It's the social workers who come in in like mop it up and they're not seeing for role and they're not dismissing it but literally it feels like a janitorial role. We actually even heard social workers describing going to people's homes and cleaning up their homes so that the families can go

home after discharge so that the janitor Rayle was another one that I would say doesn't appear in the textbooks. And I wonder to what I was thinking about is those kinds of tasks that you're mentioning like custodial work often don't get noticed until they're not done. Exactly exactly thankless and under appreciated often. Absolutely right. And within that it was also articulated that was sort of interesting is that the social workers were sort of conceptualizing this in a way that they were sort of protect the other staff from having to deal with these unpleasant issues that Barb was addressing which is sort of interesting I think. Very interesting. Yes exactly. And so this particular role was one of the rules that so within this sort of cholesterol there were roles that some social workers felt very proud some of the higher status roles. And this was one of the lower status roles within that that they sort of talked about sometimes through gritted teeth. But the feeling was is this is something we have to do to sort of maintain our place works in some cases even said that to keep our jobs within their healthcare settings which again was sort of interesting fish. Why don't you get one of the nicer rules. OK. So glue right. So another rule that was articulated.

[00:27:39] And let me just read a quick sentence about that is this idea of glue. So the participants really said at one particular participant that social work is the glue to organize and hold all of the family meetings and hold all of the communication together and pulled together the discharge plan. And I also have to provide consultation to that are sometimes beyond the social work role to the members of the interprofessional team. So this is also related to you and another participant said within interprofessional team I have to debrief both on a personal level and sometimes I feel like their counselor and then do the same thing with patients too. So the discussion of glue was certainly a discussion of what we witnessed perhaps as the job which would be covered in more or less the job description. So holding the patients and the families and the treatment plan together. But in addition there was this sort of secondary use of the idea of Gutu of providing that support as well and really being the glue that holds the interprofessional team together. And so this second one was sort of an implied or yes certainly an implicit another implicit expectation. I believe that is what if there's any sort of conflict within the interprofessional team or if perhaps the doctor is having a hard time with his or her adolescent than they sometimes come to social worker and talk about some of the personal issues that are happening within their lives and those secondary expectations of Gulu and support within the interprofessional teams.

[00:29:18] Again not things that are captured in job descriptions or in the way that we look now at patient outcomes or in the way that we look at our time but certainly they take up a great deal of energy for services as well. So the idea of being glew was certainly one that they held in high status but it was really interesting that then during that discussion that kind of split into a sort of the related job expectations and then this sort of secondary implicit discussion. And I'm struck by as I'm hearing you pulse that this may be one of the really important things in the work that you're doing is to start articulating all these implicit roles because yeah it's difficult to think about how an interdisciplinary team can function without somebody monitoring the health of the functioning of the team. But who else on the team has the skill set or the inclination to do that. And so by articulating it is the first step towards losing it from implicit to explicit acknowledge and appreciate and makes me think to of some of the gendered ness. Mmm. Excellent point. And do you want to speak to them all. I think you've essentially said it because it is a profession in terms of the frontline that's dominated by women. Certainly the majority about 90 percent of our participants were. And so that then lends itself to what the gender expectations are as well. I think that's something we need to consider when we're discussing this because it is an expectation I think for women. And then we sort of layer on that it's an expectation of social workers and then perhaps we wonder why people are burned out.

[00:31:10] Also you know in addition to the gendered part of it it's also you know we're very much not the primary service delivery people I mean we always have to remember we're like I don't know we're not even secondary we would go like at most hospitals doctors and nurses in the primary

fields and we're somewhere in the next line of things. So now we feel like we're a little bit like still some of the gaffed staff. Yeah. Which is interesting given the more research we do the more clear it is that behavioral health and physical health are inextricable and in spite of all that research and all of that knowledge. It's not translating into practice. And I think it hasn't necessarily made it leak has certainly it's been a few radical underpinnings are in the textbooks. But how that rubber meets the road in what you do need the textbooks. I think right. And the use of those skills in high pressure environments. So some of them could be maybe what we would expect to be more typical social skills for example. This idea of Broecker which has been found in social work generally but is also certainly with regard to our participants but the description of Broecker which included certainly discharge planning really included the fact that they had to do this quickly. They had to really broker services quickly oftentimes in families that they would only see one time and so that I think is also certainly that covered in the textbooks but how to do that in teaching students and teaching practitioners how to do that in an incredibly efficient fashion. Because that's the expectation. And one of the other interesting findings around this idea of Broecker which again was quite a bit the discussion of discharge planning in the end.

[00:33:11] Croque here and delivery of tangible resources other professions and other disciplines are certainly moving into this discharge planning arena. I know that certainly happened in many cases in the U.S. and that's certainly happening here. But the concern was that discharge planning it was some people were fairly ambivalent and some felt strongly that Social Work should be involved and does discharge planning it wasn't one. It's not a particularly high status role for social work but many of the social workers that we spoke to really articulated this idea of risk discharge planning and really providing durable discharge plans so that there isn't this idea of quote unquote frequent flyers that come back in repeatedly which are often the more vulnerable populations that we contend with in healthcare settings. And this was really something that was articulated as something that acquired quite a bit of training around psychosocial issues. And again the Social Determinants of Health to really assess risk and enhance the idea of durable discharges so that there isn't a revolving door. And we can really facilitate healthy discharge with folks that continue to have an upward trajectory once they leave the hospital setting and aren't compromised because we're essentially pushing them out by completing a checklist and handing them some flyers. So that I thought was interesting but also this kind of discharge planning takes longer. I think some of the more traditional ways that we would think about discharge planning that I thought was fairly interesting as well.

[00:34:44] And I was just going to say that along the lines of the broker role which is you know something we're more comfortable with the role of firefighter is something else that we're so comfortable with because I think one thing we do train our students in in most social workers are comfortable with it. Crisis intervention. So you know we are kind of trained to put out fires. I think in medical setting fires can be slightly different but the people we spoke to really talked about it when you need to run in immediately and help people. So somebody is suicidal or something's going to happen immediately. We're very good at dropping everything and running in and that's something that I think crisis intervention is something that social workers have been doing for years and the social workers said they've been doing it for years but perhaps maybe with the increase in the quantity of work and the less money in the system there's more crazies and more fires to put out there definitely was the recognition that they spent a greater percentage of their time than they used to. For those that have been in the system for a long time dealing with these fires and doing crisis management and much less time in sort of this other idea of sort of general counseling provision in the way that it normally conceptualize. So I think that really gets to the changing nature as well as the funding that Barbara simulative certainly is an area to serve. We're losing more and more towards crisis instead of prevention. I just want to make sure recently getting the last two rules. So Shelley I want to take an extra juggler. Sure. So just this idea of juggler the fact that the health Kushel workers were expected to transition between multiple roles from firefighter to glew quickly

and seamlessly to the pressures of the hospital environment.

[00:36:46] So just having to be a juggler. So one of the participants says I have to constantly have one hat on at the right place at the right time. It's very different depending on what I am doing or who am seeing. So then in a minute you practice something else. So that was kind of interesting the need to again articulating the need to move rapidly within the. And the final rule which is not surprising for social work is a challenger. So that's that advocacy you know helping challenge system healthy to go out in the community and advocate. And I think that's something that again is comfortable with social workers. That's what we're trained to do. It's being seeing things from the point of view of the patient and to me and helping to articulate that in the system. So those are the kind of more macro rules that I think we're trained to do and we're more comfortable then being janitors and bouncers anyway. So trying to figure out just sort of what's next with this one fuselages. Again there seems to be great interest in people to speak about this. And then a question of what we do with it. As Shelley mentioned in the beginning this is unfunded from our hearts research. So we would love to find a funder because we feel it's important research and then we're curious how these roles hold up across the country maybe across the border in both situations. And then to see how we can take this and think about the education and preparation of future social workers in health care settings.

[00:38:22] And I suppose also advocacy about this to help social workers in their cities define what they can do in a way that other professions do. And I feel that social workers may not do as well. I think we're really good at empowering our clients. And I think we're very good at helping other people define who they are and what they do. My beef is I don't think we're as good as we're not as good doing it for ourselves. Shelley and I would of course completely agree with that and I think that occasionally in the course of the focus groups there were a few people that were initially a little ambivalent. They said why are we talking about ourselves. Shouldn't we really be talking about patients or the vulnerable families that we're serving. And then there was that sort of a recognition that if we're not in a healthcare setting or if we are not able to clearly articulate what it is that we bring to the table then there will be less support for those vulnerable patients and families. So I think we're a little bit harder to conceptualize and advocate for ourselves sometimes. I think that that is something that the certainly the university affiliated folks can help bring to the table and we are really looking also at now that we have a sense of how the health social workers articulate their roles then really move into what the value add is in health care settings because there was again with a lot of our participants and we hear there's still a lot of anxiety about the future of Social Work and healthcare settings.

[00:39:58] So there's some concern about how secure they were and in many cases well-founded because of a lot of the budgetary challenges. So in order for us to continue to move forward with some of this advocacy piece we want to really think about operational and figuring out what the value add is. That's different than other professions related to our training and then start to operationalize the value within these settings both to patient as well as for the over organizational settings. So that's essentially part of our trajectory is we really want to help social workers and work together with social workers. And on the frontlines in healthcare settings continue to move forward in defining the roles and the skills required so that we at the university level can certainly support them in amazing work that they're doing as well for vulnerable children and families. Well I think that that is these are really important foundational piece of research that if we can't define it then we can't articulate it to anybody else. We can't as you put it you can't attach a value to it. You can't explain it to anybody else. And one of the things I was thinking about is that has the impact patience for education. How can you teach if you can't define it and how can you research it. I think about biological sciences if you differentiate one kind of tree from another you can't study them. You know you need to know we're talking about this species. This is what social work in medical settings. And but what is the thing that seems really profound about the implications of your work

are the policy implications both small. What is our hospital policy.

[00:41:49] Our clinic policy on social work services and also the broader public policy implications. And I wanted to take a little while. We completely agree that there are some significant policy implications. We're not I would say a couple of things. We're not entirely sure what those could be. I think because part of it will be the way that you describe it really as we are able to define and articulate our value then there will be policy pieces in terms of really being able to push for inclusion of social work across health care settings and then ultimately defining what we do and what we bring to the table so that we're clearly able to articulate that so that we're included more frugal in budget and budgetary discussions and then from that able to significantly impact some of the more vulnerable populations and their social determinants of health and we think that there are also some prevention implications. Even though the health care settings are really just dealing with the crisis and intervention management we think that there also could be prevention implications as well. That comes from this even in dealing with populations that might not be at this point chronically ill figuring out how to incorporate social work more frequently for example into maybe a school clinic settings to really address the social determinants of health. And that kind of thing we do think that there are certainly policy and policy practice implications as well.

[00:43:25] I do feel like we're so we just want to make sure that what we do with always rooted in the actual perception and work the front lines those workers that are actually doing the work so that those policy implications would have to be derived from or arise from our continued work with our hospital partners as well. The only other thing that I think that this is because we've become so aware of the impact of the social determinants of health we're still not that I agree all that the prevention possibilities that are out there. Because I think we're still being caught in something of a sign on there where you know you're poor planning does not constitute my emergency. But we actually are caught up in that fear because we're not planning and thinking from the earlier phases or from a prevention kind of model. We do end up with crises to deal with at the last minute. And I think there is great policy work that can be done to think about what we can do. Earlier on in the process rather than having everything be it a dramatic clean up act at the end when are the other implications. I see is for the Larcker field I wonder if globally we're in a place where we could be thinking about defining and articulating who we are and this work can contribute to that broader conversation as well. I agree and I think it's funny that hiatus between degrees and a 25 year hiatus between my MSW and Ph.D. and looked at our professional literature about our identity for a long time. But what I remembered was what I learned 25 years ago that the social work was a Samie profession and not a nice but we were still defining the profession which I find interesting. We can't quite get ourselves to a point where ever thinking of verse as a profession.

[00:45:25] I think our identity we are a field full of heart and full of desire to do the right thing. And until I think we're all over the place with what our role is and who we are. I think if we did this study with people in community mental health settings we might hear the same thing possible we hear very similar responses. I'm not sure but I think it would be interesting to move you know into other settings and outside of North America just to hear what we hear and see. We're all in the same boat in this regard. It's true. And this is surely what I do know. Although Canada is doing fairly well in at least starting to discuss social determinants of health. Although I would argue that social work is we are not leading that charge. I do think that other countries particularly some of the European countries are really starting to discuss social determinants of health and social work and probably increasingly thoughtful way. So it would be I think really interesting to really talk about some of these issues internationally and sort of identify what different what the various countries are doing related to. Certainly schools of social work but also current practitioners and how they are addressing the social determinants of health in their actual practice. And I'm sure that there's a great deal that we could learn from many of those countries as well so that is certainly hope that we have. I really appreciate your time here today and looking forward to hearing more about where we take

this work. Thank you so much. You've been listening to Dr Shelley Craig and Barbara Muskat discuss their research on the changing roles of social workers in medical settings.

[00:47:11] Thanks for listening. And join us again next time for more lectures and conversations on social work practice and research. Hi I'm Nancy Smyth Professor and dean at the University at Buffalo School of Social Work. Thanks for listening to our podcast. For more information about who we are our history our programs and what we do we invite you to visit our website at www.socialwork.buffalo.edu. At UB we are living proof that social work makes a difference in people's lives.