HOW HOSPITAL SOCIAL WORKERS ADDRESS POVERTY

HOW HOSPITAL SOCIAL WORKERS ADDRESS POVERTY

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Abstract

This research study began with an interest in understanding how social workers address poverty and/or low income in hospital settings. It discusses the ways in which hospital social workers address poverty in front line practice, while connecting how the experience of poverty and/or low income can further complicate one's health and access to healthcare. This paper also discusses the ways that macro political ideologies, structural barriers and societal stigma impact how social workers address poverty in frontline hospital practice.

Poverty is a social determinant of health, which is why understanding how hospital social workers address poverty in front line practice is important. Given the influence of neoliberalism and its impact on the growing gap between the rich and poor, it is suggested that poverty and low/income will continue throughout Canadian society. This paper also discusses, how accessing healthcare and navigating the system may become difficult for those experiencing poverty.

This study is based on a thematic analysis of the findings from six semi-structured interviews with individuals practicing as social workers in two large teaching hospitals in southern Ontario. The data is interpreted and discussed using a critical framework, specifically, anti-oppressive practice and Marx theory.

The subsequent findings indicate that in practice front-line social workers address poverty in practical ways. Major themes that emerged from this research

include: addressing stigma, navigating “the system”, systemic and structural barriers, no family, no friends, and connecting with resources.

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Introduction

The influence of neoliberal ideology continues to contribute to the erosion of the welfare state in Canada. Both social and income support programs have been drastically cut and reduced since the 1970s. Such changes to the welfare state have negatively impacted individuals experiencing poverty and low income, thus contributing to the shrinking middle-class. Literature has revealed that income support recipients and members of the working-poor class experience a higher burden of ill health (Bartley, 2002; Davey Smith, 2003; Gould, 2002; Raphael, 2004). It is important to measure how the experience of ill health impacts individuals experiencing poverty, as they navigate the healthcare system.

Poverty is a topic that is discussed in great detail within social work education. Yet the ways in which social workers are able to address poverty in front line practice may differ, depending on the organization for which they work. This research project investigated the ways in which hospital social workers address poverty in frontline practice. This project discussed the following questions:

What can hospital social workers do in responding to poverty?

What do they wish they could do and what barriers impact how they are able to address poverty?

This research project involved a qualitative study using semi-structured interviews to explore the experience of social workers in hospital settings, and their

interactions working with patients who experience poverty and low income. Participants worked within a hospital setting in a large urban city in southern Ontario. An analysis of participants' contributions suggested that with the presence of growing poverty in society, due to social policy reform, and the influence of neoliberalism and managerialism, social workers in hospital settings are only able to address poverty in material and practical ways. There is little room for social justice orientated work in resisting poverty in frontline practice within the hospital setting.

This research was influenced by my own work as a frontline social worker in a hospital. I often worked with individuals experiencing poverty or low-income. In some cases, I would spring into 'action mode' trying to assist in meeting whatever material need I could. It became the norm for me to find someone new clothing from the donation room, or assist in getting a patient medication(s), or to help individuals to navigate the healthcare system. This work could include explaining how to apply for Ontario Works (OW), Ontario Disability Support Program (ODSP), or other programs such as Employment Insurance (EI), and programs through Ontario Trillium Benefit, to name a few. Other times, I found myself scrounging through the hospital cupboards searching for personal hygiene items. In one case, a woman in her thirties required feminine hygiene products. She was unable to afford the expensive products found in the hospital tuck shop. She unfortunately had been given a brief (diaper) rather than a feminine pad. Other times, I have called shelters trying to locate available beds, or have negotiated with residential care facilities looking for subsidized beds when discharge

planning. In participating in this work, I have often wondered if I was making a difference or positive impact at all. In the moment, it helped meet a material need, but on the larger scale I felt conflicted and annoyed, assuming that such practical work made little or no difference in a patient's personal life.

I also recognised that some of this concrete work could be seen as controversial, viewed through the lens of anti-oppressive social work literature, because controlling access to resources could be viewed as exercising forms of "power over" the patient (Grant and Cadell, 2009). Yet in practice, I would assess how sick or tired a patient was and provided resources that I thought they were unable to access at that moment in time. In my work, I often found that the experience of ill health left those I was working with feeling deflated and exhausted, so providing practical assistance seemed like the best way to help. I still grappled with the limitations of front line work and wondered if there was any chance of making a difference on a macro scale.

Literature Review

Healthcare Policy Review & the Influence of Neoliberalism

In this section I will discuss how social health policy developed in Canada, has been changed, and negatively influenced by neoliberalism. Poverty, low income, and health will also be discussed.

Poverty is recognised as a social determinant of health that negatively impacts one's health and wellness. The Canadian Medical Association (2013) reports a direct correlation between low-income/poverty and a lower life expectancy than those of higher-economic class status (Noble, 2004). In capitalist societies such as Canada, individuals in higher-class status have access to a better quality of life than those of lower-class status. Members of upper-class can better situate themselves in society due to their ability to access higher education, own their own labour and participate in the free market (Gray and Webb, 2009).

Canada's welfare system is comprised of income security support programs and social service programs. According to Hick (2007), healthcare falls under the social service programs within the welfare system. Social service programs are designed to help people "improve their well-being by providing non-monetary aid to persons in need" (Hick, 2007, p. 4). On the other hand, income security programs are designed to supplement income and/or provide a minimum income level. Some social service programs are considered universal programs, which are designed to be available to everyone. They can, however, be limited to specific categories, such

as those with Canadian citizenship or age (Hick, 2007). This means that even though universal programs are designed to be available for everyone, there are still limits placed on them.

Universal healthcare policy in Canada allows for the delivery of free healthcare service to Canadian citizens across the country. Every Canadian has the ability to access healthcare services, which includes: hospital service, family physicians, and medical clinics without a fee for service regardless of income or class status. Universal programs differ from targeted programs in that universal programs are designed to be accessible to all citizens, whereas targeted programs use means testing to determine eligibility to access services. Universal healthcare policy is arguably one of Canada's better social programs. Healthcare policy has been referred to by Burke and Silver (2006) "as a source of immense collective achievement" (p. 375), because it is unlike any other Canadian social welfare policy. What makes healthcare different from other social welfare policies is that it is influenced by concepts of distributive justice. Distributive justice, according to Sefton (2006), is based on principles of equity and support of socially just allocation of goods and services in society. Another attribute that makes healthcare unique from other social policies is that its sole determinant to accessing service is based on need for service, not on one's ability to pay. This suggests that, "no one has a prior entitlement based on status, wealth, race, or other social differences" (Burke and Silver, 2006). These values are impressive; however, this project highlights the fact

that despite the universal intentions of Canada's healthcare system, individuals with low economic-class status have a greater need and less access to services than those with greater incomes.

Universal healthcare services are distributed as a social right. They are supposed to be accessible to all citizens "in a manner that does not involve any humiliating loss of status, dignity or self-respect" (Burke and Silver, 2006, p. 378). There is also no assumption of personal blame or failure in receiving such healthcare services.

Healthcare was originally formed out of a social democratic normative framework. This framework values social rights, based on societal values (Burke and Silver, 2006; Hick, 2007). In this framework, the welfare state has the capacity to grant "social rights" which are "embedded in citizenship and distributed outside the market" (Burke and Silver, 2006, p. 377). The government manages such services.

Canadian healthcare policy originated with two pieces of legislation: The Hospital Insurance and Diagnostic Services Act of 1957, and the Medical Care Act of 1966 (Burke and Silver, 2006; McKenzie, and Wharf, 2010). Universal coverage at the onset of healthcare policy meant that every resident would be covered for healthcare services, either in hospitals or a family physician's office. These services were meant to be portable so that all Canadians would qualify to receive healthcare services across the country. Healthcare was meant to be comprehensive, meaning

that all medically necessary services would be covered by the healthcare system (Burke and Silver, 2006). These values still remain relevant in the current healthcare system. Yet these policies did not cover all aspects of health. Excluded services ranged from dental coverage, medication coverage, physiotherapy, general therapies, mental health services, etc. Today, the only program from those excluded that has received coverage is services for individuals that live with mental health concerns. Thus, although defined as allowing for universal care, healthcare policy focuses on hospital and physician care and not on preventative measures. It is here where the concept of universality can be challenged as people with limited incomes will not have the resources to access treating illness, such as prescription drugs, assistive devices, dental, and various therapies to help to prevent illness and disability.

Even though the formative values of the healthcare policy that were developed in Canada are still relevant, the impact of neoliberalism has eroded the social safety net resulting in cuts to health and social services. These cuts have affected both universal and targeted services leaving people with limited incomes with fewer opportunities to avoid the negative health impacts of poverty.

According to Gray and Webb (2009), neoliberalism has been described as an umbrella term used to reference the different theories that together, have a "central emphasis on the market as the organizing principle of social life and economics" (p. 109). According to Burke and Silver (2006), neoliberalism, as a political ideology,

"calls for a profound reconfiguration of social welfare responsibilities among the public sector, the private sector, the family, and the non-profit sector" (p. 386). Neoliberalism and neoliberal political agendas continue to impact welfare programs. McKenzie and Wharf (2010) have defined neoliberal agendas as "cutbacks, privatization, and deregulations" that have "disastrous effects on both the economy and well-being of families" (McKenzie and Wharf, 2010, p. 32). This can be connected to healthcare, as families are being asked to take patients home from hospitals sooner, all the while being required to fill financial gaps to cover hidden costs. Healthcare is not immune to the impacts of neoliberalism. More and more programs and services are being cut. Patients and families have become required to pay hidden costs of healthcare, such as providing free labour to care for family members at home.

Neoliberalism has contributed to what Hick (2007) calls the erosion of the welfare state. The current environment is one where less concern is placed on social welfare and more value is placed in the private market. Mulvale (2001) explains how the welfare state in Canada has dramatically changed since the mid-1970s. As the federal government reduced its responsibility for social welfare programs, more and more responsibility has been downloaded to provincial and municipal governments. This became apparent in the 1990s. There were significant changes to the delivery of funding for social welfare programs from the federal to the provincial governments. In 1996 the federal government phased out the Canada

Assistance Plan (CAP), which was a cost-sharing program that involved both the federal and provincial governments each sharing responsibility for fifty percent of social spending (Hick, 2007). These and other funding changes reflect themselves in the provincial governments' increase in autonomy over health and social services.

Social welfare programs in Canada have been scaled back due to the influence of neoliberalism. Larner (2000) refers to this as the "post-welfare state citizenship regimes" (p. 5). In fact, in recent decades Canadians have seen significant cuts to social welfare programs. According to Herd, Lightman and Mitchell (2009), neoliberalism has gained more prominence since the 1990's, which has influenced social policy cutbacks.

In Canada, neoliberalism has also impacted welfare reform with cuts to income support programs, such as Ontario Works (OW), Ontario Disability Support Program (ODSP), Employment Insurance (EI), and Old Age Security (OAS). Financial cuts can impact one's overall health and can push individuals further onto the margins of society. Mikkonen and Raphael (2010) explain that finances are directly related to one's ability to obtain quality education, food and housing. When cuts are made to income support programs, this directly prevents recipients from obtaining the basics of life. The Community Social Planning Council of Toronto published a report in 2009 titled "Sick and Tired: The Compromised Health of Social Assistance Recipients and the Working Poor in Ontario". This report explains that social

assistance recipients and members of the working poor carry a higher burden of ill health than the non-poor.

Poverty and low income have negative effects on many aspects of one's life, including making routine acts of living difficult. When illness is added to one's experience it further complicates the situation (Raphael, 2011). Studies have proven that financially poor groups are comprised of a disproportionate larger number of women, Aboriginal people, members of racialized groups, and immigrants (Community Social Planning Council of Toronto, 2009). It has also been found that social assistance recipients have dramatically higher rates of ill health and chronic health conditions, while working poor groups have significantly worse health than non-poor groups (Community Social Planning Council of Toronto, 2009). The Social Planning and Research Council of Hamilton (SPRC) (2012) explained that

> the before tax Low Income Cut-Off (LICO), is one of Statistics Canada's most widely available measures of low income, and used extensively as a poverty line. In 2011, the before tax LICO was $22,229 for a single person, $27,674 for a single parent with a child, and $41,307 for a family of four, in large cities like Hamilton (p. 1).

They continued to recognise that "social assistance rates are far from being a basic standard of living. A single person on Ontario Works receives less than $8,000 per year, which is only 35% of the poverty line" (SPRC, 2012, p. 1). This level of income does not leave room for additional costs of living or sudden unplanned expenses.

As previously mentioned, social assistance recipients and working poor groups face difficulties in affording out-of-pocket expenses and other hidden costs

related to accessing healthcare services (Gould, 2004). These concerns regarding the experience of poverty or low-income while navigating the healthcare system, were influential in why I wanted to research how hospital social workers were able to address poverty. Research participants shared their concerns about out-of-pocket expenses and hidden costs, which led to conversations about how they were able to provide support to patients with whom they worked.

Values and the Disconnect Between Poverty and Ill Health

Neoliberalism has influenced changes regarding societal values. Society has become more individually focused with less concern placed on community and society at large (Finkel, 2006; Mulvale, 2001). Classical economic theory, which underpins capitalism, values money gained through employment. The risks of precarious employment have been transferred to workers and individuals with no work are devalued. This is because economics has become the central value in society. People with less money, or lower-class status, get excluded from participating fully in society because money gained through employment becomes the measure of an individual's worth. Herd et al., (2009) suggest that neoliberalism has changed the way society views labour and the economy. Individual blame is placed on those who experience job loss or lay-off. Social assistance recipients are viewed negatively because their income does not come from employment. Neoliberalism and globalization have changed the value of work and how labour is

conducted. Due to the increasing experience of privatization and factory shutdowns, risk is often placed on workers. Workers become concerned that companies will shut down and relocate overseas for lower operating costs related to wages and corporate profit (Lee, 2011; McKenzie and Wharf, 2010). Societal values have been influenced by capitalist opinions. These views place value in the paid work environment, which does not recognise or value unpaid work completed in the home, such as caring for children, the elderly or the sick. This can been seen in healthcare with cuts to hospital in-patient stays, leaving families responsible to fill the gaps in care at home, without pay or subsidy (Herd et al, 2009).

Values about social policy and social welfare have been influenced by neoliberalism and globalization. Opinions about poverty have become more negative, placing individual blame on those who are disadvantaged. Neoliberalism "favours individual explanations of poverty and unemployment that stress deficient education, insufficient work experience, moral failings such as poor work habits, or all three" (Herd et al, 2009, p. 131). Neoliberalism views those who are disadvantaged as experiencing this lifestyle because there is something wrong with them individually. Poverty and/or low income is not recognised as a societal or structural problem.

These values are very problematic because they disregard structural barriers that contribute to one's experience of financial hardship. These values, influenced by neoliberalism, create negative dichotomies such as 'good and bad' or 'us and

them'. This ultimately excludes individuals from participating in society and places blame on them, making it that much more difficult for individuals to overcome hardships. This is important because the gap between the rich and poor is growing, as the emphasis on market economy and globalization continues to erode the middle class (Lee, 2011; Hick, 2007; McKenzie and Wharf, 2010). Less value is being placed on health and social services as we enter a multi-tiered system of private and public healthcare, which ultimately impacts the universality and accessibility of healthcare services.

Currently, healthcare faces threats of privatization and financial cuts to services. These threats impact individuals on the margins of society more negatively than they do those in the dominant groups. It is also known that poverty, low-income, and homelessness negatively impacts one's health and access to care. Raphael (2004) explains that, "without adequate income, access to nutritious food, housing, or basic prerequisites of good health is increasingly difficult. Without adequate income, the likelihood of social exclusion increases as more and more Canadians are unable to participate in commonly assumed economic, social, cultural and political activities" (p. 19). The Canadian Medical Association (2013) also finds that individuals in the lowest socio-economic groups "carry the greatest burden of illness" (p. 1). Individuals experiencing poverty, or low-income, also feel the pressures of hidden costs involved with healthcare. These costs include paying for transportation, parking, medication, treatments and non-funded healthcare

providers. In addition, Marmot and Wilkinson (2006) find that high-unemployment and low income can lead to adverse health outcomes.

There are relationships between income, overall wellness and access to health. Income acts as a marker of different status among social determinants of health. It also marks differences in overall quality of life as it relates to accessing post secondary education, maintaining affordable housing, food security, and affording the basics of life (Hick, 2007; Marmot, 2006; Raphael, 2004; Raphael and Mikkonen, 2010). Gould (2004) explains that individuals who are members of the working class often do not have paid sick days from their employers. If they are required to attend treatments or are too ill to work due to medical reasons, they often cannot afford to take the time off work. This leaves individuals with limited choices, often having to choose to miss their medical treatments to avoid loss of pay or employment. Individuals who are in receipt of OW or ODSP do have access to drug card benefits, however this does not cover parking, transportation, or nutrition costs. This makes accessing healthcare difficult for members of the lower, working, and poor class. When an individual is homeless, or living at-risk of homelessness, their overall wellness is at risk. Hick (2007) links homelessness with chronic ill health concerns. Living in low-income, poverty, homelessness, or at-risk-of homelessness leaves individuals unable to cover the expensive hidden costs of healthcare.

This is also an example of how neoliberalism has changed the labour market. The job market has changed to offer casual, part-time, or contract work without full-time status, medical benefits or paid sick days. This leaves many individuals vulnerable to not having the ability to access healthcare services and medical benefits. Out-of-pocket expenses for health care may not be an option for individuals living in low-income, or for individuals who are in receipt of OW, ODSP, CPP and OAS.

It has been suggested that a long-term solution to precarious health is to connect the poverty, homelessness, at-risk-of homelessness and low-income conversations to healthcare policy conversations (Raphael, 2006; Hick 2007). As indicated in the literature, there are many connections between ill health and living in poverty yet social policies, such as affordable housing and the creation of a living wage are addressed separately from healthcare policy. Given the recognition that individuals experiencing poverty and low-income also have increased health concerns, it seems imperative that social and health policies should be connected.

As previously discussed, individuals face stigma and blame around issues of poverty. Yet the connection between living-in-poverty and overall health is not part of the public discourse nor often addressed by politicians. This issue is difficult to promote with the larger public and politicians because of the stigma associated with individuals experiencing financial hardships. In addition, the influence of neoliberalism further perpetuates negative opinions, making the connection

between living-in-poverty and overall health a difficult conversation when trying to influence public opinion.

Managerialism

The influences of both neoliberalism and managerialism have contributed to the government adopting business-like methods and approaches. According to Armstrong and Armstrong (2009), this has lead to the increase of for-profit healthcare services. It has also contributed to changes in the workforce, creating an environment that O'Neil (2014) describes as a "more flexible public sector labour force who will more readily accept precarious employment" (p. 20). This has also contributed to changing the discourse in healthcare, where arguments are presented in support of privatization or the development of a private/public model. Tsui and Cheung (2004) explain managerialism as "a set of beliefs and practices that assumes better management will resolve a wide range of economic and social problems" (p. 437). They go on to link managerialism with the dominance of capitalism and its ability to "exercise control over labour" (p. 437).

Concepts of managerialism have also been influenced by capitalism. Capitalism thrives on notions of efficiency and productivity (Walker, 2010). This ideology has also been adopted by healthcare systems. In an effort to improve the efficiency of the healthcare system in Canada, we have continued to see the adoption of private business models to help speed up the process (Fine, Golden, Hannam, and

Morra, 2009). Political and societal opinions about accessing healthcare have been driven by the focus on hospital wait times (Holden, 2010). In response to the focus on efficiency and productivity of Canadian healthcare, hospital organizations have adopted a human resource management model, based on the Japanese business-model (O'Neil, 2014). Holden (2010) describes the most widely adopted model based on the Toyota Motor Corporation, called the "lean approach". Lean focuses on creating more value for clients and patients with fewer resources. It allows an organization to identify areas for process improvement by, eliminating waste, reducing inefficiencies, improving access flow, quality and safety and ensuring optimal utilization of all resources" (Ontario Hospital Association, 2014). The "lean approach" has been adopted by private manufacturing businesses to help improve a company's bottom line (Holden, 2010; O'Neil, 2014). The "lean" management concept has been sold by the private market to the public sector, and to many healthcare organizations in Canada (O'Neil, 2014, p. 17). This program is believed to be more efficient in producing better outcomes with fewer financial resources.

Social work practice in hospital settings began in the early 1900s in the Massachusetts General Hospital in the United States (Beder, 2006). Care was shifting from the home to the hospital due to illnesses and issues such as tuberculosis, syphilis, polio, teenage pregnancy and poverty (Beder, 2006; Gregorian, 2005). The implementation of the social worker in hospital settings is based in the vision of Dr. Richard Cabot. Dr. Cabot recognised the importance of

"creating the position of social worker" (Beder, 2006, p. 2), to address the increasing concern that patients were blocked from carrying out their medical treatment plans due to social problems. Historically, hospital social workers were utilized in assisting the physician in identifying psychosocial issues (Gregorian, 2005). Today the role of hospital social work has transformed to include more administrative tasks (Gregorian, 2006; O'Neil, 2014). Concerns and pressures around patient flow and length of hospital stay have become the priority of hospital administration. Social workers have been utilized as discharge planners to assist with patient flow (Beder, 2006; O'Neil, 2014).

Social work also has a long history of attempting to address income and health concerns at both micro and macro levels; however, frontline social work practice has also been influenced by policy reform and neoliberalism through ideas about efficiency, time and management. Managerialism has influenced departmental structures in social service and health organizations. Specific to health care, managerialism influenced the adoption of program management models, resulting in the dismantling of social work departmental models. Thus, social workers familiar with collegial and consultative practice no longer have social work supervision, nor mechanisms for peer supervision (Sterling, 2009). They practice as somewhat isolated individuals.

Aronson and Sammon (2000) recognised that the consequences of program management have impacted how social workers collectively address practice related

issues. This can be applied to issues of a patient's poverty and opportunities for ethical discussions about how to address poverty related issues. Hospital social work practice has become fragmented and task oriented. It has become a fast-paced and cost-conscious environment (Aronson and Sammon, 2000; Gregorian, 2005; Globerman, White and McDonald, 2002). The influence of program management has impacted hospital social work practice by placing more emphasis on administrative tasks and less focus on more traditional social work skills such as supportive counseling, adjustment counseling and addressing psychosocial issues (Miller and Solomon, 2002; Gregorian, 2005; Beder, 2006).

Theoretical Framework

The methodology used in this research project was informed by a critical theoretical approach. Neuman (1997) described a critical approach as research that "critiques and transforms social relations" (p.74). Critical research is "action oriented" and the researcher is "dissatisfied with the way things are and seeks dramatic improvements" (p.74). I adopted a critical approach because I am interested in addressing social injustices. This approach "criticizes positivism for failing to deal with the meanings of real people and their capacity to feel and think" (Neuman, 1997, p. 74). I wanted to learn about the real experiences of social work hospital practitioners when working with individuals experiencing poverty or low-income. I also wanted to understand how they are able to address structural barriers that impact how they work with them. I specifically adopted an anti-oppressive practice (AOP) and Marxist analysis to inform this research project. These theories assist in explaining why poverty relates to ill health and how current health care policies negatively impact members of the lower socio-economic class.

The reason I decided to use a critical approach was to analyse the system and the structural and systemic barriers within the system that negatively impact individuals experiencing poverty and/or low income. I was not using this approach to criticize social workers or the participants' practice. Later in this paper I explain that I followed an interpretive model when it came to understanding the individual participants' stories.

I often rely on AOP and Marxist theories, because they explain and criticize structural barriers that impact one's experience from fully participating in society. AOP theory identifies intersections of oppression that negatively contribute to how one is located in society (Mullaly, 2010). To explain this point, I will begin by recognising that Canadian society was traditionally built from Anglo-European patriarchal and capitalist values (Hick, 2007; Mullaly, 2012). These values have contributed to structures that have better situated people of privileged backgrounds while disadvantaging others, creating structural barriers in society that consistently impact some individuals from being able to fully participate in that society. Even though universal health care exists, structural barriers such as class, race, gender, ability etc. prevent some citizens from accessing health care, which contributes to ill health and other chronic health conditions. With the creeping erosion of healthcare, one might fear that only members of the upper class will be able to purchase private healthcare services, leaving others vulnerable to fragmented and limited healthcare service. Canadian society has contributed to both covert and overt forms of structural oppression, which unfortunately continue at the present time (Mullaly, 2010). The intersections of oppression are related to the multiple layers of one's identity that can bump up against the experience of structural oppression.

Marxist theory was also used to underpin the overall critical framework for this research because of its recognition of class status and how class matters in terms of equity, access and social inclusion. Neuman (1997) also suggests that

Marxist theory is important to the critical social work perspective due to its analysis of class and explanation of class structuralism. An understanding of class status is important when discussing the patient experience in hospital settings as it relates to the hidden costs of healthcare, which will be addressed later in this paper. Finally, the use of Marxist theory explains how income security and class status impact individuals and communities in capitalist societies.

Economic-class status can be seen as a form of oppression through classism. When addressing access to healthcare, one can connect how low-income further limits one's ability to obtain healthcare services. It can impact one's ability to obtain healthcare services, or can impact the choice of healthcare service. An example of this can be seen in use of Emergency Department visits (Community Social Planning Council of Toronto, 2009). Some individuals may find using the Emergency Department more accessible and where drugs and other prescribed services are paid for, whereas they are not when issued from a doctor's office. It is important to recognise that out-of-pocket hidden expenses of healthcare may not be an option for individuals living in poverty or low income.

Class matters in the conversation about healthcare policy, because poverty and social inequality are a determinant of health. As previously mentioned, the Canadian Medical Association (2013) reports a direct correlation between low income/poverty and a lowered life expectancy than those of higher-economic class

status. Marxist theory allows one to connect this as an unfair advantage for higher-class status individuals. In capitalist societies such as Canada, individuals in higher-class status have access to a better quality of life than those of lower class status. Due to the nature of capitalism, with an influence of neoliberalism, members of the upper class can better situate themselves in society, due to their position of economic power, ownership of labour, and the free market (Gray and Webb, 2009). This means that members of the upper class are able to access and afford post secondary education. This, in turn, provides them with the opportunity to obtain better employment with higher income levels, which means they are able to afford better housing and shelter in safer neighbourhoods.

Methodology

Methodology is a guide in determining how research should proceed (Carter and Little, 2007). Methodology informs how research is conducted and methods describe what was done. This produces the data and knowledge obtained in the research process (Carter and Little, 2007). The choice to use qualitative research methodologies within this study was based on my desire to gain a better understanding of how poverty is addressed by social workers, within the context of a hospital setting. Carter and Little (2007) describe qualitative research as a form of "social research in which the researcher relies on text data rather than numerical data, analyzes those data in their textual form rather than converting them to numbers for analysis, aims to understand the meaning of human action" (p. 1316). Mason (2012) suggests that qualitative research is most commonly associated with interpretivist sociological tradition or phenomenology. The purpose of qualitative phenomenological research is to gather information about a "lived experience". Using a phenomenological methodology enabled me to interpret the experiences of the research participants by listening to each of their stories, while looking for common meanings linked to both the literature and my own work experiences. Qualitative research, within this study, involved seeking research ethics board approval, organizing research questions, recruiting participants, conducting in-depth interviews, and using open coding to generate meaning and themes.

Research Methods

In order to obtain an understanding of how hospital social workers are able to address poverty in frontline practice, while meeting the requirements of the McMaster MSW program, I was required to complete the Hamilton Integrated Research Ethics Board application (HIREB). In order to receive ethical clearance my thesis supervisor was also required to complete ethical testing.

Upon ethical approval from the HIREB, I conducted six in-depth semi-structured qualitative interviews with hospital social workers. The social workers practiced in more than one hospital organization. The choice to include more than one hospital organization was made for two reasons. The first was to broaden the research participant pool and the second stemmed from concerns regarding my employment status as a hospital social worker at one of the two hospital organizations. I was employed as an occasional part-time (casual) social worker in the emergency department at the beginning of this project. I had also been employed in contract social work positions and built relationships with colleagues in that hospital system.

The ultimate goal of these semi-structured interviews was to gain a better understanding of how hospital social workers are able to address poverty in frontline practice, while identifying the structural barriers that impact this work. There were a number of concerns that were given consideration throughout this research process. Previously, I shared that when I started this research study, I was

a practicing social worker in one of the hospital organizations. I was concerned that my own experiences as a hospital social worker could have influenced or biased the stories shared by participants. This influence or bias could have been achieved through the ways in which I interpreted what participants shared with me. I had to constantly engage in acts of self-reflexivity throughout this process. I did this by taking notes after each interview, and being aware of and reflecting on any personal biases based on my position as an insider researcher. Engaging in self-reflexivity allowed me to ensure that my own personal biases and interpretations did not influence the course of the interviews. I also had to address the concern that participants may not feel comfortable sharing their stories with me, knowing that I was also a hospital social worker within the same hospital network.

Another problem that presented itself during recruitment for this study was that I changed employment roles within the hospital where I worked. In consultation with my research supervisor, it was decided that I would disclose the change in my employment status to potential participants that responded to my recruitment methods. This new position involved me no longer practicing as a frontline social worker, and instead working with patient flow and access initiatives. I was not in a supervisory or managerial position in relation to the social workers. When disclosing my new role, I gave interested participants the option of not responding to my email and ensured that they were in no way, shape or form compelled to participate. In hindsight, it may have been beneficial to my research to

have not changed employment roles part way through this study. I have also wondered if it would have been more beneficial to have had interviewed social workers in a hospital in which I did not work. However, due to the limitation of time, and the McMaster University MSW completion requirements, I felt that this was not an attainable option.

Participants & Recruitment

The research participants involved in this study were all practicing front-line social workers from two different academic teaching hospitals in Southern Ontario. A recruitment letter (see Appendix A) and letter of information and consent form (see Appendix B) was sent to both hospital organizations and to their staff social work email distribution lists. An intermediary person viewed as social work practice leaders, were used in each hospital organization so that potential participants would not feel pressured to take part in the study. I was particularly concerned that colleagues from the hospital where I worked would feel additional pressure to participate, due to some of the relationships I had built during my employment as a contract front-line social worker. The recruitment letter and consent outlined my interest in understanding how hospital social workers are able to address poverty in front-line practice in hospital settings. I explained that this research was part of the Masters of Social Work Program at McMaster University under the supervision of Professor Sheila Sammon, and had received ethical

clearance from the HIREB. I invited potential participants to engage in an individual hour to one-and-a-half hour semi-structured interview to discuss their experiences at a time and place that was most convenient for them.

Confidentiality was maintained throughout the research process. Written and informed consent was secured from each participant prior to engaging in the interview process (see Appendix B). This included options of sending participants follow-up summaries and themes found from this study. A demographic questionnaire was not distributed in this study, as the information that would be generated would have no influence on my findings. This is because the main goal of my research was to seek out information pertaining to how hospital social workers perform, or are able to perform, duties regarding poverty intervention or activism.

Over the course of the interviews, participants did disclose how long they had been employed as front-line hospital social workers. This was not included within this thesis to provide an additional layer of confidentiality. Particular attention was also given to maintain gender neutrality in this study to help protect the identity of participants. Gender-neutral pseudonyms were used to assist this process.

Interviews

To facilitate discussion, the interview questions were circulated to participants prior to their interview, allowing participants the time and opportunity

to reflect on their experiences. A semi-structured interview guide was used as a guide for conversation only (Mason, 1996) (see Appendix C). I chose to conduct face-to-face interviews because I wanted to hear and understand each participant's specific experiences and stories (Seidman, 2006) in exploring how hospital social workers address poverty in front-line practice. Participants were asked how often they worked with individuals experiencing poverty or low-income. They were also asked how they were able to address poverty in front-line practice through providing practical assistance. Further questions explored structural barriers, or challenges, that impacted their ability to address poverty in front-line practice in hospital settings and how they are able to advocate or influence structural barriers.

In another effort to ensure confidentiality, pseudonyms were used to replace any reference to patients, clients, families, healthcare providers, hospitals, organizations, programs, etc. As previously mentioned, gender-neutral names were used to protect the identity of participants. The following names were given to participants: Taylor, Casey, Alex, Chris, Lee, and Morgan. Participants were informed that the interview would be digitally recorded. They were given the option to withdraw their participation at any time and were given the option to refrain from answering questions they did not feel comfortable answering. Participants were also given the option of receiving a summary of research themes found from this study.

Data Analysis

The process of data analysis began with completing the transcription process. All six interviews were transcribed by myself, along with the help of an outside party who signed a confidentiality agreement (Appendix D). Together we listened to each interview and carefully transcribed the interviews into a word document. To ensure accuracy, I read through each transcript while listening to the audio-recorded interviews. In the transcription process, I had considered hiring an outside transcriptionist, or utilizing an electronic system to help expedite the process. In researching how best to complete this portion of the research process, I decided to complete the transcription process myself, using one assistant in helping to check the transcription accuracy, to allow me to fully immerse myself in the work. Lapadat and Lindsay (1999), suggest that the researcher is able to develop a deeper understanding of the data by completing the transcription process. I wanted to ensure that I was fully engaging with and understanding the research and the collected data.

Upon the completion of the transcription process, I read and re-read the transcripts a number of times. This is described by Ristock (2002) as using an analytical process to disentangle the meanings of shared stories, and to better understand embedded power dynamics. Upon completing the transcription process I used a critical theoretical framework to better understand, analyse and interpret

the data. During the examination process of the data, I looked to answer the following questions:

- In what ways are hospital social workers able to address poverty?
- What systemic and structural barriers impact the way they are able to respond to poverty?
- How are they able to support individuals experiencing poverty?
- How do they address issues of stigma?
- What recommendations do they have in working with individuals experiencing poverty?
- Where does social justice fit in hospital social work practice?

In order to answer these questions, I studied the transcripts and applied open coding data processes to generate categories and themes found in the data (Strauss and Corbin, 1998). Goulding (1998) describes open coding as a way to break down data into smaller single entities, to allow the researcher to conceptualize meanings and label data. Brown, Stevenson, Troiano and Schneider (2002) suggest that the labels and meanings are then developed into themes that have evolved through the analysis process. By specifically reviewing each sentence, I was able to identify the major concepts and ideas that were brought forward by participants (Strauss and Corbin, 1998). Once this initial analysis was complete, I compared the areas of importance against the ones found in each of the interviews, and then compared the themes that emerged from each interview. Through using the constant comparison

procedure, I was able to compare and contrast the similarities and differences found within the data that belonged to certain themes (Spiggle, 1994).

Throughout the entire data analysis process, I continued to reflect on my own experiences as a front-line social worker in a hospital setting. It was important that I remained aware of personal biases based on my own work experiences. I strived to minimize researcher bias by focusing on the meanings shared by the participants in their interviews and story telling.

Locating the Researcher

Within qualitative research, it is necessary for the researcher to identify their location or role within the research process (Unluer, 2012). Roles that can be assumed are referred to as "insider researchers" and "outsider researchers" (Adler and Adler, 1994; Unluer, 2012). An "insider researcher" refers to a researcher who belongs to a group that is being studied whereas an "outsider researcher" does not belong to the group being studied and can be considered a complete stranger (Adler and Adler, 1994; Unluer, 2012). As a result, my role as a hospital social worker positioned me as an "insider researcher" within this study.

According to Unluer (2012), and Bonner and Tolhurst (2002), there are many advantages of being an "insider researcher". Within this role, the researcher is said to have a greater understanding of the group they are studying, are able to establish rapport based on commonalities and guide the interview in a natural way (Bonner

and Tolhurst, 2002; Unluer, 2012). In addition, the "insider researcher" shares a common language, identity and experience with the participants (Corbin Dwyer and Buckle, 2009; Asselin, 2003). Throughout this study, I was able to use my "insider knowledge" to gain rapport with my participants, and understand the language used that is specific to hospital social workers. I believed this allowed participants to be able to speak more openly and honestly without having to worry if I understood what they meant.

Although there are many positives to being an "insider researcher", it is important to note that there are also challenges associated with this position. At times, there can be risks that the level of objectivity may be compromised (Unluer, 2012). As a result, the researcher could make false assumptions, based on their current and prior knowledge (DeLyser, 2001; Hewitt-Taylor, 2002; Unluer, 2012). Here, it is important for the researcher to engage conscious self-awareness; also referred to as reflexivity. According to Finaly (2002), reflexivity "involves a shift in our understanding of data collection from something objective that is accomplished through detached scrutiny of "what I know and how I know it" to recognizing how we actively construct our knowledge (p. 532). The researcher can then engage in reflexive analysis where "the researcher is aware of experiencing a world and moves back and forth in a kind of dialectic between experience and awareness" (Finlay, 2002, p. 533).

It is also important to note that my role as an "insider researcher" shifted throughout this process. Over the course of the research, I accepted a managerial position within the hospital where I worked. This position did not result in my having direct supervisory responsibility over social work colleagues; however, it did involve me having discussions about patient care and discharge planning. I was sensitive to the fact that this position may result in participant discomfort and influence their willingness to share their story. I was honest with participants and disclosed my own work experience as a frontline social worker to regain common ground; however, the level of rapport may have been diminished as a result of this new role.

Findings

The analysis of the six interviews revealed many important issues relating to the ways in which hospital social workers address poverty. A number of structural and systemic barriers were also revealed regarding how this work is completed. I focused on five dominant themes that were present across all the interviews, along with the subcategories related to such themes. The five major themes that emerged were:

1) Addressing Stigma
2) Navigating "The System"
3) Systemic and Structural Barriers
4) No family, No Friends
5) Connecting With Resources

Addressing Stigma

The literature revealed that negative societal opinions about individuals experiencing poverty are related to beliefs that individuals are responsible for their own poverty. This discourse does not connect poverty to larger societal problems. All of the participants noted that societal attitudes toward "the poor" affected the patients and their work. They also discussed internalized stigma, which developed into a sub-theme in this research.

Taylor shared that in some cases, patients internalize stigma about poverty and "don't want to identify as being poor, or not having the dollars or resources to be able to pay for stuff." In these cases, patients may feel the need to hide their poverty to avoid having to explain their situation to healthcare workers; further, they might be embarrassed or ashamed. People who live in poverty are not immune to the societal message that the poor are somehow to blame for their poverty. It is also important to recognise that some individuals may not identify with labels and therefore may not view themselves as financially poor. Internalizing stigma about poverty may also be connected to opinions about "deserving" and "undeserving poor".

It is not just the patients who are influenced by societal attitudes toward the poor. Healthcare workers, like the rest of society, are influenced by the societal messages about "the poor" and, in a busy, complex environment, it is difficult to step back and consider social forces that influence patients. Taylor explained that healthcare workers reactions to how a patient who lives in poverty behaves reflect their beliefs about individual responsibility for the patient's socio-economic status. It was shared that

> Some people can present as shy, remote or distant because they don't want to talk about what they don't have. Others can present as having high expectations of what should be available to them...I think those people get labeled in hospital as being undeserving.

This led to a conversation about judgment from colleagues within the hospital towards patients experiencing poverty or low income. This point was identified by all participants.

Morgan stated that at times it was "shocking to hear some of the statements that you get from team members about patients in poverty. As a social worker, I know it is coming from a place of classism, labeling and judgment. Morgan continued to share that at times, this had been addressed by reminding teammates that there was a "bigger picture" when responding to comments made about patients making "personal choices of poverty." When asked about how such experiences are addressed, participants explained that it is difficult knowing when to say something or not. Jordan shared that it can be "frustrating because sometimes you want to say something but at the same time, you don't want to embarrass your colleague…and at the end of the day, you have to work with these people everyday". In this example, the social worker is found to be in a difficult position. They described trying to advance social justice, however they struggled with team dynamics and how addressing comments pertaining to poverty could impact team members. This example is interesting when connected back to the earlier discussion on program management and managerialism, because the social worker can be seen as particularly vulnerable. Not only can strained interpersonal dynamics affect a social worker's sphere of influence on a team, there is also the

possibility that they could face being replaced by other disciplines if they become confrontational.

Taylor discussed situations of observing stigma related to patients experiencing poverty and/or low income by colleagues and "the system" around discharge planning. Discharge planning with individuals living in poverty can be complex and may lead to extended hospital stays because patients may have lost their housing or may have to wait for a shelter bed. Taylor also stated that there were times when patients did not want to leave the hospital. This could create,

> Rumblings among staff around the discharge and getting the person out. I always think well…this is a pretty terrible place. It's a harsh environment with bright lights, noise and staff bugging you…if this is better than where you came from, then how bad is it at home? I mean it's got to be really bad to think this place is better. To me that is a big red flag.

This opinion was echoed in the interview with Casey, who talked about additional pressures placed on social workers to find housing for patients in preparation for discharge from hospital. Alex also noted that patients who are poor can have a longer length of stay on the unit and that (s)he has to address staff attitudes:

> Some teammates become annoyed when patients feel insecure about leaving the unit. Sometimes I have shared to staff that maybe they have fears because in the area of town they live in, they were at risk of break-ins and other unsafe experiences.

Dealing with stigma and negative assumptions regarding people experiencing poverty, was described by participants as 'frustrating' and 'difficult'.

Knowing when to address comments made by colleagues further added to participants' frustrations. Stigma was a concern shared throughout the conversations held with participants and will be echoed in other themes in this study.

Navigating the System

"The system" was a term used by all participants. At times, it was referred to as the hospital system, and other times it was used to describe governmental policies and structures. Navigating the system was also recognised as one of the ways in which participants were able to address poverty. Some connected this to being one of the practical ways they are able to address poverty while supporting patients during their hospital experience.

As previously described in this paper, income support recipients often face increased ill health and chronic health conditions. All participants described working on behalf of patients when they were too sick and tired to negotiate with their OW or ODSP workers. Sometimes this would be for specialized medication coverage that was not normally covered, or accessing community start up funds. Other times, it was done to connect patients with transportation services to help them get to appointments. Morgan gave the example of "completing employment insurance (EI) sick leave benefits, while patients are in hospital, rather than making

them run around the city to their family doctor once discharged." It was shared that getting such "benefits started up can take a long time and it is often better to help patients through the process by filling out the form and asking the doctor to sign it." Completing forms may appear as a logical task for workers to complete; however, with caseloads increasing in size and the additional roles, there is pressure for social workers to shift tasks onto the patients, their families, or other workers. Participants of this study indicated that through filling out these forms, it was one of the ways in which hospital social workers were able to assist patients in the hospital. This brings the question of what happens when patients are not followed by social work support? Are they able to easily obtain the doctor's signature? Are they left to get such forms completed by their family doctor? If so, are they well enough to meet their family doctor after their hospital stay?

Alex described examples of navigating the system by calling supportive housing programs and connecting patients to community resources. An example given describes a scheduled session with a particular patient. The appointment was supposed to be used to complete their therapeutic work, but instead, the time was spent providing immediate support around housing and food. In this case "the patient had been a working-class guy in the service industry." He had always worked and had never received any social assistance. He did not know how to navigate accessing services. Alex was able to help connect this patient to services. Within a mangerialist world, Alex had the specific responsibility to complete therapy

with patients; however, Alex recognised that it was more important to address the resource needs of the patient. Alex also reflected on a foundational social work principle: that therapy cannot be engaged if someone's basic needs are not met.

Morgan provided the example of advocating on behalf of a very ill patient to their ODSP worker for increased transit expense coverage. In this case the patient had become very weak and was no longer able to use city transit. Providing this support was very important to the improving the patient's ability to attend medical appointments. It also provided some risk prevention against falls due to fatigue and exhaustion in trying to climb in and out of a city bus. This work was necessary and can be recognised as another way that social workers help patients navigate the system. Yet, at the same time, it reveals how the system is set up in a way that an individual receiving income support is required to prove their need to their ODSP worker. Navigating the system is just one example of the practical ways in which social workers provide support.

Systemic & Structural Barriers

Systemic and structural barriers were identified at both the government and hospital levels. These barriers impacted both the patient's experience and how social workers were able to intervene when assisting patients. A recurring topic was the government's inadequate income supports for people living below the poverty line. As discussed in the literature review, the neoliberal agenda has kept income

supports low and perpetuated negative and stigmatizing opinions pertaining to people living in poverty. Income support rates are far from being a basic standard of living (SPRC, 2012). As discussed earlier in this paper, income support recipients receive an income that is well below the poverty line in Canada (SPRC, 2012). This can be connected to how the government has created structural barriers keeping individuals who are unable to work below the poverty line.

Chris discussed examples from the lives of clients in a community-based hospital-supported out-patent program. The majority of clients received ODSP and a few received OW. Chris described, "governmental barriers that keep service users in poverty, or such a low rate of income, they cannot afford adequate housing or nutritious meals." Chris went on to explain that "people in positions of power create policies, yet I worry that they don't realize how low they have set the bar". Chris shared the example of the low living standards individuals receiving income supports live in by explaining that there is "no room for error or extras". One of the clients in the community-based program had not been able to manage the cost of her hydro bill. This bill had "significantly racked up and the hydro was eventually disconnected". As a result, the client ended up owing hundreds of dollars, which was difficult for her to afford. This was exacerbated by her situation as an ODSP recipient and she did not earn enough money to pay off the hydro bill. Chris provided assistance and was able to negotiate with the client and hydro company to

reduce the monthly hydro payments. Chris worked with the client to achieve one monthly manageable payment schedule for hydro.

Opinions concerning structural barriers were echoed by Taylor who shared concerns with "decision makers influencing policies about poverty, yet they have never been poor, never experienced staying in a shelter, and probably never will". As a result, these "decision makers" have not experienced how low the standards are, therefore, resulting in the implementation of polices that can have significant consequences for individuals experiencing low socio-economic status.

These examples describe the participants' analysis of the problem and the practical ways they have intervened in supporting the patients or clients with whom they work; however, they do not address what they are doing about systemic and structural barriers. Only one participant discussed engaging in larger social justice actions, such as protest work in the fight against poverty, while being employed in a community service organization. This participant shared that this work was something that was missed since becoming employed in a hospital setting. The participant described demonstration work and larger acts of social justice work as not part of the hospital social workers responsibilities, and suggested that this work has been left to community workers.

Other examples of systemic barriers were hospital specific. Hospitals are very bureaucratic systems, with multiple layers of red tape and departmental models. Participant Lee shared many examples of how the hospital system limits

the ability to quickly and efficiently assist patients in obtaining completed medical forms and paperwork. One example related to a patient's Canada Pension Plan (CPP) terminal illness application. The patient was "a very sick man who was approaching the end of his life. His family had shared concerns about finances". Lee began the application process for CPP terminal illness benefits. It was described as "a great form that can be quickly filled out, signed by a doctor and sent to Service Canada". The hospital, however, had a number of barriers to completing forms quickly. Lee explained that "first the form goes to the privacy office and then they send it to the billings department before it can be sent off to Service Canada." In this particular case, the patient had been discharged from the hospital and sent home. Lee assured them that the form would be taken care of and the benefit would arrive within a week or so. Weeks later, the family called asking about the form. When Lee looked into what had happened, it was discovered that the hospital's billing department had not sent the form to Service Canada. Staff in the billing department had taken summer holidays, and there was a hospital policy allowing thirty days to process completed forms. When asked if the patient lived long enough to receive the benefit, Lee shared that it was too painful to find out and added, "I couldn't dare ask the family".

This is an example of how running a "lean" cost efficient operation, leads to poor service that likely affects poorer clients who need forms to get their medical needs met. It is likely that no one in the billing department had deliberately ignored

completing the processing of the form; rather they were operating within the designated hospital policies and guidelines. This is one way that systemic barriers such as hospital policies can negatively impact patients experiencing low income or poverty.

Morgan shared a similar example. In this case, the patient had been in hospital for a week and was "very fatigued and very ill." Morgan described the patient's wife as "barely holding it together. She was working full-time; they had three small kids, plus trying to take care of forms and visit her husband." Morgan took the insurance disability forms from the patient's wife to assist in getting them completed. Morgan filled out as much as possible prior to sending them off to the doctor. A few weeks had gone by after the patient was discharged. His wife called asking about the insurance forms because the money had not come in. Much like Lee's example, when Morgan looked into it, the form was sitting on the doctor's desk. It had not been completed or sent off.

Both Lee and Morgan, described ways of getting around the system. Lee discussed an example of one of the physicians who rarely completed forms in a timely manner. This was followed with the Lee's statement "if you are the problem within the system, I <u>will</u> get around you". This was done by having residents sign the forms instead of the most responsible physician

Morgan gave a similar example when stating, "I now try to use advocacy about poverty and income so the team is aware of how serious these issues

are…now I only bring forms to the residents. I never let them leave with the form. In fact, I don't even let the form go. I just wave it in front of them to sign." In this example, Morgan referred to advocacy pertaining to poverty, as knowledge sharing with team members, so they can also understand and recognize the importance of financial documents. These examples are also lessons that participants have picked up in front-line practice. Rather than following specific hospital processes they bend the rules, such as getting the resident rather than the attending physician to sign forms, to benefit the patient.

Other hospital barriers discussed centered on the pressures to discharge patients from the hospital. Casey connected this pressure to the "lean model", which was discussed earlier in this paper. Casey shared that historically discharging patients to shelters was not a common practice, nor was it an acceptable discharge location. Shelters can present concerns regarding physical and environmental safety, especially for medically vulnerable people. Shelter workers also do not have the appropriate medical training required to provide physical care. In addition, shelters do not have the same cleaning staff or stringent policies and procedures that hospitals or care facilities have, regarding the prevention of infections and diseases. These are just a few reasons why shelters are not a common discharge location.

Today it has become common practice and acceptable to discharge patients experiencing poverty or homelessness to shelters. Casey continued to connect this

to the influence of the "lean model" and its "pressures to push patients through the system like automobiles, in the front door and out the back"; shelters have become a catch-all for disadvantaged and vulnerable people. Casey connected this to hospitals "no longer meeting the bigger psychosocial needs of patients. This has been downloaded to the community and shelter workers". This brings forward questions about social work within front-line practice. In time, will hospital social workers become discharge planners, leaving psychosocial needs to be addressed by other services?

Taylor shared similar concerns and questioned the use of shelters as adequate discharge locations. An example was given about a working-class patient who worked many contract jobs without benefits and had always made enough money to get by until he ended up in hospital. Due to the hospitalization for a number of weeks, the patient was unable to work, missed rent payments, and had to forfeit his apartment. When it came time for discharge, Taylor had to discuss going to a shelter. In this case the patient had never been to a shelter before. Taylor described this as one of

> the worst conversations. They don't know what it means to be going to a shelter…but we do. We know what it means. How awful it is…and all the hospital wants us to say is well…you can't stay here anymore. We know we are really sending them to live on the street.

The influence of neoliberalism has created an environment where it has become increasingly acceptable to discharge people to shelters. It has created an

environment where work is fragmented and efficiency glorified. Social workers end up describing their role "as making the best of a bad situation".

No family, No Friends

Our healthcare system is currently predicated on the assumption that all patients have families and/or friends who will provide shelter, basic needs and care for people who are sick. The neoliberal agenda, as mentioned before, has shifted care responsibilities from the state to the family, from society to individuals. The business model of efficiency allows for the downloading of care responsibilities to families and friends (Aronson, 2006). Therefore, those people who do not have family (involved family) or friends are at a particular disadvantage when it comes to discharge. Very often people who live in poverty are without family and friends who are in a financial position to help post-discharge.

Casey, Lee, and Taylor all shared stories of how the system has also seen the increase of downloading care to families and friends. Taylor shared that the emphasis on families caring for their own " works in theory but what if you don't have family or friends to couch surf until you can get back on your feet? Where do you go?" Chris shared similar concerns when asking, "What about if you are too sick to go back to work, and you are too young for long term care, but not ready to die…where do these people go?" Lee described our system as a "great system for the middle class, but a dismal system for the poor". This may present even more future problems given the shrinking middle-class as discussed earlier in this paper. Clearly,

the system is currently designed for people who have the social supports and income to provide care post-discharge.

The participants noted that some patients they have worked with are not in financial need but know how to "talk-the-talk of the system." Examples were given where some families refuse to a take family members home and tell hospital workers "no I'm not taking my parent to my house; they need to wait here for long-term care". Alex shared "in these cases, they are able to afford the co-payment to stay involved with ALC" (alternative level of care). Most individuals experiencing low income cannot afford these costs and, therefore, are unable to refuse to leave the hospital. This experience is different for income support recipients, because OW and ODSP would cover the cost of the co-payment. At times, examples such as this can be frustrating for hospital workers who criticize the family for not taking their family member home. This can also be recognised as healthcare workers buying into neoliberal opinions, that care should be downloaded to families.

Connecting with Resources

A final theme presented in this research was helping patients connect with resources. Each participant described the ways in which they connect patients and families to various resources and community programs. Taylor, Morgan and Chris all suggested that social workers need to gain a good understanding of resources to

be able to quickly assist people in need. Taylor went on to advise and encourage new social workers to work toward building strong connections with other workers from other services. This was echoed by Casey when explaining, "knowing whom to call to provide additional support is essential." Lee and Alex shared similar thoughts in their interviews, suggesting that social workers need to have an understanding of what resources are available to patients, because it is an important aspect of the social work role.

Each participant shared examples of connecting patients, or families, to resources. Some examples related to income supports, others related to housing and homelessness. Sometimes it would be around shelter services or food bank information. Other times it was navigating the system through the process of applying for assisted living or connecting patients to the Community Care Access Centre (CCAC). These are just some of the examples shared by participants around connecting patients and families to community resources.

Discussion

Impact of Poverty on Patients

As illustrated within the literature review, the neoliberal agenda has impacted people who live in poverty in a number of negative ways. Negative consequences of this agenda can be seen through the exacerbation and/or contribution to health problems and limited access to prevention and treatments. As a result, hospital social workers have observed many ways in which neoliberal agendas have influenced their patients who are members of the poor and working class.

Within the hospital setting, changes that have occurred in social work practice have been influenced by managerial concepts such as "lean healthcare". Social workers have become required to implement the "lean" model by creating fragmented discharge plans that include discharging patients to shelters and other precarious discharge locations.

Some participants who have many years of social work experience possess knowledge and have experience working in various discharge environments influenced by managerial concepts. As a result, these participants have been able to adapt to these new policies and procedures by finding individualistic ways of addressing and mitigating poverty to achieve a better patient outcome. Social workers who are new to the field often do not have this same level of experience and knowledge and therefore may not have an understanding of the implications of the

"lean" discharge plan. They may also not understand how these pressures directly affect individuals experiencing poverty and/or low income.

The participants of this research shared their concerns pertaining to stigma related to individuals living in poverty and/or low income and the structural and systemic barriers built within society, which impact how poverty is addressed in frontline practice. The topic of addressing stigma in participants' workplaces was connected to larger negative societal opinions about poverty. As previously mentioned, healthcare workers are not immune to the negative societal assumptions about poverty and/or low income. It has been recognised that society blames the problem of poverty and/or low income on those that experience it and does not address the larger systemic and political policies that contribute to and perpetuate poverty within society. Another interesting finding was that some participants discussed internalized stigma by patients. This again can be connected to the larger societal opinions about self-blame and judgment. It is possible that patients who are experiencing poverty and/or low income do not want to reveal their situation to avoid being judged by healthcare workers.

Participants shared their concerns with the growing reliance on friends and family to pick up the shortcomings of the system. They also described the gaps individuals face when they do not have friends or family to rely on for help when their life experiences are complicated by illness. The reliance on family and downloading care to families has been described as a hidden cost of healthcare

(Aronson, 2006; Gould, 2004) because family members are not compensated for providing care at home. The problem with this expectation is that it leaves those without family or friends without the support that the hospital expects one to have in place. It is also important to note that reliance on "family" within the Western context often refers to the reliance on women. Within society, women continue to be held primarily responsible for providing care to others (Mullaly, 2010).

Social Workers & the Enactment of Social Justice

Hospital social workers also conduct small acts of social justice oriented work in their everyday practice. The practical work they were able to perform was essential in helping patients experiencing poverty and/or low income, to navigate the system at a time they are most vulnerable. Hospital social workers were able to assist in meeting the practical needs of patients while in hospital. However, due to the influence of "lean" healthcare, this meeting of practical needs often replaces the limited time resources available to larger psychosocial needs. In addition, hospital social workers felt that their hands were tied when it came to addressing the larger societal problem of poverty. One participant discussed engaging in larger social justice actions, and referred to it as demonstration work. This was also described as not part of the hospital social workers "*scope of practic*e". Instead, it was suggested as work that has been left to community workers. This is interesting because upholding social justice is in fact part of all social workers scope of practice,

regardless of where they are employed (CASW, 2005). I also connect this to some of the other stories I heard from participants regarding the offloading of psychosocial needs of patients to community and social service organizations. This is simply due to the influence of managerial concepts where time and efficiency are prioritized in hospital settings. Working under time pressures and with the complexity and fragmentation of their hospital employment, hospital social workers simply do not have time in their workday to participate in social activism. Instead, hospital social workers engage in resistance through small acts of individual social justice work through frontline practice. Options to address poverty on a mezzo or macro scale within hospital social work practice can be completed by participating in committees, and/or research about poverty reduction and healthcare.

Perhaps the small acts of social justice work, such as treating patients with dignity and respect, not making assumptions about their lived experience while providing them with practical assistance, is enough to make a difference. Much like participant Alex described, "listening to patients may be all they need in difficult times of ill health". Being the one person in a faceless system that is able to listen to their story, while providing practical assistance and connecting them to resources may be enough. Hospital social workers also have to work in the confines of the system while meeting their employment obligations. Participating in small acts of social justice may be all they can manage. Again, I connect this to what participants shared about not owning the system, just working in it.

Participants shared the ways in which they maneuver around hospital systemic barriers. They shared the consequences for patients and families when systemic barriers and hospital bureaucracy block them from obtaining financial resources. Navigating the system was described as a significant way that hospital social workers provide assistance to patients. Devising practical ways of getting around the bureaucracy was described as beneficial to the patient experience. Although important work, the problem with requiring help to navigate the system is that it could create a dependency on workers to unveil resources that should be readily available to the public. The system is complex, creating an environment where one needs a worker to find what they need; yet hospital social workers are only one part of one system. As a result, this contributes to forms of classism, where some individuals require the assistance of professionals while others do not. This unequal access is not created by social workers or other healthcare workers, but rather is formed by the complex system and its structural barriers.

When linking this back to my own work experiences discussed earlier, I wondered if the practical assistance I was able to provide made a difference in the lives of patients experiencing poverty and/or low income. The participants shared similar examples regarding how they are able to intervene, while explaining the ways they get around the system in helping patients and families.

Providing practical assistance can be connected to Phillips & Waterson (2002) and Lechman and Duder's (2009) work, that found that there are increased

pressures on social workers to complete administrative tasks, with less time to spend on patients' psychosocial needs. This is very similar to the stories shared by participants in regards to completing forms and providing resource information. Although the participants were able to provide a strong analysis of the systemic and structural barriers, they shared that they can only provide respectful care and connect patients and families to resources, but do not seem to be able to address bigger issues. Providing practical and individual assistance is clearly an important aspect in contributing to the patient's experience and can be connected to aspects of helping patients' and families navigate the system. This paper did not address if this work made a change in the lives of patients on a larger scale, other than assisting in helping them understand the healthcare and social service systems.

The Role of Managerialism in Hospital Social Work

There is a profound limitation for social workers in addressing larger societal injustices. Participants provided a good analysis about poverty and demonstrated their passion in providing whatever support they can to these patients even though the constraints of managerialism have impacted how they do their jobs. Some of the work they were able to do before has been downloaded to community workers and organizations and it is clear that hospital social workers continue to find alternative ways of addressing the day-to-day needs of patients living in poverty. The time constraints, the overpowering demands of their jobs, their vulnerability in a "host"

setting, and the ideological discourse all contribute to limiting their opportunity for more macro interventions.

Under the current managerial environment, social workers practice under program management models, creating professional isolation. Less collective discussions about a patient's experience of poverty and/or low income happen in program management settings, allowing for less questioning about discharge plans. Working under program management settings has also placed constraints on the social workers' abilities to advocate against social injustices. They have to tiptoe around issues and weigh the pros and cons of addressing stigma in the moment.

In my own work experiences, I have heard colleagues argue that the hospital cannot be everything to everyone, which appears to be an accurate statement, however, social workers have the responsibility of addressing social injustices as per their code of ethics. This brings the question, who is responsible for the outcomes of the increasing numbers of poor and low-income individuals and families; and the impacts this has on the healthcare system? This paper has already discussed the negative societal opinions pertaining to poverty and low income. Also criticized were the uninformed views about placing individual blame on people who are experiencing poverty and/or low income. Mullaly (2011) debunks the myth of hard work and the "American dream", which is the idea that if one works hard enough, they will be successful. Participants also argued against the valorization of hard

work and argued that there is a "bigger picture" contributing to the experience of poverty and/or low income.

Barriers are found in both hospital and government policies making them deeply embedded and complicated. As a result, these policies can leave hospital social workers with the feeling that they can provide only practical assistance when working with individuals who are experiencing poverty and/or low income. This results in many questions, including how does this impact the role of the social worker? How does not being able to facilitate meeting psychosocial needs and not being able to create adequate discharge plans impact the role of the social worker? Social workers in hospital settings work under the pressures of constant organizational restructuring under managerial concepts. This adoption of restructuring and managerial concepts is in essence "pro-market, business-like management solutions, rather than non-market initiatives stressing social connection, equality, and a public service ethos" (Baines, 2011).

This study also discussed the structural and systemic barriers that impact hospital social workers ultimately revealing that there is far too much bureaucracy and layers of red tape in large hospital organizations. This was seen in the example of the family that did not receive the terminal illness benefit due to hospital specific bureaucracy. In this example we learned that departmental policy superseded the patient's need.

Other concerns were discussed with the downloading of psychosocial needs to community service organizations around housing, homelessness, shelter, food and health. This was also connected to the influence of "lean" healthcare, which has created an environment that supports getting people through the system. This could also be recognised as a narrowed social work role, where discharge planning and not providing psychosocial support is now the preferred value in hospital settings.

Implications for Social Work Practice

The study revealed how important it was for social workers to be familiar with community resources and to network with service providers outside of the hospital. Working under program management models can make "staying connected" difficult, because it becomes the individual task of the social worker to build multiple relationships, rather than working as a collective group in building community connections. There is an importance of not feeling alone in a managerial influenced system. Social workers need to build support systems within the hospital, comprised of other social workers or like-minded allies. It is also evident how important it is for social workers to know the workings of the hospital system in order to access services and to get around bureaucratic barriers. There is also an importance of responding to negative stereotypes and to educate other health workers about poverty.

Implications for Social Work Research

This research study could be conducted with a larger research sample. It would also be beneficial to interview social workers from smaller community hospitals, as this study only interviewed social workers from two large teaching organizations.

I am also left wondering if hospital social workers had the time and opportunity, what could they do to intervene at a larger macro level? Would they be able to advocate about poverty and educate other health professionals about the social determinants of health?

It would also be interesting to research what other allied health workers think about poverty? Is there an opportunity to build allied coalitions in healthcare to address poverty reduction?

There were a number of limitations of this study. First, my being an insider researcher and former colleague to some of the participants could have influenced the findings. The participants may not have felt comfortable in explaining all the ways they are able to maneuver around the system. Also my new position may have contributed to discomfort around this topic. Participants may have had concerns that I might judge them from the positions of both insider researcher and my current employment as a manager (not a manager of social workers) in the system. Some participants may have withheld aspects of their story. It also would have also

been beneficial to ask more explicit questions around macro and mezzo interventions.

Conclusion

This research study began with an interest in understanding how social workers address poverty and/or low income in hospital settings. In conducting individual interviews with hospital social workers, five themes emerged that illustrated how providing practical assistance is the predominant intervention that hospital social workers use when addressing poverty. Discussed were the ways in which hospital social workers address poverty in front line practice, while connecting how the experience of poverty and/or low income can further complicate one's health and access to healthcare. Also discussed were the ways that macro political ideologies, structural barriers and societal stigma can impact how social workers address poverty in frontline hospital practice.

Poverty is a social determinant of health, which is why understanding how hospital social workers address poverty in front line practice is important. Given the influence of neoliberalism and its impact on the growing gap between the rich and poor, it is suggested that poverty and low/income will continue throughout Canadian society (Hick, 2007; McKenzie and Wharf, 2010). As discussed in this paper, accessing healthcare and navigating the system may become difficult for those experiencing poverty. Participants shared the practical ways in which they are able to address poverty; however, they also shared that the influence of "lean" healthcare has limited their ability to address psychosocial needs and has limited their ability to participate in larger social justice activities.

The hospital social workers that participated in this study acknowledged that poverty was a societal and political problem; they had a strong analysis about the structural and systemic barriers related to addressing poverty in the health care system and were articulate about their concerns for patients who experienced poverty. However, they were limited in what they could do. The ways in which they were able to push back against poverty as a social injustice remain unclear or nonexistent in their practice. As a social worker I understand how providing practical assistance is sometimes the only way in which poverty can be addressed, yet, like many of the participants, I long for and search for ways in which to address poverty beyond the individual level.

The pressures from both the College of Social Workers and academic settings to uphold social justice can be intimidating when doing frontline work. While working for an organization, social workers must balance being a social worker and an employee while meeting a number of competing demands.

This study was motivated by my own experience. As I mentioned in the introduction, when I participated in assisting patients experiencing poverty, it left me wondering if I was making a difference in their lives. I often left my shift feeling a sense of hopelessness when I could not provide any more support to individuals experiencing poverty or low-income. Participants also shared their feelings of hopelessness when explaining how they are able to provide support to patients and families. One participant even shared her desire to find other social work

opportunities, because discharging patients without "solid" plans went against her ethical obligations. Perhaps the small acts of social justice work, such as treating patients with dignity and respect, not making assumptions about their experience while providing them with practical assistance is enough to make a difference. I am still left with the question: is it enough?

APPENDIX A: Recruitment Letter

Recruiting Email for Hospital Social Workers

Cover Email:

Please see the message below and attached information about a study being conducted by Christina Gitta-Low towards her MSW thesis. I encourage those of you in roles that involve helping patients in financial need to consider participating. For more information, or to express your interest in the study, please contact Christina Gitta-Low directly.

Dear Social Workers:

I am conducting a research study on the front-line experience of hospital social workers response to poverty and low-income of patients they support. I want to explore how hospital social workers respond to poverty as a social determinant of health. I want to investigate what hospital social workers are able to do in addressing poverty and what barriers system pressures play in addressing poverty.

This study is part of the requirements for the completion of my Masters in Social Work at McMaster University, under the supervision of Professor Sheila Sammon. It has received ethical clearance from the Hamilton Integrated Research Ethics Board.

I am looking for volunteers who have a role is front-line social work practice, supporting patients and families in financial need, to participate in individual interviews of approximately one hour in length. I will pick a time and location that is convenient for you. I will send you information prior to the interview so that you can reflect on your experiences. You will be asked to review a summary of themes from the interview so that you can offer feedback on the findings.

Any names used in the interview (of yourself, your patients/clients or their family members, work colleagues, of hospital or other organizations) will be replaced with pseudonyms. Any information about the participants will be presented in aggregate form so that no one individual will be identifiable. I will make every effort to preserve your confidentiality.

The detailed information sheet and consent form for this study is attached for your perusal.

If you are interested in learning more about this study and possibly participating, please email me at gittac@mcmaster.ca

Thank you for considering this request! I hope to hear from you.

APPENDIX B: Consent Form & Letter of Information

LETTER OF INFORMATION / CONSENT FOR SOCIAL WOKRERS

Front-line Hospital Social Work: Response to Addressing Poverty as a Social Determinant of Health

Investigator:

Professor Sheila Sammon
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McMaster University
Hamilton, Ontario, Canada
905-525-9140 ext. 23780
sammon@mcmaster.ca

Student Investigator:

Christina Gitta-Low
Department of Social Work
McMaster University
Hamilton, Ontario, Canada
905-525-9140 ext. 23780
gittac@mcmatser.ca

Purpose of the Study

You are invited to participate in a research study conducted by Christina Gitta-Low about the experiences of hospital social workers on responding to poverty as a social determinant of health. This is a student research project conducted under the supervision of Professor Sheila Sammon.

My name is Christina Gitta-Low, and I am a Masters in Social Work candidate, presently enrolled at McMaster University. I am in the process of completing the thesis requirement of the program. The purpose of my study is to explore how hospital social workers respond to poverty when working with patients and families in frontline practice. I will conduct personal interviews that will discuss your work experiences in how you are able to address poverty. This information may be emotionally triggering as politically charged topics about systemic barriers may arise.

Procedures involved in the Research

I would like to invite you to attend an hour-long interview to share your experiences in responding to poverty as a social determinant of health. I am interested in learning more about how you define poverty as a social determinant of health. How you are able to address poverty when working with patients and families. What system pressures act as barriers in how you are able to respond to poverty? I would like to better understand how you connect addressing poverty to upholding social justice in front-line social work practice.

With your permission, the interview will be audio recorded and transcribed. I will be asking you basic demographic information such as: years of experience in the field. The interview will take place at a time and location that is convenient for you.

I am also asking your permission to a send you a summary of themes from my study, for your comments. You are free to decline and still participate in this study.

Potential Harms, Risks or Discomforts

The risks involved in participating in this study may seem minimal. Yet, there could be emotional and social implications such as: feeling uncomfortable with describing your experiences, you may find it stressful to remember an unpleasant event or experience. You might worry that your response reflects poorly on your work site or that specific statements you make may be tracked back to you. You may worry that punitive actions may result from your participation in this study.

I will take every precaution to ensure the confidentiality of any and all information that you provide. During private interviews, I can guarantee that your identity and those of the patients/clients you work will remain confidential. You do not need to answer any questions that make you uncomfortable or that you do not want to answer. You can choose to only participate in the personal interviews and decline receiving a summary from this study.

In terms of reporting the findings, every effort will be made to preserve your confidentiality. The information I collect about you (for instance, years of service and the place you work) will be used only to describe the sample, and not linked to any quotes of yours that I may use.

You can withdraw from the study at any time until July 1, 2014, without consequence. A final opportunity to withdraw is due to this being a Masters thesis project and my graduation is pending completion of this project.

Potential Benefits

It is my hope that through participation in this study you will be given the opportunity to share your concerns about poverty in our current economic and political climate. I hope that the information you share helps to improve the experience of patients and families in poverty and/or low income while in hospital settings.

Confidentiality

I want to assure you of the importance of confidentiality. Every precaution will be taken in this endeavor. Anything that I find about you that could identify you will not be published or told to anyone else, unless I obtain your permission. Information that you provide will be presented in a manner that is non-identifying and only relates to this study. I will ask other participants to respect your privacy should you choose to also participate in a focus group.

The information obtained by me will be kept on my person or in a locked file cabinet. It will only be available to my academic supervisor and me. The computer that I will be using is my personal computer which is password protected. Upon successful defense of my thesis the information you provide will be shredded, and audiotapes will be destroyed.

Participation and Withdrawal

Your involvement in this study is voluntary. If you agree to participate, you can decide to stop at any time, even after signing the consent form or part way through the study. If you decide to stop participating, there will be no consequences to you. In cases of withdrawal, any data that you have provided to that point will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, and you can still be in the study.

Information about the Study Results

I expect to have this study completed by September 2014. If you would like to receive a brief summary of the results sent to you personally, please contact me via my email address that has been provided.

Questions about the Study

If you have any questions or need more information about the study itself, please contact me at gittac@mcmaster.ca

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This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a

research participant, please call the Office of the Chair, HIREB at 905.521.2100 x 42013.

Consent

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study by Christina Gitta-Low, of McMaster University. I understand that I will receive a signed copy of this form.

1. I agree that the interview can be audio recorded. Yes / No

2. I agree to participate in an individual interview. Yes / No

3. I agree to be asked to review a summary of the study themes, which I understand I can decline. Yes / No

4. I would like to receive a summary of the study's results. Yes / No

   If yes, where would you like the results sent:

   Email:

   Mailing address _____
   _____
   _____

_____
Name of Participant (printed)

_____ _____
Signature Date

Consent form explained in person by:

_____
Name and Role (printed)

_____ _____
Signature Date

APPENDIX C: Semi- Structured Interview Guide

Interview Questions

This interview will discuss the experiences you have in frontline hospital social work practice. Questions will be about your experiences working with patients and families experiencing poverty, and the ways in which you are able to address poverty. I would like to learn more about the practical ways in which you are able to respond to poverty, as well as, learn about any barriers that impact your work. Some aspects of this conversation may be emotionally or socially distressing. Please feel free to share as much or as little as you are comfortable with.

How often do you support patients or families experiencing poverty?

Please describe how poverty impacts some of the patients that you work or have worked with.

Prompt: regarding discharge, medication, financial benefits etc.

When you are involved with patients or families experiencing poverty, how do you become aware of their experience?

For example, do other staff members send you a referral?

If social work is not involved with a patient that is experiencing poverty, what might be the implications?

If yes please expand

If no please expand

When you are involved with patients or families experiencing poverty, please describe the ways you are able to intervene and provide support.

Prompt: OW/ODSP/EI forms, shelter bed location, transportation, assisted living options, subsidized community beds etc.…

What might be the barriers that you address?

Prompt: systemic/personal labels

Have you found that there are hidden costs of healthcare?

If yes please expand

If no please expand

Please describe how poverty impacts patient discharge planning?

If yes how?
If no please expand

Does poverty impact care planning?
If yes please expand
In no please expand

What are your general observations about people affected by poverty and healthcare?
Prompt: for example, being homeless or lower-income and their situations when encountering the healthcare system

If a patient is homeless, how are you able to intervene in providing support?

Are there challenges in responding to poverty?
If yes please expand
If no please expand

Please describe any specific situations when you were able or unable to help?

How do you feel when you are able to meet patient's material needs that are related to experiences of poverty?

How do you feel when you are unable to meet patient's material needs that are related to experiences of poverty?

Please describe any hospital structural barriers that impact your ability to address poverty?
Prompt: managerialism, burden of tasks, cut backs etc.

What might be your suggestions for hospital social workers in supporting patient and families experiencing poverty?
If yes please expand
If no please expand

Is there anything you would like to add or anything I have missed that you would like to share in this topic?
(If applicable: free conversation directed by participant)

APPENDIX D- Oath of Confidentiality

Oath of Confidentiality

(*Check the following that apply*)
I understand that as:
[ ] an interpreter
[ ] transcriber
[ ] audio assistant
[ ] video assistant
[ ] research assistant
[ ] other (*Please specify*) _____

for a study being conducted by Christina Gitta-Low of the Department of Social Work, McMaster University, under the supervision of Sheila Sammon, confidential information will be made known to me.

I agree to keep all information collected during this study confidential and will not reveal by speaking, communicating or transmitting this information in written, electronic (disks, tapes, transcripts, email) or in any other way to anyone outside the research team.

Name: _____

Signature: _____

Date: _____

Witness Name: _____

Witness Signature: _____

Date: _____

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