CLINICAL SUPERVISION FOR HOSPITAL SOCIAL WORKERS

CLINICAL SUPERVISION FOR HOSPITAL SOCIAL WORKERS: PROMISE VERSUS REALITY

By

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A Thesis

Submitted to the School of Graduate Studies

In Partial Fulfilment of the Requirements

for the Degree

Master of Social Work

McMaster University

MASTER OF SOCIAL WORK (2009) McMaster University
Hamilton, ON

TITLE: CLINICAL SUPERVISION FOR HOSPITAL SOCIAL WORKERS: PROMISE VERSUS REALITY

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NUMBER OF PAGES: vi, 89

Abstract

Clinical supervision has long been a hallmark of social work practice, but recent changes to the practice context has threatened its survival. The changing face of social services, brought on by the growing neoliberal ideology in North America, has led to a drastic change in social work practice, and to the availability of clinical supervision. How well is undergraduate social work education keeping pace with the current practice reality?

This qualitative study involved an analysis of the introductory texts used at the schools of social work in Ontario, combined with interviews completed with five hospital social workers. The goal was to explore the notion of clinical supervision for social workers in hospitals, their current practice reality, and the message that is provided to new social workers through the introductory textbooks used in undergraduate programs.

The text analysis revealed that the discourse of available supervision is deeply imbedded in the materials used in introductory social work courses, and helps to set up an expectation about supervision as being both necessary and available in social work practice. The interview participants discussed a very different practice reality. In hospitals where program management has occurred, there is no formal clinical supervision available. These changes have led to feelings of isolation, regular use of informal consultation, an increase in unpaid work, and fears about the surveillance aspect of supervision.

The disconnect between the messaging available to students and the reality of social work practice in hospitals pointed to several important implications including: a need for hospitals to recognize the benefits of formal supervision; the suggestion to explore group supervision as an alternative; and a push for schools of social work to teach the reality of practice settings, and to continue to teach students to be self advocates for their own professional development.

Acknowledgements

I would like to express my thanks and gratitude to Sheila Sammon for her ongoing encouragement and insightful ideas that continually inspired me. I knew I was missing something without formal supervision in my workplace, so it was great to have the leadership and mentorship that can only come from this type of relationship.

The second invaluable piece of my supervision team was Jackie Fox who kept me sane and made me laugh, all while being the best supervision partner a girl could ask for. Jackie, we did it!

To my professors, Sheila, Jane, Roy and Bill who taught me to truly enjoy and revel in the luxury that is graduate school. I feel honoured to have completed this journey with such a dedicated faculty.

To my participants, who thoughtfully shared their experiences and helped to bring my ideas to paper. Keep up the great work that you do everyday in our hospitals. We are lucky to have you.

To my family, friends and coworkers who put up with me through a long two years where I continually felt that I could only do one piece of my life properly. Thanks for helping me to keep my priorities straight, and for your motivating words and forgiving nature. Extra special thanks to Mom, Dad, and Kaeli for your last minute edits.

And finally, thanks to my love. Nick you have been my partner, editing guru, and one-man cheerleading team for ten years. Thanks for going on this journey with me, and for giving up your dining room table for two years. You are my very best friend and I am blessed to have your love and support.

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Introduction

The current political and economic climate in Canada has had a detrimental impact on some aspects of hospital social work practice. The growth of program management in hospitals has led to a decrease in formal opportunities for clinical supervision, and as a result has led to feelings of isolation, loss of professional identity, and low morale (Aronson & Sammon, 2000; Berger & Mizrahi, 2001; Globerman, White, Mullings & Davies, 2003; Miller & Solomon, 2002). These impacts, documented in the literature, point to clinical supervision in hospitals as a pertinent area of study.

It is within this context that the question of role for profession-specific supervision arises. How are social workers maintaining their professional identity and skills without structures for formal clinical supervision in place? How has social work supervision been affected by the current political context? How are social workers coping with this change, and how are they obtaining support for difficult cases and emotionally draining experiences? These are some of the questions that I hoped to explore through my research.

Schools of social work have a responsibility to prepare social workers for the practice world, and a strong connection to the realities of practice is essential. Textbooks that are used by the schools have the weight of expert knowledge behind them, and the discourse that is used can provide a message for students. Implicitly imbedded messages can provide expectations about the availability of clinical supervision that may not be consistent with the current realities.

My personal experience, in the move from supervised field placements to work in a hospital without formal supervision, was an impetus for this study. I was surprised that the realities of practice were so far removed from my expectations as a student. I was intrigued to learn more about the experiences of other hospital social workers, and to have a chance to delve into the messages presented to students by schools of social work.

This research explores the current practice reality for social workers in hospitals, and the messages about supervision that are provided to new social workers though introductory textbooks used in schools of social work in Ontario. My goal with the research was to explore the relationship between the messages provided for social work students about the availability of supervision, and the current practice reality for hospital social workers. I hoped to hear from practicing social workers about the current practice reality in hospitals and their suggestions for schools of social work. The findings and analysis point to several important implications for social workers, hospitals and schools of social work.

Literature Review

Current Context of Social Work Practice in Hospitals

Program Management – The Impact of Neoliberalism and Managerialism on Social Work Practice in Hospitals in Ontario

The changing political and economic climate in Canada has had an important impact on social work in hospitals. The 1990s through to today have been characterized by many cuts to social services, including hospitals; and the resulting restructuring and downsizing has affected the environment for social work practice (Aronson & Sammon, 2000; Baines, 2004; Berger, Cayner, Jensen, Mizrahi, Scesny & Trachtenberg, 1996; Berger & Mizrahi, 2001; Brodie, 1999; Globerman, White & McDonald, 2002; Globerman, White, Mullings & Davies, 2003; Miller & Solomon, 2002; Ross, 1994). It was during this time period that the political movement known as neoliberalism began to grow in popularity in Canada. Neoliberalism "emphasizes the primacy of the capitalist market as the steering force in society, deregulation of the economy and the displacement of public goods onto the market" (Brodie, 1999, p. 38). The shrinking of governments and government-based funding resulted in an increase in private industry and the growth in the use of business models and business language in social services (Aronson & Sammon, 2000, p. 186; Brodie, 1999, p. 36; Lawlor, 2000, p. 46). Excellence and efficiency became new buzzwords, and they became imbedded in the social services (Brodie, 1999, p. 36; Stein, 2001). In order to ensure that these essential concepts were being achieved, there was a growth of managerialism.

Managerialism is defined as the belief that "services and assets initially created in the public sector are better delivered and maintained through market mechanisms and the price system" (Brodie, 1999, p. 40). The growth of managerialism led to an increase in privatization and regulation. Hospitals, along with other social services, were forced to examine the way they 'did business' and make changes based on the new dominant ideology. There was an emphasis placed on the increasing importance of placing management above everything else. Lawlor (2000) describes how managers were given increasing responsibilities (p. 37) and were asked to operate using private sector management techniques (p. 41). This move resulted in a shift away from individual professional autonomy to a 'managerial' model (Lawlor, 2000, p. 38) where there was an increased need to demonstrate authority, manage budgets, and provide performance appraisals of previously autonomous professionals (Lawlor, 2000, p. 46). Lawlor (2000) says, "one consequence [of this change] is increased tension between professionals and managers" (p. 49). In social work this has led to a change in the experience of supervision. The former clinical emphasis of supervision has been shifted to one of an entirely authoritative focus, which can lead to increased conflict between social workers and their managers. The reduction in social work-specific supervisors also compounds these tensions.

Managerialism and the neoliberal ideology also led to other changes that impacted social work practice, including an emphasis on increased accountability and the subsequent growth in surveillance of professionals in social services (Moffatt, 1999; Munro, 2004). The new political agenda questioned the financial sustainability of the

welfare state, creating fear about how it is properly managed. As a result, there was a demand for greater accountability from social services (Munro, 2004, p. 1077). This effort, to justify financial aspects of social services in this new political regime, necessitates the same sort of accountability that is required in private agencies. There is a belief that "taxpayers have the right to know their money is being spent economically, efficiently and effectively, and that citizens as consumers are entitled to monitor and demand certain minimum standards of performance" (Munro, 2004, p. 1077). The current political ideology supports the use of increased surveillance through regular audits and accounting for every decision that is made. The new emphasis towards client as consumer has required social work - along with other professionals - to constantly account for their choices and actions. A reduction in the availability of clinical supervision has led to social workers being entirely individually accountable without professional support.

As mentioned previously, hospitals have not been immune to the growth of the neoliberal agenda that emphasizes fiscal restraint and reduced structures through government funding cuts (Aronson & Sammon, 2000; Globerman, White & McDonald, 2002). In particular, many hospitals in North America have experienced amalgamations, and the collapse of operational structures resulting in the reduction of separate professional departments including social work (Aronson & Sammon, 2000; Berger & Mizrahi, 2001; Globerman et al., 2003; Globerman, White & McDonald, 2002; Miller & Solomon, 2002). The new system, known as program management, which developed as a move away from the traditional hierarchical system with profession specific departments,

is the new status quo in many hospitals (Miller & Solomon, 2002). Staff are now grouped along program lines and "professional accountability has shifted away from social work with increased reporting to nurse managers" (Globerman et al., 2003, p. 4). Studies have demonstrated some negative effects of program management on professions such as social work and physiotherapy, including decreased professional autonomy, increased isolation, (Aronson & Sammon, 2000; Berger & Mizrahi, 2001; Globerman et al., 2003; Miller & Solomon, 2002) feelings of loss of professional identity, (Aronson & Sammon, 2000, Miller & Solomon, 2002) and low morale (Miller and Solomon, 2002). There are also documented negative impacts on patient care including an emphasis on more administrative duties that take time away from front line practice, fewer standards of practice for each profession, and a reduction of professional development opportunities (Miller & Solomon, 2002).

Social workers are practicing without the support and education that had traditionally been available, and as a result there is the potential for decreased professional competency. It is ironic that a program and policy change that claims to be consumer-focused through its cost-effectiveness has actually been shown to negatively impact patients. The literature demonstrates that supervision for social workers benefits clients through the increased accountability and increased professional development of the worker (McCafferty, 2005). Increased competence and assistance through ethical dilemmas enable the social workers to receive feedback that could improve their work with clients (Rinehart & Graziano, 2004). These patient factors need to be considered when formal supervision is no longer available for social workers.

Supervision in Social Work

There is debate within the literature as to the definition of supervision, but the most readily accepted definitions suggest that supervision includes administrative, clinical, and educational functions (Holloway, 1995; Kadushin & Harkness, 2002; Shulman 1992). In traditional hierarchical agencies, a supervisor would take on versions of all three roles and would focus on leadership, mentorship, and increased skill development (Berger & Mizrahi, 2001, p. 2). Thomas & Spreadbury (2008) suggest that the "increasing dominance of managerialism in social work through audit, notions of 'best value,' and other bureaucratic tools has arguably had the effect of boosting the managerial function of supervision at the expense of its educational and supportive roles" (p. 253). This has resulted in a move away from the other very important areas of supervision.

For the purpose of my thesis, I am most interested in exploring the embattled educational and clinical supervision, also referred to in the literature as supportive supervision. The challenges that these forms of supervision are facing, in the neoliberal context, make it compulsory for the social work profession to continue to study them. In order to fight for its survival, it is essential that its value for practice is properly understood. Supportive supervision is described as "provid[ing] the psychological and interpersonal context that enable the worker to mobilize the emotional energy needed for effective job performance and obtain satisfaction in doing their job" (Kadushin & Harkness, 2002, p. 219). This emphasis on emotional energy and psychological impact is essential in social work because of the high levels of job stress and difficult client

experiences (Shulman, 1992, p. 27). It is important for social workers to receive assistance in mediating complex client situations with which they are faced. Supportive supervision acknowledges the personal, interpersonal, and contextual complexity of social work practice and works with supervisees to improve job manageability (Shulman 1992, p. 27). Clinical supervision is described by Hollowoy (1995) as "focus[ing] on the professional development of the supervisees' skills within the organization. Clinical supervision emphasizes the educational and supportive functions of the supervisory role" (p. 3). Many of the resources for supervisors involve strategies for assisting their supervisees to deal with trauma, feelings of disillusionment, and low morale (Kadushin & Harkness, 2002, p. 222; Shulman, 1992, p. 258). This acknowledgement of feelings, and ability to tune into the emotional experiences of supervisees is unique in clinical or supportive supervision (Caspi & Reid, 2002, p. 98 & Shulman, 1992, p. 96).

A supervisor's contribution to professional development for social workers includes the teaching of skills through modeling and advising, the translation of theory and research into practice, and guidance for self-evaluation (Holloway, 1995). Supervisors help to maintain standards of practice, and assist supervisees to carry out their work effectively (Brown & Bourne, 1996, p. 9). These features of clinical supervision all suggest that social work supervisors need to be social workers.

The literature implies that in order to teach skills and maintain standards of practice it is necessary for supervisors to have obtained this knowledge themselves. Authors describe a good social work supervisor as an experienced clinician with professional practice experience as a social worker, (Holloway, 1995, p. 1; Brown &

Bourne 1996, p. 20) someone who has been supervised themselves, (Brown & Bourne 1996, p. 21) and someone who understands the emotional impact of social work practice with clients (Caspi & Reid, 2002; Holloway, 1995; Kadushin & Harkness, 2002; Shulman, 1992). Supervisors need to have the ability to assist in translating theory and research into practice through the sharing of social work knowledge (Holloway 1995, p. 2; Shulman, 1992, p. 21). This description is contrary to the form of supervision that exists in the current program management system, which has removed the social work departments and instated managers without social work professional backgrounds. It is counterintuitive to believe that non-social workers would be providing the same clinical and supportive supervision that social workers would provide. This is not to say that there is no value to the support and supervision offered by professionals other than social workers. Clearly, individual managers can provide great support and leadership to any of the professions, and there may be many excellent managers working within the program management system. Nevertheless, there is still increased value to social workers engaging in clinical supervision, and therefore it is a worthy area of study.

Clinical supervision is also traditionally thought of as occurring in an individual one-on-one supervisor supervisee relationship (Caspi & Reid, 2002; Brown & Bourne, 1996; Holloway, 1995; Kadushin & Harkness, 2002; McCafferty, 2005; Shulman, 1992). It is viewed as a relationship-based model that involves regularly arranged meetings, and it is suggested that it is a resource that all social work staff are entitled to receive (Brown & Bourne, 1996, p. 9 & 15). In some social work settings, such as child welfare, supervision is not only an entitlement, but also a requirement of practice. This is

sometimes viewed as a criticism of supervision because of the potential loss of professional autonomy. A mandatory educational or authoritative use of supervision could "imply that the [social workers] are without authority to self-direct (Brashears, 1995). It is important to remember that a supervisor is meant to be "a more experienced professional [that] oversees the work of a less experienced professional with the objective of helping that person develop greater adequacy in professional performance" (Kadushin & Harkness, 2002, p. 129). The educational and teaching aspects of supervision should not inhibit the social worker's autonomy, but rather help to increase their confidence and independence as practitioners. One way that this is accomplished is through the application of adult learning theory.

Adult learning principles support clinical supervision, and guide the teaching process involved in supervision (Brown & Bourne, 1996, p. 14; Kadushin & Harness, 2002, p. 189; McCafferty, 2005). The belief is that adults learn best when they can choose a specific area of focus and can design an individual learning plan that fits their skills and learning needs (Brown & Bourne 1996, p. 14; Kadushin & Harness 2002, p. 189). Educational supervision is defined as "teaching the worker what he or she needs to know to do the job and helping him or her to learn it" (Kadushin & Harkness, 2002, p. 129). The on-the-job training and support provided by educational supervision is invaluable. A study by Demartini and Whitbeck (1987) found that supervision was more effective than graduate school in determining how social workers used the knowledge that they received.

While individual supervision is described as the historical norm, there is also a growing literature that describes the methods of group style supervision (Browne & Bourne 1996; Holloway 1995; Kadushin & Harkness, 2002; McCafferty, 2005; Rinehart & Graziano, 2004; Shulman, 2002; Sulman, Savage, Vrooman & McGillivray, 2005). This involves having a supervisor providing supervision to a group of social workers at one time (Kadushin & Harkness, 2002, p. 390). The literature documents both benefits and disadvantages of this alternative model for supervision. Benefits of using group supervision include the fact that it helps to decrease feelings of isolation, (McCafferty, 2005; Sulman et al, 2005) helps to provide opportunities for mutual support, (McCafferty, 2005; Rinehart & Graziano, 2004; Sulman et al, 2005) and requires fewer administrative costs and time (Kadushin & Harkness, 2002). It can also be less intimidating for some workers in comparison to a one-on-one relationship (Kadushin & Harkness, 2002). There are also some disadvantages that include less individual attention and more problems maintaining confidentiality, (McCafferty, 2005) the potential for peer competition and less individual responsibility for learning (Kadushin & Harkness, 2002). While there are documented disadvantages of this form of supervision, the cost-effective nature of group supervision alone makes it an important area to explore in the era of neoliberal cutbacks in social services.

With these definitions in mind it is important to examine the literature around social work education, and to explore the ways that supervision is taught to social work students. What is the traditional model for social work education? Are social work schools explicit in their instruction about the expectation of available supervision in

future practice, or is it more embedded in the discourse that is used in the courses and field education? These questions helped to guide my literature review by encouraging me to explore the current model for social work education.

Social Work Education – Using Components of Adult Learning Theory

As mentioned previously, adult learning theory is an essential component of supervision, but it is also a central theory to explore in relation to social work education in general. A traditional model of formal education and learning is one that involves an educator or leader who has the role of planning, implementing, and evaluating all the learning that takes place (Merriam & Caffarella, 1991, p. 24). Traditional lecture-style courses with the use of academic textbooks are an example of this form. While universities still engage in components of this traditional model, alternate models have also gained popularity that acknowledge the uniqueness of adult learners (Merriam & Caffarella, 1991). One of the best-known models is Knowles' *andragogical model of instruction* (Knowles, 1980). Knowles' model involves small group work, where the instructor is still responsible for facilitating, but the individual adult learners take the responsibility for all areas of their education including planning, carrying out research, and evaluating their own learning (Knowles, 1980). This model is focused on self-directed learning, which is a growing field in the area of education (Merriam & Caffarella, 1991). Although not purely self-directed, the growing use of seminar-focused classes in social work schools can be thought of as using similar principles of adult learning. Both lecture and seminar teaching are utilized in within schools of social work in order to teach social work theories, principles, and substantive topics. Discussions of

supervision tend to be more implicit in these courses through the use of textbooks that talk about supervision.

The other essential component of social work education is the field placement. Within this model of education, supervision (often called field education or instruction) is built-in and therefore experienced by students as an essential part of practice (Canadian Association of Social Work Education (CASWE), 2008).

Learning is viewed as a process and several models have also been described to explain the way that people learn (MacKeracher, 1996). Kolb's Learning Cycle (Kolb, 1984) is one such model that is commonly used and is a good fit for understanding the field component of social work education. The model involves four stages; concrete experience, reflective observation, abstract conceptualization, and active experimentation (Kolb, 1984). The experiential component of social work education is an important focus of the bachelor of social work (BSW) degree program. Social work students go through Kolb's stages in their field placements by experiencing practice first hand, engaging in reflective observation with their supervisors, conceptualizing new ideas to try in their approach with clients, and then actively using their ideas at their next opportunity. Bogo & Vayda's (1998) seminal work on field instruction provides a similar model known as the Integrating Theory and Practice (ITP) model. The ITP model includes going through the following stages: *retrieval* of information; *reflection* on the information that they gathered; *linkage* of theory to practice; and implementing their *professional response,* which includes taking action (Bogo & Vayda, 1998). These methods, which are used by schools of social work to teach supervision within the field instruction context, allow

social workers to learn strategies that can be used to continue their professional development in their practice. They make the teaching about supervision explicit to students, and these models can impress upon students the to desire to continually learn and process their learning in their practice. This is a positive aspiration to have, but it could lead to expectations that formal supervision will be readily available in the practice context, and this is not the case in all settings.

Schools of social work offer a variety of learning opportunities for students using a range of methodologies. For the purposes of my thesis, I am most interested in learning about the ways that supervision is taught both through implicit messages in textbooks and explicit demonstration in field education. These varying methods can both impact the future social workers as they enter the practice world.

Maintaining Standards in Social Work Education – Accreditation Review

One way of ensuring that professional educational standards are maintained and consistent between different schools of social work is through accreditation review. These forms of reviews demonstrate the areas of education that are given weight as important areas to focus on and the schools need to ensure that they are meeting the standards and expectations that are set up for them by the accrediting bodies. Schools of social work in Ontario undergo an accreditation review by the Canadian Association of Social Work Education every two, four, or seven years depending on the type of accreditation status awarded (CASWE, 2008). The assessments for the BSW program include a focus on six key areas: mission statements; structure, administration, governance and resources; faculty and professional staff; students; curriculum standards;

and field education standards (CASWE, 2008). In the area of field education, students are required to complete a minimum of 700 practice hours, which includes mandatory field supervision (CASWE, 2008, SB 6.2 and SB 6.5, p. 9). The emphasis placed on field education, which includes a requirement for supervision, demonstrates the importance of this area in social work education. Along with the requirements for practice hours, there is also a requirement for the professional background of the field instructors.

> "The field education component shall provide students with a field instructor with social work qualifications, or where this is not possible the school will ensure social work faculty involvement in field supervision" (CASWE, 2008, SB 6.13.2, p. 10)

The requirement to have a social worker either in the field or within the faculty to provide field supervision demonstrates the accrediting body's expectation that social work supervision is provided best by social workers. This expectation during education could also set up future social workers to expect this same type of profession-specific supervision when they enter the practice field after graduation.

Link Between Academia and the Practice World

The literature that focuses on the changing context of social work practice in hospitals describes a gap between practice and academia, and critiques the schools of social work for being disconnected to the field (Browne, Smith, Ewalt & Walker, 1996; Ross, 1994). Ross (1994) describes a widening gulf between the universities and the field of health social work. "It is imperative for curricula to keep pace with the changes in practice and for faculty to remain connected to those who are working in the field" (Ross, 1994, p. 154). As hospitals continue to experience changes related to

neoliberalism and reduced government funding, it is imperative to strengthen the ties between educational organizations and the field. It will be important for the curriculum offered to future social workers to be relevant and effectively linked to the field (Browne et al., 1996, p. 268). My research seeks to explore this phenomenon in detail, and to assist in providing insight from the practice field to aid in increasing the relevancy of current social work education related to clinical supervision.

Organizational Background

Brief Historical Overview of Research Site

Department VS. Program Management

The literature review details the shift in Canadian hospitals from a department-based model of management of professions to program management, where each individual program manages a group of staff from a range of professional groups. This shift also occurred at the organization where I completed my research. Some of the participants in my study have worked within both models, and as a result a brief description of the local historical changes will be provided here to provide some context to the experiences detailed later by the participants.

Social work professional practice during the department-based era included a model where senior social work staff provided formal supervision in a variety of ways to a small group of four to five social workers. These supervision groups would have monthly team meetings that included group discussions and case sharing; monthly staff meetings for all staff; and monthly one-on-one meetings between individual staff and the supervisor. In addition, each month one of the supervision groups would take the lead on

putting on social work rounds, where educational information was presented to the larger group. Due to their connection to, and management by, the Social Work Department, the staff were freed up to attend these educational and supervisory events (L. Issenman, personal communication, April 20, 2009).

In the mid 1990s, a group of four separate hospitals in the city amalgamated to create the larger corporation that still stands today (L. Issenman, personal communication, April 20, 2009). At this time, the departments experienced the growing pains of program management, mergers between hospitals, and a time of significant downsizing across the organization. Union issues and a change in the professional practice model had a significant impact on social work. Originally in program management, profession representation was maintained through the role of a professional lead. This role was only twenty percent of a full time equivalent position, and did not have additional money or coverage available. Since that time, the professional role has grown and developed to include a fulltime senior leadership position for each of the professions.

Social Work Professional Practice at the Research Site – Current

Currently, the leadership of the social work group at the research site includes one formal senior leadership role, namely the Chief of Social Work Practice. This role includes advocacy-related responsibilities for the social work profession in the area of strategic planning, quality patient care and service, education and research, human resource management, fiscal management, and communications (Hamilton Health

Sciences (HHS), 2004). This role does not include formal clinical supervision of staff, nor does it include managerial responsibilities over staff.

The Social Work Mentoring Program was created by a group of social work staff in order to facilitate connections between new staff and more experienced social workers.

> "The program is intended to help the Mentee identify with the profession within [the group of hospitals] and provide opportunity to discuss job related issues, career concerns, as well as dealing with the challenges and demands of the social work profession" (HHS, 2005).

The goal is to have all new social work staff connected with a mentor and to meet for at least a year. This program is entirely voluntary for both mentor and mentee. I will discuss this program further in my discussion as some of the participants commented on the program.

The second forum for professional practice issues is the Social Work Professional Practice Council. This is a social work committee comprised of twelve social work staff and the chief of practice, that describes itself as aiming to,

> "develop, implement, and evaluate annual strategic plans for social work, which will promote best practices that are patient and family centered, responsive to professional and legislative standards, supportive of quality of work life, and embrace a spirit of practice excellence" (HHS, 2007).

Membership on this council is entirely voluntary, and new members are identified based on a yearly call for volunteers.

The social work team at the research site has also developed a list of Social Work Resource Consultants, that can be used as a resource for other social workers when they need assistance in dealing with clinical issues (HHS, 2008). The list details specific

clinical issues and the various social workers on site that have experience or expertise in this area. Social workers were invited, again voluntarily, to sign up for certain issues.

Needless to say there have been significant changes to professional practice for social workers at my research site. This historical background and description of current practice provides the context for my study, and will be referred to later in discussion by some of the participants.

Methodology

Goal of the Study

The goal of this study was to explore both the notion of clinical supervision for social workers in hospitals, and the message that is provided to new social workers through the introductory textbooks used in BSW programs. It also explores the current reality of supervision that the social workers experience in their practice in hospitals. My central research question was two-fold. Does the current BSW education provide future hospital social workers with expectations about clinical supervision that are not readily available in the practice world? And, in the current context of program management, what are social workers in hospitals doing in order to obtain some form of clinical supervision? In order to answer these questions, I used a combination of qualitative methods. First, I completed an analysis of the social work practice textbooks used in the schools of social work in Ontario, looking for discussions of supervision. Second, I completed qualitative interviews with social workers at an organization consisting of group of six teaching hospitals in a city in southwestern Ontario. I hoped to learn what the social workers expected in terms of supervision, what supervision looked like to them in the current health care context, and what they wished they knew prior to starting to work in the hospital. My goal with the text analysis was to learn about what information is actually provided for future social workers, and to explore a more implicitly imbedded discourse of supervision.

Theory and Epistemology

This study utilizes a social constructionist theoretical approach combined with a Critical Social Science (CSS) epistemology (Neuman, 1997). Both approaches will be described here in detail. First, I was interested in learning about the ways that social workers and schools of social work construct meaning related to supervision and social work practice. As a result, social constructionism seemed to be a natural fit. Authors differ in their descriptions of social constructionism (Burr, 2003; Gergen, 2001; Shotter, 1993). I have chosen to use the concept as described in detail by Burr (2003). Burr states that one of the main concerns of social constructionism is a "critical stance towards taken-for-granted knowledge" (p. 13). This theory encourages scholars to question what they have always known to be true, and to look more deeply into commonly held beliefs to see how social phenomena are created and institutionalized (Burr, 2003). In my research, I chose to examine the issue of clinical supervision in social work and to explore what social workers in hospitals believed about this issue. The commonly held belief in social work practice and education, as demonstrated by popular language and teaching methods, is that clinical supervision is alive and well, and essential, in social work practice. I questioned whether this was the case, and wanted to know more about what clinical supervision looked like to social workers in hospitals and how this affected their practice experience. Was the commonly held belief the reality for hospital social workers? How did the potential rift between this belief and reality affect the social workers? What meaning did the social workers attribute to clinical supervision (or the lack of it) in their practice?

Historical and cultural time periods and their impact are important areas to attend to when using the social constructionist theoretical lens (Burr, 2003, p. 14). The context in which research is being completed must be examined. The increased managerialism in institutions during the last fifteen to twenty years has had a significant impact on work in hospitals as well as on academic centres. As a result, this was a vital area to delve into when thinking about my analysis. How does the current context of Ontario in 2009 affect my participants, their education, and their workplaces?

Burr (2003) also states that knowledge is actually created and sustained through interactions people have with one another in their environment. This can be done through conversations, written text, and other modes of communication. I chose to combine interviews with a text analysis in order to look at a few different ways that the knowledge related to clinical supervision is constructed. The interviews allowed me to hear directly from practitioners about their experience and understanding of clinical supervision in their practice contexts. The text analysis allowed me to examine the actual language that is used in schools of social work to teach about clinical supervision. The fact that the texts are chosen and used by schools of social work implies that they are presented as expert knowledge, and this puts another layer of context on the constructionist analysis.

In combination with my social constructionist lens, I also chose to employ Neuman's (1997) critical social science epistemology (CSS). Neuman (1997) lays out three approaches used in the social sciences to help guide research: positivist, interpretative, and critical social science. They are described as "different ways of

looking at the world – ways to observe, measure and understand social reality" (Neuman, 1997, p. 62). The approach that seemed to most fit my orientation as a researcher is the critical social science approach. Neuman (1997) says that "critical researchers conduct research to critique and transform social relations…The critical social researcher is action oriented. He or she is dissatisfied with the way things are and seeks dramatic improvements" (p. 74). I believe that this is exactly why I chose to do the research. I was interested in critiquing the current system and offering practical suggestions about how to make change for the better. "CSS says that people are constrained by the material conditions, cultural context, and historical conditions in which they find themselves" (Neuman, 1997, p. 77). This demonstrates the importance of describing and analyzing people within the context that they live and work. For example, as discussed previously, describing the context of neoliberal reforms and program management in hospitals is absolutely essential for being able to understand where the participants are coming from, and being able to understand the reality in which they are situated. In my research, I wanted to learn about how people were coping within the current context, and discover the ways that they were making changes to thrive within this reality.

The combination of social constructionism theory and critical social science epistemology allowed me to gain a rich analysis of the important themes emerging in my research. These lenses provided me with a solid theoretical foundation to guide my analysis.

Methodology

I chose to use a qualitative methodology for several reasons. The very nature of the social constructionist approach, including its emphasis on discourse and examination of social encounters, lends itself well to qualitative methods (Burr, 2003, p. 35). This approach puts an emphasis on detail and working through a particular issue in depth (Johnson & Waterfield, 2004). I was interested in the rich narrative detail that can be gained by qualitative methods such as interviews and text analysis, and it felt like a good fit. Another strong feature of qualitative research that was also quite appealing was the "capacity to allow [the] assessment of researchers' subjective experiences and their impact on the setting" (Gribich, 1999, p. 8). My insider status in my research setting had important implications that will be discussed later in this chapter.

I chose to combine the interviews with a text analysis in order to look at the actual words that are provided for social work students. The power of language and discourse has been discussed many times, especially within the social constructionism literature. Burr (1995) says "the way people think, the very categories and concepts that provide a framework of meaning for them, are provided by the language that they use. Language therefore is a necessary pre-condition for thought as we know it" (Burr, 1995, p. 7). If language shapes our thoughts, then it is important to see what words and descriptions of supervision are provided for social workers in the texts used in BSW programs. The words that are provided in texts are given the status of expert knowledge, and direct the way that social workers think about and plan for their practice. Overall, qualitative

methods were a good fit for my study and allowed me to explore the issues of clinical supervision in hospitals in depth.

Locating the researcher

An important feature to attend to in qualitative research is the notion of reflexivity (Mays & Pope, 2000). While it is a strength of the qualitative approach, it is necessary to be sensitive to the impact of the researcher on the study, and be explicit about the ways that the researcher can shape the study through biases and assumptions (Mays & Pope, 2000, p. 51). In order to do so, I wanted to explore my dual status as a researcher and employee in my setting. As an insider in the large organization where I completed my research, it was impossible to remove myself entirely from the research, but I believe that there were many strengths resulting from my inclusion in the process. The use of qualitative methods allowed me to analyse the unique impacts of my experience on the study. In particular, my insider status, as a social worker in the hospital where the participants also worked, raised an important question for my study. How would this privileged, yet potentially contentious, insider status affect my experience with the research?

There are several benefits to researchers having an insider status including ease of obtaining participants, ability to engage and establish rapport with participants, and the ability to formulate questions that are relevant to the group (Lasala, 2003). That being said, there are also some potential limitations, including missing out on important themes that appear obvious, or projecting the researcher's own ideas about similar experiences onto the responses by participants (Lasala, 2003). There are several areas that could have

been affected by my insider status that required some forethought. For example, how would my position as an insider affect pragmatic things like ethics and participant identification? Would it be ethical for me to interview social workers that work in the same organization as me, and if so, would they be comfortable talking with me about potentially contentious issues? Secondly, would my insider status allow me to get at deeper issues more quickly because I understand the workplace and the tensions that exist, and could be seen as an ally, or would it cause me to miss important pieces of analysis because I am too connected? Also, I found myself wondering how the results I gather and share broadly would affect my working relationship with social work administration at my place of work, particularly if the research uncovers some negative feelings amongst the staff?

I was pleased to discover that overall my insider status appeared to be a benefit. I found that the participants were comfortable engaging in frank discussions, and my role within the organization did not seem to impede any of the interviews. The participants seemed comfortable discussing their experiences in the hospitals, and did not seem to hold back in bringing up contentious issues. I also found my insider status to be a benefit because I was able to understand the colloquial language that was used, without the need to ask for any further clarification that may have interrupted the flow of the interviews. I felt that it was easy to gain rapport with the participants, as they seemed to view me as one of them. There was however, one incident in the interviews, where I felt that my insider status had a restrictive impact, and this will be discussed in the limitations chapter.

The ethical issues that I anticipated based on my status as an insider were raised by the Research Ethics Board, and will be discussed in detail later in this chapter. Although some modifications to my original study plan were made, they did not negatively impact my recruitment or my research.

Study Design

Sampling

In order to obtain my sample of interview participants, I used a judgmental purposive sampling strategy, which allowed me to target participants who fit into my criteria (Kreuger & Neuman, 2006). Using a purposive sample is described as "selecting cases with a specific purpose in mind" (Kreuger & Neuman, 2006, p. 211). This type of sampling is considered acceptable in qualitative research because the goal of the research is to explore a few cases in depth, rather than to obtain a fully representative sample (Kreuger & Neuman, 2006, p. 211). My sample was also considered a convenience sample, which is defined as a sampling strategy where potential participants "volunteer, are self-identified by advertising, or are recruited by a third person" (Munhall, 2007, p. 531). I relied on potential participants to volunteer for the study by responding to an email sent out to the social workers at Hamilton Health Sciences. In particular, I chose to direct my recruitment at social workers that graduated no more than fifteen years ago from a BSW program in Ontario. It was important for me to have this exclusion criteria because I wanted to gain a deeper understanding of the experience of social workers in hospitals who remembered the BSW curriculum well enough to comment on it. My original goal was to recruit a sample size of approximately four to eight participants. I

chose this sample size in order to keep it manageable for my thesis, while still providing me with a variety of experiences from which to draw on for my analysis.

In order to obtain my sample for the text analysis, I completed a search of the websites of the nine accredited undergraduate schools of social work in Ontario, namely Carleton University, McMaster University, Kings College – University of Western Ontario, Lakehead University, Laurentian University, Renison University College – University of Waterloo, Ryerson University, and York University. I searched for the course outlines of introductory social work practice and / or interviewing courses. From these course outlines, I found textbooks that were used for each course and I requested them through the interlibrary loans system. I made the decision to exclude any texts that were a collection of readings, rather than a textbook, because they would not be available to me via interlibrary loans. I chose to include the textbooks from all of the schools of social work in Ontario in order to obtain a complete sample. I decided to use the introduction to social work practice courses because they provide a foundation for the students in the BSW programs. I believed that the way the schools of social work choose to introduce social work practice speaks volumes to the students about what to expect in their social work practice careers.

Recruitment

In order to obtain my sample for the interviews, I used a passive recruitment strategy. In particular, I asked an administrative assistant in the Professional Affairs department, with access to a group distribution list, to send out an email with an attached information letter written by myself to all the social workers working at the group of

hospitals (see Appendix B). The email directed those who were eligible and interested in participating in the research to contact me directly. This strategy ensured that I would hear from the potential participants who were interested in participating without requesting a response personally. This was particularly important in this study because I work in one of the hospitals and could potentially know or work with future participants. In order to avoid any feelings of coercion, I choose this type of recruitment strategy so that the potential participants heard about the study from a neutral third party, rather than myself directly. This was an important ethical concern for my study, that I had anticipated as a result of my insider status, and one that the Research Ethics Board (REB) had apprehension about. The REB asked me not to recruit social workers from my own site and as a result, I had to limit my recruitment to the other five hospitals within the organization.

Ethical Considerations and Informed Consent

Prior to the interviews, I sought informed consent from the participants. One of the guiding ethical principles in research is the respect for free and informed consent (Canadian Institute of Health Research, Natural Sciences and Engineering Research Council, Social Sciences and Humanities Research Council (CIHR, NSERC, SHERC), 2005, p. I.5). I created a participant information sheet and consent form that covered important details in clear and understandable language, such as the purpose of the study, the nature of the study, the requirements of the participants, the potential risks and benefits for participating, and the permission to withdraw from the study at any time (see Appendix C). It is important to remember that informed consent is an ongoing process

(CIHR, NSERC, SHERC, 2005, p. 2.1). I continued to assess consent through all stages of the research. For example, I was careful to assess if the participants were feeling anxious during an interview, and I was ready to remind them of their rights to refuse to answer a question, or withdraw from the study, and offer to turn off the tape recorder. None of the participants chose to refuse to answer a question or withdraw from the study.

Instrumentation

I completed semi-structured qualitative interviews with the five participants, with the use of an interview guide (see Appendix A). The interview guide was divided into five sections including demographics/experience, definitions and types of supervision, use of supervision, structural issues, and BSW education on supervision. Each area was covered in all of the interviews, but the order that the questions were covered varied depending on the participant. The goal of the interviews was to engage in a frank conversation about the issues related to supervision, and I allowed the conversation to flow in an order that was comfortable to the participants. With each interview, the interview guide developed, and additional areas were covered, in the subsequent interviews. This is a strength of the semi-structured interview guide. In this way, the data analysis began during the interview phase, and themes began to emerge and continued to be enriched with each interview.

Data Collection

In order to obtain the data from the interview portion of my study, I recorded the interviews, with the participants' permission, using a digital recorder. Following

completion of the interviews, they were transcribed word for word by a professional transcriptionist, who had signed a confidentiality agreement (see Appendix D).

In order to obtain the specific qualitative data from the textbooks, I scanned the textbooks using a set criteria including the following questions: Is the term supervision or consultation located in the index or glossary? Is there a chapter on supervision? Are the following issues discussed: ethical dilemmas or decision making; debriefing; burnout/self care; self-awareness? If those issues are discussed in the textbook, is supervision mentioned? Any reference to supervision in these sections was marked and copied verbatim for future analysis.

Following this systematic review of the textbooks I scanned the entire textbook again, looking for any other direct reference to the word supervision in any other areas of the text. Any reference that I found using the two scans was marked and copied verbatim. These segments of text from the books made up the qualitative data that I analysed for this portion of the study.

Data Analysis

I chose to complete a thematic analysis of my data. This is one of the most popular forms of analysis used for qualitative studies in the health care field (Pope & Mays, 2006, p. 69). Thematic analysis involves a detailed examination of the transcripts from the interviews searching for reoccurring themes and categories, including those that I identified prior to the study through my literature review, those that arose during the interviews, and those that arose during the analysis phase (Pope & Mays, 2006, p. 70). In particular, through my literature review I was able to anticipate some themes surrounding

the notion of the changing context of health care, and the effects of program management. Also, the idea of non-social work professionals providing supervision, and the varying forms of supervision that are now available (including informal consultation by peers, and group supervision) were potential areas of focus. The literature describes this as the changing face of supervision in hospitals, and I was interested to see if the results of my study pointed to similar experiences. I also anticipated finding some themes that had not been written about before.

In order to identify additional themes, I completed a coding process following the transcription of my interviews. Coding assists with data management and analysis by assisting with developing themes from the original data (Kreuger & Neuman, 2006, p. 437). This allowed me to reduce the long transcripts into smaller more manageable pieces of data (Kreuger & Neuman, 2006, p. 437). I began by performing open coding, which involves reading through the transcripts, searching for themes and coming up with initial codes (Kreuger & Neuman, 2006, p. 438). This initial coding also helps to begin the analytic process.

I then engaged in a process of axial coding, which helped to streamline my thoughts by focusing on the initial codes rather than the entire transcripts (Krueger & Neuman, 2006, p. 439). It also assisted with data management, because I was looking to see if the original codes could be divided or combined with others to refine my codes and reduce the data I needed to go over (Kreuger & Neuman, 2006, p. 439). Finally I used selective coding to go through the data and find the cases that demonstrated the themes and codes I had found in the earlier stages (Kreuger & Neuman, 2006, p. 439). Once my

data was fully coded, and organized by themes, I began my analysis using the social constructionist and critical social sciences theoretical and epistemological lenses. The following chapter details my findings and analysis.

Findings and Analysis

Text Analysis

My goal with completing the text analysis was to explore the messages about supervision that are being presented by schools of social work through their use of textbooks. I was interested in seeing how the concept of supervision was presented to the reader, and to explore the potential impact on social work students. I was also interested in comparing the way that supervision is described, to the experiences of my interview participants. I collected the textbooks from eight of the nine schools of social work in Ontario. See Table 1 below for a list of the texts, and the corresponding schools of social work, that were obtained for the text analysis section of my study.

Table 1: Introduction to Social Practice / Interviewing Skills Courses in the BSW Programs in Schools of Social Work in Ontario.

Textbook	Schools of Social Work (Course Title)
Hepworth, D. H., Rooney, R. H. and J. A. Larsen (1997). *Direct Social Work Practice: Theory and Skills* (7th ed.). California, CA: Brooks/Cole Thomson Learning.	McMaster (SW 2A06)
Cournoyer, B. (2001). *The social work skills workbooks (3rd ed.).* Scarborough, ON: Brooks/Cole Thomson Learning.	McMaster (SW 2A06) Windsor (47-211)
Healy, Karen (2005). *Social Work Theories in Context: Creating Frameworks for Practice.* New York, NY: Palgrave.	York (SOWK 5010) Ryerson (SWP 331)
Shebib, B. (2007). *Choices: Interviewing and counselling skills for Canadians* (3rd	Lakehead (SOWK 3315) Carleton (SOWK 3201)

ed.). Toronto, ON: Pearson Prentice Hall.	
Kirst-Ashman, K., & Hull G. (2006). *Understanding generalist practice (5th ed.).* Belmont,CA: Brooks/Cole Thomson Learning.	Kings College (Social Work 2204) (University of Western Ontario)
Carpetto, G. (2008). *Interviewing and brief therapy strategies. An integrative approach.* Boston, MA: Allyn & Bacon.	Laurentian (SWRK 2315)
Collection of Readings *** (excluded from the study)	Renison University College (SW220R) (University of Waterloo)

Using a tool that I developed and described in the methodology section, I completed a systematic scan of the textbooks looking for specific references to supervision. See Table 2 below for results.

Table 2: Systematic Review of Textbooks for Direct Reference to Supervision

	Hepworth et al McMaster	**Cournoyer** McMaster Windsor	**Healy** York Ryerson	**Shebib** Carleton Lakehead	**Kirst-Ashman** Kings College	**Carpetto** Laurentian
Chapter on Supervision						
Supervision in glossary or definitions						
Supervision in index					X	
Consultation in index	X				X	
Debrief in index	X	X	X	X	X	
Direct reference to supervision (word)	X	X	X	X	X	

Implied reference to supervision	X	X	X	X	X	
Debriefing	X			X	X	
Supervision mentioned?	X			X	X	
Ethical dilemmas/ decision making	X	X		X	X	
Supervision mentioned?	X			X	X	
Self-Awareness	X	X	X	X	X	
Supervision mentioned?	X			X	X	
Burn out / Self care	X			X		
Supervision mentioned?	X			X		

As seen in the chart, none of the textbooks have a dedicated chapter on supervision, or a reference to supervision in the glossary. Only one textbook has supervision listed in the index. I chose to examine the index and glossary in the texts to see if the message about supervision was explicitly presented to the reader as a key topic. I was initially surprised to see little direct reference in each index, because I believed that the message about supervision was prevalent in the texts. As I moved to a more detailed search of particular subject areas including debriefing, ethical dilemmas and decision-making, self-awareness, and self-care, I began to see the more implicit mentions of supervision. While none of the textbooks pointed out sections on supervision to the reader, all but one of the textbooks, representing eight out of nine schools, made direct

reference to the word supervision as well as reference to many of the features of supervision without using the exact word. This implicit imbedding of supervision demonstrates the prevalence of the topic in the social work textbooks, and the inherent acceptance of the topic as a common part of social work practice. Since there is no need to call direct attention to it, perhaps one can assume that supervision is perceived as a commonly used term and it does not need detailed description.

I was particularly interested in the language that was used by the authors to describe supervision in the texts. My social constructionist lens directed me to pay careful attention to the language that was used because of the importance of discourse in impacting thought and belief (Burr, 2003). I began to notice terms like essential, important, and necessary being used to describe supervision. The following few quotes demonstrate this language. "Work colleagues and supervisors are *essential* for helping counsellors manage their emotional reactions to clients, such as fear and anger (Shebib, 2007 p. 26). [emphasis added] "In such instances [value conflicts with clients] it is *important* to acknowledge such feelings and to explore them through supervision or therapy" (Hepworth, Rooney & Larsen, 1997, p. 65). [emphasis added] "Until counsellors have received the *necessary* training and supervised practice, they should not work in specialized areas of practice, such as interviewing children in abuse situations or administering or interpreting psychological tests" (Shebib, 2007, p.47). [emphasis added] In these instances, supervision is described as *essential* to help manage emotions and feelings, and even *necessary* to work in certain areas of practice. The language that is used strongly implies that supervision is an important and available piece of social work

practice. If it was not readily available, terms such as *necessary* and *essential* should not be used to describe its importance.

The belief that supervision and social work should be closely intertwined is demonstrated very well by the following quote from one of the textbooks. "Part of working as a generalist practitioner involves receiving and using supervisory input appropriately" (Kirst-Ashman & Hull, 2006, p. 8). This simple description can impact students significantly by stating that part of social work involves using a supervisor. This raises questions such as: what if you do not have a supervisor available to you? Does that make you a bad social worker?

One thing that I did notice is that several of the references to supervision or supervisor included an apparent qualifier statement that identified supervisor or colleague. This helps to lessen the impact of the need to have a specific designated supervisor. This could have been a way for the authors of the textbooks to present the fact that not all social workers will have access to supervision, but it is not possible to know if this was their intention. This type of qualifier was not used in every reference to supervision so the probability still exists for new social workers to expect supervision.

I also knew that it was important to examine the historical time period in which the textbooks were written. The textbooks' publication dates ranged from 1997 to 2008 and were all being used in schools of social work in Ontario during the 2008 to 2009 school year. They were also all published within North America. This contextual information gives the reader some more background to consider when examining the texts. For example, in the context of this study, the dates demonstrate that they were all

written or updated in a time period where the neoliberal agenda was present, and where the changes that are detailed in the literature review, including cuts to social services and a change to program management in hospitals, had already occurred. This is important because I was concerned about the messages provided by the current schools of social work to their students through textbooks. This message is still being presented to students today despite the documented changes in social work practice.

One of the textbooks, namely the text by Carpetto (2008), which is used at Laurentian, did not include any direct or implied reference to supervision. This book was different from the other books in many other ways as well. Its emphasis appeared to be on exploring specific therapy strategies in detail. The other textbooks all included a more broad how-to approach for new social workers, and explored all aspects of practice for new practitioners. This book seemed more targeted at current social workers interested in learning about specific approaches in more detail, rather than new learners in need of a general overview.

Social constructionist theory seeks to explore the way that knowledge is created and institutionalized (Burr, 2003). One way that this is done is through the production of language and discourse, and its inherent ability to become a part of our every day usage, without us questioning its presence. As language becomes commonplace and imbedded in our social worlds, the impact can be an internalized belief (Burr, 2003). The textbooks used in schools of social work are one of many tools used to teach new social workers about practice. The language that is used in the textbooks that I examined provide new social workers with certain expectations about what is required of them in

their practice, and also what to expect when they enter the workforce. The fact that they are the textbooks used in introductory social work practice courses provides them with the added weight of expert knowledge. This can heighten the impact of the content for the reader. The impact of language such as *necessary*, *important*, and *essential* could influence social work students by providing them with false prospects about what is available in the practice world, and increasing fears of inadequacies if they begin work in an area where supervision is not readily available. This is an important area of analysis to share with schools of social work. Shera & Bogo (2001) state "schools of social work have a responsibility to be responsive to the changing needs of the social service and health service communities, as well as to the realities and constraints of everyday practice" (p. 200). As experts and mentors for new social workers, the schools need to be aware of the message that is being presented in all of the different forms of education available to students.

Following completion of the brief text analysis, I began the interviews with current practicing social workers. The results from these interviews will now be presented.

Interview research participants

A total of five social workers contacted me in response to my recruitment email and information letter, and they all expressed interest in participating in my study. I was able to schedule interviews with all five. The participants were all social workers working at the corporation, which is made up of six hospital sites.

The participants were all women, and they had varying degrees of experience working at the hospitals from four years to ten years, with many different patient populations including; medicine, surgery, rehabilitation, maternity, emergency, and intensive care. In addition to their vast hospital experience, the participants had worked as social workers in a variety of settings including community mental health, long term care, and residential care homes. Their years of experience in post-BSW social work practice ranged from five years, to fifteen years. All five participants had BSW degrees. Of the five, one of the social workers had completed her masters (MSW) degree and was beginning work on her doctorate (PhD) degree, and another was currently completing her MSW degree. The diversity of the experience amongst the participants allowed for rich discussion on a variety of topics, and a range of experience with supervision in multiple settings.

Impact of Program Management – Supervision Then and Now

The five participants were from a total of three different hospital sites within the larger corporation. Each of the six hospital sites in the corporation has a unique culture as they each joined the corporation at different points in time, with one hospital having recently been added through amalgamation. Four out of the five participants reported having no formal clinical supervision available to them at the present time. The fifth participant worked at a site where a department model was still in existence, and as a result had quite a different experience that included regular formal clinical supervision. However, this was being threatened due to potential changes sparked by recent amalgamation. Three of the four social workers currently working within the program

management system had worked in hospitals prior to the change and described a very different system for supervision. One participant said,

> I can recall going to her [Director of Social Work's] office and talking about very specific patient issues, clinical issues and getting immediate direction and feedback and being able to talk through issues and actually at one point even getting the Director of Social Work to come and help me with a capacity assessment because that was something new to me.

In contrast to the current schedule of meetings, another participant shared,

> So then things were a lot more structured. We would be meeting at least, absolutely weekly. There would be, that weekly meeting of the social workers, the more senior social worker and the other BSW worker going over cases and program planning and so forth.

For the most part, these descriptions of previous supervisory practices varied quite strongly from their present experiences. The structured meetings that are currently in place within the program management system were described as having a strong administrative focus, and included team meetings with their clinical managers, and a monthly social work meeting with the Chief of Social Work practice. Four of the five participants described the regular meetings with their clinical manager as being almost entirely administratively focused. One social worker said, "they're not focused on clinical issues they're focused more on practical day to day program management issues, team issues." A second participant said, "[the supervision is more in terms of] making sure that you're here on time, you're putting in your hours, you're not putting in, you know, too much overtime." Another large difference between the department management and program management period was the fact that social workers are no longer reporting to other social workers. The four participants who work within program

management report solely to their clinical managers who are all registered nurses. This administrative focus to supervision of professionals in program management hospitals is detailed in the literature (Miller & Solomon, 2002; Thomas & Spreadbury, 2008). Thomas & Spreadbury (2008) describes the growth in managerialism as increasing the focus of administrative forms of supervision at the expense of supportive and education supervision (p. 235). As auditing and cost containment becomes more important in hospitals, there will likely continue to be a focus on monitoring social work practice through administrative supervision, rather than a focus on professional development and education. Impacts of this focus, and an increase in non-profession specific managers, include fewer professional development opportunities as well as a decrease in profession-specific standards and policies (Miller & Solomon, 2002).

The one participant working within the department model described a very different method of supervision. She said,

> So right now once a week the social workers within the hospital get together for a lunch time meeting. … On top of the weekly meetings I could at any point call my clinical leader and ask her if she had time if we could meet because I wanted to talk to her about a case. And so then we would schedule a time and sit down and I would present the case to her and we'd have supervision.

This participant's experience was in stark contrast to the other social workers in my study. The practice of regular group meetings and one-on-one clinical supervision with a social work supervisor was not available to the social workers at the other sites who practice within the program management system.

The shift from clinical supervision and decreased opportunities to rely on social work supervisors for assistance has had negative consequences for the participants. The

literature describes feelings of loss of professional identity in this environment (Aronson & Sammon, 2000; Berger & Mizrahi, 2001; Miller & Solomon, 2002). This was discussed by every one of the participants who talked about the need to connect with other social workers, and the larger corporation in general. Monthly site meetings that are run by the professional practice leader are the only formal scheduled meetings for social workers within the program management hospitals. These meetings focus primarily on administrative matters. All of the participants, in this system, state that they believed that these meetings were not well attended, but interestingly, they all stated that they themselves make the effort to attend each month. The reasons they attended included a desire to connect to the larger corporation, and a need to connect with other social workers. One participant said,

> I've always attended them. I prioritize them because I think it's a good way to connect with what's going on in the larger corporation as much as I possibly can. I like to know what's going on in the bigger picture, which I think our professional leader does a good job of bringing that to the table.

The participants who said that the monthly meetings were not well attended all stated workload as a major reason for the poor attendance. A few of the participants alluded to other reasons why the meetings were not well attended but did not tell me why. One even said, "I won't get into them, but I don't think it is entirely workload." I sensed that my insider position as a social worker within the same hospital setting may have impacted their desire to speak openly about other more controversial reasons, and this will be discussed in more detail in the limitations chapter.

Social Workers 'Get It' – Seeking informal help in a program management setting

One of the major changes that has occurred with program management in hospitals is the lack of supervision and management provided by social workers. The concept of managerialism applied to program management suggests that managers can manage anything. Lawlor (2000) details the belief that the skills that are important are not profession specific, but rather business specific. If you can manage money and programs in one area, then you can do the same in another area. The participants talked about the difference between reporting to social workers versus reporting to people from other professional backgrounds, such as nursing or physiotherapy. One participant said that she would prefer reporting to a social worker because,

> Well I just think then there's not a lot of explanation that needs [to be provided], a lot of background that has to go into things, into questions that you're asking or issues that you're dealing with because you're coming from the same framework and same knowledge base. They get it. They get it.

This appeared to be a large factor in the participants searching out informal consultation from other social workers. The need to consult with other social workers was not being met formally so they made the effort to seek it out in an informal manner.

All of the participants discussed extensive use of informal peer support and consultation. The identification of a peer for informal consultation was an interesting area to explore. Many of the participants talked about consulting with people based on physical proximity. Having multiple social workers on one unit, or in one shared office, was described as an asset because of the ease of finding someone to talk through issues. Other participants talked about pre-existing personal relationship as helping to identify whom to consult with.

The regular use of informal support as a replacement for clinical supervision presents several potential challenges, and should not be thought of as an equal replacement to clinical supervision. There are a few contentious implications to relying on informal support. Nothing formal is arranged, and as a result it is not always available when necessary. In a traditional formal supervision relationship the supervisor would be freed up from other responsibilities and likely be more available in times of crises. Reliance on another busy practitioner can lead to a loss of options due to workload. One participant discussed an emotionally charged experience where the informal channels that she had for support, failed her.

> I felt so incredibly helpless in that moment. I actually picked up the phone in the waiting room and called down to ER and said I need help here from one of my colleagues, knowing that I could reach out to them. Unfortunately they were in their own crisis and couldn't help but you know and I couldn't get that help from anywhere and that was horrible…That would have been good to have somebody to go to and say you know I'm at a point that I can't be this family's advocate and be the police and…this is impacting on me as well personally so I need some help here, I need somebody else to take on some of this role. Or even afterwards to be able to reflect on it more and sort of think of the next step and where to go. I felt so very much on my own with all that.

This participant's experience also highlights the need for supervision as a method of debriefing and emotional support. Without the formal channels in place for support social workers can be left completely alone to deal with troubling cases, and the resulting emotional impact. Shulman (1992) states that formal supportive supervision acknowledges the complexity of social work practice and the potential impact of this on job manageability (p. 27). This formal contextual understanding can aid social workers by helping them to work through issues, and potentially prevent burnout. A peer dealing

with similar emotional and complex issues may not have the same impartial view as a formal supervisor who is more removed from the frontlines of practice. Also, a peer does not have the same ability as a formal supervisor to make any formal administrative changes to aid social workers with their workload (Kadushin & Harkness, 2002, p. 265). This lack of power to effect change and provide emotional support could be discouraging, and result in the social worker ceasing to ask for any assistance.

Another concern with relying solely on peer supervision is the potential loss of the critical, reflective, questioning piece of formal supervision. Peer relationships are not designed for providing education, challenging and correction. Are peers (who are often friends and colleagues) likely to provide the critical feedback that is required? All of the participants said that the peers they consult with help them to engage in self-reflection and point out other options to explore, but the majority of the exchanges were based on support and validation. This is not surprising because peers are not likely to want to be in the position to have to confront one another. Often peers are chosen because of a pre-existing relationship, and they may want to protect that relationship.

A traditional supervisor – supervisee relationship involves dialogue where the supervisor asks directing and challenging questions that allow the supervisee to reflect on their practice in a critical way (Kadushin & Harkness, 2002, p. 149). The reliance on informal consultation could mean that the challenging questions are not asked. In fact, I wonder if most social workers are looking for support from their peers, and are interested in validation, suggestions, and support rather than challenges. They may even avoid peers who provide them with more critical feedback when they are looking for support.

This could result in even less consultation around cases and a potential for stagnation in practice. With no one helping to push the social workers forward, to encourage them to explore new ideas, they may stick with old routines and this could have a negative impact on clients.

Similarly, I would hypothesize that peers providing informal consultation are much less likely to encourage one another to look more deeply into structural impacts on their practice. For example, a formal supervisor would often encourage social workers to reflect on their own social location and the potential implications of their personal background and individual lens on cases. This discussion would be built into formal supervision and would allow social workers to take the time to consider the impact of issues such as racism, classism, ableism, ageism and others on their clients and their practice in general. Social justice issues could easily be missed in informal consultation relationships for the same reason that critical feedback from peers is lacking. These are essential areas of supervision and social work practice, and the potential for their absence in the lack of formal supervision is quite alarming.

An issue with informal consultation that is important, but was only articulated directly by one of the participants, is the issue of legitimacy and accountability.

> I don't think I would ever, I would never chart if I sought informal supervision. I would chart, you know I consulted with program or my clinical lead but I would never chart [that I] consulted with another social worker cause its not legitimate right? It's not. It doesn't feel legitimate...its not formalized. It's not structured.

This demonstrates an important result of the void of formal supervision. Social workers are now increasingly being made to be solely accountable for their decisions. The role that a formal supervisor would have taken in traditional hierarchical settings would have

led to shared liability for decisions that were discussed during supervision (Kadushin & Harkness, 2002, p. 82). Social workers in hospitals are more and more on their own with their decisions.

Benefits to Consultation – Self-care and improved service to patients

Despite the contentious issues related to informal consultation, the participants all really valued the opportunities that they had to consult with other social workers. They viewed the experiences as beneficial, not only to their practice and service to clients, but to their emotional well-being as well. There is a clear need to fill the void that has been left behind in program management settings. One participant described an experience where she went to a colleague to debrief about a troubling case. She said,

> And I needed to and I knew that. I couldn't you know I couldn't function, I couldn't go back at it, same family and same issues without having...to sort of share that with somebody and talk it through...[it] wouldn't have gone away. Without supervision [the emotions] just kind of get left there.

She acknowledged that she viewed the informal consultation and debriefing as necessary. The difficult case had made a significant impact on her, and she needed help to deal with it. The method of informal consultation seemed to be used as a form of self-care for all of the participants. Another participant said,

> I think people need the opportunity to share in situations that are overwhelming, difficult, complex. Maybe not even [to] ask people's opinion but being able to debrief about difficult situations.

Another theme in this area was the need to focus on the reflective nature of social work practice. One of the participants mentioned that she viewed this part of social work as providing a large benefit to clients. She said,

> One of the things that supervision should be able to facilitate is reflection: self reflection, case reflection, whatever the [case] may be... the hallmark of social work, one of the most important pieces, I believe, is that reflective piece. And so the stronger you are at doing that, the better you are at doing that, the better services you're going to be able to provide [to clients].

The participants all viewed the consultation that they engaged in as beneficial to themselves and to their clients. They were looking for any opportunities they could find to engage in dialogue with other social workers. The lack of formal supervision available in the program management settings meant that they needed to rely on the only available option, which was informal support from colleagues.

Impact of the Structure of Social Work Practice in Hospitals – Isolation

An important theme that appeared in my interviews was the feeling of isolation in social work practice in hospitals. Four of the participants discussed feeling isolated from other social workers, and having to make a concerted effort to connect with others. Surprisingly, the participant with the different experience was not the one working in the departmental model. This suggests program management may not be to blame for all feelings of isolation in social work practice. For example, working in an interdisciplinary setting where social workers are small in number compared to other professions can lead to isolation on its own. One participant said,

> It's really easy to just stay on the ward and sort of work in your own little bubble and not come in contact with social workers from other units if that's what you choose to do. You sort of have to make an effort to be in contact with the other social workers even at the same site. The sites are quite large.

Another participant described the changes related to program management, such as a decreased number of social work meetings, as being a factor in not connecting with any other social workers. She said,

> "So you're on your ward all day, right? You might go to a [social work] meeting once a month but unless you make the effort to either e-mail or phone a co-worker, to hook up with them for lunch or coffee, whatever, it might be you might not see any other social workers. The odds are you won't. Everybody's busy in their own [ward], their world is their ward."

This participant's experience demonstrates that, while it is not the only cause of isolating feelings, program management still makes an impact by denying social workers regular formal meetings and supervision. The desire for connection with other social workers appeared to be related to a need to meet and bond with other professionals who share similar perspectives and work experiences. The interdisciplinary teams that have grown as a result of program management seemed to provide good support to the participants, but there was still a desire to meet with other social workers. With a reduction in formal social work meetings there seemed to be an even greater need to connect with likeminded colleagues in an informal manner, whether it is lunchtime chats or quick hallway consultations. The interdisciplinary team on each ward can provide support, but there is something unique and comforting about connecting and consulting with other social workers.

One participant working in a program management setting described a different, less isolating, experience at her site in comparison to the other participants. She mentioned that the hospital site where she worked held regular informal social work meetings. These meetings were spearheaded by the social workers themselves, did not

involve formal leadership, and were unique to that site. "We have site meetings and they're just run by us and that's a forum where people can bring a case forward that they struggled with and get peer feedback and peer support." She described her site as having a unique culture to the other sites. "Some site's social workers say 'I never see the other social workers', but here they meet regularly...we eat lunch together most days and it's just a regular thing, we see each other all the time." This experience demonstrates the unique culture at each site. The different hospitals used to all be individual hospitals, and over the years they have joined together with the other hospitals in the city, but much of their individuality has remained. An important piece of this different example is the fact that the social workers at this site were able to create relationships and structured time together despite the confines of program management. I think this example gives hope to other sites that are struggling. It shows that it can be done and likely will just take a few strong informal leaders within social work to take the lead and make some changes within their sites.

Another factor that seemed to make a difference with feelings of isolation was the factor of part time versus full time work. Two of the participants discussed the differences in their experiences when they used to work part time compared to their full time work now.

> Being regular days when everybody else is here is quite a different experience [than] the after hours shift experience. You know more about what's going on and have that collegiate rapport, where after hours you're the only social worker here.

Once again the important theme that comes up with this example, is the need to connect with other social workers. The need for informal connection with other social workers is only accentuated during after hours work. This is an important area to think about, because after hours and part time contract work is where many new social workers begin their work at the hospitals. How are hospitals supporting new social workers, and could more formal structures aid in connecting these workers with full time staff?

One way that this could be done is through a mentoring program that links experienced staff with new staff. The research setting has implemented a mentoring program for new social workers, and so I spoke with the participants about their experience with this program. All of the participants had heard of the program, but only one had formally been involved in the program in the role of a mentor. I was surprised that not more of the participants had been mentors because of their extensive history at the hospital. Their experience would have been invaluable to new workers. In general, there did not seem to be a lot of knowledge about the program and how it works. Even the participant who had previously been a mentor did not know what was happening with the program at this time. This finding is specific to my research site and provides some specific implications for the organization to consider.

Supervision as Surveillance - Exploring Issues of Competency and Associated Anxiety

One of the most surprising themes that appeared in my interviews was the idea that supervision was described by some of the participants as surveillance, or as a way to

identify incompetence in social work practice. I had not anticipated this theme and was surprised to hear this from three of the five participants.

One participant said,

> I think that [supervision would bring out] those who practice more competently than others. I see lots of people practising that probably shouldn't be practising or are not practising as competently as they should be and that's allowed to continue because there's no ... close connection or close supervision.

Another participant talked about seeing other social workers not practising to their full potential. She said,

> I don't mean to be derogatory but sometimes people in their roles will perform an instrumental kind of focus and you know maybe it should be more of a preventative kind of management, like do what we're good at doing. Let's get in there and build a rapport with the patients and their families... I mean, you would never want it to really jeopardize a person's career but if [supervision] could be to help to nurture the person in the role and you know maybe look at competency.

I was surprised to hear this presented as a potential benefit to supervision because it seemed negative at first. However, when you look to the literature around supervision, the educational features are prominent, and I chose to explore this aspect of maintaining competence in more detail. Professional development including increased skills and mentoring, and the maintenance of standards of practice are important markers of clinical supervision in social work (Brown & Bourne, 1996). Holloway (1995) discusses the importance of supervisors sharing social work knowledge with their supervisees through the use of assistance in translating research into practice. When you look at competency issues from the perspective of increasing educational opportunities, and maintaining standards, it does not have the same negative connotation that I first picked up on during the interviews. After closer analysis, I was able to see that the participants that I spoke

with were interested in increasing the professional standards of social work practice at their hospitals. The emphasis was not on picking out 'bad social workers', but rather on improving practice overall with a focus on improving service to the patients.

Along with the benefits to maintaining standards of practice, there was also a theme related to anxiety linked to the issue of supervision as a form of surveillance. Many of the participants discussed feelings of fear and anxiety in anticipation of supervision, or when reflecting on their previous experiences with supervision. One participant shared,

> I was nervous about supervision because I thought 'oh, that's somebody watching me, and what if I'm not doing a good enough job?' So I was nervous about it, but at the same time ... you know thinking, ok, at least I have some support, somewhere to go because, as a new social worker, starting out you think 'gosh, I know nothing, I need somebody to talk to bounce ideas around with'.

Another participant discussed her discomfort with sharing or looking for support in a group supervision setting.

> I guess I wouldn't be comfortable if I thought maybe it was something that someone might think, 'well she should have known the answer to that'. So it would really depend. So I think I would really give it [a lot of] thought before sharing it with a larger group.

Whether it is the negative historical view of social workers as the observers with an agenda, or the growth of monitoring in social service agencies, surveillance, as a theme in social work practice, is not new (Margolin, 1997; Moffatt, 1999). With the increasing reliance on audits and a strive for efficiency, no matter what the cost, the amount of surveillance has been stepped up in social work settings (Moffatt, 1999). Practitioners are not immune to the changes that have been occurring, and a natural response to these practices would be fear and anxiety. I can see a potential for risk if

social workers are afraid to show their vulnerabilities as practitioners. I would worry that social workers would attempt to tackle complex issues on their own, without seeking guidance for fear that their skill level as a practitioner was being judged. Perhaps the fact that supervision is only available in terms of an administrative focus in hospitals helped to increase the anxiety for the participants. Supervision needs to remain a place where social workers can be open and honest and feel supported. If the hospitals had opportunities available for clinical and supportive supervision, the social workers may be less fearful and more willing to engage in this important process without fear of reprimand or punishment.

On My Own Time

All five of the participants talked about taking the time to engage in informal supervision outside of regular work hours. Every single participant mentioned using their lunches and coffee breaks as a time to consult informally with other social workers. A few participants talked about arranging times to meet at breaks, but one participant described how it often happens without any plan in place. She said, "I mean we would meet for lunch [and] the next thing you know we're talking about a difficult case". Her description illustrates the common experience of the way that work can easily extend into other areas of a social worker's life.

Baines (2004) tells us that one of the results of the changes in reducing funding and changes in organizations has been an increase in the amount of unpaid labour (p. 19). This is often as a result of the workforce being reduced with no changes to the workload. Workers are continually asked to do more with less. Baines' (2004) study showed that

"most workers, including multiple job holders, reported a number of unpaid overtime activities including: working through lunch hours, coffee breaks, into the evening and on weekends" (pg. 21).

Clearly, the participants' experiences were in line with this literature. In addition to the reduced funding and subsequent reduction in the workforce, this is likely also a result of the move away from formal supervision. Formal structures for supervision would include regular scheduled meetings within the confines of the workday. There likely would not be as much need to spend your breaks looking for support, if it was properly scheduled into your day. The social workers in hospitals are now solely responsible for finding the time to consult with one another, and as a result are often doing it on their own time. One participant said it well when she said "I think in acute care you take [it] when you get it, and try and get it when you need it" in reference to informal support from other social workers. The potential for negative consequences of this type of unpaid work is quite high. If the social workers are not taking any downtime, or space to relax and not think about work, burnout can become a real problem. Workload is continuing to increase, and without the formal structures in place for debriefing and consultation, the social workers have the potential to become overwhelmed and stressed.

Definitions of Supervision from Undergraduate School

When I asked the participants about their BSW programs, and their memories about the way supervision was taught to them, they all mentioned their experiences with placements. This was not a surprising result because this is an important feature of social

work education. The structure of the placements in the school curriculum is one of the ways that the teaching about supervision is made explicit for students. The students' first experiences with social work practice are under the careful guided watch of a supervisor. As difficult cases come up, the social work students are not only encouraged, but they are actually required, to speak with their supervisors in order to come to some form of resolution. I hypothesized that this, in combination with the textbooks, which carry an implicit expectation of supervision, would result in the participants expecting similar supervision relationships when they entered the work place.

The participants' impressions about what supervision was seemed to be in line with the literature on supervision. One participant said,

> The concept in my mind was that there needed to be regular, accessible access to [another] social worker who could give you feedback, direction, information. To not only help solve imminent issues but also to, I think, look at furthering your knowledge base and improve your ability to provide service to patients or clients.

The literature about supervision does state that a supervisor should be another social worker, and that this is important for professional development (Brown & Bourne, 1996; Holloway, 1995). Also Shulman (1992) talks about a supervisor's role in helping social workers to take theory and concepts that they have learned and read about, and translate them into their work with clients (p. 21). Four of the five participants were seeking the type of supervision that was detailed in the literature. The one-on-one relationship that they had experienced in their placements was remembered fondly, and viewed as something that should be available when they entered practice. One participant had a placement supervisor who emphasized the importance of supervision for practice so much, that he suggested that she might have to pay for it privately in order to achieve it.

This was the only discussion of private supervision that came out in all of the my interviews, but it was interesting to hear that a supervisor was preparing his students for a practice reality that was not necessarily in line with the current school curriculum. I was interested in the fact that none of the participants had decided to seek private supervision in the void of available formal supervision. As discussed previously, they seemed to rely on informal consultation more than anything else.

Another very interesting moment in the interviews occurred when one of the participants talked about her impressions of supervision when she was in school. Four out of the five participants had mentioned having the impression that supervision was an expected, necessary, part of social work practice, when they were learning about the concept in school. The fifth participant mentioned to me that her impression of supervision was that it was only important when you were in school. She said "I saw it as mandatory. I mean, I liked it, I needed, and enjoyed it. It was beneficial but [I] definitely saw it as only part of doing the social work practicum." This was contrary to the comments of the other four participants, who had all had viewed it as something that was a part of practice following school. This difference in assumption could come as a result of the more implicit imbedded discussion of supervision in classes or textbooks. If it was never mentioned explicitly to her that supervision was to be a necessary part of practice, she may have simply separated her experiences as a student from that of a future practitioner. The participant attended the same school of social work as three of the other four participants and had not completed any further social work education past her BSW degree. There was no specific identifiable explanation for this difference in opinion. The

difference may simply show that all students learn differently and are impacted by their education in unique ways.

Group Supervision – Benefits and Disadvantages of a New Form of Supervision

The literature review prepared me for a focus on group supervision. While, one to one supervision is the historical norm, there has been a growing emphasis on the use of group supervision (Brown & Bourne, 1996; Holloway, 1995; Kadushin & Harkness, 2002; McCafferty, 2005; Rinehart & Graziano, 2004; Shulman, 2002; Sulman, Savage, Vrooman & McGillivray, 2005). I asked the participants what they saw as the benefits and disadvantages of using this form of supervision. I had the assumption that group supervision may be used more frequently in a hospital setting, so I was interested in hearing what the participants thought of this idea. The main benefit raised was the number of ideas that can be generated in group brainstorming sessions. The participants believed that having more than one social worker focused on a problem could be quite beneficial. One participant described this benefit by saying "You get multiple perspectives… so I always think the more brains the better, right? Like more people thinking about it, the better. You get a whole slew of ideas."

All of the participants also discussed some disadvantages that could come from supervision in a group setting. As the example discussed earlier suggested, most of the concerns seemed to be related to the fear and anxiety of being in a group, and being judged. Two participants said they might be uncomfortable asking questions in a group, because they would be afraid of looking bad and having others think that they should

have known the answer. Another participant said she thinks that being in a one-to-one setting would allow more opportunity to focus on your individual issue. The benefit of having multiple perspectives in a group supervision setting can also be seen as a disadvantage when you have too many options available to you. Having the opportunity to reflect carefully on your case and the options, one-on-one may be more beneficial than multiple varied perspectives.

While there were both advantages and disadvantages raised in terms of group supervision, there seemed to be the general assumption that group supervision would be better than no supervision at all. In the current context of decreased funding and fewer social workers in a formal leadership role, this may be a way for hospitals to increase the formal supervision that is available to social workers. It may not be the most preferred method, but it could allow for some much needed formal support.

Another important finding is an issue that was not discussed by any of the participants. Its absence from the interviews is precisely why I think it is essential to mention. None of the participants brought up or discussed issues of structural impacts on practice as a reason for the decrease in supervision. Program management was discussed but the underlying political implications were not. I find this lack of identification of structural issues to be an important area for analysis. The implications of neoliberalism and managerialism have had tremendous negative impacts on hospitals, social services in general, clients, and social workers. This imbedded political ideology is essential to be aware of in order to begin to work against it. As I mentioned previously, one of the implications of decreased formal opportunities for supervision is

the lack of opportunity to reflect on these types of issues. Without the opportunities to discuss and question structural issues, there is a danger that they will be forgotten and lost from social work practice. This is an essential piece of social work practice and one that needs to continue.

The findings that have been detailed here have provided numerous opportunities for analysis and discussion. The following chapters will discuss the limitations of my research and several potential implications for social work practice, education, and research.

Limitations to the Study

There are a few limitations to my study that are important to address. Due to the fact that this is a limited thesis completed for the requirements of a Masters degree, my sample size for the interview portion of my study is small, at only five participants. This sample allowed me to hear from social workers with limited organizational diversity, due to the fact that they were working at three different hospital sites within one large organization. Even though I was pleased with five participants, more participants could have helped to increase the variety of the sample, and broaden the results and areas for discussion. My text analysis is also limited because I chose to only examine the textbooks from one course at the different schools of social work. My analysis could have been strengthened had I chosen to examine the texts in more courses, or chose to explore other forms of teaching methods used in the schools of social work.

The results of my thesis are not generalizable for several reasons. My recruitment strategy involved using a convenience sample of volunteers who contacted me as a result of a recruitment email. This means that my sample was likely made up of social workers that already had a vested interest in the topic of supervision, and were interested in discussing it in detail. These participants are unique and probably more likely to respond to my questions in a manner that emphasizes the need for supervision. Secondly, my participants were all from one corporation of hospitals. The experience at this corporation is not necessarily representative of all other hospitals. The differences that were seen between the different sites of the corporation demonstrate the importance of

considering the effect of organizational culture and history on the experiences and perceptions of the social workers. It is likely that social workers practising in other locations would also have different experiences based on their unique hospital culture and structure.

A final area that could have been seen as a limitation of my study is the fact that I was completing the research from an insider position. I am a social worker interviewing other social workers at the corporation where I work. In order to mitigate the potential for my insider position to have a negative impact, I chose not to recruit participants from my own hospital site. Lasala (2003) cautions that sometimes an insider researcher can impact the responses that are given by participants. However, there was only one time in my study where I felt that my insider status had a potentially restrictive impact. A few of the participants mentioned that they believed there were reasons other than workload for poor attendance at monthly social work meetings, but they did not want to share the reason. I recognized this discomfort during the interview and chose not to explore the issue of non-attendance anymore, because I did not want to affect the rapport of the interview. Overall, I believe that my insider position was an advantage due to the fact that the participants did not have to explain the structures in place, and I was comfortable with the language and terms that were used, but it could be viewed as a limitation of the study.

The limitations that have been detailed are important to identify and discuss, but I believe that the results I was able to obtain are a valuable representation of the views of the participants. Their opinions and stories are important to examine as they can provide

a detailed perspective of five social workers working in the hospital setting. Their experiences can help to provide a forum to begin the discussions on the importance of supervision in the current challenging context of social work practice in hospitals.

Implications

Implications for Practice – Hospitals and Schools of Social Work

The results of my study present several important implications for social work practice and education. The context for social work practice in hospitals has changed, and it is important to address this, and to think about ways to support social workers and advocate for changes. The lack of formal supervision available in program management hospitals demonstrates an alarming trend. I believe that it is important to ensure that hospital administrators are made aware of the benefits of clinical supervision.

Hospital administrators face difficult decisions trying to balance excellent health care and complex funding dilemmas. Social work practitioners contribute an essential role and support to hospitals and patients. Excellent patient care is regularly achieved through the utilization of the social work skill set and knowledge base, which excels in attending to patient's psychosocial needs (Ross, 2004, p. 246). A natural link between exceptional patient care and formal supervision opportunities for social workers can be made. The literature demonstrates that supervision benefits clients through the increased accountability and increased professional development of the worker (McCafferty, 2005) as well as by providing social workers with assistance through ethical dilemmas (Rinehart & Graziano, 2004).

In these economic times, with the regular threat of downsizing, hospital administrators could be interested in learning that formal clinical supervision for social workers can also be seen as providing service to patients in a more efficient and effective

manner (Kadushin & Harkness, 2002). By providing oversight to staff, supervision helps to improve practice standards and improve service to patients. As fiscal restraints continue to impact our rapidly changing health care system, the desire to provide effective and efficient health care will increase. Supervision is also known to decrease burnout in staff (Kadushin & Harkness, 2002, p. 260; Bogo & McKnight, 2005, p. 51). Decreased burnout means less sick time and less staff turnover. These impacts of burnout are very costly to the organization and disrupt teams. Any measure that can be put in place to prevent these negative outcomes would be beneficial, even if from a purely financial standpoint. I would also argue that my findings demonstrate that formal structured supervision could help to decrease feelings of isolation and improve job satisfaction for social workers in hospitals. Increased funding for formal supervision could be shown to pay off in many other areas. These are all important markers for administration to be aware of and explore in more detail. The benefits and strengths of social work in hospitals are well documented and acknowledged by hospital administration, so there is a possibility that they would be willing to look into additional ways to support this valued professional group.

One suggestion for hospitals would be to explore the option of group supervision. While the participants raised both benefits and disadvantages to this practice, it may be seen as a cost-effective method that still allows for the much-needed formal structure for supervision. The literature describes some new group strategies for social work professional development in hospital. Sulman et al (2005) describes the development of social work groups based on collective decision making that aim to provide

accountability, support, and professional development of social workers in hospitals. These groups have been found to provide support for individual social workers, and also to raise the profile of social work in hospitals (Sulman et al, 2005). Examples such as this one should be explored in more detail in order to better understand the implications for individual hospital settings.

It is important to remember that two of the participants in the study raised the unique needs of after-hours workers. The results demonstrated that the need for the connection to other social workers, which could be addressed by formal supervision, may be accentuated in after-hours work. Any alternative measures that are explored should consider this particular group. For example, if group supervision was implemented, would this group be left out, or would there be options available that would respect their non-traditional hours?

I believe that the findings from this study will help individual social workers by building a case for the importance of formal supervision, which will hopefully aid in their day-to-day work. For the time being, I would encourage social workers to search out other means of formal arrangements, whether it is through a resurgence and revamping of their local mentoring programs, or through hiring private supervision support. Of course, the cost of hiring private support could be prohibitive for some practitioners, so it is not a universal solution.

There is likely a need for more education about the mentoring program, at the corporation where I completed the study, in order to advertise the purpose and needs related to the program. Perhaps its voluntary nature also played a role in the lack of

knowledge and participation in the program. I would urge the corporation to re-examine this program and explore ways to increase its awareness. There are many benefits that could result from a successful and well-utilized mentorship program

The results suggest that social workers should be cautious about the sole reliance on informal consultation. Seeking collegial support is different than receiving formal supervision or consultation. The results further suggest that established social workers can be good role models for new social workers and students, in order to demonstrate for new learners the importance of formal supervision and maintaining practice standards.

The participants themselves outlined two implications for schools of social work. The first piece of advice the participants had for schools of social work was to 'teach the reality'. Three of the five participants use this exact phrase. There seemed to be a belief that the schools of social work should better prepare students for the different practice realities. For example, one participant said,

> I think they need to teach the reality. I think that graduating social workers need to be aware that the experiences [of supervision] can't be the same in every area of practice. Not that they can teach the way things are everywhere but just to be aware that you may need to be an advocate for your own supervision and to be aware of your own needs.

While there was an acknowledgement that it would be difficult to describe all practice settings for social work students, the participants believed that there should be an explicit mention that formal supervision is not available in every setting. The belief was that if social workers were aware of the lack of supervision in some areas, they maybe better prepared to make alternate plans when they enter the workforce.

I am aware of a caution that exists in schools about not wanting to support negative government policies, such as the neoliberal ideals that led to program management, so there may be a hesitancy to 'teach the reality'. Schools want to provide students with the ideals for social work practice, and do not want them to accept less or give in to the negative structures that are in place. But, I would worry that the schools are doing a disservice to students if they do not provide them with an honest representation of practice realities. My participants had a few strategies on how to do this that included having guest speakers in from various community settings to speak about how supervision works in their settings, and building the conversation into the field placement, so that students know that the supervision they experience at placement may not be the same that is offered when they enter the practice field. Both of these suggestions involve the schools connecting strongly with their communities. This thought is echoed in the literature. Shera and Bogo (2001) stress that "education programs need to maintain relationships with social work practitioners, students, field instructors and administrators of the social agencies" (p. 200). This connection can help the schools of social work to have a good understanding of the current practice realities and other important issues that may be affecting their students (Shera & Bogo, 2001, p. 200).

Another important implication for schools of social work to consider is the uniqueness of each individual student. In addition to a wide variety of field settings, there are also a wide variety of students. The participant, who shared her expectation about supervision only being necessary for students in field placements, demonstrates

that individual students can interpret the same message in different ways. This needs to be recognized in schools of social work.

The second main strategy that I, and the participants, recommend to schools is to teach and encourage students to be self-advocates, and to be proactive in recognizing their own needs and seeking out supervision. All of the participants spoke of the need for social workers to be aware of their own learning and practice needs. The fact that self-reflection is such an important piece of social work education helps in this area. One participant said, "I think that there needs to be an emphasis on self care [and] self reflection. Encouraging students to [be] asking the question how do you develop a support base for yourself?" I believe that this will continue to become an important area of focus for social workers in hospitals. This is an increasingly independent practice setting, and practitioners who are interested in working in this field need to be proactive and autonomous, and be prepared to be their own advocates for supervision. The regular use of self-reflective practice will encourage the social workers to actively seek out formal structures that can support them in their needs. Schools of social work can support students by continuing to stress self-reflection practices and by encouraging students to be autonomous advocates for their own professional development.

A serious implication of the lack of formal supervision for hospital social workers is the potential for decreased awareness of structural and social justice issues. This is another area for schools of social work to address in their courses. If social workers are not going to be exposed to regular formal supervision that helps to draw out and articulate these issues in their workplaces, then schools of social work should ensure that

this is embedded in the curriculum. Social workers need to have a strong base in awareness of structural and social justice issues in order to begin their work in the field.

Implications for Future Research

This study raises some important implications for future research. There is a limited amount of research on the current context of social work practice in hospitals. Much of the research about the impact of program management was completed soon after the change from the department model. Now that over fifteen years have passed since the change, it would be important to carefully examine the ways that social workers are successfully practicing in this environment. Due to the amount of time that has passed since the change occurred, there are likely many new social workers working who have only ever worked within a program management system. Their experience would be essential to document in order to carefully explore the methods that are being used to survive in this context. These new social workers have likely developed new strategies for professional development and support, and these would be important to explore in detail.

There is also very little research specifically on clinical supervision in hospitals. This may be due to the impacts of program management, and the resulting decreased opportunities available for clinical supervision in this setting. Researchers may be thinking that there is little to discuss because of the lack of available formal supervision, but I strongly disagree. I believe that clinical supervision is an essential piece of social work practice, and it is important to examine what is being done in practice areas where there are many obstacles in place. The participants have demonstrated that they have a

need to receive the benefits that come from clinical supervision and have been creative in their attempts to improve their practice without the formal structures in place. This creativity should be celebrated and explored in more detail.

The reliance on informal consultation in hospitals is also an area in need of more study. The participants have shown that they all rely heavily on the support of their colleagues to fill the gaps left behind in the void of formal supervision. Careful study of this phenomenon would be very valuable.

Further research that explores the impacts of clinical supervision would be valuable to help to build the case for supervision in hospitals. Bogo & McKnight (2005) encourage this type of research as well, and in particular they recommend exploring how supervision affects caseloads, wait lists and duration of service (p. 63). Any increase in evidence that supports the use of clinical supervision would be a valuable addition to the literature.

Conclusion

This study examined the messages about supervision that are provided by social work textbooks, and the current practice reality for hospital social workers. The text analysis revealed that supervision was usually presented as an essential part of social work practice and implied that it is available in practice settings. This demonstrated that the textbooks could set up expectations for students about the availability of supervision that is not a reality in hospital settings. The participants shared their experiences in both departmental and program management settings, and discussed the implications of having no formal structures for clinical supervision.

The disconnect between expectations from school and the realities of practice is important to recognize, and leads to several implications for hospitals, schools of social work and future research. Hospital administration needs to be made aware of the benefits of formal supervision, and the potential drawbacks to social workers relying solely on informal consultation. Group supervision is an alternative to individual supervision, and could be a cost-effective strategy for hospitals to consider. This area should be explored in more detail. Schools of social work must stay current and connected to the practice field in order to provide students with a realistic preparation for work in hospitals. A special focus on structural and social justice issues in schools will allow social workers to be better prepared to face some of the issues they experience in practice settings without formal supervision. As the context for social services continues to change, it will be important for new social workers to be strong advocates for their own professional

development, and the schools of social work can aid in this area by nurturing strong, autonomous, and reflective practitioners.

Clinical supervision is a vital area of social work practice and one that needs to be recognized and supported by both practice settings and educational institutions. Social workers need to actively work to continue this important tradition and essential piece of our practice. It not only improves professional development opportunities and maintains a strong base in the analysis of structural and social justice issues, but it also improves the outcomes for our clients.

References

Aronson, J., & Sammon, S. (2000). Practice amid social service cuts and restructuring: Working with the contradictions of 'small victories'. *Canadian Social Work Review*, 17(2), 169–187.

Baines, D. (2004). Seven kinds of work – only one paid: Raced, gendered and restructured work in social services. *Atlantis*, 28(2), 19-28.

Berger, C., Cayner, J., Jensen, G., Mizrahi, T., Scesny, A., & Trachtenberg, J. (1996). The changing scene of social work in hospitals: A report of a national study by the society for social work administrators in health care and NASW. *Health and Social Work*, 21(3), 167–177.

Berger, C., & Mizrahi, T. (2001). An evolving paradigm of supervision within a changing health care environment. *Social Work in Health Care*, 32(4), 1-18.

Bogo, M., & McKnight, K. (2005). Clinical supervision in social work: A review of the research literature. *The Clinical Supervisor*, 24(1/2), 49-67.

Bogo, M., & Vayda, E. (1998). *The practice of field instruction in social work: Theory and process* (2nd ed.). Toronto, ON: University of Toronto Press.

Brashears, F. (1995). Supervision as social work practice: A reconceptualization. *Social Work*, 40(5), 692-699.

Brodie, J. (1999). The politics of social policy in the twenty-first century. In D. Broad and W. Antony (Eds.), *Citizens or Consumers? Social Policy in a Market Society* (pp. 37-45). Halifax, NS: Fernwood.

Brown, A., & Bourne, I. (1996). *The social work supervisor: Supervision in community, day care and residential settings.* Philadelphia: Open University Press.

Browne, C., Smith, M., Ewalt, P., & Walker, D. (1996). Advancing social work practice in health care settings: A collaborative partnership for continuing education. *Health and Social Work*, 21(4), 267-275.

Burr, V. (1995). *An introduction to social constructionism.* New York, NY: Routledge.

Burr, V. (2003). *Social constructionism.* New York, NY: Routledge.

Canadian Association of Social Work Education. (2008). *Standards for accreditation.* Retrieved May 2, 2009, from http://www.caswe-acfts.ca/vm/newvisual/attachments/866/Media/MicrosoftWordStandardsofAccreditationMay2008.pdf

Carpetto, G. (2008). *Interviewing and brief therapy strategies. An integrative approach.* Boston, MA: Allyn & Bacon.

Caspi, J., & Reid, W. (2002). *Educational supervision in social work: A task-centered model for field instruction and staff development.* New York, NY : Columbia University Press.

Canadian Institute of Health Research, Natural Sciences and Engineering Research Council, Social Sciences and Humanities Research Council. (2005). *Tri-council policy statement – Ethical conduct for research involving humans.* Ottawa, ON: Public Works and Government Services Canada.

Cournoyer, B. (2001). *The social work skills workbook* (3rd ed.). Scarborough, ON: Brooks/Cole Thomson Learning.

Demartini, J., & Whitbeck, L.B. (1987). Sources of knowledge for practice. *Journal of Applied Behavioural Sciences*, 23, 219–231.

Gergen, K. (2001). *Social construction in context.* London: SAGE publications.

Globerman, J., White, J., & McDonald, G. (2002). Social Work in Restructuring Hospitals: Program Management Five Years Later. *Health and Social Work*, 27(4), 274-283

Globerman, J., White, J., Mullings, D., & Davies, J. (2003). Thriving in program management environments: The case of social work in hospitals. *Social Work in Health Care,* 38(1), 1-18.

Greenhalgh, T., & Taylor, R. (1997). How to read a paper: Papers that go beyond numbers (qualitative research). *British Medical Journal*, 315, 740-743.

Gribich, C. (1999). *Qualitative research in health and social care: An introduction.* London: SAGE Publications.

Hamilton Health Sciences. (2004). *Hamilton Health Sciences – Chief of a professional practice accountability statement.* Retrieved April 29, 2009, from Hamilton Health Sciences intranet site: http://corpweb.hhsc.ca/workfiles/SOCIALWORK/SW%20Programs/ChiefofProfessionalPractice2004.doc.

Hamilton Health Sciences. (2005). *Social work mentoring program.* Retrieved April 29, 2009, from Hamilton Health Sciences intranet site: http://corpweb.hhsc.ca/workfiles/SOCIALWORK/Mentoring%20Program.doc

Hamilton Health Sciences. (2007). *Hamilton Health Sciences - Social work professional practice council: Terms of Reference.* Retrieved April 29, 2009, from Hamilton Health Sciences intranet site: http://corpweb/body.cfm?id=1321

Hamilton Health Sciences. (2008). *Hamilton Health Sciences - Social work resource consultants.* Retrieved April 29, 2009, from Hamilton Health Sciences intranet site: http://corpweb.hhsc.ca/workfiles/SOCIALWORK/ACF1F00.doc

Healy, Karen (2005). *Social work theories in context: Creating frameworks for practice.* New York, NY: Palgrave.

Hepworth, D. H., Rooney, R. H., & Larsen, J.A. (1997). *Direct social work practice: Theory and skills* (7th ed.). California: Brooks/Cole Thomson Learning.

Hollowoy, E. (1995). *Clinical supervision: A systems approach.* Thousand Oaks, CA: SAGE Publications, Inc.

Johnson, R., & Waterfield, J. (2004). Making words count: The value of qualitative research. *Physiotherapy Research International, 9*(3), 121–131.

Kadushin, A., & Harkness, D. (2002). *Supervision in social work* (4th ed.). New York, NY: Columbia University Press.

Kirst-Ashman, K., & Hull G. (2006). *Understanding generalist practice* (5th ed.). Belmont, CA: Brooks/Cole Thomson Learning.

Knowles, M. (1980). *The modern practice of adult education.* New York, NY: Cambridge – The Adult Education Company.

Kolb, D. (1984*). Experiential learning: experience as the source of learning and development.* New Jersey: Prentice-Hall.

Kreugar, L., & Neuman, W. L. (2006). *Social work research methods. Qualitative and quantitative applications.* Toronto, ON: Pearson Education Inc.

Lasala, M. (2003). When interviewing "family': Maximizing the insider advantage in the qualitative study of lesbian and gay men. *Journal of Gay and Lesbian Social Services,* 15(1), 15-30.

Lawlor, J. (2000). The rise of managerialism in social work. In E. Harlow and J. Lawlor (Eds.), *Management, Social Work and Social Change* (pp. 33-55). Aldershot: Aldgate.

MacKeracher, D. (1996). *Making sense of adult learning.* Toronto, ON: Culture Concepts Inc. Publishers.

Margolin, L. (1997). *Under the cover of kindness: The invention of social work.* Charlottesville, VA: University of Virginia Press.

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, 320, 50–52.

McCafferty, P. (2005). Developing a model for supervising social work students in groups. *Journal of Practice and Teaching*, 6(2), 24-42.

Merriam, S., & Caffarella, R. (1991). *Learning in adulthood: A comprehensive guide.* San Francisco, CA: Jossey-Bass Publishers.

Miller, P., & Solomon, P. (2002). The influence of a move to program management on physical therapist practice. *Physical Therapy*, 82(5), 449-458.

Moffatt, K. (1999). Surveillance and government of the welfare recipient. In, A. Irving & L. Epstein (Eds.), *Reading Foucault for social work* (pp. 219-245). New York, NY: Columbia University Press.

Munhall, P. (2007). *Nursing research: A qualitative perspective.* Sudbury, MA: Jones and Bartlett.

Munro, E. (2004). The impact of audit on social work practice. *British Journal of Social Work*, 37, 1075-1095.

Neuman, L. (1997). *Social research methods: Qualitative and quantitative approaches.* Boston, MA: Allyn & Bacon.

Peled, E., & Leichtentritt, R. (2002). The ethics of qualitative social work research. *Qualitative Social Work*, 1(2), 145-169.

Pope, C., & Mays, N. (2006). *Qualitative research in health care* (3rd ed.). Malden, MA: Blackwell Publishing Ltd, BMJ Books.

Ross, J. (1994). Health social work: Narrowing the gulf between practice and academia. *Health and Social Work*, 19(3), 154.

Rinehart, B. & Graziano, R. (2004). Group field instruction: A model for supervising graduate students providing services to older people. *Journal of Gerontological Social Work*, 44(1/2), 223-242.

Shebib, B. (2007). Choices: Interviewing and counselling skills for Canadians. (3rd ed.). Toronto, ON: Pearson Prentice Hall.

Shera, W., Bogo, M. (2001). Social work education and practice – planning for the future. *International Social Work,* 44(2), 197–210.

Shotter, J. (1993). *Conversational realities: Constructing life through language.* London, UK: SAGE publications.

Shulman, L. (1992). *Interactional supervision.* Washington, DC: NASW Press.

Stein, J. G. (2001). *The cult of efficiency.* Toronto, ON: The House of Ansani Press Limited.

Sulman, J., Savage, D., Vrooman, P., & McGillivray, M. (2005). Social group work. *Social Work in Health Care*, 39(3), 287-307.

Thomas, J., & Spreadbury, K. (2008). Promoting best practice through supervision, support and communities of practice. In, K. Jones, B. Cooper & H. Ferguson (Eds.). *Best practice in social work: Critical perspectives.* (pp. 251-266). New York, NY: Palgrave MacMillian.

Appendix A

Hamilton Health Sciences

McMaster University Health Sciences

Study: Clinical Supervision for Hospital Social Workers: Promise versus Reality

Interview Guide

Demographics / Experience:

When and where did you complete your bachelor of social work (BSW) degree?

What areas of social work practice have you worked in since graduating with your BSW?

If you have worked somewhere other than a hospital, what was your experience with supervision?

How long have you been working at the hospital?

Definitions of Supervision:

What was your understanding of the definition of supervision when you were completing your BSW degree?

Has that understanding changed since you have been working at the hospital? If so, how?

Types of Supervision Available:

What type, if any, of formal structured supervision is available to you in your workplace?

Do you engage in any informal supervision, or consultation, in your workplace?

If you engage in informal supervision, or consultation, what does it look like?

Have you engaged in interprofessional/interdisciplinary supervision?

Have you engaged in group supervision?

Use of Supervision

If you participate in supervision, formally or informally, do you find it helpful?

Describe a good supervisor.

Do you have an example of the types of situations where you would consult a supervisor?

If you do not have a social worker as a formal supervisor, do you have an example of a complex issue where you would have liked to have one?

Structural Issues

Is time for supervision built into your position?

How does program management (e.g. Reporting to someone from a discipline other than social work) affect your supervision?

BSW Education about Supervision

Do you feel that the BSW program emphasized the importance of supervision?

How was the practice of supervision taught to you?

What were your expectations about supervision when you graduated?

- What, if anything, has been different in your work in health care?

Do you have suggestions for social work schools about ways to teach supervision?

What advice would you give to graduating BSW students about work in a hospital?

Appendix B

Hamilton Health Sciences

McMaster University Health Sciences

Letter to Social Workers at Hamilton Health Sciences for Recruitment for Research Study

To: Social Workers at Hamilton Health Sciences

From: Erin Stirling, BA/BSW, MSW student and Principal Investigator
Sheila Sammon MSW, McMaster University School of Social Work, Thesis Supervisor

Re: Upcoming Study: Clinical Supervision for Hospital Social Workers: Promise versus Reality.

I would like to invite you to participate in a research study examining clinical supervision for social workers in hospitals. This study is being done as requirement for a Masters of Social Work thesis. The purpose of this study is to explore the relationship between what is taught in schools of social work in Ontario about clinical supervision, and the reality of what social workers experience in practice in hospitals. In particular, we are looking to interview social workers that graduated from a Bachelor of Social Work program in Ontario in the year 1994 or later. If you have obtained further education since that time you are still eligible to participate.

If you volunteer to be a part of this study, you will participate in an individual interview with the researcher at a time and setting of your choosing. This interview will be audio taped and will last for approximately one hour. Following professional transcription of the interview the researcher will contact you one more time via telephone to have you review the transcripts and make any changes that you request. You will not be paid for your time and your participation is voluntary.

Disclaimer: Please note the researcher is also an employee of Hamilton Health Sciences. There is a chance that you may know her and interact with her during your work. Confidentiality will be strictly held and the researcher will never disclose your role as a participant or make reference to it during later interaction.

Thank you for your consideration of my request.

Anyone interested in participating, or if you have any questions please contact the Principle Investigator, **Erin Stirling, at (905) 521 2100 x 76498 or stirlinge@hhsc.ca** as soon as possible. The goal is to hold interviews in March – May 2009. Thank you for your interest.

Appendix C

Hamilton Health Sciences

McMaster University Health Sciences

Participant Information Sheet / Consent Form

Title of the Study: Clinical Supervision for Hospital Social Workers: Promise versus Reality

Local Principal Investigator: Sheila Sammon, Associate Professor, School of Social Work, McMaster University
Principal Investigator: Erin Stirling, RSW, BA/BSW, MSW student

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You are being invited to participate in a research study conducted by Erin Stirling because you are a social worker working at Hamilton Health Sciences, and you have worked no more than 15 years post graduation from a Bachelor of Social Work program in the province of Ontario.

This is a student research project conducted under the supervision of Sheila Sammon. The study will help the student learn more about the guidelines that are provided in the bachelor of social work programs about clinical supervision and the strategies that are used by social workers working in hospitals to obtain clinical supervision. The study will also help the student develop skills in research design, collection and analysis of data, and writing a research paper.

In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study, which will be discussed with you. Once you understand the study, you will be asked to sign this form if you wish to participate. Please take your time to make your decision.

WHY IS THIS RESEARCH BEING DONE?
Clinical supervision is seen as an important part of social work practice; however, it is not always readily available to social workers in hospitals. The researcher is interested in learning abut the expectations that social workers had when graduating from their bachelor of social work programs about clinical supervision, and their experience in their work in hospitals. Bachelor of social work education provides students with regular

clinical supervision in their field placements. This suggests that the social workers will continue to have supervision available to them while they are working. The researcher is interested if this has been the experience of the participants in their work in hospitals.

WHAT IS THE PURPOSE OF THIS STUDY?
The purpose of this study is to explore the relationship between what is taught in schools of social work in Ontario about clinical supervision, and what social workers actually experience in their practice in hospitals.

This study will help us to better understand:

- Social work practice in hospitals today and the effect on the availability of clinical supervision
- The formal and informal strategies that are being used by social workers in hospital to get clinical supervision
- What social workers remember about the way that clinical supervision is taught in bachelor of social work programs in Ontario
- What changes might be recommended to schools of social work so that they can prepare future hospital social workers for the truth about what clinical supervision is available.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?
If you volunteer to participate in this study, we will ask you to do the following things:

- The researcher will contact you via email or telephone to set up a time for an interview.
- An interview will be held at a time and location that is convenient for you.
- The interview will last approximately 1 hour and will include semi-structured questions.
- You will be given the questions ahead of time so that you can review them.
- This interview will be audio taped and transcribed.
- The researcher will contact you one more time via email or telephone (your preference) after the interview to ask you to look over the notes that were made and make any necessary changes. You can choose not to look over the transcripts. If you agree to this second contact, it should take no longer than 30 minutes.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?
It is possible that you may experience some discomfort discussing your practice with or without clinical supervision. You may also experience discomfort or anxiety talking about, and remembering, situations or cases that were difficult for you in your work. You may choose to not answer any question during the interview if you feel any discomfort. Also, given that the researcher is an employee of Hamilton Health Sciences there is a

chance that you may know the researcher and interact with her during your work. Confidentiality will be strictly held and your privacy will be respected. The researcher will never disclose your role as a participant or make reference to it during later interactions.

HOW MANY PEOPLE WILL BE IN THIS STUDY?
This is a small qualitative study that will include approximately 4 to 8 participants. Every participant will be interviewed individually.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND / OR FOR SOCIETY?
You may benefit from your opportunity to think and talk about your personal experiences with clinical supervision and the expectations that you had while completing your bachelor of social work. You may be helping to show that social workers in hospitals are able to achieve some form of clinical supervision even without formal structures in place. Your strategies may provide future social workers with some ideas about how to obtain supervision when formal strategies are not in place. You will also be helping to document for schools of social work that there may be a need to make changes to the bachelor of social work curriculum to better reflect the current practice reality, and to better prepare new social workers for work in hospital settings. You will also receive a short summary of the results if you wish.

WHAT INFORMATION WILL BE KEPT PRIVATE?
If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published. Given that the researcher is an employee of Hamilton Health Sciences there is a chance that you may know the researcher and interact with her during your work. Confidentiality will be held and the researcher will never talk about your participation in the research. Only members of the research team and a professional transcriber, who has signed a confidentiality agreement, will listen to the audiotapes. They will be destroyed after December 2009. All data with your name or contact information will be kept in a locked drawer in a locked office, and destroyed after December 2009. Your personal information will not be shared without consent, except as required by law.

CAN PARTICIPATION IN THE STUDY END EARLY?
If you volunteer to be in this study, you may withdraw at any time. If you choose to withdraw from the study any information you have provided to me will be destroyed unless you request otherwise. If you choose not to answer a question, you may remain in the study.

INFORMATION ABOUT STUDY RESULTS:
If you are interested in reading results of the study you can contact me and I will provide you with a short summary of the findings. These findings will be available in September 2009.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?
You will not be paid to participate in this study.

WILL THERE BE ANY COSTS?
Your participation in this study will not involve any additional costs to you. The researcher will travel to a location chosen by you at a time convenient to you.

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHOM CAN I CALL?
If you have any questions about the research now or later, please contact Erin Stirling, 905-304-6388, stirlinge@hhsc.ca or Sheila Sammon (supervisor) 905-525-9140 ext 23780.

If you have any questions regarding your rights as a research participant, you may contact the Office of the Chair of the Hamilton Health Sciences / Faculty of Health Sciences Research Ethics board at 905 521 2100 ext 42013

CONSENT STATEMENT

SIGNATURE OF RESEARCH PARTICIPANT

I have read the participant information sheet in detail. I have had the chance to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

_____
Name of Participant (please print)

_____ _____
Signature of Participant **Date**

Consent Administered by:

_____ _____
Name of Investigator **Date**

Appendix D

Hamilton Health Sciences

McMaster University Health Sciences

Oath of Confidentiality

I understand that as an interpreter / transcriber / audio/ video assistant/ or research assistant *(circle one)* for a study being conducted by **Erin Stirling** of the Department of **Social Work**, McMaster University under the supervision of **Professor 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 any other way it to anyone outside the research team.

Name: _____ Signature: _____

(Print)

Date: _____Witness Signature: _____