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Interprofessional dynamics that promote client empowerment in mental health practice: A social work perspective

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Abstract

Summary: Interprofessional practice has been broadly endorsed as a strategy which supports the delivery of high-quality health care. However, very few studies have addressed the dynamics inherent to interprofessional mental health practice in an era in which client empowerment is prioritised and valued. Social work perspectives are also underexplored in the studies which have been published on interprofessional health care, despite the increasingly important role of this discipline in community mental health care contexts. This study explored the perspectives of mental health social workers in two geographically and culturally distinctive settings (i.e., Hong Kong and Sydney), through 26 semi-structured interviews, and identified a strong theme encompassing their concerns and experiences regarding facilitating client empowerment in interprofessional care settings.

Findings: Participant accounts direct attention to the strategies which are required to co-constitute the shared territories of the different mental health professions. Findings also highlight frustrations with recent mental health reforms which aim to challenge power differentials in interprofessional decision-making. Strategies were proposed for supporting the construction of shared language among different professions, revealing the creativity and insight of practitioners in managing the conflicts arising through interactions between different professional knowledge systems. The comparison of Hong Kong and Sydney accounts highlights the importance of structural and cultural influences in supporting not only

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interprofessional collaboration but also the independence and effectiveness of distinct professional roles.

Application: Our paper provides unique insights which aim to strengthen the contribution of social work to interprofessional practice in the promotion of empowerment-oriented interprofessional practice and education.

Keywords

Social work, inter-professional, empowerment, mental health, community care, social work practice

Introduction

Propelled by the psychiatric survivors movement of the 1960s, the concept of empowerment has become a familiar and valued dimension of the culture of mental health services. Today, by adopting a multilevel framework that recognises the individual, relational and structural conditions that shape mental health, empowerment-oriented practice seeks to promote strength, agency, civic engagement and social justice for people with mental health issues (Linhorst, 2006). Interest in empowerment has been strengthened by many initiatives in mental health policy and practice (Khoury & Rodriguez del Barrio, 2015). Perhaps most notable is the growing attention given to recovery discourse, described as a framework that prioritises the search for a meaningful life over the search for a cure or even amelioration of psychiatric symptoms (Davidson et al., 2005). Empowerment is viewed as one of the fundamental components of recovery discourse, as essential for improving personal responsibility, strength and control over life in the context of mental health (Leamy et al., 2011). While this alignment between the concepts of empowerment and recovery has been emphasised by many scholars (Khoury & Rodriguez del Barrio, 2015; Glajz et al., 2017),

those writing from a critical mental health perspective argue that empowerment in recovery discourse primarily centres on the individual dimension, which means that interpretations or interventions at a broader societal level are increasingly silenced or depoliticised in the implementation of a recovery approach (Trivedi, 2010).

In this complex pro-empowerment context, increasing attention has been given to understanding the role of interprofessional practice, which refers to a process of bringing together professionals of different disciplines and teams to deliver efficient and holistic health and social services (McNeil et al., 2013). In many Anglophone and European countries, the legal systems that respond to mental health crises require interprofessional decision-making to safeguard client wellbeing and rights (Winters et al., 2015). In mental health policies that emphasise principles of recovery discourse, interprofessional practice has been often underscored as a major strategy for ameliorating service fragmentation and for promoting a bio-psycho-social approach to accommodating people's lived experience and personal needs (e.g., see Mental Health Commission of NSW, 2014; Social Welfare Department & Hospital Authority, 2016).

While the endorsement of interprofessional practice has been generally welcomed, research also highlights the challenges and dynamics it brings to health service settings. As some studies have found, interprofessional practice, particularly focusing on collaboration between health and social service professionals, can actually hinder team performance (McNeil et al., 2013), failing to achieve the goal of advocating for client rights and social justice (Ambrose-Miller & Ashcroft, 2016). Another complex issue is the ambiguity in the concept of interprofessional practice, which is described using a range of associated terms such as interdisciplinary, multidisciplinary and transdisciplinary practice. Many scholars have tried to distinguish these terms. Whittington (2003) considers interprofessional (or interdisciplinary)

practice to be a process of sharing values and ideas and creating innovative practice, with a focus on interaction and collaboration; conversely, multidisciplinary refers to the juxtaposition of professionals with distinctive professional boundaries. More recently, there has been an increase in research and political interest in transdisciplinary practice, which features a broader level of collaboration, involving not only those in the 'traditional' disciplines, but also non-professionally affiliated workers, peer support workers, as well as users and family members with lay expertise drawn from their lived experiences (Burris et al., 2018; National Disability Insurance Agency, 2014). Nonetheless, despite this ongoing work to define terminology, conceptualisations of interprofessional practice remain contentious, and terms are often used interchangeably (Pullen-Sansfaçon & Ward, 2014). This indicates that interprofessional practice could take up various frameworks and objectives in service delivery, which may shape the input of different professions and teams in facilitating empowerment. However, there has been little research exploring how the complexities associated with interprofessional practice are perceived and negotiated in contexts in which empowerment is prioritised, making exploration of these issues based on practitioners' frontline experiences both interesting and important.

This study explored the experiences of frontline social workers in relation to interprofessional practice in the process of facilitating empowerment at two sites (i.e., Hong Kong and Sydney). Social workers play an increasingly significant role in the delivery of community mental health services, and perhaps no other profession has demonstrated greater investment in empowerment-oriented interventions than social work (Brophy et al., 2015). Social work values, particularly in terms of promoting self-determination, strengths perspectives and social justice, are considered to be well aligned with the principles underpinning recent mental health initiatives, including recovery-oriented and personalised service models (Brophy et al., 2015). However, the contribution of social work to interprofessional mental

health services has been challenged over the decades (Delavega et al., 2019). This often relates to a significant perceived schism between medical and social work knowledge systems. As some scholars have observed, medical knowledge tends to operate as a scientific and objective system, while social work knowledge tends to be viewed as more subjective and value-based (Yip, 2004). Due to the primacy given to clinical expertise in the health service context, social work knowledge and client-based outcomes are often not equally valued in interprofessional settings, and social workers are typically positioned below medical and paramedical staff in the clinical hierarchy of decision-making (Morley et al., 2014). Therefore, it is important to explore how social workers seek to demonstrate their professional strengths and capacities to perform empowerment-oriented practice, within this deeply rooted set of hierarchical power relations in mental health settings.

While a broad range of empirical studies in the health service context have investigated the challenges faced by frontline practitioners involved in interprofessional practice, most focus on the perspectives of nurses or physician-nurse collaborations (e.g., see Collette et al., 2017; Dahl & Crawford, 2018; Liberati et al., 2016). Fewer studies have explored the accounts of social workers in interprofessional settings. Social work research reviewed for the purpose of this study highlighted issues such as professional identity and role clarification (Beddoe, 2013; Heenan & Birrell, 2018), team communication (Ambrose-Miller & Ashcroft, 2016), ethical conflicts (Heenan & Birrell, 2018), power differentials (Mason & Evans, 2019), and organisational culture and structures that facilitates or impedes collaboration (Karidar & Glasdam, 2018).

However, very few of these social work studies have addressed the dynamics inherent to interprofessional mental health practice in an era in which empowerment is prioritised. This forms a gap for this study, which focuses on the following questions: (1) what are the vital

interprofessional practice issues that affect social workers' motivation and capacity to facilitate empowerment of people with mental health issues? And (2) How do social workers respond to and negotiate these issues in frontline practice? We argue that such an investigation offers a range of insights and strategies to strengthen the contribution of social work to interprofessional practice in the pro-empowerment era of mental health services.

Two research sites with both shared and non-shared attributes were chosen for this study. Hong Kong (China) and Sydney (Australia) are both populous cities with an accredited training and qualification system for the social work profession, as well as an advanced health service system that retains some features of the original British colonial system (Cui et al., 2019a). Community mental health systems in Sydney and Hong Kong include not only specialised mental health services, but also a range of familial, vocational, and residential community services that support but are not limited to users with mental health issues. In the policy context, discourses of recovery, personalisation and holistic care have become increasingly influential in guiding the delivery of mental health services in both Hong Kong and Sydney (Cui et al., 2019b). A key difference lies in their dominant cultural orientations, as the two cities represent examples of what are often described as featuring collectivist and individualist cultures, despite their similar cosmopolitan representations as multicultural and multiracial societies. While the individualist-collectivist divide has been at times criticised as over-simplified and unhelpful for analysis (Law & Lee, 2016), there remain a number of benefits of exploring the way in which culture influences and shapes the implementation of globally circulating policy and practice frameworks such as empowerment and recovery. However, most studies exploring practitioner accounts of interprofessional collaboration and empowerment so far are contextualised in Anglophone and European contexts, silencing the contribution of cross-cultural explorations to eliciting insights at wider social, political and cultural levels.

Methods

This analysis forms part of a broader study with frontline social workers exploring the various influences on empowerment-oriented mental health practice at two culturally distinctive sites. The interview sample consisted of 14 social workers located in Hong Kong and 12 in Sydney. These social work practitioners were recruited from community-based mental health organisations and professional networks of social workers. To ensure participants were familiar with social work knowledge and mental health service delivery, the inclusion criteria required that informants were qualified social workers with at least one-year post-qualifying experience of working with people with mental health issues in the community. At the time of research, the majority of these practitioners (n=20) were employed by specialised community-based mental health services. For the remaining six frontline practitioners, all were working in community-based settings, including residential, vocational, and family services, and all had a considerable portion of clientele with mental health issues. This selection aligns with the major policy agenda at both sites to shift the focus on the specialised mental health service to people's holistic needs and lived experience.

Data were generated through semi-structured interviews, which took one hour on average and in languages (i.e., Mandarin, Cantonese or English) that participants deemed appropriate. An interview guide followed a range of primary themes, developed from a systematic literature review, piloted with 2-3 frontline social workers at each site and reviewed by the co-authors. The guide began by seeking information about participants' educational background and career history, followed by their understandings of key mental health concepts such as empowerment and recovery. The major part of the interviews focused on how participants facilitated what they believed to be empowerment in everyday practice. A particular focus

was given to how their practice was supported or hindered in interprofessional settings and how this was negotiated alongside the perspectives of other professions.

All interviews were digitally recorded with a high-quality device, transcribed verbatim and underwent a standard de-identification process. The transcriptions in Chinese languages (Mandarin or Cantonese) were translated into English by the first author and checked by the fourth author. We employed thematic analysis as the main approach to analyse the interview data. Using Nvivo, we undertook thematic analysis in several steps, informed by the research of Braun and Clarke (2013). First, the first author checked all transcripts against the audio records and coded them line-by-line, producing a rich description of the dataset. This coding process was then reviewed by co-authors for refinement. These codes derived from practitioners' perspectives were developed into a set of themes, which were then reviewed across all data extracts and dataset to ensure that they reflected an accurate picture of the coding process and the dataset as a whole. In the final stage, the previous coding and theme developing process was reviewed and repeated in the course of producing the report of this analysis by the first author under the supervision of the co-authors.

Findings

In both Sydney and Hong Kong, participants reported that their work with people with mental health issues in the community involved teamwork with professionals of different disciplines, in either the same or separate physical locations or agencies. Four themes were identified in the analysis, representing the dominant concerns over interprofessional dynamics in empowerment-oriented practice.

Beyond the medical versus non-medical divide

The first theme describes how professional responsibilities are distributed, and roles are clarified, in areas which participants believe affect their empowerment-oriented practice. It should be noted that when using the term 'medical professionals', participants were often referring to psychiatrists and physicians as well as nurses. Many participants observed that medical professionals tended to divide service responsibilities into two domains - medical and non-medical - and to see their role as pertaining only to the medical domain.

> When we work alongside our medical colleagues—psychiatrists, doctors, nurses—they take care of the medical side of things (SYDP1[2], 3 years).

This distinctive approach to boundary-making was perceived by many participants as a constraint to the promotion of empowerment for people using mental health services:

> I tried before to get psychiatrists on board in helping clients with the strength model. I wrote a letter to a client's psychiatrist reporting the client's improvement after strength-based interventions. The psychiatrist just ignored this and didn't talk about it with the client. Maybe he thought it is fine as long as the client was proved mentally stable and on medication. Things other than those were not his focus of attention (HKP1, 11 years).

HKP1 frequently mentioned their use of strength-based interventions throughout the interview as a proud example of empowerment-oriented interventions. However, HKP1 also indicated their frustration that this approach was not valued or supported by the psychiatrist who worked with the same clients, despite their attempt to involve psychiatrists. Here, HKP1 attributed this lack of interprofessional support to two factors: on the one hand, the

[2] In this article, SYDP has been used as shorthand for 'Sydney participant' whereas HKP is used for 'Hong Kong participant'. Participant's number of years of experience working with people with mental health issues is also noted in brackets.

psychiatrist's seemingly primary attention to symptom management and medication only, i.e., the narrowly defined medical field; on the other hand, strength-based interventions being viewed as the sole responsibility of social workers, i.e., the equally narrowly defined non-medical domain.

Some participants further problematised the narrowly-defined medical versus non-medical boundary by highlighting what they believed to be the indivisible nature of clients' needs:

> My client reported many side effects of his medication, such as a blurred vision, fatigue and slower thinking, which disabled him to have a stable job…Then we tried to discuss with his psychiatrist, but the psychiatrist refused to change the medication, considering it most effective to help this client maintain mental stability. I think from the psychiatrist's perspective, having side effects is better than experiencing a relapse. But what he did not consider is that even if the client does not have any delusions, if he always experiences side effects and feels incapable, he will become unhappy and lose his hope for life (HKP6, 2 years).

HKP6's account indicates an overlapping role between social workers and medical practitioners in assessing problems and planning interventions, which can lead to either an alignment or a conflict, when practitioners respond in defence of their own territory (Booth & Hewison, 2002). In this sense, maintaining a distinctive medical versus non-medical boundary impedes the performance of interprofessional teams to cater efficiently to clients' various needs.

Overall, participant accounts pointed to an important focus: the need for negotiation among different professional groups and with other stakeholders (e.g., clients) regarding the ways in which a shared domain of interprofessional roles and responsibilities can be formed and orientated based on client benefits rather than professional boundaries. Although some

participants, such as HKP1 and HKP6, reported that they had tried to involve medical professionals in discussions or interventions beyond the medical domain, a sense of frustration was clearly expressed. This also relates to power differentials in interprofessional practice, which will be discussed in the next section.

Meaningful or symbolic power sharing

Having limited power in interprofessional practice was another central concern of social work participants working in the mental health space. This sense of powerlessness was often linked to what participants viewed as a restriction on their participation in interprofessional decision-making, for example, in deciding whether a client needs hospitalisation, medication, compulsory treatment order, or other significant social support and welfare. Particularly in situations related to major clinical interventions, medical professionals were seen to hold a position of indisputable power, to be 'the ones that make ultimate decisions' (SYDP10, 6 years) so that 'what they say goes' (SYDP4, 30 years).

Some participants believed that empowerment-oriented initiatives such as recovery discourse had the potential to shift the dominance of medical professionals towards a more transdisciplinary form of interprofessional practice which may enable joint decision-making with input from clients and other non-medical professionals:

> I think that doctors do have the final say and [the power to make] a lot of decisions about people's care, but then there is a lot of movement happening as well towards the recovery model and a more systemic view of people with mental illness…I think just that final decision on whether people have to take medication, whether they have to be in hospital, does fall on the doctors and it does fall on their symptoms and their diagnosis (SYDP8, 2 years).

However, as SYDP8 argued in another part of that interview, the uptake of recovery model is not enough to fundamentally challenge the hierarchical power relations within interprofessional teams, in which medical professionals are often ascribed power (formally or informally) to make final decisions when different perspectives are involved. In this sense, at least in the current era, it appeared that in spite of policy and legislation promoting recovery, the adoption of such a discourse has not been embedded in the structure of mental health services sufficiently to ensure all stakeholders to have a genuine say in service delivery. Some participants more explicitly argued that the participation of clients and other allied health professions in the processes of decision-making regarding clinical interventions was likely to carry a more symbolic meaning. For example, HKP13 (8 years) observed that the assessments conducted by social workers would be taken as only a reference by medical professionals, rather than having independent authority.

The challenge also extends to another situation involving critical decision-making with regard to accessing resources and welfare. Participant accounts of this issue focused mostly on describing how the participation of different professionals in this process is valued by the health and social service system. In Hong Kong, many participants described how the health and social service system exclusively entitled medical professionals to exercise power over the distribution of resources and welfare benefits across different mental health conditions. This lack of power and influence over the social service opportunities and supports for clients may make it particularly difficult for social workers to intervene or appeal on behalf of their clients at a later stage.

> Psychiatrists' signature is needed in a lot of situations, such as to prove whether a client can apply for the public housing or whether he can apply for disability allowance…Whether a client can get disability allowance is decided by his psychiatrist and the result is mailed

> directly to Social Welfare Department. We do not even know what was written nor how clients could exert their influences in this process (HKP14, 7 years).

In Sydney, although some participants also recognised the leading role of medical professionals in welfare allocation—such as the comment from one Sydney participant that medical professionals act as 'a gatekeeper to diagnosis' (SYDP2, 5 years)—many participants considered social workers to have power in deciding whether and how to support clients to access public resources.

> We can make a lot of those referrals, for example, housing and Centrelink (welfare support services). Social workers can do [that], and we can fill out all the paperwork (SYDP10, 6 years).

Although SYDP10 later revealed that 'reports can have more weight if they come from a doctor', their account clearly indicates that these reports are not officially required in many decision-making situations. This means that social workers can have a more active role in negotiating with medical professionals, and without a consensus, they have the ability, as enabled by the welfare system, to carry out interventions to accommodate clients' welfare needs independently. This comparison between the Hong Kong and Sydney accounts highlights the importance of systematic and policy support for social workers to play a meaningful and competent role in interprofessional decision-making.

Asserting social work expertise and credibility

The third theme relates to the ways in which the importance of different systems of professional knowledge are evaluated in interprofessional practice. The dominance of medical professionals was linked by many participants to the privileging of medical knowledge in mental health services, which can undermine the contribution of social work expertise to interprofessional practice. HKP9 (9 years) felt that the assessment of clients'

social needs was often considered easy and common knowledge by medical professionals. SYDP5 (3 years) observed that social workers were often viewed as having a small piece of information which was not as valued as other professions.

Interestingly, divergent attitudes towards the privileging of medical knowledge were identified in participant accounts, revealing different approaches to asserting social work expertise in interprofessional practice. First, some participants resisted prioritising medical perspectives, particularly when making decisions regarding social welfare, through highlighting medical professionals' lack of regular and intense contact with clients:

> I have objections to designating psychiatrists to approve applications for social resources. Social workers have already assessed the conditions of a client and we assist clients to apply for services such as accommodation or employment services based on this assessment. Psychiatrists should not have the final say on this just because they have their so-called very professional medical knowledge. We work with clients regularly. They see clients five minutes every three months, but they are vested with the power to decide everything. I think it is not right (HKP12, 6 years).

In line with HKP12's view, some other participants also believed that abilities to foster close client engagement and knowledge gained through such processes should be prioritised as one of the fundamental aspects of mental health expertise. As SYDP5 (3 years) elaborated, 'knowledge deriving from direct interactions with clients in itself is empowering because it then makes the client or the consumer as the centre and in control of what they need'. In this sense, privileging the knowledge of medical professionals, which may not be based on sufficient direct contact with clients, is disempowering to clients, as their actual needs may be obscured. Therefore, these accounts placed social work knowledge, which is often believed to be client-centred, in a more central position in interprofessional decision-making.

While some participants resisted the privileging of medical knowledge, others believed there were appropriate and necessary limits in social work knowledge and utilised other strategies to assert their expertise. Using common language was considered key. In Sydney, some participants highlighted using common terminology or shared values/understandings in communicating with medical professionals to replace social work terminology that may sometimes lead to ambiguity:

> I wouldn't use the word empowerment in multidisciplinary team meetings because that's very much a social work word…empowerment's too broad, and people from other professions may see that as a bit of a fluffy word to be used. But I would talk about, you know, their rights to decline a service, or their rights to access certain services, or their rights to make a complaint about the service as well, so I would talk more about people's rights and responsibilities (SYDP11, 3 years).

In contrast to emphasising the empowering nature of social work knowledge, SYDP11 highlighted the inadequacy (or inappropriateness) of social work language, as social work terms such as empowerment were considered too 'fluffy' (SYDP11) to facilitate clear and effective interprofessional communication. Indeed, this ambiguity regarding the concept of empowerment was also addressed by other participants, who observed that some medical professionals understood it as 'doing exercise and having a diet' (HKP3, 3 years) or even as 'getting them (clients) to be symptom-free' (SYDP5, 3 years). Thus, instead of using social work terms in interprofessional communication, SYDP11 preferred the use of language highlighting the importance of patient/client rights, which not only represents a core aspect of social work ethics, but also can be understood more consistently by different professions. In this case, a more commonly valued perspective was deployed in framing the work of non-social work professionals, so that the opinion of social workers could be taken more seriously

in interprofessional practice and empowerment-oriented interventions could be more effectively facilitated although not in the name of "empowerment".

In Hong Kong, some participants also acknowledged the limits of social work knowledge and appeared to be comfortable deferring to medical professionals' expertise on matters they considered outside the scope of social work:

> The system is basically dominated by them (medical professionals). Why? Because even I feel unconfident at times, as I do not know much about medical knowledge, especially regarding psychiatric medication…so we feel that in making decisions regarding treatment and medication, psychiatrists should have more authority and take the lead (HKP5, 4 years).

HKP5 believed that medical professionals dominate the mental health system for the right reasons, arguing that medical knowledge was the most appropriate source of expertise to inform decisions, particularly regarding treatment and medication. To some degree, HKP5's account reflects Yip's (2004) observation in Hong Kong that many mental health social workers undergo a process of medicalisation (i.e., rationalisation of medical dominance) in response to the strong dominance of medicine (e.g., psychiatry) in interprofessional contexts. Compared with the Sydney group, the participants in Hong Kong tended to emphasise better comprehension of medical knowledge as necessary for earning respect in interprofessional teams.

This tendency to defer to medical expertise in Hong Kong appeared to be not only due to participants' belief in the importance of medical knowledge, but also a desire to maintain a sense of hierarchical order and harmony in relationships, which has been described as a common value in Chinese culture (Huang, 2016).

> If you don't know it (medical knowledge) and you only talk about empowerment, other practitioners would think you know nothing about this field [of mental health care] and doubt your opinion (HKP2, 5 years).

> If all people do it in this way (the medical way), there seems no reason why you do not follow. It is hard to be a heretic (HKP14, 7 years).

These participants indicated that in the Hong Kong context, speaking from a social work perspective – which may be different from the dominant perspective established in interprofessional teams – had the potential to provoke both embarrassment and criticism. Therefore, in Hong Kong, overcoming this fear was considered particularly important for ensuring that the social work contribution was articulated and valued by other professions:

> When you work with psychiatrists or other medical professionals, you need to express your own professional opinion, not reporting clients' progress or situation in terms of their mental state, but from psychosocial or your own perspectives. Why not tell them more about what you have done or what you want to do for the client…In the beginning they (medical professionals) may think you are very arrogant or think you are someone who doesn't recognise their own professional limits. But if you can show your confidence, you will gradually earn their respect. If you are always passive in expressing your ideas, always seek medical opinion, they will definitely consider you to have no expertise (HKP13, 8 years).

These accounts highlight the courage required to challenge authority and stand out from others as a particularly important element of establishing social work expertise within interprofessional communication dynamics in Hong Kong.

Managing professional capacity to be an efficient practitioner

The pressure to be an efficient practitioner represents the fourth theme which participants perceive affect empowerment-oriented social work practice in interprofessional settings.

Most participants attributed this pressure to their limited professional capacity in terms of the time and resources they have to invest in direct contact with clients:

> My current workload is quite heavy. I think it exerts a huge influence on my practice because a big workload makes it difficult to have time to get to know clients at a deeper level and to really care about different aspects of clients beyond a focus on their mental state (HKP7, 1 year).

Many participants indicated that this lack of intense contact with clients, as a result of heavy workload, may undermine practitioners' motivation and capacity to work towards empowerment, especially when working with medical professionals:

> When a client has an emotional problem, the views between nurses and social workers are quite different. Nurses prefer arranging an early medical follow-up for the client to adjust medication or hospitalisation; social workers think it is not necessary to use medical interventions every time there is an emotional problem. We need more time to talk with the client, know the causes of the problem, so that we may find a more empowering way to handle it. However, the difficulty now is that we don't always have this extra time to do that (HKP9, 9 years).

Here, HKP9 indicated a common perception among participants that empowerment-oriented practice can be time-consuming, as it requires practitioners to be 'able to really have the time to engage with clients properly' (SYDP8, 2 years). The lack of such proper engagement may prevent social workers from effectively negotiating with other professionals because they lack time to gather valid justification to support their interventions.

Different strategies to address limited professional capacity were identified. Some participants managed a heavy workload or caseload through developing a strategic time

allocation among clients. For example, SYDP10 (6 years) indicated that choosing the right client to work with becomes an awful but necessary way to work efficiently:

> If I'm working with somebody who is 60 with low motivation and has had schizophrenia for 30 years, whereas if some of the people I work with [are] in their later twenties and still have really good function but their motivation is low, then I'll try to work with them a lot more intensively…our caseloads are ridiculous and to a certain extent, you almost need to look at that and go, 'Well, who am I going to invest the [time]' (SYDP10, 6 years).

While some participants emphasised prioritising clients with the most potential for recovery (SYDP10) or 'in a crisis' (SYDP6), other participants discussed focusing on professional tasks or activities that may accelerate service delivery or be considered essential to the current system:

> For mental health social workers, one of the ways to manage our heavy workload is to follow the medical model. It is the easiest and fastest way because there is not much to do if you follow the medical model. In that way, what we need to do is just check whether clients have their medication, whether they see their psychiatrists, and whether their symptoms increase or not (HKP13, 8 years).

> All their (staff members') time is [spent on making] sure that the people are getting their injections rather than actually being able to help people to understand why they hate it and how we can help them get off it (SYDP8, 2 years).

In this case, assisting medical professionals in managing symptoms and medication becomes an essential task of social workers. Indeed, this strategy makes work-life easier for social workers as it obscures most of the tensions previously identified in participant accounts, and makes it faster to reach more clients as these tasks may not require intensive client interactions. Importantly, the deployment of such a strategy suggests that tasks involving the

monitoring of clients' mental health symptoms have been set as a default responsibility for mental health professionals including many social workers, while empowerment-oriented interventions remain dispensable. HKP10 (6 years) articulated that social workers have a range of service requirements to fulfil, but empowerment is not an important one. These accounts reflect an important way in which structural factors are undermining social workers' motivation to focus on fulfilling core social work missions in mental health services, highlighting the importance and necessity of the current study.

Discussion

Analyses of these four themes extend the literature on interprofessional practice in several important ways. First, this study identified key concerns regarding role clarification in interprofessional mental health practice. Participant accounts suggest that the medical versus non-medical division of professional roles, adopted by many medical professionals, undermines the implementation of empowerment-oriented interventions, which were perceived to be positioned as additional tasks or to represent an intrusion of social workers into medical territory. While many studies have emphasised a clear distribution of responsibilities among different disciplines as necessary to enhance interprofessional practice (Ambrose-Miller & Ashcroft, 2016; Dahl & Crawford, 2018), this analysis points to another direction in developing strategies that practitioners can manage to negotiate professional boundaries and co-constitute the shared territories in interprofessional practice. These strategies are particularly important to social workers, as studies have found that medical professionals often play a more dominant role in negotiating and maintaining professional boundaries in the health service context (Liberati et al., 2016). It thus highlights the training needs of interprofessional and intersectoral communication skill for social workers. Although this has been listed as a core social work competency by many professional associations (e.g.,

the Australian Association of Social Workers and the Hong Kong Social Workers Registration Board), research has suggested that this skill is not developed in social work education sufficiently (Social Work Task Force, 2009; Xun, 2019).

Power differentials in interprofessional decision-making were identified as another key concern of social work participants, aligning with the literature that highlights hierarchical power relations in mental health settings (Bland et al., 2015). What is interesting is our findings regarding what supports and complicates the ways in which these power differentials can be addressed. Recent health service reforms aim to inspire positive shifts towards a transdisciplinary form of interprofessional practice (Delavega et al., 2019). Such expectation was reflected in participant accounts which described clients and social workers' participation in service decision-making. However, participants also expressed a deep concern that these reforms, such as the promotion of the recovery model, have not generated changes profound enough to challenge the undisputable power of the medical profession, as they continued to believe that their collaboration in these negotiations more often carried only a symbolic function. This indicates that the traditional governance modes leading one profession to overpower other professions have not been fundamentally shifted. The importance of structural influences was made clearer in the comparison of participant accounts across the two sties which shows that social workers in Sydney are more supported by the system to work efficiently and independently than their Hong Kong counterparts (e.g., when facilitating clients to access public resource). Importantly, this study shifts our focus to look more closely at structures that may ensure the independence and productivity of individual professions in interprofessional practice, while efforts were often dedicated to exploring forms of cooperation.

Further, many scholars insist that when multiple knowledge systems intersect, remaining open to understanding each other's values and perspectives is essential (Jovchelovitch, 2006; Pollard, Bugler, & Hayes, 2016). Achieving mutual understanding may not be easy in the mental health context, considering the diverse perspectives that are brought together to understand fundamental issues in mental health. In the face of the prevailing dominance of medical perspective in mental health service, social work scholars often advise against social workers becoming overly medicalised and advocate for 'a firm grasp on the unique perspective that social workers often brought to the team' (Ambrose-Miller & Ashcroft, 2016, p. 107; Bland et al., 2015; Yip, 2004). To some degree, an antagonistic and falsely binary distinction has been established historically, and is constantly reinforced, between the medical and the social work profession. Participant accounts in this study point to a more nuanced and dynamic set of interactions when different knowledge systems intersect. Some participants believed that professional expertise does not necessarily require the practitioner to dwell on affirming the importance of social work knowledge and terminology alone. Finding common ground, existing or emerging connections between core social work ethics and other knowledge systems may well offer new insights and viable alternative options to facilitate interprofessional communication.

Research into the challenges of negotiating interprofessional practice in health and social service often focuses on the issues and dynamics at a personal level (e.g., on professional identity or communication skills) and between different professions (e.g., on role clarification or power dynamics) (e.g., see Ambrose-Miller & Ashcroft, 2016; McNeil et al., 2013; Pollard et al., 2016). Less attention has been paid to the challenges posed by broader structural and political factors, highlighted in the analysis of the last theme in this study. In fact, neoliberal health reforms that result in organisational and structural changes have been more often considered a driver in developing interprofessional practice (Pullen-Sansfaçon & Ward,

2014). A key purpose of interprofessional practice, as expressed by Barr (2000, p. 176), is to 'optimise the use of resources by avoiding duplication', underpinning a neo-managerialist goal towards improving system efficacy. In this study, however, instead of being a facilitator of interprofessional collaboration, the mantra of improving service efficiency without adequate acknowledgement of the values of client-centred service has been widely criticised as seriously constraining frontline social workers' professional capacities and undermining their unique contribution to interprofessional team efforts. It is highly likely that without proper organisational and systematic support, neo-managerialist service models could deviate from supporting meaningful interprofessional collaboration by ignoring the value of integrated and holistic care and reinforcing the continued medical dominance in disguise of a narrowly defined service efficiency.

Comparing participant accounts in Hong Kong and Sydney uncovered some differences between the two sites which offer unique insights into organising empowerment-oriented interprofessional practice. Cultural influences were revealed in the exploration of the different strategies which social workers employed to negotiate interprofessional dynamics. To assert social work expertise in interprofessional teams, some Sydney participants highlighted the rights-based dimensions of social work ethics to facilitate empowerment in interprofessional communication, while some Hong Kong participants emphasised the importance of having the courage to challenge authority and demonstrating professional contribution. This may be linked to the difference between the emphasis in an individualist culture on citizen rights and the emphasis in a collectivist culture on harmony and respect for authority. This calls for more attention to be directed to the development of cultural reflexivity in social work training and practice, as practitioners' cultural assumptions not only affect practice with ethic and minority clients, but are also crucial to developing strategies to interact interprofessionally.

As mentioned earlier, participants in this study were encouraged to discuss the interprofessional dynamics within practices of facilitating what they viewed as an idealised notion of empowerment. Importantly, as shown in the analysis, most participants tended to frame the concept of empowerment-oriented practice beyond direct client-practice interactions. At times, the focus in participant accounts was given to resolving interpersonal and power issues which impact on the relational and structural levels of empowerment, for example, reinforcing the input of clients and social workers in clinical decision-making and restraining psychiatrists' power in determining people's access to welfare. This indicates that, as an important strategy in recovery-oriented policy, interprofessional practice may open up opportunities for greater efforts to be directed at the meso-level of empowerment that addresses interpersonal issues arising from broader complex relationships in practice. This effort may help to address the criticisms that recovery discourse predominantly frames the unit of change for empowerment within individuals, and thus better line up the discourse with multi-levelled empowerment practice and social work missions.

Limitations of the Study

The paper has several limitations. As mentioned previously, although the majority of our participants were social workers employed in specialised community mental health settings, we did not exclude practitioners of mainstream services who had a considerable portion of clientele with mental health issues. No significant difference between the two settings was identified in participant accounts at each site. Nonetheless, this may be due to the relatively small sample size that may affect the effectiveness for between-group comparison. Future studies may extend this paper to explore how the dynamics in interprofessional practice may be affected by the nature of organisations and service settings.

Furthermore, while most participants linked empowerment-oriented practice in interprofessional settings to dynamics between disciplines, the focus was seldom placed on collaborations with lay experts such as peer support workers and carers who are often family members or close friends. This was observed despite the recent promotion of various peer support programs in both Hong Kong and Sydney (Mental Health Commission of NSW, 2014; Social Welfare Department & Hospital Authority, 2016). This highlights an important agenda for future research on strategies to broaden the conceptualisation of interprofessional practice beyond professional groups, to more meaningfully involve perspectives of non-professional (lay person) and consumer groups, who may have different concerns about the issue of empowerment in shared decision-making and teamwork.

Conclusion

By exploring the interprofessional dynamics social workers experienced when promoting client empowerment, this study offers practitioner wisdom regarding the complexities of interprofessional practice. Participant accounts problematised the distinctive approach to professional boundary-making, highlighting the need for negotiation regarding the way in which empowerment-oriented interventions could be embedded into practice as a shared territory for the enactment of diverse professional roles. This extends the existing strategies which have aimed to construct shared visions and languages among professions through revealing a variety of ways in which participants managed the potential conflicts arising from interactions between different professional knowledge systems. Importantly, through comparison of participant accounts in the Hong Kong and Sydney mental health settings, the study sheds light on the importance of broader structural and cultural influences which may support or complicate practitioners' strategies for negotiating interprofessional dynamics. To translate these findings into social work research and practice, this analysis calls for

professional training of interprofessional communication and cultural reflexivity, as well as the systemic and policy supports that encourage productive and mutually beneficial interprofessional interactions.

Research Ethics

The study was approved by the UNSW Human Research Ethics Advisory Panel G (HC16481).

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Authorship

Jialiang Cui, Christy E. Newman and Limin Mao developed the research idea and interview guide. Jialiang Cui conducted the interviews, coded the data and wrote the manuscript. All of the other authors contributed to reviewing coding, developing themes and revising the manuscript.

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