PEER RELATIONSHIPS AND SOCIAL WORK PRACTICE IN CANADIAN HOSPITALS

by

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Abstract

This masters' thesis is a modest exploratory study which seeks to better understand social work peer relationships among front line social workers in Canadian hospitals. The study utilized the qualitative research approach Interpretative Phenomenological Analysis to determine how staff make sense of the impact of peer relationships on the delivery of social work services in a hospital setting. Three participants at hospitals in an urban city in Alberta were interviewed. The analysis yielded four themes: yearning for social work leadership, navigating peer relationships, contributing to professional development, and challenges of practicing social work in a medical model. It was found that participants actively sought out peer relationships and mobilized to support each other in the workplace. Social work peer relationships appear to be highly valuable to participants because they supported effective social work practice. A notable finding was that among participants, they may benefit from additional social work leadership in the hospitals.

List of Abbreviations Used

CASW	Canadian Association of Social Workers
IPA	Interpretative Phenomenological Analysis
ACSW	Alberta College of Social Workers
PPL	Professional Practice Lead

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Chapter 1: Introduction

Across the country, under Canada's publicly funded health care system, social workers are employed in hospitals. Social workers in hospital settings work in medically, ethically and emotionally charged situations (Fantus et al., 2017) and engage with patients and families to address how problems in their social environment impact their health and mental health. This could mean providing practical and emotional support to an elderly couple where one spouse is transitioning from hospital into a nursing home due to worsening dementia. It may also mean working with a young adult who is experiencing homelessness and addiction to help them navigate various government and community systems in order to meet their basic needs. In the workplace, social workers interact with patients and families, the interdisciplinary team, community stakeholders, leadership, and their social work peers. It is the relationship between social work peers in the hospital that is the focus of this research study.

Social work peer relationships, often understood in the context of supervision, are constructed in the literature as peer or informal supervision, collegial support, peer group supervision, peer debriefing, peer consultation and peer support (Bailey et al., 2014; Beddoe et al., 2014; Berger & Mizrahi, 2001; Chiller & Crisp, 2012; Dempsey & Halton, 2017; Gangy-Guedes et al., 2016; Grant et al., 2017; Hair, 2013; Kadushin et al., 2009; Petruik et al., 2017). Outside of supervision, the professional peer relationship and how it impacts social work practice in Canadian hospitals is not well studied in the literature. For the purpose of this study, peer relationships are defined as those relationships that social workers have with other social workers in the workplace, excluding any social worker in a formal leadership position that has authoritative power over them.

Peers play many roles for other peers in the workplace. Peers can be an informal source of support (Gangy-Guedes et al., 2016), a person to turn to for support, advice, and guidance, and someone who can contribute to professional learning and growth (Grant et al., 2017; King et al., 2017). Conversely, peers can be the perpetrator or bystander of workplace bullying which can have devastating effects on health and well-being of social workers (Cassie & Crank, 2018; van Heugten, 2013; Whitaker, 2012). Peers seem to contribute to effective social work practice, despite being embedded in the supervision literature. While researchers have noted that there are social workers not receiving social work supervision in hospital (Kadushin et al., 2009), or receiving limited social work supervision (Nicholas et al., 2019), and given that a hospital social worker must be skilled at dealing with complex issues (Sims-Gould et al., 2015), it becomes important to better understand what mechanisms are available to support front line social workers in hospitals.

It is important to state that I have over nine years of experience working in an acute care hospital in Alberta. I approach this research with experience and knowledge of the local health care system, social work practice in an acute care setting, challenges faced by patients and families that arise from problems in the social environment, and stories of resilience and strength in overcoming barriers. Furthermore, my professional experience of social work peer relationships in the workplace was the impetus to this study. Despite having social work leadership in my workplace, and being new to hospital practice, my peer relationships were foundational to developing my professional practice. There was a group of experienced social workers who helped me navigate what it meant to practice social work in a hospital setting. I knew I could trust what they said because

they were well respected in the department and the hospital, grounded in social work values and practice, had years of experience and knowledge, and worked alongside me in the field. My peers were my mentors and I looked up to them. While not every interaction was related to patient care, they held space for me to discuss complex cases and work through the emotional turmoil of our jobs. Several of our interactions occurred over a cup of coffee in the food court of the hospital and I learnt quickly that it was important to make time for these moments.

This thesis is organized into six chapters. Chapter 1 introduces the topic including my professional experience with social work peer relationships. Next, Chapter 2 provides a review of the literature of the topic, categorized into hospital practice, supervision, and professional peer relationships. The literature review will show how the experiences of social work peer relationships in hospital settings are not well understood in the social work literature. Chapter 3 introduces the study's methodology and the qualitative research approach of Interpretative Phenomenological Analysis (IPA) is explained. This study is guided by the primary research question: How do staff make sense of the impact of professional peer relationships on the delivery of social work services in a hospital setting. Two objectives were identified to answer the research question. Firstly, to better understand how social work staff make sense of their professional peer relationships. Secondly, to better understand how these relationships impact social work practice in a hospital setting. Moving forward, Chapter 4 presents the analysis of the interviews in themes with direct quotes from the research participants to support the themes. Next, Chapter 5 discusses the research findings identified in the superordinate themes in relation to the associated research objectives. This discussion

will answer the primary research question noted above. This chapter also discusses the findings in the context of the literature, as well as expectations, assumptions and surprises of the research study. Finally, Chapter 6 concludes with a review of the relevance and limitations of the methodology, a discussion on the implications for social work practice and ideas future research questions.

In conclusion, this study will explore the relationships between social work peers in hospitals. The purpose of this study is to better understand how these relationships impact the delivery of social work services in the workplace.

Chapter 2: Literature Review

The purpose of this chapter is to review the literature on the broad topic. On review, three areas that relate to social work peer relationships in hospitals have emerged. They are, hospital social workers in Canada, peer relationships and social work supervision, and peer relationships among social workers. Ultimately, the review will show that the experiences of peer relationships between social workers in hospitals in Canada haven't been thoroughly explored in the current literature.

2.1 Hospital Social Work in Canada

Given Canada's vast geographical terrain, hospital social work practice across the provinces and territories will vary due to the cultural, economic and political landscape of that community. With a particular focus on patients who are disadvantaged and vulnerable, hospital social workers see the patient in the context of their social environment, including housing, income and social supports, to better understand how these factors interact to impact a patient's health and mental health. Social workers facilitate empowerment with people who then use their own skills and resources to problem solve their issues, while at the same time social workers address systemic issues that impact resource availability and accessibility (CASW, 2008). This approach to practice means that social workers in hospital settings work with patients to address their basic needs while also advocating for more inclusive health or community resources to address gaps in service.

Canadian scholars have identified the roles and practice of hospital social work and include conflict resolution, counselling on relocation, collaborative work with families, contributing to transitions in care (Sims-Gould et al., 2015), administrative and

managerial roles (Fantus et al., 2017), roles of firefighters, jugglers, glue, challenger, janitor, bouncer, broker (Craig & Muskat, 2013), and conducting assessments, advocacy, counselling, case management, research (Craig et al., 2013), discharge planning, case management (Fantus et al., 2017), and discharge planning (Galati et al., 2011). These studies demonstrate the diversity of social work practice in the hospital. Understood in relation to the descriptions of Craig and Muskat (2013), social workers deal with child abuse, elder abuse, and domestic violence cases that result in hospital admissions. Social workers coordinate discharges for patients while at the same time they may be providing end of life care for another patient. They facilitate family conferences and debrief with families following the meeting when information and further discussion is still warranted. Social workers advocate to doctors against early discharges and to community agencies for access to services. They locate family members for deceased patients and go into patient's home to retrieve items for their treatment plans. Social workers are called in to support patients who are labelled 'non complaint', and they coordinate services with the patients, family, hospital and community supports to facilitate safe discharges.

In a participatory action research study of social workers in hospitals in a Western Canadian city, Nicholas et al. (2019) and colleagues outlined the core competencies for introductory hospital social work practice:

> (a) a strong work ethic, and ability and confidence to work under limited supervision, (b) interpersonal skills for multi-disciplinary team work, (c) an understanding of roles and power dynamics, (d) accountability for one's own work/practice and commitment to professional development and learning, (e) reflectiveness on practice, (f) a base of knowledge that is relevant to social work

> in a health care setting, (g) an understanding of the health care system and implications for social work, and (h) accountability and reflexivity in service delivery. (p. 602)

What is interesting about these competencies, especially for social workers new to practice, is how the practitioner would manage their learning and growth despite only receiving limited supervision. While it would be ideal for social workers to have these competencies when they enter hospital practice, this is not always the case and competencies must be developed and refined in the workplace. There seems to be an expectation that social workers self-monitor their own competency development, which isn't unrealistic for an experienced professional. However, when you're new to practice and your knowledge and skills are still developing, it may be challenging and distressing to have to determine on your own whether or not you are meeting these core competencies. Furthermore, while supervision in the hospital was limited, yet acknowledged as a need, participants' believed that social workers would benefit from having the capabilities, confidence, and initiative to not only work independently but to also know when to ask for help, asking for help, and receiving and integrating the constructive feedback into practice (Nicholas et al., 2019). It is unclear who social workers were asking for help and support, but it can be assumed that social workers sought out their peers based on Nicholas et al. (2019) reference that participants debriefed difficult cases with their colleagues. While this research provides valuable information about competency of hospital practice, it also raises questions about the role of supervision in relation to addressing core competencies, the impact of limited supervision on peer relationships, and the overall impact on patients and families.

Additionally, Canadian research on hospital social work has focused on reflective practice (Petruik et al., 2017), moral distress (Fantus et al., 2017) and compassion fatigue, burnout (Klassen et al., 2012; Ray et al., 2013). While reflective practice was seen as foundational for hospital social work, in order to maintain critical reflection social workers require the support of their peers, supervisors and a positive organizational culture (Petruik et al., 2017). What this research demonstrates is that social workers need opportunities and access to peers who understand their practice in order to debrief about difficult situations, as well as support from the organization to facilitate these interactions. The research also suggests that peer support and supervision can complement each other in the field.

Hospital social workers also address the social determinants of health (Craig et al., 2013; Craig et al., 2015; Nicholas et al., 2019). The social determinants of health are the living conditions experienced by people that have a deleterious impact their health, many of which people have little to no control over (Mikkonen & Rahpael, 2010). According to Raphael (2009) the 14 social determinants of health in Canada are: aboriginal status, disability, early life, education, employment and working conditions, food insecurity, health services, gender, housing, income and income distribution, race, social exclusion, social safety net, unemployment, and job security (Mikkonen & Raphael, 2010). In one study that examined hospital social work and the social determinants of health, researchers found that 98% of social workers intervened with a person impacted by at least one social determinant of health and 91% with a person impacted by three or more social determinants of health (Craig et al., 2013). Social work interventions involved assisting patients to acquire services, providing education about

resources, and advocating for the use of more relevant social determinants of care patient care that helped to mitigate the negative effects of marginalization and oppression on health (Craig et al., 2013). Moreover, the social determinants of health found to be addressed most often were health care services, housing and disability status; whereas early life, Aboriginal status, racism, gender and social exclusion were not attended to, which the researchers speculate have to do with addressing the immediate micro needs rather than more complex macro concerns (Craig et al., 2013). This research demonstrates that some social determinants of health are more likely than others to be addressed in a hospital setting. Social workers in hospitals are expected to prioritize matters that may prevent a patient from being discharged from hospital when they are medically stable. When working with a patient experiencing homelessness, hospital social workers may have to focus their efforts on getting the patient into a shelter and securing emergency medication coverage as there may not be enough time to address the systemic issues of lack of appropriate and affordable housing and income insecurity.

Hospital social workers also provide patient and family centered care (Craig et al., 2015; Nicholas et al., 2019). The practice is built on the principles of dignity and respect, information sharing, participation and collaboration (Institute for Patient- and Family-Centered Care, 2016). In theory, social workers have already been practicing patient and family centred care as the guiding principles are similar to those found in the Code of Ethics (CASW, 2005). In one study, researchers found that hospital social workers greatly contributed to patient and family centered care given that they took a holistic approach to the patient's health, were highly engaged with patients and families and were communicating extensively with the interprofessional team (Craig et al., 2015).

Conversely, participants acknowledged the structural and environmental barriers that made the work more difficult which include reduced power, being isolated from other social workers due to program models, and issues with defining the role of social work (Craig et al., 2015). This research raises the notion that social work leadership may have a role in addressing the barriers to practicing patient and family centered care. It also suggests that isolation from social work peers brought on by organizational change impacts the way social workers practice in hospitals.

Social workers in hospitals are members of interprofessional collaborative teams and are valued for their ability to broaden the medical model of understanding and enrich team collaboration by bringing forth and addressing the psychosocial, environmental, and socioeconomic context of a patient's life (Ambrose-Miller & Ashcroft, 2016; Sims-Gould et al., 2015). The interpersonal skills that are important for social workers on multi-disciplinary teams have been discussed (Nicholas et al., 2019) as well as how issues with role clarity can hinder interprofessional collaboration (Ambrose-Miller & Ashcroft, 2016; Glaser & Suter, 2016). Furthermore, there is a need for social workers to have a well-defined scope of practice and strong relationships with the team as social work skills and contributions go unrecognized to other health professionals (Craig et al., 2015).
These studies speak to the importance of developing healthy working relationships with the health care professionals on the interdisciplinary team. These studies also suggest that effective social work practice in hospital may require social workers to use their own skills to navigate organizational issues of role clarity and their scope of practice on the interdisciplinary team; a task that may be difficult for social workers new to practice where their skills and knowledge are still developing.

Finally, one organizational factor that has been consistently noted in the research was the restructuring of Canadian hospitals in the 1990's towards the program management model and away from profession based departments, effectively reducing time spent with social work peers and social worker supervision (Globerman et al., 1996; Globerman et al., 2002; Globerman et al., 2004; Michalski et al., 2000). Social workers formed practice councils to address continuing education and standards of practice (Globerman et al., 1996), although years later there were reports that these councils were being disbanded and social work leadership positions reduced even further (Michalski et al., 2000). While social workers acknowledged receiving some peer consultation, they described feeling isolated from their peers and the profession, had to become more autonomous in their practice, and took on the responsibility of maintaining professional standards (Globerman et al., 2002; Michalski et al., 2000). What is promising is that later research found that social workers emerged as leaders for their profession through the development of standards of practice and evaluation and by addressing practice skills specific to hospital social work practice (Globerman et al., 2004). While this research was specific to hospitals in Ontario, what these studies suggest is that alongside hospital restructuring, and with each successive reduction in leadership, followed the expectation for social workers to be more autonomous in their practice. Social workers providing peer consultation and forming councils to address professional practice demonstrates that social workers have long been supporting each other where the organization has failed them, and that peer relationships appear to important for effective social work practice in these hospital settings.

The above studies provide an outline to social work practice in Canadian hospitals, including some mentioning of peer relationships for debriefing (Nicholas et al., 2019), to support critical reflection (Petruik et al., 2017), in patient and family centered care (Craig et al., 2015), and in being impacted by hospital restructuring (Globerman et al., 1996). While preliminary, these studies suggest that social work peer relationships support effective social work practice in hospital settings and are also impacted by organizational factors.

2.2 Peer Relationships and Social Work Supervision

As noted in Chapter 1, professional peer relationships are often understood in the context of social work supervision. Often, social workers are first exposed to supervision in their field placements during their professional education. After graduation, local governing bodies set out standards for receiving supervision in the field including a number of sanctioned hours they must receive in order to obtain professional registration. This suggests that supervision is not only important early on in a social workers career, but that there is an expectation that the practice of supervision is available, in some capacity or another, for the duration of their career. This expectation is confirmed locally by the provincial regulating body, the Alberta College of Social Workers (ACSW), which recognize that "a social worker will have ongoing practice/clinical supervision or peer consultation appropriate to their field of practice and setting" (ACSW, 2019, p.29). Furthermore, the Standards of Practice define consultation as the offering of professional expertise for the process of problem solving (ACSW, 2019), and according to the ACSW's continuing competency program, social workers can count peer supervision and consultation as credits towards their yearly renewal (ACSW, n.da). This suggests that

there is already an understanding that social work peer relationships are important to professional practice, similar to supervision, by providing support to each other for problem solving.

The purpose of social work supervision is to support the provision of appropriate service to clients (Kadushin & Harkness, 2014; Wilkins & Antonopoulo, 2019). Likewise, O'Donoghue and Tsui, (2015) suggest that supervision that focuses on client issues leads to better client outcomes. According to Davys and Beddoe (2010):

> Professional supervision, therefore, is not about complying to ensure that the rules are followed, rather it is the application of professional skills, knowledge, and principles to the variations of professional practice. As such, supervision provides a forum wherein practitioners can critically engage with their practice, reflect on their actions, review their decisions and learn. (p. 21)

These studies suggest that social workers need a space and access to a supervisor who is a social worker who can help them navigate their practice and that these efforts will have a positive impact on their clients.

There are three functions of the supervision process- administrative, educative and supportive (Kadushin & Harkness, 2014). Davys and Beddoe (2010) argue that support is not a function of supervision, rather a core condition, because having a supportive relationship between social worker and supervisor encourages tolerance and acceptance of the challenging aspects of practice. How the functions of supervision are experienced by social workers has been explored and the results are varied including social workers who find accountability and management oversight more helpful than emotional support, decision making, reflection, and analysis (Wilkins & Antonopoulo,

2019), the predominance of administrative and task based supervision rather than practice supervision (Sweifach, 2019), and social workers who acknowledge the need for knowledge and skill development, emotional support, and administrative tasks (Hair, 2013). What these studies suggest is that supervision practice is diverse and will be impacted by a variety of factors including the type of social work practice, the supervisory relationship, and organizational factors.

Studies show that the function of social work supervision is similar to social work peer relationships in the sense that social workers turn to their peers for support and education (Bailey et al., 2014), collegial support (Beddoe et al., 2014), for professional and knowledge development (Dempsey & Halton, 2017; Helm, 2017), for support, advice, and guidance (King et al., 2017), to discuss emotions in practice (Ingram, 2015), and to facilitate reflective practice (Petruik et al., 2017). While the research on peer relationships seems to be similar to the educative and supportive functions of supervision (Kadushin & Harkness, 2014), how supervision is provided between peers and supervisors is different. Specifically, Bogo and McKnight (2006) argue against peer supervision as being supervision because of the lack of authority between peers that is innate to the supervision process. Peers are unable to hold peers to the same account because the relationships are more egalitarian than in supervision. This power dynamic raises the question of whether or not authority is necessary to facilitate learning opportunities and provide support, as much as it is for maintaining administrative accountability.

Participants in their study believed that in order for supervision to be effective the relationship between supervisor and supervisee must be safe (McPherson et al., 2016) and

there must be a culture of belief and trust (Kim & Lee, 2009). Studies have found that power in the supervisor relationship can be used to strengthen the supervision experience and to hinder it (Hair, 2014) and impact whether or not social workers feel safe to bring up ethical and practice issues knowing that their supervisors conduct evaluation and performance appraisals (Hair, 2013). Similarly, trust and safety are also important in peer relationships in order to facilitate emotional support for social workers (Gangy-Guedes et al., 2016). What these studies suggest is that if social workers don't feel safe with their supervisor or their peer, they may be unlikely to discuss practice issues which leave them feeling vulnerable, yet could very well prevent them from discussing the most ethically and professional challenging aspects of their practice. This would certainly be a disservice to clients and speaks to the importance of having trusting supervisory and peer relationships to be able to work through and grow from the difficult aspects of practice that challenge social workers ethically and professionally.

The benefit of social work supervision on the social worker has been studied and show that supervision can alleviate the impact of workplace stress and support job satisfaction (O'Donoghue & Tsui, 2015), promote well-being and workplace retention (Chiller & Crisp, 2012), prevent burnout and turnover (Kim & Lee, 2009), and contribute to "job satisfaction, organizational commitment, psychological well-being, worker effectiveness" (Mor Barak et al., 2009, p. 15). The contribution of supervision on client outcomes is not well documented in the literature (O'Donoghue & Tsui, 2015), which is interesting given that the purpose of supervision is to help social workers help clients. The impact of social work peer relationships on client outcomes is also a gap in the research. Regardless, it is reasonable to assume that because of the interconnected nature

of the social worker and client relationship, positive outcomes for the practitioner could also have positive outcomes for the client.

Different models of supervision, specifically in hospitals in the US, have been studied and include traditional supervision, peer supervision, non-social work supervision, solo, and combination models (Berger & Mizrahi, 2001,) individual supervision, group work model, teamwork model, peer consultation, and no social work supervision (Kadushin et al., 2009). Supervision models are shifting. One-to-one traditional supervision was once available (Berger & Mizrahi, 2001). Now, more autonomous clinical supervision on an as needed basis has increased in popularity (Kadushin et al., 2009). Participants frequently noted informal peer consultation as a forum for clinical guidance and support and was sought out by staff who did not have social work supervision (Kadushin et al., 2009). Changes to the organization and health care environment, specifically cost cutting measures and fiscal monitoring, were central to both studies and saw a negative impact on supervision, social workers felt devalued as a profession (Kadushin et al., 2009), and one-to-one supervision was reduced (Berger & Mizrahi, 2001). No studies were found that examined supervision models in Canadian hospitals. The research suggests that in the US at least, while social workers were already feeling the effect of neoliberal policies in the hospitals, they were also acting as a resource for each other for professional development and support.

Further to supervision models, King et al. (2017) described a self-managed model of supervision whereby professionals actively sought out support, advice, and guidance through their own professional networks. While the research identified colleagues and contacts inside and outside their organization and field as part of their professional

network (King et al., 2017), it is reasonable to assume that their networks included social work peers. Research cautions however that this form of supervision requires careful monitoring and creates additional demands on decision making because once social workers receive information from their networks, they need to determine its value and applicability (King et al., 2017). Determining the usefulness of the material may be challenging for social workers new to hospital practice who are yet to understand how different information relates to the field, or who don't have access to a social work supervisor for discussion.

Social work peer relationships intersect with supervision as an addition to individual supervision by way of a reflective peer support group (Dempsey & Halton, 2017), as another forum to discuss emotions in practice (Ingram, 2015), as a mechanism for career supervision when time limited practice supervision for new social workers ended (Hair, 2013), and to promote professional resilience (Beddoe et al., 2014). This research suggests that social work peer relationships can complement supervision, and may also be more important in the absence of a safe supervisory relationship, or supervision focused on administrative tasks.

It is cause for concern that some social workers in hospitals were going without supervision or receiving limited supervision and often relying on their peers for support (Kadushin et al., 2009; Nicholas et al., 2019; Sweifach, 2019). Sweifach (2019) does not specify who these peers are that social workers rely on, but it can be assumed that some of these peers are their own social work colleagues. While Kadushin et al. (2009) and Nicholas et al. (2019) have been discussed above, Sweifach (2019) found that participants in interprofessional practice settings, including hospitals, weren't receiving

supervision, or only receiving sporadic supervision, due to organization barriers such as issues with the practice setting, lack of social work supervisors, administrative views of supervision as unnecessary, and cost. Furthermore, for social workers receiving supervision from another discipline, despite having a good relationship with their supervisor, they still felt alone and isolated and acknowledged a lack of understanding from these supervisors (Sweifach, 2019). These constraints raise the question of whether or not organizations are aware that they may be downloading the responsibility of supervisors onto the duties of front line staff without recognition or compensation for the extra work it entails.

While there is a breadth of supervision research, there seems to be an ongoing presence of peer relationships in the literature, albeit with different language (i.e. peer supervision or consultation, colleagues, etc.). These findings would suggest that peer relationships as Kadushin and Harkness (2014) explain, assist social workers to provide appropriate service delivery to clients. Although there is limited local research on the peer relationships of hospital social workers, they are an important relationship worthy of exploration on their own, rather than as an adjunct to the supervision literature.

2.3 Peer Relationships Among Social Workers

While not as well studied or defined in the literature as supervision, the social work peer relationship seems like an obvious workplace relationship. Understood as peers or colleagues, social workers turn to each other for support and learning (Beddoe et al., 2014; Chiller & Crisp, 2012; Grant, 2017; Helm, 2017; Ingram, 2015). Participants described receiving support from their colleagues to help them acknowledge their limitations in practice and for knowledge and learning (Beddoe et al., 2014). Regardless

of other formal supports, participants valued the support and informal supervision that they received from their colleagues, and described their experience in the following way: "support, teamwork, conversation, connection, constructive challenge, relationships, debriefing, and encouragement" (Chiller & Crisp, 2012, p. 238). For newly qualified social workers, colleagues were important sources of support for advice and guidance (Grant et al., 2017). In order to make sense of information and promote critical thinking, participants acknowledged the importance of having the choice to interact with peers and having access to trusted colleagues (Helm, 2017). Similarly, research found that informal peer support was the preferred forum for discussing emotions because of peers shared expertise, the informal relationship, the accessibility of being in close proximity in offices, and being able to prepare ideas for more formal forums (Ingram, 2015). What these studies suggest is that the social work peer relationship has supportive and professional development capabilities that help social workers to perform their job. Peer support appeared to be delivered in the workplace and was sought out by new and experienced social workers alike which demonstrate that social workers had access to peers who they trusted enough to go to for help regardless of where they were at in their career. Peer support appears important to social work practice, which presumably would benefit the organization and the client. Peer support encourages autonomous practice whereby social workers seek out peer support on an as needed basis, and would complement the self-managed model of supervision described above by King et al. (2017).

The group format was also cited as a mechanism of peer support and learning (Bailey et al., 2014; Dempsey & Halton, 2017; Gangy-Guedes, 2016). Bailey et al.

(2014) found that the peer consultation group promoted professional development whereby participants were able to witness the mistakes made by their colleagues, common challenges they shared, and to normalize feelings of self-doubt and inadequacy. Additionally, Dempsey and Halton (2017) found that a reflective peer support groups for child protection workers provided a space for social workers to work through divergent discourses of accountability and rationalism with human rights and social justice. Similarly, Gangy-Guedes et al. (2016) found that social workers using Facebook as an online forum for informal peer support provided emotional support and a sense of connectedness where ideas and resources could be shared. What these studies suggest is that there is utility in peers coming together in a trusted group setting where they feel safe to share their experiences, to express their challenges, and critically think through their practice. In a group setting, social workers have the ability to listen, witness, validate, and affirm each other's work which may also create a sense of connection. Groups may also reduce isolation and promote confidence in social work practice through their shared experiences.

While there appears to be an understanding of the function of social work peer relationships, what isn't well known in the literature is how the peer relationships are formed, maintained and the challenges the peer relationships face. There is some understanding of the process of social work peers seeking each other out for support and learning that have to do with the personal characteristics of the social workers involved (Beddoe et al., 2014; Helm, 2017; Nicholas et al., 2019). Specifically, Helm (2017) pointed out that social workers may only seek out colleagues who have similar opinions to them, which could be problematic if what they would benefit from is a different

perspective. Likewise, social workers need to be engaged by being open and willing to ask each other for help and utilizing the support provided, and to offer help to each other (Beddoe et al., 2014; Nicholas et al., 2019). What these studies suggest is that the social worker has insight about what they need help with, and take the initiative to ask for help. It also suggests that other social workers are willing to devote time and energy, in addition to their own workload, to help their colleagues out which speaks to a sense of shared connection between peers. If a peer does not trust their colleague they will be less likely to go to them for help which could be problematic for social workers on smaller teams or those new to the field. Likewise, if more experienced social workers are not willing to make themselves available to their peers, the peer efforts to seek out support will be unsuccessful. Similarly, once social workers receive information from their peers, they need to determine its value and applicability (King et al., 2017); which may prove to be a difficult task for new social work graduates or hires, and whether or not they have access to supervision or peers they can trust.

Social work peer relationships are not without their challenges. Unfortunately, negative workplace culture could be exacerbated through peer interactions if peers aren't able to value diversity and tolerate uncertainty (Helm, 2017). While workplace bullying is an unfortunate reality of professional peer relationships, few articles discuss the social work experience, and it isn't always clear who the staff member is that is bullying others (Cassie & Crank, 2018; van Heugten, 2013; Whitaker, 2012). One social worker's experience of workplace bullying by a peer noted that the most challenging part was having their work devalued and disrespected, which created feelings of self-doubt; similar to that of an abusive relationship (Whitaker, 2012). The role of peers was

discussed in another qualitative study of workplace bullying, mainly in hierarchal positions, whereby social workers suffered health related issues, lost control over their work lives, had diminished self-confidence and experienced professional and social isolation, (van Heugten, 2013). Research found a delayed response in social workers supporting their peers who were being bullied, which initially exacerbated their isolation (van Heugten, 2013). What this limited research suggests is that workplace culture impacts social work peer relationships which can in turn impacts their work with clients. While there are few examples of workplace bullying in the research this is not to suggest that these practices are not happening, but rather they are not being discussed in the academic literature.

The studies above suggest that peer relationships are valued by practicing social workers for their supportive capabilities and their contribution to their professional development. The experience of how peer relationships form, are maintained, and the impact of the organization is not well understood in the literature; especially in a hospital setting. Social work peer relationships are not immune to a toxic work culture or bullying, but the research on these is limited. These findings and gaps inform this research study. How social workers make sense of their professional peer relationships is arguably an important professional practice question for hospital social workers.

Chapter 3: Methodology

The purpose of this chapter is to outline the research methodology for this thesis. The study uses an approach to research known as Interpretative Phenomenological Analysis (IPA) which has shaped the research objectives, study design, sampling, data collection, data analysis, strengths and limitations, and ethical considerations.

3.1 Research Objectives

The objectives of this research study are 1) To better understand how social work staff make sense of their professional peer relationships, and 2) To better understand how these relationships impact social work practice in a hospital setting. Therefore, the research question guiding this study is: How do staff make sense of the impact of professional peer relationships on the delivery of social work services in a hospital setting?

3.2 Study Design

This study used a qualitative research approach known as Interpretative Phenomenological Analysis (IPA; Smith et al., 2012). IPA explores how participants make sense of their lived experience by mobilizing ideas from phenomenology, hermeneutics, and idiography as its theoretical framework (Smith et al., 2012; Smith & Osborn, 2008). IPA was developed in the field of health psychology and remains focused on the participant as a cognitive, physical, affective, and linguistic being (Smith & Osborn, 2008). Researchers play an active role in IPA by facilitating access to the participants lived experience and then interpreting the meaning of that experience (Smith & Osborn, 2008). IPA informed all stages of this qualitative study including the research question, sampling, data collection, analysis and discussion (Smith et al., 2012).

Furthermore, IPA is appropriate to use in studies that try to understand an individual's perception of a particular situation (Smith & Osborn, 2008) which is the case with this study of professional peer relationships and social work practice. Additionally, I chose to use IPA as it was the only research method I had practical experience with. At the time of designing this thesis I was working with IPA in my field placement and I intended to apply this experience to my thesis. Unfortunately the research team encountered issues with the study and my involvement ended shortly after ethics approval was received. While I was involved in developing the study, I did not get the opportunity to interview, analyze or discuss the research findings using this particular research approach.

Specifically, IPA is phenomenological as it is interested in the participant's personal and social world and in particular, their personal perception of that world (Smith & Osborn, 2008). According to Larkin and Thompson (2011), an assumption of IPA is that people understand the world through their interpretations of experience. IPA is influenced by philosophers of phenomenology. Specifically, IPA borrows from Husserl who established phenomenology's focus on the individual's perception of their experience (Smith et al., 2012). Secondly, IPA also borrows from Heidegger, Merleau-Ponty, and Sarte, who built on Husserl's work to maintain that our experience is personal to us and is shaped by our context- our culture, language, relationships, which we are fully immersed and embedded in (Smith et al., 2012). While participants grant access to their life experiences by sharing their story with the researcher, in order to engage with an experience, participants must use the process of reflection to turn their focus from the outer objective world, to the inner personal world (Smith et al., 2012).

IPA draws on hermeneutics, the theory of interpretation, because IPA is an interpretative process that seeks to understand how participants make sense of their lived experience (Smith et al., 2012; Smith & Osborn, 2008). Humans are sense-making beings and will naturally try to understand an experience through the meaning they give it (Smith et al., 2012). IPA also borrows from hermeneutic philosophers. The influence from Heidegger is how the phenomenon under question appears, or comes to be understood, and the central role of the analyst, (which in this case the researcher), in the interpretation and sense making of this phenomenon (Smith et al., 2012). Likewise, the contribution of Heidegger and Gadamer are how the process of interpretation is influenced by the relationship between what we already know (our fore understanding) and the new text (Smith et al., 2012). An assumption of IPA is that it is important for researchers to have ongoing awareness and to continually reflect on their own assumptions and experiences throughout the study (Larkin & Thompson, 2011). Interpretative work, including IPA, involves the hermeneutic circle and maintains that the part of something can only be understood through its whole and likewise the whole can only be understood through its parts (Smith et al., 2012). Therefore, IPA works through the hermeneutic circle and analysis becomes an iterative process whereby the researcher moves from their own conceptions to the participant text, then back to their conception then the participant text (Smith et al., 2012).

Finally, IPA is idiographic in its analysis because it is committed to the particular (Smith et al., 2012). IPA uses idiography in two ways: a detailed and in-depth analysis, and in understanding how particular people make sense of a particular phenomenon (Smith et al., 2012). While IPA considers each participant case on its own first, before

searching for patterns across all of the participant accounts, in the end, both the voices of participants and their shared experience will be reflected in the findings (Smith et al., 2012). IPA research is focused on the interpretation of the participant's experience in an effort to elicit what that experience means to that person. While this approach is valuable, a critique from a social work perspective is that IPA does not focus on the need for social change nor analyze the structural context that may explain why participants find themselves in this situation that they are in.

3.3 Sampling

Researchers using IPA explore an area of concern in detail, using a small, purposive sample of participants who have an experiential understanding of the topic (Smith & Osborn, 2008). The study population is front line social workers who are part of the social work department at hospitals in an urban city in Alberta. Social workers must be registered with the local governing body and hold a bachelor's degree or higher. While the intention was to interview 4 to 6 participants, only three were recruited, as recruitment was halted due to the COVID-19 global pandemic. Regardless, because IPA studies capture in detail the participant experience, three participants are still sufficient for suggested IPA sample sizes for new researchers (Smith & Osborn, 2008) and IPA studies at a masters level (Smith et al., 2012).

Participants were included if they were part of the social work department at the chosen hospitals, registered social workers with a minimum bachelor's degree, front line, and have a minimum of two years of employment with the department (not including time spent in a student field placement role). Participants were excluded if they were not part of the social work departments, are team leads, professional practice leads,

supervisors, managers, directors or anyone else in a leadership role, have less than two years of practice with the department, or have a past or current relationship with me.

I screened interested participants over the phone by reviewing the above inclusion and exclusion criteria, determining their preferred method of communication (email or phone), clarifying if they can leave voicemail messages on the phone if required, confirming they have received the consent form, and determining the location of the interview if necessary.

3.4 Data Collection

The flyer and the consent form were emailed to the social work department leadership for distribution through their email list. Participants were invited to contact me directly by email or phone.

The in-depth interview is an ideal way to capture the rich accounts of the participants lived experience that IPA is after (Smith et al., 2012). I collected data using one semi-structured interview that ranged from 45 minutes to 1.5 hour in length, either in-person or over the phone. The nature of the semi-structured interview requires flexibility and allows for the questions or sequencing to be adjusted during the actual interview so as to stay with the participant as they make sense of their experience (Braun & Clarke, 2013; Smith et al., 2012). I audio-recorded the interviews and then transcribed them verbatim.

3.5 Data Analysis

The analysis is an iterative and interpretative process that produces themes which illuminate the meaning of the phenomena under question (Smith et al., 2012; Smith & Osborn, 2008). The following process, as described by Smith et al. (2012), is not meant

to be prescriptive but is encouraged for those new to the IPA approach, which is the case for myself. To begin, I familiarized myself with the data by reading and re-reading the text (Smith et al., 2012) and by listening to the audio-recording. Next, I engaged in exploratory noting which involves freely commenting on the text in order to generate a detailed and comprehensive account of the data (Smith et al., 2012). I then used the initial notes to develop emerging themes that reflect a description of the participant's own narrative and the researcher's interpretation (Smith et al., 2012). Once established, I found ways to connect the emergent themes together (Smith et al., 2012). Next, I repeated the same process over with each participant case (Smith et al., 2012). A technique called 'bracketing' is used to bracket ideas that may arise from the first analysis, to allow for new ideas to develop from the other participants' data (Smith et al., 2012). Finally, I searched for patterns across all of the participant cases and developed superordinate themes (Smith et al., 2012), which highlight the meaning of the participants lived experience (Smith & Osborn, 2008). In the last stage, I presented the findings in a narrative account of themes and verbatim quotes from the participants (Smith & Osborn, 2008) and a discussion section where the findings are interpreted in relation to the literature.

3.6 Strengths and Limitations

The topic at hand is important for social workers as it extends the understanding of professional practice and may contribute to future development of the social work profession. Knowing how hospital social workers make sense of their professional peer relationships may shed light on a resource that supports them to navigate the difficult and complex nature of their job. Conversely, the lead researcher as a graduate student is new

to conducting research in general and in particular using the chosen approach. Even with the supervision support of experienced social work researchers and educators, it is anticipated that the overall lack of research experience may present challenges to the research process.

3.7 Ethical Considerations

Ethics approval was sought and received from both Dalhousie University and the local Research Ethics Board through the regional health authority. Consideration was made for two possibilities- that the interview was perceived as an inconvenience as it will take time aware from the participant's workload, and that disclosure of concerns about professional practice which could portray the organization in a negative light are made. For the former, as a way to mitigate the impact on workload, participants have approval from their supervisors to complete 45 minutes of the interview on work time. Participants were able to choose what time they want to complete the interview, and if they wanted it to occur outside of work hours altogether. For the latter, several mechanisms are in place to safeguard confidentiality should a disclosure of professional practice take place which could put the participant at risk of reprisal from the organization. The research is focused on social workers personal experiences and reflections on their relationships and practice, rather than institutional evaluation. Concerns about professional practice including incompetent, unethical and unprofessional practice are more likely to arise in the latter type of research. Nevertheless, if disclosures of professional practice are made, data is de-identified and findings are presented thematically. Since IPA uses direct quotes from participants in the

findings, any quotes related to concerns of professional practice will be reviewed with the participant before submission.

3.8 Enhancing Trustworthiness and Confidence

Two strategies were used to enhance trustworthiness and confidence: member checking and independent audits. Member checking can be done in different ways including checking the study analysis with the research participants (Braun & Clarke, 2013) or having participants review their interview transcript (Birt et al., 2016). I chose to review a small number of quotes with participants, specifically those related to concerns regarding professional practice that I wanted to include in the discussion. Participants were able to confirm if they were comfortable with the quote used verbatim, or if they would prefer it to be paraphrased. Likewise, independent audits where the researcher shares the initial transcript coding and themes with the supervisor who reviews for rigor and provides feedback. (Smith et al., 2012) were conducted throughout the analysis phase with each participant transcript as well as the analysis as a whole.

Chapter 4: Analysis

This chapter will present the analysis of four superordinate themes (and seven sub themes) produced by an interpretation of the participant interviews of Hannah, Mary, and Priscilla. In order to maintain confidentiality, the names used here are pseudonyms which were chosen by study participants. The themes are yearning for social work leadership (supervision, social workers understand, professional relationships between peers), navigating social work peer relationships (strategies to build peer relationships, uniting and dividing practices), contributing to social work professional development (peer consultation and peer support, peers as role models), and challenges of practicing social work in a medical model. Direct quotes from the interviews are included to support the themes.

4.1 Yearning for Social Work Leadership

4.1.1 Supervision

Participants spoke about their part time social work professional practice lead which is a social work leadership position that supports practice standards for front line workers and may involve mentorship, supervision, and consultation. While participants acknowledged having a professional practice lead, they highlighted the limitations to the current position such as being located off site. Furthermore, Hannah and Mary note that the current position is part time, the role was not defined by the social work profession, and the position was responsible for several health care centers. Despite having a professional practice lead, no participant acknowledged going to them for supervision, debriefing, or consultation. This suggests that this social work leadership position, which is intended to support front line staff, may be under resourced for the current need.

> We have a PPL, we do have a PPL but they are stretched out in so many ways. They're part of the hospital and for rural areas, so nobody sees them…and they only work part time, so we got nobody. (Hannah)
>
> Now we have a professional practice lead but if you really look at the scope of this person's practice and the reach of that person, that practice is developed by non-social workers because it's standardized right. So every discipline has a professional practice lead and their role has to focus on how do you get the social worker in their jurisdiction to practice, to standardize practice....It's limited because a- resources, our professional practice lead is part time…their area is huge. You can't, how much time can you spend right…. (Mary)

While Hannah acknowledged that she is not currently receiving any supervision, she spoke highly about her past experience of social work supervision which highlights the benefit and ease of having social work leaders who are available and accessible to front line staff. Hannah spoke about a case that left her devastated and needing to debrief her experience. Her rhetorical question of "who else" could she have turned to in that situation demonstrates that the professional practice lead was the best possible support for her in that time of distress. While it's helpful that social workers can rely on peers to debrief complex cases, it raises concerns about professional well-being such that front line social workers are not only further burdened with the emotional and mental impact of complex cases, but that they also have to witness and support their peers who may also be in distress. The thought that some social workers do not talk about or go home with the emotional and mental weight of these cases in the absence of having someone to debrief with is even more concerning.

> ….what supervision? So there is supposed to be supervision? That has not happened at all at all. I have had supervisions in the past and that is because my manager and my PPL both were social workers and they worked right in the building. So anytime there was any situation, I could easily go to my PPL. (Hannah)

> And I was so devastated, and I needed to debrief about what happened. Who else could I have turned to other than my PPL?....Right now, the way it is most of the places are run not by a social worker, so who do I go to for supervision? There isn't anyone. So, maybe we go to your own coworkers, or you just don't talk about it, or you bring it home. (Hannah)

Participants did not appear to have social work supervision. While they seemed to have access to a supervisor who is a health care professional in a leadership role, which they felt they could go to with questions or for help, they didn't appear to be receiving one-to-one supervision on a regular scheduled basis that provided a space to discuss social work practice. Priscilla acknowledged that it was her responsibility to seek out her supervisor if she had questions or concerns.

> ….I don't get regular supervision….it's really up to me then to seek out support from my supervisor besides that. (Priscilla)

Both social work supervision and supervision in general were acknowledged as a gap in hospital social work practice. Mary and Priscilla outlined the challenges of speaking with health professionals in leadership positions who were trained in a different practice lens or who didn't understand the role of social work. Social workers address the problems in the social environment that impact a patient's health and mental health.

This practice differs from medical model practice which addresses the physical symptoms of the patient. Once the physical symptoms have been addressed, the patient is generally ready for discharge. Ethically, social work practice prioritizes social justice as a core professional value which can be difficult for other professions to conceptualize. Understandably, a social worker would find it challenging to communicate with a health professional who is not trained or versed in social work practice that applies a social justice approach to address the problems in the social environment that contribute to the patient's illness.

> You know that's a gap in our profession, a huge gap. My supervisor, so we've had several in the time that I was there and only one is a social worker. They've all been physiotherapists, nurses primarily. You know, we are professionals. We do our job. They're lovely you know good leadership. I feel very supported, but they don't really understand what I do, and they don't understand the lens that we look at things through. They don't get it and not that they don't want to, but that's not their scope. Like I said that's not their lens, so do I have leadership- yes. Do I have social work leadership- no. (Mary)
>
> It's really difficult having managers who aren't social workers. Who you're supposed to be going to and don't really know what your role is [laugh] and just say 'keep on doing what you're doing' and you're like 'but I [laugh] don't know if I'm doing it right' [laugh]. But that's definitely a challenge for sure. I can say right now in our hospital we're very well supported, but that hasn't always been the case. (Priscilla)

Priscilla highlights her experience of beginning her career with social work supervision then transitioning to no supervision. The sanctioned supervision she describes is mandatory for first time registered social workers in the province (ACSW, n.db). Priscilla highly valued having regular contact with someone who could check her work and address her concerns. Her use of the word "life saver" demonstrates how important validation and support are for developing competency as a new social worker, and in Priscilla's case developing confidence in her skills. When the sanctioned supervision ended, Priscilla was "fending" for herself until she figured out which of her peers she could trust to support her in practice.

> I can say that as a new grad I had to go through my accreditation in Alberta so I had a social worker that I met with on a regular basis and who was like my direct kind of supervisor for the ACSW right. Those accreditation hours and that was sure a life saver and really grateful that the ACSW has that in place to make sure that competency wise someone is going over my work and addressing any concerns for us. But I've worked in many different areas of social work so since that occasion, its meant kinda fending for myself right and figuring out who are those coworkers that you can trust…. (Priscilla)

4.1.2 Social Workers Understand

Education and experience have equipped social workers with a common understanding and language of professional knowledge and skills, code of ethics, and practice approaches that are unique to the profession. As a result, social workers are in the best position to understand social work practice in the hospital. In the absence of social work supervision and with limited leadership, participants in the study seem to turn

to one another for support and consultation. Priscilla describes how she consults her social work peers for her social work problems. While the supervisor is aware of and supportive of the arrangement, which demonstrates her insight into her limitations as a non-social work supervisor, the arrangement does place a greater burden on social work peers for dealing with practice related issues- which may be most work-related problems. It also raises the question if peer consultation is a suitable alternative to social work supervision. Social workers need to apply their own professional judgment to the information they receive, a task that could be difficult for social workers new to practice.

> They understand what I do, they understand the caseload…. (Mary)
>
> I know for myself I'm much more likely to go to my coworkers if I'm stuck on something than my supervisor unless it's not social work related, and then I'd be more likely to go to my supervisor. But I know that there's just a lot of general knowledge my supervisor doesn't know and they're not offended by that. They're understanding and want us to go to your peers…. (Priscilla)

Hannah acknowledges that she will go to those peers whom she feels comfortable with and are relatable. By seeking out those peers who she has a relationship with, Hannah demonstrates that social workers need to feel safe if they are going to openly discuss the difficult aspects of their practice that have the potential to put them in a vulnerable position.

> I just go to a coworker that I feel more comfortable with. Because whoever I have that relationship, I go to a coworker…. (Hannah)
>
> ….you cannot go to someone who cannot relate to you. (Hannah)

Mary articulates her need for someone who understands and can hold space for her to reflect on and work through the moral and ethical distress she feels after witnessing a doctor override the consent of a patient, rather than someone who is simply going to tell her what to do. This example, and Hannah's statements above, demonstrates how a social workers understanding and orientation to the values and beliefs of the profession position them to support one another with moral and ethical dilemmas in practice that may not be held in the same regard by other health professionals who have a different orientation to helping the patient.

> ….my supervisor will listen, but their solution is a very task orientated solution. I know how to do that, this is what we do for a living. But what I'm seeking or I think we all need to get is that empathy, that understanding piece, that emotional professional support. What does it mean when you're a social worker and you've just sat across the table next to a physician who said 'I'm taking your rights away and I'm giving you an injection'? Morally, ethically, professionally, that's against what we believe in right, that distress, that's what they don't understand….
>
> (Mary)

4.1.3 Professional Relationships Between Peers

Priscilla appears to be aware of the limitations of peer consultation and peer training for new social workers. Her statement suggests that while years of practice may not be synonymous with competency and that social workers practice differently, social workers must apply their own professional judgment to assess the information they receive. For new social workers, professional judgment is likely still developing. While Priscilla highlights the diversity in practice among social workers in that "every one of

them is going to do this differently", her statement raises the question if diversity in practice may actually be a lack of centralized direction for front line social work practice in the absence of social work leadership. Priscilla also demonstrates how peers can informally take on an authoritative position among peers to "keep each other in check" which seems to have the potential to create an unhealthy work environment, especially in situations where these is a lack of trust among peers.

> Yeah I think that's a challenge for people who are new that just because some of the social workers have been in their position a very long time doesn't mean they're actually providing accurate information to families. And I think that's something that's hard about social work being so diverse, and our sites being so spread out, is we all have our own way of doing things right. So if you're a new worker and job shadow with a couple coworkers, every one of them is going to do things differently and [laugh] you have to decide for yourself who you're going to end up trusting right. So I think that's a really hard point and can definitely bring disagreement and conflict between my coworkers as different people maybe overstep in offering what they think is the correct way to handle things, or maybe reprimanding someone that they're not in charge of. So that's the hard piece about not having a social work supervisor is we kind of have to keep each other in check when were not responsible for each other. And if there's relationships of trust and understanding that's great, but if people are sensitive or abrupt, or have hurt each other in the past then that can create a lot of disunity. (Priscilla)

The idea of a lack of centralized direction for front line social work due to limited leadership is furthered by Hannah who describes how there is no one to train social

workers how to properly document. This lack of direction or "learn how to chart as we go along" suggests that front line social workers have developed their own way to document, which may be different between social workers, and may present challenges when social workers cover for each other. Documentation is another way that the social work profession communicates their role and value to the interdisciplinary team. Diversity in practice, as described by Priscilla and Hannah, which may be a lack of centralized direction for the profession, could inhibit rather than support role clarity and professional understanding between social workers and other health professionals.

> We don't have someone who would teach us on how to document that is required by hospital standards for social work notes. Social workers are basing our charting on how we learned in the university. We learn how to chart as we go along. We need someone who is checking our charting on a random basis to make sure the information suffice if court ordered, if we have covered all necessary areas or are we are opening a 'can of worms' that cannot be resolved in a medical setting. For example, childhood sexual abuse. Most of us do not know what it is like to have a social work manager and to have a PPL right onsite, someone to debrief on cases during ethical dilemmas, crisis, grief etc. (Hannah)

Mary acknowledges that when there is no social work supervision, she turns to her peers for support. In this quote and throughout the interview, Mary spoke about her social work peers using language of "weak" or "strong". Baines' (2017) distinctions between mainstream social work practice and social justice-orientated practice may help us to understand what Mary means. In mainstream social work practice, social problems are viewed in a depoliticized way that focuses on individual short-comings with the use

of individual interventions (Baines, 2017). Conversely, social justice-orientated practice would analyze and attempt to address the oppressive structures in society while working with the individual (Baines, 2017). From Mary's perspective, weak social workers take a mainstream approach to practice, whereas strong social workers are more orientated to social justice practice. With limited social work leadership to support social justice practice, peers are left with the responsibility to use their professional judgment to navigate their working relationships with each other.

> Well when that happens [no social work supervision] this is where I rely on peer support. And you know if you're not working with strong social workers your job becomes that much more difficult. And I have worked at sites, I've had really really strong peers, colleagues and I have I work at sites where I have very very weak. And it's not because of weak in terms of abilities…. (Mary)

Despite having a part time social work professional practice lead, and a non-social work supervisor they could go to with questions, participants yearned for social work leadership as someone who could provide supervision and debriefing, understood the moral and ethical dimensions of practice including an orientation to social justice, and who could provide centralized direction for hospital social work practice. In the absence of adequate social work leadership, it appears that a burden is placed on front line social workers in these settings. Social workers were providing peer consultation, support, debriefing, and training to one another because of their professional knowledge and shared understanding and language of social work practice. While this process seemed to be self-driven and informal such that social workers sought out their peers on an as needed basis, the added responsibility of supporting and debriefing with peers raise

questions about how social workers address their own professional well-being. These findings also raise questions if peer consultation is a suitable alternative to social work supervision, and about the competency of the social worker providing the consultation. Likewise, social workers receiving information from peer consultation and training must use their professional judgment to assess the information they receive; professional judgment likely to still be developing in new social workers. Furthermore, without social work leadership, peers had to use their professional judgment to navigate their working relationships with each other when it came to social work issues. These situations include the creation of informal authority structures between peers, a possible lack of centralized direction for social work practice, and differences in practice styles related to social justice.

4.2 Navigating Peer Relationships

4.2.1 Strategies to Build Peer Relationships

Hannah is intentional about her efforts to build peer relationships and she does this through the physical act of sharing food together or as she puts it, bringing a "human touch" to the relationship. She suggests that peer relationships are "better" when they're personable and friendly, not just professional and clinical.

> I think what makes the relationship better is when I reach out to them and say let's meet for lunch. And I want to try to break up the fact that I'm only reaching out to them for some kind of advice or just in handover, you know, and just trying to normalize. If I bake something at home I'll bring it over so I can share with everyone. Just to have that human touch and not be so professional…. (Hannah)

For Priscilla, it's important to know which of her peers she can trust, and she is clear in her distinction of what makes a peer trustworthy or untrustworthy. The former is reliable, safe to be vulnerable with, and who is going to help you problem solve, while the latter is someone who gives incorrect information and belittles or gossips about you. Her use of the word "figuring out" demonstrates that there is a process to determine which peers are trustworthy, or not, and that the process involves risk. Priscilla further elaborates on risk by suggesting that she gives her peers a chance to "prove" their trustworthiness by assessing how they react to a situation.

> ….figuring out who are those coworkers that you can trust that are gonna have your back and support you when you do make a mistake and figure out how to make a solution. And unfortunately who are your coworkers that are going to give you incorrect information, or aren't gonna have your back right and they're maybe going to belittle or gossip about you. (Priscilla)
>
> And I think they just prove you take a risk and how they respond to you tells you if you can trust them or not. (Priscilla)

Mary acknowledged that building peer relationships require all social workers to participate and involve spending time together and sharing aspects of each other's personal lives. Mary's reference to "compromising privacy" suggests that she is aware of the risk of sharing private details of her life, yet appears to mitigate this risk by only sharing details with social workers who she respects; suggestive of those peers who share similar social work values. Her example demonstrates a more informed decision-making approach to building peer relationships than both Priscilla and Hannah.

> Time I think. The time you spend together, the willingness on both parties or all the parties to come together and share these experiences…. (Mary)
>
> ….we talk about other things and to think for me if I'm willing to share a little bit about my private life that builds that relationship that trust. Not everybody can do that and I'm not willing to do that with everyone. That hinders a relationship and I fully acknowledge that. I fully own that. But again that comes to compromising my privacy myself right. If I don't see a value in that or if I don't respect that of you, I'm not going to and that's a problem. I agree with that but I'm not willing to compromise that. (Mary)

4.2.2 Uniting and Dividing Practices

Priscilla touches on several practices that contribute to strengthening relationships among social work peers. Her use of the word "definitely" highlights the importance of self-care for peer relationships. Being honest and asking for help from peers can create vulnerability and suggests that there must be a degree of trust between peers before these disclosures can happen. The use of validation and gratitude to acknowledge peers imply the reciprocal nature of building relationships. Priscilla's acknowledgement of a "good supervisor" speaks to the impact that leadership can have on peer relationships.

> Oh definitely if they're taking care of themselves, if people are not sleeping well, or not dealing with home stress that certainly impacts it. And I think also like honesty, if someone's willing to tell us what's going on and why they're not doing well there's just so much understanding right. And asking for help when were overwhelmed. Yeah when things are left unsaid right then there's no understanding, so that really helps. Also showing appreciation, taking

> opportunities to complement coworkers and to thank them for their work, then when there is a situation that's not going so well you have that trust and support. So I would speak to that. I also think having a good supervisor…. (Priscilla)

Hannah and Mary demonstrate how working on similar units with similar caseloads, patients and teams, or working to achieve a common goal such as a discharge, brought some front line social workers together and divided others who don't share these things in common. While some social workers may have more in common with others, this example speaks to the need for creating opportunities that bring peers together. It also raises the notion of intentionality when it comes to unit assignments and office space such that new social workers may benefit from sharing space or working on a unit with more experienced social workers who may, in a way, act as informal mentors.

> But on a day to daily basis, I have nothing to do with them. (Hannah)
>
> ….it's helpful when you have peer support in your area…. (Mary)
>
> ….we are working together to get a patient discharged, that is my common goal on a day to day work. (Hannah)

Hannah further discusses the concern for new social workers who do not have things in common with their peers and how this can create isolation by confirming she has "felt that in the past". Her statement suggests that front line social workers early on in their career need more support, and likely a different kind of support, from their peers than social workers who have been in the field longer.

> Well because I have been in this field for so many years it doesn't affect me as much. But if somebody, if a new student or a newly hired social worker was in

> my position, she would feel very alone. And yes I have, I felt that in the past when I newly did this job…. (Hannah)

Physical proximity was also something that had the ability to unite some peers and divide others. Priscilla describes how social workers sharing offices can facilitate peer support but can also be problematic because shared space lacks privacy. Her example of providing "grief and loss" support to a patient is prevalent in hospital settings and within the scope of hospital social work practice. This example highlights the ethical responsibility that peers have to one another as colleagues in the workplace and the importance of having social work leadership as a resource to support front line staff.

> I think that there's definitely opportunity for support right. If you've just had a difficult conversation to be able to know that you can go back to your office and be supported. But is also very hard when maybe you're having a conversation about grief and loss and someone is laughing in the background while you're doing that on the phone. Or when someone has loud maybe inappropriate music on and you're trying to have a professional conversation on the phone. (Priscilla)

Hannah shared how coming together as a department of social workers to celebrate events or holidays united social work peers. This demonstrates the importance of spending time together outside of patient care which furthers Hannah's belief that peer relationships are better if they are personable and friendly or have a "human touch" to them.

> So you kind of keep that relationship by everyone meeting as a team. Sometimes out of the blue we all try to go and meet for dinner. Then the other one is we try to have Christmas lunches…. (Hannah)

Mary is insightful of what contributes to "burnout" for her as a professional. Despite everyone having the same education and training, Mary's professional ethics seem to be challenged by those social work peers who she perceives to be aligning with the interdisciplinary team at the expense of advocating for patients who are vulnerable. By Mary highlighting that this situation is more difficult than being "yelled at and screamed at" suggests that conflicting ethical viewpoints may contribute to burnout.

> I also have colleagues that their responses "Mary, they can't stay in the hospital forever". I'm offended by that. Those are the colleagues that perpetuate the things that we went to school to fight against. That was very very offensive to me and that's probably harder for me to work with than a difficult patient, family, or physician. I can deal with a really difficult physician, I can be yelled at and screamed at but I struggle with dealing with a colleague who went through the same education, we committed to this profession, to work with vulnerable people. That's harm. So those are the people I struggle with and will burn me out in the profession before anything else. (Mary)

Hannah and Priscilla briefly touch on challenges they've encountered in their peer relationships including peers who are more approachable than others and managing personalities different from their own. While their statements provide a glance into what can divide peers in the workplace, more information is required to better understand these challenges.

> There are some people that I wouldn't approach because they're just not easy to talk to. (Hannah)

> It was just that piece of how challenging it can be just navigating different personalities. (Priscilla)

The strategies that participants spoke about were all intentional acts to build relationships with their social work peers. Most often, participants appeared aware that there was a risk to building these relationships. These strategies include making peer relationships more personable and friendly by sharing food together, the process of figuring out which peers are trustworthy depending on how they respond to a situation, and spending time together and sharing personal details with those peers who have shared values and beliefs. Participants spoke at length about uniting and dividing practices including self-care, validation, gratitude, leadership, sharing common work practices, physical proximity, spending time together unrelated to patient care, value conflicts, and personalities. Participants raised the negative effects of professional peer relationships including finding out a peer isn't trustworthy, experiencing isolation because of division or exclusion from peers, and burnout due to value conflicts with peers. Ultimately, navigating peer relationships are about building relationships of trust that require social workers to be intentional, reflective, and reciprocal about their actions.

4.3 Contributing to Professional Development

4.3.1 Peer Consultation and Peer Support

Hannah describes her experience of peer consultation and peer support and how her social work peer relationships are based on who is accessible and available to help her meet "the need of the hour". While Hannah acknowledges that she has peers she can consult with, the hesitation she feels and awareness that her peers "do not have my back" suggests that she may not trust her peers. Given the lack of trust she may feel, suggests

that Hannah would be particular about who she goes to for resources or advice, and who she discusses or debriefs more emotionally laden topics with.

> ….what the need of the hour is. If I need some resources, if I need some advice, yes I can talk to them. At least there is some kind of relationship where I feel I can reach out to them and they can reach out to me, and so it is cordial. It is professional…. (Hannah)
>
> In the professional level, if I need anyone to help me, I could turn to them for help, if I need help yes. But then again you have to think twice or three times…. (Hannah)
>
> Staff at work do not have my back, yes. (Hannah)

Hannah further describes her experience of peer support in that she does have peers she can go to for help. This suggests that there are some peers who she trusts enough to be vulnerable with in order to debrief a case or discuss a concern.

> I like having them because I can go to them when I have any questions or concerns or any debriefing. Sometimes there's something that management talks about you don't like it or you like it, you want to talk to your peer…. (Hannah)

While Hannah acknowledges that her peer relationships haven't affected her practice because she is the only social worker on her unit, she speaks to the importance of having social work peers in the hospital rather than working in isolation. This distinction suggests that she is confident working as the only social worker on the unit, but prefers to have social work peers in the building who are available and accessible if a need arises. This also demonstrates that Hannah would rather have a partial relationship with peers who she doesn't fully trust than to not have any peer relationships at all.

> I don't think it [peer relationships] affects my relationships with my patients. It is the same because I'm not working with another social worker. I will provide the same level of care on my unit with my interdisciplinary team…. (Hannah)
>
> I don't think I would have liked working if I was the one social worker in the whole building. I don't think I would have liked the job. If they only needed one social worker for the whole hospital, I don't think I would have liked it because I need, I like having other peer social workers, they are important. (Hannah)

Hannah acknowledges how she values the "knowledge" of her peers which supports the idea that social workers are in the best position to help social workers because they understand each other. In this case it is their professional knowledge which demonstrates the value of peer consultation for her social work practice.

> I value their knowledge and that they are more knowledgeable than I am because of the discipline that they work, and so they may know things that I don't so I need them. (Hannah)

Hannah spoke passionately about her peer relationships with her interdisciplinary team which appeared to be more meaningful than the social workers because of what they share together: patient care on the unit and details from their personal lives. These interactions suggest that Hannah shares a degree of trust and connection with her interdisciplinary team that she doesn't share with her social work peers. Her use of the metaphor "bread and butter", and repetitive use of the word "joy" to describe how she feels at the hospital suggests that the peer relationships she has with her interdisciplinary team provide sustenance for her in the workplace and can make up for the trust and sense of connection that seem to be missing from her social work peer relationships.

> ….that is my bread and butter, the joy of the day, the interdisciplinary team; because I have a reason to have a relationship with them. The other people I am only having a relationship with them because I think I must, or I have to, or because I do see them once a month. (Hannah)
>
> I get so much joy if I'm hanging out with the OT/PT, NP and we are all going for dinners. Because we all have been talking, we are working on the same unit, we joke about something, we all laugh about what happened over the weekend. You know, they talk about something funny that their family did or their kids did, they exchange photos, and they talk about their husband or where they- so that unit becomes the people that you work with more so…. (Hannah)

While there is a sense that there is a lack of trust between Hannah and her peers, she does seek them out for consultation and support when a need arises, specifically information sharing, debriefing, and advice. However, it is Hannah's peer relationships with her interdisciplinary team that are meaningful and bring joy to her in the workplace.

Priscilla describes her experience of peer consultation and peer support through the sense of belonging with her peers and views their relationships as being part of a social work team. On a team, members take care of one another or "rely" on each other as she described. As noted by Priscilla, peers advocate for each other and in her case, support her mental health. Priscilla demonstrates how social work peers can work together to overcome challenges in the workplace including isolation and workplace stress, but also to acknowledge and celebrate practice such as social work week. Her expression twice over about "checking in" with her suggests that she appreciates when someone makes an effort to ask how she's doing. This act seems to be performed by

peers which would suggest that Priscilla's social work peers are important for coping with stressors in the workplace.

> It means that as a team we really need to rely on ourselves, to look out for each other and to advocate for each other. But we can't do this job on our own. (Priscilla)

> I work on a busy unit where no one acknowledged social work week at all. And that's fine, but also just that it's so busy that likely no one's checking in with me and seeing how I'm doing. And so my peers, my social work peers, are really important to my mental health at work. So to see how I'm doing and checking in. (Priscilla)

Priscilla recognizes the importance of her social work team to provide peer support in contrast to her multiple statements about working in isolation. While she acknowledges that she requires peer support on a "daily" basis which speaks to the difficulty of social work practice in a hospital, it also suggests that her peer team is accessible and available to support her. Priscilla's use of the word "privilege" describes how fortunate she feels in both her professional and personal life to have her peer relationships extend outside the workplace as friendships. The importance of her peers "walking with me" speak to a sense of togetherness; Priscilla and her peer team are on a similar path and are there to not only support one another as challenges arise, but to also share in moments of success and celebration.

> I'm grateful that we're not isolated on our own, that we do have a supervisor that's looking out for us and supporting us how they can, and when I do have coworkers that support me on a daily basis. (Priscilla)

> They're really important. I have the privilege of calling many of my coworker's friends and knowing that they support me outside of work. I could not be a social worker working at a rural hospital by myself. I know that's something I couldn't manage. For me I know it's really important to have other people in my profession who are walking with me. (Priscilla)

While it may not be the case for all front line social workers in Priscilla's hospital, peers seemed to go to each other for consultation. Priscilla acknowledges that patient care would suffer if she didn't have peers who she could trust who shared information on community resources with each other. Her example demonstrates the breadth and importance of resources required for hospital social work practice, and how peers contribute to that knowledge base. Priscilla's orientation to her social work team meant that she was aware of the challenge that peers as new graduates and hires would face coming into the hospital. While she referred to these concerns throughout the interview, there was a sense that the peer team would be there to support the new social workers through their struggles.

> I think that some people just have personalities where it's easier for them to humbly bring up their questions to their coworkers, and be able to problem solve and I think that on every team there's going to be some more experienced social workers that are more open to supporting new grads and others that aren't…. (Priscilla)
>
> ….if I didn't have coworkers I could trust, I know will help me out even if they're busy, my clients wouldn't get nearly as good care. Because we're all aware of different supports in the city or different contacts if we're not getting the answers

> we need [laugh]. So having good peer relationships is so important. Which is why I said new grads shouldn't be left to fend on their own because their clients aren't going to get nearly as good care. It's just a reality…. (Priscilla)

From her perspective, Priscilla's peer relationships constitute a peer team. The peer team is important for professional development because they provide Priscilla with consistent peer support that strengthens her mental health (checking in, reliance, advocacy, reduce isolation, friendships) and access to peer consultation (asking questions, problem solving, resource sharing) ultimately resulting in what she perceives as better care for her patients and their families.

4.3.2 Peers as Role Models

Early on in her career, Mary had the opportunity to experience social work mentorship that she described as "most memorable" and "important influence". Her description suggests that the mentorship she received contributed to the foundation of Mary's social work practice that is still relevant today. Mary perceived her mentor as someone with a strong sense of professional ethics and social work identity, and someone who was patient centered. Mary learnt that if social workers aren't true to the values and beliefs of the profession they can be "absorbed" by the dominant systems that they are working in. Mary's example also demonstrates the struggle of practicing in an environment that challenges your values and beliefs.

> One of my most memorable and important influences and mentors in my life you know as a social worker that I met was my mentor. And to me.... she was grounded, she had a strong moral compass, she knew who she was, not always, but she knew. More importantly, she took the time to know who the patient was.

> And she's the one that taught me that this profession that you work in, that we work in, if we're not true to self we're going to be absorbed…. (Mary)

Mary applies her teachings from her mentor to her own peer relationships. She is critical of her peers and refers to them in terms of "strong" or "weak" depending on their orientation to social justice practice. While Mary suggests that what makes a social worker "weak" is if they lack the awareness of the power differential inherent in the relationship between the social worker and the patient, she recognizes this may happen "unknowingly". Mary is also aware of her own limitations when she acknowledges her "rigidity" and is empathetic to her colleague's experiences in that there may be another reason why they practice as they do. One obvious question is whether her peers received the same quality mentorship early on in their career as she did?

> ….when you're working with a vulnerable population, when you recognize that there's a power differential between you and the other person that do no harm piece is so important. I have worked with weak social workers who don't recognize that and do harm, unknowingly, which perpetuates the racism, the discrimination…. (Mary)

> I also recognize that maybe that's my rigidity and maybe we're supposed to be understanding and compassionate. Maybe there is other reasons that this person is, you know for the same reason the patient is the way they are, the colleague is the way they are. (Mary)

Mary finds value in the perspectives that her peers offer. The peer perspective creates an opportunity for Mary to reflect on her own professional values and beliefs and to stay grounded to her professional ethics. Mary's expression that "I need" them to do

her job, and the "discomfort" of this awareness demonstrates how social work peer relationships can act as a guide to indicate when someone has shifted from their interpretation of social work values and beliefs. Mary's strong language of "fighting my profession" speaks to the distress she experiences of finding herself at odds with the profession that she has dedicated her career to.

> My peer relationships are that professional connection side that I have, and I need to do the work that I do. We cannot work, social workers cannot work in isolation, we can't. We need more perspectives otherwise, right, because our world becomes smaller. We don't have that awareness that I need to do the job, that we do. So those relationships are really really important to me. (Mary)
>
> It's made me more self-aware and that self-awareness piece it makes me uncomfortable. And I think we need to be in a place of discomfort. For me I will say that because complacency, apathy is very harmful in what I do for a living, [pause] it probably challenges me more than I care to admit sometimes because I'm not just fighting the system, I'm fighting my profession. (Mary)

When Mary experienced what she considered memorable and influential social work mentorship early on in career, her mentor modeled how to apply social work ethics to practice as a hospital social worker, particularly in terms of social justice. The opportunity to witness her mentor in practice supported Mary's professional development and growth as a social worker. Even though Mary is distressed by the difference in values and beliefs with some of her peers, she is empathetic to their experience and aware that they provide an opportunity for Mary to reflect on how her practice aligns with her own professional ethics.

Priscilla's encounter with peer role modeling came from her witnessing her social work peer's experience of "severe burnout". Given that Priscilla was able to witness her peer in this state, it seems to have taught Priscilla that if she didn't make changes to how she managed her time and workload, that she too could experience burnout. Priscilla's statement suggests that there is value in learning from social worker peers who have been at this work longer; that they have knowledge to be passed down to those social workers new to practice who are open and willing to learn from their experiences or "mistakes".

> I've had one peer who's dealt with a lot of severe burnout over her career, and that has certainly impacted how I do social work. Understanding the importance of taking breaks, and leaving on time, and not taking cases home with me because those years and years of even little traumas certainly add up. So I think having peers that have been at social work longer and learning from them and learning their mistakes when I'm young is vital to be able to keep up this profession. (Priscilla)

Mary goes on to further explain how her peers act as role models, whether their practice is "different", good, or "bad", and that learning can occur when she observes them in practice. Mary differentiates between the knowledge and experience that social workers bring to practice, and that the "art" of social work practice is the applications of this knowledge and "lived experience" in order to create safe environments that allow patients to experience the difficulties of life. Mary's statement highlights the importance of having access to peers in the workplace for role modeling opportunities and raises the question if social workers know they are role models for each other? Mary's openness to

learn from her interactions with her colleagues demonstrates that learning can occur from both new and experienced social workers.

> I learn a lot from my colleagues because patients are different, we are different. So what works for them or what works for me or what doesn't work for me, I may not know that there's a different way, a different approach. We don't just come to practice with what we know, we come to practice with who we are. And the people that are most influential in my life are those that come with that lived experience and that ability to create safety and comfort for the person. That's an art, and I learn from every time I hear how a person interacted with whoever, not just a patient but with a colleague or with a coworker. And I watch how they approach them and I think 'wow I never knew that you know'. Because I can google a resource. I can't google how you made a patient feel safe where she disclosed that she was raped. That's not something I can find, that's a skill, an art. So I learn from them, so that's really important for me. The other, the flip side of it when I see bad social work, I learn from them. I learn what not to be. (Mary)

Social work peer relationships of participants contribute to professional development through peer consultation and peer support. While there was a sense of a lack of trust and connection with her social work peers, Hannah still values their professional knowledge. Hannah felt that she could go to her peers for consultation, and that there were peers who she could discuss more emotionally laden topics with. Priscilla's peer team provide her with consistent support which she felt benefited her mental health, and consultation which in her perspective led to better patient care. Moreover, professional development for participants also occurs through role modeling.

Social work peers act as role models for each other and create opportunities to witness and learn from their practice. Both Mary's mentor and her peers act as role models who provide opportunities for Mary to see the application of social work ethics to practice, how to apply knowledge and lived experience to practice, and to reflect on how her practice aligns with her own professional ethics. Priscilla's peer role modeled the impact of burnout which motivated Priscilla to make changes to her time and workload management so as to prevent herself from such an experience later on in her career.

4.4 Challenges of Practicing Social Work in a Medical Model

Participants perceived that they were working in a medical model which focused on physical symptoms, was hierarchal in nature, and prioritized discharge and fiscal restraint. Conversely, participants' conceptualized social work as having a unique set of values and beliefs that inform practice and recognize social justice as a core value, work with the problems in the social environment that contribute to illness, and patient centered. Challenges in the workplace are inevitable for these participants because they are practicing in a system with inherently different ways of thinking and doing.

> Oh, I guess the lack of happens because the demands are high. Hospital setting is very empty the bed and get someone new. (Hannah)
>
> In the hospital we work in a medical model where discharge discharge discharge is the main goal. (Mary)
>
> ….but a social worker's job is to assess the physical, the psychological, emotional, mental, spiritual, you assess everything about them. But a medical model is not set up that way to assess all the needs. And only then only then let the discharge happen…. (Hannah)

Priscilla provides two examples from the field that outline the challenge of practicing social work in a medical model: advocating to physicians and defining the social work role to health professionals. She also demonstrates how confidence is a skill that is developed over time and informs both processes. Priscilla's orientation to the peer team suggests that peers can help new graduates and hires to build their confidence that will in turn help them to advocate for those patients who are in vulnerable positions. Likewise, it may also help in role definition when other disciplines disregard the autonomy of the profession and try to direct social work practice themselves.

> I started working in health care right out of university. And so I think my own confidence has really grown in that I use to be quite intimidated of doctors, especially doctors that are abrupt. So I think that my own skills have really grown in that knowledge, that years of working with the same physicians, have given me the confidence to [laugh] call them on things, and to disagree, and to be more confident. Telling my clients they need to keep on bringing up their concerns if they don't feel like their being addressed....but that's definitely I think hard skills for social workers to have right out of school, when other health professionals are maybe defining their role for them, or telling them what they shouldn't be doing. (Priscilla)

Mary explains that when social workers align with the medical model, competition and conflict between peers can follow. Mary's reference to agreeing with the team is interpreted as aligning with the medical model. Advocating on behalf of the patient may lead to disagreement with the interdisciplinary team, may delay discharge, and may create the perception that the social worker is the "barrier". She suggests that

when social work practice is judged based on the number of patients discharged; higher numbers mean "better" social worker practice. Evaluating social work practice based on medical model standards appears to be problematic for peer relationships and could also offer a misguided sense of competency and validation for social workers.

> ….you're the better social worker then because you discharged more patients. The system builds that, it fosters and nurtures that because the goal is to get them out. So when the social worker buys into that it creates conflict, it's meant to create competition, it's meant to propel you to get them out. So how do you get a patient out? Well you agree with what everybody is saying. I don't know if this is your experience, we have historically been viewed as the barriers to discharge. (Mary)

Hannah and Mary address another challenge in that social work practice is not well understood by those who ascribe to the medical model, therefore inhibiting the hiring of social work leaders. As explained above, social work practice can be difficult to conceptualize and to communicate to other health professionals who are not orientated to the language and concepts of social justice and problems in the social environment that contribute to illness. Rather than understanding the value added by social work practice in hospitals, social workers are seen as a profession who, as Mary states, will "delay discharge". Delaying discharge is contradictory to fiscal restraint. As a result, there is a perception from participants that social work leaders are not hired. Similarly, it may also explain why the current leadership role is underfunded to meet the needs of front line social workers. How the lack of social work leadership impacts social work peer relationships has been outlined above in the first theme.

> The reason we don‘t have social work managers is because the hiring team themselves do not value or understand the need, the respect you need to give them. (Hannah)
>
> We don’t have enough of that, we don’t value mentors enough and we burn them out, we really really don’t. And I will say from a hospital business perspective we don’t want that person there, they’re gonna delay discharge. (Mary)

Mary explains how “strong” social workers, suggestive of those practitioners who are more orientated to social justice, are well suited to grow into mentors and leaders if they can last in the field. Mary describes how her mentor struggled to maintain her “best ethical self” but was ultimately unable to resist the dominance of the medical model overtime and was “pushed out”. Mary’s example demonstrates the physical and mental toll that it takes to practice in an environment which conflicts with a person’s professional values and beliefs. This loss of mentorship, as a peer and informal social work leader, means that front line staff lose an opportunity for guidance and support from a social worker who is knowledgeable and experienced in navigating social work practice in a hospital setting.

> We as a profession don’t have enough of it because we don’t have enough time to grow into that. You don’t graduate out of school one day and then the next day you become the mentor that I think we, the profession needs and deserves. That takes time. That takes time to grow this person. We don’t have enough time to grow them, and by the time these really special individuals grow to be the people that we need, that I need, the system has burnt them out. And the weak ones by far outnumber the strong ones and they get pushed out and that’s exactly what

> happens. So my mentor was pushed out because of where she stood and what she needed to do to be true to her best self, but also her best ethical self. The system doesn't allow for that to happen. (Mary)

Priscilla explains that a successful peer team is one that works together to get the job done. Her use of the word "challenging" to describe the units or clients that require extra help suggest that the consulted peer would have a degree of practice knowledge and experience to equip them to navigate those situations. Priscilla's expression that peers coming together reinforces the team mentality, that there are limited resources in the hospital, and the suggestion that social workers must prioritize each other since the hospital dose not, gives a sense of an underlying expectation that help will always be available from the team if you need it. This notion of expectation raises the question of how social workers who provide support to their peers manage their professional well-being if they already struggle to meet each other due to heavy workloads and multiple responsibilities.

> ….it means stepping in and helping coworkers when they have specific challenging units or challenging clients on a specific day. But because there's limited resources and limited staffing, that in order to be a successful team we need to be willing to cover each other's pagers or take referrals. I also think that the hospital doesn't, we're not their priority [laugh], of making sure were getting educated or appreciated or well supported because they have so many needs…. (Priscilla)

Hannah and Mary both felt that practicing in a model that prioritized discharge left them with little time to meet with their peers over coffee or lunch. Unfortunately,

missing out on these opportunities to gather informally over food also meant missed opportunities to build peer relationships.

> Everybody ends up having lunch at different time, not everybody gets to have lunches at the same time. Not everybody goes for coffee. Ah heck coffee doesn't even happen…. (Hannah)

> We have 7.75 hours in a day to do our work and sometimes within that time we hardly have time to sit down for coffee or have lunch, let alone sit and share and talk. (Mary)

Participants acknowledged the challenges of practicing social work in a medical model, two practices that are inherently different, and how this relates to their peer relationships. Peers may help build confidence in each other to support social workers in advocacy and role definition. When social work practice is evaluated based on medical model standards, specifically prioritizing discharge planning, and social workers aligning with the medical model, it can create conflict and competition between peers. There is a perception that social work leaders are not hired because of a misunderstanding of the social work practice in hospitals. Consequently, front line social workers inherit this gap in practice.

Social work mentors who are oriented to social justice practice are burnt out by a system that continually challenges their values and beliefs. As a result, front line social workers lose out on valuable mentorship that provides guidance, support, and leadership. For one participant, given the team mentality, limited resources, and prioritization of social workers amongst each other, there is a sense of expectation that help will be available from your peers if you need it. This expectation speaks to the reciprocal nature

of peer relationships but raises questions about how social workers who are providing this continual support to peers manage their own professional well-being and self-care. Finally, working in a medical model leaves social workers with limited time to meet and build relationships with their peers. In the end, participants found that practicing social work in a medical model created inevitable challenges for front line social workers. Peer relationships are also impacted and while the experiences are varied, peers seem to be informally tasked with supporting each other to manage these challenges.

Chapter 5: Discussion

This chapter will discuss the research finding identified in the superordinate themes in relation to the associated research objectives. This discussion of the research findings will answer the primary research question: How do staff make sense of professional peer relationships on the delivery of social work services in a hospital setting?

The chapter is organized into four parts. In the first two sections I will discuss the research question in relation to the two research objectives by exploring the related superordinate themes, findings, and the literature. These research objectives are firstly, to better understand how social work staff make sense of their professional peer relationships. Within this research objective I will discuss the related superordinate themes of yearning for social work leadership and navigating peer relationships. In the second research objective, to better understand how these relationships impact social work practice in a hospital setting, I will discuss the superordinate themes of contributing to professional development and challenges of practicing social work in a medical model. Thirdly, I provide concluding remarks to discuss a notable finding of this research study. The final part of the chapter is a discussion of expectations, assumptions, and surprises related to the research.

5.1 Objective #1: To Better Understand How Social Work Staff Make Sense of Their Professional Peer Relationships

Participants made sense of their social work peer relationships at the hospital by understanding them in relation to direction and modelling from their social work leadership role models as well as the current social work leadership. Participants'

relationship to leadership resulted in navigating the dynamics of forming and maintaining working peer relationships with social workers in the hospital. The participants reported a gap left by a lack of social work leadership in the face of their own need for guidance, support, consultation, and debriefing from social workers. Thus for effective social work practice, social work peer relationships appeared to be an especially important substitute for supervision that front line social workers at the hospital actively pursued on their own initiative.

5.1.1 Yearning for Social Work Leadership

Participants felt that the social work leadership role at the hospital was limited because it handled multiple sites, was allocated as part time, was located off site, and was defined by non-social workers. Despite having this social work leadership position, no participants acknowledged currently accessing them for their supervision, consultation, or debriefing needs. Participants were looking for social work leadership at the hospital as someone who understood the moral and ethical dimensions of social work practice, which go beyond the medical model and includes an orientation to social justice. While participants felt the medical model focused on symptom management and discharge planning of the patient, some participants were more orientated to social justice and recognized the need to address the underlying power dynamics in the relationship between the patient, health care practitioners, and systems. Specifically, social justice-orientated practice according to Baines (2017) would analyze and attempt to address the oppressive structures in society while working with the individual. There was also a sense that participants were also looking for social work leadership that could provide supervision and debriefing, and centralized direction for hospital social work practice.

Three findings were found to be linked to yearning for social work leadership are discussed below.

One finding that was unanimous among participants was that they were not currently receiving social work supervision, but that they had experienced some supervision or mentorship earlier on in their career. This finding highlights that the need for social work supervision may be higher when a social worker first begins to practice while they are developing their own professional knowledge and confidence in their skills. This need is supported by provincial standards that require social workers to have received a particular number of hours for first time registration in the province (ACSW, n.db), and by the literature where Hair (2013) found that social workers need for supervision following graduation and for new employees rated extremely high among participants.

Whether or not peer consultation is an appropriate alternative for social workers needs to be understood in the context of the different practice needs of new and experienced social workers. Peer consultation may be appropriate for new social workers when the interactions include discussions on theory to practice, use of ethics including social justice, and navigating power dynamics in relationships and systems. However support of this detail may be difficult to offer in the workplace due to heavy workloads and time constraints.

Furthermore, the need for supervision for participants did not seem to disappear over their career but rather shifts such that it is required in particular practice situations, namely stressful or distressing events (e.g. patient death, ethical dilemmas). Alternatives to career long supervision for support and ongoing skill development as found in the

literature may be peer consultation once time limited supervision ends (Hair, 2013) or self-managed supervision where social workers exercise more autonomy in who they reach out to for help (King et al., 2017). These options may be especially relevant for workplace settings with limited leadership resources.

The impact of not receiving social work supervision, or limited supervision, was varied in the literature. While Nicholas et al. (2019) focused on the individual traits of the worker- flexible, confident, assertive, self-directed, that would help social workers in hospital navigate the limited supervision that was available, Kadushin et al. (2009) found that social workers felt the profession was devalued by the organization, and the workers' ability to obtain their practice license was inhibited by non-social work supervision.

Furthermore, Sweifach (2019) noted participants' experiences of not receiving social work supervision some of which include feelings of isolation, acknowledging the benefit of having someone to go to who has social work skills, and the importance of having social work supervision early on in one's career rather than in later stages. What the literature and this study finding suggests is that discipline specific supervision is important to professional practice at the start of a social worker's career, but in situations where it isn't readily available, social workers need to take responsibility for their own supervision needs, which may be difficult for social workers new to practice or graduates who are transitioning from structured field placement supervision.

Moreover, an explanation for the lack of supervision is the presence of organization barriers such as cost cutting measures and fiscal monitoring (Kadushin et al.,2009), and issues with the practice setting, lack of social work supervisors, administrative views of supervision as unnecessary, and cost (Sweifach, 2019). This

research supports the current study which found that the availability of supervision was impacted by organizational factors, such as the dominance of medical model practice which will be explained further below.

Another consistent finding was that participants felt that their social work peers were better suited than other health professionals to provide consultation, support, debriefing, and training because of their shared understanding and language of professional knowledge, skills, ethics and practice based on their education and experience. This finding demonstrates that in the absence of discipline specific leadership, participants actively sought out other social workers because they understood each other. This finding is supported by the literature that reveals that social workers sought out their peers to debrief cases because supervision in the hospital was limited (Nicholas et al., 2019) and they accessed their peers for informal supervision in the absence of supervision in interprofessional practice settings (Sweifach, 2019). Likewise, since social workers felt strongly that their supervisors needed to be social workers and have prior social work experience (Hair, 2013) it is understandable that participants in this study were going to their peers for help.

The data would also suggest that social work peer relationships function similarly to the educative and supportive functions of social work supervision (Kadushin & Harkness, 2014). Provincial standards recognize peer consultation as an alternative to supervision (ACSW, 2019), which would be practical for participants, with no social work supervision, to consult with their peers for problem solving. While social workers providing consultation have an ethical responsibility to only do so if they have the knowledge and competence of that area of practice (CASW, 2005b), there is a possibility,

whether intentional or unintentional, that social workers providing consultation may do so out of their area of expertise.

Similarly, peer consultation could be limited if social workers lack knowledge and experience which is required to be able to problem solve with other social workers seeking support. With no formal process in place and peer consultation being the only option available to problem solve social work issues, front line social workers would need to decide who they trust to provide this necessary support. Conversely, when a social work supervisor or leader is available to provide supervision, there is already an established understanding that the person in this role is competent to provide this service to front line social workers, and that this person would be checking in with the social worker on a regular basis. While, social workers receiving information from their networks still need to determine the value and applicability to practice (King et al., 2017), having a designated person for supervision may be more relevant for new graduates while their professional judgement is still developing.

A finding experienced by all participants was that they used their professional judgement to navigate their working relationships with their peers in relation to social work related practice situations. The situations that arose in practice were the creation of informal authority structures between peers, a possible lack of centralized direction for social work practice, and differences in practice styles related to use of social justice. This finding suggests that participants had to not only use their own internal resources to compensate for the lack of social work leadership, but that they were also put in difficult situations that they had to navigate with their peers which could be damaging for relationships and may impact their work with patients. The finding is supported by

Dempsey and Halton (2017) who highlight that peers regularly need to negotiate interpersonal matters with each other given that they don't typically choose their teams nor may be working with peers who they share similar opinions with. Social workers in hospital have raised the importance of interpersonal skills to navigate their relationships with the multi-disciplinary team, including conflict situations (Nicholas, et al., 2019) so it would be reasonable to assume that social workers are flexible in their practice and also use their interpersonal skills to navigate the dynamics in their peer relationships.

5.1.2 Navigating Peer Relationships

Participants acknowledged that in order to do their work effectively they need guidance, support, consultation, debriefing, and someone who understood social work practice. The gap left by the current social work leadership role, and possibly prior gaps in social work leadership, compelled participants to seek out and build peer relationships, which can be a risky, challenging, and rewarding process. Three findings that are linked to navigating peer relationships are discussed below.

A finding among participants was that they used strategies to build peer relationships, and were aware of the risks involved to building relationships. Strategies included sharing food together to make the relationship more personable and friendly, figuring out who they could trust by seeing how peers respond to a situation, and sharing personal details with peers who have similar values and beliefs. This finding suggests that building peer relationships is an intentional process that participant's undertook to figure out who they could trust. Engaging in such strategies was also found by Helm (2017) who studied social workers in a child welfare context and discovered that they created a 'secure base' in their office by sharing food, making coffee, and moving rooms

in order to create relationships of trust that would support in-depth cognitive and emotional analysis of their work.

Furthermore, participants were aware that there are peers who are not trustworthy, and that they open themselves up to being vulnerable by sharing personal details about their life. Similarly, Bailey et al. (2014) acknowledge the vulnerability present when members of the peer consultation group share experiences from their professional life. The presence of vulnerability highlights the need for trust and safety in peer relationships to be able to access the difficult aspects of a social worker's practice.

Participants appeared to recognize that in order to grow the peer relationships they needed to move their interactions beyond patient care and the workplace and into more personal domains. This was expressed by participants through sharing homemade food, celebrating events together, and disclosing more personal details about their lives outside of the hospital. The intentionality of participant's actions and the presence of vulnerability that comes with learning to trust a colleague demonstrate that the peer relationships add value to their social work practice at the hospital. Interestingly, trust wasn't essential to all peer relationship as one participant was willing to have partial relationships with social workers who she didn't fully trust rather than working in isolation.

Conversely, the literature highlights that trust is important to social work peer relationships (Dempsey & Halton, 2017) and that trust was essential to create a safe environment which allowed social workers to experience a high degree or support from group members (Gangy-Guedes et al., 2016). Likewise, Ingram (2015) found that social workers felt safe with peers because their interactions were informal, which allowed them

to explore the emotional aspects of practice. In partial peer relationships which lack trust, it may mean that social workers avoid more emotionally laden topics about their practice and access their peers for more surface level activities like information or resource sharing. A partial peer relationship may also suggest that a social worker is confident in their own practice such that they can self-direct challenges they face with less peer support.

Another consistent finding was that participants engaged in uniting practices to build and maintain the relationships with their peers. In general, uniting practices identified by participants were individualistic such as engaging in self-care, using validation and gratitude towards peers, and spending time together unrelated to patient care such a celebrating events or holidays. Others were organizational including leadership, sharing common work practices such as units or caseloads, and physical proximity including shared offices or units. The finding suggests that when participants engage in these uniting practices it will create a sense of connection among peers that is important to build relationships of trust which make peers more likely to go to each other for support, consultation, and debriefing. The literature supports this finding such that when social workers came together informally over Facebook for a common purpose, the informal peer support provided created a sense of connection amongst each other (Gangy-Guedes 2016). Likewise, Ingram (2015) found that when peers worked in close proximity to each other, the accessibility encouraged discussions about the emotional aspects of practice.

Uniting practices had the ability to bring some peers closer together while challenging relationships with others. One practice noted by a participant- shared office

space, had the potential to unite peers by creating a space for support and consultation to happen, but also presented challenges to individual practice due to a lack of privacy and in turn could be damaging for peer relationships. The dual nature of shared office space among social workers was also raised in the research by Helm (2017) who spoke to the potential of shared space to discuss different discourse and promote critical reflection, but also as a way to maintain the dominant discourse and inhibit critical reflection. Social workers faced with these situations would be required to use their professional judgement and interpersonal skills to navigate their working relationships with their peers.

Conversely, a finding shared by all participants was that there were certain practices at play in the hospital that divided peers and created dynamics among each other that severed peer relationships. These practices, in general, were individualistic such as value conflicts, personality styles, and organizational such as being excluded from the uniting practices identified above including not sharing common work practices and physical proximity. Participants acknowledged that being divided from their peers' may result in isolation, especially if they were new to the organization, and that this can contribute to burnout. The finding on dividing practices suggests that when participants or their peers engage in these practices it could discourage a sense of connection and trust in the peer relationship and could be detrimental to professional well-being and practice because social workers would not have access to peers for support, consultation, and debriefing. Thus social workers would be left to navigate their practice on their own, including difficult cases, which seems especially problematic for graduates or those new to hospital practice.

Despite the potential for the negative implications of dividing practice, the literature speaks to a varied experience among social workers. While researchers have outlined how organizational changes in the form of hospital restructuring and service delivery models created isolation between social work peers and supervisors (Craig et al., 2015; Globerman et al., 1996; Globerman et al., 2002; Michalski et al., 2000), social workers also emerged as leaders for the profession and their peers by supporting initiatives for standards of practice, evaluation, and skill building (Globerman et al., 2004). Moreover, peers can also be their own answer to combat isolation as was the case for social workers who felt less professional isolation by participating in a peer support group (Dempsey & Halton, 2017). The findings here and the literature suggest that peer responses to dividing practices are varied, depending on the context of the situation, and can change over time.

Furthermore, a highlight of the finding of uniting and dividing practices is that both front line social workers and leadership have a shared role to play in creating opportunities for front line social workers to gather. Although there is some overlap in terms of uniting and dividing practices, in general, social workers navigate individualistic practices and leadership navigates organizational practices. Moreover, the role of leadership is highlighted when participants identified that one of the challenges to practicing social work in the current hospital environment is that front line workers have little time to gather at work. This challenge calls on leadership to be intentional about creating and supporting opportunities for staff to connect- be it through department gatherings, shared office space, or unit assignments. The role of leadership to create opportunities for peers to gather is also found in the literature, as Dempsey and Halton

(2017) outline how leadership approved and supported the development of a social worker led peer support group. This study demonstrates how leadership can facilitate opportunities for peer relationships by supporting the development of peer led initiatives in the workplace.

5.2 Objective #2: To Better Understand How These Relationships Impact Social Work Practice in a Hospital Setting

Effective social work practice at the hospital required participants to have guidance, support, consultation, debriefing, and someone who understood social work practice. Peer relationships had a positive impact on social work practice in the hospital because they contributed to professional development. Peer relationships and social work practice were also impacted by the challenges that front line workers faced by practicing in a context where the medical model is the dominant practice model. The inherent differences in the practice models are a potential source of tension and value conflict between social work peers.

5.2.1 Contributing to Professional Development

Peer relationships contributed to the professional development of participants in the hospital because they created opportunities for ongoing learning and growth to occur in the workplace. The opportunities are peer support, peer consultation, and role modeling. Two findings that are linked to the contribution to professional development are discussed below.

A unanimous finding was that all participants sought out peer support and peer consultation to assist them to learn and perform their work effectively. This finding suggests that peer relationships are an important practice resource for participants. It also

suggests that participants had insight into the help they needed and actively sought out their peers for this help. Researchers discuss the importance of personal characteristics in this help seeking process including social workers being open and willing to engage in seeking out help from their peers, and to provide help to each other (Beddoe et al., 2014; Nicholas et al., 2019). Openness to engagement and flexibility were evident in the study participants for this research project.

Peer consultation and peer support were described by participants throughout the study and at times the terms appeared interchangeable. The participant experience of peer consultation was described as information, knowledge and resource sharing, asking questions, giving advice, going to peers if stuck, addressing a need, problem solving, for help, and for a different perspective. Broadly speaking, the experiences of participants fits with the ACSW's (2019) description of consultation as a problem solving process, and seems to focus on resolving a practice related issue. The literature supports the finding that peer consultation contributes to professional development (Bailey et al., 2014) given that social workers sought out peer support for advice and guidance (Grant et al. 2017; King et al., 2017), and created opportunities to refine social work skills and professional growth (Gangy-Guedes et al., 2016). These findings, in addition to having a sense of connection and trust to engage in the problem solving process with other front line social workers, would suggest that peer relationships indirectly support patient care. More information about what happened between participants during the peer interactions would be helpful to understand how the relationship contributes to learning and growth; while taking into consideration the different practice needs of new and experienced social workers.

Furthermore, the participants' experience of peer support was described as an alternative to supervision, support in your area of work, after a difficult conversation, help, to discuss concerns or dislikes, debriefing, relying on and advocating for each other, checking in, connection, daily support, friendships, and togetherness. While there is currently no definition for peer support in the Standards of Practice (ACSW, 2019), or the Code of Ethics (CASW, 2005a; CASW, 2005b), there is reference to the ethical responsibility that social workers have to each other to be respectful, to collaborate and consult, and to manage disputes (CASW, 2005b).

There is a sense that the function of the colleague relationship is for consultation for professional practice when it is in the clients' best interest (CASW, 2005b), which may also involve providing peer support to the social worker alongside the consultation. Conversely, in the literature, Solomon, (2004) defined "peer support as being emotionally focused and involving individuals with shared similar experiences" (Ingram, 2015, p.899). This also appeared to be the case for an informal peer group held over Facebook which provided emotional support for social workers (Gangy-Guedes et al., 2016). It could be suggested that peer support that is emotionally focused and provided by social workers was found in the participant descriptions above.

Moreover, in reference to the supervision research, peer support seems to shift between being a function of the relationship as explained above by Kadushin and Harkness (2014) and as a core competency of the relationship according to Davys and Beddoe (2010). While participants described peer support as both- something the relationship provided the social worker with and something that was fundamental to the peer relationship, there is a sense that peer support is whatever the participant needs it to

be in that moment. Even though there is overlap between participant's description of peer consultation and peer support, the former appears to be more specifically related to problem solving practice scenarios. These findings, as well as the sense of connection that arises from uniting practices and empathizing with each other's shared challenges, would suggest that peer support is a coping mechanism for workplace stressors and a support for professional well-being. The literature supports this idea given that Chiller and Crisp (2012) found that peer support and informal supervision were important to social work practice, the relationship had a protective nature to it, and it helped social workers deal with workplace stress.

Another finding was that some participants saw their peers as role models. This finding suggests that learning and growth, especially early on in one's career, appear to be aided by having opportunities to witness, discuss, and reflect with social workers on the integration of theory to practice, ethical practice including the use of social justice, navigating power dynamics in unjust systems, and how to prevent burnout. For participants, role modelling occurred in several ways. One participant's experience of witnessing peer burnout brought to light the importance of making changes to their own practice so as to support their own health and longevity in the field. Another participant had the opportunity to experience good mentorship early on in her social work career and this experience appeared to have a positive and lasting impact on her social work practice. Their relationship highlights the benefit of having a trusted and experienced mentor who is willing to model professional ethics, social work identity and patient centered care in the field.

The finding is supported by research whereby despite being a peer consultation group that met outside of work, having regular contact with peers was a benefit because it created opportunities to witness and learn from each other's practice (Bailey et al., 2014). Moreover, Grant et al. (2017) found that newly qualified social workers preferred dialogue with their colleagues and management over shadowing them; which brings to light the importance of peer debriefing as a means to discuss the decision making process of social workers in practice. Finally, one participant witnessed how to apply knowledge and lived experience to practice, as well as a range of practice scenarios which provided her with an opportunity to reflect on how her own practice aligns with professional ethics. Similar findings were found in a peer support group which helped social workers to deal with the emotional aspects of practice and the integration of personal and professional values, ultimately strengthening their professional agency (Dempsey & Halton, 2017).

That peers can learn through reflection, debriefing, and observing each other in practice was further confirmed in the literature on simulation based learning for social workers in educational (Craig et al., 2017) and hospital settings (Xenakis, 2018). Likewise, social work practice can be further enhanced by peer debriefing and critical reflection (Petruik et al., 2017). This finding, and the literature, demonstrates that while peer role modelling creates opportunities to witness peers' practice, reflective practice is required for learning and growth. Likewise, peer debriefing may enhance role modelling as it creates additional opportunities for discussion about the decision making process. Unfortunately, peer role modeling would be difficult for social workers who work in isolation, such as being the only social worker in a hospital which may be the case in

rural settings. This finding also highlights the role of leadership in supporting these opportunities for peer role modeling due to the presence of organizational barriers in hospital such as heavy workloads, time constraints, and given that social workers often work alone on a hospital unit.

5.2.2 Challenges of Practicing Social Work in a Medical Model

Since participants recognized that the dominant operating model of the hospital is the medical model, despite rhetoric about being interdisciplinary, the peer relationships that were formed in the workplace were impacted by this model of practice. Participants described medical model practice as oriented to symptom management, hierarchical authority with patients and social workers towards the bottom, and a prioritization of discharge and fiscal restraint. Conversely, participants' conceptualised social work practice by recognizing social justice as a core value, addressing problems in the social environment that contribute to illness, and patient centered. These discrepancies create challenges in the workplace. Two specific findings that are linked to the challenges of practicing social work in a medical model are discussed below.

An important finding as expressed by one participant was that when peers align with the medical model and social work practice is evaluated based on medical model standards, conflict and competition between peers can arise. The participant explained the finding in the context of discharge planning. Specifically, a social worker aligning with the medical model would agree with the interdisciplinary teams discharge plan for a patient, rather than resisting and advocating for an alternate plan that from a social work perspective was in the better interest of the patient, but would delay discharge. Resisting the team's plan would not only result in less desirable discharge numbers for the

participant and put them in conflict with their peers, but there is a sense that it would also put them at odds with the interdisciplinary team which could increase workplace stress.

The notion of aligning with the medical model can be understood by Baines' (2017) description of mainstream social work practice. Mainstream social work practice is often pathologizing and depoliticized as interventions are focused on the individual's limitations and their problems are not understood within the social context of their lives and the power imbalance present in their existing relationships (Baines, 2017). A depoliticized approach to discharge planning could mean that a social worker doesn't challenge but rather agrees with the interdisciplinary team's plan for discharge even though the plan doesn't account for the impact of the problems in the patient's social environment that will likely exacerbate their health conditions.

This has been the case for patients being discharged to homelessness. Despite being a common scenario for social workers in hospital, the reality of bed pressures and fiscal restraint as well as insufficient housing and economic resources in the community make it difficult to appropriately address homelessness from the hospital. Regardless, even the act of verbally resisting and encouraging the team to think about the discharge plan from a different perspective is political because it challenges the status quo's perception that the patient is to blame for their lack of housing, when in reality their homelessness is perpetuated by systemic barriers. Similarly, uniting and aligning to support peers who are experiencing discharge dilemmas as described above rather than competing or faulting each other over numbers would also be a political act as it resists the medical model and promotes solidarity among peers. Understandably, there is a

sense that consulting peers who align with the medical model would be conflictual because it seems to be misaligned with the profession's core value of social justice.

However, social work values and ethics are open to the interpretation of the practitioner and are influenced by the social workers own context. While the participant does acknowledge that there may be another reason why her peers practice the way they do, she appears empathetic towards their experience. This finding suggests that peer relationships may be negatively impacted if social workers have different practice styles from their peers that align them closer to the medical model and further away from social justice. There is also a sense that for social workers who do resist the medical model and practice from a place of social justice that there may be a sense of connection and empathy for the shared struggle they all experience.

Social work ethics and practice seem to be challenged by the current operating model of the hospital and front line social workers need to decide how they will approach this challenge in their practice; which may impact their relationships with their peers. While understanding that the health care paradigm is an important competency for introductory social work practice in hospital (Nicholas et al., 2019), it should be revisited throughout one's career because experiencing the medical model in practice will continue to develop and refine how a social worker understands and relates to it. Research shows that practicing social work in the hospital has the potential to put social workers at odds with the interdisciplinary team because social workers challenge the medical model (Craig & Muskat, 2013), while at the same time they can broaden the medical model of understanding (Ambrose-Miller & Ashcroft, 2016).

To that end, learning how to implement professional values into practice and how to navigate challenges brought on by practice in a medical model setting may be aided by having an intentional space to reflect critically on this topic with another social worker. Researchers found this to be the case where social workers in a child welfare setting found a peer support group helpful to discuss the divergent discourses in their practice (Dempsey & Halton, 2017).

While social work peer relationships may be strained because of conflicting practice styles with their colleagues, some social work peers may also be united for their resistance and commitment to social justice practice. Efforts that alone would seem grand and daunting appear more manageable as a group. Collective efforts of social workers united in practice could be leveraged to promote social change related to unjust policy or services inside the hospital, or in the community.

Another finding is that participants believed that social work leadership positions are limited because of a lack of understanding of the social work role by other health professionals and because social work mentors are burnt out from resisting the medical model in practice. This finding suggests that organizational barriers prevent participants from being able to access valuable guidance, support, and leadership, divert this responsibility to peers and non-social work leadership, and that this challenge would be shared among all front line social workers who work in the hospital. Moreover, the detrimental impact to social workers reinforces the above reasons as to why social work leadership is important for social work practice.

This thesis study reflects what research has said about the presence of organizational barriers that impact the availability of social work supervision in hospital

settings including hospital restructuring and program model change (Globerman et al., 1996; Globerman et al., 2002; Globerman et al., 2004; Michalski et al., 2000) cost cutting measures and fiscal monitoring (Berger & Mizrahi, 2001; Kadushin et al., 2009) and issues with the practice setting, lack of social work supervisors, administrative views of supervision as unnecessary, and cost (Sweifach, 2019). The findings of this study and the literature highlight the systemic barriers at play, most of which front line social workers have little control over.

Beyond organizational barriers, a structural analysis of why social workers may find themselves with limited social work supervision and their subsequent reliance on peers may be explained by neoliberalism. Neoliberalism promotes the free market rather than government regulation and programs, seeks to reduce spending on public services especially for social programs, and expands free trade agreements that favor multinational corporations (McKenzie & Wharf, 2016).

Alberta is familiar with the neoliberal agenda, as the mid-90's were characterized by Premier Klein's use of restructuring and budget cuts of health care, social services, and education in order to eliminate the deficit (Sonpal-Valias et al., 2016). While spending in health care did increase in the following years, and has continued to increase since (Sonpal-Valias et al., 2016), hospitals would feel the impact of these spending cuts for years to follow. Despite being years later, the massive cuts to public health care during the mid-90's, which greatly impacted hospitals, may have contributed to the limited number of social work leaders in these hospitals.

Hospital social workers deal with heavy caseloads and rely on the public and social services in the community in order to help patients meet their needs. Cuts to

public services and changes to program eligibility impact the availability and accessibility of the resources that social workers require in order to perform their job effectively. As a result, these changes further marginalize people in already vulnerable positions and cause social work in hospital to be even more challenging. Understandably, social workers turn to their peers for support during stressful times, as was indicated by study participants and the literature. In a study of hospital social workers in Greece faced with strain caused by austerity measures, Pentaraki (2018) found that social workers sought out their colleagues for support which encouraged them to continue their work with patients. Social workers in Alberta are currently facing the government's austerity measures, including cuts to and proposed privatization of public health care and social services in an effort to reduce the provincial deficit. Social workers will be expected to do the same quality of work, if not more, with less access to resources. While these measures will undoubtedly increase workplace stress by limiting the availability and accessibility of resources, peer relationships may be even more important in supporting front line social work practice.

However, even in the presence of these barriers, there is hope. Participants in this study are actively seeking out their peers to meet their practice needs and are mobilizing to support each other. Social workers took it upon themselves to support initiatives for standards of practice, evaluation, and skill building in response to hospital restructuring (Globerman et al., 2004). Likewise, social workers could redirect their advocacy efforts towards hospital administration in an effort to meet their practice needs given that social workers are advocates by trade. Finally, Helm (2017) instills hope by acknowledging

the possibility of rearranging the way social work peers collaborate in an effort to release underutilized resources often present in teams.

5.3 Concluding Remarks

5.3.1 Social Work Leadership

It appears that the lack of social work leadership positions in these hospitals create gaps in practice and put additional responsibilities on front line social workers. While social workers in the current study mobilized to support each other and their profession, they weren't able to totally fill the gap left by the lack of social work leadership. While peers lack any authority over each other and the nature of the work environment is that caseloads are large and with multiple responsibilities, social workers are often overworked and may not always be available to support their peers. However, despite the risk and challenges involved to building trusting peer relationships, these relationships appear to encourage effective practice by providing support, consultation, and debriefing from someone who understands social work practice. Given that participants actively sought out peer relationships, in light of workplace pressures, this suggests that the peer relationship is important for effective social work practice in hospitals and those participants are motivated towards ongoing learning and growth.

In conclusion, a notable finding of this study would suggest that participants may benefit from having additional social work leadership available to them that could provide supervision and debriefing, who understood the moral and ethical dimensions of practice including an orientation to social justice, and who could provide centralized direction for hospital social work practice. Peer relationships would continue to exist as complementary to the social work leadership role which would hopefully alleviate the

responsibility placed on front line workers to informally perform these duties. Since study participants were experienced social workers, it isn't known if the current social work leadership role was being accessed by new graduates or new hospital employees. In addition to the above noted characteristics, it appears that having social work leadership that is appropriately funded and located on site for social workers to access as needed for supervision, debriefing, and training would positively impact social work practice and in turn their work with patients and families.

5.4 Reflection of Study Findings: Expectations, Assumptions, Surprises

This section will discuss the research objectives and study findings in light of expectations and assumptions at the beginning of the study and surprises that have arisen now at the end.

Given that the study was influenced by my own positive experience of peer relationships with social workers in the workplace as described in Chapter 1, I expected to find that social work peers were important to effective practice because of the support, consultation, and debriefing they provided to each other. Social workers made sense of their peer relationships by how these relationships helped them to do their jobs. There is value in social workers providing support to social workers not only because of their shared understanding of education, training, and ethics, but also from the shared understanding of the workplace culture at the hospital. Empathy for the peer experience differs from those in leadership positions because peers work as front line social workers who are responding to the shared pressures of the hospital and their caseload, which leadership is often removed from. Peer relationships and social work leadership can complement each other in practice to support the needs of front line social workers.

Unfortunately, with limited social work leadership, the lines of authority and expertise between peers can be blurred.

Based on my review of the literature, I assumed that organizational factors would impact the peer relationships, which happened to be the case for the hospital's main organizing model- the medical model. How social workers orient their practice to this model seems to have the power to divide peers, and may unite others. All participants at some point in the interview shared their experience of how practicing social work in a medical model creates challenges which suggests they are aware of the inherent differences between the two. I would be curious if these are conversations had between participants and their peers given their shared challenge, as sharing things in common has the ability to bring some social workers together and exclude others.

In my experience, practicing social work in a medical model is a tiring and daily struggle of resistance and surrender. I've learnt to be strategic about my practice in order to balance social justice, maintain working relationships with the interdisciplinary team, and manage self-care. My social work peers and I have had informal discussions about how to manage these challenges, and they've also role modeled their way of navigating them in practice. That being said, my peers and I already held similar values and beliefs about the profession and there was a strong sense of connection and trust between us. I was able to safety explore the topic and didn't feel judged or criticized if my opinion differed. If the conversations had been with social work peers with a different orientation to practice and the medical model, or those who I didn't feel a sense of connection to, undoubtedly my experience would have been different. While it's important that these discussions occur in settings that are safe, exposure to different and competing discourses

would create opportunities for deeper reflection and discussion with peers, and should be encouraged in practice.

I found it surprising that there wasn't more said about the potential strain of peer relationships on professional well-being given the amount of peer support, consultation, and debriefing that is happening at the hospitals. Three factors contribute to this surprise. First, according to participants, peer consultation and support appeared to be the only resource available for social workers by social workers. Second, there seems to be an expectation that help is always available from peers, at least in the experience of one participant who conceptualized her peer relationships as a peer team. Third, participants spoke about their busy workloads and their struggle to even meet with peers which doesn't factor in the added pressure of finding the time and energy to actually support peers to navigate complex cases, including the emotional and mental toll that often accompanies the work. Together, these factors raise questions about the additional pressures placed on front line social workers to meet the needs of their peers and what impact these relationships may have on professional well-being. In my own experience of providing help to my social work peers in the workplace, I have felt the pressure and the guilt that comes from not having enough time to provide them with the support that they need.

Chapter 6: Conclusion

The purpose of this chapter is to conclude the research study by discussing three final topics. Firstly, I will discuss the relevance and limitation of the methodology in relation to the study. Next, I will review the five implications of the research findings for social work practice. Finally, the chapter ends with two suggestions for future research questions regarding social work peer relationships.

6.1 Relevance and Limitation of Methodology

This modest exploratory study utilized a qualitative approach to research known as Interpretative Phenomenological Analysis (IPA) which is underpinned by the theories of phenomenology, hermeneutics, and idiography. I was able to elicit the participants' experience of peer relationships through interviews, and interpret the meaning of their peer relationships on social work practice. Peer relationships appear to be highly valuable to participants because they supported effective social work practice at the hospital.

Phenomenology was used to focus on a topic that all participants had experience with: peer relationships and hospital social work practice. Participants shared their perceptions of their experiences at the hospital that were unique to them but that were also shared amongst each other.

The theory of hermeneutics was applied by using interpretation to better understand the meaning of the participant peer relationships. While participants first made sense of their experience through the interview process by having to recall their peer experiences, I made sense of their experiences through interpretive analysis. The analysis was complicated by my own experience as social worker in a hospital. While I

reflected on my own peer and practice experiences throughout the research process, it was at times difficult to stay focused on the participant experience. There was a strong pull, during interviewing and the initial stages of analysis, to understand the participant experience in how they aligned with my assumptions and experiences.

I noticed early on of the potential for confirmation bias and worked diligently to stay with the participant experience, whether or not it supported by own assumptions and experiences. The bracketing technique was a helpful tool because it helped me recognize when I had shifted from the participant experience to my own thoughts, and when I needed to shift back to the participant story. Bracketing was also helpful to allow me to focus on analyzing the individual interviews first, as naturally I was drawn to look for patterns and themes to connect the interviews together while I was still in the early stages of analysis. This is how I understood bracketing and my own process of working through the hermeneutic circle. I knew that my own practice and experience would be present in this process regardless, but I tried to be as diligent as I could about staying with the participant experience whether it was similar to mine or not.

Idiography was used to focus on the particular participant experience. Each interview was analysed first before analysing them collectively to generate the superordinate themes. Likewise, given the small sample size, I tried to include direct quotations from each participant throughout the superordinate themes and subthemes so that each of their voices could be represented in the analysis.

Finally, a limitation of IPA is that it tends to focus on interpretation, although an important factor, rather than the structural context that may explain why participants find

themselves in the situations they are in, and the need for social change. Despite this limitation, the research approach did sufficiently answer the research question.

I initially intended to interview 4 to 6 participants but recruitment was disrupted by the COVID-19 global pandemic. In the end, only three social workers participated which is still sufficient for suggested IPA sample sizes for new researchers (Smith & Osborn, 2008) and IPA studies at a masters level (Smith et al., 2012). It didn't seem ethically appropriate to continue recruiting participants who were on the front lines during the pandemic. In my experience as a front line social worker in hospital, staff were expected to adapt to a new way of working in light of rapid process and policy changes to coordinate a systematic response to the pandemic. I assumed it would be the same for social workers in hospitals province wide. Even through the sample size is within the suggested IPA amounts, additional participants would have allowed for more content to analyze, as not all the interviews were as rich as I would have hoped. Having additional experience in qualitative interviewing may help to capture richer data in future projects. Likewise, a broader sampling strategy could have yielded a higher sample such as recruiting through the ACSW, rather than particular hospitals as participants may have been discouraged to participate because of the focused sampling.

With regard to enhancing trustworthiness and confidence, member checking was not accurately completed. As noted above, member checking can happen in different ways such as checking the study analysis with the research participants (Braun & Clarke, 2013) or having participants review the interview transcript (Birt et al., 2016) . In the member checking process the participants were able to review the quotes related to concerns of professional practice flagged by me, rather than the data analysis.

Participants were able to choose to include the quote verbatim or have it summarized. According to Birt et al. (2016) having participants review the transcript does not actually address trustworthiness, but rather the accuracy of the interview transcript. In my case, only reviewing a modest number of quotes would not allow me to make claims about the accuracy of transcription, nor contribute to the trustworthiness of the analysis. Member checking as identified by Braun and Clarke (2013) could have involved providing the analysis to consenting participants and having them comment on how well I understood their experience and meaning. This process is complicated by the fact that qualitative analysis involves the researcher's interpretation of the participants' experiences (Braun & Clarke, 2013) which may not always be aligned with the participant's interpretation. Likewise, while this process may have been manageable with only three study participants as was currently the case, it may have been less likely if all six social workers had been recruited. Instead, I gave participants the opportunity to add any final comments at the end of the interview, or withdraw parts of or their entire interview in a two-week window. These practices are not member checking, although important parts of the research process, as participants weren't provided with a transcript to review for accuracy nor an analysis to comment on the interpretation of their own experiences.

A study of three participants limits the generalizability of the findings to the wider population. Specific to qualitative research, the study is limited in transferability because I did not provide detailed information on the participants beyond the inclusion criteria and information captured informally during the interview in the write up. Transferability, as noted by Lincoln and Guba (1985) calls on the researcher to provide rich descriptions of the study setting, circumstances, context, and participants so that the reader can

determine if the findings are transferable to their particular situation (Braun & Clarke, 2013). I didn't collect any demographic data on participants, and I decided against including a section detailing the individual participant experience of their social work peer relationships prior to the analysis of themes. This decision was out of caution for the confidentiality of participants and risk of identifiability by their peers because of the small sample size and purposive sampling strategy.

6.2 Implications for Social Work Practice

The study findings have practical implications for front line social workers and leadership and will be discussed here.

First, despite not receiving supervision, participants had taken responsibility for their own practice needs by actively seeking out their peers for consultation, support, and debriefing because of their shared understanding. Participants were also experienced social workers who had received social work supervision or mentorship early on in their careers. In this case, and as Hair (2013) also found, social workers appear to be in the best position to decide how to handle their supervision needs. Front line social workers in these settings need to decide if the support they are receiving from their peers is sufficient, or if alternative arrangements for supervision and support need to be explored. While leadership has a responsibility to ensure their employees have the tools to succeed in the workplace, employees are also responsible for managing their professional practice. Social work graduates and new employees coming into the hospital should be mindful that supervision may not be readily available and to inquire about what support is available help them learn and grow professionally. Furthermore, attention must be paid

to the support available for new social workers who have different practice needs that may not be as conducive to peer consultation.

Second, when it comes to navigating peer relationships, the implications for practice are that social workers and leadership have a shared role in peer relationship building and should be intentional about creating opportunities for staff to gather as well as actively address situations that may exclude or create isolation among peers. While a number of examples were raised by participants including shared office space, unit assignments, and department gatherings, opportunities would have to be unique and meaningful to the practice setting in order to be effective and for social workers to participate. It is especially important to be mindful of social workers who are new to the hospital to ensure that they have opportunities to connect with their peers. Furthermore, this research highlights the importance of discipline specific teams and how they indirectly contribute to patient care in addition to the interdisciplinary team that directly addresses patient care.

Third, peer relationships contribute to professional development though peer consultation, support and role modeling, which further reinforces why it is important for social workers to have relationships with their peers in the workplace. The implication for practice is that peer relationships appear to be resources that support effective social work practice and indirectly contribute to patient care by creating opportunities for ongoing learning and growth in the workplace. Furthermore, while both social workers and leadership have a responsibility in creating opportunities where peers have the ability to witness how their colleagues practice in the field, reflective practice by the social worker is highly important for the learning and growth to occur. While there is

something to be said for informal, ad hoc interactions with peers which seem to be the case for study participants, there also appears to be capacity for learning and growth in more formalized group arrangements as has been shown in the literature.

Fourth, the study brought to light that difficulties could arise in peer relationships if social workers align their practice with the medical model and further from social justice. The implications for social work practice are for practitioners to be aware of how they practice in the context of the medical model and the ethics of the profession. It also provides a venture point for more salient discussions, whether peer or leadership led, about how social workers practice social justice in hospital settings and how they navigate the challenges to practicing social work in a setting that challenges their professional values and beliefs.

Another implication for social work practice is how social work peers can leverage their collective efforts to promote social change in hospital settings. How can social work peer relationships which are characterized by shared understanding and values become a catalyst for change? Specifically, social workers could be involved in speaking opportunities, research and knowledge translation at hospitals that promote an understanding of the social work role and how the social environment impacts a patient's health and mental health. While these efforts would provide an alternative perspective to the thinking that is characterized by the medical model, it may be difficult for social workers to find the time to dedicate to activities that take time away from patient care.

Finally, the concluding finding of the study is that participants may benefit from having access to additional social work leadership. The practice implications are that this study contributes to the discussion on social work leadership in Canadian hospital

settings by providing insight into the impact of social work leadership on practice and peer relationships and the type of leadership that front line social workers in hospitals are seeking. This study may further discussion among social workers in hospitals where social work leadership is limited and how this gap in practice impacts their work with patients and families. While health care spending and fiscal restraint are recurring political debates organizationally and provincially, social workers may need to be advocates for their own practice and profession by redirecting their skills towards administration to create change from the bottom up. Moreover, given that participants believed that the medical model impacted the hiring of social work leadership and the retention of social work mentors, this further reinforces the need for front line social workers to be directly involved in those change efforts.

6.3 What's Next? Questions for Future Research

Given that hospital social work practice will vary across Canada due to the unique cultural, economic and political landscape of communities, this research can be expanded on to better understand peer relationships of hospital social workers in other parts of the country. Additionally, there are two areas of research that could be explored in the future.

First, the experience of social work mentorship as a peer relationship in hospital settings to promote effective social work practice would be worthy of further exploration. Peer mentorship could take shape as a formal program structured similar to time limited student field placements, with one to one support or in a group format. Conversely, it could remain informal as seemed to be the case for the study participant. Mentorship opportunities between new and experienced social workers may be a more fiscally viable

option in hospital settings with limited leadership resources. It would also be pertinent to consider the competency and practice approach of mentors, including their orientation to social justice, and how peer mentorship would complement supervision or other forms of support offered in the workplace. These factors suggest that some oversight of social work mentorship may be required. In carrying on with the notion of releasing underutilized resources on teams (Helm, 2017), peer mentorship may create opportunities for experienced social workers, especially those nearing the end of their careers, who have a breadth of practice experience and knowledge ready to be passed down to social work graduates and new employees that may otherwise go unacknowledged.

Finally, given that participant peer relationships seem to function similar the educative and supportive functions of social work supervision (Kadushin & Harkness, 2014), these similarities raise the question if the positive worker outcomes noted in the supervision literature are also present for those social workers engaged in peer relationships? Benefits include how supervision can alleviate the impact of workplace stress and support job satisfaction (O'Donoghue & Tsui, 2015), promote well-being and workplace retention (Chiller & Crisp, 2012), prevent burnout and turnover (Kim & Lee, 2009), and contribute to "job satisfaction, organizational commitment, psychological well-being, worker effectiveness" (Mor Barak et al., 2009, p. 15). There is a sense from participants that peer relationships contribute to professional well-being; however more research is needed to examine this claim.

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Appendix A: Recruitment Flyer

DALHOUSIE UNIVERSITY

Study Title: An Interpretative Phenomenological Analysis of Professional Peer Relationships and Social Work Practice in Canadian Hospitals.

CALL FOR RESEARCH PARTICIPANTS: **Hospital Social Workers**

We are looking for volunteers for a research study. We want to explore professional peer relationships between social work colleagues. We want to know how these relationships impact the delivery of social work services at the hospital.

Are you someone who:

- **Is a Registered Social Worker [redacted] and part of the social work department?**
- **Is a front line social worker?**
- **Has a minimum of 2 years of practice with the department (not including time spent in a student field placement role)?**

Taking part in this study is your choice. You will be invited to participate in one interview (in-person or by phone) approximately 1 to 1.5 hours in length.

Your story will help us better understand the professional peer experience and its impact on hospital social work practice.

To learn more about this study, or to take part, please contact the lead researcher:

Erin Bryksa BSW RSW (Lead Researcher)	Email: er709423@dal.ca Telephone: [redacted]

The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at Dalhousie University (2019-4901) and the University of Alberta (Pro00095457).

Appendix B: Informed Consent Form

Title: An Interpretative Phenomenological Analysis of Professional Peer Relationships and Social Work Practice in Canadian Hospitals

Lead Researcher: Erin Bryksa, [redacted], er709423@dal.ca

Supervisor: Marjorie Johnstone, 902-494-2117, marjorie.johnstone@dal.ca

Introduction

You are invited to take part in a research study being conducted by me, Erin Bryksa, a student at Dalhousie University. This study is my social work master's thesis. I am also a social worker at [redacted] AB. This study has been inspired by my work at the hospital over the past eight years. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on you if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

You should discuss any questions you have about this study with me. Please ask as many questions as you like. If you have questions later, please contact me then.

Purpose and Outline of the Research Study

This study will explore the professional peer relationships between social work peers in hospitals. The purpose of this study is to better understand how these relationships impact the delivery of social work services. We are looking for 4-6 social workers to tell their story. The findings can help to inform future research or program development. Findings will be recorded in the thesis. Findings may also be published in academic journals or shared at workshops or conferences.

Who Can Take Part

You may participate in this study if you are a Registered Social Worker who is part of the [redacted] hospital social work department, are a front line social worker and have a minimum of two years of practice with the department. This does not include time spent as a student. You may not participate in this study if you are not part of the department, are in a leadership role (team lead, professional practice lead, manager, etc.), have less than two years of experience, or have a past or current relationship with the lead researcher.

What You Will Be Asked to Do

You will then be asked to take part in one interview ranging from 1 to 1.5 hours in length. You will be asked open questions about social work practice, supervision, professional peer relationships and the impact of the relationship on your practice. You have the right to refuse to answer any question, opt out of discussions, stop the interview or end the interview at any-time without penalty. The interview can be in-person or over the phone. If in person, the interview can be at the hospital or at a location of your choice. The interview will be audio-recorded for the purpose of analysis. You may request to shut off the recorder at any time. We may include direct quotes from the interview in our reported findings. If quotes are used they will be de-identified. If quotes are related to concerns about professional practice, the lead researcher will review it with you before publishing.

Possible Benefits, Risks and Discomforts

Participating in this study might not benefit you, but we might learn new things that will benefit others. You may experience the interview as an inconvenience as it will

take time away from your busy workload. You can choose when you want to complete the interview (pending availability of the lead researcher) which could mitigate the impact on workload. Supervisors have given general approval that you may use 45 minutes of your work hours to complete the interview. However, they do not know who will take part in the interview. You are encouraged to use your lunch break for the interview and work hours for the remainder- lunch provided by the lead researcher. You can also meet at the end of your day with the remainder of the interview on personal time- coffee/tea provided by the lead researcher. The lead researcher will give participants the option to review the informed consent over the phone, or at the beginning of the interview. This may also reduce the inconvenience.

You will be asked to speak openly about your professional peer relationships. Concerns about professional practice may come to light. This may be disadvantageous for the employer. You can decide if you want this data to be included in the findings. All data that is reported will be de-identified and presented in themes. Every effort will be made to ensure others do not know you took part in the study. See below for "How Your Information Will Be Protected."

Compensation

You will not receive compensation for participating in this study.

How Your Information Will Be Protected

Steps are taken to ensure others do not know who took part in this study. Data is being collected from multiple hospitals. You are invited to contact the lead researcher directly about the study. They will discuss the best way to stay in contact- by email or phone. If by email, the subject line will say "Social Work". If by phone, you will say if

messages can be left. Interviews will take place in a room away from the department, a location of your choice, or over the phone. The lead researcher will work with hospital staff to book the interview room.

You will be asked to choose a made up name and to refrain from using identifying information in the interview. If shared, identifying information will be taken out before analysis. The interview is audio recorded then typed up for analysis. The audio recording is stored on Dalhousie's One Drive- an encrypted program on Canadian servers, in case it is needed in analysis. Your information will be kept in locked cabinets in a safe location that only the lead researcher can access. Your consent form and interview information will be kept separate to protect your identity. Your typed up interview will be stored on Dalhousie's One Drive which is an encrypted program. Only the lead researcher and supervisor will have access to the data. Data shared between the lead researcher and supervisor will occur over FileExchange. Only data that is de-identified and encrypted will be shared. Your data will be analyzed and reported as themes. If disclosures of professional practice (i.e. high risk material) are captured in the findings, they will be presented as themes. Verbatim quotes that are high risk will be reviewed with the participant before the write up. The write up of the thesis will only report hospitals in an urban city in Alberta. When the study is complete, your data will be kept for 5 years. Before being deleted off the OneDrive, digital data will be transferred to an encrypted USB and kept in a locked cabinet. After 5 years, all data will be destroyed.

The researcher has a duty to disclose to the proper authorities abuse or neglect of a child, or an adult who is in need of protection

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating, you can also decide if you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can decide up to two weeks after your interview if you want us to remove any or all of your data. After that time, it will become impossible for us to remove it because it will already be analyzed. To withdrawal and/or request to remove your data from the study contact the lead researcher (Erin Bryksa- er709423@dal.ca or [redacted]). If your interview is withdrawn, audio and transcript data will be destroyed. For comments removed, the transcript will be amended.

How to Obtain Results

The lead researcher will present the study and results to the social work departments. The lead researcher will email a copy of the final thesis to participants who want one, and will be asked this during the screening for the study. No individual results will be provided.

Questions

We are happy to talk with you about your participation in this research study. Please contact the lead researcher (Erin Bryksa) or the supervisor (Marjorie Johnstone) at any time with questions, comments, or concerns about the research study.

If you have ethics concerns about your participation in this research, you may contact Research Ethics Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (REB file # 2019-4901). You may also contact Research Ethics at the University of Alberta at (780) 492-2615 (REB file# Pro00095457).

DALHOUSIE UNIVERSITY

Signature Page

Title: An Interpretative Phenomenological Analysis of Professional Peer Relationships and Social Work Practice in Canadian Hospitals

Lead Researcher: Erin Bryksa, [redacted], er709423@dal.ca

Supervisor: Marjorie Johnstone, 902-494-2117, marjorie.johnstone@dal.ca

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I am being asked to take part in one interview that will occur at the hospital, at a location I choose, or over the phone. I understand that the interview will be audio recorded and that direct quotes of things I say may be used without identifying with me. I agree to take part in this study. My participation is voluntary. I understand that I am free to withdraw from the study at any time and that I may withdraw any or all of my data up to two weeks after my interview.

_____ _____ _____

Name Signature Date

Appendix C: Interview Guide

1. What drew you to this study?
2. Could you tell me what you do as a social worker at the hospital? Possible prompts: What is your role? What social work services do you provide?
3. Can you tell me how you practice social work at the hospital? Possible prompts: What influences your practice? What strengthens your practice? What hinders your practice?
4. Could you tell me about your experience of social work supervision at this hospital? Possible prompts: Who provides supervision? Describe what happens in supervision?
5. Can you tell me about your professional relationships with your social work peers at the hospital? Possible prompts: Does anything make the relationship better? Does anything make the relationships worse?
6. What do your professional peer relationships mean to you?
7. How does the workplace environment influence your professional relationships with your social work peers? Possible prompts: How does the social work department influence the relationship? How does the hospital influence the relationship?
8. Can you describe how your professional relationships with your social work peers affect the work you do with patients and their families? Possible prompt: How

does it affect your day to day work? How does it affect your professional learning and growth?

9. How, if at all, have your professional relationships with your social work peers influenced how you practice social work at the hospital? Possible prompts: How does it influence your practice methods? How does it influence your self-care?
10. How, if at all, have your professional relationships with your social work peers changed the way you think or feel about your social work practice?
11. Is there anything that we haven't talked about that you would like to discuss?