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REVIEW ARTICLE

The value that social workers' competencies add to health care: An integrative review

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Abstract

Health and social care professionals' competencies have traditionally been separated because of the different aims of the two professions. These competencies need to be integrated, to make sure that seamless services are provided that meet the often complex needs of patients and clients in a coordinated and timely way. The aim of this integrative review was to identify, describe and synthetise previous studies on integrated competencies in health and social care. Electronic literature searches were carried out on the CINAHL, ProQuest, PsycInfo, PubMed, Scopus and SocIndex databases for peer-reviewed scientific papers that were published in English between 1 January 2007 and 31 December 2019. This identified 3,231 papers, after duplicates were removed, and 18 focused on the integration of social workers' competencies with health care. Other types of integration were not found. The value added by integrating social workers' competencies with health care focused on engaging working orientation, improving communication with family members, increasing understanding of service resources and mastering successful discharge procedures so that they met comprehensive, complex health and well-being needs. Social workers added value when they worked with multi-professional teams, but there were challenges to integrating competencies and these were related to professional collaboration and fragmented leadership. In future, more attention needs to be paid to diversifying and optimising the integration of professional health and social care competencies that meet clients' and patients' care and service needs. It is also vital to focus on developing the professional and leadership strategies that are needed to combine those competencies.

KEYWORDS

competencies, health care, integration, integrative review, profession, social care

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What is known about this topic:

- Health and social care professionals have traditionally been educated separately and responded to different service needs.
- The increasing need for a more joined up approach to addressing multidimensional health and well-being needs has highlighted the importance of integrated competencies.
- An overview of studies on integrated competencies in health and social care was lacking.

What this paper adds:

- The integration of social workers' competencies in health care was investigated at a sector level and focused on patient care, particularly, the challenges of hospital discharge.
- More attention needs to be paid to integrated competencies at a professional level and to effective leadership strategies that optimise integrated competencies in health and social care.

1 | INTRODUCTION

The competencies of health and social care professionals create a basis for high-quality care and services (Soares et al., 2019). Professional competencies consist of the knowledge, skills, attitudes and self-efficacy that professionals need to carry out their work (Kang et al., 2013; Mulder, 2014) They ensure safe and high-quality outcomes for individuals and populations (Langins & Borgemans, 2015). Knowledge consists of information and understanding of the subject area (Camelo & Angerami, 2013; Mulder, 2014). Skills refer to a professional's ability to use their knowledge effectively and they can be motor, cognitive and social skills (Handel, 2003). Attitudes refer to professionals' long-term views of the subject, human beings or practices (Dijkman et al., 2017). Self-efficacy refers to individuals' perceptions of their ability and capacity to influence actions (Bandura, 1977). Thus, professional competencies require a certain level of social and emotional intelligence (Langins & Borgemans, 2015) to reflect on what is needed and to apply it in practice in a purposeful, intentional and professional manner (Council of Social Work Education & CSWE, 2015; WHO, 2006).

The competencies needed by health and social care professionals have traditionally been separated and have reflected the different aims of these two professional areas (Dijkman et al., 2017). The aims of healthcare professionals are to improve health, prevent diseases and alleviate the suffering of patients (Spitzer et al., 2015; WHO, 2006). Healthcare competencies are specific to different professions, but these core competencies all focus on disease and health (Stanhope et al., 2015), patient advocacy, people-centred care, communication, team work and continuous learning (Langins & Borgemans, 2015). Social workers have to address psychosocial needs in order to promote individual and community well-being (CSWE, 2015; Rosen et al., 2003; Spitzer et al., 2015; Woods & Hollis, 2000) and justice in society (Wakefield, 1998). The competencies that they need are ethics and diversity, evidence-based and policy-led practices, engagement and the ability to assess, intervene and evaluate practices that affect individuals and communities (CSWE, 2015). The different aims and competencies that are needed reflect the different legal bases for health and social care and different educational provision.

It is important to note that the health and well-being of individuals and groups are influence by various social determinants in social and health care. These include factors relating to the individual, their family and the society and environment they live in (Stanhope et al., 2015). This has led to complicated health and well-being needs, which professionals from just one sector have not been able to address (DeGraaf et al., 2020; Lee et al., 2019; Spitzer & Davidson, 2013). The result has been that patients and clients have received services that have been delivered by highly educated, but separate, professionals with different competencies, working in a complex, fragmented system. Different professionals have had to work together to identify and provide the services needed by patients and clients (Spckalingam et al., 2020; Spitzer & Davidson, 2013). A number of specific service users have been identified that need care provided by professionals with integrated competencies. These include older adults who want to manage their own daily life activities and people with health disparities (Soares et al., 2019; Spitzer & Davidson, 2013), chronic diseases (McGilton et al., 2018; Webbkamigad et al., 2020) and mental health needs (Spckalingam et al., 2020).

During the last few decades, the need for health and social care professionals with integrated competencies has been highlighted (McGilton et al., 2018; Spckalingam et al., 2020; Webbkamigad et al., 2020). This has included the need to integrate professional competencies that cross existing health and social care sectors. There is also a need to respond to the need for shared competencies that address new or emerging fields of health and social care (Nummela et al. 2019). Although integrating professional competencies in health and social care can play an essential role at patient and client levels, this also has implications for service development. Despite this, an overview of the current knowledge on the topic has been lacking. Synthetised knowledge would deepen our understanding of the integrated competencies that need to be developed to meet the needs of health and social care education and practice development.

2 | AIM

The aim of this integrative review was to identify, describe and synthetise previous studies on the integrated competencies of health and social care professionals. It aimed to respond to three research questions: what methods have been used to study integrated competencies in health and social care, what type of integrated competencies have been studied and how have the benefits of these competencies been described in studies?

3 | METHOD

We used a five-stage integrative review method to identify and synthesise knowledge of studies, which had been carried out using different methods (Whittemore & Kanfl, 2005). These five phases were identifying the research problem, literature searches, data evaluation, data analysis and presenting the synthesis of the results.

3.1 | Identifying the research problem

The first stage was to identify the research problem by conducting preliminary electronic literature searches (Whittemore & Kanfl, 2005). According to that method, we used different sets of search terms regarding competencies and health and social care professionals to find the most effective combinations.

3.2 | Literature searches

The second phase was carrying out electronic literature searches using the CINAHL, ProQuest, PsycInfo, PubMed, Scopus and SocIndex databases (Figure 1). The search terms were formulated by the research group with the help of a university information specialist. In order to ensure that these searches were comprehensive, we used both free words and MeSH or subject terms and combinations of those. The search terms covered the concept of competencies and health and social care professionals and are presented in Figure 1. The searches were limited to peer-reviewed papers that were published in English between 1 January 2007 and 31 December 2019. In addition, the searches on CINAHL, SocIndex and ProQuest were limited to "abstract available" and the Scopus search was limited to the subject area of "Title-Abstract-Keywords" (Figure 1).

3.3 | Search outcome and selection

The electronic searches identified 3,592 papers and, after removing the duplicate items, 3,231 studies were included in the data. We then selected papers based on their titles ($n = 927$), abstracts ($n = 75$) and full texts ($n = 18$), using our inclusion and exclusion criteria. Our inclusion criteria were as follows: (a) that the original studies included search terms and their synonyms, (b) that they focused on any type of integrated competencies of health and social care professionals, (c) that they covered both health and social care contexts, (d) that they involved at least two professional groups from different fields and (e) they were empirical studies. Our exclusion criteria were that the original study focused on didactic methods or approaches for competencies or organisational or managerial factors. The selection process was independently carried out by all four authors.

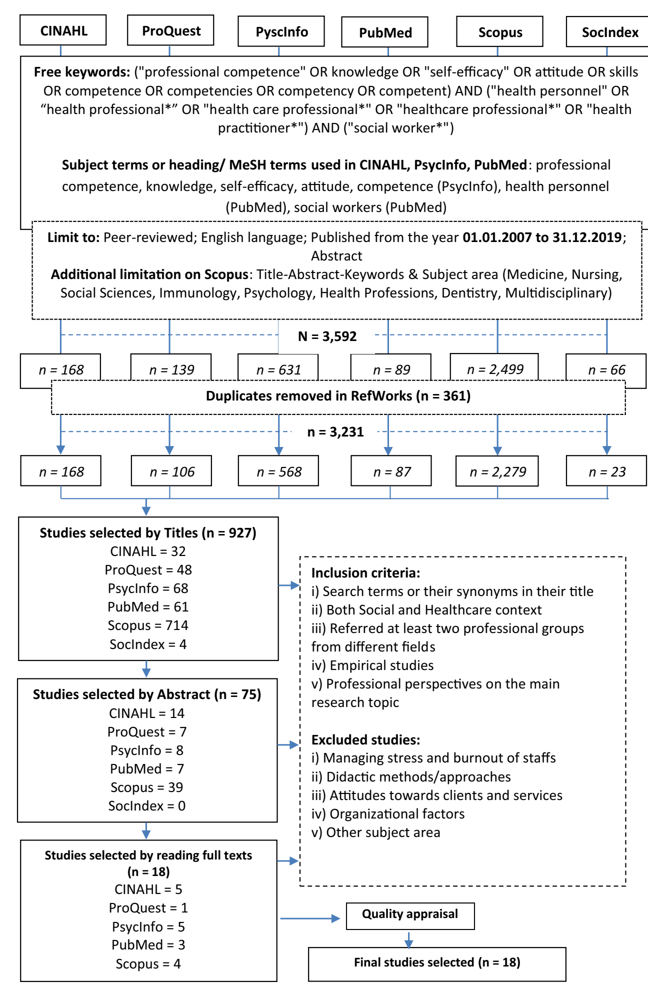

FIGURE 1 Flowchart of literature searches

3.4 | Quality appraisal

The third phase was data evaluation and we used method-specific quality appraisal criteria (Caldwell et al., 2011; Gifford et al., 2007; Greenhalgh et al., 2004). The evaluation consisted of 13 general items, 9 items for the qualitative studies and 8 items for the quantitative studies (Table 1). The evaluation was based on three levels: one for yes, zero for no and not applicable for not stated or not relevant. The maximum points were 22 for the qualitative studies, 21 for the quantitative studies and 30 for the mixed qualitative and quantitative study methods. The mean score for the quality appraisal of the

TABLE 1 Summary of the 18 papers covered by this review

Author(s), year, country Quality appraisal	Aim	Research methods
Abendstern et al., 2016, UK 19/22 points	To evaluate the contribution made by social workers when they worked in multi-disciplinary teams caring for older people with mental health issues.	Method: qualitative study. Study context: community mental health care. Participants: 42 staff members of community mental health teams, including team managers, psychiatrists, nurses and social workers. Data collection: semi-structured interviews Analysis: grounded theory.
Albrithen & Yalli, 2015, Saudi Arabia 14/21 points	To evaluate social workers' perceptions of interprofessional work issues that can influence their abilities to maintain their effective contribution to the healthcare team.	Method: quantitative study. Study context: hospital. Participants: 260 social workers (response rate 84%). Data collection: questionnaire. Analysis: statistical methods.
Bronstein et al., 2007, USA 20/30 points	To address the fit between social work education and their ability to practice in health care.	Method: mixed-method study. Study context: health care. Participants/data: 179 social workers and 15 syllabi. Data collection: questionnaire with closed and opened-ended questions. Analysis: statistical methods and content analysis.
Fouche et al., 2013, New Zealand 20/22 points	To explore the perceptions of healthcare professionals and social workers on competencies needed in the field of chronic care.	Method: qualitative study. Study context: primary and community health care professionals. Participants: 21 psychologists, physicians, nurses, occupational therapists, pharmacists, physiotherapists, social workers and speech therapists. Data collection: focus group interviews. Analysis: thematic content analysis.
Gearing et al., 2007 Canada 21/22 points	To identify social workers experiences during a severe acute respiratory syndrome outbreak in a children's hospital in Canada.	Method: qualitative study. Study context: hospital. Participants: 19 social workers. Data collection: focus groups with open-ended discussions. Analysis: phenomenological theory.
Horevitz & Manoleas, 2013, USA 18/21 points	To identify key practice domains for social workers in integrated behavioural health settings. To assess whether social workers feel adequately prepared to work in such settings.	Method: quantitative study. Study context: integrated behavioural health in primary care. Participants: 84 social workers. Data collection: questionnaire with structured and open-ended questions. Analysis: statistical methods and content analysis.
Jones et al., 2013, UK 24/30 points	To explore how different professionals within multi-professional teams define their own core professional competencies, characteristics and contributions and those of other professions.	Method: mixed-method study. Study context: health care. Participants: 64 social workers, nurses, occupational therapists, community matrons, psychologists, psychiatrists, speech therapists, physiotherapists and dieticians. Data collection: interviews with Likert scale. Analysis: statistical analysis.
Kang et al., 2013, Republic of Korea 16/21 points	To report the processes and results of developing hospice and palliative care competencies by multi-disciplinary experts in Korea.	Method: quantitative study. Study context: hospice and palliative care settings. Participants: 15 physicians, nurses, social workers and members of the clergy. Data collection: two-round Delphi survey. Analysis: descriptive statistical methods.
Keefe et al., 2009, USA 19/22 points	To examine the perspectives of key providers about the benefits and challenges of integrating social workers into primary care teams.	Method: qualitative study. Study context: primary care. Participants: 25 physicians. Data collection: focus group interviews. Analysis: grounded theory.

(Continues)

Health and Social Care in the community

TABLE 1 (Continued)

Author(s), year, country Quality appraisal	Aim	Research methods
Korazim-Körösy et al., 2014, USA 25/30 points	To examine interdisciplinary community collaborative experiences, by exploring the views of six different professional groups.	Methods: mixed-method study. Study context: community care. Participants: 50 including lawyers, social workers, psychologists, nurses, physicians. Data collection: questionnaire and open-ended questions. Analysis: statistical methods and grounded theory.
Lynch, 2014, USA 19/22 points	To investigate factors affecting satisfaction with communication between social workers and paediatricians.	Method: qualitative study. Study context: primary care. Participants: 26 social workers and paediatricians. Data collection: ethnographic interviews. Analysis: content analysis.
Maybery et al., 2014, Australia 18/21 points	To determine practice differences between different professions working in adult mental health services in terms of their family-focused work.	Method: quantitative study. Study context: mental health care. Participants: 307 adult mental health professionals comprising psychiatric nurses, social workers and psychologists. Data collection: questionnaire. Analysis: statistical methods.
O'Connor & Fisher, 2011, Australia 19/22 points	To explore team members' perceptions and experiences of team dynamics in psychosocial palliative care.	Method: qualitative study. Study context: palliative care. Participants: seven professionals – nurse, physician, medical specialist, psychiatrist, social worker, counsellor and occupational therapist. Data collection: semi-structured interviews. Analysis: constant comparison.
Ramgård et al., 2015, Sweden 19/22 points	To identify barriers and opportunities for interprofessional collaboration. To use participatory action research to support collaboration in health and social care planning.	Method: qualitative study. Study context: older people's care. Participants: 18 registered nurses, physiotherapists, occupational therapists, social workers, senior managers and physicians. Data collection: participatory action research. Analysis: content analysis.
Sanders & Swails, 2009, USA 19/22 points	To determine how professionals view their work with end-stage dementia patients and their caregivers.	Method: qualitative study. Study context: dementia care. Participants: 13 hospice social workers. Data collection: interviews, in-field observations and chart reviews. Analysis: constant comparative analysis.
Sims-Gould et al., 2015, Canada 21/22 points	To examine the role of social work and social workers handling the care transitions of patients with hip fractures.	Method: qualitative method. Study context: hospital care. Participants: phase 1 – 17 social workers. Phase 2 – six patients, five family caregivers, and 32 healthcare professionals. Data collection: semi-structured Interviews. Analysis: ethnographic analysis.
Sumser et al., 2015, USA 9/21 points	To investigate how well prepared health social workers felt to provide palliative and end-of-life care with regard to preparation, training and self-assessed competencies.	Method: quantitative study. Study context: palliative and end-of-life hospital care. Participants: 1,149 healthcare staff and social workers. Data collection: questionnaire. Analysis: statistical methods.
Swallow et al., 2015, UK 21/22 points	To report interactions between health and social care professionals and parents working in a network of children's kidney units.	Method: qualitative study. Study context: paediatric hospital unit. Participants: 112 psychologists, dieticians, doctors, nurses, pharmacists, play workers, therapists and social workers. Data collection: group interviews. Analysis: content analysis.

qualitative studies was 19.7 (range 19–21), it was 15 (range 9–18) for the quantitative studies and it was 23 for the mixed-method studies (range 20–25). The main weakness was poorly reported research ethics, which were missing in 14 of the 18 studies. The four authors of this review independently conducted the quality appraisal. When necessary, they discussed the findings and reached a common

consensus. As our aim was to assess the quality of the papers, rather than to exclude them for low quality, we included all of the selected studies in the review.

3.5 | Data analysis

The fourth phase of review was the data analysis and we used the constant comparison method to provide an integrated conclusion about the research problem (Whittemore and knafl, 2005). The first stage of the analysis was to read all the selected papers several times to get an overview of the entire data. These were then tabulated, according to the author(s), years of publication and the aims, methods and sample. In addition, we identified the information about the study environments and data collection methods. After that we started the reduction phase of the analysis (Whittemore & Knafl, 2005). This involved extracting the data from the primary sources about the integration of professional competencies in health and social care. The extracted data were then collated, so that the entire content could be displayed. Then, we examined these data displays of the primary sources and used the constant comparison method to group these based on their similarities and differences. The groups were initially categorised into eight sub-categories and then we abstracted them again into two main categories. The analysis up to the sub-subcategory stage was carried out by two of the authors (MK, AH-L) and the final analysis was conducted by all of the authors working together.

4 | RESULTS

4.1 | The methodology of the studies

Based on our findings, all 18 of the selected studies focused on how social workers' competencies were integrated with health care. No other types on integration were found.

Of the 18 original studies in the review, nine used qualitative methods, six used quantitative methods and three used mixed methods (Table 1). The data collection methods in the qualitative studies were individual (O'Connor and Fisher 2011, Abendstern et al., 2016; Lynch, 2014; Sims-Gould et al., 2015) and focus group interviews (Fouche et al., 2013; Gearing et al., 2007; Keefe et al., 2009; Swallow et al., 2015). The focus groups used semi-structured questions (Abendstern et al., 2016; Lynch, 2014; O'Connor & Fisher, 2011; Sims-Gould et al., 2015) or those that generated open-ended discussions (Gearing et al., 2007). The studies used interviews with participants (Ramgård et al., 2015), field observations and chart reviews (Sanders & Swails, 2009). The data in the qualitative studies were analysed using grounded theory (Abendstern et al., 2016; Keefe et al., 2009), thematic analysis (Fouche et al., 2013), content analysis (Lynch, 2014; Ramgård et al., 2015; Swallow et al., 2015) and constant comparison (O'Connor & Fisher, 2011; Sanders & Swails, 2009). In addition, phenomenological theory (Gearing et al., 2007) and ethnographic analyses were carried out (Lynch, 2014; Sims-Gould et al., 2015).

The quantitative studies used questionnaires to collect the data (Albrithen & Yalli, 2015; Horevitz & Manoleas, 2013; Maybery et al., 2014; Sumser et al., 2015) and one study used a Delphi panel (Kang et al., 2013). The mixed-method studies combined data from surveys with syllabus analyses (Bronstein et al., 2007), open-ended interviews (Korazim-Körösy et al. 2014) and interviews that included both qualitative and quantitative analyses (Jones et al., 2013). The qualitative data were examined using content analysis (Bronstein et al., 2007) and grounded theory (Korazim-Körösy et al., 2014) (Table 1).

There were 333 participants enrolled in the qualitative studies (range 7 to 112 participants, mean 10) and 1,815 in the quantitative studies (range 15 to 1,149, mean 363). The three mixed-method studies comprised 293 participants. Social workers took part in all of the studies and the healthcare professionals who were enrolled were nurses, physiotherapists, occupational therapists, physicians, psychologists, dieticians, pharmacists, play workers, members of the clergy, lawyers, managers and mental health professionals. Patients and family caregivers were included in one study (Table 1).

In four studies, the research environment was a hospital (Albrithen & Yalli, 2015; Gearing et al., 2007; Sims-Gould et al., 2015) and one was specifically described as a paediatric care hospital (Swallow et al., 2015). In the rest of the studies, the research environment was described as health care (Bronstein et al., 2007; Jones et al., 2013), community health care (Korazim-Körösy et al. 2014, Abendstern et al., 2016) and primary care (Fouche et al., 2013; Keefe et al., 2009; Lynch, 2014). In addition, health care was specified as integrated behavioural health in primary care (Horevitz & Manoleas, 2013) and mental health care (Maybery et al., 2014). Research was also carried out at in various palliative care settings (Kang et al., 2013; O'Connor & Fisher, 2011; Sumser et al., 2015), in older peoples' care (Ramgård et al., 2015) and in dementia care (Sanders & Swails, 2009).

The selected papers comprised seven from the United States, three from the United Kingdom, two each from Canada and Australia and one each from Sweden, Saudi-Arabia, New Zealand and the Republic of Korea.

4.2 | Integration of social workers competencies with health care

Based on the selected studies, the integration of social workers' competencies with health care focused on: *engaging working orientation*, *communication with family members* and *understanding service resources*. Social workers competencies were also highlighted with regard to *successful discharge*, *comprehensive and complex health and wellbeing needs* and *working with multi-professional teams*. In addition, there were a number of challenges with regard to integrating social workers' competencies in health care and these were identified as profession-based reasons and fragmented leadership.

4.2.1 | Engaging working orientation

In health care, social workers provided knowledge about engaging working orientation, which focused on how their work could engage with their clients to identify the personal strengths and resources they needed to move forward. Studies referred to this in relation to social workers' ethical competencies (Abendstern et al., 2016; Bronstein et al., 2007; Korazim-Körösy et al., 2014) and patient's individual issues and vulnerabilities (Bronstein et al., 2007). They had competencies that enabled them to empower patients (Kang et al., 2013) and advocate for them (Kang et al., 2013; Swallow et al., 2015). They also supported patients' rights to make autonomous decisions (Ramgard et al., 2015) and recognised how emotional (Gearing et al., 2017; Sims-Gould et al., 2015), cultural and religion aspects influenced the individual´s care process (Sumser et al., 2015).

When it came to clinical issues, social workers contributed to a wide range of client-centred care, including pain and symptom management (Sumser et al., 2015), bereavement care (Kang et al., 2013), mental health advice (Kang et al., 2013; Lynch, 2014) and recovery (Abendstern et al., 2016). They provided care planning and coordination (Kang et al., 2013; Keefe et al., 2009), care interventions (Kang et al., 2013; Sumser et al., 2015) and were able to use working methods to carry out risk (Jones et al., 2013) and functional assessments (Horevitz & Manoleas, 2013; Kang et al., 2013). They also provided motivational interviewing, relaxation training (Horevitz & Manoleas, 2013) and patient education and follow up (Abendstern et al., 2016; Horevitz & Manoleas, 2013; Keefe et al., 2009; Lynch, 2014).

4.2.2 | Communication with families

Social workers contributed to communication with family members, as they provided knowledge on how to see patients in their social context (Abendstern et al., 2016; Kang et al., 2013; O'Connor & Fisher, 2011). They also provided knowledge on family systems (Horevitz & Manoleas, 2013; Sumser et al., 2015), how hospitalisation and diseases affect families (Sanders & Swails, 2009; Sumser et al., 2015; Swallow et al., 2015) and how families and caregivers support patients (Gearing et al., 2017; Keefe et al., 2009). In addition, their expertise was useful when professionals needed to know how to communicate (Sims-Gould et al., 2015) and work with families (Keefe et al., 2009; Maybery et al., 2014; Sims-Gould et al., 2015). Social workers also had competencies that enabled them to resolve conflicts and mediate between family members, as well as between patients and healthcare professionals (Sims-Gould et al., 2015). They were able to carry out family meetings (Sims-Gould et al., 2015; Sumser et al., 2015) and provide care interventions for whole families (Sumser et al., 2015).

4.2.3 | Understanding service resources

Social workers had a wide understanding of service resources and how they worked (Abendstern et al., 2016; Fouche et al., 2013; Gearing et al., 2017; Kang et al., 2013; Keefe et al., 2009; Lynch, 2014; Sims-Gould et al., 2015). Studies reported that social workers had competencies that related to older adults placed in long-term care facilities and accessing community-based services (Keefe et al., 2009). They also understood service availability (Abendstern et al., 2016; Sims-Gould et al., 2015), chain and management (Fouche et al., 2013; Kang et al., 2013; Lynch, 2014). They had competencies that enabled them to advocate for patients and families when they needed services (Gearing et al., 2017) and to assist them with regard to insurance issues with health and social care (Lynch, 2014). In addition, social workers understood legislation and were able to help with issues such as guardianship and the laws that were used to review people in different circumstances (Abendstern et al., 2016).

4.2.4 | Successful discharge

Social workers had competencies that enabled them to handle the successful transition from hospital discharge back to the patient's home (Kang et al., 2013; Sims-Gould et al., 2015; Swallow et al., 2015). Studies also recognised that they had the practical skills that enabled them to make patients and their family members aware of the practical consequences of being cared for at home (Swallow et al., 2015). They were experienced in using different methods to evaluate the person's home situation and evaluate whether, for example, older people were able to live at home after they had been hospitalised (Keefe et al., 2009). Social workers had competencies that enabled them to evaluate the family dynamics at home, including substance abuse risks and whether the person would get enough nutritious food during the care transition. They also had skills that enabled them to follow up people after they were discharged (Sims-Gould et al., 2015).

4.2.5 | Comprehensive and complex health and well-being needs

Social workers had competencies that enabled them to deal with the most comprehensive and complex health and well-being needs of patients (Fouche et al., 2013; Sims-Gould et al., 2015). For example, these could include patients who were vulnerable (Bronstein et al., 2007) because of multiple morbidities (Fouche et al., 2013), suicidality (Keefe et al., 2009), immigration (Swallow et al., 2015) or alcohol and drug abuse (Horevitz & Manoleas, 2013). These patient typically had needs that crossed several sectors outside health care (Fouche et al., 2013).

Studies reported that social workers had competencies to provide so-called social care models of illness and recovery (Abendstern et al., 2016), and holistic care that responded to patient's individual life situations (Fouche et al., 2013; Korazim-Körösy et al., 2014). They were used to recognising and carrying out multidimensional assessments of patient's individual psychosocial, environmental (Bronstein et al., 2007; Fouche et al., 2013; Sims-Gould et al., 2015; Swallow et al., 2015) and economical challenges (Sims-Gould et al., 2015;

Swallow et al., 2015) and how they adhered to care packages and used medication (Fouche et al., 2013). They also had competencies to assess, and provide interventions for, alcohol and drug abuse issues (Horevitz & Manoleas, 2013). The competencies that enabled them to handle complex situations also included how to mediate and resolve patient's conflicts and crises with their families and their community (Bronstein et al., 2007; Sims-Gould et al., 2015).

4.2.6 | Advantages of working with multi-professional teams

Working with multi-professional teams was seen as part of the social workers' competencies (Horevitz & Manoleas, 2013, Albrithen & Yalli, 2015, Sumser et al., 2015, as Gearing et al., 2017) and they used various methods for collaboration (Sumser et al., 2015) and team working (Horevitz & Manoleas, 2013). In addition, they supported, and advocated for, health professionals in hospital settings (Gearing et al., 2017).

Social workers' competencies made a crucial contribution to healthcare teams and added knowledge (Abendstern et al., 2016). They contributed to the work of healthcare professional teams in a number of ways. These included optimising information sharing (Swallow et al., 2015) and pooling knowledge (Fouche et al., 2013), which meant that the combined health and social care teams possessed much wider knowledge than the individual professions (Fouche et al., 2013). From the patients' point of view, this gave social workers more strength to achieve their goals and advocate for patients (Horevitz & Manoleas, 2013) and improve patients' health outcomes (Abendstern et al., 2016; Bronstein et al., 2007; Fouche et al., 2013; Kang et al., 2013; Keefe et al., 2009; Sims-Gould et al., 2015) and quality of care (Fouche et al., 2013). In addition, combined health and social care teams found that collective collaboration promoted the patients' knowledge of clinical issues (Swallow et al., 2015). From a service process point of view, social workers were able to get services delivered more effectively (Albrithen & Yalli, 2015) and the same was true for care processes. In addition, making sure that services were provided at an early stage (Abendstern et al., 2016) was preventive, as it avoids crisis situations developing (Keefe et al., 2009).

4.3 | Challenges for integrating social workers' competencies

However, there were challenges relating to the integration of social workers' competencies, and their wider contribution, when it came to professional collaboration and healthcare structures.

4.3.1 | Professionals' collaboration

The key problem with integrating competencies was if there was a conflict between professional goals and how to provide the best possible service for patients (Fouche et al., 2013). In addition, both health and social care professionals were reported to have a poor understanding of the content and tasks of each other's professions (Albrithen & Yalli, 2015; Fouche et al., 2013; Lynch, 2014; Ramgard et al., 2015). For example, healthcare professionals were not well informed about what social workers did in hospitals (Albrithen & Yalli, 2015), what knowledge they had and what professional qualifications they had (Lynch, 2014; Ramgard et al., 2015). Physicians who had demanding schedules were concerned that social workers would take up too much of their time discussing issues. Nurses were afraid that social workers will take over nurses' non-medical tasks and after that nurses role will be expanded for medical issues (Keefe et al., 2009). Integration was also challenging because the health and social care workers had a poor understanding of each other's work values and of the different terminology that was specific to each profession (Ramgard et al., 2015). The lack of clear role boundaries and knowledge of each other's professional roles created dilemmas (O'Connor & Fisher, 2011) and led to inefficient collaboration (Albrithen & Yalli, 2015).

Social workers felt that integrating their competencies with health care was ignored, or not put into action, because the medical views of healthcare professionals took priority (Lynch, 2014; Ramgard et al., 2015) and they had more authority (Albrithen & Yalli, 2015). Gender hierarchy was also an issue, as physicians were mainly men and social workers were mainly women (Lynch, 2014). Ineffective communication between social workers and healthcare professionals resulted from cultural diversity and health professionals' negative attitudes towards social workers (Albrithen & Yalli, 2015). In addition, social workers felt that they did not have sufficient knowledge about all the healthcare issues where their competencies were expected to contribute to patients care (Sanders & Swails, 2009; Sims-Gould et al., 2015).

4.3.2 | Fragmented leadership

One challenge faced by social workers with regard to integrating their competencies with health care was fragmented leadership in interdisciplinary teams. Instead of coordinated teamwork, any collaboration was carried out between individuals without formal, facilitating structures. Poor leadership was also encountered when different professions did not work at the same healthcare facilities and that caused misunderstandings and a lack of awareness of each other's roles (Keefe et al., 2009). However, organising structured and shared in-service training was seen as a way of supporting social workers, so that they could contribute to health care (Albrithen & Yalli, 2015; Fouche et al., 2013; Gearing et al., 2017). Interdisciplinary team training was needed to increase the social workers' understanding of the culture and content of medical education and the dynamics of patient–physician relationships (Horevitz & Manoleas, 2013).

4.4 | Discussion

Based on our synthesis, studies examined the added value that the integration of social workers competencies could provide in hospital and community health care. The integration of social workers

competencies played a crucial role in improving patient's health outcomes and quality of care, engaging working orientation in health care, improving communication with family members and increasing understanding service resources. In addition, the integration of social workers' competencies played an important role in successfully discharging patients, with complex health and well-being needs and working with multi-professional teams. However, integrating competencies was also associated with challenges in relation to professional collaboration and fragmented leadership in interdisciplinary team work.

4.4.1 | Integrating competencies between, and within, professions

The studies in this review frequently referred to integrating competencies, where social workers' competencies were based on their education and combined with the competencies of other professionals. Discussions on integrated competencies focused on established social worker competencies, namely, professional ethics, evidence-based team work and service delivery (CSWE, 2015). They provided multi-dimensional support for patients that focused on all aspects of their lives, including families and finances (Sims-Gould et al., 2015; Swallow et al., 2015) and understanding service resources that crossed health and social care disciplines (Abendstern et al., 2016; Gearing et al., 2017; Sims-Gould et al., 2015). It is noteworthy that when different professions worked side by side, the supposed content of their competencies was seen as borders between the professions that could not be crossed. This can lead to the risk that some care needs and services are not covered and clients and patients can fall between the gaps in the borders between different professional competencies. These gaps can risk patient safety or increase their future needs for care and services. This highlights the need to critical analyse and identify not just different professional competencies but their integration. So that health and social care professionals can work seamlessly to meet complex needs in a holistic way. Thus, the integration of competencies can help to build up a more complete picture of what patients and clients need and how health and social care professionals can work together to meet those needs.

In future, more attention should be paid to the integrated competencies of health and social care professionals. The integration of competencies should also involve the horizontal integration of the knowledge that is required by all professionals, including social workers, physiotherapists, nurses and physicians. This will ensure that services can be provided for people with diverse needs and backgrounds. Traditionally, integrated competencies of this nature have referred to human rights and understanding different cultures (Burchill & Pevalin, 2014). However, they have been expanded to cover topical subjects such as how health and social care professionals can help to protect the environment by adopting green policies (Nichols et al., 2020) and the skills and knowledge they have demonstrated during the unique conditions and problems created by the COVID-19 pandemic (Boyd, 2020). These type of competencies are often novel and are increasing for all professions. They may create non-hierarchical content and learning in these fields, as staff at all levels need to get involved. In future, we need to carry out more research on integrated competencies, to make sure that health and social care professionals are able to respond to other emerging issues in the future.

4.4.2 | The value that social workers' integrated competencies added to health care

Based on this review, studies investigated social workers' competencies with regard to patient care and focused on the fields that have been identified as core competencies for both social and healthcare professionals (CSWE, 2015; Langings & Borgemans, 2015). However, the added value of social workers' integrated competencies has been highlighted by studies that focused on the most vulnerable groups, such as older people (McGilton et al., 2018; Ramgård et al., 2015; Stanhope et al., 2015; Webbkamigad et al., 2020), families with small children (Gearing et al., 2007; Maybery et al., 2014) and patients with mental illness (Palmer et al., 2018; Stanhope et al., 2015; Zhao et al., 2019) and substance abuse (Daw et al., 2017; Stanhope et al., 2015). It has been reported that when patients and their caregivers have multiple chronic conditions (Webbkamigad et al., 2020) and complex needs (Spckalingam et al., 2020), they require care for longer periods of time (Palmer et al., 2018; Zhao et al., 2019) and that those need to be provided by multi-dimensional support services (DeGraaf et al., 2020; Lee et al., 2019; Peters et al., 2018). Such patients would benefit from early needs assessments and easy access to low-threshold services (Spitzer et al., 2015). Thus, in future we need to pay more attention to how the social workers' competencies could be integrated with health care, so that these patients could receive adequate services in a timely fashion (Pinelli et al., 2017). Timely provision also cuts costs in the long run (Harrison et al., 2019). Both health and social care professionals need competencies to achieve this.

It is interesting to note that social workers' competencies were integrated for complex cases on a horizontal level (Nicholas et al., 2019; Spckalingam et al., 2020), but also related to vertical level care processes during hospital discharges. Discharge poses serious risks for patient safety (Waring et al., 2015; Yu et al., 2017) and continuum of the care (Yu et al., 2017). In addition, unsuccessful discharge leads to deterioration in the lives of both patients and caregivers (Everall et al., 2019) and can lead to readmission (Prusaczyk et al., 2019). However, as summarised in this review, these challenges need to be tackled by integrating how professionals' knowledge is planned and used (Pinelli et al., 2017) and ensuring close communication with community care. Social workers' competencies play a central role in this process. Studies have highlighted that social workers have the knowhow to promote the well-being of individuals and groups through social and family interaction and as a part of health and social care (Harrison et al., 2019). In addition, they have the competencies to follow-up patients after they are discharged from hospital, to prevent the readmission (Goldman et al., 2016).

4.4.3 | Optimising integrated competencies

Integration of social workers' competencies into health care creates new opportunities for professionals to renegotiate and re-establish their presence, purpose and role in the healthcare system (Spitzer et al., 2015). It requires changes in practice and changes in the perceived values and attitudes of professionals working in different sectors (Holt et al., 2010). Furthermore, it creates challenges, as there are obstacles to aligning different professional competencies and ethical values (Spitzer et al., 2015). The smooth transition of health and social care reform also calls for new skills, knowledge and competencies.

Because the health and well-being needs of both patients and clients are intertwined, this calls for sustainable multi-professional partnerships (Halbreich et al., 2019) to plan (Prusaczyk et al., 2019) and deliver services (Humphris, 2007). Different determinants influence health and a number of integrated competencies are required to provide effective care and create a health and social care workforce that can meet the demands of service users. The target is to provide care and services for patients that maximise outcomes (Bird et al., 2010). Previous studies have identified that social workers could play a role in care coordination or management (Keefe et al., 2009; Waring et al., 2015). However, clear leadership is needed to meet patients' and clients' needs in an optimal manner and this would need to be supported by professional cooperation, organised care meetings and shared medical records (Meranius & Josefsson, 2017). The fundamental question is how to coordinate and manage the integration of different professional competencies as a single structure (Goldman et al., 2016). As this review indicates, the integration of social workers competencies needs to be recognised.

5 | Limitations

The limitations of the review were related to the search strategy and selection process (Whittemore & Knafl, 2005). Although we carried out systematic searches on six databases, we limited our searches to papers published in English from 2007 to 2019, which could have excluded some relevant studies. Manual searches or grey literature could have improved the breadth of our findings. Our inclusion criteria identified studies that focused on all types of integrated competencies among health and social care professionals, but we found only one type of integration and that was how social workers integrated with health care. However, we included an information specialist in our interdisciplinary research team and worked together to ensure that the searches were both comprehensive and accurate in terms of the search parameters and the unbiased selection of papers. The selection and quality appraisal was carried out by four researchers.

6 | Research Ethics

We followed the ethical principles of reliability, honesty and respect during the entire research process (ALLEA, 2017). The reliability of the review was ensured by the methodical and rigorous reporting of all review phases. We treated the studies we reviewed with honesty and respect and carried out in a transparent and systematic way (ALLEA, 2017).

7 | Conclusions

The competencies of health and social care professionals need to be integrated to meet the multi-dimensional needs of patients and clients. Previous studies have focused on how social care workers competencies were integrated to health care. The integration of social worker's competencies has highlighted their engaging working orientation, how they improve communication with family members and their professional understanding of service resources. They could also play a key role in making sure that patients with comprehensive and complex health and well-being needs are successfully discharge from hospital. Multiple types of integrated competencies in health and social care would improve early interventions that provide adequate care and services in a timely fashion. Any future studies on the integration of health and social care competencies should adopt a more multi-dimensional approach and they should recognise the horizontal integration of rising and novel fields that require new competencies. Environmental practices and the COVID-19 pandemic are good examples of these. In addition, structured and planned leadership is needed to prevent care and service gaps and ensure the sustainable development of integrated health and social care competencies.

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