Bouncers, Brokers, and Glue: The Self-described Roles of Social Workers in Urban Hospitals

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Social workers delivering services in health care settings face unique challenges and opportunities. The purpose of this study was to solicit input from social workers employed in urban hospitals about their perceptions of the roles, contribution, and professional functioning of social work in a rapidly changing health care environment. Using qualitative methods, the university and hospital-based research team conducted seven focus groups (n = 65) at urban hospitals and analyzed the data using an interpretive framework with ATLAS.ti software. Seven major themes emerged from the participants’ description of their roles: bouncer, janitor, glue, broker, firefighter, juggler, and challenger. Along with descriptions of the ways social workers filled those roles, participants articulated differences in status within those roles, the increasing complexity of discharge planning, and expectations to provide secondary support to other health care professionals on their teams. Implications for practice and research are discussed.

KEY WORDS: hospitals; qualitative research; social work practice; social work profession

Although social workers have delivered services in North American medical settings for over a century (Globerman & Bogo, 2002), they currently face unique challenges and opportunities in a rapidly changing environment (Kim & Lee, 2009). Health care is facing many challenges, such as funding shortages, added costs of life-saving approaches for chronic diseases, increasing expenditures related to medication and hospital visits, and more patients with complex health conditions using added services (Naylor & Naylor, 2012). It is increasingly recognized that the social determinants of health and the associated health disparities cannot be addressed without intervention in the social circumstances of patients (Schrecker, Chapman, Labonté, & De Vogli, 2010). This is a role that, historically, has been filled by social workers in the health care system, yet the pressures of changes in health care influence service delivery in the current context.

Health social workers (HSWs) bring a holistic perspective to health care practice, by incorporating a full range of psychological and emotional factors (Rachman, 1995) and by focusing on the social aspects of illness (Volland, 1996). Social workers are trained within an ecological perspective, which asserts that individuals function within larger social systems (Claiborne & Vandenburgh, 2001), and use a biopsychosocial approach, which emphasizes understanding a person within the context of his or her environment (Berkman, 1996; Cowles & Lefcowitz, 1992). HSWs work collaboratively as part of institutional and community interprofessional teams to support recovery, to promote quality of life in the context of chronic illness and disability, and to advocate for societal change to address social disadvantages (Praglin, 2007).

Although research conducted by social workers about the profession’s impact in primary health care settings is limited, physicians and nurses have identified critical social work skills, including strong assessment and problem-solving abilities, with possessing knowledge to positively affect systems and properly use community resources (Geron, Andrews, & Kuhn, 2005; Scharlach, Simon, & Dal Santo, 2002). It has been suggested that HSWs tend to identify many more patient psychosocial problems than do their physician peers (Mizrahi & Abramson, 2000); are closer to service users, when compared with experts from other disciplines (Herod & Lymbery, 2008); provide a continuum of patient care coordination and support (Keefe, Geron, & Enguidanos, 2009); are crucial in what they offer to medical interdisciplinary teams; and provide services that other health care professionals do not address (Herod & Lymbery, 2008). Furthermore,
clients identify the functions of HSW as building relationships, displaying empathy, offering practical assistance, and acting as advocates, which are critical components for the social work role (Gibbons & Plath, 2009).

In health care settings, social workers have often focused on specific tasks such as assessment (Gehlert & Browne, 2006), yet social workers’ roles have been found to be defined by their interactions with other professionals (Bywaters, 1986), often resulting in a discrepancy between self-ascribed roles and those assigned by other colleagues. In fact, most professionals are unfamiliar with the rich variety of services provided by medical social workers (Frost, Robinson, & Anning, 2005). Physicians do not always understand social workers’ roles as they relate to patient care and tend to rate their interprofessional collaborations differently than social workers would (Mizrahi & Abramson, 2000). However, through occupational boundary maintenance (Lymberry, 1998) and existent hierarchical structures that perpetuate a lack of understanding regarding the value of various professions within health care settings (Baum, Begin, Houweling, & Taylor, 2009), it has been suggested that an undermining of social workers’ roles has been legitimized by the medical profession’s dominance in terms of power and status (Davidson, 1990). HSWs need to be able to clearly articulate their roles and responsibilities within the medical teams (Lymberry, 1998), to both internal and external parties (Egan & Kadushin, 2004; Mizrahi & Berger, 2005); to advocate for a distinct social work domain (Davidson, 1990); to develop health care providers’ awareness of social workers’ roles in enhancing vulnerable patients’ care (Keefe et al., 2009); and to improve overall patient outcomes (Wagner, 2000), as well as advance the provision of services to vulnerable populations, who are often considered to be the most resource-intensive users of the health care system.

Despite the apparent value of services provided by HSWs, little research exists about social workers’ perceptions of their roles within health care settings. Encouraging practicing social workers to define their own roles may provide opportunities to accurately advocate for the importance of social work in such settings. This approach “begins where the worker is” to construct a profile of professional roles and needs that emanates from the frontline professionals most intimately engaged in the activities under study. For example, frontline child welfare workers were recently questioned about their roles, the perceptions of their contribution to the discipline, and their overall experience (Hughes & Lays, 2012) to strengthen national advocacy efforts. The authors anticipate that social workers’ role definitions specifically focused on urban hospitals would support a different conceptual contribution than traditionally described roles within the social work literature and suggest that HSWs in medical settings may have different roles than social workers employed in other types of social services agencies. Such a conceptual contribution not only sheds light on the roles of HSWs in urban hospitals in a rapidly changing environment, but also helps lay a foundation to further understand the relationship of HSWs to patient outcomes in a time of increasing complexity within the health care system.

METHOD
Study Design
To deepen the understanding of the meaning that HSWs ascribe to their roles, qualitative methods were used (Denzin & Lincoln, 2005). Such an approach extracts details that are more challenging to ascertain through quantitative methods (Strauss & Corbin, 1998). Focus groups were used for data collection (Morgan, 1997), with group interaction explicitly used as part of the method (Kitzinger, 1995), as focus groups allow participants to express their thoughts and ask questions while also challenging each other’s ideas, thus allowing similarities and differences among members to arise and be analyzed and compared. McCracken’s (1988) in-depth interview method and an interview guide that contained open-ended, semi-structured questions were used to elicit rich description using the participant’s own words, to give them latitude to convey experiences relative to their individual perceptions and style of presentation, while being prompted to remain within the scope of the interview topics. Finally, an iterative process informed modifications in the guide as data were collected and analyzed (Charmaz, 2006).

Recruitment and Data Collection
A large city in Canada was chosen for the study as it contained multiple hospitals employing many HSWs. A purposive sampling method was
used; however, effort was taken to ensure that focus group participants encompassed enough diversity of opinions to stimulate discussion, while being similar enough for members to compare ideas (Barbour, 2005). Participants were recruited through contact with social work practice leaders in hospitals who distributed an informational flyer to social workers in their settings. The focus groups were facilitated by two-person teams: a member of a social work faculty and a social work leader in a hospital. A research assistant was also present in the groups to document group interaction (Rothwell, 2010). Group sessions lasted between 45 and 70 minutes. The study was approved by the research ethics board at the principal investigator’s university. Seven focus groups (n = 65) were facilitated in seven different settings. These settings included hospitals serving adults, children, and patients with medical and mental health issues and encompassed staff who work with a broad variety of medical conditions. One additional focus group was convened at a provincial conference on social work in health care, and information about the focus group was advertised in conference materials. Before the start of each group, each participant completed a consent form for participation in the study and for audiotaping as well as a demographics questionnaire.

Study participants represented a range of professional and demographic backgrounds. The average age of participants was 43.07 years (SD = 14.02) and ranged from 22 to 65 years. Participants identified as female (87 percent) or male (13 percent), and as heterosexual (91 percent) or sexual minority (9 percent). Race and ethnicity were reported as Caucasian (75 percent), Asian (12 percent), mixed (9 percent), aboriginal (2 percent), or African (2 percent). Responses about the highest level of education achieved indicated that MSW (83 percent) was most frequently mentioned, followed by BSW (13 percent) and PhD/DSW (2 percent). Participants had worked as HSWs for an average of 11.83 years (SD = 10.63), ranging from two years to over 20.

Participant’s job titles included social worker (66 percent), professional practice leader (10 percent), advanced practice clinician (9 percent), counselor (9 percent), and case manager (6 percent). Although quantitative data were not collected, participants identified qualitatively that they worked in chronic care, rehabilitation, emergency care, outpatient counseling, oncology, and cardiac care. In terms of job duties, most HSWs were conducting assessments (61 percent), followed by carrying out advocacy work (42 percent), counseling (35 percent), case management (33 percent), and research (9 percent).

**Data Analysis**

Interpretive description was applied as the analytic framework for the study. Interpretative description is commonly used for small-scale qualitative studies of clinical phenomena because it focuses on understanding individuals’ experiences and grounds these experiences within the context of practice. The ultimate goal of this framework was to generate ideas that contribute to clinical practice (Thorne, Reimer-Kirkham, & O’Flynn-Magee, 2004). All interviews were audiotaped, transcribed verbatim, and uploaded into ATLAS.ti software (2010) for data management and analysis. Transcripts of each session were analyzed by three coders. Codes were constantly compared with each other and across interview transcripts, and connections between codes were identified. Codes were combined and transformed into categories and emergent themes. A systematic and thorough investigation of the data moved it from a level of description to that of analysis (Barbour, 2005).

To ensure rigor and methodological soundness, trustworthiness measures were used to ensure credibility, confirmability, dependability, and transferability (Lincoln & Guba, 1985). These measures include prolonged engagement (the investigation team has considerable experience working in the area of hospital social work and together represent expertise in quantitative and qualitative research methodologies), peer debriefing (numerous formal and informal discussions examined ideas and possible preconceived notions among the investigation team), and thick description (generated themes include rich descriptive accounts and quotes that present contexts and circumstances of sampled participants, findings, and interpretations). In addition, an audit trail was maintained by the research team to describe the research process and track research decisions made along the way. Finally, bias in the research team because of team members’ experiences working in urban hospitals was examined through the use of reflexivity and bracketing, which consisted of debriefing after every focus group and bracketing through a frank analysis of the ways in
which their own experiences may have influenced interpretation of the material.

RESULTS
As previous studies have found that role ambiguity is a significant predictor of burnout, and excessive role demands are associated with increased emotional exhaustion among health workers (Zellars, Perrewé, & Hochwarter, 2000), understanding such roles may help to better prepare and support social workers in health care settings. The daily work of HSWs is challenging, and a lack of recognition and understanding of the range of roles from colleagues further contributes to their workplace stressors (McLean & Andrew, 1999). Roles that have been articulated for social workers in health care settings generally include specific tasks such as assessment, case management, advocacy, delivering interventions, and administration (Gehlert & Browne, 2006). With a focus on urban hospitals, this study found some similarities to these existing roles as well as some more vivid clarifications and interpretive description about what they mean to the daily work of HSWs. Seven major themes that described social work roles in health care settings emerged from the analysis: bouncer, janitor, glue, broker, firefighter, juggler, and challenger. These themes are described using the participants own words. All of the quotes were from different participants.

Bouncer
Participants noted that they often had to play the role of bouncer. A bouncer is generally considered an individual who has to forcibly control a setting. Although the role of bouncer does not generally occur in health care settings, social workers described that they felt that they were placed in the position of carrying out similar duties, such as crowd control, dealing with behavior problems, or informing families that a patient could not stay in the hospital. It was particularly interesting that this seemed to be a fairly unexpected role. This role can be compared most closely to the established role of mediator or arbitrator (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larson, 2009); however, it differs in the level of assertion required to fulfill the role. It implies having to take charge and forcibly remove, rather than use diplomacy (the role a mediator would play), to achieve the required ends.

Often on the trauma and neurosurgery floor we get asked to play the role of bouncer and that’s something that I did not expect to do as a social worker. Sometimes that includes mediating very, very challenging moments for families to the best of our abilities but, if we are lucky, is basically boundary setting to help people understand that this is not the time and place for conflict.

The social workers do that decision making when people are acting out. We’re like the traffic cops on the street corner, and all the little cars are stopping and waiting for us to tell them what to do, and we’re really good at it.

Janitor
Participants identified that they often were expected to do the less glamorous work in the hospital, the clean up or the janitorial services, often without thanks or without other professions understanding the importance of these tasks. Most of the participants were not particularly happy with these roles, but the majority identified that they were aware of the significance of these duties and expressed willingness to continue in these roles. The role is most closely associated with the idea of “filling the void” (Gehlert & Browne, 2006), which has been identified in previous discussions of HSWs; however, the role of janitor fully describes a tangible filling of the gaps and a “cleaning up of the messes made by others,” which is a much more succinct description of this expectation.

We have to get the pants. Someone shows up into the emergency room or is ready for discharge, and they need pants. We get them. We now have a closet full of clothes so that we are ready.

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The physical therapists, the occupational therapists, speech pathologists, and nurses don’t want to deal with any of these issues that we deal with, and they feel entitled to not have to do that. It’s like, social work will take care of it, and we do. Many, many times people are okay with letting the social workers do the tough stuff, which they were uncomfortable doing. The more unpleasant work that comes the way of the hospital, and that’s what social workers are at times useful for, dealing with
unpleasant things, less clean, less clinical, left-over problems, I’m not saying that it’s a bad use, it just is.

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We’ve set up homes for families; we’ve cleaned their homes filled with bugs, dogs, cats before discharge.

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We have to find families of a dead person. Seriously, I just had to do that. No family, no identification, and just a dead body, and they call the social worker.

Glue

Participants described the role of social work as the glue that holds all of the patients and families, the treatment plans, and even the team together. Providing staff support as well as patient support was described as important to social work efforts. This system linkage role is essentially a more vivid example than the previously described roles of team member and facilitator (Hepworth et al., 2009).

Social work is the glue, to organize and hold all the family meetings and communication together and all the discharge planning.

I definitely feel like a lot of the disciplines usually come to me for a lot of steps. Not just discharge, but consultations. I definitely feel that sometimes beyond the social work role that they are coming to kind of debrief both on a personal level; with staff as well, I feel like their counselor at times and then with patients too.

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A lot of times families are really angry and need a lot of support, a lot of it is because sometimes their son or daughter or loved one is in a complex system they don’t understand…. I know that that’s a big piece that I cover—keeping them all together by giving them information.

Broker

With regard to linking and working with families, the social worker frequently facilitates communication within families and between the medical team and families. Within this role, participants considered themselves critical links and brokers of information to families and services. This role was articulated as different from glue, which involved providing support as opposed to more tangible and active negotiation of services. Previous literature has identified the role of broker as critical to social work (Hepworth et al., 2009), and the present study reinforces this role for social workers in urban hospitals. Specifically related to case management for the HSWs in this study is the engagement in very complex and active types of community service linkages involved in discharge planning.

Social workers are often the ones who do the transitioning and do it very well from inpatient or whatever into community. We broker resources through discharge planning and navigate all of that.

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The definition of discharge planning in social work is very different than it is to many of the other professions. We should erase discharge planning language as we really do risk discharge planning. Years ago they used to say that psychotherapy was what we should be doing and anyone that is doing discharge planning wasn’t really doing social work. I think that it is something we should embrace, because we do it very well. I think that they need to move people out of the hospital. They don’t want a revolving door, and I think we can facilitate and really enhance the idea of durable discharges by assessing the risks.

HSWs continue to broker services, particularly for patients and their families, through discharge planning and the provision of concrete items, such as clothing. Existing research has found that physicians and nurses perceive the role of the social worker to be focused on enhancing the environmental support and resources of patients, including the patients’ families as part of their support system (Cowles & Lefcowitz, 1992) and using discharge planning to meet patients’ needs (Judd & Sheffield, 2010; Schneideman, Waugaman, & Flynn, 2008). Social work involvement has been found to relate to higher numbers of
discharges (Galati, Wong, Morra, & Wu, 2011). Although discharge planning was rarely articulated as a favorite role among this study’s participants, or a role that they thought they would be providing on the basis of their social work education, the challenges and importance of this role were highlighted in the discussion. For example, the high level of skill required to manage complex discharges mirrored themes that have been discussed in recent literature (Auerbach, Mason, & Heft-Laporte, 2007; Preyde, Macaulay, & Dingwall, 2009). One particularly intriguing finding is the suggestion from several participants that instead of merely helping to free bed space in the hospital, HSWs are actually providing “durable discharges,” meaning that those discharged do not immediately return in acute crisis. These discharges could be understood as “proactive actions that promote positive patient outcomes” (Judd & Sheffield, 2010, p. 32), which might lead to lower rates of hospitalization and fewer readmissions (Galati et al., 2011; Keefe et al., 2009), shorter lengths of stay and premature rehospitalization for vulnerable patients (Berkman, 1996).

Thus, although emerging research explores the continued importance of social work involvement in discharge planning, it may not completely capture the knowledge and skills that were discussed as critical for the types of discharges and durability of discharges undertaken by HSWs.

Firefighter
Participants stated that they were often dealing with crises or responding to requests that required them to drop everything and deal with an immediate problem. Several identified that this was a role that other professions depended on social workers to fulfill. Although crisis intervention is certainly an expected role for social workers (Roberts, 2005), HSWs in this study identified that it was an increasing part of the job in urban hospitals and expressed a certain amount of pride in the reliance of other professionals on social workers for this role and the skill that HSWs brought to such challenges.

Juggler
In addition to the roles already mentioned, participants stated that they had to juggle the various roles themselves as well as the expectations of hospital setting, while managing complex cases. HSWs expected to transition between multiple roles quickly and seamlessly due to the pressures of the hospital environment. This role also identifies the challenges of providing services in a rapidly changing system.

Challenger
Participants identified that they often had to advocate for patients, both within the hospital team and within the community. This role was very important to the HSWs as they described the ways in which they would challenge the medical model within the hospitals to ensure that all of a patient’s needs were addressed by interprofessional teams.
My role is a challenger that champions. Especially serving frontline, in addition to working with individuals and families, certainly advocacy is the key piece of effective work in the community, but I also see my role as an advocate within the team.

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It goes to a point where you have to get into a community action, like social action, because people are not listening, people don’t see what you see, or what should be seen, in a way that should be dealt in safe planning, so you have different levels of advocacy, at some point you really have to take a stand and say “this is what needs to be done and this is how it needs to be done,” and, if it is not, it will be a very unsafe situation for our patients. You know, really working from the patients’ perspective, or you’re going to get that patient back very quickly into the system, in a much declined way, and that’s not what you would want for someone who’s going through a health crisis.

DISCUSSION

The purpose of this study was to solicit input from social workers employed in urban hospitals about their perceptions of the roles, contribution, and professional functioning of social work in a rapidly changing health care environment. There are several significant practice implications emerging from this research. Social workers in urban hospitals inhabit a wide spectrum of roles. We found it interesting that as participants discussed their various roles, they also articulated some differences in perception of status between those roles. Although social work status within interprofessional teams has been investigated (Schneiderman et al., 2008), participants chose to discuss differences in status related to their daily roles and not compared with other professions. For example, roles such as janitor, bouncer, or broker were perceived as having relatively low status and were not considered to require a great deal of expertise. This is contrasted with higher status roles such as glue or challenger. When articulating the role of glue, HSWs identified that social work is a critical component of the functioning of both interprofessional teams and the work with families through keeping all of these complex relationships intact. A challenger was an advocate for the needs of patients, both in teams and in the community. Such higher status roles may also reinforce existing ideas of social work identity described in documents such as the Code of Ethics (NASW, 2008), which outline the responsibility of social workers to advocate for vulnerable populations.

In contrast, lower status roles, such as janitor, may not align with the way that HSWs conceptualize their professional identities. HSWs do not seem to highly value concrete service delivery, even though social workers are directed to champion the needs of vulnerable populations, who may indeed have tangible needs. We would suggest, however, that these low-status roles, which seem to be maligned by some of the research participants and not championed by current social work educational initiatives, are quite important and often difficult to successfully fulfill. For example, the role of bouncer, removing and de-escalating a hostile person in a highly stress-filled situation, requires a high level of skill in conflict resolution. As such, perceptions of status associated with social work roles in hospitals may have a relationship with professional social work identities.

This study found that primary social work tasks such as brokering services and support for families and patients, often in the form of discharge planning and crisis intervention (Auerbach & Mason, 2010; Bristow & Herrick, 2002), are part of the daily roles of social workers in urban hospitals. However, increasingly, HSWs are expected to provide a secondary level of services to other disciplines that are not necessarily easily tied to patient outcomes. Participants provided examples such as supporting the interdisciplinary functioning of the team, acting as a therapist for team members, resolving intergroup conflict, and managing these relationships while advocating for the needs of vulnerable patients and their families. Previous research has found that social work facilitation of collaborative relationships is necessary to meet family and patient goals (Bristow & Herrick, 2002) and that social work within interprofessional collaboration is particularly critical for vulnerable clients (Mizrahi & Abramson, 2000). The participants in the present study also recognized and valued their participation and contribution to those efforts. Such participation might require extra effort because such activities are generally not recognized as part of their job descriptions, not counted in workload statistics, and not appreciated during performance evaluations. Such involvement could add to the stress already experienced by HSWs, and the
influence of such implicit expectations of their roles, particularly on patient outcomes, may need further investigation.

Finally, our study suggests that despite a wide range of titles and years in hospital settings, HSWs are fulfilling critical roles with a focus on urgent basic needs regardless of specialization, department, or specific hospital setting. Examples of this include brokering services or “firefighting” crises. Such themes emerged from all focus groups, despite the variety of settings. For example, the ability to negotiate and engage with families and teams as “glue” was important for all HSWs, regardless of whether they worked exclusively with pediatric patients or with adults in emergency room settings. Such findings provide a greater understanding of the importance of developing those skills in professional training and educational opportunities and valuing their presence within health settings.

Limitations

Despite these findings, the present study has several limitations. Notably, this research was unfunded and, thus, concentrated on one urban area with an abundance of MSW educational programs and hospitals. In addition, the researchers conducted the focus groups during typical business hours because those were the times social work had the most coverage, but as participation in the focus groups was voluntary, not all HSWs attended, so all opinions are not represented. Such limitations should be considered in the context of the findings that emerged from the engaged participants.

Recommendations for Research and Practice

The findings from this study suggest that HSWs in urban hospitals are fulfilling a wide range of important roles, yet in a time of shrinking resources, their activities are more focused on meeting immediate needs, with less available time for counseling or treatment planning. As funding, reimbursement, and professional expectations continue to focus on service efficiency and best practices, social workers should strive to demonstrate that their efforts effectively and positively influence patient outcomes (Judd & Sheffield, 2010). Partnerships between community- and university-based researchers using a practice-based research approach, such as those used in this study, can assist HSWs to identify their value to patients and to the overall health system.

Further investigations should try to understand the expectations placed on HSWs to provide psychosocial services to members of their own interprofessional teams as well as patients and families and the effect that role status has on overall functioning within the urban hospital context. Cowles (2003) has articulated a need for further role clarity within health settings to ensure maximum interdisciplinary collaboration. In addition, further interdisciplinary training opportunities should be provided to encourage a deeper understanding of roles and responsibilities between and across team members.

The results of this study, as well as the high level of engagement across all of the focus groups, suggest that HSWs want to discuss their roles and have much expertise that could further illuminate the role of the profession in health care. Further opportunities should be provided to enable HSWs to share their skills and expertise, especially within hospital settings, as HSWs have experience in developing innovative responses to the needs of vulnerable populations (Beddoe, 2011). Acknowledgment of the diversity of roles that social workers are expected to fill requires both expert and generalist knowledge and skills that should not be minimized, even by HSWs themselves. Further articulation of the underlying skills required for each family or team intervention may be one way of educating others about the critical nature of these roles. Furthermore, openly discussing expectations and negotiating roles within teams and health care settings may empower social workers to structure their work in a more active fashion. Although Payne (2006) stated that the professional identity of social work is created through the “negotiation of roles alongside practitioners and service users, where effective relationships contribute to a developing enactment of what social work does, rather than any prescribed or mandated definition” (p. 139), the increasing challenges facing HSWs and the frustration expressed by some study participants about the breadth of expectations suggests that some common elements might be useful in supporting those at the frontlines.

Additional attention should be focused on understanding the structure of the work that HSWs do in their daily activities, family and team interventions, or crisis management, to help hospital administration and even our own profession understand the strengths that social workers currently bring to hospital settings. Examples of such strategies could include the development of a
scope of practice for HSWs, or a rebranding effort (Silverman, 2008) that would identify the talents and skills and illuminate the efforts of HSWs. Furthermore, national organizations have taken active steps to articulate a broader understanding of the roles and associated skills of social workers in health care settings. Although we were not able to locate a scope of practice that encompassed all HSWs, specializations such as oncology social work have created an excellent example (American Oncology of Social Work, 2001), and NASW has generated helpful standards of care for palliative services (NASW, 2004) and health social work generally (NASW, 2005). Although shared competencies and skills such as negotiation and advocacy are shared themes throughout these documents and in the present study, the importance of delivering services in a timely fashion with a focus on meeting the immediate needs are critical to the current practice of HSWs and should be used to help recognize the need for a broad range of competencies required for social workers in their current work contexts (Silverman, 2008). In addition, the findings from this study have implications for social work education, as in all of the focus groups HSWs articulated that they “were not trained for this” or “it was not part of my social work education.” Coursework should strive to prepare students for the complex, challenging roles required for social workers in health care settings through focused attention on developing skills such as enhanced crisis intervention, problem solving, and communication skills. Nevertheless, the varied roles fulfilled by HSWs are critical in an era of increasing challenges for both vulnerable patients and health care delivery. HSW

REFERENCES


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