

The Role of Social Workers in Interprofessional Primary Healthcare Teams

Rôle des travailleurs sociaux dans les équipes interprofessionnelles de soins primaires



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Abstract

Background: In Ontario, Canada, social workers are employed in a number of primary healthcare (PHC) settings such as Community Health Centres (CHCs) and Family Health Teams (FHTs). However, many aspects of social work practice within PHC settings are unknown.

Objectives: The objectives of our study are to determine the amount of social work services provided in CHCs and FHTs, identify the types of services that social workers provide in CHCs and FHTs and ascertain the methods social workers use to deliver services in CHCs and FHTs.

Method: An analysis of a cross-sectional data set obtained from a survey conducted in June 2016 in Ontario was performed.

Results: The majority of practices (84.2%) had a social worker, although several practices also hosted other types of mental health workers. In virtually all practices with social workers, they (and individuals designated as mental healthcare providers) were also involved in practice level efforts to support mental healthcare delivery. In several practices, the care they delivered extended beyond that related directly to mental healthcare, ranging from preventive care and health promotion (64.5%) to palliative care (16.8%). In several practices, these workers also offered group appointments related to healthy behaviour (43.6%) and self-management (~33%).

Interestingly, the role of social workers in practices where they were the sole designated mental healthcare worker was not meaningfully different from practices where other mental health professionals work.

Conclusions: In PHC, social workers deliver or support the delivery of mental healthcare, but their role extends beyond that domain to encompass a broader set of services that contribute to the individual's health and wellbeing.

Résumé

Contexte : En Ontario, au Canada, des travailleurs sociaux sont employés dans nombre d'organismes de soins de santé primaires (SSP) tels que les centres de santé communautaire (CSC) et les équipes Santé familiale (ESF). Toutefois, plusieurs aspects du travail social au sein des organismes de SSP demeurent inconnus.

Objectif : L'objectif de notre étude est de déterminer la quantité de services en travail social proposé dans les CSC et les ESF, d'identifier le type de services offerts par les travailleurs sociaux et de connaître les méthodes employées par ceux-ci pour offrir leurs services.

Méthode : Nous avons procédé à l'analyse d'un ensemble de données transversales obtenues au moyen d'une enquête menée en Ontario, en juin 2016.

Résultats : Il y a un travailleur social dans la majorité des organismes (84,2 %), mais plusieurs organismes comptent aussi sur la présence d'autres types d'intervenants en santé mentale. Dans pratiquement tous les organismes qui offrent des services de travail social, ces derniers – et les personnes désignées comme prestataires de services en santé mentale – sont aussi impliqués dans les efforts de l'organisme pour appuyer la prestation de soins de santé mentale. Dans plusieurs organismes, les services qu'ils offrent débordent les soins directement liés à la santé mentale, allant d'activités de promotion de la santé et des soins préventifs (64,5 %) aux soins palliatifs (16,8 %). Dans plusieurs organismes, ces travailleurs animent aussi des groupes pour favoriser les comportements sains (43,6 %) et l'autogestion (~33 %).

Il est intéressant de constater que le rôle du travailleur social n'est pas significativement différent entre les organismes où il constitue le seul travailleur désigné pour les services de santé mentale et ceux où travaillent aussi d'autres professionnels de la santé mentale.

Conclusion : Dans les SSP, les travailleurs sociaux offrent des services de santé mentale ou y contribuent, mais leur rôle s'étend au-delà de ce domaine et comprend un plus large éventail de services qui favorisent le bien-être et la santé des individus.

Introduction

Canada has a universal healthcare system that covers the majority of healthcare costs, such as physician costs, hospital care and tests, but that public insurance system does not include services by most non-physician healthcare professionals. This lack of insurance for services provided by non-physician healthcare professionals is especially detrimental for those with mental healthcare issues (found in 17% of the Canadian population), the costs for which are often prohibitive to those without private insurance (Corscadden et al. 2019; Sunderland and Findlay 2013). Improving access to mental health services in primary healthcare (PHC) settings can improve care quality, coordination of care and outcomes for patients struggling with mental illnesses (Rush 2014). Team-based care also improves the prevention and management of chronic diseases and is linked to lower costs (Beaulieu et al. 2013; Kates et al. 2011; Kiran et al. 2015).

In Canada, Ontario has led the way in funding interprofessional PHC teams with the introduction of Family Health Teams (FHTs) in 2005 (Brown and Ryan 2018) – which now serve approximately three million Ontarians (22% of the provincial population; Glazier et al. 2012) – and by investing in the expansion of Community Health Centres (CHCs), a PHC model established in the 1970s that serves the more vulnerable segments of the population (Collins et al. 2014; Hastings 1972). Different PHC models are intended to serve different patient populations, community needs and provider preferences (Ashcroft 2015; Glazier et al. 2012; Hutchison and Glazier 2013). In Ontario, FHTs are an example of a professional PHC model that has physicians as the main providers who hold a high level of responsibility; care is preventative, diagnostic and curative; and, historically, FHTs have little community involvement, serving a limited number of enrolled patients (Ashcroft 2015). CHCs are an example of a community PHC model aimed to meet broad health needs of the population from a social determinants perspective and serve their respective neighbourhood catchments (Collins et al. 2014).

Although both FHTs and CHCs are designed to meet local community needs, CHCs have distinct services that enable them to address the broad health needs of the more vulnerable segments of the population that they provide care for (Glazier et al. 2012). For example, compared with FHTs, CHCs typically offer a broader range of health promotion services to address the social determinants of health faced by the disadvantaged populations that they serve and are involved in a range of community engagement activities outside of their practice organization (Glazier et al. 2012). FHTs were established with the intention to improve

access to comprehensive healthcare services, interdisciplinary team-based care, patient-centred care and mental health services, as well as to improve services' continuity across other parts of the healthcare system (Ashcroft 2015; Aggarwal 2009; Brown and Ryan 2018). The interprofessional composition within FHTs and CHCs varies from practice to practice, but it typically comprises family physicians, nurses and nurse practitioners, as well as other allied health professionals, such as social workers, pharmacists and dietitians, who provide a range of health and mental health services without the burden of direct costs assumed by the patient (Glazier et al. 2012; Gocan et al. 2014; Marchildon and Hutchison 2016).

Integration of social work in PHC

The absolute numbers of social workers practising in primary care settings across Ontario are currently unknown. Yet, the surge in the emergence of interprofessional teams since the early 2000s has significantly increased the availability of publicly funded social workers in Ontario PHC settings (Ashcroft et al. 2018). For example, social workers now represent the third largest group of interprofessional health professionals in FHTs, following physicians and nurses (Ashcroft et al. 2018). The number of publicly funded social workers in FHTs ranges from approximately 0.4 to 56.7 FTE (Ashcroft et al. 2018), which suggests that some smaller FHTs have one part-time social worker and larger FHTs have hired multiple social workers across multiple sites (Ashcroft et al. 2018). Moreover, the actual number of social workers employed in interprofessional PHC settings is even more difficult to ascertain because some social workers are hired into roles that are explicitly titled "social worker," whereas other similarly trained social workers are employed in PHC settings as a "mental health counsellor" (Kates et al. 2002).

Social work's scope of practice in PHC settings

The biopsychosocial approach, person-in-context philosophy and clinical expertise of social work align well with those of PHC (Ashcroft et al. 2018; Mann et al. 2016; Rabovsky et al. 2017), particularly because patients in PHC settings are increasingly confronted with complex psychosocial and mental health problems that benefit from social work interventions (Mitchell 2008; Van Hook 2003). Social workers assist a range of patient populations and provide services in areas including mental health conditions and addictions, chronic disease, children and youth illnesses, geriatrics illnesses, grief, trauma, parenting issues, palliative care, dementia and other neurological issues, financial stressors, housing issues and a broad range of other general psychosocial issues (Ashcroft et al. 2018; McGregor et al. 2018; Sverker et al. 2017).

Patient care activities of social workers in PHC settings include providing psychosocial assessments and interventions, completing comprehensive risk assessments, providing psychotherapy as well as other types of counselling, making referrals to community resources, supporting medical provider interventions, conducting health promotion activities, engaging

in systems navigation and care coordination, providing ongoing case management, improving relationships between the medical provider and the patient, assisting in team building and, at times, assisting in the education and training of other healthcare providers (Ashcroft et al. 2018; Horevitz and Manoleas 2013; McGregor et al. 2018; Sverker et al. 2017). The typical length of appointments with social workers in PHC settings is unknown, although sessions tend to be shorter than sessions in other mental health specialty care contexts (Horevitz and Manoleas 2013).

The delivery of social work services in PHC settings may take on various forms. For example, patient care may occur in-office via direct face-to-face individual, couple and/or family appointments (Kates et al. 2002; Sverker et al. 2017). Social workers in PHC settings may conduct home visits for homebound patients as in the case of palliative and end-of-life care and other types of complex biomedical and psychosocial situations (Reckrey et al. 2014; Steketee et al. 2017). Group services are an alternate mode of care, in which social workers in PHC settings may facilitate a range of different types of psychoeducation or therapeutic group interventions (Ezhumalai et al. 2018; Kates et al. 2002; Steketee et al. 2017). Indirect interventions are also used, where the need for face-to-face contact, such as with completion of referrals and other types of documentation, is less (Horevitz and Manoleas 2013). Social workers may also lead a range of activities within PHC contexts that are not direct patient care interventions such as community development and outreach, some health promotion activities, education and training, supervision and taking on various formal and informal leadership roles (Ashcroft et al. 2018).

Despite the rapid increase of social work services, there is limited information and research conducted on social work in the current PHC context (Ashcroft et al. 2018; Dinh and Bounajm 2013; Mitchell 2008). The purpose of this study is to determine the extent to which social work services are integrated into the current PHC context in Ontario, Canada. The research question guiding our study is as follows: What social work services currently exist in CHCs and FHTs in Ontario, Canada? The objectives of our study are to (i) determine the number of social work services in CHCs and FHTs, (ii) identify the types of services that social workers provide in CHCs and FHTs, and (iii) ascertain the methods social workers use to deliver services in CHCs and FHTs.

Method

Design and context

An analysis of a cross-sectional data set obtained from a primary care setting survey conducted in June 2016 in Ontario, Canada, was performed. In Ontario, the Ontario Health Insurance Plan covers most medical care facilities for the entire population, including the primary care services provided by family physicians, but it does not cover the services provided by allied health professionals, including mental health professionals, in the non-acute

out-patient setting for most Ontarians. For this reason, and to determine the extent of services provided by allied health professionals, including social workers, a survey was considered as the appropriate method to reach a large number of primary care settings across Ontario. Only patients receiving care at a CHC or FHT may have free access to the services of a social worker or psychologist or other mental healthcare worker if that practice's team comprises such a professional. Thus, our survey targeted CHCs and FHTs because of the integration of allied health professionals within these PHC models.

Participant recruitment

The survey targeted all primary care settings that provide comprehensive care (i.e., excluding specialized and walk-in clinics) in the province of Ontario. Practice sites working together under a single organization across different geographical locations were considered unique practices and a questionnaire was sent to each. The survey was promoted through the Ontario College of Family Physicians, newsletter. Local Health Integration Network primary care leads were asked to promote the survey within their network of primary care providers. The survey was promoted by the INSPIRE PHC network through their e-mail listserv. Finally, the Ontario Association of Community Health Centres (now the Alliance for Healthier Communities [AOHC]) and the Association of Family Health Teams of Ontario (AFHTO) promoted the survey among their members each by way of membership listserv. The AOHC and AFHTO sent an invitation for their members to complete the survey on three separate occasions. This study is limited to the subset of practices in these interprofessional models. At that time, there were 184 and 73 CHCs and FHTs, respectively. One organization may have a single practice site or be composed of more than one practice site working collaboratively under the same management.

Data source

The research tool we relied on was an online survey developed to capture primary care attributes that could be studied for their relationship with the quality of care delivered. The survey was largely based on the "Measuring Organizational Attributes of Primary Health Care" survey developed by the Canadian Institute for Health Information and released in 2013 and the Evolution survey used in Quebec (Levesque et al. 2014; Pineault et al. 2012), and supplemented with additional questions to capture all required information.

Description of variables in the research tool

We assessed the practice's primary care model, team composition and services provided. For the last question, items were divided into services provided during individual appointments, group appointments and practice-level initiatives or programs. The respondent was asked to record whether that service was provided, and by whom. The options provided were doctor, registered nurse or registered nursing assistant, nurse practitioner, pharmacist, dietitian,

mental health worker and other. These questions are provided in Appendix 1, available online at longwoods.com/content/26292.

For the question that captured team composition, respondents could identify the presence of social workers and other mental health workers separately. No definition was provided for either term. The section that captured services provided six specified categories (MD, RN/RNA, Nurse Practitioner, Pharmacist, Dietitian and Mental Health Worker) and an Other category for which the respondent was asked to provide details. We created a Social Worker category to capture the sites that had identified that the service was provided by a social worker in the “Other” category. Because there was no Social Worker category available to the respondents, some practices likely recorded the work performed by these professional under the category “Mental Health Worker”. PHC practices that included social workers were identified based on the proportion of practices having reported that an activity was performed by an “other mental health worker” yet did not check “mental health workers” in their team profile. Considering the three most commonly reported services for that group, the proportion was as follows: psychosocial services, 69%; primary mental health care, 71%; and prevention and health promotion, 76%. Given that the majority of services captured under Mental Health Worker were likely performed by a social worker, we describe activities having been reported as performed by a “Mental Health Worker” or a “Social Worker” under the “Other (specify)” together for all 101 practices eligible for that analysis. As a sensitivity analysis, we also report on these activities in the subset of 68 practices having indicated that no other mental health workers or psychologists were present in the practice.

Study size

In total, 68 CHCs and 77 FHTs completed at least a portion of the survey. Of these, 10 CHCs and 14 FHTs did not complete the principal section of interest and were excluded, resulting in 58 CHCs and 63 FHTs included in the analyses. The analyses pertaining to a social worker’s role are limited to 43 CHCs and 58 FHTs having reported the presence of these professionals.

Analyses

We reported on proportions and averages for various professionals or of activities performed. Although we provide the data by model, because the intent was to understand these practices’ features in the different models, and not to identify differences, we did not conduct statistical comparisons between models.

Results

The survey was completed primarily by an administrative or clinical manager (57.0%) or executive directors (34.7%), although a practice physician, other managerial health professionals, or junior administrative staff were also involved (18.5%) in completing the survey.

Practice description

Of the 121 CHCs and FHTs, 53.7% were part of a multisite organization. Most respondents were from academic sites (70.0%) involved in teaching medical students or residents, situated in the community (93.4%) rather than attached to a tertiary care centre and established at least five years earlier (88%).

Staffing

The staffing profile in CHCs, FHTs and others is shown in Table 1. Family physicians, nurse practitioners and nurses were the most predominant health professionals at the sites. The majority of practices (83%) reported having at least one social worker on staff, and some practices (18%) had psychologists on staff. Social workers were slightly more common in FHTs, whereas other mental health workers were more common in CHCs. Thirty-one practice sites (approximately 25%) reported having an other mental health worker, a term the survey did not define in more depth. In total, 11 (35.5%) of these 31 practices did not report having a social worker on staff.

In the 101 sites that reported having a social worker on staff, the full-time equivalent ratio of social workers to primary care providers (i.e., family physicians or nurse practitioners) was 0.24, although this ratio was considerably lower in FHTs (0.16) than in CHCs (0.34).

Services provision

We limited our analyses to practices reporting having a social worker(s) on staff ($n = 101$). Among these, only 20 practices reported having Other Mental Health Worker on staff. Survey results strongly suggested that, in the absence of a Social Worker category, respondents most likely codified some activities performed by the social worker into the Other Mental Health Worker category. We show the results of the respondents that selected Mental Health Worker or specified that the activity was performed by a social worker under “Other: specify” combined. When the data set is limited to practices without any mental

TABLE 1. Human resources

Human resources	Practices with such a team member Number (%)			Full-Time Equivalent Average (SD)		
	CHC	FHTs	Overall	CHC	FHTs	Overall
Family Physicians	55 (96.5%)	63 (100%)	118 (98.3%)	3.0 (1.5)	7.8 (5.0)	5.6 (4.4)
Nurse Practitioners	57 (100%)	57 (90.5%)	114 (95.0%)	3.4 (1.8)	2.1 (1.2)	2.5 (1.5)
Registered Nurse	53 (93.0%)	63 (100%)	116 (96.7%)	4.1 (3.0)	3.8 (2.9)	3.9 (2.9)
Social Worker	43 (75.4%)	58 (92.1%)	101 (84.2%)	2.0 (1.5)	1.5 (1.0)	1.7 (1.3)
Psychologist	6 (10.5%)	16 (25.4%)	22 (18.3%)	0.5 (0.4)	0.6 (0.4)	0.6 (0.4)
Other Mental Health Worker	23 (40.4%)	8 (12.7%)	31 (25.8%)	1.7 (1.2)	0.8 (0.8)	1.5 (1.2)

Full-Time Equivalent is calculated for only practices where that team member is present. Registered Nurse includes registered practical nurses.

health professional other than the social worker ($n = 68$), the activities' profile is largely unchanged (Table 2). These professionals are commonly involved in direct, one-on-one patient service delivery, and they influenced the programs offered at the practice level. They were less likely to deliver group services.

Discussion

Amount of social work in PHC practices

There is a variation in the amount of social work services integrated across CHCs and FHTs. Although more FHTs are likely to have social workers on site (92.1% vs. 74.1%); however, the FTE is somewhat higher in CHCs than FHTs (2.0 vs. 1.5 FTE). In these practices, the ratio of social worker to FTE primary care providers was 0.24. Given the existing wait-list for social work services in many FHTs and CHCs (Ashcroft et al. 2018), determining the recommended ratio of social work services per family physician or nurse practitioner

TABLE 2. Services offered by social workers/mental health workers [practices with social worker(s) only]

Services	Percentage of practices offering the service			
	All practices (N = 101)		Practices (N = 68) without other mental health worker or psychologist	
	Overall	CHC	FHT	Overall
Individual patient appointments				
Psychosocial services	95.0	97.7	93.1	92.6
Primary mental healthcare services	90.1	88.4	91.4	85.3
Prevention and health promotion	76.2	65.1	84.5	72.1
Liaison with other healthcare organizations	64.4	65.1	63.8	69.1
Home visits	39.6	48.8	32.8	35.3
Lifestyle counselling	35.6	34.9	36.2	36.8
End-of-life/palliative care	16.8	18.6	15.5	16.2
Group appointments				
Lifestyle and healthy living	43.6	39.5	46.6	41.2
Patient self-management plans	33.7	32.6	34.5	32.4
Chronic disease management	31.7	23.3	37.9	26.5
Practice-level initiatives/programs				
For patients with mental disorders	93.1	90.7	94.8	89.7

Group appointments = group appointments for education and self-management programs.

may help to meet patient care demands (Keefe et al. 2009). Organizational features of a PHC setting have a profound effect on patient care, including the degree to which healthcare providers such as social workers are integrated into the team (Ashcroft et al. 2018; Hogg et al. 2008). Knowing the recommended amount of social work services considered optimal to meet patient care demands in a given PHC setting, and in relation to organizational variations, will aid policy and decision-makers make evidence-based decisions about future resource allocation to meet patient care demands.

Type of services provided by social workers

Social workers provide a broad range of services, including psychosocial care, mental health care, patient education and sometimes end-of-life care, in CHCs and FHTs, with little differences across models. Given that social workers were not involved in the survey completion, we suspect that these represent underestimates of the actual numbers of the types of social work services. For example, given that all of social work services fall under the umbrella of psychosocial care, we would anticipate that psychosocial care would likely be reported at 100% if social workers completed the survey (Ashcroft et al. 2018; Mann et al. 2016; Mitchell 2008; Rabovsky et al. 2017).

Contextual variables such as patient population characteristics, geographical setting and availability of community resources understandably influence the types of services offered in PHC settings (Hogg et al. 2008), including social workers' scope of practice (McGregor et al. 2018; Mitchell 2008; Sverker et al. 2017). Social workers in CHCs and FHTs are providing services to Ontarians with mental health care needs, yet the range of other types of patient populations who are recipients of social work's services such as prevention and health promotion, home visits, lifestyle counselling and chronic disease management remains unclear. Variations exist in the types of social work services provided in different PHC settings in Ontario (Ashcroft et al. 2018), yet the differences that exist between northern and southern regions remain unknown. In addition, it is unknown how the scope of practice of social workers in CHCs and FHTs is developed in relation to existing resources in different communities and the mechanisms in which social workers are liaising with other health organizations.

Methods of care delivery

A range of modalities help deliver social work services in PHC settings (Kates et al. 2002; Sverker et al. 2017). According to our data, a majority of a social work services are being provided via in-office appointments, with the emphasis more on individual appointments than on group appointments. The average length of social work appointment is unknown and was not asked in our survey. The data showed that home visits are being offered by some social workers, although the types of clinical situations and patient characteristics to benefit most from home visits by social workers in CHCs and FHTs remain unknown. Less than half of the practices having a social worker(s) reported that these professionals offered group

appointments for lifestyle and healthy living, patient self-management plans and chronic disease management. There may be even more opportunities for social workers to apply their expertise in group appointments than in what currently exists (Ashcroft et al. 2018). Future investigations will help determine the optimal modalities for practice in PHC settings to meet the high demands for social work services, given the increasing patient complexity (Ashcroft et al. 2018; Ashcroft et al. 2019).

Challenges to optimizing integration of social work in PHC

The inclusion of social work in CHCs and FHTs has made a range of services available to PHC that can help improve individual and population health outcomes. However, more data are needed to help demonstrate the impact of social work services on care processes and patient outcomes (Ashcroft et al. 2018). For example, research has shown that patients of FHTs experienced considerable improvement in diabetes care over time compared to patients of primary care physicians who were not a part of an interprofessional team (Kiran et al. 2015); yet contributions of social work, if any, to these or other types of patient outcomes despite their involvement in providing lifestyle counselling, helping with patient self-management planning and engaging in chronic disease management activities, are unknown. One of the challenges is that it is difficult to capture social work's contributions to care in administrative databases that are used to determine the population-based impact of care. Only recently has CHC interprofessional team data, including data on social work and the patients they serve, become available. Outcome data was beyond the scope of this study, although we recommend that leaders and social workers in PHC settings integrate the collection of data within the practice setting to help highlight the impact social workers are having on patient care and health outcomes. We encourage academic FHTs and CHCs to make this integration a priority, given their capacity for research.

POLICY IMPLICATIONS

The integration of social work in PHC has expanded substantially because of a systematic pan-Canadian PHC reform that began in the early 2000s (Ashcroft et al. 2018). Considerable investments have been made, leading to the accelerated inclusion of social workers in PHC settings in Ontario and elsewhere across Canada (Ashcroft 2015; Ashcroft et al. 2018; Hutchison et al. 2011). Now that social workers are flourishing in numbers in PHC settings (Ashcroft 2015; Ashcroft et al. 2018), our study suggests that there is an opportunity for key stakeholders to determine how best to sustain the social workers currently embedded in PHC practices, to maximize their contributions in patient care. This suggestion is particularly timely, given the recent provincial policy priorities to enhance patient access to mental health services, which directly align with social workers' scope of practice in PHC settings (The Canadian Press 2020).

In a previous study, social workers indicated that some leaders have a limited understanding of social workers' roles in PHC settings (Ashcroft et al. 2018). Despite the

limitation, we felt that it was important to carry out this study because the participants who completed our survey are the same leaders in PHC settings making influential decisions on the number of social workers to employ in a practice, the types of activities that fall within a social worker's role within their practice setting and the modes of service delivery that are permitted and encouraged. Despite the gaps of having non-social workers as respondents, our survey provides an opportunity to provide an understanding from a perspective that highly influences social work's role in PHC settings (Ambrose-Miller and Ashcroft 2016; Ashcroft et al. 2018).

LIMITATIONS

There are two key limitations for consideration. Using a survey to answer our research question meant that the range of responses and the depth of understanding of social workers' roles are limited to categories within the survey itself. The second limitation is that the survey relied on participants who are non-social workers and who may not be able to fully articulate the amount, range or methods used to deliver social work services in PHC settings (Ashcroft et al. 2018).

Recommendations

Our study raises additional recommendations for social work practitioners, educators and researchers. Role clarity is essential for team collaboration and for ensuring that social workers in PHC settings are contributing to patient care at an optimal level by providing the most effective types of services (Ambrose-Miller and Ashcroft 2016). We encourage social workers to identify themselves as social workers even when not hired in the role that has the social work title (such as mental health counsellor). Doing so will help clarify the scope of practice to patients, other team members and administrators (Ambrose-Miller and Ashcroft 2016). We also encourage PHC leaders to hire social workers in roles using the formal title "Social Worker" instead of the general term "Mental Health Counsellor." Furthermore, where applicable, we advise that the job title of social worker be taken into consideration and included in collective agreements. Any person who uses the title "Social Worker" or "Registered Social Worker" is registered with a provincial social work regulatory body, which then provides some assurance for educational requirements and performance standards that guide scopes of practice (Collins et al. 2002). There is substantial value in having PHC professional organizations (e.g., AFHTO and the Ontario College of Family Physicians) and social work professional organizations (e.g., Ontario Association of Social Workers) collaborate to help determine how to maximize social workers' scope of practice in PHC settings. The reason for this is because healthcare is a complex system, and by effectively nurturing the ongoing integration of social work in PHC settings, local PHC leaders will benefit from ongoing direction and supportive infrastructure at a macro level (Corrigan et al. 2017; Sørensen et al. 2018).

Educators have a role to ensure that social workers are prepared to provide a range of services using multiple modalities that are required in comprehensive and fast-paced PHC settings (Horevitz and Manoleas 2013). Academic practice sites are well-positioned to facilitate educational opportunities for social work students, given their long history of training medical students and family medicine residents (Soklaridis et al. 2007). Early exposure to PHC teams, and learning in “real time” (with trainees from other disciplines), can increase the social work practice readiness in primary care settings (de Saxe Zerden et al. 2018). Further embedding social work within the training provided at academic practices will better prepare students from other disciplinary backgrounds for collaborative care practices inherent to PHC (de Saxe Zerden et al. 2018). When social work students are included in interprofessional training opportunities, students from other disciplinary perspectives gain a greater understanding of group process, improve communication skills for difficult conversations, feel more confident when encountering adversity and improve group decision-making abilities – which leads to better patient care outcomes (Charles et al. 2011; Reeves et al. 2017). We encourage the academic practice sites involved in our study to also prioritize education and training of social workers.

We recommend that researchers develop surveys in a way that can capture social workers’ contributions in PHC settings. Complexities exist in doing so because of the many roles assumed by social workers in PHC settings. For example, many mental health worker positions are held by a social worker. It is challenging for surveys to capture person-centred, relational and multipronged approaches of social work unless these are designed from the outset with this particular intent. Future research can help determine the most optimal types of activities, approaches and delivery modalities for social workers to use, to best address the needs of increasingly complex patient issues within the current PHC context.

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