Exploring the role of medical social work:

Findings from a pilot project in a national health center in Cambodia

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Abstract

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Limited literature is available to describe the practice of medical social work in resource-constrained countries and what is available often provides descriptive accounts of practice rather than explicitly named or systematically identified roles. There was no model for medical social work in Cambodia prior to the implementation of a pilot project at a major national health center in Phnom Penh in 2013. This study examined the perceived role and value of social workers and interactions with medical provider in this setting.

Methods

Semi-structured key-informant interviews were conducted with physicians, unit head nurses, social workers, and a social work supervisor at a national health center, where a pilot social work program had been operating since 2013. Interview data were transcribed and analyzed using open coding for

preliminary theme development with observational data used to triangulate an understanding of the social work role and interdisciplinary interactions.

Results

Results described group agreement for six primary roles of social workers including information gathering; patient/family education; emotional support and counseling; discharge planning; referrals and linkage; and providing or coordinating material resources. Social workers described subthemes for each of these roles and uniquely identified an additional role in addressing behavioral health issues. Descriptions and examples of each role are presented along with data regarding the processes through which team members learn about the role of social work.

Discussion

While there was significant agreement across respondent groups regarding the role of medical social workers, discussion focuses on dynamics that may influence differences in perception of the depth and breadth of social work practice particularly with regard to mental health care. Attention is given to the role of education of both medical providers and social workers regarding the scope and practice of social work in health care settings with recommendations made for approaches to continuing education for all team members. Finally, core principles of the evidence-based model of team-based care is considered to describe both existing dimensions of team functioning at the national health center along with an exploration of communication challenges and opportunities to improve team engagement and understanding of social work roles.

INTRODUCTION

Medical social work has been formally operating in highly resourced countries like the United States for more than a century[1] and remains a large segment of the workforce.[2] The development of social work in resource-constrained countries has varied greatly but is often intertwined with history of colonization, semi-colonization, and the exportation of Anglo-American ideologies including the context and materials used for social work education.[3] For example, British colonial occupation influenced the pathway for the first medical social worker appointed in India in 1946[4] while the profession did not proliferate in Zimbabwe until the rapid expansion of social and health programs became a focus of a post-independence government in 1980.[5] Literature describing the histories and practice of medical social work in resource-constrained countries is quite limited with a much smaller body of literature describing essential roles and core functions in daily practice. Regardless of country context, improved understanding of medical social work roles and functions has the potential to impact models practice, clinical efficacy and outcomes, and the future of training and professional development. In the context of globalization, the study of local social work practices in non-Western settings is also a pathway for decolonizing its history and integrating imported knowledge with local wisdom.[6]

Different approaches have been used to define the role and function of medical social work practice in the United States ranging from the establishment of professional standards,[7] literature review,[1] national surveys,[8] qualitative evaluations,[9,10,11] and in practice role recommendations to secure power and security for the discipline.[12] Given the relative size, nascence, and/or capacity of the profession, literature from resource-constrained countries consists largely of descriptive accounts of the settings and practice of medical social work, psychosocial issues faced by patients, and historical, political and systems influences on care. Social work roles are more often described in such literature rather than explicitly named or systematically identified. Social work roles and activities described in low- and

middle-income countries were used to explore context for the design and analysis of this study (see table 1). Gross national income (GNI) per capita of these countries at the time of their publication ranged from $630 (Zimbabwe) to $5,610 (Botswana) compared with Cambodia's estimated GNI of $1,230 at the time of this study. [13]

Table 1
Medical social work roles and activities noted in selected literature from low- and middle-income countries[13]

First Author	**Acharya[4]**	**Chitereka[5]**	**Hassan[18]**	**Hossain[16]**	**Malinga[15]**
Country	**India**	**Zimbabwe**	**Pakistan**	**Bangladesh**	**Botswana**
Year of Publication	**2018**	**2010**	**2016**	**2017**	**2010**
GNI per capita, Year of Publication	**$2010**	**$630**	**$1310**	**$1520**	**5610**
SW ROLES & ACTIVITIES					
Formal Assessment	X		X		
Patient Education	X			X	X
Emotional Support & Brief Counseling	X	X	X	X	
Mediation/Advocacy	X		X		X
Grief/Bereavement	X	X			X
Discharge Planning	X			X	X
Discharge Follow-Up	X	X	X	X	
Referrals & Linkage	X	X	X	X	
Material Resources	X	X	X		
Research	X	X			
End of Life or After Death Planning	X	X		X	
Home- & Community-based Services	X				
Student Training	X				
Community Health Education	X				
Information Gathering			X		
Family Search					X
Crisis Intervention		X			
Reporting		X	X		
Interdisciplinary Teamwork		X	X		

This body of literature dedicates significant attention to the challenges social workers face spanning micro, mezzo, and macro system levels, similar to the pressures noted for practitioners in the United States. [10] For example, challenges facing role definition in the United States are similar though amplified in resource-constrained contexts. Multiple authors in resource-constrained countries identify the limited understanding of roles and functions of medical social workers by interdisciplinary team members as a central challenge in defining their practice. [14,15,16] Discussing hospital-based social work services across

twenty-six health institutions in Botswana, Malinga and Mupedziswa echo others lamenting that this lack of understanding limits an appreciation for the time, physical space, and other resources needed to address complex psychosocial issues. Despite these limitations, they note the pressure on social workers to have significant impacts on patient care and failing to meet these expectations leaving team members doubting the effectiveness of the role of the social worker in hospital settings. [15]

Interdisciplinary team members' priorities and perceptions also define the scope of social work practice by controlling the referrals process for services. In describing challenges faced by medical social workers in Malaysia, Crabtree comments that physicians' positional authority allows them to define the parameters of care for other disciplines including social work.[14] For example, while social workers may expect to focus on counseling and psychosocial problems, other professionals may see them as performing "instrumental tasks" such as arranging transportation and discharge placement which underutilize their skills. [5,17] More than simply defining the focus of referrals, perceptions of medical providers regarding the role or efficacy of social workers is also indicted for a reluctance to refer for social work services. [14,15,16] Crabtree noted concern that this power may lead to service becoming under-utilized and redundant and did little to educate medical staff about the role of social work and appropriate referrals, except through the "tedious method of trial and error." [14]

This positional power is also reflected in the standing of social work departments in the larger institution and their ability to exert influence. Chitereka describes medical social workers in Zimbabwe who are employed almost entirely by Government Central Hospitals as operating in a "second setting" as outsiders to the hospital and experiencing boundary tensions at the bottom of rigid hierarchies. [5] In India, hospital social workers are noted to lack professional recognition and are referred to as hospital

social service officers.[4] Authors also note role clarity may be further constrained when social workers are supervised by other healthcare disciplines imposing their own role definitions.[15,16]

The complex issue of defining the role of medical social work is closely connected to its valuation and is seen with great consequence. Chitereka reports that his colleagues face low salaries, poor working conditions[5] while Malinga and Mupedziswa also note challenges with burn out and staff retention.[15] It's not surprising that their counterparts in the United Sates advocate for the continued explication of medical social work roles and activities but also the impact social workers can make for patients, communities, and organizations along the health care continuum.[8] Social workers in some resource-constrained settings may also practice without formal or advanced education or specialized training in medical social work. Authors describe subsequent reliance on on-the-job learning and challenges in limited preparation for practice in health settings and lack of knowledge of health related issues.[15,16] This knowledge gap is likely to exacerbate communication barriers with medical providers and perceptions of social work practice, exacerbating power dynamics that impact role definition.

Medical social workers may also contend with limited understanding of their role in the broader culture or political sphere. Hossain, who outlines the struggles faced by medical social workers in Bangladesh, indicates the profession is not formally recognized in the country.[16] Describing challenges in Pakistan, Hassan describes a lack of understanding of medical social work by politicians and bureaucrats and the politicization social welfare programs leading to underfunding of hospital-based social service programs which are funded directly by the government.[18] In many contexts, social workers are often providing functions traditionally assumed by informal supports further complicating role identity and reinforcing stigma of accessing services.[14,15,16,18,19] Such issues mirror the process of professionalization in the

United States where practitioners worked to distinguish themselves from “old-style” charity workers nearly a century ago. [1]

Social work is a new profession in Cambodia with the bachelor’s degree program at the Royal University of Phnom Penh (RUPP) conferring their first degrees in 2012. Two additional social work degree programs have since been developed, professional network groups have been established, and efforts have been made to draft proposed practice standards for the country. Despite these signs of a burgeoning profession, the Cambodian government does not formally recognize a job class for social work in the public sector. Seeking to expand social work practice into other sectors including health care, the RUPP Department of Social Work and the University of Washington School of Social Work created Partnering for Health (PFH), a joint venture focused on developing a model of medical social work practice. A needs assessment was conducted in 2012 with the pilot project initiated in 2013 at a national health center. This study examined the perceived role and value of social workers and interactions with medical provider in this setting. Such insights may lead to a better understand of practice implementation challenges and opportunities, improve services for patients and teams, and creating visibility of the social work profession for stakeholders with the power to sustain its presence in health settings.

METHODS

Study Design

This study focused on a pilot medical social work project operated by Partnering for Health (PFH), a collaboration between the University of Washington School of Social Work and the Royal University of Phnom Penh Department of Social Work. The project was sited at a national health center, within a unit serving medical and surgical patients who cannot pay the full cost of their care. Semi-structured key-

informant interviews with medical providers, social workers, and a social work supervisor were conducted in Phnom Penh, Cambodia in July 2017 with on-site observations conducted concurrently through August. Given the nascence of medical social work practice in Cambodia, this study examined the perceived role and value of social workers and interactions with medical provider in this setting.

Sample

A total of 17 interviews were conducted. This included interviews with 12 physicians and two Unit Head nurses who, for the purposes of this study, are collectively referred to as "providers." Participants also included two social workers and one social work supervisor. To increase the likelihood that participants had experience working with or as social workers, sampling excluded staff who have worked in the unit for less than three months and those who spend less than 50% of their clinical time in the low-income unit.

Physicians represented the majority of the provider group (n=12, 67%) which was also overwhelmingly male (n=10, 71%). This group was diverse in their range of clinical backgrounds specializing in endocrinology, cardiology, gynecology, pain management, infectious diseases, nephrology, and general surgery. They also had a significant range in years of clinical experience (range: 1-38; median: 13), years of experience working at the health center (range: 1-38; median: 9) and years working in the low-income care unit (range: 0.5-24; median: 5). Half of physicians also held a leadership role within their specialty, the low-income unit, or at the health center.

The two full-time employed social workers of PFH held Bachelor of Arts in Social Work degrees from the Royal University of Phnom Penh (RUPP). One of the two social workers had two years of experience working in the low-income care unit and the other only two months and neither had prior experience in

healthcare before working at the health center. The PFH social work supervisor was a consultant who provided on-site and remote clinical support and had a MA in Social Work and more than 20 years of clinical experience as well as taught in the Department of Social Work at RUPP.

Measures

All key-informants were asked to identify their role and the number of months or years of experience in their discipline, at the health center, and in the low-income unit. Questions for all groups focused on perception of the roles of social workers, the referral process for social work services, and the value and challenges regarding social workers and the pilot project. Social workers and the social work supervisor were also questioned about their practice with assessments, interventions, and care coordination and the process and content of clinical supervision.

Data Collection

Recorded interviews were conducted in English and Khmer in a private setting at the health center. A Khmer interpreter was present for all interviews and observations. Informed consent was obtained with verbal agreement for participation. No incentives for participation were offered. Detailed memoing and field notes were utilized during interviews.

Analysis

Interview data were transcribed and analyzed using open coding for preliminary theme development based on the interview questions. This level of analysis paid particular attention to process information and decision making for social work service utilization; information sharing and communication; and expectations of the social work project. Observational data were used as complementarity to key-informant interviews in order to triangulate a more accurate and rich understanding of the social work

role and interdisciplinary interactions. Preliminary results were shared with PFH leadership to test the perceived accuracy of data.

Ethical Statement

The Human Subjects Division of the University of Washington waived the need for a full review for this study. Informed consent from participants was obtained verbally before participation. The consent was audio-recorded in the presence of a witness.

RESULTS

Both provider and social work groups identified many of the same primary roles of social workers including information gathering; patient/family education; emotional support and counseling; discharge planning; referrals and linkage; and providing or coordinating material resources. Social workers described subthemes for each of these roles and uniquely identified an additional role in addressing behavioral health issues (see table 2). Data regarding the processes and dynamics through which providers learn about the role of social work in the low-income unit at the health center are also presented.

Table 2
Social work roles & subthemes as identified by group

Social Work Roles & Subthemes	Providers	Social Work
Information Gathering	X	X
Family Search	X	X
Assessment		X
Patient Education	X	X
System Navigation		X
Emotional Support & Brief Counseling	X	X
Mediation/Advocacy		X
Grief/Bereavement		X
Discharge Planning	X	X
DC Follow-up		X
Referrals & Linkage	X	X
Resource Mapping		X

Material Resources		X	X
Behavioral Health			X
	Screening & Assessment		X
	Crisis Intervention		X

General Role of Social Work

Providers and social workers noted a distinction between providers' role in providing technical aspects of treatment while social workers were seen as skilled in attending to psychosocial and socioeconomic concerns. This was seen by both groups as complimentary to providers' roles with one doctor stating, "to make good health must have good physical and psychological care." One provider stated, "I think we have to work together… so we can improve the patient care." Providers frequently noted that social workers were an important part of the multidisciplinary "team" and "partners" in patient care. Many providers appeared to view social work as an essential service and some said they have communicated to hospital administration about the need for continued support from PFH to provide social work services. Other references were made to the value of social work services would have in other units at the health center and in other health facilities.

Providers often described the role of social workers in the context of specific issues or patient needs. Nearly every provider discussed the need for social work services for patients who are poor, have no family support, or lack secure housing though noted they were also needed for a range of other issues. For example, they reported that referrals were indicated for patients with complex or chronic health conditions; diagnoses such as HIV, cancer, or end-stage disease; and low medical literacy and barriers navigating medical care. Providers commonly noted that social work was *not* indicated for patients with only medical or surgical complaints and who had family support, had their basic care needs met, and did not present additional challenges to the medical team. Referrals to social work by providers were seen as a necessary step for engaging their services for patients and families. Referrals appeared to be made

on a case-by-case basis as specific needs arise with no apparent standard or systematic screening for potential social work referrals.

Providers also frequently discussed the unique qualities of social workers noting their relational skills and general character with one participant noting, “Their character is good—they have sympathy.” Providers also called upon social workers for their unique problem solving skills with difficult cases with one provider saying, there are “some problems that only social workers can solve,” offering an example of their role in care coordination and discharge for an unidentified foreign national with a serious injury. Many also discussed the availability of time social workers could invest in meeting with patients as essential in supporting their roles in patient care. This was juxtaposed by reflections from both groups that providers did not have time to meet many of the social, emotional, and problem-solving needs of patients and families.

Specific Roles of Social Work

Information Gathering

Foremost, social workers were identified as skilled collectors of information needed to provide and coordinate care. This included gathering patient psychosocial background and sensitive personal and health information which was noted to be particularly important in a Cambodian context where patients may not disclose certain information to providers when they feel information is not relevant to their care—such as housing status or lack of family support—or due to stigma related to topics such as HIV status or substance use. Such information was seen as valuable in contributing to care and discharge plans.

Social workers also worked to locate family for patients, particularly for those unable to communicate due to traumatic injury, acute illness, or mental illness. Family contact allowed social workers to gather collateral information, engage supports, and facilitate discharge planning. Social workers described contacting NGO's as well as provincial and village authorities to identify family and coordinating with foreign embassies to identify ex-patriate patients and notify family.

While providers described outcomes of information gathering, social workers also described the process of completing formal assessment including patient and family histories, patient concerns, and mental health concerns. They also described assessment by observing patient behaviors and family interactions. Social workers also described a role of information gathering from providers to support other roles with patients including education and emotional support. This includes taking notes during patient rounds, consulting with providers, and reviewing charts. They also discussed the importance of gathering patient information early in care, particularly for complex cases such as acute injury or difficult discharge.

Patient / Family Education

Providers called upon social workers to educate patients and family members about diagnosis, prognosis, or treatment plans. Social workers were seen as having more time and different communication skills than providers to engage with patients regarding these issues. Examples included helping patients learn to manage chronic disease and discussing treatments with patients seen as resistant to medical recommendations. Discussing limited medical literacy, one provider stated, "Some patient doesn't understand what the doctors do—that's why they need a social worker." Social workers also described the use of skills like goal setting and motivational interviewing to help patients consider health behavior change. Both groups noted that social workers may be asked to discuss life-limiting conditions with patients and families. In such situations, social workers highlighted a role helping

families navigate a cultural norm of deciding what if any information to share with patients regarding a serious diagnosis or poor prognosis.

Social workers uniquely described their role in helping patients navigate the healthcare system, particularly for people coming from rural areas who have little experience with the city or large hospitals. Examples were provided of helping patients understand the process of care, wayfinding in the hospital, or discussing cost or care or payment concerns.

Emotional Support & Brief Counseling

Social workers provided emotional support and brief counseling to patients and families coping with a difficult diagnosis or changes in health and functioning. Both groups viewed social workers as having "special skill" talking with patients and showing sympathy with sensitive issues. Providers recognized these interpersonal skills from witnessing social workers sitting with patients, providing comfort, or helping to "motivate the patient to have more hope." Providers frequently referenced the value of this support for patients with new HIV or cancer diagnoses with one reference to supporting sexual assault survivors.

Social workers also described receiving referrals from providers to meet with patients who are visibly distressed. They also described grief support for patients with serious illness or parents of a child born with significant disabilities and bereavement support for family members after a patient death. Social workers also described referrals from providers for patients who are unhappy with care, are disruptive on the unit, have family conflicts related to care, or resist discharge. Social workers described such scenarios as requiring them to mediate between providers and patients/families, assessing the support or information needs of parties, and advocating for patients with providers.

Social workers described this work as helping patients in “developing hope” and to “make the patient feel not alone,” while also motivating them to engage in care. They stressed the importance of building rapport with patients, maintaining confidentiality, and respecting patients’ decisions. Social workers also described helping patients with problem solving and reported tracking psychosocial goals and goal progress throughout a hospitalization.

Discharge Planning

Providers noted engaging social workers to assist with discharging patients, particularly those with complex psychosocial needs and barriers to discharge. Discharge planning sometimes involved locating family members, arranging transportation home. At times this involved coordinating transfers to local pagodas, religious organizations, NGOs, or government centers which provide lower acuity care, particularly for patients with serious illness, disability, or who are at end of life. Special circumstances were also described including locating family or NGO support for children of deceased patients, coordinating NGO services when children are unwanted by parents after birth.

Social workers also supported discharge for patients who lack housing and alternative placement by offering emotional support and discussing plans to meet basic needs despite limited community resources. Given the complexity of care and limited community resources, one social worker described how their role as discharge planner needs “to adapt to the medical professionals, the family, and the intervention.”

Social workers also described discharge follow-up contact for some patients, particularly those described as “serious cases” and without family supports. Examples included calling a patient with

anemia needing follow-up transfusions; contacting family of a seriously ill patient discharged home; visiting a patient discharged to an NGO care facility; and requesting calls from a patient with persistent thoughts of suicide who was also homeless to engage ongoing safety planning and crisis intervention. Social workers described the goals of these contacts included ensuring access to care, learning of patient outcomes, offering emotional support, and providing crisis intervention and safety planning.

Referrals & Linkage

Social workers also provided referrals and linkage to community-based services after discharge including programs for infectious diseases such as HIV or chronic diseases such as diabetes; palliative and end of life care; and after-death services; and very limited community-based behavioral health services. While availability of community-based services was quite limited, social workers noted that maintaining knowledge of such resources allowed them to accurately assess the appropriateness, accessibility, and acceptability of services for patients. Social workers also engaged professional networks to identify available resources and reported visiting local organizations to better understand services and facilities.

Providers saw these connections as important to patients' continued health and wellbeing and relied on social workers to know and explain resources to patients. Providers did not discuss social workers' efforts in gathering or maintaining information and relationships with outside agencies but did recognize the constraints that social workers faced with limited number and varying quality of referral options.

Material Resources

Social workers also helped patients to access material resources including food, clothing, funds for transportation, and medication for those unable to pay for them. This was especially needed for patients without family supports who would typically provide these resources while also providing bedside

caretaking. Social workers supplied these resources with a small emergency fund provided by PFH or through connections to community-based NGOs which providers said offset personal funds they sometimes gave to patients. Both groups expressed a desire for increased patient support funds.

Behavioral Health

Social workers were seen by some providers to have helpful skills for working with patients with mental illness but related to other social work roles. For example, social workers were referred to meet with patients presenting with acute mental health crises for emotional support; to collect collateral information from family regarding a patient with acute psychosis and somatic delusions; and to provide referrals to limited existing community mental health services. As noted previously, the information gathering role of social workers was seen as valuable for revealing patients' history of substance use but social workers did not appear to be referred for specific assessment or intervention related to substance use. Social workers similarly highlighted these roles working with patients with behavioral health concerns.

Social workers, however, uniquely described a direct role supporting patients impacted by depression, anxiety, suicidal ideation, and substance use—issues often identified during formal assessment. They also noted providing behavioral health interventions, most commonly psychoeducation and brief counseling including discussions with patients and families about common mental illnesses, the benefits of outpatient counseling, health risks related to substance use, and motivational interviewing for health behavior change. There were at least two examples noting supporting patients with suicidal thoughts or behaviors which included assessment of recent stressors and plans for future attempts as well as safety planning which involved contacting the social worker for crisis intervention after discharge. While this

area of practice was a very small proportion of their work, social workers and PFH staff noted it as an area of potential growth in the social work role.

Despite feeling that behavioral health issues should be within their scope of practice and are important to address in patient care, social workers reflected upon their limitations with training, knowledge and skills in this area, particularly with more complex psychiatric conditions including psychosis, PTSD, and personality disorders. They noted awareness of screening tools for anxiety and depression and the potential benefits of tracking scores over time though such tools were infrequently employed in practice. Providers also noted their own limitations in training and intervention experience with behavioral health issues and some commented that behavioral health was not the focus of care in the low-income unit which focuses on medical and surgical care. As one physician stated, "There is another hospital for psychotic patients… We are not the psychiatric doctors."

Provider Education about the Social Work Role

Most medical providers did not have experience with social workers prior to PFH's presence in the low-income unit. Many physicians described contact with social workers while receiving medical training outside of Cambodia, most commonly in France. They also noted awareness that this was context specific with stable government funding for social work services and more community resources to support patient needs than exists in Cambodia. Some providers reported experience with social workers from external NGO services offered at the health center in the past though more narrowly focused on supporting patients with HIV/AIDS and disease-related psychosocial issues. Very few providers reported any direct education about social work roles, awareness of the education or training social workers receive, or training in addressing psychosocial issues.

Given this lack of experience, most providers described an iterative learning process regarding the role and functions of social workers through direct contact with them in the low-income unit. They reported increasing awareness of services through the experience of referring to social workers; witnessing social workers interact with patients and colleagues; discussing social work with provider colleagues including recommendations from colleagues to utilize social work services; and by requesting information from social workers about their role. Increased experience and knowledge of social work was noted to have improved providers' appreciation of and utilization of social work services. As one provider commented, "because [some doctors] never work with social work before they think that social work is not useful… but when they work together, they think the social worker has a role."

Social workers documented their work with patients for clinical and programmatic purposes. However at the time of this study, as the health center did not have an electronic medical record system, documentation is not easily accessible across professions or individual clinicians.

DISCUSSION

Perspectives on the Social Work Role

Providers and social workers showed significant agreement in identifying six of seven primary roles of social work at the health center. Despite this overlap, social workers described greater breadth and specificity with sub-themes to roles. For example, while both groups identify a primary role as "Information Gathering," social workers describe searching for family members as a specific type of information gathering and describe the distinct process of completing social work assessments. Similarly, within the primary role of "Patient Education," providers focused on education about medical care and health management while social workers further describe the education about and navigation

of health systems—a dimension of social work practice physicians in the United States has also been found to under-acknowledge. [20]

One area of difference between groups in identifying the role of social workers was in relation to behavioral health issues. While providers did not explicitly identify a role for social workers in addressing behavioral health concerns, social workers were aware of the opportunities in growing their role capacity to provide screening, assessment, and intervention for mental illness, substance use, and suicide risk. These findings are consistent with studies in Western contexts comparing social work and physician perceptions of the social work role in which social workers often identified greater breadth to their roles, particularly regarding counseling and mental health services, [21,22,23] a dynamic which has improved but persisted in more recent literature. [24] This may simply represent an expected outcome of a discipline having greater perspective on their own work as well as the tendency to understand other disciplines in the context of one's own scope of practice. Given that providers made very few references to behavioral health issues in general, this gap in perspective on potential social work roles may also represent a broader gap in understanding of psychosocial patient needs or resources for care. For example, Cambodia has tremendous limits in access to psychiatric care with fewer than one hundred trained psychiatrists in the entire country at the time of this study (J. LoGerfo, oral communication, April 2022), noted concerns about the quality of mental health care, and very low recognition of mental health problems. [25] These limitations may also impact the skill of providers recognizing behavioral health concerns of hospitalized patients and subsequently missing opportunities for interventions including referrals to social work.

While these difference in role perception between social workers and providers might seem small, it is important to remember that they exist in a setting where provider referrals are required to engage

social work services. As discussed in literature in other resource-constrained settings, this positional power relies on provider perceptions of the social work role and skills to determine which patients have access to services and for what issues.

Education about Social Work Roles

Differences in perceptions between groups may be related to reports of how providers learn about the roles of social workers: primarily witnessing daily care and interacting with social workers. These informal methods of learning are reasonably expected given the lack of provider training related to social work, experience working with social workers in a healthcare setting in Cambodia, or access to systems for shared documentation with social workers. However, these methods are also likely to produce a relatively slow pace of shared learning in an iterative process that also relies on the interpretation of providers within their existing frameworks for understanding of psychosocial needs, social work practice, and healthcare more broadly. They are also likely to impact referrals based on case-specific experiences and to reinforce referrals for work that is already visible.

Reliance on witnessing practice and informal communication as means of developing a shared understanding of the social work role are also limiting in that they are not systematic or likely to be consistent across the care team. One way to catalyze this shared model of learning is to proactively educate team members about the role of social workers in patient care and their range of skills including counseling patients and families. [20,26]

Continued education, training, and clinical supervision for social workers may also help social workers further define their role in healthcare settings. Given the nascence of medical social work in the country, there is currently no formal social work curriculum or educational internship opportunities focused on

practice in medical settings, unlike in more resourced countries which often require this training for employment. Development of specialty training within a social work program as well as opportunities for continuing education on topics related to illness, treatment and health systems may support continued exploration of how social work might best operate in health settings. Additionally, since the Ministry of Health does not formally recognize the role of social work, there are no mechanisms for the government to identify practice standards or competencies or to support training efforts.

Team-Based Care

Many of the dynamics of role definition, shared learning, team building, and communication described between provider and social workers in the low-income unit are common within healthcare teams and the focus of team-based models of healthcare. An abbreviated definition of team-based care from an Institute of Medicine (IOM) working group is described as the provision of health services by at least two health providers who work collaboratively with patients and their caregivers to accomplish shared goals to achieve coordinated, high-quality care. [27] Research that indicates team-based care is associated with improved patient outcomes including decreased readmission rates to the hospital for high-risk patient populations, decreased adverse events for hospitalized patients, and decreased length of stay in the hospital as well as positively affecting patient satisfaction with care. [27,28,29,30] The World Health Organization has also developed education and practice competencies for team-based care noting that it, along with models of task shifting, can be tailored to meet country needs even in resource constrained settings. [31]

The IOM working group proposed a set of core principles for this model which include shared goals, clear roles, mutual trust, effective communication, and measureable processes and outcomes. [27] These principles are similar to recommendations in Western contexts for social workers to improve provider

appreciation and valuation of social work services by clearly defining their role, documenting and communicating what they do well, and providing evidence that their interventions are both beneficial to the patient and to the hospital. [26] Dimensions of these core principles were present in discussions with providers and social workers at the health center, the most obvious of which is the work of clarifying roles of team members in providing patient care. However, as a nascent profession in Cambodia and new program at health center, defining the role of social work remains an iterative process of mutual learning. The IOM group recommends supporting role clarification with time and support dedicated to interprofessional education,[28] an intervention already noted as a request from providers.

In regards to mutual trust, providers in the low-income unit appear to have developed trust in the social work team frequently describing positive professional qualities and noted that they are an important part of the multidisciplinary "team" and "partners" in patient care. Despite being employees of PFH sited at the health center, social workers were not viewed as "outsiders" as referenced in literature from other settings. However, at least one senior leader at the health center had raised a concern that providers' perception of social workers may be influenced by previous experience with NGO social workers contracted to work at the health center. Therefore, it was recommended to consider changing the title for social workers working in hospitals (e.g., patient care facilitators) to better differentiate them and bridge integration to the team (J. LoGerfo, oral communication, April 2022).

While explicit focus on any of these core principles has the potential to improve team functioning, the most salient principle to improving understanding of the social work role in the low-income unit may be that of effective communication. The IOM authors identify three factors that sustain effective communication: 1) providing ample time, space, and support for team members to meet to discuss direct care and team processes, 2) ensuring that team members are trained in shared communication

expectations and techniques, and 3) utilizing digital capacity such as an electronic medical record and e-mail to facilitate easy, continuous, transparent communication among team members. [27] Focusing on these three factors, social workers in the low-income unit can also help to define their role during daily patient care. For example, social workers can capitalize on existing communication forums such as patient rounds by creating a shared expectation of their social work participation of patient care discussions. Likewise, creating expectations for follow-up between providers and social workers after meeting with patients/families can be an opportunity to explicitly name roles and describe functions that highlight less visible aspects of practice such as addressing behavioral health concerns. Social workers can also continue to develop communication skills, particularly those tailored to meet the needs of providers. For example, as providers frequently stress limitations in their time available to address psychosocial issues, brief and focused communication is most likely to be effective. SBAR (Situation, Background, Assessment, Recommendation) is an example of a tool promoted by WHO that is designed to craft succinct patient care communication and which is shown to reduce adverse events in hospital settings and promote patient safety. [32] Without access to a shared electronic medical record it is understandably difficult for the team at the health center to maintain digital communication about patient care. However, the use of lower-tech tools like phone texting with providers and printed social work documentation shared in hardcopy patient charts viewed by all team members may create additional brief and accessible ways to communicate about social work interventions.

Limitations

Another limitation is the potential bias in self-reporting for all participants, particularly as the primary researcher has a working relationship with PFH and its leadership. While confidentiality was discussed with each participant, this dynamic may result in underreporting or over-reporting as well as potentially

avoiding topics considered too sensitive or perceived to have a negative impact on individuals or the program.

Differences in language and culture between the researcher and participants remains another limitation. While an interpreter was utilized for all interviews and available for consultation during data analysis, many respondents spoke using some English with others communicating predominantly in English which may limit the nuance of the data. Cultural cues in communication may also have been missed or misinterpreted limiting context in participants' engagement and responses.

Postscript

Since data collection for this study, the health center chose to hire one of the social workers to continuing working in the low-income unit though more narrowly focused on serving patients with HIV. This social worker was initially hired as a contract worker but later the role was hired as a government civil servant position as a "technician." After this transition, PHF made the decision not to pursue ongoing funding and ended their provision of social work services at the health center. In a country where most social service interventions rely on funding from a large number of international nongovernmental agencies, the sustainability of programs is often uncertain and certainly felt by team members at the health center. When asked about hopes for the future of the social work project, one physician stated, "We always thinking about the future. But if one year or next year the social worker they stop work here… that's why I cannot discuss about the future."

Declaration of Interests

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Appendix A: Key-Informant Interview Questions

Medical Providers

Background Information

1. Please state your name and your title.
2. How long have you been practicing medicine?
3. How long have you worked at this health center?
4. How long have you worked in the low-income unit?
5. How many hours do you work in the low-income unit in a week or month?
6. How much of your time at this health center is spent in the low-income unit?

SW Role

7. Can you describe how you work with social workers in the low-income unit?
    a. Can you share an example of a recent experience working with social workers?
8. How would you describe the role of social workers in the low-income unit?
    a. Can you tell me about an experience that shaped your understanding of the role of social workers?
9. How does your understanding of social work now compare to before working with them in the low-income unit?
    a. If your understanding is different, what experiences changed your understanding?

SW Referrals

10. What types of patients or situations might cause you to refer to social workers?
    a. What is your process of identifying patients to refer to social work?
    b. What things do you consider when deciding if you should refer to social workers?
    c. Can you share some examples of referrals you have made to social workers?
    d. How often do you refer to social workers?
11. Can you explain the process of making a referral to social workers?
    a. What information do you share with social workers when you make a referral?
    b. Can you tell me about communication with social workers after a referral is made?
12. What do you expect from social workers when you refer them to see a patient?
    a. Can you think of a time when those expectations were not met?
13. Are there situations you believe might not be appropriate for a social work referral?
    a. What is an example of a time you considered referring to social work and decided not to?

SW Value and Challenges

14. What benefits to patient care benefits have you seen from social work involvement?
    a. Are there examples of times that social work had a positive impact on patient care?
    b. What things do you believe social workers are best at doing?
15. What, if any, challenges have you experienced when involving social workers?
    a. Are you aware of any situations when social work involvement had a negative impact on patient care? If so, can you tell me more about the situation?
    b. If so, what do you think the problems were? What might have been done differently?
16. How is working in the low-income unit different since the social work program started?
    a. How has the social work program impacted your work as a medical provider?
    b. Can you tell a story that reflects this impact?
    c. Would you prefer working in a hospital with or without social workers? Why?
17. What do you hope to see from the social work program in the low-income unit moving forward?

a. Are there specific things you hope social workers will continue to do? Things you hope they will do more of?
b. Are there examples of ways the social work program could be improved?

Close

18. Is there anything else I haven't asked about that you think is important for us to know about? Anything else you want to share?

Social Workers

Background Information

1. What is your name and your role?
2. How long have you been practicing social work?
3. How long have you worked with the pilot project?
4. Can you describe your previous experience in SW? in healthcare?
5. Why work in healthcare setting?

SW Role

6. How would you describe the role of social workers in the low-income unit?
7. How did you learn about your role?
8. What do doctors think the role of social work is? How is it different than your idea?
9. How do doctors learn about the role of social workers?
10. Are there aspects of the social work role that providers are not aware of?
    a. Example of something that social workers CAN do that they are not asked to do now.
11. Which doctors best understand your role?
12. Example of common patient work. Uncommon.

SW Referrals

13. Tell me about the referral process to social work
14. What information do you receive with a referral? Is there other information that would be helpful? Are you able to get this information? How?
15. What is communication like between the social workers and the medical team when you are working with a patient over time? And after working with a patient?
16. What is your role in morning rounds?
17. Who else besides doctors make referrals?
18. Do you see patients without a referral? In what situations?
19. What could make the referral process better?

SW Assessment

20. What information do you get from patients – what do you think is important?
21. Tell me about your assessment process.
    a. What tools do you use for social work assessments?
    b. What are your goals when completing assessments?
    c. What challenges do you face when completing assessments?
22. Besides talking with patients and doctors, what other sources of information do you use?
23. Are there differences between the reason for referral and the needs you identify in the assessment?
24. Do you ever use the PHQ9? Other mental health assessment tools?

25. If a doctor asks you to get information from a patient, what information do you think they want? How do you know?

SW Intervention

26. What are the most common things you do to help patients?
27. Are there things you think about doing for patients that you feel you cannot do for some reason? What things? What reasons?
28. Tell me about the social work emergency fund. What is it and how is it used?
29. Do you ever talk to patients with the doctors together?
30. What is your role with patients with cancer? With patients with HIV? With patients with psychological or emotional issues? With other types of patients?
31. What do you do when a doctor asks to you to educate a patient about a medical condition or treatment? What are the challenges in these situations?

SW Care Coordination

32. How do you identify and track patient goals? What kinds of goals do you focus on?
33. On average, how many patients are you keeping track of every day?
34. How do you divide work with coworker?
35. Who are the partner organizations? How are they identified? How are those relationships developed? What challenges exist with them?
36. What contact does social work have regarding patients after they are discharged?

SW Supervision

37. Tell me what happens in supervision?
    a. What types of cases do you seek supervision for? Can you give me an example?
38. What additional support would help you in your work? What training or education? What materials or resources?

SW Value and Challenges

39. What are the benefits to patients from social work services?
40. Are there benefits to doctors?
41. What challenges have you experienced or might you expect when working with doctors?
42. What are the biggest challenges in your work?
43. What factors in the low-income unit impact social work practice?
44. What factors within the hospital impact social work in the low-income unit?
45. What factors outside of the hospital impact social work in the low-income unit?
46. What could improve the social work program in the low-income unit?

Close

47. What do you enjoy most about your work?
48. Is there anything else I haven't asked about that you think is important for us to know about? Anything else you want to share?

Social Worker Supervisor

Background Information

1. How long have you been practicing social work?
2. How long have you worked with the pilot project?

3. Can you describe your previous experience in SW and in healthcare?

SW Role

4. How would you describe the role of social workers in the low-income unit?
5. How is it different than other types of social work?
6. How has your idea of medical social work changed since the program started?
7. How do you communicate that role to the social workers?
8. How do you communicate that role to medical providers?
9. How has the medical team's understanding of the social work role changed since the start of the program? What caused it to change? How do they learn about what social work is?

SW Referrals

10. How would you describe the referral process to social work?
11. What challenges do you think exist in the referral process?
12. What things are social workers trained to do that they are not often referred for?
13. Are there aspects of the social work role that providers may not be aware of still?

SW Assessment

14. What tools or strategies are used for social work assessments with patients?
15. What information is gathered?
16. MH screening tools?
17. What are the goals of a social work assessment?

SW Intervention

18. What are the main interventions that social workers use?
19. What factors influence the interventions that social workers use with patients?
20. Are there things that make it difficult to start or complete a social work intervention?
21. What the social work role with patients who have cancer? HIV? Chronic disease? End of life? Stroke? Mental health?

SW Care Coordination

22. What goals do social workers develop in working with patients? How do they develop those goals? How do they track them? What is your role with this process?
23. Who are the partner organizations? How are they identified? How are those relationships developed? What challenges exist with them?
24. How much contact do social workers have with patients after they discharge? What is the goal or purpose of this contact?

SW Supervision

25. How often do you communicate with the social workers? How often is this by phone or in person? How often are you at this health center?
26. What types of cases are you consulted about?
27. How do you structure supervision time? What is your goal in supervision?
28. How do you address problems with social workers? How do you address problems with their work? What process do you use to find out about problems?
29. What special skills or training do social workers need to work in hospitals?
30. Do you have any direct communication with medical providers?
31. What is the biggest challenge to you as a supervisor?

32. What training or support would help you as a supervisor?
33. Can you tell me a bit about the Network?

SW Value and Challenges

34. What were the biggest challenges to the social work program when it first started? What has changed since then?
35. What challenges does the social work program face now?
36. What benefits to patients have you found or might you expect from social work services?
37. What are the benefits of SW to the hospital?
38. What factors in the low-income unit influence social work practice?
39. What factors within the hospital influence social work in the low-income unit?
40. What factors outside of the hospital influence social work in the low-income unit?
41. What could improve the social work program in the low-income unit?

Close

42. What do you enjoy most about this work?
43. Is there anything else I haven't asked about that you think is important for us to know about? Anything else you want to share?