Realising Values: Experiencing and Negotiating Value Demands in Health Social Work Practice

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ABSTRACT

Values are an abstract concept, being numerous, interrelated and hard to discern in practice. Social work values represent the profession's fundamental beliefs about what is important, and they serve to guide actions and practice perspectives. This research involved an examination of how social work practice is enacted within District Health Boards in Aotearoa New Zealand in order to locate the influence of professional values in practice. The research specifically investigates how health social workers working with newborn infants, and their whānau, experience and negotiate professional and contextual value demands. This constructivist grounded theory research involved two phases of semi-structured individual interviews. A critical incident technique was utilised initially with 15 participants to discern the realities of health social work practice. The participants were then re-interviewed to collaboratively explore the emerging theory derived from their collective critical incidents about how value demands are negotiated in the complex landscape of health social work practice.

The theoretical knowledge developed from this research is that health social workers endeavour to control the middle ground of a very complex practice environment riven with competing value demands. Within this practice context, the participants felt that their role was often misunderstood and under-recognised. Health social workers' unique professional perspective situates them within the middle ground, between medical professionals and patients, and attending to issues of social need. They work predominantly within the meso-system to generate space and voice to enhance the way that patients and their whānau navigate the health system, courageously working to ensure that rights and obligations are

upheld, and that voices are heard. The place of social justice as the primary organising value that underpins social work practice is affirmed by this research

The research findings suggest that health social workers practise in a hectic, crisis-ridden environment, which means that macro-oriented social justice action was very restricted and secondary to reacting to unfolding urgent demands and organisational requirements. Health social workers with newborn infants hold a unique skillset and body of knowledge that is suited to managing complexity and juggling competing demands. This is partly due to a critical understanding held by them about systems-in-action. Strengthening health social workers collective voice and identity through a focus on the profession's values would allow them to have a stronger influence on future policy directions. If enabled through community outreach, they are well placed to manage the middle ground between hospital and home, and be crucial lynchpins between whānau, child protection services and DHB services to effectively address the systemic drivers of health inequities.

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GLOSSARY

KEY ACRONYMS

ANZASW	Aotearoa New Zealand Association of Social Workers
CYF	Child, Youth and Family
DHB	District Health Board
EPOA	Enduring Power of Attorney
FGC	Family Group Conference
IASSW	International Association of Schools of Social Work
IFSW	International Federation of Social Workers
MDT	Multi-Disciplinary Team
ROC	Report of Concern to Oranga Tamariki
SCBU	Special Care Baby Unit
SWHIN	Social Work and Health Inequalities Network
SWRB	Social Workers Registration Board

TE REO MĀORI TERMS

Aotearoa	New Zealand
Aroha	To feel love, concern, compassion, to empathise
Āwhi(na)	Help, assist, support
Hapū	Sub-tribal group
Iwi	Tribal group
Kaiwhakatara	Mentors, conscience-prickers
Kaitiaki	Trustee, minder, guard, custodian, guardian, caregiver, keeper, steward
Kaupapa	Topic, policy, matter for discussion, plan, purpose**,** Issue
Kaumatua	Elder
Kotahitanga	Unity, togetherness, solidarity, collective action

Pākehā	New Zealander of European descent
Pono	Truth, validity
Mana	Authority, spiritual power, freedom
Manaakitanga	Hospitality, kindness, generosity, support, showing respect and care
Mātātoa	Fearless, unconcerned, unafraid, courageous
Nga takepū	Māori wellbeing principles
Ora	To be well, safe, healthy, healed
Pā whakawairua	Refilling, replenishing and strengthening workers
Rangatiratanga	Self-determination, sovereignty, autonomy
Tamariki	Children
Tangata Whenua	People of the land, Indigenous
Te ao Māori	Māori knowledge and worldview
Te reo Māori	Māori language
Te Tiriti o Waitangi	Distinct te reo Māori version of the Treaty of Waitangi, Aotearoa New Zealand's founding document
Te Whare Tapa Wha	Māori health model
Tikanga	Correct procedure, custom, intergenerational traditions and methods
Tino rangatiratanga	Self-determination, sovereignty
Tīpuna	Ancestor
Wairuatanga	Spirituality
Whakapapa	Genealogy, lineage, kinship
Whākawhanaungatanga	Process of establishing relationships to relate well to others
Whānau	Extended family, family group
Whanaungatanga	Valuing kinship, connections and belonging

CHAPTER ONE: INTRODUCTION

1.1. Overview

Values are the foundation from which professional social work practice emerges. The value base of social work is the central focus of this research project. Values represent fundamental principles and beliefs about what is important; they guide actions and inform perspectives. Values shape interactions, motivations and help to establish conventions for action, reflecting what is perceived to be important, constructive and worthwhile. Values inform beliefs about what is right and wrong and can be held individually, or as part of a cultural group. Social work values are perceived to be a fundamental and cohesive ingredient in social work practice internationally, due to the diversity of practice across multiple settings (Banks, 2012; Hartman, 1994).

This research concentrates on how social workers experience and negotiate values within the field of health social work practice with newborn infants and their whānau (extended family, family group). The thesis has come to its conclusion at a time when the social work profession in Aotearoa New Zealand is at a critical transition point. The Social Workers Registration Legislation Act 2019 has enabled social workers to achieve professional status, with all social workers required to be registered by February 2021. Under this legislation, the regulatory authority for social workers, the Social Workers Registration Board (SWRB) has been allocated the task of determining scopes of practice. When completed, it is intended that the scopes of practice will strengthen the profession's collective identity and increase understanding about the nature of social work practice nationally (SWRB, 2019). Alongside this historic legislative change, the Aotearoa New Zealand Association of Social Workers (ANZASW, 2019) Code of Ethics has been significantly

revised. These achievements mark a new era of practice within Aotearoa New Zealand social work. During times of change, being able to delineate the place of values in practice will assist social workers to stand strong in their professional identity.

The centrality of social work's professional values is widely touted by researchers into social work values as the point of difference between social work and other helping professions (Abbott, 2003; Bisman, 2004; Reamer, 2006). The profession's value base is evident in its Code of Ethics that serve to guide professionals through conflicting situations. The newly drafted ANZASW (2019) Code of Ethics has been revised to centre more significantly on a description of seven core values that underpin social work in Aotearoa New Zealand. Ife (2010) states that, "a useful framework for discussing [social work] practice is to think of it as comprising three components: knowledge, values and skills. Each of these is important in its own right and each also interacts with others" (p. 223). Values are an essential component of good practice, and Ife (2010) perceives that, without values to guide practice, a social worker is a 'mere technician'. As a profession, it can therefore be argued that we need to continue to develop understanding about all three components, and that research into social work values should not be neglected but given prominence alongside social work knowledge and practice skills.

This research seeks to locate the place of values in current social work practice within Aotearoa New Zealand and to discern how values support the art and craft of professional practice. Schön (1983) asserts that, "in some professions, awareness of uncertainty, complexity, instability, uniqueness and value conflict has led to the emergence of professional pluralism" (p. 17). Social work is diverse across many fields of practice and consequently, competing views of professional practice have emerged. The competing

views of practice are also fuelled by the disruptive disparities in pay scales between health social workers, Oranga Tamariki social workers, and social workers employed by non-governmental organisations. Oranga Tamariki is the statutory child protection service in Aotearoa New Zealand. Schön (1983) states that, "social workers have produced multiple, shifting images of the nature of their practice" (p. 17). The specialised knowledge contained within social work practice cannot be easily transposed onto well-defined tasks across various practice contexts. Despite this divergence, the professional values embedded within the ANZASW (2013, 2019) Code of Ethics hold firm, and are evident in the artful ways in which social workers deal with uncertainties and value conflicts in practice (Schön, 1983).

The landscape of social work practice in Aotearoa New Zealand is experiencing a series of successive adjustments that will have a profound effect on the future of social work practice. In times of change, the profession's values create a sound standpoint for action. At critical junctures, it is important to stop and purposefully reflect before continuing. Social workers are notoriously time-poor but, as we move into a new era of professional practice, time needs to be taken to reconsider the profession's function, purpose and role in terms of its value base. This research into how professional values are experienced and negotiated by social workers has enabled a re-examination of how social work practice is enacted within health social work.

1.2. Background to the Study

The decision to research social work values has been primarily derived through my own practice experiences. I came into the profession due to being attracted to social justice action and wanting to 'help' people. The value base of the social work profession felt congruent with what I hoped to achieve. Looking back, it is evident that, for me to feel

successful in social work, I needed to feel that I was making a difference in people's lives. Through experience in practice, I began to fully appreciate the importance of making a micro-level difference. A fundamental challenge for social workers is understanding and constructively reacting to the systemic links between policy, practice and management decisions, so that difficult decisions in practice are located within the broader socio-economic and political context (Spolander et al., 2015). The challenges of making these links overt and working to engender social change at a macro-level is something that I have grappled with throughout my career. The challenge still feels interminable, despite the hope and belief that I have in societal change.

My background in social work initially involved working for the Women's Refuge movement in the mid-1990s, before conducting statutory child protection work, and then predominantly health social work. From 2011, I have been employed as a social work lecturer. Since the 1990s, neoliberalism has increasingly shaped the limits and boundaries of professional practice. A retracting welfare state and increasing rationalisation of services have made it progressively harder to gain meaningful resources for people and communities. As I moved into social work education, I became increasingly concerned about newly qualified social workers' practice realities and their ability to adhere to their social justice practice imperatives. It was this concern about the ability of the profession to uphold its professional values in a neoliberal environment that planted the seeds for this research.

Values are an abstract concept. Values are numerous, interrelated, contradictory and hard to determine in social work practice. They consciously and tacitly inform decision-making within the business of day-to-day practice. In risk situations with newborn infants, value-based decisions about the primacy of the infant become paramount. Health social work with newborn infants involves close attention to issues of child maltreatment and,

because of this, day-to-day practice can involve intensive co-working with Oranga Tamariki social workers.

The intention behind concentrating exclusively on health social work with newborn infants and their whānau was that the research would gain the depth of data about values grounded in a specific practice setting to develop theoretical knowledge about how value demands are experienced. The research focuses on the inherent and often ineradicable tensions that exist within situations of value demands. Consideration is also given to how individuals achieve cognitive consistency in situations where the values of the District Health Board (DHB), the profession, and/or the patient and whānau do not immediately correspond with social workers' personal values and preferred practice approaches.

This research considers how DHB values, alongside socio-economic and political norms, influence complex decision-making; it explores health social workers' experiences of values alongside of their work expectations. Social work practice frameworks are influenced by personal perspectives and values, are informed by theories and practice approaches, and are also supported by professional dimensions. These professional dimensions are visible in social work practice standards, core competencies, scopes of practice definitions, codes of conduct, and codes of ethics. Further consideration is also given within this research to the way neoliberal ideology has shaped workplace responses to value dilemmas, due to the primacy of contractual and managerial requirements.

The research also came into fruition because of my curiosity about how value demands are consciously recognised, experienced and resolved in situations of competing values. Due to the multiplicity of values (Clark, 2000; Marino, 2013), there is likely to be tension derived from value demands in everyday social work practice. Value conflict brought

about through competing demands can occur due to a perceived gap between an individual's practice vision, work expectations and their practice experiences. This research was developed to examine the contexts in which individual social work practitioners identify that their practice values are not congruent with their practice style, and to explore the reasons for this. This involves attention to social constructions pertaining to when, and how, social workers recognise and manage value discrepancies. It also incorporates an examination of the movement from unconscious to conscious recognition of practice dilemmas, and the stage at which social workers take action to address the underlying value dilemma.

This first chapter contains the rationale for the research and provides a general overview of the thesis that communicates the research question, objectives and methodology. This chapter also provides a definition of values, social work values, and considers the influence of Māori perspectives alongside the uniqueness of bicultural social work practice within Aotearoa New Zealand. Further consideration is given to the journey into the question, the importance of the research topic with attention being paid to the way that my professional background has shaped this research. Perceptions on insider positioning are explored in relation to this research. Another function of this introductory chapter is to deliver clarity about terms used and to situate the research by providing a brief reflection on political and legislative changes that have occurred during the research project. The chapter concludes with an outline of the structure and organisation of the thesis.

1.3. Values Characterised

As this research is concerned with locating how values are experienced and negotiated in practice, it is therefore important to ensure that there is conceptual clarity

about what values are, and what is meant by the phrase *social work values*. This section of the chapter provides clarification on how values are defined, and how I have interpreted social work values, to provide certainty about how values are articulated and conceptualised throughout the thesis.

To define values, Clark (2000) and Reamer (2006), two prominent writers on social work values, draw on what Reamer refers to as "Rokeach's classic definition of personal values" (Reamer, 2006, p. 28). In his book titled *The Nature of Human Values,* Rokeach (1973) defines values as:

> A value is an enduring belief that a specific mode of conduct or end state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence. (p. 5)

Social change would not happen if values were rigid and unchanging (Rokeach, 1973). Conversely, if values were unstable continuity would not exist. Values can therefore be perceived as enduring, but open to change.

Levy (1973) asserts that there are three principal dimensions that represent the main social work value orientations. These value orientations relate to "preferred conceptions of people, preferred outcomes for people and preferred instrumentalities for dealing with people" (Levy, 1973, p. 34). These dimensions embody the collective values shared by social workers, providing a guide for action in professional practice, and enabling a standard by which professional practice can be measured. Rokeach (1973) states that values are comprised of *cognitive*, *affective* and *behavioural* elements. The cognitive component relates to the desirable value, whether it is ideals about how to behave, or how to achieve a particular goal or end state. The affective component is due to the fact that values generate emotions, while the behavioural component relates to the propensity of values to generate

action. Given the multiplicity of values and the complex use of the word *values* there can be no definitive definition; instead, context-specific working definitions are best utilised to avoid misinterpretation or controversy (Clark, 2000).

For the purposes of this research, I will follow Banks' (2012) definition of values and social work values. Banks (2012) argues that values are defined as meaning "the particular types of belief that people hold about what is regarded as worthy or valuable" (p. 8). Banks (2012) asserts that literature about *professional values* relates to ethical principles about how people are treated, demonstrating the accepted wisdom on what actions are good, and what is right or wrong. Therefore, according to Banks (2012):

> ... the term *social work values* refers to a range of beliefs about what is regarded as worthy or valuable in a social work context – general beliefs about the nature of the good society, general principles about how to achieve this through actions, and the desirable qualities or character traits of professional practitioners. (p. 8)

Within this research, the term *social work values* will relate to the beliefs and principles that social workers as a profession accept as essential to have in order to achieve a healthy society; as well as the desirable characteristics of an individual in professional practice.

As social workers perceive their profession to be propelled by its values, conceptual flaws about values have been neglected (Clark, 2000; Shardlow, 2009). When values are referred to in Aotearoa New Zealand social work literature, it is recurrently in an abstract manner that is interrelated with principles and ethics. When it occurs, the lack of distinction between values and ethics can be confusing as it can obscure the influence of values on practice. An integral starting point for this research was gaining conceptual clarity about the differences between values and ethics, and attention is given here to the way in which the differences are perceived.

The end result of combining values and ethics without distinction is that social workers tend to list their professional values and then use them interchangeably with ethics (Clark, 2000). Values inform the ethical decisions that are made in social work practice. Ethical principles represent universal prescriptions for good conduct. Applying ethical principles contained within codes of ethics needs considerable support as practice dilemmas invariably involve conflicting principles, and decision-making is influenced by values (Raines, 1994). Ethical codes cannot prescribe a course of action. Codes of ethics operate instead like a lighthouse; signalling a standard, providing a point of reference and a warning of impending danger (Clark, 1999).

Technical competence or following a grand ethical standard will not necessarily ensure a satisfactory level of professional practice (Clark, 2006). Conducting ethical thinking in social work practice is a moral undertaking that requires a clear rationale for action (McAuliffe, 1999). Ethics involve a philosophical consideration of moral virtues and political duties. In professional practice, these virtues and duties refer to customary rules and acceptable practices that denote a prescriptive structure of obligations (Clark, 2000). Alternatively, values reveal an individual's beliefs about how to utilise and prioritise universally accepted principles. In decision-making, values inform the identification of the right action for a given situation and illustrate how a person chooses to 'be' (Raines, 1994). Professional ethics embody core professional values, and are formulated to assist members of the profession to apply them to action (Clark, 2000). Values on their own are relatively weak, and Bowles asserts that the only agreed set of values would be those published within codes of ethics (Bowles et al., 2006). Ethical codes represent a systemised framework of values for practice.

Values are perceived as beliefs. Consequently, they are longer-lasting than an attitude, opinion, or preference (Pullen-Sansfaçon & Cowden, 2012). Ethical self-reflection involves an exploration of how one should act – what is the right thing to do; while an individual's values create the moral framework from which action develops (O'Conner et al., 2003). A key distinction between values and ethics is that values are aspirational ideals about what is good, while ethics are rules that provide direction on how to behave by defining appropriate and inappropriate behaviour (Barsky, 2010). These rules are usually agreed upon and established by a group or culture to govern and guide behaviour. Ethics can be perceived as values in action (Nathanson et al., 2011). Within this thesis, social work ethics are considered to be social work values in action.

1.4. Importance of the Research Topic

Continuing research into the profession's values in Aotearoa New Zealand's distinctive social work practice environment is warranted to ensure that the acknowledged value base of social work is conversant with contemporary practice. Alongside legislative and social policy changes, the social work practice landscape evolves through advances in medical knowledge and information technologies. Variations to practice are brought about through environmental changes and issues surrounding sustainability, population trends, and the impact of increased globalisation and neoliberalism (Reamer, 2006, 2013). Societal norms about whānau and community also respond to these changes. Ongoing theoretical development about values and ethics is required as economic policy, politics, societal change and environmental demands have altered the circumstances in which social work is practised (Reamer, 2013).

The 1970s and 1980s was a prolific period of writing about social work values and ethics, as this was a period of time when social work gained professional recognition (Reamer, 2006). There is a paucity of knowledge about how values specifically support social work practice in Aotearoa New Zealand. Most of the available literature from research on values stems from the United States and the United Kingdom, with some literature available closer to home, from Australia. Banks (2012), Barnard et al. (2008), Beckett and Maynard (2013), Clark (2000), Fenton (2016), Gordon (1965), Gray and Webb (2010a), Hugman and Carter (2016), Levy (1973), Parrott (2006), Reamer (2013), and Timms (1983) have all written considerable works on the influence and place of values on social work. Authors such as Abbot (1999, 2003), Greeno et al. (2007), Groessl (2013), Nathanson et al. (2011), Schartza (2006), and Woodward and Mackay (2011) have all researched the measurement of social work values.

Barsky (2010), Hatiboğlu et al. (2019), Landau (1999), Osteen (2011), and Papouli (2016) have all contributed to research knowledge about teaching values in social work education. Bisman (2004) conducted research into adherence to social work values and Boehm (2013) has investigated the integration of values into social work interventions. Calderwood et al. (2009), Csikai (2000), Doyle et al. (2009), Gallina (2010), Landau (2000), McAuliffe and Chenoweth (2008), Raines (1994) and Stewart (2013) are researchers who concentrated on the role of values in situations of complex decision-making. Hugman (2013), Houston (2012), and Landau and Osmo (2003) have conducted research into value pluralism in social work practice. These researchers have all made significant contributions to the body of knowledge about social work values, and I have considered their work as part of the development of this research.

Social work values are problematic to research empirically. It is difficult to obtain accurate information about the function and nature of values in professional practice. Issues such as social desirability bias can also complicate research relying on self-reporting of values in practice (Congress & McAuliffe, 2006). Connolly (2007), in her writing on the Aotearoa New Zealand Practice Framework for child welfare, specifies the core values of the social work profession in Aotearoa New Zealand as being "non-discriminatory, democracy and human rights, service user participation and integrity" (p. 827). These values are congruent with those listed in the ANZASW (2013, 2019) Code of Ethics. In social work literature, values are often listed and are recognised as being central to the profession; but little research appears to have been done in Aotearoa New Zealand on how values support everyday social work practice. To my knowledge, there has been no research undertaken in Aotearoa New Zealand about how value demands are experienced and negotiated in practice in terms of influence and support.

This research has been designed to contribute to the limited knowledge base about how social workers experience and negotiate values in social work practice within Aotearoa New Zealand; this knowledge will have broader relevance to global debates and considerations. In a time of rapid socio-economic and environmental change, this study on values assists the social work profession and social service providers for the following reasons:

- It adds to the framework of professional knowledge about what Aotearoa New Zealand social work practice is and how it is conducted in a health setting.
- It aids understanding as to how social workers experience value demands in practice, and how these experiences influence their practice and their professional identity.

- It illuminates the ways in which social workers are supported in situations where value demands exist in complex situations, as well as contributes to a body of knowledge about supporting social workers in their day-to-day practice.
- It considers values as a means to foster resilience in practice.

1.5. Research Question, Objectives and Methodological Overview

This research sought to generate knowledge in order to answer the following question:

> *"How do Aotearoa New Zealand health social workers understand and negotiate professional and contextual value demands when working with newborn infants and their whānau?"*

In developing the PhD research proposal about how health social workers experience and respond to professional and contextual value demands, the following three specific objectives were formulated:

1. To explore the situations and circumstances (context) in which social workers are conscious of their values in health social work practice with newborn infants and their whānau.
2. To explore how value demands are negotiated in situations of complex decision-making in health social work practice with newborn infants and their whānau.
3. To describe value demands in terms of perceived influence on day-to-day behaviour and management of role, as well as perceptions of self-efficacy and professional identity in health social work practice with newborn infants and their whānau.

This research utilises a constructivist approach to inform the use of a qualitative research strategy that employed a constructivist grounded theory design (Charmaz, 2014). In this study, I explore, through the use of the critical incident technique (Flanagan, 1954; Fook & Gardner, 2007), the lived experiences of health social workers who work with newborn

infants and their whānau. The critical incident narrative is used as an initial platform from which to analyse how health social workers recognise and manage value discrepancies in everyday practice.

The research participants are all Aotearoa New Zealand registered social workers. At the time of the first interview, the participants were all working in health social work with newborn infants and their whānau or had significant experience in this field of practice in the previous five years. Non-probability purposive and snowball sampling procedures were utilised to access the participants, with 15 participants recruited initially. The research had two distinct phases of data collection; see Figure 1 for a visual breakdown of the two-phase process. The same group of participants were interviewed across the two phases of data collection, with one participant withdrawing after the Phase 1 interview.

Figure 1. Phases of data collection.

This research utilises the personal constructs of health social workers to examine the impact of the current working environment on them. Distinct research questions were developed for the two separate research phases; they were constructed to gain the clarity about values needed to resolve the overall research question. The phase one data-collection process utilised the critical incident technique (Flanagan, 1954; Fook & Gardner, 2007) as a

platform to comprehend the demands placed upon health social workers, and to analyse how health social workers recognise and manage values in practice. The specific question underpinning the phase one research process was:

> *How do Aotearoa New Zealand health social workers **negotiate** professional and contextual value demands when working with newborn infants and their whānau?*

The phase one research process allowed the first research objective to be achieved, as the critical incident technique illuminated situations and circumstances in which health social workers are conscious of their values in practice. The critical incident narratives provided a strong foundation of rich data, laying the groundwork for information about how values guide professional practice to be imparted in order to achieve the final two objectives in the phase two data-collection process.

The phase two research process built on the earlier research phase. The question underpinning the phase two research process was designed to extend the development of the second and third research objectives. The phase two research process was designed to gain clarity about how the participants perceive the influence of values on their day-to-day practice. The specific question underpinning the phase two research process was:

> *How do Aotearoa New Zealand health social workers **understand** professional and contextual value demands when working with newborn infants and their whānau?*

The difference between the specific questions for the two research phases is that the critical incident narratives provided insight into what the participants do; the focus of the phase two interviews was on the participants' perceptions of health social work practice, when viewing their collective action and narratives through a lens focusing on values.

The phase two interview involved sharing salient quotes on cue cards that illustrated the developed focused codes from the phase one interviews. This subsequent interview was primarily about targeting critical reflection from the participants to deliberate on how they collectively manage values, and value-related tension and conflict in practice within the DHB environment. This stepped amplification of research questions and objectives through the research phases was devised to develop clarity into how values shape health social work practice. The process allowed for an iterative examination of the link between social work values and the multiple realities of day-to-day health social work practice, and therefore generated knowledge grounded in the participant data to answer the overall research question.

It became increasingly evident during the analysis of the research findings that the participants referred to systems in practice, utilising ecological systems' thinking to underpin their critical thinking about the nature of health social work practice. The ecological perspective was not overtly spoken about as a formal theory by many of the participants but it was clear from the participants' narratives that they made sense of their working environment through analysing it in terms of interrelated systems within a wider ecology. A decision was made early in the writing of Chapter Six (Discussion) to utilise an ecological perspective to inform the inquiry when discussing the findings. The ecological perspective underpins social work knowledge development and the professions traditions (Healy, 2014; Pardeck, 1988). This assertion is evident in the way that the participants spoke about systems in practice, and the assertion is also true about the way that I, as a researcher, innately organise and frame social work knowledge. It can therefore be concluded that the ecological perspective would have been innately and obliquely employed throughout the course of this research project by both the researcher and the participants.

In the discussion of the phase one findings in Chapter Four (Phase One Findings), further detail is provided about the conscious choice to use an ecological perspective to assist with framing the analysis from the findings.

The principal analytical categories, *Contextual complexity* and *Controlling the middle ground* were formed by the exploration of how values are experienced and negotiated over the two phases of data collection. In the discussion chapter, these categories are then positioned alongside the ecological perspective and relevant literature to achieve the final research objective – to discern the influence of value demands on day-to-day practice, management of role, and perceptions of professional identity and self-efficacy.

An overarching theoretical perspective provides a conceptual framework to assist with developing a coherent central argument for a thesis (Adams & Buetow, 2014). From the outset, symbolic interactionism is the theoretical perspective employed to support the theoretical underpinnings of this research. Duckles et al. (2019) state that symbolic interactionism powers the critical inquiry of constructivist grounded theory through its core focus on how meaning is made through interactions, human agency, communication, and interpretation. Within this research, symbolic interactionism facilitates the development of key understandings about how meaning is derived from action within health social work practice. Further explanation about the philosophical assumptions, the theoretical perspectives, and the methodological underpinnings of the research project is located in Chapter Three.

1.6. Journey into the Question

In keeping with the constructivist orientation, it is important to declare my insider knowledge as my experiences, assumptions and disciplinary perspective have influenced the

research question (Charmaz, 2014). As acknowledged earlier, the journey into this research had many different beginnings. It has been partly drawn from my own observations and practice experiences across a range of fields of social work practice, including health social work practice on paediatric and maternity wards. The research topic became clearer through my subsequent experiences as a social work lecturer preparing social work students for the demands of professional practice. As an educator, I have (to a certain extent) travelled with the students through their first experiences of professional practice and gained insights into how their field placement experiences shaped their thoughts about what it means to be a social worker. These insights also provided me with a window into the working environment of the agencies in which these students conducted their field placement and the strengths and the struggles of these agencies.

Each year I teach a 'Social Justice, Ethics and Law' paper to social work students. In the course of this paper, students examine social justice and ethical issues, drawing on their placement experiences to further develop their understandings of the legal, ethical and professional responsibilities alongside of the values of the profession. Time in class is spent exploring ethical decision-making and dilemmas. Social workers encounter ethical dilemmas when they are required to choose between two equally unwelcome alternatives that represent conflicting values and an unsatisfactory outcome (Banks, 2012). In teaching these students, I have found myself making comparisons between the ideals of emerging social workers and my personal experiences and observations of social work practice. My reflections on the students as beginning practitioners and my observations of social workers whose practice is often proscribed by the confines of their agencies' mandate lead me to a place of curiosity about how social workers make decisions in situations where there is

value conflict. When they are in risk situations or experiencing an ethical dilemma, how does their organisational context impact upon their beliefs about what needs to be done, and what should be done? Are social workers who are required to adhere to a rigid proceduralised approach to practice still able to satisfactorily realise the values that underpin their profession? These types of questions began to grow in significance as I searched for ways to support students through their own personal journey to practice.

These questions generated a sense of disquiet and, at the outset of this research, I pondered about how the values that social workers hold work to support and inform the role and function of professional practice. Core social work values impart a sense of duty towards ensuring that social rights are realised and maintained. I became inquisitive about how values are conceptualised within day-to-day practice and I wondered whether social work values were hard to pragmatically conceptualise and realise due to the reactive nature of day-to-day practice. I believe that social work students and experienced practitioners alike aspire to work at both micro and macro levels to address social inequity and maximise self-determination of their clients, but I wondered how organisational norms and practice mandates affect the realisation of these values. To understand more about this, I wanted to investigate the way that social workers encounter values in practice. This research has been designed to explore the ways in which social workers reflect on situations of value conflict. I wanted to examine the contexts in which social workers recognise values in practice, or how values become visible via manifestations of value conflict; to consider the impact value conflict has on social workers' practice behaviour and perceptions of self-efficacy. I was also curious about how value demands are resolved, and what social workers identify as being useful in their successful resolution.

I was interested in what situations individual social workers identify that they feel discomfort in due to value conflict and what situations may lead them to feel disempowered, conflicted and burnt out due to value demands. I was concerned about what happens to social workers when they experience discomfort about the funding provisions that they work under, when issues about need and unmet need, client choice, or capacity make it hard for social workers to advocate for their clients. These questions lead me to query how often do social workers disregard their clinical wisdom in practice and work according to the agency mandate, and I wanted to analytically question the 'what, when, how and why' of values in terms of supporting good social work practice (Charmaz, 2012).

The emphasis given here to my journey into the question is important as it acknowledges my own subjectivity in relation to my work experiences and this study. Charmaz (2005) claims that silent authorship masks the interpretive and intuitive nature of writing, stating that social justice researchers should assert their audible voice in their writing. Within the critical paradigm, reporting on reflexive processes is an important validity measure in qualitative research, as it demonstrates the social, cultural and political forces affecting the researcher (Creswell & Miller, 2000). Transparent reporting on how values, beliefs, motivations and bias shape the research inquiry enables increased understanding of the research itself. In addition to explaining my position as a researcher, it is also important to recognise the active role that I take in the research, therefore I write in the first person throughout this thesis.

In summary, this research project originated from a desire to discern how social workers experience and respond to professional and contextual value demands. It is designed to explore how professional values can support practitioners in complex situations

with conflicting demands, in a macro-level environment infused with the tenets of neoliberalism. Health social work with newborn infants and their whānau is located within an extremely complex and demanding practice environment, and it was therefore chosen to be the sphere from which to explore the impact and effect of values on social work practice. A constructivist grounded theory design was utilised to construct meaning from the findings (Charmaz, 2014). The employment of a constructivist research approach has assisted in allowing me to have the reflexive space needed to holistically consider values in order to co-construct theory about the influence of values on practice. Utilising a constructivist approach has enabled critical reflection upon my views and interpretations as a social work researcher while still giving primacy to the participant's narratives, views and experiences. It was my hope at the beginning of this research that it would provide a new perspective on the currency of values in social work, as well as help devise strategies to utilise values to best support social work in the current practice environment. I continue to hope that the research findings will assist heath social workers with understanding their support needs in situations of value conflict.

1.7. Reflexivity on Self

Reflexivity on self is vital to a social constructivist research approach; not just in how professional background and personal experiences influenced the research, but also to critically consider the impact of self on the data-collection procedures. In this research all the participants were women as no men responded to the call for participants. Social work is often perceived as a female profession and due to the patients being women and babies, health social work with newborn infants is also gendered in its practices. I was aware that, as a female social worker, I strongly identified with the health social workers working with

newborn infants and their whānau. My most recent social work practice experiences outside of the university environment had been that of a maternity/paediatric social worker. Ideologically, I felt in tune with the group that I was researching as they were women who, through their distinctive social work status, identified with similar professional values and had comparable practice experiences. It was challenging to study a societal group to which I felt ideologically aligned. Reflection on self is warranted before defining one's own research perspective (Mutch, 2013). I felt it necessary to openly declare information about my work history to the participants when I first met with them. I was aware of the potential for role conflict, but felt that an open, reflexive approach was the best solution, alongside being honest with the participants about my past professional experiences (Colbourne & Sque, 2004).

Within this subsection on reflexivity on self as a researcher, it is also important to locate myself in terms of who I am personally, as well as professionally. I am a mother, daughter, sister, and aunt; embedded in a large supportive whānau. I was born in Aotearoa New Zealand. I had a rural upbringing on an orchard with extended whānau living adjacent. The values and intrinsic ways of making sense of the world have been transmitted in part through the generations. The various branches of my family tree have all been born in Aotearoa New Zealand for many generations. My ancestors are predominantly from Ireland, England, Scotland, Wales, with some Danish heritage, but I identify as a Pākehā (New Zealand-born European) woman.

I have built a life with a Māori partner of Ngāpuhi and Ngāti Whakaue descent, my life has been shaped by my upbringing and day-to-day commitments. I grew up on the outskirts of Maketū, a predominantly Māori community. My partner and three children

whakapapa (genealogical lineage) to this community, and we now live in Tauranga Moana. Through their eyes I see bicultural values in action – the contrasts and the connections. What this means for this research is that I also recognise how my personal life informs my understanding of how values are experienced and negotiated. An example of this is the way in which I view family or whānau. In conversations, I speak of family in the Māori sense of whānau, which reflects the blood ties beyond the immediate nuclear family unit.

When dealing with matters of health and wellbeing, constructions of whānau are significant. Elder (2018) warns against using the words whānau and family interchangeably, stating that "reducing the concept of whānau to that of family means that health potential and health needs can remain invisible and unmet" (p. 90). Constructing concepts of family through Western perspectives marginalises, limiting both policy and practice through failing to unlock resources and impacting upon issues of self-determination (Elder, 2018). Durie (1985) explains that:

> Family, in a Māori sense, denotes an extended kinship system, rather than a nuclear family, and it has many implications for health. An important one is in the field of child health. Traditionally, Māori children were nurtured as much by tribal elders as by their own parents. (p. 484)

Traditionally the raising of tamariki (children) has been a collective responsibility, and the wellbeing of women and children is central to the wellbeing of the whānau (Pihama et al., 2019).

This conception of whānau is vitally important in work with newborn infants. In this research, I will use the word whānau to reflect both constructions of family and whānau. Even though I do not have a hapū (sub-tribal group) or iwi (tribal group) the word whānau, with all the nuances that it brings, encapsulates what blood ties are. The concept of

whānau, with newborn infants being embedded and belonging in an extended kinship system that looks back to the past and into the future is fundamental to identity, wellbeing and social work practice (Pohatu & Pohatu, 2007). Reflexivity and knowledge of self helps to ensure that the way that I conceive of, and value, whānau does not disrupt the research process. This value statement about whānau informs the lens through which I view practice as a researcher. This lens needs to be formally noted so that readers of the research can appreciate how opinions about whānau as a construction have informed the development of this thesis.

As social work values in Aotearoa New Zealand have been shaped by Te Ao Māori (Māori knowledge and worldview) and, as part of my commitment to bicultural practice, I sought Kaitiaki to provide support and guidance over the aspects of this research that relate to Māori. Rev. Māori Marsden defines *tiaki* as "to guard… to keep, to preserve, to conserve, to foster, to protect, to shelter, to keep watch over" (Royal, 2003, p. 67), with the prefix, *kai,* denoting the agent who guards, preserves, conserves and protects. As a Pākehā woman writing about social work values in Aotearoa New Zealand, I needed to be guided by kaumatua (elder/s) in order to be culturally safe and accountable in the way that I represented Te Ao Māori within this research. Emma Webber-Dreadon (ANZASW Life Member) and Hori Ahomiro (Bay of Plenty ANZASW Kaumatua) responded generously to my request for support. They met with me after I had completed the findings chapters, again when I had completed the recommendations, and prior to thesis submission, so that I could consult with them about the way that I had interpreted and written about matters pertaining to values in relationship to Te Ao Māori. As Kaitiaki, they challenged, guided and supported, and allowed me to email them questions about my analysis for feedback. This process made available an alternative lens from which I could view my developing analysis.

This support and guidance helped me to feel satisfied with the way in which I perceived concepts relating to Te Ao Māori, thus giving me increased confidence in the emerging theory.

This research contains many value-related constructions pertinent to race, racism and cultural competence. I have made a conscious decision to primarily explore these concepts within the realms of Te Ao Māori, in acknowledgment of the status of tangata whenua (People of the land, Indigenous) and of the profession's bicultural commitment to Te Tiriti o Waitangi (Aotearoa New Zealand's founding document). Matters pertaining to multi-culturalism or work with other people of the Pacific have not been focused on to the same extent. It is acknowledged that Pacific social work draws from a distinct set of knowledges, informed by values that are deeply ingrained in a distinct Pacific-Indigenous worldview (Mafile'o et al., 2019). This decision to focus primarily on bicultural practice has been made with considerable reflection, especially given the large Pacific diaspora that exists within Aotearoa New Zealand. Given the concerning health and wellbeing statistics that Māori withstand, this decision is in alignment with the severity of the concerns that the participants held towards working towards equity for tangata whenua within health. With caution, I state that it is fair to acknowledge that, aside from issues of Indigenous rights and colonisation within Aotearoa New Zealand, many similar types of experiences regarding racism and discrimination are generally applicable to other non-dominant cultures within Aotearoa New Zealand. These experiences cannot be discounted.

1.8. Māori Perspectives

The values of social work practice are specifically formulated for the profession within Aotearoa New Zealand and a core value statement is presented in the ANZASW

(2019) Code of Ethics. The revised ANZASW (2019) code strengthens the ethically mandated actions and focus that social workers have to represent and hold to account the bicultural context of practice. Values provide insight into the profession's belief systems and principles that guide social work action. Values also, subconsciously or consciously, inform the choice of theoretical knowledge that social workers choose to employ in everyday practice. Researching values within this unique bicultural context provides valuable insights into practice choices, and how value-based decisions inform the utilisation of knowledge and evidence to validate social work action.

At the outset of this research, there was an absence of research into social work values in Aotearoa New Zealand. Recently there has been increased attention to social work values as evidenced in the adoption of the ANZASW (2019) Code of Ethics, which has a strong emphasis on seven core values that emanate from Te Tiriti o Waitangi. These seven core values have been drawn directly from the professional capabilities framework developed by the 'Enhancing the Readiness to Practice of Newly Qualified Social Workers' research project (Beddoe et al., 2018). The Readiness to Practice project was conducted by a group of social work academics from across Aotearoa New Zealand (Ballantyne et al., 2019).

This doctoral research project was initiated in 2013 and utilised the ANZASW (2013) version of the code of ethics to inform the analysis of how values bolster ethical practice in Aotearoa New Zealand. The ANZASW (2019) code was revised because of the changes brought about through the introduction of the Social Workers Registration Act 2019, which established mandatory registration for social work practice. The legislative changes facilitated a movement to a less prescriptive code of ethics, centred on values rather than rules. With the shift to mandatory registration, the SWRB's role of monitoring social work practice has been strengthened. ANZASW is no longer involved in complaint resolution or

disciplinary processes, as all social workers will now be subject to the standards contained in the SWRB (2016) Code of Conduct. This has allowed ANZASW (2019) to devise a new formulation of their code of ethics that is centred on value-based aspirations for practice, rather than regulations for assessing possible misconduct by non-registered social workers.

It is important to include the value statements of the different versions of both ANZASW (2013, 2019) codes of ethics as they have informed the way in which values have been discerned throughout the course of the research. Chapter Two contains a summary of the core value position of the ANZASW (2013) Code of Ethics in order to demonstrate the way in which values were presented in the professions ethical code for the majority of this research. Both ANZASW (2013, 2019) codes of ethics are bicultural documents, with the new version maintaining the profession's commitment to bi-cultural practice. In Aotearoa New Zealand, eminence is given to Te Tiriti o Waitangi in social work practice (Fraser & Briggs, 2016), with tangata whenua accounts of social policy and social work practice being informed by ngā takepū Māori (Pohatu, 2003; Ruwhiu et al., 2016). Ngā takepū are explained by Pohatu (2008) through the following statement:

> Takepū as applied principles signpost to generations how to live life and behave, and then engage with people as they pursue the quest of their aspirations and needs. They are cultural positions that provide cultural insights, filters, markers and tools, offering well-tried ways of connecting in relationships and kaupapa (topic, policy, matter for discussion), demonstrating that they are constantly thought about and used in everything we do. (p. 247)

The ANZASW (2019) Code of Ethics states that it draws its core value statement from the nation's founding document, Te Tiriti o Waitangi. The core values as listed in the (ANZASW, 2019) Code of Ethics are Rangatiratanga, Manaakitanga, Whanaungatanga,

Aroha, Kotahitanga, Mātātoa and Wairuatanga. These will each be explained in accordance with the wording in the ANZASW (2019) Code of Ethics on pages 10–14 of that document.

- **Rangatiratanga:** Social workers value diversity and cultural identity. We use our practice to advocate for and support self-determination and empowerment of others.
- **Manaakitanga:** Social workers recognise and support the mana (authority, spiritual power, freedom) of others. We act towards others with respect, kindness and compassion. We practise empathic solidarity, ensure safe space, acknowledge boundaries and meet obligations.
- **Whanaungatanga:** Social workers work to strengthen reciprocal mana-enhancing relationships, connectedness and to foster a sense of belonging and inclusion.
- **Aroha:** Social workers acknowledge our mutual responsibility for wellbeing. We recognise our common humanity with people who use our services and hold people to account, using professional judgement without being judgemental. We focus on people's strengths and finding solutions.
- **Kotahitanga:** Social workers work to build a sense of community, solidarity and collective action for social change. We challenge injustice and oppression in all its forms, including exploitation, marginalisation, powerlessness, cultural imperialism and violence.
- **Mātātoa:** Social workers act with moral courage in situations that are uncomfortable, challenging and uncertain. We use critical reflection and questioning to work through contradictions and complexity.
- **Wairuatanga:** Social workers attend to the wellbeing – spiritual, emotional, psychological and physical – of self and others. We acknowledge the significance of whakapapa, self-awareness and self-care

Māori values are unlike Pākehā values, and it would be tokenistic to simplistically explore them or apply them to Western value constructs (Patterson, 1992). Any consideration of Māori values when written about from a Pākehā perspective is to be done with caution. It is destructive for Western values to be imposed upon Indigenous value

systems, especially given that conceptualisations such as individualism, objectivism and professional distance characterised in Western social work practice may not be culturally relevant and could possibly alienate Indigenous people (Gray et al., 2008). It can be strongly asserted that Māori values and perspectives inform social work practice in Aotearoa New Zealand through imparting different ways of knowing and making sense of the world. Application of Māori values within social work moves practice beyond mono-cultural or multi-cultural interpretations. Gray and Coates (2008) assert that, "making culture central to social work forces the profession to question the primacy of Western (modernist) values and to rethink just what is universal" (p. 21). To be a morally active social work practitioner, a reflexive approach to practice needs to be permanently adopted to shun the structural propagation of discrimination and racism (Husband, 1995). Māori values need to be profoundly understood, with further deepening in appreciative understanding through praxis across a social work career in order to meaningfully achieve the SWRB (2015) Core Competency One: Competence to practise social work with Māori. Achieving this core competency is not a means to an end, but part of a wider social justice commitment to address the ongoing colonisation processes and widespread inequities that Māori withstand.

Māori worldviews have had, and continue to have, a significant contribution to social work practice and policy discourse (Munford & Sanders, 2010). Pohatu (2003) portrays Māori worldviews as Kaitiaki, that provide a "wealth of concepts, principles and 'voices' created, nurtured and applied thorugh time" (p. 2). Ruwhiu (2001) warns that, while Māori knowledge and worldviews contain 'solutions or resolutions' to issues facing Māori, deep cultural understanding is needed to effectively practise social work in a bicultural manner.

Cultural integrity is needed to safely bridge the constantly contested divide between Māori and non-Māori worldviews, so that tino rangatiratanga (self-determination, sovereignty) is activated (Pohatu, 2003; Pohatu & Pohatu, 2007). Allegiance to bicultural practice in social work legitimatises the equal contribution of Māori knowledge and processes for conducting social work (King, 2017) allowing for space to be claimed for Māori cultural principles in practice (Pohatu, 2003).

Māori worldviews inform an humanistic approach to relationships, encapsulating aspirations, obligations, heritage and traditions; opening up further options of ethical approaches to relational engagement (Pohatu, 2003). Walsh-Tapiata (2008) asserts that traditional values for Māori social workers will always be relevant, as they are a primary source of strength in practice. Dobbs and Eruera (2014) state that, when working with whānau, tikanga represents the "practice of Māori beliefs and values; collective practice" (p. 9). Concepts such as tikanga are difficult to conceptualise from a Western framework, and need to be approached cautiously, checking continually for appropriate and correct understanding. It can be asserted, though, that tikanga Māori relates in part to customary values and practices (Mead, 2016). Tikanga is perceived by the Rev. Māori Marsden as correlating to Māori customs, and intergenerational traditions and methods that reflect "the right way of doing things" (Royal, 2003, p. 66). Tikanga Māori can also be appreciated as forming the theoretical basis to Māori social work practice (Hollis-English, 2015).

Tikanga is defined by Eruera and Ruwhiu (2015) as "our cultural ways of responding" (p. 12) – with tikanga practices being explained by Māori social workers to demonstrate how values are implemented in professional practice (Hollis-English, 2012, 2015). Indigenous values may not be demarcated as values within a Western tradition, but are nevertheless

fundamental to ethical decision-making (van Heugten & Gibbs, 2015b). Social workers in Aotearoa New Zealand are required to remain alert to the processes of colonisation that restrict knowledge of cultural values and practices (Eruera & Ruwhiu, 2015). As Webber-Dreadon (2010) concludes, for Māori "tikanga is a gift handed down by our Tīpuna [ancestors]… to question westernised notions of theory and knowledge" (p. 77), fortified by core values and principles to enhance self-determination. The authors mentioned in relationship to Māori knowledge, worldview and tikanga have, among others, provided valuable commentary on the way that Māori values embedded in tikanga and how Māori worldviews inform social work practice.

1.9. Clarifying Terminology, Contextual Changes and Thesis Structure

Since this PhD project's inception in 2013, there have been significant changes in legislation and social policy. As acknowledged earlier in this chapter, social work in Aotearoa New Zealand has recently undergone considerable changes. Mandatory registration has been introduced, a new value-based ANZASW (2019) Code of Ethics has been published. Many other socio-economic and political changes have also occurred. These changes have consciously (and unconsciously) informed the analysis of how values are experienced and negotiated. This concluding section of this chapter provides clarity about terminology used, significant contextual changes that occurred over the course of the PhD study, and provides an outline of the thesis structure. An explanation is given as to how recent legislative changes have altered the terminology around statutory child protection services social work roles. Key terms used in this research have been chosen strategically, and the way in which te reo Māori (Māori language) and other terminology relating to differing types of social work roles, and patients will be explained. To locate the thesis from the outset within some

key socio-political events relevant to the current backdrop to health social work practice with newborn infants is provided, as well as an explanation of some of the important changes that have occurred over the course of the research process. This chapter concludes with an overview of the thesis structure.

The manner in which words are used in research can have significant consequences, as nuances in meaning that are clear in the interview may not be so easily deciphered away from the research context. Charmaz (2014) asserts that word choice should respect and reflect the traditions and social locations of the research participants. The following decisions and selection of word choices have been made to best represent the meaning and intent of the participants; it is therefore anticipated that they will also best reflect the values that underpin the social work profession in Aotearoa New Zealand. Te reo Māori is a valued and integral part of the social work vernacular in Aotearoa New Zealand, and it is one of the official languages of the country. A list of te reo Māori terms contained within the glossary functions as a guide to support language comprehension. The Māori words will also be concisely translated, in brackets, in the first instance within the body of the thesis. Subsequent to the initial explanation of a te reo Māori word, only the Māori words will be used in order to honour the unique concepts contained within them.

For the purposes of the research, I have chosen to refer to social workers who are directly employed by District Health Boards (DHBs) as *health social workers*. This is to differentiate them from other social work practitioners who are not constrained and/or assisted by being part of the immediate DHB workforce. I have tried to avoid the word *patient* when referring to the person specifically being cared for within the medical service, endeavouring instead to use individual, person, mother, newborn infant, or whānau

whenever possible. The needs of newborn infants are interwoven with their mothers and whānau, and often the mother and newborn are both perceived to be patients but may be discharged from the health service at differing times.

Health social work with newborn infants is closely aligned with child protection social work due to the vulnerability of newborn infants. Some of the key changes relating to this field of practice have been further summarised here. Child protection legislation has been undergoing considerable revision over the past few years. The Children, Young Persons and Their Families Act 1989 title was repealed in July 2017 and was renamed the Oranga Tamariki Act 1989/Children's and Young People's Well-being Act 1989. Within this thesis, the legislation will simply be referred to as the *Oranga Tamariki Act 1989*. When I was conducting the interviews for this research, the statutory child protection social work service in Aotearoa New Zealand was a governmental agency called Child, Youth and Family (CYF). This agency was disestablished in March 2017 and replaced with a new governmental agency, Oranga Tamariki – Ministry for Children. Oranga Tamariki – Ministry for Children became operational on the 1st of April 2017. This date was after the participant interviews had been completed. CYF and Oranga Tamariki provide essentially many of the same statutory child protection services. Oranga Tamariki has been structured to provide five core services that are centred around: prevention, intervention, care support, youth justice, and transition into adulthood for youth who are leaving state care (Keddell, 2017). Throughout this thesis, when the participants refer to CYF (as it was commonly known), I have changed their quoted words to *Oranga Tamariki*. Within this research, *Oranga Tamariki* will refer to Oranga Tamariki – Ministry for Children, while the social workers employed by them will be referred to as *Oranga Tamariki social worker/s*.

Statutory child protection practice has been subject to increasingly vocal criticism about a lack of commitment to bicultural practice that honours Te Tiriti o Waitangi, given the dislocation of Māori children. Compared to other children, Māori children are significantly more likely to be reported to Oranga Tamariki over child maltreatment and experience an out-of-home placement (Rouland et al., 2019). The disproportionate negative outcomes for Māori children are incongruent with bicultural practice, and inquiries into Oranga Tamariki are under way. When the Oranga Tamariki Act 1989 was first passed, the legislation was perceived to be ground-breaking as whānau were enabled to share in the decision-making process about their children. The recent amendments to this legislation have been perceived to significantly weaken whānau participation in the decision-making process (Boulton et al., 2018). These changes are significant for health social workers who work with newborn infants, as a primary task for them when working with at-risk infants is to support the whānau and ensure the safety of the newborn infant during child protection processes.

The phase one participant interviews were predominantly held between October 2014 and November 2015. At that time in Aotearoa New Zealand, the centre-right National Party was in power; its term went from November 2008 until October 2017. The phase two participant interviews took place in the second half of 2016. In these final interviews, the participants expressed a sense of frustration that the retraction of the welfare state under the National Party might continue into a fourth electoral term. This was not to be, in the 2017 general election the Labour Party was elected, forming a minority coalition government with New Zealand First.

Since the change in government, a substantial 'Government Inquiry into Mental Health and Addiction' (2018) has been completed, with optimistic results signalling a whole-of-government approach to tackle issues relating to health and wellbeing. Within the midst of all these changes, public voice and concern are also mounting about growing inequality and the need to take action to protect the environment. Alongside these concerns, the Association of Salaried Medical Specialists (2019) have released a report about the precarious state of hospital services in Aotearoa New Zealand. They describe an escalating crisis, and state that hospital admissions have spiralled at twice the rate of population growth due to the chronic under-funding of the health system. They conclude that "hospitals have been ill-served by policy-makers in the past few decades, including privatisations, restructurings, amalgamations, real funding cuts, and imposing narrow, politically motivated targets without appearing to understand their consequences" (Association of Salaried Medical Specialists, 2019, p. 1).

There was a sense of growing criticism and frustration by the participants across the phase one and phase two interviews that the current social and economic environment makes it increasingly difficult for social workers to adhere to its traditional humanitarian principles. It was apparent right from the critical incident interviews that the participants had a strong sense of social justice and were motivated to enact societal reform at a political level but were finding it difficult to maintain their social activist function. The advent of the Labour Party being elected into power brought about a slight ideological shift that gives more authenticity to notions of wellbeing. This shift has been signalled in the Prime Minister taking on the portfolio of Minister of Child Poverty Reduction. It has also been evidenced in part through the 'Government Inquiry into Mental Health and Addiction' (2018), which

focused on the changes needed to the mental health system to ensure better outcomes, especially for Māori and other marginalised groups. One in five children in Aotearoa New Zealand currently lives in households that experience food poverty and therefore cannot access enough food or afford the nutritious food that they require to remain healthy (Rush, 2019). In order to ensure a better future for newborn infants, drastic and urgent action is needed to address issues of wellbeing, especially regarding achieving targets to reduce child poverty.

Addressing social justice issues across the individual to macro-level continuum is an ongoing challenge in social work practice in Aotearoa and internationally (Austin et al., 2016; Dotolo et al., 2018; Lavalette, 2019; McBeath, 2016; O'Brien, 2011b). Attention to wellbeing and equity of outcomes is central to social work practice; however social work practice in Aotearoa New Zealand is still embedded in a climate of neoliberal ideology. For social work practice with newborn infants and their whānau, this means that the ideology, vision and values contained within the ANZASW (2019) Code of Ethics, Te Tiriti o Waitangi and Pūao-te-Āta-tū (Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare, 1988) are yet to be delivered and are tremendously challenging to achieve.

The structure of the thesis is as follows:

- Chapter Two introduces the logic behind the timing of the literature review. Summary information is supplied about the broader context of health social work practice within Aotearoa New Zealand and, specifically, with newborn infants and their whānau in order to develop a mutual understanding about the health social work practice environment. A literature review is then introduced to initially contextualise values within contemporary social work practice.

- Chapter Three explains the manner in which this research into social work values was conducted. Outlining the philosophical assumptions, the underpinning theoretical perspective, the grounded theory design and the decision to utilise Charmaz (2014) constructivist grounded theory. The chapter also details the procedures of inquiry, explaining the process behind the emergent grounded theory design, and explains issues of subjectivity, data integrity and the ethical considerations pertaining to the research.
- Chapter Four details the phase one interview findings. The chapter concludes with a brief discussion about the nature of health social work practice within Aotearoa New Zealand to situate the research; and introduces the ecological perspective that was utilised during the write-up of the discussion.
- Chapter Five presents the phase two interview findings which demonstrate the participants' collective thinking about the impact of values on their professional practice.
- Chapter Six presents the analysis drawn from the participant interviews and supported by pertinent literature. The chapter provides in-depth detail about how the two principal analytical categories, *Contextual complexity* and *Controlling the middle ground* illustrate the participants' experiences of values within practice.
- Chapter Seven brings together the key points from the research and presents the theory that has emerged from this research into how social work values are experienced and negotiated within health social work practice with newborn infants. The concluding section of this chapter presents the implications for practice from this study and explains how the developed knowledge can contribute to social work practice.

CHAPTER TWO: LITERATURE OVERVIEW

2.1. Overview

This research is concerned with determining how social work values support and influence day-to-day practice. An investigation into social work values involves the exploration of individual health social workers' descriptions of practice, so that specific experiences of professional and contextual value demands can be better understood in practice. The chapter contains the literature used to shape the thesis. The timing of the literature review is a contentious issue within grounded theory due to the risk of preconceiving codes and categories (Charmaz, 2014). In line with the principles of constructed grounded theory, an initial scoping review of the literature was conducted in 2014 prior to commencing data collection. This was done to contextualise the research by providing an overview of the nature of values. This chapter reflects an emphasis on the literature that provided the foundation for the process of data collection and analysis. The material contained within the literature review of this chapter seeks to define and locate values in relation to the challenges facing social work practice in Aotearoa New Zealand. More recent literature has subsequently been incorporated into this chapter to contribute to the understanding of the way in which the place of values is broadly located within social work practice.

This chapter begins with an explanation for the way in which personal and professional experiences and knowledge have been used to integrate theory and literature into this research project. After explaining the place of prior knowledge and literature within this thesis, literature is then presented to explain the context of health social work practice within Aotearoa New Zealand, before specifically examining health social work practice with

newborn infants and their whānau. Attention then turns to defining core social work values, considering how values are discerned within the profession and how they are categorised. The centrality of values in social work practice is then considered relative to value judgements, value conflict and value discomfort.

2.2. Whose Knowledge? Integrating Theory, Literature and Methodology

The place of literature in grounded theory is a highly contentious topic amongst grounded theory researchers, especially the use of literature during the initial research stages (Birks & Mills, 2015). The timing of the literature review needs consideration due to the risk of preconceiving research codes and categories – which runs contrary to the constructivist grounded theory method (Charmaz, 2014). This introductory section of the literature overview chapter considers the application of knowledge to the research project and describes my process and thinking around the place of literature in this research.

Having worked as a health social worker with newborn infants and their whānau, I was profoundly aware of how these professional experiences could shape my interpretations of practice in relationship to value constructions (Charmaz, 2014). Strauss and Corbin's (1990) positivist approach to grounded theory states that personal and professional experiences are often the source of problems when using a grounded theory approach, as they are embedded with existing motivations. However, Strauss and Corbin (1990) also acknowledge that these experiences can serve as an indicator of a potentially successful research subject.

The timing of literature reviews in grounded theory also generates debate about the risk of pre-conceptualising research through reviewing literature extensively (Dunne, 2011;

Holton, 2008; Kettle, 2014; Thornberg & Dunne, 2019; Timonen et al., 2018). Holton (2008) states that undertaking a comprehensive literature review prior to the emergence of a core category infringes on the basic principles of grounded theory, as theory is meant to emerge from *data* rather than from existing theory. Glaser and Strauss (1967) originally advised researchers against conducting a literature review prior to data analysis, to avoid the risk of extant literature influencing emergent categories. Glaser has held onto this initial premise, while Strauss has not (Dunne, 2011). However, Glaser and Strauss (1967) also originally advised that theoretical sensitivity is needed to have insight and the capacity to reflect on the research process and data in theoretical terms.

Charmaz (2014) defines theoretical sensitivity as "the ability to understand and define phenomena in abstract terms and to demonstrate abstract relationships between studied phenomena" (p. 161). Strauss and Corbin (1990) assert that theoretical sensitivity stems from familiarity with literature and personal experience. Kelle (2007) believes that there are inherent contradictions in managing the place of literature and developing theoretical sensitivity, as it is difficult to avoid literature and develop theoretical sensitivity at the same time. Kelle (2007) asserts that, during category development theoretical sensitivity is needed in order to 'see relevant data' and reflect upon data with the aid of theoretical terms. Thornberg and Dunne (2019) advise that grounded theorists should ensure that they consciously employ a deliberate and informed stance on the use of extant literature before research commences.

For guidance on the timing of the literature review, I have turned to Charmaz (2014), as it aligns with my sensibilities. Charmaz (2014) acknowledges that researchers may be familiar with the research topic and relevant literature prior to conducting their research. She asserts that researchers in this situation need to remain open to what they 'see and

sense', and not rely on their existing perspectives or standpoints. My professional experience within health social work combined with my academic teaching background means that I am already sensitised to the topic. I therefore began this study of social work values with the vantage point of existing practice and research on this topic, and an acknowledgement that I needed to be critically reflective about the background assumptions that I carry. Charmaz (2006) asserts that "sensitizing concepts and disciplinary perspectives provide a place to start one's research, that they are not limiting, but add to the research design" (p. 17).

Researchers do not disregard extant literature within a grounded theory methodology. However, care needs to be taken to first identify what is occurring in the data, before interweaving germane literature into the emerging theory. In terms of the literature review contained within the original PhD proposal, it was done with the intention of contextualising the research that I was about to embark on. My aim was not to produce an extensive review of literature, but to contextualise the way values are spoken about in social work practice by demonstrating the ontological nature in which they are understood, rather than to reflect the reality of values embedded within practice. I took precautions with extant literature, delaying some of my reading, so that it did not distort what I would later identify in the data. I then used existing research to embed the developing theory contained within the principal analytical categories within current and historical debates and arguments. This was done to develop the emergent theory, and to advance positions and perspectives taken. The literature overview which is presented within this chapter contains much of the initial scoping review of the literature which was conducted early in the PhD project. This literature has also been subsequently added to in order to remain current and

to further develop understandings about the place of values within health social work with newborn infants.

2.3. Health Social Work

In the introductory chapter, the research question, objectives and methodology were explained, alongside the background to the study and the reasons underpinning the motivation to research values. Values were defined with attention to Māori perspectives and the bicultural practice environment. Now that the issues and decision made related to integrating literature in this grounded theory thesis have been explained, information will now be provided about the context of health social work in Aotearoa New Zealand. As part of laying the groundwork for the thesis, consideration is given within this section to the complex environment in which health social work with newborn infants and their whānau is located.

Within this research, the word *context* refers to the circumstances and facts that surround specific events and situations, to illuminate the environmental conditions in which things exist or action takes place (Kerson et al., 2016). Understanding context empowers social work practice through providing a frame of reference to understand historical underpinnings of situational challenges, and help prepare for future developments that will continue to shape practice (Kerson, 2002). Attention to the context of practice is always important as, within any social work practice setting such as health social work, there are external forces that impinge upon the way in which practice is enacted. These forces stem from the wider political, societal and economic environment in which practice takes place. They represent social norms that are often invisible, which can appear to be 'just common sense', and can therefore be internalised by both the practitioners and patients alike

(Jordan, 2007). Within health social work *context* pertains to the circumstances and conditions that shape the lives of patients, their whānau, the communities and wider socio-political environment in which practice occurs (Finn & Jacobson, 2003; O'Brien, 2014).

Health social work in Aotearoa New Zealand is located in a national healthcare system that is universal and publicly funded. There is also a unique public health funded Crown entity that administrates a universal no-fault accidental injury scheme called Accident Compensation Corporation (ACC). The Minister of Health (2016) Health Strategy spans from 2016 to 2026, and it states that the New Zealand health system will have a strategic focus on wellness and primary care. DHB objectives are set out by the New Zealand Public Health and Disability Act 2000. The Ministry of Health ensures compliance with health regulations, providing funding and monitoring performance on key indicators and governmental priorities. There is an increased focus on prevention of ill-health and a drive to integrate health services across the social service sector in order to reduce inequities and support those most in need (Minister of Health, 2016; Ministry of Health, 2014, 2018). Research pertaining to maternity care indicates that Māori women experience significantly more maternal risk factors than other women, and also experience inequalities in accessing maternity care compared to other women (Barnes et al., 2013; Rumball-Smith, 2009). An emphasis on whānau-centred care built on Māori models of health, such as Durie's (1985) Te Whare Tapa Wha is perceived to be a way forward to overcome the current health disparities (Duncan, 2018). These inequities are a legacy of colonisation and culturally incongruent healthcare provisions that put Māori women, their newborn infants and whānau at greater risk than other ethnicities (Pihama et al., 2017). The current government recognises the far-reaching economic cost of health inequity and has given a mandate to the

health sector to have a pro-equity approach (Ministry of Health, 2018). This movement from treatment to prevention, and addressing health inequities provides more scope for social work practice within integrated primary healthcare services; due to the profession's ability to engage with communities suffering from health inequalities and issues with access to health services (Döbl et al., 2015).

Social workers play a critical role in the delivery of healthcare services in Aotearoa New Zealand. Since the 1940s, health social work has been a significant aspect of social work practice, with most of the health social workers functioning within multi-disciplinary teams (Beddoe & Deeney, 2012). A survey of 150 Bachelor of Social Work graduates between 1979–1983 found that 42% were employed by hospital boards, the next largest grouping was the Department of Social Welfare which employed 14% of graduates (Dale et al., 2017). DHBs are the largest employer of social workers within Aotearoa New Zealand. The SWRB (2019a) Workforce Survey reported that DHBs employed 38% of the social work workforce, NGOs and Iwi providers employing 31%, with Oranga Tamariki employing 19%.

Traditionally, health social workers in Aotearoa New Zealand have worked in hospitals; however, health social workers are present within preventive, primary, secondary, tertiary and research settings within health (Döbl et al., 2017). The IFSW (2008) policy statement on health states that health social work is framed by two central social work values: human rights and social justice. In the field of health social work practice, social workers strive to achieve equality of social conditions that supports wellness, and work to ensure access to health services while also dealing with the consequences of illness. The IFSW (2008) policy on health states that health issues impact upon all fields of social work, whether it is in practice, education, research or policy making, as social workers address issues around health prospects and health experiences. Maternity and paediatric social

work are two distinct areas of expertise that sit within health social work. The research listed below does not specifically relate to health social work with newborn infants, but the occupational conditions and demands are similar, and a certain degree of generalisation can be made.

Health social workers conduct comprehensive bio-psychosocial assessments as a central part of their role. These assessments focus on the person's wellbeing and their environmental and social context. This involves a holistic exploration of the patient's internal and external obstacles to recovery, as well as their strengths (Beddoe 2017; Weld, 2010). Hospital social workers assist patients and their whānau throughout their hospital stay and work to ease the transition out of the hospital. This involves advocating for access to services across complex and interconnecting healthcare and social service systems, providing information, working to ensuring the availability of required services and assistance, and working to improve overall service effectiveness. Ethical and value-laden problems are encountered every day in health social work practice, and social workers often function as the 'conscience of institutions' advocating for patients and challenging policy, care provision and service procedures (Suppes & Cressy Wells, 2013)

Craig and Muskat (2013) researched the occupational challenges that social workers face within the field of health social work. They highlighted the growing complexity of discharge planning and noted that health social workers were relied upon to provide secondary support to their colleagues. Through their research, Craig and Muskat (2013) created the following seven themes to describe the way that hospital social workers described their roles: bouncer; janitor; glue; broker; fire-fighter; juggler; and challenger. Health social work practice centres on the relationships that the social worker establishes, whether those are with the patient and whānau, the other members of their

multidisciplinary team (MDT), or their relationships with outside community providers. These relationships are fraught due to increasing costs of healthcare brought about through technological advances and complex health needs. These costs are evidenced by the fact that governmental spending on New Zealand healthcare has more than doubled as a share of gross domestic product (GDP), increasing from around 3% in 1950 to 6.9% in 2009 (Bell et al., 2010). The Ministry of Health (2016) Health Strategy reported that, in 2013, government spending on healthcare was 9.5% of GDP, a significant increase from 6.9% in 2009. For the 2018/2019, the second-largest area of Crown expenditure in Aotearoa New Zealand was health at $18.3 billion, with $28.8 billion being spent on social security and welfare, and $14.3 billion on education (The Treasury, 2019).

Health social workers work collaboratively in multidisciplinary settings, alongside other professionals such as medical doctors, nurses, psychiatrists, psychologists, speech language therapists, physiotherapists, occupational therapists, and nutritionists. The individual values that underpin social work are not unique to the profession; many of these other vocations also prescribe and adhere to them. However, social work values are distinctive due to the way they in which they are combined, in the profession's direct connection to social welfare provisions, and the pre-eminence given to working holistically alongside the vulnerable to empower them (Giles, 2016; Hepworth et al., 2010). A holistic focus held by social workers supports understandings of complexity, interconnectedness and multiple interpretations of need. In health social work, the values of members of the healthcare team may be the same, but the difference lies in the hierarchy that is assigned to these values, both within the team and by the organisation as well (O'Donnell et al., 2008).

Within a healthcare MDT, the social worker is often the only member of the team who does not hold a professional medical qualification or directly tend to the medical needs

of the patient. This can generate a distinct sense of purpose regarding role and function within a team. Given this distinction, it is advantageous for health social workers to be conscious of, and able to articulate, conflicting value positions when encountering them in practice in order to confidently advocate for the social needs of patients. Landau (2000) researched ethical decision-making in hospital settings and states that social workers struggle to articulate how they make decisions in complex situations; and concludes that social workers need to be confident in their own 'ethical self-knowledge', as well as how ethical principles apply to practice. Landau's (2001) research involved interviewing 32 hospital social workers in Israel about what factors influenced the resolution of ethical dilemmas. Landau (2001) found that ethical decision-making in hospitals is a multidisciplinary process, which is affected by "rivalry between social workers and other members of the health team, personality differences, type of ward and the nature of the ethical dilemma" (p. 75). Multidisciplinary teams challenge the scope of practice through emphasis on the technical roles – the consequences of this can be task-fragmentation and de-skilling of individual professions (Malin, 2000). Within this contested environment, social workers need to ensure that they stay relevant and identifiable as professional entities to support the people that they work with.

Social work often resides within a framework of crisis, whether it is because of the need to respond to an individual's personal crisis, a whānau or community dilemma, or a predicament brought on due to changes in public policy or contracting arrangements. Within a crisis situation there is a need to act quickly and respond to situations as they arise – due to the urgency, values may not be a prominent or a conscious part of decision-making. Values, however, are a vital component – they directly inform ethical self-knowledge,

especially when considering issues of power and vulnerability. The application of values to a given situation will shape an intervention approach.

2.3.1 Health social work with newborn infants and their whānau

Newborn infants or neonates are babies who are less than 28 days old. Within Aotearoa New Zealand, health social workers who work with newborn infants work primarily within the confines of the maternity ward, special care baby units (SCBU) or neonatal intensive care units. Some health social workers are also community-based, working alongside midwifery or nursing teams or other allied health professionals. For health social workers, regardless of whether they are working in the community or in the hospital, health and wellbeing are the central foci of their job. The primary task of health workers is to prevent or resolve health concerns (Miller & Nilsson, 2009) and, given the extreme vulnerability of newborn infants, there is a strong emphasis on protection from maltreatment and adverse environments.

Social workers have a central role in supporting women during the perinatal period (Parsons, 2009). Health social workers' assessments and planned intervention with psycho-social issues are particularly beneficial, as they can work alongside women to improve their formal and informal support systems. Health social workers hold knowledge about the psychosocial needs of pregnant women and services available, as well as the specific risk factors that pertain to women and newborn infants (Rabkin et al., 1995). Health social workers are trained to recognise and be articulate about the impact of colonisation and inequality, and their knowledge of anti-oppressive practice can be used to model alternative practice norms within MDT (Pack & Brown, 2017). In a maternity ward, the health social worker's role is generally to help women and their whānau navigate their way through

maternity services, and they have an understanding of medical and social issues that pertain to maternity services and neonatal care. Health social workers in these roles provide confidential support and counselling service to women and whānau. They assist with accessing practical supports and provide information on relevant support groups, community services, and welfare entitlements. Alongside this, they also respond to crisis situations such as issues relating to child protection, intimate partner or family violence, drug and alcohol addictions, grief and loss, mental health and general health issues, and stress and change management. This aspect of their practice, the assessment and management of risk to newborn infants, will always take priority over other work. The wellbeing and best interests of the vulnerable infant are the paramount considerations in practice, as set out in section 4A of the Oranga Tamariki Act 1989.

Weld (2010) asserts that, even though health social work in Aotearoa New Zealand is one of the largest fields of practice, it is not always well understood. This claim applies even more so to health social work with newborn infants. It has been difficult to locate specific academic literature on the role of health social workers who work with newborn infants, and their experiences of complex ethical decision-making within Aotearoa New Zealand or internationally. This review of literature regarding the place of values in social work and complex decision-making provides a background from which to consider how Aotearoa New Zealand health social workers understand and negotiate contextual value demands in everyday social work practice. To my knowledge, no research has been done specifically on this subject; while aspects of the research question have been addressed in overseas studies, a comprehensive research project is yet to be completed.

2.4. Defining Values

There is a substantial amount of literature on ethical theory and the development of ethical professional practice that relates directly to the topic of values in action in social work practice. The aim of this literature overview is to contextualise the way values are spoken of in social work practice by demonstrating the ontological nature in which they are understood, rather than to reflect the reality of values embedded within social work practice. This section of the chapter considers the different ways that the social work profession defines and discerns values. Thirty years ago, Timms (1983) stated that, as a profession, social work's use of values was 'disordered'. Timms argued that it is not enough to simply list values, that their origins need to be understood, and that values need to be conceptualised and recognised within social work practice. Today the term *values* is still a contested one, in that there are numerous definitions of what values are in relation to social work practice (Banks, 2012; Beckett et al., 2017; Pullen-Sansfaçon & Cowden, 2012).

Values are subjective and at times can feel elusive in social work practice. Values are hard to classify and utilise conceptually. Values are an essential component of social work practice as they form the foundation from which action is taken. There is no general understanding about the purpose of values in social work practice, continued professional dialogue is needed to clarify values in practice (Clark, 2000). Stewart (2013) believed that a "universal or perhaps even general agreement upon the best delineation of values never existed, despite the continued insistence of values centrality to the profession" (p. 163). This is, in part, due to the fact that, to some extent, values do not exist in isolation (Mullaly, 2007); they are at times contradictory and, like social work practice, continually evolve (Clark, 2000). Values are also culturally located, for example, Māori social workers utilise

practice methods that align with their cultural values and traditions to ground them in Tikanga Māori (Hollis-English, 2012).

The *Oxford Dictionary of Social Work and Social Care* (Harris & White, 2012) defined values as "principles or ideals that shape people's attitudes and behaviour" (p. 471). Values are strongly felt ideals that influence the way a person understands ideas and interprets the world (Allen & Friedman, 2010). A defining feature of values is that they represent emotional perceptions of what is desired (Reamer, 2006). Values are more than declarations about how the world should be, they also represent beliefs, inclinations and assumptions about how life should be lived, what is good and desirable (Mullaly, 2007). Values are personal and are concerned with what individuals and groups or society should do, or what one should do (Parrott, 2006). These interpretations of values relate to Beckett and Maynard's (2013) contention that values are needed to make choices, as they inform our analysis of what the consequences of our choices might be. It can be argued that values are therefore used to determine future directions and rationalise past actions (Pullen-Sansfaçon & Cowden, 2012). What people value can change in accordance with their current disposition or circumstances; however, people tend to subscribe to a set of values which makes up their 'value system' (Beckett et al., 2017). Value systems are often not consciously recognised, and they are also less likely to vary over time. Values serve to provide information about the 'guiding forces' that govern choices and behaviour; and as a result they are a useful conceptual tool to consider when examining decision-making (Raines, 1994). These guiding forces can be framed as ethical codes.

Clark (2000) dissected the meaning of social work values by drawing on different professional fields to illustrate the diversity of meaning behind the word. In summary, he considers values, in an economic sense, to be assets; from a philosophical sense, values can

be perceived in terms of true values, standards of goodness, what ought to be achieved, or even the ultimate good. From a religious perspective, values are about how to live a good life (Banks, 2012; Clark, 2000). Sociologists conduct surveys of social values to discern the character of specific groups, organisations or societies through questioning attitudes, beliefs, communication and behaviour; but, as values cannot be directly observed, there are issues with subjectivity (Clark, 2000). According to Clark (2000), the study of values by psychologists is focused primarily on value acquisition in terms of development and socialisation. He asserts that there are issues with circularity if values are constructed as a principal explanation for action. Clark (2000) explained circularity through the example of racial equality in the United Kingdom. He observed that, if racial equality is assessed as having low value due to the poor standards of health and well-being of 'black people', it cannot then be assumed that the value of 'white dominance' is highly valued. It is a fallacy of logic to decide that values can be defined by each other in a circular fashion.

From a subjectivist's viewpoint, values are either socially constructed or do not exist in a 'real' sense (Stewart, 2013). Contrary to this, moral realism theorises that there are true moral statements that reflect moral facts (Borrmann, 2010). Barsky (2010) took a moral realist's position on values by asserting that values should not have to be defended, they are irrefutable and cannot be categorised as 'right or wrong'. A moral realist position perceives values as being founded in human nature, as individuals and groups attach positive value to things that they need to achieve and maintain their personal well-being. If human need is the source of values, then norms function to safeguard these needs. From this perspective, social work action can therefore be justified to protect universal needs (Borrmann, 2010).

It would be difficult to take an absolute values position within social work, as values are relative to a particular standpoint or cultural framework. Cultural relativism perceives

values to be relative to cultural perceptions of what is good or right, while ethical relativism recognises values as being good or right in accordance with the way people think when they are making decisions between actions (Hugman, 2013). Values are commonly conceived to be shaped by one's cultural standpoint (Crichton-Hill, 2013), as culture is derived from shared values. The influence of culture on values is illustrated by Ruwhiu's (2013) assertion that Māori values are practised within the relational constructs of whānau. Skegg (2005) cautioned that, while social work's value-based human rights focus is intrinsically necessary, it is also a Western imposition, and warns against monocultural perspectives.

Utilitarianism and social contract theories allow for value 'creation' in that there can be general consensus around values, and that values can change due to a particular situation or consequence (Stewart, 2013). Postmodern thinking rejects universal value perspectives, embracing plurality, contingency and uncertainty (Hugman, 2003). Relativism views values as a way of discussing morality, and values are a 'statement of preference' (Stewart, 2013). Values are socially located and there is no single set of values that everyone subscribes to. Due to this lack of consensus about values, they are a continued source of debate and discussion across many spheres of public and private life (Hugman, 2013). Values are not culturally neutral and cannot be simplistically presented as universal; they represent the views of the dominant group and conceptions of fairness or justice can be biased towards that group (Husband, 1995). Healy (2007) asserted that social workers must find their own position on the universalist–relativist continuum. Healy (2007) observed that professional ethics tend to follow a moderate universal approach to values to ensure that universal rights are met. Due to these types of issues regarding the classification of values and the inherent difficulties in observing and measuring social work values, there appears to

be a scarcity of research into how values inform decision-making in social work practice, and this provides further rationale for this research.

2.4.1 Core social work values

Rokeach (1973) asserted that a "value system is a learned organization of principles and rules to help one choose between alternatives, resolve conflicts, and make decisions" (p. 14). Professional values create a framework of core ethical principles that are visible in social work codes of ethics, and they serve to strengthen and support the profession (Banks, 2004). The ANZASW (2013) edition of the Code of Ethics informed the analysis about the way in which values are positioned in Aotearoa New Zealand for the course of the research, as the revised 2019 edition was not released until the research was nearly completed. The ANZASW (2019) version of the code was revised, in part due to the ANZASW no longer being involved in complaints resolution due to the introduction of mandatory registration and is subsequently more focused on the ethical aspirations of the profession. The ANZASW (2019) version of the code strengthens the profession's active commitment to Te Tiriti o Waitangi, through actively promoting the rejection of monocultural control and action to challenge racism when it is encountered. The core values statement of the ANZASW (2019) Code of Ethics is listed and explained in Chapter One. As the earlier ANZASW (2013) edition informed the research from its inception, it is explained here in relationship to how values are conceived. It is important to note also that the core value statement of the ANZASW (2013) edition was the one that the participants would have been familiar with at the time of their research interviews. The ANZASW (2013) version of the code was also written to inform competency processes and is therefore more specific than the revised 2019 version.

In the ANZASW (2013) edition, it is written that the primary purpose behind their Code of Ethics is to create a systematic statement of knowledge and values that guides ethical social work practice in Aotearoa New Zealand. Listed below is the core values position that illustrates the value system to which the ANZASW (2013) stated its members are committed:

- social service legislation, structures, organisation and social work practice grounded in the Articles of Te Tiriti o Waitangi
- service for the welfare and self-actualization of their fellow human beings, who are the individuals, families, whānau, hapū, iwi, groups and communities that make up Aotearoa New Zealand society
- the growth and disciplined use of all forms of knowledge which inform and enable social workers effectively to carry out their role and function
- the development and just allocation of the resources that enable everyone to achieve their full potential, and to
- action for social change that is necessary to achieve social justice (p. 5).

The moral and political ideas underpinning social work reflect the fact that social work is primarily a Western invention, and denotes the individualised norms of Western society (Clark, 1999). Reamer (2006) proposed that Gordon (1965) in his writings titled *"*Knowledge and value: Their distinction and relationship in clarifying social work practice" provides "one of the best known attempts to outline core social work values" (pp. 20-21). These values are very Western in their expression, and are listed as:

1. The individual is the primary concern of this society.
2. Individuals in this society are interdependent.
3. Those individuals have social responsibility for one another.
4. There are human needs common to each person, yet each person is essentially unique and different from others.

5. An essential attribute of a democratic society is the realization of the full potential of each individual and the assumption of his or her social responsibility through active participation in society.
6. Society has a responsibility to provide ways in which obstacles to this self-realization (i.e., disequilibrium between the individual and his or her environment) can be overcome or prevented.

This value formulation reflects the value statements evident in the ANZASW (2013) Code of Ethics. The key difference between the two being the acknowledgement by the ANZASW of the obligation and commitment that social workers have to honour Te Tiriti o Waitangi, and the emphasis on knowledge development and application. Conversely, the principles outlined in Te Tiriti o Waitangi also, to some extent, replicate the underlying principles in Gordon's value framework, in that they consist of democratic and humanitarian ideals. A Māori worldview would reject the emphasis on the individual as it is reflected in this value framework (Pohatu & Pohatu, 2011). To illustrate this worldview within the context of health, Durie (1985) asserted that Māori approaches to health and wellbeing move beyond an emphasis on personal dysfunction and inequality to consider the wider cultural factors that affect the whole community. To achieve this, elders need to be consulted and movement is needed beyond monocultural goals to ones that are more relevant to Māori thinking.

Social work values function as a guide for professional behaviour, while serving to maintain and inform the profession's identity (Parrott, 2006). The ANZASW (2013, 2019) codes represent these functions, assisting with ethical decision-making, elucidating collective aspirations, and providing value statements that represent the identity of professional social workers within a bicultural Aotearoa New Zealand. Being cognisant of a professional code of ethics does not mean that a social worker will act as an ethical

practitioner when faced with an ethical dilemma that contains conflicting values and/or ethical principles (Congress, 2000). The various professional bodies within social work have never given a conclusive decree about the relationship between individual social workers and values (Stewart, 2013). Codes of ethics represent aspirations for value-based practice, while the SWRB (2016) Code of Conduct is more instructive regarding complaint resolution or disciplinary processes should the code be violated. The professional values that are listed within social work codes of ethics refer to internally held beliefs that are more challenging to sanction (Stewart, 2013).

In summary, values are important in social work practice as they: reflect the mission of social work; inform codes of ethics; shape the relationships that social workers have with others, as well as the practice approaches that social workers utilise; and assist with the resolution of ethical dilemmas (Reamer, 2006). Values also inform the way that knowledge is selected and applied to practice situations, and therefore help to generate the distinct nature of social work across the many different fields of practice. Conceptual clarity about a profession's core values is needed to navigate through competing demands in complex practice situations.

2.4.2 Value categorisation

Values can be categorised in a variety of ways. Values can be separated in terms of those that are fundamental and those that are instrumental (Hugman, 2005; Mullaly, 2007). Fundamental values are characterised by the ideals and goals to which a profession aspires, while instrumental values stipulate how these ideals and goals can be achieved. Mullaly (2007) stated that "humanism and egalitarianism are the foundational ideals that underpin social work practice, and that the instrumental values that social workers employ to achieve

consistency with these ideals are acceptance, self-determination, and respect" (p. 56). Another way of categorising values is to consider them in terms of traditional and radical values. Braye and Preston-Shoot (1995, p. 36) listed traditional values as being: respect for persons; paternalism and protection; normalisation and social role valorisation; equality of opportunity; anti-discriminatory practice; and partnership. They listed radical values as being: citizenship; participation; community presence; equality; anti-oppressive practice; empowerment; and user control.

Value differences exist across cultures, or even individuals; however, there are still shared common values (Stewart, 2013). Fundamental values are universal and are evident in the International Federation of Social Workers (IFSW) and International Association of Schools of Social Work (IASSW) (2014) preamble to the Global Definition of Social Work. The IFSW/IASSW (2014) definition states that social work's professional values stemmed from 'humanitarian and democratic ideals', and they are centred on respect for the worth, equality, and dignity of people. Mullaly (2007) asserted that values can be illusory and have less currency in countries that prioritise economic individualism over social equality. The consequences of inequality are that those with economic resources are best placed to self-determine. People using social work services want social workers to advocate for them, to take on an activist role (Boehm, 2013). Mullaly (2007) believes that the mission of social work must be to achieve a social order that promotes its value base, referring to this as a 'progressive vision' that is unachievable in a neo-conservative environment.

Boehm (2013) asserted that, as a profession, there are a variety of social work values that are culturally located; however, he stated that there are also central universal values that are appreciated globally such as "human dignity, social justice, service to humanity, fairness and competence" (p. 967). This is affirmed by Abbotts' (1999) cross-cultural study

of social workers that suggests that 'respect for basic rights' and 'self-determination' are common social work values that are consistent across cultures. There was a lack of consensus, however, about the values of 'social responsibility' and 'commitment to individual freedom'. Correspondingly, Calderwood et al. (2009) conducted research into value difference between immigrant social work students and Canadian-born students. They found that the social work students' values were similar, apart from the consistent exception of the importance of maintaining a strong family system over freedom of choice for the immigrant students. The researchers noted that immigrant students experienced discomfort and emotional distress when dealing with issues pertaining to freedom of choice, as these students adapted their behaviour while their values remained unchanged.

Skegg (2005) cautioned that, while social work's value-based human rights focus is intrinsically necessary, it is also a Western imposition and warns against monocultural perspectives. Shek (2017) provided commentary on social work values in the Asia-Pacific region that includes Aotearoa New Zealand, stating that "traditional values such as filial piety and familyism have weakened whereas Western values such as individualism and social justice have grown" (p. 1). Just prior to the turn of this century, Payne (1999) referred to this value tension by stating that, for Asian social workers, the focus is on interdependence rather than independence. More recently, Shek (2017) stated that Western social work theories are predominantly grounded in individualistic ideologies, which are increasingly challenged by Indigenous populations, and are not necessarily applicable to societies with collectivist features. Māori and Pacific Islanders have collectivist cultures, similar to Asian cultures in that regard. Aotearoa New Zealand is primarily an individualistic country (Brougham & Haar, 2013; Podsiadlowski & Fox, 2011), and this creates challenges for social workers and for those using social work services.

Social policy that is based on Western values is often problematic for Indigenous people and other non-Western cultures, as it is predominantly directed towards emphasising individual freedom (Meo-Sewabu & Walsh-Tapiata, 2012). Attention to individualised freedom is challenging for Indigenous people and other ethnicities who have a stronger emphasis on a collective group identity. This challenge exists for both the people receiving the service and the professionals providing it if the values of the service emphasise individual freedom and self-determination (Meo-Sewabu & Walsh-Tapiata, 2012; Walsh-Tapiata, 2008). Care is needed when categorising values as universal, as the dominant discourse contained within this type of discussion serves to exclude, marginalise and further alienate Indigenous and other ethnic groups whose values may not mirror those of Western society.

Another way that values can be categorised is to make the distinction between professional and personal values. Personal values possibly will not be mutually appreciated by all people in an occupational group (Banks, 2013). Values are fundamental beliefs, they influence routine actions, and therefore guide everyday social work practice (Connolly, 2013). Raines (1994) conducted research to identify the values that influenced nurses' perceptions and behaviour, via the use of hypothetical vignettes. The findings were that the nurses who participated in the research had clearly defined choice preferences; they identified a 'hierarchy of values' and that, in situations of uncertainty, they relied more heavily on rules or external protocols. Raines (1994) conducted the research into values because nurses (like social workers) have a key role in ensuring that ethical decision-making is founded upon open dialogue that is consistent and is sensitive to the nuances of the situation.

Harrington and Dolgoff (2008) asserted that value clarification, alongside the development of a personal hierarchy of ethical principles, will help social workers when they are faced with complex ethical dilemmas through being more conscious of the choices that are needed. A keen awareness of values is needed to solidify a professional identity and support ethical decision-making. Having entrenched personal hierarchies of ethical principles could create rigid and inflexible practice that promotes technical processes over unique situational needs. It would be naïve to assume that individual social workers' values are uniform (Ejrnæs & Monrad, 2019), and social workers need to ensure that the personal values that they hold do not have undue influence on others who hold an alternative value position (McAuliffe, 2019).

Dodd (2007) researched ethical discomfort experienced by graduate social work students during fieldwork placement. Findings were that tensions were situated primarily over issues regarding beneficence versus organisational policies, and beneficence against autonomy. Value clashes between professional social work values and the values of other professionals in either MDT's or the organisations values were identified as being the secondary source of discomfort and tension for the students. Supervision and peer consultation were the principal tools used to deal with the discomfort, and the professional code of ethics was only utilised by a small proportion of the students. These findings about the use of social work code of ethics mirrors the findings of a study conducted by McAuliffe (1999) that explored the use of the Australian Association of Social Workers' (1989) Code of Ethics. The research findings were that only three out of the 25 research participants referred to their code of ethics during the resolution of an ethical issue, but the code itself was perceived as a "useful construct in laying down the basic values of the profession" (McAuliffe, 1999, p. 19).

Ejrnæs and Monrad (2019) questioned the notion that value differences are predominantly located in MDTs, acknowledging that there can be disagreement about value-based judgements between social workers when considering practice vignettes and ranking ethical principles. Landau and Osmo (2003) examined the effect of competing ethical principles and found that social workers adapted their ethical hierarchies according to the situation, and that there was no difference between individuals' professional and personal ethical hierarchies. They stated that this lack of difference may be due to the impact of professional socialisation. Their research required a group of social workers in Jerusalem to rank their ethical professional and personal principles after reading specific vignettes. From their research they concluded that not every social worker constructs their value hierarchies in a similar manner. It is interesting to note that the most highly ranked ethical principle was that of 'protection of life' while 'equality and inequality and public good' occupied the lowest positions. They stated that social workers demonstrate ethical pluralism, which does not detract from a commitment to the central values of social work. Their research led them to conclude that social workers adhere to an internal hierarchy of ethical principles which allows them the freedom to be flexible and creative in their ethical decision-making (Landau & Osmo, 2003).

Alternatively, Comartin and Gonzalez-Prendes (2011) believed that conflict between personal and professional values can be commonplace in social work practice. They concluded that "when conflict between competing values arises, personal core beliefs may highlight biases and prejudice attitudes that underlie the dilemma" (Comartin & Gonzalez-Prendes, 2011, p. 11). Personal values cannot be discarded within a professional realm and, if they are not congruent, values can be contentious and contradictory (Beckett & Maynard, 2013). Regardless of congruence or incongruence between personal and professional

values, time is needed to think through the source of value conflict. Time allows for a critical consideration of the pluralistic nature of values and the complex system in which the conflict resides. In situations of value conflict, critical reflection, supervision and collegial support are needed to reconcile the competing values to ensure safe practice. Value pluralism means that decision-making is complex, and clashing values makes professional decisions even more challenging.

Clark (2000) stated that social workers refer to values in terms of two differing aspects of belief, the first form being value beliefs about how to behave and how to treat others in terms of good (and bad) behaviour. Through this frame of reference, values are not about technical judgement or practicality but are about what is technically right; for example, ensuring that consultation is had with a client about a referral to another service before it proceeds. To do this, practice might be impeded, but social work values inform the situation as consultative action is perceived as morally right and therefore necessary. The second aspect of value beliefs builds on the first by giving primacy to values in practice, by social workers utilising values in order to campaign for a course of action that overrides practical considerations (Clark, 2000). Rights-related values such as human dignity and liberty involve abstract thinking and they are not always easily perceived in everyday social work practice (Connolly, 2013).

Doyle et al. (2009) conducted research into ethical decision-making with regard to personal and professional values. They state that more research is needed regarding the rationales for action in situations of ethical decision-making. Their research found that personal and professional values impact upon decision-making processes to such a degree that they can help predict discrepant ethical decisions in practice. Value pluralism means that decision-making is complex, and clashing values makes professional decisions even

more challenging (Gray & Webb, 2010b). Values, whether they are consciously acknowledged or not, influence decision-making. An understanding of the points of difference between one's personal, professional and organisational values is necessary to practise safely in challenging practice environments in order to meet the needs of people who use social work services (McAuliffe & Chenoweth, 2008).

2.5. Centrality of Values in Social Work Practice

Values are perceived to be a fundamental and cohesive ingredient in social work practice internationally due to the diversity of practice across multiple settings (Banks, 2012). The profession positions itself on enabling clients, whānau, groups and communities to achieve specific objectives, with the pursuit of social and economic justice being a unifying core purpose (Hepworth et al., 2010). Social work interventions cannot be value free, as values inform the very choice of intervention approach, and therefore, neutrality in practice is not achievable (Clark, 2000). Social workers are generally legitimatised by public policy, they have an active role in the distribution of scarce resources, and this means that their work is involved with economic trends and shifts in welfare policy. The social work function of allocating goods and services in a resource scarce environment and in the face of social ambivalence generates tension (Clark, 2000). This tension exists between personal, professional, societal and organisational value systems. It is the existence of tension within instances of value conflict that will be examined throughout this research.

Claims are made by social work researchers that it is the value base of social work that makes it distinct from other professions, and that values should be utilised to guide sound practice (Abbott, 2003; Bisman, 2004; Reamer, 2006). Values are central to practice as they define social work's professional identity and purpose (Bisman, 2004; National

Association of Social Workers, 2008; Reamer, 2006). Social work identifies itself by its normative core, which provides a grouping of values that allows the profession to describe itself as 'morally driven' (Stewart, 2013). The humanistic values that informed the growth of the profession still underpin social work, despite the influence of secularism (Furness et al., 2013).

Reisch and Jani (2012) stated that, while social work proclaims itself to be a 'value-based profession' informed by a combination of normative judgements and scientific principles to achieve social justice and human rights, it has been social workers' use of social science to demonstrate inequitable structural issues that has been more successful in advancing social change. In social work dialogue about values, there is a tendency to frame values as all-encompassing (Clark, 2000). Decision-making based on values alone is precarious due to risks relating to individual and organisational bias, assumptions, privilege and power. Sound, ethical decision-making is also informed by evidence, theory, and a reflective practice approach that involves the counsel of others and employs cultural sensitivity (McAuliffe & Chenoweth, 2008). Social work practice takes place in a political, economic and ideological context that is often contrary to the mission of social work. The profession must be attentive to prerogatives that depoliticise professional practice, and be alert to the prioritisation of institutional goals that emphasise individuals over communities, and equal opportunity over equity (Reisch & Jani, 2012). Social work practice is arguably not apolitical, and a critically reflective approach will help to discern the way in which values are categorised in a given situation or organisation.

2.5.1 Value judgements

Social workers strive to be scrupulous and rigorous in their decision-making and to be critically reflective about value judgements (Payne, 1999). This level of care is needed to conscientiously manage the contradictions between social control and empowerment that exist at the heart of social work practice (Banks, 2013). Connolly (2013) defined value judgements as everyday decisions that are made in practice and involve allocating positive or negative value to situations; for example, benefit fraud being valued negatively. Defining value judgements as everyday decisions makes immediate the link between the cognitive and emotional processes involved in value judgements and the behavioural component of decision-making. All of which is informed by theoretical knowledge which is consciously or tacitly applied in decision-making. Knowledge of power, control, oppression and hegemony is held by social work practitioners and on some level would be informing decision-making through situating issues within a wider socio-political and cultural context. Situated ethics moves ethical decision-making beyond the responsibility of the individual decision-maker, considering also the relational dynamic between professionals and people within broader contexts (Banks, 2016a).

Connolly and Ward (2008) asserted that value judgements are made in relation to worth, or what is either valued or disvalued. There are differences between social workers as to what constitutes a significant value judgement. A given situation may be experienced as problematic by one social worker due to having to choose between significant competing principles, but the value-laden conflict may not be experienced by others in similar circumstances (McAuliffe, 2005). Connolly and Ward (2008) argued that value judgements are made according to consequential beliefs in which a person's perception of what benefit or harm an action might take will influence their decision-making. Upholding professional

values in practice over agency regulations can have long-term professional consequences. Ethical conflict can undermine social workers' confidence and ability to work constructively in practice and adequate support is needed (McAuliffe, 2005). Critical reflection provides an opportunity for deep learning as it involves unearthing and identifying previously unquestioned cultural norms and assumptions (Fook & Askeland, 2007). Developing a critically reflective understanding of how values underpin decision-making strengthens decision-making processes and reduces the risk of burnout. McAuliffe (2005) asserted that there is learning to be had from value conflict in complex situations; that distressing situations can, through supervision and support be reflected upon to engender learning and develop "future practice wisdom" (p.9).

Taylor (2013) distinguished between reflective practice and critically reflective practice by equating 'critical' to emancipatory politics of social change linked to a poststructuralist perspective. Reflective practice attempts to enhance practice through individual endeavour and a politically neutral stance. A critically reflective stance endeavours to understand how social work practice is shaped by current and historical social, political and cultural contexts (Taylor, 2013). This delineation between reflective practice and critically reflective practice is important as it rejects the political neutrality of social work practice. Problematic power relationships within organisations can be revealed through considering cause and effect, asking why, and deliberating on the subjective manner in which meanings are assigned within given contexts. Critical reflection, when done well, promotes professional growth and organisational change (Fook & Askeland, 2007).

Social work practice involves moral choices (McAuliffe & Sudbery, 2005). Prescriptive rules are not congruent with making moral choices in risk situations that are often situation specific (Harrison & Smith, 2004). To elucidate on this, in the instance of responding to an

individual who is engaging in benefit fraud, a statutory social worker may instantaneously know that they have negative feelings towards benefit fraud. They would, however, have to pause for reflection to critically discern the values that underpin their judgement. The value pluralism at play could generate conflict between values such as confidentiality, self-determination and integrity, alongside personal concerns about the integrity of the benefit system as a functional safety net. Moral choices that involve employing specific values need to be made in situation like this to effectively consider what action or inaction would be taken (Bowles et al., 2006).

To make these moral choices, a range of different ethical theories can be applied. Bowles et al. (2006) stated that there are three main modes of ethical thinking that reflect the different types of ethical theories that underpin Western social work practice: *virtue-based ethics*, *deontology*, and *consequentialism*. Virtue-based ethics relate to the development of positive character traits, such as being open-minded or having moral courage. Having a virtue-based approach to practice involves using judgement when applying rules and breaking the rules if deemed necessary. Deontology is often referred to as duty-based ethics, and considers professional social work actions in terms of how they align with ethical codes (Gray, 2010). If duties conflict, and a dilemma forms, then deontological thinking in a risk-averse environment makes it difficult to resolve competing rights, obligations or principles (Bowles et al., 2006). Consequentialism is the third mode of ethical thinking – the perspective views actions as being right or wrong on the base of their consequences. Social workers in practice will often use these modes of ethical thinking eclectically considering duties, virtues and consequences when resolving a dilemma; others use 'practice wisdom' as the foundation of their decisions (Congress, 2000). In situations like the one described earlier, consequentialism is important in value-based decision-making as

it is aligned with promoting action that will achieve social work practice goals (Bowles et al., 2006).

Alongside the impact of social workers being increasingly under the control of a managerialist agenda, social work frequently engenders public and political controversy, resulting in further issues over professional recognition and feelings of disparagement. Epstein (1999) states that social work, and many other 'helping' professions, work together to collectively manage the population. Working within a wider team or system to encourage people to adapt to social norms can sharply contrast with social justice practice priorities. Critical reflection is needed when considering whether value judgements informing social work action are made in accordance with organisational practice requirements, or alternatively to challenge structural inequality. Conceptions of social workers as agents of social change or social control need to be continually reflected upon, as organisational and professional practice imperatives shape our interpretations of situations and impact on everyday judgements made in practice.

2.5.2 Value conflict

In situations of competing values, conflict is unavoidable (Hugman, 2005). Value conflict occurs when an individual's values are incongruent with significant organisational or governmental bodies' articulated values, or in an absence of values (Stewart, 2013). Hartman (1994) stated that, for social workers, "multiple value commitments shape our practice but also lead us into value dilemmas, to tensions between individual and the social good, to conflicts around social change and social control" (p. 42). It is this tension that is inherent in value dilemmas that is a challenge for all social workers (Hartman, 1994).

When considering situations of value conflict, it is important to bear in mind that values cannot be prescribed, because there is no confirmation that one value is better than another. Value systems are constructed by individuals, groups, societies and organisations as a way of organising beliefs relative to importance (Clark, 2000; Rokeach, 1973). Clark (2000) argued that, while sociologists carry out value surveys to try and account for the characteristics of social groups, values are not able to be directly observed in practice. Listening to conversations about practice can serve to locate and highlight underlying professional and personal values at work, as expressed views can demonstrate discord in beliefs about how people and communities are being treated (Akhtar, 2013).

To study values in social work practice, an individual's values cannot be considered in isolation from their practice environment, as practice does not take place in a vacuum. Research into values in practice must also consider the impact of external value systems that shape practice and influence decision-making on a day-to-day basis. To study values in social work practice, it is necessary to study the values of the individual practitioner alongside the values of the:

- social work profession
- individual, whānau, and community
- dominant culture and class
- Indigenous and other minority cultures
- organisation
- social work team and MDT.

This recognises that it is not only an individual social worker's values that shape practice decisions, but also acknowledges the impact of the wider ecological systems that influence value-based decision-making. It is important to note that, as values cannot be prescribed, and because there is no clear indication that one value is better than another, value systems

are constructed by individuals, groups, societies and organisations as a way of organising beliefs in terms of their relative importance (Clark, 2000; Rokeach, 1973).

The Nathanson and Giffords Ethics Scale (NGES) utilises practice scenarios in which social work practitioners need to choose between sets of competing values and obligations. The key value conflicts that are outlined represent extreme value positions, and they are:

- Empowerment versus enabling
- Self-determination versus need to protect
- Respect for human dignity versus intolerance
- Diversity versus homogeneity (ethnocentricity)
- Promotion of social justice versus individual self-interest
- Social responsibility versus individual responsibility
- Confidentiality versus disclosure
- Equal access to service versus discriminatory provision of service
- Social welfare versus individual welfare. (Nathanson et al., 2011, p. 135)

Literature on social work values places a strong emphasis on the need for value clarification, as values influence social workers' views on the people that they work with, their choice of approach and how they define a successful outcome (Reamer, 2006). In order to make ethical decisions, social workers must identify and act upon the values that apply to the situation (Nathanson et al., 2011). Value conflict can occur for a wide variety of reasons, whether it is due to issues with organisational policy, law or a competing set of obligations or circumstances. Ethics are perceived as values in action (Nathanson et al., 2011) and, in situations of value conflict, ethical dilemmas may become apparent. Circumstances which contain contradictory values can produce multifaceted ethical dilemmas that require systematic exploration and reflection upon practice (Sasson, 2000).

Ethical dilemmas occur when a person has to choose between two equally unwelcome alternatives, and these alternatives may present conflicting ethical values (Banks, 2012). Situations that involve ethical dilemmas are intrinsically difficult as there is no 'right' answer (McAuliffe & Sudbery, 2005). Social workers are not able to act on all of their values simultaneously (Reamer, 2006). For example, due to issues relating to risk of harm, the value of self-determination or privacy may sometimes be superseded. These types of situations are, in essence an ethical dilemma, as there is a clash of core values and a decision needs to be made about value preference (Reamer, 2006). At times these dilemmas are made clearer by legal and technical matters, such as the Crimes (Substituted Section 59) Amendment Act 2007 in respect of the use of force in child discipline. However, Banks (2012) asserted that law is often ambiguous and it is still often left up to individual social workers to interpret it, as laws clearly state what can be done, but not what needs to be done. In the same manner that the law does not explicitly prescribe practice, neither do codes of ethics or practice standards (Higham, 2006).

Decision-making in practice is influenced by underpinning values. Professional decision-making involves interpretation of multifaceted organisational, ethical, political and legal issues that require social workers to make a judgement about. Higham (2006) contended that there is a danger that codes of ethics and codes of conduct can provide a false sense of consciousness about values in practice and safe practice. Codes of ethics and codes of conduct are not constructed to be a substitute for individual deliberation on what needs to be done. Ethical decision-making models such as McAuliffe and Chenoweth (2008) 'Inclusive model of ethical decision-making' provide a non-linear framework to deal with the complexity of professional practice. This model allows a holistic consideration of professional accountabilities, cultural sensitivity, consultation and critical reflection as the

ethical dilemma is defined, with stakeholders and alternative solutions identified so that a range of approaches and actions can be critically considered and evaluated. Models such as this, or Mattison's (2000) 'Framework to analyse ethical decisions' help to illuminate value conflict, alongside professional requirements and organisational obligations.

2.5.3 Value discomfort

When considering situations of value conflict in social work literature I unearthed the terms, *cognitive dissonance, emotional dissonance, disjuncture, ethical discomfort,* and *moral distress*. These terms have been used to describe the emotional state that can occur as a result of discordance between belief and behaviour in social work practice. Cognitive dissonance (Festinger, 1957; Festinger & Carlsmith, 1959) can arise in situations where there are conflicting attitudes, and is a term used for behaviour that is inconsistent with a person's attitudes or beliefs (Stroebe, 2012). DiFranks (2008) and Fenton (2012) used the term *disjuncture* to describe dilemma-induced distress that occurs when belief and behaviour are highly discordant. Dodd (2007) conducted a study of graduate social work students on fieldwork placement to find the most prominent cause of ethical stress and used the phrase 'ethical discomfort' to describe the conflict and tension that they felt. O'Donnell et al. (2008) researched value conflict in social work practice and used a term found in nursing literature, *moral distress* to define a painful feeling of psychological disequilibrium that occurs when appropriate action does not happen due to institutional obstacles. This suggests that moral distress can depict a sense of powerlessness that can be linked to decreased job satisfaction.

There appears to be an inherent conflict between why people want to become social workers and the realities of their agency environment, which fuels situations of value

discomfort. The IASSW and the IFSW (2004) listed four key problem areas relating to value discomfort in their joint policy statement entitled 'Ethics in social work: Statement of ethical principles'. The following characteristics of social work practice are seen to be the cause of moral challenges or dilemmas:

- The fact that the loyalty of social workers is often in the middle of conflicting interests.
- The fact that social workers function as both helpers and controllers.
- The conflicts between the duty of social workers to protect the interests of the people with whom they work and societal demands for efficiency and utility.
- The fact that resources in society are limited.

Social workers have, since the 1990s, become increasing confined by the tenets of neoliberalism. The root of the moral challenge and value discomfort is due to the divided loyalties listed above. This research was designed to examine the context in which value demands are experienced so that insights could be gained about the way that values can support the goals of social work practice.

CHAPTER THREE: RESEARCHING PROFESSIONAL VALUES

3.1. Overview

This chapter describes the manner in which this research was conducted, detailing the philosophical assumptions, the theoretical perspectives and methodological underpinnings. Explanations are provided about the procedures of inquiry, before explaining the detail involved in the data collection and analysis processes. The philosophical worldview and theoretical approach that form the foundation for this research are explained to demonstrate how a constructivist approach, alongside symbolic interactionism, informed the research process. The methodology is described, with information provided about the qualitative research strategy and grounded theory research design. The procedures of inquiry are provided to describe and justify the decisions made related to gathering and analysing the data. This includes information about the sampling strategy, data-collection, and data-analysis processes. Information is also provided about managing an emergent design, issues of subjectivity and data integrity. The chapter concludes with an explanation of the way that ethical issues were accounted for within the research project. The central aim of this chapter is to clarify the philosophical assumptions that support this research and to provide a justification for employing constructivist grounded theory, so that the relationship between the philosophical assumptions, theoretical perspectives and methods of inquiry are clear.

3.2. Philosophical Assumptions

Attention to the philosophical assumptions that inform this research delivers clarity about how this research was formulated. The philosophical assumptions that researchers

hold provide the platform from which research emerges (Creswell, 2014). An explanation is first provided about the philosophical assumptions and the theoretical perspectives employed, before going on to explain the research methodology. This outline is designed to demonstrate the logic behind how a constructivist approach informed by symbolic interactionism assisted with the employment of a qualitative research strategy employing a grounded theory design.

Constructivism is an ontological position that challenges an existence of reality that is independent of social actions. Constructivism also refers to the belief that researchers' accounts of the world are also constructions (Bryman, 2012). Within a constructivist worldview, meaning is constructed through individuals' interpretations of their worldly engagements. Action is a central focus of constructivist research, with constructivist researchers studying *how* and at times *why*, the participants have constructed certain meanings and actions in a given situation (Charmaz, 2014). Day-to-day activity is therefore understood through cultural, social and historical perspectives which are specific to given contexts (Creswell, 2014; Lincoln et al., 2011).

Interpretations of data within constructivist research are also perceived to be shaped by the researcher's personal experiences and background (Creswell, 2014). It is therefore appropriate to consider my stance as a constructivist researcher alongside my philosophical assumptions. As acknowledged in the introductory chapter, I have become increasingly concerned about the profession's ability to adhere to its social justice practice imperatives in a neoliberal policy environment. These concerns about the ability of social workers to be agents of social change propelled my decision to research professional values.

Smith (2012) asserted that, “just as social justice lies at the heart of skills, knowledge and values in social work practice, so should it be an essential driver of inquiry and investigative activity in social work research” (p. 446). Social justice research involves a critical consideration of personal and structural experiences of domination, discouraging individualised notions of blame, and emphasising emancipatory research action for social change (Fook, 2016). Constructivist research rejects simplistic notions of linear causality and objective reality. A constructivist approach seeks to understand meaning and social realities, so that voices are heard, and attempts are made to grasp thoughts and feelings. I have joined the ranks of many other social work researchers and practitioners who are seeking to understand how social workers can adhere to the profession’s social justice mandate in the current socio-political environment. To accomplish this inquiry, I researched the practice realities of health social workers, analysing their narratives about their social justice successes and their concerns so that recommendations could be made to support professional values in practice.

For the purposes of this research I will follow Charmaz’s (2008a) constructivist framework which advocates for an examination of the following factors as part of the research inquiry:

- the relativity of the researcher’s perspectives, positions, practices, and research situation
- the researcher’s reflexivity
- depictions of social constructions in the studied world. (Charmaz, 2008a, p. 398)

Constructivism fosters reflexivity about how both the researchers and the participants construct social reality and interpret data. My experiences of practice in health social work with newborn infants, combined with my experiences as a social work academic influence my interpretations of how values are depicted. I do not perceive myself to be a

passive observer of a neutral, objective reality, and constructivism allows for an acknowledgement of the subjective nature of reality, and the researcher's interpretations of multiple meanings contained within data.

In summary, as a constructivist researcher I believe that meaning is constructed by people, rather than discovered. That people understand and interpret their social world through interactions which are shaped through cultural, social and historical influences. Knowledge developed about values can be generated through concentrating on how social workers speak about values in practice. Knowledge about value demands can be derived through analysis of how people make sense of their day-to-day practice experiences, in accordance with the historical, socio-economic and political influences that impact upon them. I take an ontological position that reality is socially constructed and contained within circumstances in a specific context. These beliefs result in the need to consider complexity in participants' viewpoints and use broad, open-ended questions so that views are shared freely, with attention also being given to context.

3.3. Theoretical Perspective

Theoretical perspectives function as anchors to locate and frame the developed research analysis and argument within wider discourses (Charmaz, 2014). For health social workers managing emotional, social and environmental requirements with competing obligations and values means that theoretical knowledge needs to be employed to develop and maintain critical understanding. What is true for practice is certainly true for social work research. Turner (1986) asserts that "theory helps us to recognize patterns and relationships that aid in bringing order to the reality with which we are confronted" (p. 11). It can be difficult to acknowledge the impact that values have on practice, as value-based knowledge

is often tacit within the busyness of what is often reactive day-to-day practice. (Oktay, 2012). Within this research, symbolic interactionism is a pragmatic, theoretical perspective that was employed to consider how health social workers perceive themselves, society, and their own reality, through interaction with others (Charmaz, 2014).

Feminism was a theoretical perspective that I considered utilising for this study. A feminist critique is significant, social work practitioners are predominantly women and the perspective would have assisted with understanding the way in which maternity care is constructed and construed within society. Feminism as a theoretical perspective would have enabled critical analysis about the impact of encountering a principally male-dominated system that implements welfare provisions (Epstein, 1999). After further consideration about the place of theory in this research, symbolic interactionism was the theoretical perspective chosen as the perspective clearly illuminates values in action. A synergy also exists between feminism and symbolic interactionalism due to the "shared concern for the ultimate liberation of all people everywhere (including males) from oppression imposed by dehumanizing social, economic, and political institutions and structures" (Gitterman & Germain, 2008, p. 69).

Symbolic interactionism will assist with understanding the place of values in health social work practice as it provides insights into the way that people behave in accordance with the meanings that they have derived through interactions with people and systems (Blumer, 1986). As a theoretical perspective, symbolic interactionism aids critical thinking through allowing close consideration of how meaning changes through interactions across differing contexts, time and situations. Symbolic interactionism also contains many shared perspectives with the social work profession, viewing people as active in their environment,

with their identity being shaped through their interactions with individuals, communities and society.

Symbolic interactionism is based on three premises: that people act toward things according to the meanings that they have assigned them, that these meanings are derived from social interactions, and that meanings are managed and modified through interpretive processes (Blumer, 1986). Symbolic interactionism views reality as dynamic, with the 'self' constantly changing in relationship to social interactions (Oktay, 2012). Symbolic interactionism led me to question how the research interviews were affecting subsequent thinking about values in practice for the participants. It was noted in the phase two interviews that a few of the participants commented that, because of their involvement in the research they are more aware of their values in conflict situations.

Symbolic interactionism probes beyond intrinsic meanings given to objects, considering instead meaning derived from what they do with the given object. Within this research categories of people (patients, different professional groups), organisations and other types of social institutions can be considered as 'objects'; therefore, symbolic interactionism allows for consideration of how meaning is tied to these categories (Charmaz, 2014). Utilising symbolic interactionism enables further exploration of how the participants construct their professional identities, their workplace situations and the societal space in which they are located. Structure and interactions are perceived to be interwoven, as action is not solely determined by structures, nor is structure dependent on action (Hildenbrand, 2007). Symbolic interactionism, when used in research, addresses questions about the conditions in which processes, events or interaction happens, while also considering the consequences (Wiener, 2007). Within this research inquiry a

constructivist view pays attention to how the participants and I, as the researcher, construct reality. This enables a critical consideration of multiple views of reality, reflection on the co-construction of data through interaction, and reflexion about research processes and decisions made.

This study utilises a qualitative research strategy to illustrate how values are experienced and negotiated in practice. I elected a qualitative research strategy, utilising a constructivist approach to critically investigate and interpret meaning from participants' words and experiences. A qualitative research strategy is more inclusive that quantitative research of the participants' perspectives and their individual constructions of reality (Flick, 2009). Rich descriptions about social work practice were needed to portray the viewpoints and experiences of the participants. Quantitative research, with its positivist focus on deducing objective facts to produce generalisable findings, would not easily allow adequate consideration into the participants' practice realities (Charmaz, 2014). Utilising a qualitative research strategy enabled me to critically consider meaning alongside examining DHB practices and social processes (Starks & Brown Trinidad, 2007).

Grounded theory is a research design that is derived from symbolic interactionism (Oktay, 2012). The next section of this chapter will consider grounded theory and address the decision to use constructivist grounded theory. This research involved an examination of the way that health social workers use language to describe situations of complex decision-making. Examining language enabled a consideration of the relationship between meaning and action – to grasp thoughts, meanings and feelings, participant voice is vital. Symbolic interactionism pays attention to the active processes from which participants create meaning, as "meanings arise out of actions, and in turn influence actions" (Charmaz, 2014,

p. 345). Attention to the active processes from which participants make meaning is vital when researching values, as values create a moral framework for decision-making – which informs action.

3.4. Grounded Theory Design

> *Grounded theory is an excellent tool for understanding invisible things*
> (Star, 2007, p. 79)

Grounded theory is constructed to provide a systematic process of abstracting theory from data in order to inductively develop mid-range theories (Charmaz, 2005). Grounded theory starts with gathering data, relying on an iterative movement between data gathering and analysis (Charmaz, 2014). In grounded theory, the process of gathering and coding data, alongside memo writing and integration of categories is guided by emerging theory (Glaser, 1978). I have followed Kathy Charmaz's approach to grounded theory, which is clearly outlined in her book titled *Constructing Grounded Theory* (Charmaz, 2014). This text provides well-defined methodological guidelines on how to conduct constructivist grounded theory.

Charmaz's (2006) constructivist approach to grounded theory allows for multiple realities, worldviews and perspectives on action, while also acknowledging the influence of the researcher on the research subject and outcome. Social justice research is an area of growing significance and grounded theorists are well positioned to critically address issues of injustice (Birks & Mills, 2015). Charmaz (2005) asserted that grounded theory assists with studying social justice issues through enabling researchers to stay close to the world that they are researching in order to develop theoretical concepts through synthesising and interpreting data and illustrating processual relationships. Social work research is more than just a technical activity, and a critically reflective stance is needed to discern the social,

historical, economic, political and cultural domains that impact upon the situation studied (Pease, 2009). A key strength of the grounded theory method is that it enables researchers to "offer integrated theoretical statements about the conditions under which injustice or justice develops, changes or continues" (Charmaz, 2005, p. 508). Theory developed directly from practice situations is of enormous value to social work practitioners (Oktay, 2012). In this research, grounded theory allowed a holistic focus on the concept of values that enabled a movement beyond description, so as to develop theoretical knowledge about how social workers experience and respond to value demands (Charmaz, 2014; Strauss & Corbin, 1998).

3.5. Constructivist Grounded Theory

Charmaz is credited with devising constructivist grounded theory (Grbich, 2013; Mills et al., 2006; Morse, 2009). Charmaz (2014) stated that constructivist grounded theory adopts the methodological strategies of grounded theory such as coding, writing memos, and theoretical sampling, while also considering the research relationship, alongside the researcher's subjective understandings and social locations. To create a constructivist emphasis to grounded theory, Charmaz highlighted the interaction between the researcher and the participants, and stresses the need to be critically reflective in recognising and managing biases (Grbich, 2013). Constructivist grounded theory does not claim to be value-neutral and aims to reach out to human voices to provide space for the participants' experiences and worldview to be heard (Priya, 2019). Increased attention is given to maintaining the participants' voice, and keeping the participants' words intact throughout the analytical process (Mills et al., 2006).

Constructivist grounded theory enables a critical understanding of the current socio-economic and political context (Priya, 2019). Duckles et al. (2019) stated that "the power of constructivist grounded theory for critical inquiry stems from its theoretical foundations. This begins with symbolic interactionism and its core emphasis on meaning-making through interactions, human agency, language and interpretation" (p. 632). Given the alarming health statistics pertaining to Māori, a critical understanding of the experiences that Māori patients, whānau and workers is needed with researching values in health social work practice. The advice I received from the Kaitiaki, Emma Webber-Dreadon and Hori Ahomiro, was integral to developing this critical understanding about how, within the DHB socio-political context, values impact patients and their whānau, social workers, other professionals, communities, and social policy. As a Pākehā woman, I cannot truly comprehend the experience of being a Māori patient or a Māori social worker, surrounded by dominant Western assumptions about wellbeing and health. Their advice and support enhanced the reflexive process, allowing another lens through which to critically consider the developing theory in relationship to matters pertaining to Te Ao Māori.

Charmaz (2006) believes that methods are tools with consequences, shaping data collection, influencing the phenomena you see, and how you make sense of the data. Social work practice situations that result in value demands are difficult to conceptualise due to the associated nuances that correspond with complicated casework and decision-making. Accordingly, it would be problematic to evaluate and measure objectively the complex meanings that health social workers give to their values in practice (Creswell, 2007). Maintaining the participants' voices and staying close to the data was important to this research process. Grounded theory provided a foundation from which to examine data and frame my analysis (Charmaz, 2004; Glaser & Strauss, 1967). For the purposes of this

research, the central characteristics of constructivist grounded theory was that it provided a systematic, but flexible, guide to the scientific collection and management of data.

Banks (2008) stated that ethical issues should not be simply confined to problematic cases or dilemmas; this is also true of value-related issues, as ethics are values in action. Banks (2008) believed that social work literature often dislocates the problem from the motivations of the people involved, as well as their social context. Banks (2008) asserted that "this influences how practitioners conceive of and demarcate the domain of 'the ethical' and their perceptions of their ability to act" (p. 1245). Charmaz's (2014) constructivist approach allows for a holistic rendering of events pertaining to professional values as they unfolded in the critical incident narratives. The insights gained assisted with understanding the influences, motivations and contexts embedded within the participants' actions and interpretations.

Within constructivist grounded theory, Charmaz (2011) asserted that "theorists delve into the experience, but also widen the frame of inquiry to include the relative positions and realities in which this experience is situated, including those that a researcher identifies but research participants may not recognise" (p. 294). This is in alignment with postmodern and critical thinking which considers multiple realities alongside the foundations of 'acceptable' knowledge and how different forms of knowledge are privileged over others (Fook, 2016). The participants were not directly questioned about their own theoretical stance, but when preparing to write up the discussion it became increasingly apparent that ecological systems thinking underpinned the participants' practice narratives. An ecological perspective was then employed to help inform the analysis contained within the discussion sections of this thesis. The discussion contained at the end of Chapter Four was written after the analysis of the phase two findings. It is located at the end of Chapter

Four to situate health social work in light of the emerging categories, and to introduce the ecological perspective as a framework for discussing the analytical categories as they develop through the final chapters.

A critical inquiry is needed to analyse contradictions, and separate myths from reality (Charmaz, 2005). Social, cultural, political, economic and other lived realities are accounted for within this research inquiry through getting participants and researchers to consider their constructions of the researched experience (Bryant & Charmaz, 2007). This was an important aspect of the constructivist grounded theory inquiry, iteratively checking in about research constructions throughout the phases of interviewing, with the same pool of participants. As values are socially constructed, the way that health social workers construct their understandings of values in practice is central to this research. The constructivist grounded theory method enabled the participants' individual construction of values to be explicitly stated, and this generated a deeper sense of critical engagement.

Professional discourse, whether it be spoken or non-verbal, interaction contributes to the way in which social work practice is perceived, and the manner in which it evolves (Gunnarsson, 2009). Examining professional discourses through the use of a critical incident technique, Fook and Gardner (2007) generated knowledge about the norms and functions of professional social work actions through lived experiences (Gunnarsson, 2009). The process of critical reflection contained in narrating a critical incident provided a vehicle to illuminate unknown assumptions, which could then disturb and modify ideas and professional actions (Fook, 2013). Utilising a constructivist grounded theory technique (Charmaz, 2014) enabled me to move beyond discourse analysis into developing explanatory theory about how values are experienced within the ecology of practice.

Within this research, my philosophical assumptions are in line with Charmaz's (2014) research perspective in that I consider this research to be informed by my values, culture, ongoing experiences, professional knowledge and socio-political context. This constructionist belief reflects my ontological stance about the nature of reality (Creswell, 2007; Jones et al., 2006), in that it is constructed. As a researcher I aim to consider meaning, not truth, with a critical intent (Charmaz, 2000) through focusing on perceptions, action and context. Symbolic interactionism underpins the critical inquiry within constructivist grounded theory. At a micro level, symbolic interactionism illuminates processes and the way meaning is derived through social interaction while also illustrating action needed to address macro-level change processes, and issues of emergence, agency and negotiated social order (Duckles et al., 2019). The ecological perspective that was utilised to develop the discussion sections of the thesis complements constructivist grounded theory. Critical consideration of individuals' experiences within ecosystems clarifies the social world, while grounded theory systematically generates knowledge about the social world (Gibson et al., 2005). Grounded theorists naturally think systematically to detect causal relationships, intervention points, possibilities for change, and therefore action plans for intervention (Stillman, 2006).

Bryant and Charmaz (2007) asserted that a grounded theory method "produces limited, tentative generalisations, not universal statements. It brings the social scientist into analysis as an interpreter of the scene, not as the ultimate authority defining it" (p. 52). This constructionist philosophical orientation shaped my data analysis, and the resultant theoretical development and interpretation (Charmaz, 2006). Constructionism also aligns with my belief that values in social work practice are an abstract, complex and evolving human phenomena, to which individuals and groups assign meaning. My epistemological

orientation is such that I believe that knowledge is co-constructed through human interaction. The constructivist paradigm is applicable to how I view my role as a researcher (as that of an interpreter) and it gives weight to the goals and constructs of the participants (Bryman, 2012). I approached this research with the belief that facts, context, actions and values are intertwined, and therefore cannot be separated. In summary, for this research, grounded theory was my design framework, with the overall research strategy taking a qualitative approach. The research involves a predominately inductive reasoning process, contained within the principles of a constructionist epistemology that relates to an ontological stance that reality is socially constructed.

3.6. Procedures of Inquiry

This section of the chapter outlines the specific procedures of inquiry used to examine how values are experienced and negotiated in health social work practice. The section details the development of the research procedures as illustrated on the next page in Table 1, 'The Two-phase Research Process'. Phase one involved individual interviews of 15 participants in which they recounted a critical incident that they had experienced in their health social work practice with newborn infants and their whānau. Phase two involved interviewing 14 of these same participants again to consider the value statements and value demands apparent in their collective critical incidents.

Information is provided in this section about the way sampling, participant recruitment and selection were conducted. Material is reported on about the measures that underpinned the two-phase interviewing process, including an explanation about the data-collection procedures, the techniques used for data analysis, and the emergent and iterative development of the grounded theory analysis. The chapter concludes with a consideration of issues of subjectivity, managing an emergent design, and ensuring data integrity before going on to explain the ethical issues that pertain to the procedures of inquiry.

Participants: Health Social Workers working with newborn infants and their whānau. **Sampling Method:** Non- probability purposive and snowball sampling method to obtain participants who are registered social workers that have worked with newborn infants and their whānau. Same participant cohort in each of the two phases.			
	Data Collection		**Data analysis**
	Interviews	**Procedures**	**Techniques**

Phase 1
 	
15 participants, plus pilot interview
	Individual face to face interviews
	• conversational & semi-structured interviews
	• pilot interview and participant interviews were audio recorded & transcribed
	• used critical incident technique (Flanagan, 1954; Fook & Gardner, 2007)
	• utilised 3 set open ended questions.
		Participants asked to come prepared to talk about a critical incident that they have experienced in their role as a health social worker when working with newborn infants and their whānau.	• Constructivist grounded theory utilised (Charmaz, 2014)
			• NVivo 11 QSR International utilised, as well as poster paper/whiteboard and pens for coding and analysis
			• Pilot interview transcribed, but not coded. Pilot interview was reflected on in terms of process and ability to adhere to research aims
			• Data coded in batches utilising gerunds and memo writing in an iterative process
			  • first four interviews coded and analysed using a line-by-line before proceeding with further interviews
			  • next five interviews conducted, coded and analysed in accordance with categories created through line-by-line coding. Using an iterative method of constant comparisons of new data through theoretical sampling with existing data and emerging analysis
			  • then last six interviews coded and analysed using focused codes, with theoretical saturation being arrived at as no further information emerging.
			• Member checking through participants reviewing interview transcript

Phase 2
 	
14 participants, plus pilot interview
	Individual face to face interviews
	• conversational & semi-structured interviews
	• pilot interview conducted without audio recording, as per the wishes of the interviewee
	• all participant interviews were audio recorded & transcribed
	• utilised laminated cue cards containing salient quotes from the phase 1 interviews
	• utilised 10 set open ended questions derived from phase 1 themes.
		Prior to the phase 2 interviews participants received a summary of the identified themes that emerged from the phase 1 interviews.
		
		Sought and received written permission from each of the participants to share a range of selected salient quotes from their individual phase 1 interviews that reflected the key themes analysed from the phase 1 interviews. These quotes were placed on cue cards as visual stimuli from which to generate more discussion and reflection about how values are experienced in practice.
			• Constructivist grounded theory utilised (Charmaz, 2014)
			• NVivo 11 QSR International utilised, and poster paper/whiteboard pens for coding and analysis.
			• Pilot interview reflected on in terms of process and ability to adhere to research aims
			• The data from the phase 2 was analysed and coded in accordance with the identified themes that emerged from the phase 1 interviews
			  o Member checking through participants reviewing their interview transcript and through discussions about the themes identified in the phase 1 interviews, as illustrated on the cue cards and summary of phase 1 data
			• Data coded in batches utilising gerunds and memo writing
			  o first 5 interviews coded and analysed using the codes, categories and themes developed from analysis of phase 1, then conducted open coding to remain open to any new codes or categories that may emerge
			  o other interviews conducted, coded and analysed in accordance with categories and themes created. Development of theoretical concepts through reviewing and synthesizing themed categories and memos

Table 1.

The Two-phase Research Process

3.6.1 Research participants

This research focuses on the specific experiences of a particular subset of social workers. A non-probability purposive and snowball sampling method (Patton, 2002) was employed to enable insights into how values are specifically experienced by health social workers. Purposive sampling allows researchers to identify and target individuals who they believe to represent a specific population in a particular context (Davies & Hughes, 2014).

To achieve category development, grounded theory research uses non-probability purposive sampling in order to seek participants who can illuminate specific theoretical categories (Charmaz, 2014; Hutchison et al., 2010). The selection criteria for the participants were that they were Aotearoa New Zealand SWRB registered health social workers who have worked with newborn infants and their whānau for a minimum of two years. This participant criterion was selected to ensure that the participants have a depth of experience to draw upon when considering how values are located and experienced in health social work practice with newborn infants. In the phase one interviews I set out to collect data containing 'thick rich descriptions' (Lincoln & Guba, 1985) of experiences of value demands embedded within the critical incident. The phase two interviews were then designed to concentrate intently on the meanings behind the experiences described in the critical incident narratives.

Since the advent of the Social Workers Registration Legislation Act 2019, the title of 'social worker' in Aotearoa New Zealand has been protected. When recruiting for research participants, the requirement to be a registered social worker was to ensure that the participants' practice was supervised, and that they practised in accordance with SWRB

regulations. Within Aotearoa New Zealand, the pool of eligible participants was relatively small. I initially hoped to be able to target people who had experience in specific cultural contexts or from diverse ethnic backgrounds. The reason for this was to consider bicultural and multi-cultural practice, and to obtain data from a non-homogenous participant group. However, as only 16 people came forward to participate in the research, this was not possible. Regardless of this, it would have been awkward to gauge cultural context and ethnicity during the sampling process. During the phase one interviews the participants were asked about their ethnicity and there were five different ethnicities stated. There was one Māori participant, one New Zealand born participant with Polynesian heritage, two participants who were immigrants to Aotearoa New Zealand, and 11 participants who identified as NZ European/Pākehā.

A snowball sampling technique was used to locate participants with an adequate amount of experience to reflect knowledgeably on the research question. As previously acknowledged, there is a small number of social workers who are employed as health social workers in Aotearoa New Zealand to work with newborn infants. These health social workers are relatively publicly identifiable as their contact details can be obtained through their position within their respective DHBs and then linked to the public access information on the SWRB website. In accordance with the University of Auckland Human Research Ethics Approval gained, the then SWRB Deputy Registrar acted as the independent third party to disperse an advertisement to request expressions of interest in participating in the research to the potential participants identified through the process outlined above.

The first round of emails sent out by the SWRB Deputy Registrar resulted in eight potential participants. To obtain more participants, I enlisted the support of the Chairperson

of the DHB Health Social Work Leaders Council. The Chairperson gave the Deputy Registrar the email list of Health Social Work Practice Leaders and Managers across the different DHBs. The Deputy Registrar emailed the PhD advertisement outlining the research project to the Health Social Work Practice Leaders and Managers group, who then shared the advertisement with their respective social work teams. This process elicited another eight positive responses, thus ensuring 16 potential participants.

The participants had a wide variety of experience at the time of the phase one interview.

- 4 participants had 2-4 years' experience
- 5 participants had 5-9 years' experience
- 2 participants had 10-14 years' experience
- 3 participant had 15-19 years' experience
- 1 participant had 20+ years' experience.

In terms of work context:

- 8 participants worked with newborn infants and their whānau on the hospital ward
- 4 participants solely worked in community teams
- 2 participants worked a mixture of ward and community work
- 1 participant worked solely in outpatients.

It was difficult to discern at the outset of the research how many participants would be needed, and limitations on participant numbers would not be congruent with grounded theory (Foley & Timonen, 2015). Grounded theory promotes an emerging design to enable theory development, so flexibility around the number of participants was important (Charmaz, 2014). If theoretical saturation was yet to be reached after interviewing the participants, the inquiry would have been extended to further develop conceptual gaps within the categorised data (Charmaz, 2006). Throughout the two different research phases,

I coded and analysed data in batches, before going on to conduct more interviews. The ongoing iterative process of data coding and interviewing within each of the research phases assisted with discerning whether or not theoretical saturation had been reached (Charmaz, 2014).

Charmaz (2006) asserted that, in terms of sample size, it is most important that the data collected is "rich, substantial and relevant"; as constructivist grounded theory is not a verification method, but offers instead plausible accounts of the "complexities of particular worlds, views, and actions" (p. 132). Even though 16 potential participants were located, 15 people participated in the first round of interviews. This was due to the 16th participant initially being unavailable for an interview. I then made the decision not to interview this potential participant. The reason being that I had found that no new properties were yielded in the final few interviews. After significant consideration, I felt that theoretical saturation had been reached and notified the 16th person accordingly (Charmaz, 2014).

The consent process for this research was designed so that if a participant withdrew from the phase two interview, their data from the previous interview could still be used. The participants all consented to be approached regarding the possibility of them participating in the phase two interviews. Fourteen participants completed the second phase of interviews. One participant withdrew due to work commitments. The quality of the data collected during the phase one and two interviews was such that there was a vast amount of information that provided significant information about how values were experienced and negotiated in practice.

Pilot interviews

The exception to the recruitment process described above was the person who participated in the pilot study. I knew this person through my professional networks and asked her directly to participate in the pilot interviews. I interviewed this person twice to trial the interview techniques in both of the distinct data-collection phases and to foreshadow any possible problems (Sampson, 2004). I did not directly incorporate the information contained within the pilot interviews into the research analysis. As a result of the pilot interviews, extra prompts were considered. The pilot interviews particularly aided the delineation between the material to be covered in the different phases of interviewing.

McCoyd and Shdaimah's (2007) investigation into the benefits of intensive interviewing on social work research participants found that the process of being listened to by an empathic interviewer was validating. The feedback from participants was analogous to this study from the outset. The pilot interview participant stated that the process of describing the critical incident gave her a chance to further debrief and reflect on what the situation meant to her personally and politically. This was a common theme throughout the interview process with many participants making similar statements.

The phase one pilot interview confirmed that the critical incident technique was a useful tool to gain insights into how values are experienced within health social work. The phase two pilot interview helped to refine the way in which the cue cards were utilised and to consider the way in which I structured the timing of questions alongside my explanations of the phase one data analysis. The tactic of using a pilot interview with the same person before beginning both phases of individual interviews enabled me to adjust and adapt the interview process through advance testing.

3.6.2 Data collection

The procedures that underpin this research project across both phases of data collection, have been illustrated in Table 1. Conducting a series of interviews with the same participants is congruent with grounded theory (Charmaz, 2014). Intensive interviewing was needed to credibly explore how values are experienced and responded to in practice with each of the participants. The participant who did not proceed into the second phase of individual interviews gave her written consent to have salient quotes contained within her interview shared with the other participants in an anonymous fashion. This enabled the use of the information contained within her interview to be actively utilised in the phase two interviews.

Charmaz (2014) recommends that researchers write some open-ended questions before the interview, but not to plan to ask all of them. I followed this recommended process by utilising the additional questions as optional probes to assist with exploring what the participants had to say. The phase one interviews were principally devoted to the participants providing a concrete explanation of the critical incident that they had chosen. These interviews lasted between 47 and 110 minutes, an average of 67 minutes' duration. The length of time often depended on the amount of detail the participant went into regarding the background to the critical incident and the subsequent impact of it on them. The phase one interviews were conversational and semi-structured, utilising three set open-ended questions. The participants were asked to come prepared to narrate an experience/s that they have had in their role as a health social worker working with newborn infants and their whānau. I informed them that the experience would refer to a critical incident

involving decision-making in a complex practice situation. The analysis of the data from the phase one interviews informed the interview questions for the phase two interviews.

The phase two interviews were also individual, conversational, semi-structured, face-to-face interviews. I placed a range of salient quotes that illuminated the focused codes contained within the phase one findings on laminated cue cards. Ten set open-ended questions were utilised for this interview, and the questions were derived from points of interest from the focused codes generated in the phase one analysis. The phase two interviews lasted between 63–130 minutes – on average 87 minutes. These interviews were on average 20 minutes longer than the phase one interviews; this was in part due to the time spent explaining the analysis of the critical incident data, before considering the questions specific to the phase two interviews.

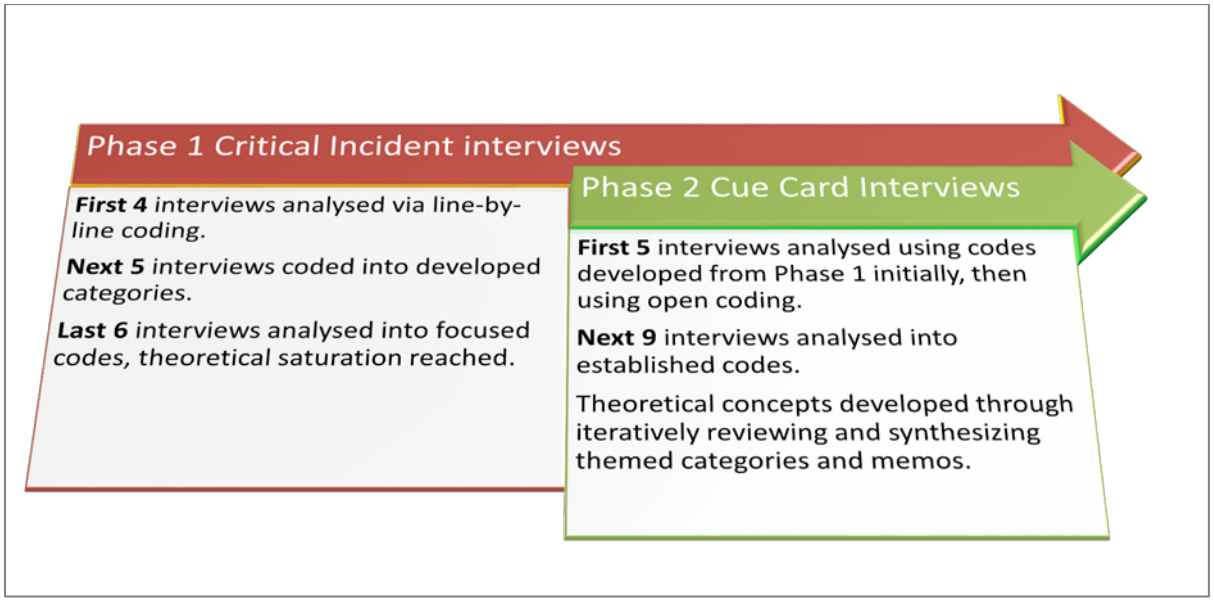


Figure 2. Two phases of data collection.

The purpose of the phase two interviews was to advance the phase one considerations and discussions of the critical incident narratives. Through interviewing the participants again I gained a more complete account of the experiences had by the

participants to further determine their understanding about how values informed their collective action portrayed in the critical incident narratives (Charmaz & Belgrave, 2012). In the phase two interviews, the participants were already familiar with the research project, and interviewing them again allowed for new leads to be pursued, for conceptual categories to be revisited and reframed, and to further develop the tentative theoretical ideas (Charmaz, 2014). Time was spent with the participants in the phase two interviews critically reflecting and deliberating on the focused codes that demonstrated their collective expressions about encountering values in practice. Further information about the data-collection techniques involving the critical incident technique and the use of cue cards are clarified and explained in the next two subsections of this chapter.

Phase one interviews

Pivotal to the data-collection process in this study was the use of the critical incident technique (Flanagan, 1954; Fook, 2013; Fook & Gardner, 2007) to reconstruct practice situations. The critical incident technique is lauded as a qualitative research method that provides concrete, detailed data (Fook & Gardner, 2007; Wertz et al., 2011). This technique was devised by Flanagan (1954) as a flexible pragmatic procedure to research psychological phenomena by obtaining raw data for analysis (Butterfield et al., 2005; Wertz et al., 2011). The critical incident technique is commonly used to reveal information about the beliefs, thoughts and feelings contained within the context of the critical incident event (Butterfield et al., 2005; Fook, 2016). Critical incident analysis can also reveal information about how theoretical and research knowledge is applied to practice, alongside wider practice principles, ethics and values (Germain & Gitterman, 1996).

Fook and Gardiner (2007) utilised the critical incident technique to enable social workers and health professionals to explain an incident that is important to them. They advised that the chosen incident needed to be important because of the significance it holds to the person (or people) who were involved in the experience, not necessarily because it involves a crisis or an emergency. Utilising the concept of a critical incident in a complex practice situation assisted with the development of 'raw and concrete' information (Fook & Gardner, 2007) about an event and, for the purposes of this research, it allowed the collection of information about how values inform social work practice. Fook and Askeland (2007) used the critical incident technique when educating social workers and social work students to reflect on professional practice experiences through reflexive, deconstructive thinking. The technique encourages cause and effect thinking about social and political context. This consideration of context is fundamental for both the participants and myself, as the researcher, to critically consider how values are experienced in practice.

I utilised a critical incident technique during the phase one interviews to gain insight into the complex values and motivations at play within health social work practice. The research is, of necessity, participant-centred, with grounded theory allowing for the development of theoretical understanding drawn out of the participant narratives about their critical incidents. The participants were asked to personally narrate and reflect on a critical incident experience that they have had in their role as a health social worker working with newborn infants and their whānau. The recounted interactions and experiences of the participants contained within the reconstructions of the critical incident were central to building theoretical knowledge about how values are experienced and negotiated in practice.

On the interview schedule that the participants received prior to the phase one interview, the participants were given the information about criteria regarding a broad set of circumstances that define and generate a critical incident. They were told that the critical incident needed to be something that they had been involved in as part of their role as a health social worker working with newborn infants, that has significance to them due to challenging issues surrounding decision-making in practice (Fook & Gardner, 2007). Through asking the participants to choose, discuss, and reflect on a critical incident involving complex decision-making, this incident became a descriptive unit that was of importance to the participant, which I then utilised for my analysis and theory development (Patton, 2002). The interview was spent exploring the context and background behind the circumstances that led up to the critical incident, and why that incident was meaningful to them. Each participant's example of practice contained within their critical incident was unique and personal to them.

The purpose of this research project and the use of critical incidents was not only to examine the day-to-day realities of health social work, but to use an iterative process to uncover abstract concepts about how values are experienced and negotiated in day-to-day practice. In the phase two interviews, the participants were presented with cue card quotes that characterised the key categories developed from the analysis of their critical incident narratives. The categories represented the participants' actions in practice, and the participants were asked to critically reflect on what their collective actions and statements meant in terms of how they experience and negotiate values in practice. This critical incident technique combined with the reflection on the cue card statements was used to provide a window into the working world of health social workers to enable consideration of

the relationship between meaning and action with reference to professional values (Charmaz, 2014).

Phase two interviews

The phase two interviews involved interviewing 14 participants, as one participant withdraw from the research due to work commitments. The phase two interviews were all conversational, semi-structured, individual interviews, utilising 10 set open-ended questions derived from the conceptual categories that emerged from the phase one data analysis. The critical incident narratives provided an abundance of data about the realities of health social work, clearly illustrating the context and decision-making processes that the participants undertook in day-to-day practice. The phase two data collection process was devised in order to gather the participants' views on the analytic categories developed in phase one so that further information could be gained to illuminate the developing conceptual categories.

The analysis from the critical incidents within the phase one interviews created Figure 3, the *Phase one category configuration* (listed below) from which to view values in action. When analysing the phase one findings, a range of salient quotes were placed under each of these headings and sub-headings to illustrate the analysis grouped under *Practice vision, Work expectations* and *Practice experiences.*

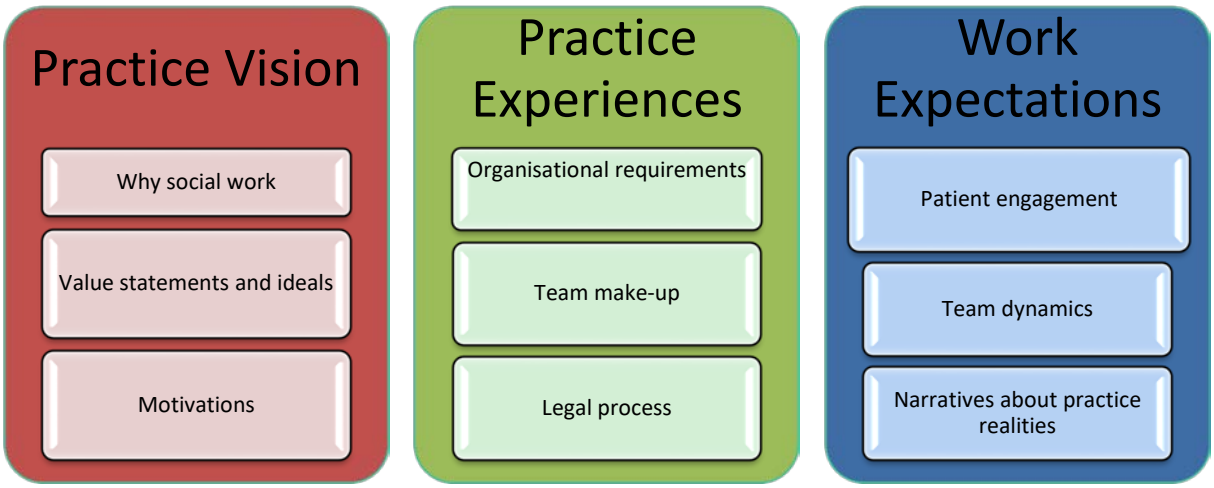


Figure 3. Phase one category configuration.

This category configuration assembles the salient conceptual categories into three main headings. Prominent quotes were selected from all the phase one participants and categorised according to the phase one category configuration listed above. These quotes pertained to the refined codes that were developed and demonstrated the analysis of how values were illustrated and negotiated within the critical incident narratives. Care was taken to ensure that the quotes selected were representative of all the participants, to avoid skewing the quotes through overusing quotes from any particular participant.

These categories are explained in detail in Chapter Four (Phase One Findings), but in summary, the categories grouped under the heading 'Practice vision' were primarily about the participants' aspirations and motivation for social work practice. The analysed data grouped under the heading *Work expectations* principally relate to organisational requirements and issues around decision-making practices. The final category, 'Practice experiences', predominantly relates to issues around patient engagement and team dynamics. The quotes represented the substantial categories that emerged from the analysis of the phase one findings, and these themes were perceived to have the greatest relevance to how the participants experienced and negotiated values in practice. The quotes

were printed onto cue cards and then laminated for easy handling, so that they could be shared with the participants during the phase two interviews. This distribution of the phase one findings analysis via cue cards allowed for further exploration of the value statements and tensions that appeared in the participants' narratives of the critical incident. The cue cards also allowed for a systematic process of member checking, as feedback about the analysis illustrated within the framework on cue cards was received in the phase two interviews.

Prior to the phase two interviews starting, the participants were sent an email to explain the process for the upcoming interviews, and to ask for consent to share some of their salient quotes from the phase one interview process with other participants. Embedded in their individualised emails were the distinct quotes that would be used on cue cards in the phase two interviews that pertained to each participant. The participants all consented to share their particular quotes anonymously on cue cards with the other participants. Approximately two weeks before the participants had their phase two interview, they were sent a document titled 'Summary of the Phase One Interview Findings'. This written summary explained the manner in which the analytical categories in the *Phase one category configuration* were clustered and reiterated that the purpose of the phase two interviews was to extend their commentary and reflections about how they experience and negotiate values in practice.

The interview schedule for the phase two interviews worked in tandem with the cue cards and was not structured for use as an independent document. The logic of the interview schedule was only comprehensible alongside the explanations of the quotes contained on the cue cards; therefore, the participants did not receive the interview

schedule in advance of the phase two interviews. Time was spent in the phase two interviews explaining the context behind each of the questions on the interview schedule, with reference to the relevant salient quotes sourced from the phase one interviews. The cue cards containing the salient quotes were used to discuss the analysis developed from the phase one interviews, and to probe deeper into understanding how the participants experienced and negotiated values in practice.

At the beginning of each interview, some participants were prompted to remember what their critical incident is about. Immediately prior to each interview, I read the participant's interview transcript from their phase one interview to remind me of how the participant spoke about values and value demands in their original interview. To assist with keeping track of the emerging analysis a document titled 'Framework for the Second Phase of PhD Interviews' was developed. This framework served as a reference point during the interview, helping to link the cue cards with the different interview questions. As the phase two interviews progressed, comments were placed in the margins of the document that contained the developing analysis. The analysis contained within the document was then continually updated and integrated into subsequent phase two interviews. The review comments also acted as prompts within the interview to maintain the focus of sharing the analysis accurately with the participants while also allowing deeper probes into the participants' experiences and responses regarding values. This process ensured that all the themes for phase two interviews stemmed directly from the analysis of the earlier phases.

The phase two interviews provided the opportunity to debate with the participants the nature of the phase one categories concerning their views and actions. For Charmaz (2014), this involves avoiding reproduction of the participants views, but a testing of the

participants' assumptions, taken-for-granted knowledge and a further consideration of the relationship between the developing theoretical categories. After receiving positive feedback about the quality and relevance of the phase one interview categories, the phase two interviews began to have a much stronger focus on the emerging analysis that was developing out of these interviews.

To give an example of how the cue cards and the interview schedule worked in tandem, below is a demonstration of how the first critical incident salient theme *'over a long period of time'* was investigated. Included is a photo of the first cue card (1a) to give a visual illustration. For this theme, two separate cue cards were used to explore the theme with each of the participants.

Cue Card (1a)
*It was meaningful to me because there's not a lot of opportunity that you get to work closely with families…it's so much like 'go – you're in – you're out – you're in – you're out' and the families that I recall…are the ones that I had the opportunities to actually build a rapport with and do some **real** social work rather than just the risk assessment and just the discharge plan… I got to actually use some of my skills around the therapeutic rapport building*

Cue Card (1b)
I think we're pretty good actually how we work with families. I work pretty openly with families about what I'm doing and why, and I think that creates success in terms of relationships with them. Yeah, often … you don't have that luxury though of time

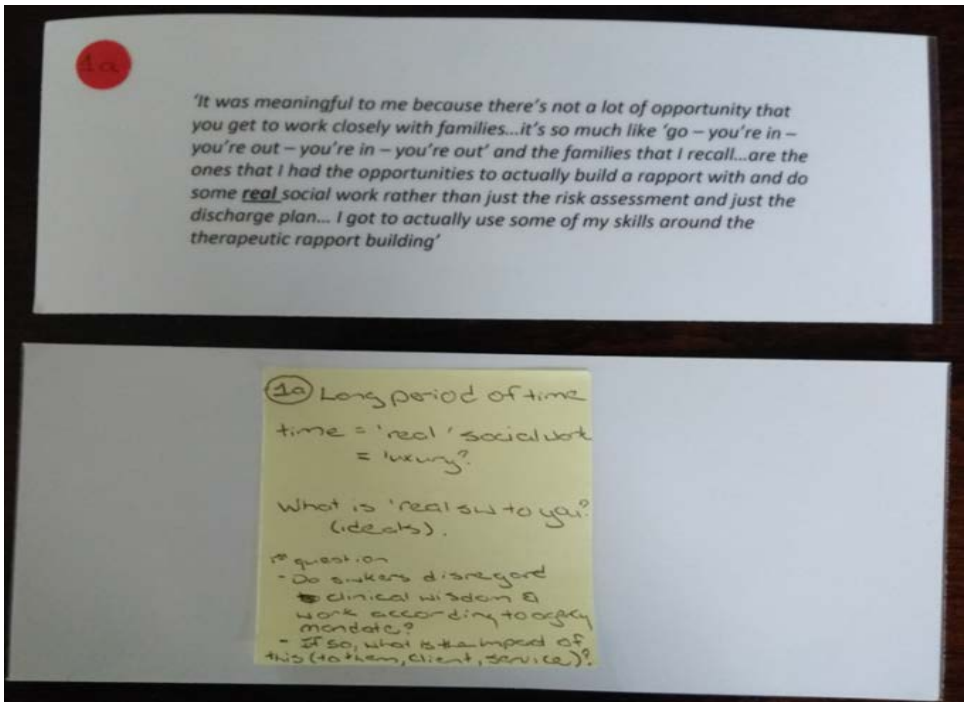
The questions on the interview schedule pertaining to these two quotes were:

a. What is 'real' social work to you?
b. Success – Is success the same as best practice?
    i. Is best practice defined by an agency, or is best practice defined by internal perceptions of good social work? (why, how….)

On the back of the set of cue cards were the following notes that were used as prompts for concepts that were to be explored further:

- Long period of time = 'real' social work, = luxury?
- What is 'real social work to you? (ideals).

Photo 1. *Cue card example*



Alongside these notes on the cue cards, notes in comment boxes listed in the margins of the document titled 'Framework for Second Phase of PhD Interviews' were continuously added, so that the emergent analysis was recorded as it developed through successive interviews. These comments then became part of the analysis that was shared with participants in subsequent phase two interviews.

Some of the questions in the interview schedule were asked repeatedly, but in different ways, e.g., Question 2 *Are values made visible through conflict?* This question requires a lot of thought and it would be unreasonable to expect a comprehensive immediate response from the participants. Initially when Question 2 was asked, often a more surface-level response was received. The question was then asked again at a later stage in the interview, from a slightly different angle by asking, in Question 6 *Are value dilemmas consciously recognised in practice, are they conceptualised?* This question was asked again in relationship to a quote about 'fudging the truth' in order to avoid conflict. The second time around, participants were more able to critically reflect on the concept of values being visible in conflict situations, through the use of the example about fudging the truth.

Research into social work values must account for the "constructed nature of social work activity, [as] the moral narratives of social work are multiply constructed" (Wilks, 2004, p. 80). The cue cards functioned as an elicitation technique to prompt thoughts and opinions that are predominantly tacit or seldom articulated (Barton, 2015). Values in practice is an abstract concept, and the cue cards enabled a deeper relationship and connection with the existing themes. The cue cards allowed the interview to become more focused on values in practice compared to the Phase 1 interviews. The cue cards facilitated a richer, more in-depth data-collection process about how values are experienced and negotiated. Memos from that time record that the cue cards were an innovative way to mover deeper into critical reflections about how the participants experience values in practice and how social work values are enacted within a health setting. The participants held the cue cards during the interview, and I held a set of matching cue cards. When they held onto the quote contained on the cue card, it appeared that they were able to connect

at an emotional level with the other participants' experiences, alongside their own experiences of health social work practice with newborn infants.

The phrase 'fudging the truth' relates to a deceptive strategy employed by a participant to avoid conflict. The cue card quotes openly illustrated the tensions and strategies employed by the participants in their day-to-day practice. This level of transparency and honesty seemed to give the participants the opportunity to be frank about their own practice in response to the cue card quotes. The use of cue cards appeared to help to reduce the social desirability bias effect, as they candidly illustrated the realities of health social work practice. The cue cards may have reduced the tendency of participants' under-reporting behaviour or attitudes that are not socially desirable (Bryman, 2012). Similarly, Wilks (2004) asserted that the use of vignettes to research social work values reduced the influence of social desirability factors through generalising common scenarios, and creating a degree of distance between the collective findings and the participants' individualised experiences. The use of the cue cards softened the interview process by normalising the stresses and tensions felt by many of the participants. Long and Long (1993) utilised cue cards for their qualitative interviews, they reported that the use of these enhanced the sense of a collaborative unfolding of the interview narrative generating continual reflection on the cue card material throughout the interviews. This finding was true for this research into social work values, the cue cards created a tangible space for reflection, they were left in plain sight as the interview progressed, and the participants were able to make strong links between the statements on the various cue cards.

The participants reported that they enjoyed the interview process. They felt that the way that the data had been analysed appears was congruent with their view of health social work and they did not note any discrepancies. During the interviews, the participants

appeared to move quickly into a political analysis of practice, considering organisational issues against practice imperatives, and providing an ecosystemic analysis of their practice experiences. These phase two interviews were about examining power, mandate and professional voice within health social work, and considering influences and factors correlated with participants' ability to adhere to their professional values. Through explaining the phase one interview analysis through the quotes printed on cue cards, participants were enabled to grasp the emerging analytical ideas and a sense of shared understanding developed relatively quickly. This ability to move quickly into analytical discussions was important and necessary, especially as over a year had passed since the participants had the critical incident interview.

3.6.3 Data analysis

This sub-section of the chapter presents the process underpinning the two phases of data analysis. The Figure 4 represents the findings across the two phases of data analysis, and the procedures undertaken to achieve these findings will be explained here.

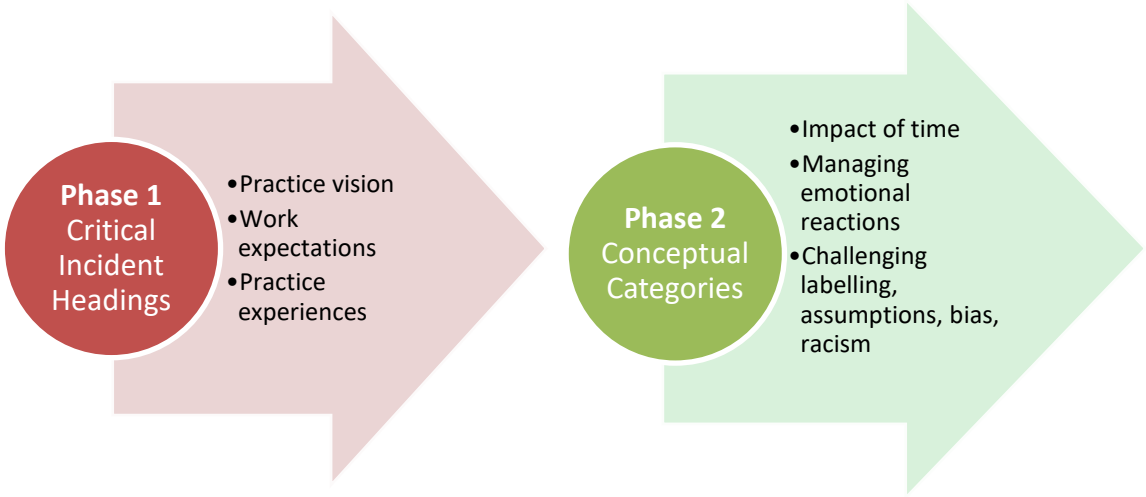


Figure 4. Phase one and two category configurations.

The three key category headings developed from the analysis of the phase one findings were: *Practice vision, Work expectations,* and *Practice experiences.* When analysing the phase two findings, these broad category headings were developed further into focused codes and then into the following conceptual categories: *Impact of time, Managing emotional reactions,* and *Challenging labelling, assumptions, bias, racism.*

Within this chapter, information is initially provided to explain the decision to use analysis software NVivo to manage and develop the collected data, and to explain how NVivo supported the process of data analysis. Due to the complex nature of constructing grounded theory about values, explicit details about the data analysis procedures are specified, starting with an explanation of how the phase one interviews were analysed. The critical incident data were analysed through an initial process of line-by-line coding to generate and test preliminary codes, before moving on to focus coding. Details are then provided about the process behind the phase two data analysis. The structure for the phase two interviews was developed after completing the phase one data analysis, and explanations are provided as to how the phase one data directly informed the analytic direction that the subsequent interviews would take.

NVivo software

I made the decision to use computer assisted data analysis software NVivo to organise, manage and develop this research project prior to the collection of data. With a qualitative interviewing technique, I knew that a large amount of data would be produced, which would then need to be categorised and organised carefully. The NVivo software complements a grounded theory approach to research, assisting with data handling and analysis processes, without inhibiting the role of the researcher in interpreting the data

(Bringer et al., 2006; Hutchison et al., 2010; Timonen et al., 2018). NVivo generated an audit trail of work done as transcripts were imported directly into the software. This allowed electronic coding, with coding stripes illustrating coding patterns alongside the transcripts.

NVivo software allowed close interaction with data, iteratively moving between sections of data, retrieving aspects of data to compare them with emerging categories. Emailed records or supervision notes were contained within NVivo, memos were attached to coding categories and emails were also entered directly into the NVivo project. The NVivo software supported me to code data, link ideas, complete text searches and design research models, while still interacting easily with the source data to develop emerging theory. Time was also taken away from the software to consider the data and emerging analysis away from the computer screen (Bringer et al., 2006). Maher et al. (2018) recommend using traditional coding tools such as coloured pens, white boards and paper to support the creative component of data analysis alongside NVivo software. I spent time away from the NVivo project, drawing up models and mind-maps of my themed codes and categories. These models, mind-maps, reflections, emails and journaling then became my log, detailing the iterative process of data analysis, and these documents were added into the NVivo project.

When coding in NVivo I worked to avoid preconceived thoughts drawn from my professional knowledge base, and to reduce the likelihood of adopting extant theories (Charmaz, 2004). I followed Charmaz's (2014) process of coding with gerunds to detect actions and processes, as opposed to descriptions. I reflexively considered how I influenced the data-collection process. I was aware of the time and the trust that the participants had given me, so I handled the data with great care. I took time out from coding to conduct journaling. I recorded my process in emails to my PhD supervisors to invite comment prior

to scheduled supervision, to ensure that the process behind the management of the data was methodologically correct, reflexive, and robust. This level of reflection and caution enabled me to feel sure of my process while moving through the different stages of data analysis.

Phase one data analysis

The process of data analysis of the critical incidents was a lengthy one, involving vast amounts of data from the 15 individual interviews. This phase one data needed to be analysed systematically to discover the emergent ideas which would give theoretical direction to the research findings (Charmaz, 2014). I transcribed the pilot interview and the first two interviews myself, then used a professional transcriber to transcribe all subsequent interviews. Prior to beginning the coding and analysis process, I read the transcripts, and listened to the audio recordings to ensure that I was conversant with the data.

Charmaz (2014) stated that, since grounded theory involves an iterative movement backwards and forwards between data and analysis, further data are needed in order to refine the emerging theory. I analysed the first four interviews through a line-by-line coding process, then I began to synthesize the initial codes, using models, diagrams and memoing as tools to assist with this process. I then moved forward with another five interviews, predominantly utilising the tentative focused codes developed through the line-by-line coding process. After completing the ninth interview, I had a significant period of reflection to consider the developing theoretical categories carefully before continuing with the final five interviews. I took time away from individually interviewing and coding the interviews after the fourth and ninth interviews to further define and categorise the analysis contained within the focused codes. Analysing the phase one interview transcripts in batches allowed

the analysed data and emerging concepts within the categories to be refined, so that they could inform the direction of subsequent interviews.

Line-by-line coding

As indicated earlier, the first four interview transcripts were scrutinised using a line-by-line data analysis method, to fracture the data (Charmaz, 2014; Glaser, 1978). Line-by-line coding involves concentrating on the text in a focused manner to provide impartial attention to the words contained within each sentence. This level of focus serves to reduce the impact of researchers' preconceptions, allowing ideas to emerge and contradictions to be explored analytically (Bazeley & Jackson, 2013; Charmaz, 2014). This process was time-consuming, but enabled the codes developed to be a more accurate reflection of the action demonstrated in the data (Charmaz, 2012). Glaser (1978) states that line-by-line coding forces the researcher to "verify and saturate categories" (p. 58) to minimise the risk of missing important categories. The process of line-by-line coding produces "a dense rich theory" (Glaser, 1978, p. 58) which is a further protection against preconceived ideas.

This rigorous process of line-by-line coding generated 173 codes with 519 references from the first four interviews analysed. To avoid being immobilised by the sheer number and variety of codes, I utilised a tree structure in NVivo. Using a hierarchical tree structure makes comparisons between codes easier (Bringer et al., 2006). To develop the tree structure, I created a category and then a sub-category, which collated similar codes into more manageable sets. The concepts contained within the codes were then placed within branches in the tree structure to collate codes with common properties as a way of concept management. The tree structure was not used as an analytical tool, but assisted with

managing the many coded concepts, and care was taken to avoid forcing concepts into set categories (Hutchison et al., 2010).

Charmaz (2014) stated that initial codes are provisional, as researchers need to strive to remain open to data, and then later follow up on codes that best fit with the data. Throughout the process of coding and memo writing, I worked to see how the codes developed were accounted for in subsequent data; looking also for potential relationships between the developing codes. The codes were then modified into tentative categories to better describe the action, processes or emotions illustrated across the data. The coding stripes function of NVivo assisted with tracking codes across text segments to consider similarities and differences across codes (Bringer et al., 2006).

The aim for the phase one interviews was to use participants' concrete experiences to build concepts grounded in data that would later be developed into finer analytical categories, and then into emerging theory. Conducting line-by-line coding enabled me to reflectively examine the data by allowing an exploration of each phrase expressed by the participants for meaning. Line-by-line coding provided an intense level of microanalysis to consider how the participants behaved within health social work practice, and why. Bazeley and Jackson (2013) asserted that this level of coding should only be done with the first few interview transcripts, unless new ideas need to be explored or contradictions resolved.

Glaser (1978) stateed that grounded theorists often feel barraged by core concepts when they begin to analyse the data and recommends proceeding slowly to sample for correct fit and relevance. Instead of analysing the data from the phase one interviews all at once, the transcripts were coded and examined in batches, before proceeding to the next round of interviews. This process allowed analysis of previous interview data to be used to inform subsequent interviews. I constantly reflected on how my interviewing style was

influencing the direction of the interviews. To try to discern the impact that I was having upon the flow of the interviews I took the time to collate all the questions and prompts that I interjected with during the first three participants' interviews. Doing this enabled critical reflection on how my questions and interjections were shaping the flow of the interviews as I moved forward with subsequent interviews.

I continued line-by-line coding with the first four interview transcripts in order to make comparisons between data to discover and refine emergent leads (Charmaz, 2012). These emergent leads were then explored further in subsequent interviews. After analysing the first four interviews, the codes were condensed from 173 to 115 nodes. These codes were confined within 28 main headings, with separations contained within the headings to differentiate and provide more detailed analysis. The framework of memos created alongside these codes became the foundation for my analysis of the interview findings. Memo writing encourages conceptual analysis about emerging concepts, assisting with clarification of category saturation, theoretical development, and providing transparency of process (Bringer et al., 2006). Memo writing enabled me to consider the conceptual links that were being developed between the codes so as to visualise meaning and action more clearly (Charmaz, 2014)

Alongside memo writing, diagramming is fundamental to the coding process, as it illustrates the connections and relationships between categories, enabling higher-level analysis of the developing conceptual categories when coding (Mills et al., 2006). Transparency about grounded theory research processes means that processes can be visualised by others, while also demonstrating congruence between the data analysis process and the methodology used (Bringer et al., 2004). For this reason, I have included Appendix 2 (Coding and memo images) to illustrate through the inclusion of three diagrams

and a memo example of the emergent analysis and code development after completing the line-by-line coding of the first four interviews. The coding and memo images contained within Appendix 2 demonstrates how data were fragmented. The first diagram illustrates one of the four pages of condensed codes after completing the line-by-line coding process. The next diagram demonstrates a NVivo model that was designed to help illuminate the connections and relationships between the developing codes, before progressing onto the next batch of interviews. The final image is the coding that was done with paper and pens to compare the initial codes, and to continue to group codes into conceptual categories. The last item in the appendix is an excerpt from a memo that was written at the time of completing these first four interviews. The memo demonstrates emerging analysis as I began the movement from initial to focused coding.

The movement from initial to focused coding

Charmaz (1996) asserted that "line-by-line coding helps you to refrain from imputing your motives, fears or unresolved personal issues to your respondents and to your collected data" (p. 37). The movement from initial to focused coding involved reflection on my own practice experiences and beliefs about health social work with newborn infants. Charmaz (2014) stated that, through "studying the data and following leads you find in them, you make fundamental processes explicit, render hidden assumptions visible, and give participants new insights" (p. 133). Line-by-line coding allowed me to consider health social work with newborn infants with fresh eyes, while comparing the critical incidents enabled the discovery of patterns, differences and similarities (Charmaz, 2014).

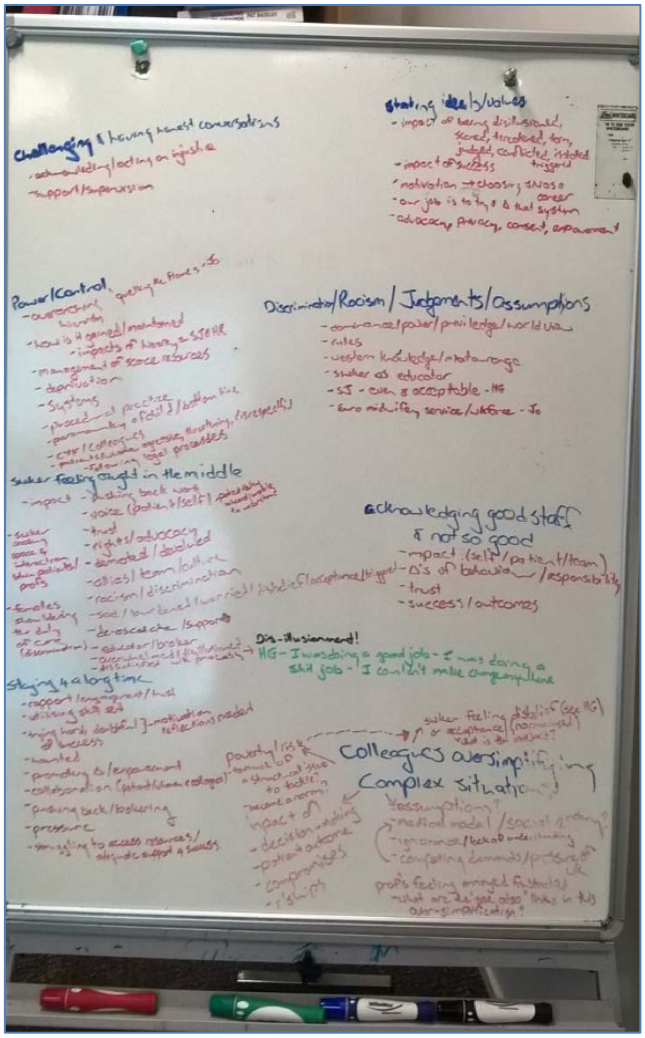
In vivo codes became pointers to consider implicit meanings and taken for granted assumptions. *'The luxury of time'* was an *in vivo* code developed early and it became a

framework to categorise codes relating to material in the data about how '*real social work'* was conducted. Medical complications often resulted in prolonged hospital stays, which meant that health social workers were able to provide in-depth support to the patient over an extended timeframe. A lot of data and categories related to the concept of the *'luxury of time'*, and the concept of time became a conceptual category that was utilised in the second phase of interviews. Charmaz (2014) stated that participants can assume that the phrase contained within the *in vivo* code is something that contains a shared meaning. The condensed meanings contained within the *in vivo* code serve as flags that alert the analyst to emergent themes and actions. As a former health social worker it was important that I reflected critically on these instances of inferred shared meaning, to uncover hidden assumptions and taken-for-granted knowledge. Charmaz (2014) stated that careful coding compels researchers to consider data differently from the participants' interpretations, making it easier to draw links between interrelated systems, and micro and macro perspectives. The process of analysis, combined with my disciplinary knowledge, made it easier to envisage larger social issues and processes at force in a manner that may not be immediately obvious to the participants. A constructivist orientation does not allow for the researcher to be perceived as a neutral observer, life experiences will always influence the research process, and therefore the researcher's voice should not be concealed (Bryant, 2003; Charmaz, 2014). Care was taken through contemplation, memo writing, conversations with colleagues and supervisors to endeavour to separate my practice experiences from those of the participants.

The process of using grounded theory felt like 'looping and weaving' through data, and the intricacy of line-by-line coding resulted in me being extremely specific in my initial coding. After coding the first four interviews, I faltered, feeling that I was unable to make

clear progress. This was largely because I had coded items very exactly, in a repetitive manner, coding minute details, as well as descriptions of actions. I had started to feel that I may not be able to 'see the forest for the trees' given the number of codes being developed from each transcript. To move ahead, I began to develop focused coding, through testing established codes. Charmaz (2008) asserts that grounded theorists consider the most frequent or significant initial codes to develop focused codes. Focused codes are more conceptual than the initial codes, and provide strong analytic direction, so that large segments of data can be coded in tune with emerging analysis (Charmaz, 2014). I needed to gain a clearer focus on the developing codes, so I stepped away from NVivo for a short period. I switched to utilising poster paper and coloured pens, and a whiteboard, as tools to consider the relationship between coding categories and emergent concepts. It was important to take time to synthesise the codes, due to the number of codes initially generated. Some of the emergent concepts that were being categorised were connected to the length of stay that the patients had on the ward, the impact of judgments and assumptions made by colleagues, challenging team dynamics, social workers being caught in the middle between

Photo 2. *Code development*



the patients and other professionals, and the medical model. These types of emerging analytic categories were reflected on and considered iteratively in light of the information contained in the various critical incidents. Charmaz (2014) states that initial codes provide pathways for analysis; after coding the first nine interviews I again felt slightly overwhelmed by the options that the different pathways presented. Further work was done to carefully condense and prioritise the concepts categorised with within the data. I was nervous of disregarding initial codes during this early stage of analysis and worked reflectively, taking time to double-check decisions made. Using a similar process to the whiteboard and poster work that I did after conducting the line-by-line coding of the first four interviews, I used a whiteboard to mind-map, and big paper charts with coloured pens to break down the NVivo codes into key points. It was important to retain the individual participants' voices while I did this, so I re-read the interview transcripts away from the NVivo software, writing down on paper what I thought were the 15 most salient themes contained within each separate transcript. I then grouped the 15 most salient themes from each of the interviews on a whiteboard, to track commonalities and refine the focused codes further. After that, I then compared my diagram of codes on the whiteboard with the analysis contained within the NVivo project. This enabled me to feel a sense of methodological rigor with the work that I had coded within the NVivo project, as the two groupings of codes were similar. This time-consuming extra measure to double-check the accuracy, relevance and significance of the focused codes gave me the confidence to move forward with further interviews.

The codes were categorised to consider the conditions in which the action or process occurs, and to consider how the category relates to other categories coded (Charmaz, 1996, 2014). At this stage, extra codes were also very occasionally being developed to contain new processes observed. This strategy resulted in 32 core categories developed at the end of the

NVivo coding process for the first nine interviews analysed. Through this process of carefully considering and comparing codes I was able to feel satisfied that I had developed focused codes that subsumed numerous initial codes. The active interaction with data allowed for an ongoing emergent process (Charmaz, 2014). In the subsequent interviews I asked supplementary questions to glean more information about these categories. I then coded the last six interviews to the condensed focused codes and categories, with some additional *in vivo* codes to immediately integrate their voices into the findings when appropriate. Through the process of focused coding I worked to frame interactions, and continued to compare codes for implied meanings, patterns, gaps in data and conceptual strength relating to how values are experienced and negotiated in practice.

The critical incident was used as a vehicle to explore narratives for hidden unconscious value statements, which enabled more overt reflections on values in the second interviews. The critical incident was more than just an exploration of professional discourse, it was also about making visible the link between action and meaning pertaining to social work values. Considering values in health social work action is difficult and complex due to the abstract nature of values. The critical incident technique allowed for a reflexive, iterative movement between action and meaning within a set context.

Phase two data analysis

The phase two interviews allowed a process of drilling down deeper into the participants' understanding of values in practice. The cue cards acted as a bridge between the phase one and phase two interviews, allowing a joint understanding to be further developed about the value statements within the critical incident and wider practice experiences. Charmaz (2014) cautioned against 'skimpy data', exhorting the need for

researchers to develop sufficient data that are rich and relevant. The phase two data collection and analysis process were undertaken to ensure that substantial data about the participants' views on how values are experienced and negotiated in health social work were gained. The phase two data were analysed and coded in accordance with the conceptual categories that emerged from the phase one interviews. The category configuration utilised within the phase two interview schedule became the foundation for analysis, which enabled data to be directly coded into the focused codes to develop greater analytical understanding about the conceptual categories.

Before beginning to code each of the transcripts, I read them and listened to the audio recordings of the interviews in order to familiarise myself with the data. As with the phase one data analysis process, the phase two data was coded in NVivo in batches, utilising gerunds. The first five interviews were coded in NVivo, before going on to complete the rest of the phase two interviews. This was done so that emergent concepts could be developed in subsequent interviews, and to allow a more responsive process to following any interesting leads that surfaced within the data. To remain focused on the research objective of discovering how the participants experience and negotiate values in practice, repeated checks of the emerging phase two theoretical categories against the conceptual categories developed in the phase one findings chapter were conducted. This process involved continual reflection on how to capture values in practice, and the need to maintain focus on expanding the rich critical incident data. Once again, time was taken away from NVivo to conduct diagramming, memo writing and use of supervision also assisted with developing the phase two analysis further.

I established codes for the phase two interviews by continuously developing the document 'Framework for Second Phase of PhD Interviews', tabling the interview process as

I went. I continuously made analytical notes on the document – these notes then informed subsequent interviews. As a result of these notes, as the interviews advanced, the style of interviewing changed. As the phase two interviews progressed, the data analysis became more focused on the increasingly distinct conceptual categories. The interview structure was adapted accordingly to reflect the emergent leads in the data (Charmaz, 1996). The interviews became less focused on the cue carded quotes, with a stronger focus on specific points of interest, such as: managing power; the alliance between courage and transparency; and the place of hope alongside motivations.

The last nine interviews were predominantly focused on developing the emerging concepts and points of interest, which were drawn directly from the initial coding of the first five phase two interviews. Theoretical development of the conceptual categories was enabled through further reviewing, refining and synthesising of the data until saturation of the identified theoretical categories was reached. When coding the last few phase two interviews into NVivo, no new codes were developed, outside of *In viv*o codes, and I was therefore satisfied that theoretical saturation had been achieved.

3.7. Issues with Subjectivity, an Emergent Design, and Data Integrity

This research focuses on the participants' subjective realities to consider the participants' constructions of the DHB practice context and how they personally encountered and negotiated values in practice. As such, the participant's words and understandings are accepted and recognised, without concern for issues relating to attribution bias or them wanting to portray themselves as virtuous social workers. The participants appeared to accept that, due to the level of risk involved that things can go wrong, and in the critical incident narratives they often disclosed mistakes made in practice

and reflected on the learnings gained from these incidents. The cue card statements utilised in the phase two interviews appeared to normalise the difficulties that health social workers collectively face and allowed space for increased openness about the challenges in practice. The cue card statements illustrated the difficulties illuminated in their combined critical incidents, and this meant that the participants did not appear to sugar coat the difficult realities of practice in relationship to how they experienced and negotiated values in practice. Regardless of this, as a researcher employing a social constructivist lens, the emphasis was always on the participants' truths and constructions of how values were experienced and negotiated in practice.

The process of interviewing, especially when aligned with the critical incident narrative resulted in a holistic mapping of situations, which allowed space for the participants to "move from micro to organizational levels of analysis and to render invisible structural relationships and processes visible" (Charmaz, 2014, p. 220). Participants commented that the interview process was therapeutic and enlightening for them. For example, one participant wrote to me after the first interview stating that "I really enjoyed our interview. Interestingly, afterwards I felt like I had actually had the most useful 'supervision' in a long long time!" These types of comments prompted me to continue to memo, reflect, and have supervision discussions on how my knowledge of health social work was influencing the research process.

The development of the grounded theory emerged in response to the analysis drawn out of the phase one data. The intention behind interviewing within the grounded theory method is to explore the participants' reflections, views, experiences and actions (Charmaz, 2006). In accordance with this, the phase two interviews were semi-structured, with several

set open-ended questions so that conceptual categories and emerging theories were responsively explored (Bryman, 2012). A flexible approach was purposefully utilised to follow leads in the developing conceptual codes through the different phases of data collection and analysis. Qualitative research and grounded theory allow for an emergent design which is responsive to adjustments to the inquiry plans during the process of data collection and analysis. This flexibility aids the process of developing a holistic account of a multifaceted phenomenon or processes, by enabling the researcher to follow leads as they emerge (Birks & Mills, 2015; Charmaz, 2006; Creswell, 2007; Schwandt, 1997).

Charmaz (2014) emphasised the need for flexibility in how constructivist grounded theory is undertaken, rejecting rigid rules and requirements. Charmaz (2014) asserted that:

> Grounded theorists evaluate the fit between their initial research interests and their emerging data. We do not force preconceived ideas and theories on our data. Rather, we follow leads that we define in the data, or design another way of collecting data to pursue our interests. (p. 32)

This assertion has relevance to the research project on two separate levels. Firstly, as a protection against developing preconceived codes given my professional experience in health social work; and secondly the original plan for the research process second phase of interviews changed once the phase one findings had been written up. At the outset of the research it was planned that the phase two interviews would involve an individualised card-sort exercise that contained cue cards to illustrate each individual participant's phrases from their phase one interview. It was initially envisaged that in the phase two interviews the participants would be encouraged to arrange their individualised phrases and quotes in order of significance to themselves, their profession and their agency context.

The focus changed, in line with the developing analysis of the phase one interview data. Instead of utilising only the phrases from the individual participants, a range of quotes

from all of the participants was depicted on the cue cards in the second individual interviews. To do this, all of the participants were sent an individual email highlighting the selected quotes that pertained directly to the developing core categories, and written consent was obtained to share the selected quotes via cue cards in the phase two interviews. These quotes were then used to illustrate the salient themes categorised from the first interview phase and were shared with the participants in the phase two interviews to further define the categories and allow for increased clarity about the emerging properties of the categories to be acquired.

Procedural logic is important when utilising the grounded theory method (Birks & Mills, 2015), and flexibility is needed to consciously move with the dictates and needs of the data in calculated ways. The change in the way that the cue card information was presented was made as it was clearly apparent that the emerging themes were relatively congruent across data. Charmaz and Belgrave (2012) asserted that, within grounded theory interviews are a valuable data-collection tool, as they communicate a collective story. The sense of a collective story is devised as grounded theorists present the conceptual analysis derived from the interviews, rather than a group of individual interviews detailed in their totality. Given the specialised area of practice in which the participants practised social work, it was perceived that the participants would be able to quickly grasp the developing conceptual analysis derived from their collective interviews. This perception was correct, as the participants indicated in the phase two interviews that they could relate to the cue card information, and the phase one critical incident analysis of how values are experienced.

Research validity is proven through demonstrating how claims to knowledge are established. Within qualitative research, validity standards are challenging to prove due to the need to demonstrate the rigor underpinning the research combined with the creative

subjective process that underpins it (Whittemore et al., 2001). In order for this research to contain a credible account of how values are experienced and negotiated in practice it was important to portray the participants' experiences and reflections accurately (Krefting, 1991). Member checking involves testing analytic categories and conclusions drawn with the participants (Lincoln & Guba, 1985). As a protection against uncritically accepting or misconstruing the participants' statements (Charmaz, 2006), member checking took place after both research phases; and the analysed data were debated with PhD supervisors and with the Kaitiaki. Corbin and Strauss (1990) asserted that presenting your analysis to others is a protection against bias and leads to further development of theoretical sensitivity through increased insights about emerging categories.

Member checking took place through the participants' review of their interview transcripts; these checks were completed after each of the interview phases. Member checking about the phase one analysis was also done in the phase two interview through discussion about the summarised phase one analysis. Additionally, member check also took place in the phase two interviews through in-depth discussions about the conceptual categories illustrated on the cue cards. Care was taken in the interview to explain the analysed categories in detail, and checks were made to see if the categories resonated with the participants. This checking was completed to see if anything within the quotes or categories did not reflect the participants' own experiences, or what they perceive to be the representative experiences of other participants. A memo written at the time of the initial phase two interviews reported that during the first four interviews approximately 30% of the interview time was spent member checking with the participants. Through receiving consistent feedback from the participants that the categorised data were accurate and

reflected aspects of their practice experience, confidence was gained to move forward with the focused codes and analytical categories. I noted at the time that the process of member checking served the purpose of pulling the participants deeper into the interview, obtaining intensive reflection on how they experience values in practice.

The 'Summary of the Phase One Interview Findings' document updated the participants on the emerging analysis underpinning the research project, while also allowing them time to reflect on the analytical categories and consider them prior to their second interview. Generating grounded theory is a collaborative exercise between the researcher and the participants. Charmaz and Belgrave (2012) explained that, during the data-collection stage the participants' views and understandings take precedence; however, during the data analysis and in the write-up of the findings, the researcher's analysis about the theoretical categories takes priority. Through familiarising myself with the phase one interview transcript prior to each of the phase two interviews, I was able to directly connect and highlight the material from the participants' phase one interview transcript that illustrated the analysis of their experiences within the various conceptual categories. Sometimes *in vivo* quotes from the participants' phase one interview were used to demonstrate the analysis of the data within a given category. This measure also provided a way of member checking the validity of analysis, through testing the interpretations made and the analytical categories deduced from the initial interview, against the participants' thinking in the second phase of interviews (Lincoln & Guba, 1985). As a validity procedure, member checking enabled the process of taking the developed analytical categories back to the participants in the second research phase to confirm the credibility of the analysed material. This measure allowed the participants to react and comment on the developing

analysis, and these responses were subsequently incorporated into the theory building process (Creswell & Miller, 2000).

The critical incident technique allowed for a study of processes, examining the participants' thoughts, experiences, actions, and decisions made in relationship to their specific incidents. Charmaz (2004) asserted that, within constructivist grounded theory, researchers need to develop understanding about what situations and processes mean to the participants in order to fully comprehend the participants' actions and intentions. From the outset of this research, care was taken to not hypothesise about the outcome of the research, or to make assumptions about the participants' actions, attending instead to the participants' constructions of their experiences. Supervision and a reflective process was utilised to avoid the adoption of pre-conceived notions, drawn from personal life experiences about values within health social work practice. During the data collection and coding sequences, the focus was on how the participants described, defined, and evaluated their behaviour and identity in terms of both personal and contextual values.

Time was spent throughout this research project reading grounded theory texts and reading about other constructivist grounded theory-based research projects in order to feel confident about the procedures used to implement grounded theory. Using NVivo software assisted with maintaining an audit trail of work done, while memo writing assisted with tracking the procedural logic behind decisions made. This was backed up by a pattern of lengthy detailed emails to my PhD supervisors, which updated them on progress made prior to PhD supervision. These emails were valuable as they enabled a focus on processes prior to supervision, they also tracked procedural and analytical decision-making processes.

3.8. Ethical Considerations and Reflexive Processes

This chapter on researching professional values concludes with detail about the procedures followed and the decisions made relating to ethical issues pertaining to this research. The ethical considerations to be covered include information regarding contacting potential participants, informed consent considerations, measures taken to protect the anonymity of participants, as well as my reflexive considerations about my role as a researcher. This research was given ethical approval by the University of Auckland Human Participants Ethics Committee on 30 September 2014. The phase one interviews took place between November 2014 and December 2015. The phase two interviews took place between July 2016 through to November 2016.

Regarding ethical considerations in recruitment of participants, I took care to safeguard against coercion through using the then Deputy Registrar at SWRB to act as an independent third party. Potential participants were contacted by the Deputy Registrar by email containing an advertisement about the research project. Social workers who contacted me with an expression of interest in participating in the research received a participant information sheet via email, which explained the research project in more detail. All the participants received the relevant Participant Information Sheet, and Consent Forms before each of their interviews. The participants also signed the Consent Forms before each interview commenced. The participants were aware of their right to withdraw from the research and were advised to use supervision as a place in which to reflect further on the practice issues relating to this research if needed.

Prior to the phase one interviews the participants also received the semi-structured interview schedule. Doing this gave the participants time to reflect on a critical incident prior to the interview, and to further consider the interview process before signing the

consent. In the phase two interviews, the interview schedule was not sent out in advance, as the interview questions linked directly to a series of quotes obtained from the phase one interviews. These quotes would not have made sense to the participants without detailed context being provided so, instead, a summary of findings was sent out to prepare them for the phase two interview.

The participants' critical incidents focused on issues of cultural difference, particularly regarding working with Māori. As a Pākehā researcher I was mindful of the Indigenous communities feeling like they are the "most researched peoples of the world" (Smith, 2005, p. 87). The ANZASW (2013) Code of Ethics states that all social work practice including social work research is to be grounded and informed by the articles of Te Tiriti o Waitangi. As a Registered Social Worker I worked to adhere to all aspects of the ANZASW (2013, 2019) Code of Ethics, the ANZASW (2014) Practice Standards, and the SWRB (2016) Code of Conduct in this regard. The specific cultural advice pertaining that I received from the Kaitiaki of this research project, Emma Webber-Dreadon and Hori Ahomiro assisted with working towards culturally appropriate understandings and depictions of matters relating to Te Ao Māori.

A significant ethical consideration is protecting participants' identities. As previously acknowledged, there are relatively few health social workers who work with newborn infants, and I took the following precautions to protect the participants' privacy. Care was taken to ensure that no identifying details were used that could link participants' experiences to the organisation or geographical location in which they are working. The participants all chose pseudonyms that were used to maintain confidentiality. Care was taken when using quotes to minimise the risk of identifying a participant or a specific DHB. At times, pseudonyms were not overtly attached to some specific quotes, this was done if

there was a risk of the quote making the participant or a DHB too identifiable. The participants' years of experience were placed into bands of experience, rather than specific years. The participants and their work context were listed as either ward based, community based, or outpatients. Another strategy used to reduce the risk of participants being identified was that participants were able to alter information in the transcripts in the fortnight after receiving their interview transcript.

Reflexivity involves a process of personal interrogation in which considerations are made about the way that the research is "shaped and staged around the binaries, contradictions, and paradoxes that form our own lives" (Lincoln et al., 2011, p. 124). Reflexivity also involves a process of consideration of how the identity of the researcher is perceived by the participants. In view of these considerations, I consciously decided to inform the participants of my previous experiences as a maternity and paediatric social worker prior to the start of the first interview. The effect of this appeared to be that the participants felt that they did not need to explain taken-for-granted knowledge or jargon that is particular to the role. This knowledge appeared to increase their confidence in trusting me with their practice experiences. This assurance is illustrated in feedback from a participant where she stated that the phase one interview process "has been very therapeutic voicing the above… to someone who 'understands'" (Mary).

It is not easy to take a neutral research position, regardless of whether you occupy an 'insider' or 'outsider' position, and acknowledging the inherent tensions that your 'self' brings to the researcher role is important (Dwyer & Buckle, 2009). It was important to me that I did not objectify or misrepresent the participants' individualised experiences and realities, and in doing so reinforce dominant neoliberal ideology (Gibson, 2007). As I was conscious of feeling a close professional connection to the participants, critical reflection

was conducted in supervision about my insider status, as a protection against assumptions and bias (Kanuha, 2000). At times, reflection on experiences of unease during interviews flagged the need to examine the data more closely in relation to emotional reactions. I also used journaling as one of the ways to assist with critical reflection on my own research processes, to help me address ethical concerns as they arose.

Dwyer and Buckle (2009) reject the binary concept of insider–outsider positioning in qualitative research, acknowledging the relationships developed through conducting research and asserting that qualitative researchers occupy a space in between. I was mindful of the trust that the participants were placing in me through describing a concrete example of their practice, and I took care to respond to the needs of the participant as their story of practice unfolded. I spent time considering and reading about the impact on the interviewee of sharing a critical incident from practice, and I undertook ongoing reflection about the benefits and risks to the participants involved throughout the research process.

CHAPTER FOUR: PHASE ONE FINDINGS

4.1. Overview

This chapter presents findings from the first phase of interviewing and concludes with a preliminary discussion that serves to further locate health social work practice within Aotearoa New Zealand. To avoid the risk of extant literature influencing emergent categories, the discussion contained within this chapter was completed after the analysis of the phase two findings. The discussion begins with material about how the ecological perspective is used to develop the discussion and then includes literature pertaining to health social work practice in Aotearoa New Zealand. Having a preliminary discussion prior to the second findings chapter is designed to advance the analysis in the phase two findings by situating the phase one findings within the context of health social work practice.

As explained in the introductory chapter, the research question specifically supporting phase one of the research process is: *How do Aotearoa New Zealand health social workers **negotiate** professional and contextual value demands when working with newborn infants and their whānau?* The emphasis in this question is on the word 'negotiate'. The movement from the phase one findings to the principal analytic categories is illustrated in Figure 5 (Development of the principal analytic categories) as a way of visually demonstrating the category development. The diagram is included here to make it easier to conceptualise how the three broad category headings from the phase one interviews developed over the different stages of the research.

The illustration visually presents the way in which the three broad headings drawn from the phase one findings were initially progressed further into three broad conceptual categories, and then into two principal analytic categories. The prevailing categories that are

addressed within this chapter are clustered under three broad category headings from the phase one findings: *Practice vision, Work expectations* and *Practice experiences*. These headings were developed through the analysis of the critical incident narratives, and the development of these headings is the primary focus of this chapter.

The three broad conceptual categories that emerged from the analysis of the phase two data are illustrated in the second box within the figure below. The three broad conceptual categories are *Experiencing the impact of time, Managing emotional reactions* and *Challenging labelling, assumptions, bias and racism*. Through the linking of the broad conceptual categories to literature they were then refined into their end state: the two principal analytic categories. The two principal analytic categories, *Contextual complexity* and *Controlling the middle ground* are illustrated in the final box in the figure below and they represent the grounded theory developed through this research project. This phase one findings chapter marks the beginning of the development of the principal analytical categories.

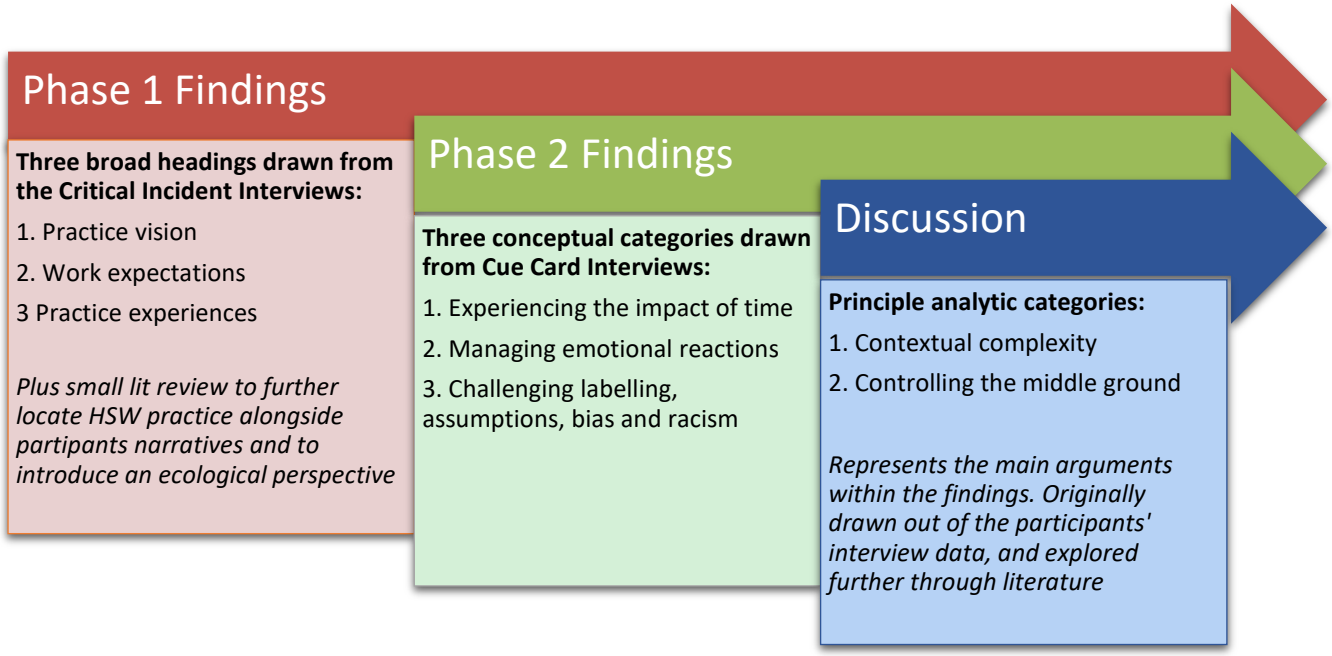


Figure 5. Development of the principal analytic categories.

Figure 5 demonstrates how the iterative processes contained within the grounded theory design allowed for the language used to explain what was happening within the data to be continually refined and developed as the study progressed. In the phase one interviews, the critical incident narratives marked the beginning of the process of locating and defining values in practice. Although each of the critical incidents was about different events and aspects of practice, there were many similarities contained within their experiences. These commonalities are presented together under three broad category headings to demonstrate both the realities of health social work practice, and how values were experienced. The first category heading, *Practice vision* identifies the reasons why the participants chose social work as a career, examining statements that indicate their practice ideals or values in relationship to the critical incident to discern the motivating forces behind their practice. The second category heading, *Work expectations,* examines organisational requirements, issues around team composition, legal processes and decision-making practices. This category is designed to signal the working environment and conditions under which social workers encounter patients in their practice. The third category, *Practice experiences,* explores issues around patient engagement and team dynamics. This category illustrates the participants' narratives about practice realities, achievements made, and the tensions involved in health social work. The broad category headings were developed from examining the critical incident, and they formed a strong foundation for the development of theory about how values are experienced and negotiated in the second phase of data collection.

4.2. Practice Vision

In order to discern why the critical incident was meaningful to the participants, they were asked why they had chosen their specific incident. The participants had a variety of reasons for their choice, but most stated that it was because the incident was salient, and highlighted issues that they deliberated over. I noted in a memo written early in the coding process that the length of hospital stay was a factor in the participants' choice. Critical incidents tended to centre on situations in which the participants had worked with the patient over a prolonged length of time. A longer period of client engagement enabled participants to have a better understanding of patient's circumstances and work more holistically, and this appeared to make the critical incident more memorable.

> It was meaningful to me because there's not a lot of opportunity that you get to work closely with families… and the families that I recall are the ones that I had the opportunities to actually build a rapport with and do some real social work rather than just the risk assessment and just the discharge plan. I got to actually use some of my skills around the therapeutic rapport building. (Joan)

Not only had Joan gained rapport with the women at the centre of the critical incident, she stated that she felt committed to her as she was young, and many people in her life, including professionals had disregarded her. This feeling of commitment on Joan's part could be perceived as a feeling of being morally obligated to the woman. Joan stated that she felt that the length of time spent together with this woman gave her a sense of investment and job satisfaction.

Sarah's critical incident involved work that she did to empower a new mother to protect herself and the baby from a violent partner. The mother was on the ward for a long time and this allowed a trusting relationship to develop. Sarah knew that the father of the

baby had an arrest warrant out due to alleged violence against another woman. Meanwhile the woman on the ward was denying the apparent violence inflicted on her by him, despite evident bruising. The central component of this critical incident for the participant was her decision-making about the rights and wrongs of disclosing the information about the warrant to the mother. As the baby was receiving lengthy hospital treatment, Sarah was not forced to make a conclusive decision as time was available to support the mother to empower her to take action to keep herself and the baby safe. In situations like this, given the potential vulnerability of the newborn infant, it would normally be Oranga Tamariki who would have made the final call on what the mother needed to know in order to keep the infant safe.

Other participants stated that they chose their incident due to the emotional impact that it had on them. For instance, HG describes being 'haunted' by the circumstances contained within her critical incident, while Kate described being 'triggered' by the circumstances of the newborn. Sandra and Jo both described a critical incident that demonstrated a 'failing in practice'. Jo described two separate critical incidents involving situations in which she disagreed with Oranga Tamariki social workers' risk assessments. Jo stated that she was 'triggered' by failed processes that resulted in poor outcomes for the mother and child. Sandra used the word 'tormented' when describing the impact on her of her critical incident. The critical incident happened when she was new to the ward, and she stated that she followed poor advice from a discharge facilitator. Sandra regrets not having the confidence to follow what she considers to be 'best practice'. Sandra stated that, because of the outcome of the events contained within her critical incident, she has learnt clear lessons about collaborative working, remaining within your role and working transparently with whānau. In another case, Mabel chose her critical incident because she

felt that it was one of her success cases in which she tried hard over several weeks to ensure that a mother with an intellectual disability was supported enough to care for her baby. Mabel stated that, while the situation and whānau dynamic were complex and challenging she felt humbled that the whānau had allowed her to guide them, and that the work that she did with them gained their respect.

Nine of the participants' critical incidents involved Māori patients, and cultural difference was a salient theme within the descriptions of practice. The prominence of difficulties noted due to cultural difference within the critical incident narratives serves to highlight the importance of continued professional development on cultural competence. Sally's critical incident centred on a practice experience with another social worker in which she was left to reflect on her understandings of cultural competence, and the needs of Māori service users. Tania is a New Zealand born woman from an immigrant family whose critical incident depicted a practice situation which also presented a cultural challenge. Tania found herself managing a risk situation in which balance was needed between the need for treatment and the right to practise Indigenous medicine. The patient shared the same cultural background as her and, for Tania, this was a point of great reflection as it was the first time that she had encountered a woman of her culture openly and independently challenging medical decisions.

The participants were all unsettled by the events they disclosed in their chosen critical incident. The incidents were varied, but when analysing them the patterns in the codes emerged clearly, and after coding the first 10 interviews, no other robust themes were apparent. The most salient themes within the data were a sense of social work as a vocation and the participants feeling caught in the middle between conflicting requirements and motivations. It was also evident that the rights of the newborn babies were the

paramount consideration. The participants expressed concern about judgements and assumptions made, especially in reference to patients who were of Māori and Polynesian ancestry. The participants spoke about practice difficulties that occurred due to the lack of appropriate cultural support, issues around proceduralised practice imperatives, and their role as educators de-briefing and supporting colleagues through traumatic situations. Out of these themes, many sub-themes emerged which will be explained in this chapter.

4.2.1 Choosing to become a social worker

Participants expressed a multitude of reasons for choosing a career in social work; some simply stated that they wanted to help. Two participants said that they choose social work because they perceived it to be more practical than counselling, addressing the 'bigger picture'. Participants reflected on personal experiences with social workers during traumatic life experiences, and how these encounters provided the motivation to become a social worker. One of the participants had spent time in residential care and her experiences provided the impetus to be an effective social worker.

> I spent some time in care as a kid myself, and I think what I wanted to do was be a residential social worker in children's homes. I used to say to the staff "I'm going to do this so much better than you one day."

When questioned why they choose social work or were still practising social work, some of the participants expressed cynicism about the lack of financial reward and the challenging nature of the work. Kim conveyed strong feelings of disillusionment. Kim felt that she was imposing help on young women who did not want her help and were likely to have their babies placed in the care of Oranga Tamariki. To indicate her disillusionment, here is a brief account of how Kim described her work with young mothers: "it's just dysfunction breeding dysfunction. It was disappointing really. I mean, the odd girl we would

help. There are some successes but there is more not" (Kim). Another participant stated that, compared to the work that she had done in child protection and with sex offenders, working in health with newborn infants is the first role that she has felt appreciated. She went on to say that she now has more successes than failures in her work and feels like the therapeutic work that she does enables her to make a difference in people's lives.

Alice expressed ambivalence about her social work career, stating that she drifted into the role, and that she does not have that strong sense of vocation that other social workers report.

> It does feel like "I'm here, and I've been doing it for a long time". I don't like having to go back and count the years…it's like "oh gosh"… but I'm still here and I think that's significant.

Alice's commentary was distinct from the other participants who indicated that social work was a calling. Some of the participants expressed frustration about their career choice, but they still strongly identified as social workers and were driven to assist others.

> My friend said, "you'd be a great social worker", and that planted the seed, but looking back on my early life it makes sense that I would be a social worker. My parents brought us up with a sense of empathy. (Sarah)

4.2.2 Statements about social work ideals

Ideals are principles or goals that we aspire to and asking questions about them in this first interview helped to gain an appreciation of the participants' understandings of best practice. When the participants spoke about the ideals that they had about social work practice in these initial interviews, they tended to speak about missed opportunities, which then led onto wider issues such as a lack of resources or poor communication. Their

discussion about their ideals was predominantly framed in a negative manner when reflecting on the critical incident, even though there was evidence of pride in the profession and the work that they do. They tended to utilise the value of hindsight when reflecting on the social work practice contained within their critical incident to consider what they believed should have happened, rather than dwelling on how their successes in practice related to their ideals about good social work practice.

Success appeared to be often achieved through honesty, respect and transparency and it is evident that the participants built trust through being empathetic, listening, and building rapport. When the participants spoke about their values or ideals in practice, they would also relate it to the need to practise transparently, to be an advocate, to be open and non-judgemental:

> I think we are pretty good actually, how we work with families. I work pretty openly with families about what I'm doing, and why. I think that creates success in terms of relationships with them. Often you don't have that luxury though of time. (Sarah)

A salient theme relating to ideals about social work practice was commentary about the need for more time to do therapeutic work. For instance, HG stated that she did not have the confidence to undertake the therapeutic work needed due to uncertainty about her ability to see the piece of work through to the end. Participants reflected about the nature of practice being crisis oriented and that they often had to react quickly. Practising in a reactive way to a continual series of crisis situations does not necessarily allow for reflective practice. The reflection comes afterwards, not in the moment when you are urgently finding solutions collaboratively with the patient, the whānau and the staff involved. The nature of health social work is that rapid responses to complex and value-laden situations are often required. The participants linked the reactive nature of practice to

the problem that resources were not there for them to provide the supports that they felt were required. The comments below illustrate both the frustration and perhaps, to some extent, the resignation around continually working in an environment in which meaningful resources to make sustainable change are not available.

> Oranga Tamariki are slow to offer meaningful resources, so that in the end they are forced to take kids anyway. (HG)

> In an ideal world there would have been a kind of safer environment for mum and dad to go together with baby, where they could be visited and supported, and it would be nearby, but that just didn't exist. (Joan)

Communication issues between professionals and agencies were seen to be a barrier to ideal practice, as demonstrated in the participants' statements about the need to meet with other professionals and agencies earlier in the social work process.

> That way you'd get a shared understanding of what was going on and what the concerns were. It would mean that the kind of interventions and the responses afterwards wouldn't be so reactive and so chaotic. (Joan)

> If we were, actually starting the journey and all communicating from back in the pregnancy things could be clearer and it wouldn't be so much kind of ambulance at the bottom of the cliff. (Jo)

> I would have met with the professionals earlier; I would have got everybody in the room earlier and really been clear about everybody having a role. (HG)

Participants perceived issues with communication as being due to not meeting with other professionals early enough, a lack of clarity about role and who accepts responsibility, as well as a general inability of professionals to be flexible in their role. These types of issues were explained in a manner that imparted a sense of powerlessness in the way that the

participants expressed them and were reflected on in terms of a failed process rather than a personal failing by any one individual.

Culture was discussed in terms of rights, discrimination and ideal social work practice. Sally felt that, for Māori, ideal practice was 'Māori by Māori', to honour Te Tiriti o Waitangi and work to ensure the best outcome for Māori patients in a Westernised medical environment. Ideal social work practice was also reflected on in terms of rights and social justice. Participants noted that outcomes for patients generally were unsatisfactory due to not having the right funded support. They expressed frustrations about needing the freedom to practise in a manner that allows people to participate, access resources and enable the resolution of identified issues.

4.2.3 Social workers defining values

The critical incident technique allowed a close consideration of the value statements apparent in the participants' narratives. This section collates some of those statements that were made in relation to defining social work values.

> Social justice and empowerment are <u>still</u> the foundations of social work practice and for me it is about things being fair. (Mabel)

Social justice and empowerment are central constructs that underpin social work practice, and it is interesting to see that Mabel has premised her statement with a 'still' in terms of them being the foundations of social work practice. This could indicate that circumstances/values have changed, or it could indicate that these values are enduring. Mabel then goes on to discuss social work as a helping profession, that social workers endeavour to make change in order for people to 'grow and develop', while still making their own choices. This speaks to collaborative, person-centred practice and Mabel names

her practice values as also being transparency, having clear boundaries and treating people with humility and respect:

> I have this thing, 'only but for the grace of god go I'. It could have been me in her shoes, or a family member in her shoes, and, to think that I am any better or whatever than people would be arrogant and obnoxious. (Mabel)

Mabel talked about the way she strives to make positive change and highlights the right of individuals to make choices so that people can grow and develop.

Sally's reflections on her values also linked in with Mabel's comments about valuing 'non-judgementalism' and spoke about empathy development through 'listening' to understand people's experiences. Sally is of European heritage and was born in Aotearoa New Zealand. She reflected on how her values have been shaped by her childhood experiences of being the minority both within Māori communities and overseas. Sally emphasised the value that she places on bicultural practice, "the idea of each person in each culture's inherent worth" and respecting the principles of Te Tiriti o Waitangi.

Tania reflected on her own personal values and how she explored them during the course of her social work training stating that:

> My [main] values are love, undivided loyalty, having a servant heart, being respectful, having a passion about what I do, being an inspiration and working with integrity.

Tania's statement about her values is closely intertwined with her aspirations. Myrtle stated that, as she has gotten older, she has become less individualistic, and has realised that the value of social work is in how social workers use connections to *"involve people in the discussion and bring resources together".* In the participants' narratives about their values, it was evident that they strive to recognise the humanity of individuals in their day-to-day practice in a manner that recognises the individual dignity and worth of people. It is also

interesting to note that none of the participants made any distinction between their personal and professional values.

4.3. Work Expectations

This second conceptual category, *Work expectations,* analytically examines the participants' experiences and statements about the requirements of their organisation, issues regarding team composition, legal processes and decision-making practices. Reflections on team dynamics are important when considering value demands as team interactions can elucidate systems issues that sit behind problems occurring in practice. For instance, Mabel spoke at length about repetitive conversations in her first interview, feeling responsible and always having to repeat the same thing "over and over again" to the different shift workers on the ward. Some of the participants' issues with colleagues often were linked to an absence of a cohesive team or regular team meetings, resulting in problems with communication and, at times, trust. Team dynamics and workplace expectations impacted directly upon the participants' decision-making processes and ability to do what they value to be right.

4.3.1 Social workers defining their team

> My official team are health social workers, out here my team are the midwives, and they are supersonic. They have embraced having me here. (Jo)

The participants had various responses to who they identified as their team with issues arising due to belonging to two separate teams. The participants often belonged to a generic health social work team and the MDT from which the service was located, whether it was in the community or on the ward. When questioned about who they thought of when I referred to 'their team', eight of the participants stated that they considered the social

workers to be their team. Three participants stated that both the social work team and the ward staff/midwives/MDT were their team, with four participants stating that the MDT or ward staff were their primary team.

> I had our team [of social workers] that I was attached to, but my team really had their own teams in their wards. (HG)

Some social workers felt that the fellow social workers were 'their team' over the MDT staff on the ward.

> [M]y team is the […] social workers, but that said, I am in some ways isolated from them because I have an office in NICU. I work a lot with the NICU team but I wouldn't quite say that I'm part of the NICU team. (Sally)

Myrtle stated that her social work team were person-centred and focused on social justice, and this focus was not so apparent on the ward in her work with other disciplines. Other participants saw the ward MDT staff as being their team and talked about the loyalty they had to their unit.

> [T]he neo-natal unit team members are my team because they're the people I have the day-to-day contact with, and the people who I trust their judgements. I think they trust my judgements too. I think social work is really valued up here. (Sarah)

Alice also felt this way and perceived the different disciplines within her team to all be on the same level as colleagues. Alice stated that the structure of social work practice, supervision and support given from other social workers was significant to her and provided her with a sounding board in complex situations. Fellow social workers were seen by participants to be a key source of support, regardless of the strength of the MDT team that the social worker was based with.

> The social workers were my team, they were my allies, they were the ones who would support me. You had more trust that they wouldn't throw you under the bus. (Joan)

Identifying who the participants referred to when they thought of their team was important as it indicated their perceptions of where they belonged. The participants appeared to be located in a middle ground, providing a social perspective, an advocacy role or even acting as the conscience of the ward or the team that they worked in. This means that they were often challenging systems and at odds with their environment. Gaining a sense of belonging in terms of who the participants identified with was important, as it informed my analysis of who they went to for support when they were feeling challenged by an ethical dilemma or value demand.

4.3.2 Team dynamics and composition

Many of the participants were the sole social worker within the ward or MDT. Some of the participants reflected on the lack of a strong social work presence upon their wards, with frustration expressed about inadequate cover when they took leave. This lack of cover for leave taken impacted upon the ability to provide a consistent social work service or placed other social workers under stress due to having to cover multiple workloads. Not having consistent social work cover on the wards that Alice and Halyn worked on was considered by them to be problematic as staff got used to not having a social worker, and this influenced perceptions regarding the relevance of the service.

Mary stated that many health social workers are managed by nurse rather than a social work department and found this to be problematic. She reflected on the need for managers to develop an understanding of social work processes and expressed the following concerns about being a sole social worker in an MDT:

> I think this has isolated many social workers, a 'divide and conquer' mentality from managers. Managers don't really know what Social Work is about and we get treated as pseudo nurses in regard to the rules and regulations. (Mary)

Mary and Sandra both worked on wards in which they saw every patient that came onto the ward, in order to normalise social work service provision. This level of service provision on their wards appeared to be valued by ward staff, with Sandra stating that the nurses on her ward refer to social workers as "guardian angels". Sandra believed that the ward staff wonder at the complexity of the social work teams work and "think that we do an amazing really difficult job, they don't know how we sleep at night".

Alice felt that becoming a valued staff member came with time and experience, and that social workers have to become 'known' to be trusted. Myrtle reflected on her experiences as a new social worker not having regular ward meetings stating that it "made it hard to get to know people and know where the heart of the place is". Both Myrtle and Mabel acknowledged that, as time moved on, they were able to build relationships and feel more comfortable expressing their opinions and providing a social work voice.

Location of office was another issue; some social workers had their offices off-site, this meant that they had considerable distance to walk to spend time with their social work colleagues. Others whose office was on the ward also felt isolated from their social work team. A few participants stated that they enjoyed being away from the main social work office due to tensions that existed within the social work team. Being physically located on the ward through having an office there meant that the participants were used by staff for support and debriefing. Sandra emphasised that the work that they do is not just with patients, and this was a common experience.

> Sometimes a nurse will come into the office and off-load their concerns, which is great. Another time a nurse might come in and burst into tears and so we are offering them support as well. (Sandra)

Sally expressed concern about diversity within her social work team, stating that there is a need to employ more Māori social workers, and that the team culture needs to change to make the team environment more culturally appropriate for other cultures. Other participants also expressed concern about the demographic of health social workers also being older, middle-class Pākehā women.

4.3.3 Challenging team dynamics

If you are not rattling the cages, you're not doing your job. (Mary)

Challenges within teams were infrequently due to differences of opinions about practice between social workers. When participants spoke about challenges with engaging with other professions, they often spoke about professionals oversimplifying complex situations. Participants spoke about challenging discussions that they had with staff to get them to be person-centred in attending to the mothers' needs as well as the babies. The participants perceived the wellbeing of both mother and child to be closely connected. Kate stated that one of the biggest challenges as a health social worker was managing other professionals' perceptions of risk and client behaviour:

> Let me think of an example – say someone is not attending appointments, that could be to do with poverty issues, but to other professionals that could be that they are not engaging, so we [social workers] are able to step back and look at the bigger picture, whereas that can kind of be deemed as being non-compliant. (Kate)

Participants referred overtly to stressful issues with bullying by dominant staff members when working on the wards. One participant spoke of her disgust at the bullying that existed between social workers. She commented on the culture of dysfunction that she observed within the department management system and questioned the safety of new staff members coming into the team. Complaints processes were seen to be ineffectual by

another participant who made a formal complaint. She perceived the bullying that she encountered to be a systemic problem, as it affected workers from a variety of different disciplines and was common throughout the hospital. Another participant stated:

> My experience initially in NICU and in the hospital altogether was quite punitive – quite a difficult place to be, and I felt that things could flip on you really quickly. So, my plan… was going **'**be careful, be quiet, do your job', slowly walk away from things without drawing attention to yourself because if you draw attention to yourself you are an easy target. (Sally)

Sally felt that these feelings of being an easy target initially stopped her from taking on leadership roles. These feelings are concerning as they may have impacted on her ability to be a strong advocate for the patients that she worked with or stopped her from taking action that she felt to be right. When Myrtle spoke about her experiences of being bullied, she said that, in one instance, she felt so nervous that she could not tell the charge nurse the truth about a decision made regarding a report of concern to Oranga Tamariki. Myrtle stated that instead she "fudged" the truth in order to avoid conflict. She said that the charge nurse would "read something and sort of jump right in my face and start talking to me about whether or not I've done things and telling me that I need to do things"'. The challenges for Myrtle sat predominantly around differing perceptions of risk, with staff being more risk averse than her. Mrytle felt that the charge nurse did not value her professional assessment of risk and that, because of this, at times she was unable to be honest about her practice decisions. Mary had similar experiences, with ward staff trying to dominate her and make her complete a report of concern to Oranga Tamariki against her professional judgement. Mary said that she saw flaws in their risk assessment rationale, saying that she resisted the pressure to make reports of concern because the ward staff:

> … cannot put things in context. They're great ones for going through historical notes… they spend hours going through the history and these women aren't allowed to change and move on because people keep raking up the past and saying 'oh, da, da, da' and you go and speak to the woman and you know she's moved on. She's dealt with the stuff, she might have a different partner, different lifestyle. (Mary)

This section highlights challenges that affect the participants due to team dynamics, illustrating instances of the impact of professionals having issues with trust or different opinions about risk or being risk averse. The participants demonstrated courage, working to adhere to what they felt was right within a given situation, even though their perception of what was needed may put them out of alignment with others around them. Risk management links into the need for professionals to be accountable in their decision-making. Part of being accountable in a neoliberal environment is following organisational rules, which promotes risk-averse proceduralised practice. Risk assessment and management in health social work can involve courage, and veracity is needed.

4.3.4 Procedural practice

Participants felt that DHBs as organisations are effective at managing and adhering to targeted outputs and standards set by government agendas. Participants expressed concern that attention was placed on these targeted outputs to the neglect of other needs. Participants discussed proceduralised practice and expressed frustration about the need to focus on targeted interventions.

> I found it really difficult because often they were targeted interventions which were meaningless for the people they were working with. They ticked boxes, they met KPI's, they said this is what we've agreed we were going to do, but….do they say what are your best hopes, what do you want from us. (HG)

> I've never been one for just going by the book. I think there's always going to be the exceptions and that's where our professional strength should be coming in to say "well, actually no". During my time here, I've made a lot of inroads and they've changed a lot of things because I've just challenged them and said "no, that's actually not right". (Mary)

Mabel asserted that she often sees procedural practice upon the ward, and stated that it:

> … causes tension and frustration for me, and there are other times when I have missed it and I have had to reflect on it, and discuss stuff in supervision going "what the shit, this happened blah blah, what do I do about it?"

A few of the participants spoke about how they responded to practice imperatives and issues around procedural practice, with the general sense being that organisational rules are followed closely. When Mabel was questioned about what she does about procedural practice when she feels the sense of unease that she described in the quote above, Mabel said that she discusses it in supervision and stated that "you just have to follow process because you know that is what the organisation says [you must do]".

HG was under pressure to discharge the client featured in her critical incident from her service. Upon reflection, HG regretted that she did not have the confidence to do what she felt was right – what stopped her was concerns about workload pressure and prescribed social work intervention times. HG then went on to express her frustration about not being able to tailor supports for the woman who featured in the critical incident by stating that:

> Because I come from the establishment, the DHB is the establishment, we have our roles, our roles mostly for this woman were never positive…Oranga Tamariki is official…all it did was remove her and really didn't give her a good start in life. Government agencies, they collect data and they watch you, and it feels like they're quite judgemental and really their services are so narrow that actually they're not

> really helpful anyway, not for a lot of the population. If you fit this narrow need here we can meet that really well, if you fall outside of that we don't even try.

Myrtle believes that nurses can be "linear in how they go about things" and celebrates social work in the fact that there is recognition that "life isn't linear and that we don't have to be quite so in control" stating that:

> …the nurses want to do what they need to do and get it done… the difference is that our [version of success] is client-centred…'what do you need', where is I think that isn't the case [for nurses].

The participant appeared to often feel overly restricted by procedures and protocols. They spoke of needing courage and confidence to step outside of regulated procedures to work beyond their set targeted outputs.

4.3.5 Paramountcy of the child and legal processes

Within the participant interviews it was initially envisaged that the participants would be questioned about value hierarchies. The nature of the interviews evolved in accordance with the developing analytical categories and the participants were not questioned directly about value hierarchies. They did, however, refer at times to the paramountcy of the newborn infant in risk situations as an overriding concern. The majority of the participants spoke overtly about how the health and wellbeing of the newborn is the paramount consideration, which is congruent with the principles of the Oranga Tamariki Act 1989.

> The baby is obviously the patient, definitely. For the nurses, that's who their main focus is. My main focus shifts, depending on the situation. So, if it's heavy care and protection concerns, my focus is that baby. It hasn't got a voice. I need to be that voice. I'll also give the mum support to enable her to do the best that she can while she's here, but that baby's my client. (Sandra)

It was apparent that the needs of the child were often felt to be congruent with the needs of the mother. The participants tried hard to bolster whānau support and advocated for funded services for the mothers to maximise support, often in the hope that the mother would be able to prove her ability to parent. Kim was the exception to this, as she struggled to maintain her hope and belief in change and questioned the need to be so supportive of mothers:

> These babies are born into dysfunction… it was all very much around the mother's got rights… but when the mothers had three kids removed and she hasn't made any changes to her drug addiction well no, that mother doesn't have rights – that baby has rights. (Kim)

Kim felt that many of the patients that she worked with lived with male violence and expressed frustration about mothers choosing to be with violent men, while the babies have no choice.

In newborn intensive care units, many value-based decisions are made about what is in the 'best interests' of a child, in terms of the limitation or withdrawal of life-sustaining medical treatment. Ethical questions were also raised by participants about the morality of using invasive medicine on very sick babies. One participant recalled an incident in which she questioned the motives of the medical professionals who followed a mother's wishes to sustain the life of what was considered to be a 'non-viable neonate' through medically invasive treatment. The social worker recalled the personal trauma and horror experienced by both her and the ward staff in witnessing the newborn undergoing this treatment. The participant recalled the anger directed towards the consultant by herself and other medical professionals in the debrief afterwards, and the lack of trust that was generated by what was considered faulty decision-making on behalf of the medical team in charge. The

participant indicated that, within this situation, she worked hard to be "the voice of the child". When this participant was asked about what support she receives surrounding the ethics of care, she indicated that she and the ward staff do not receive support and had to trust the medical professionals who are making the decisions. Within these types of situations, she believed that the consultants hold the power to make the right medical decisions, and that the team are required to support and follow their direction.

Babies who had significant health needs often had more prolonged contact with the social workers, who were then enabled to provide more support for the parents due to the increased amount of contact time. This quote from Mary illustrates the impact of a protracted hospital stay:

> This is where the ability to deal with the grief process occurs, the anxieties of parents and trying to empower the women to feel some sense of control in an institution, when in fact, often they are becoming institutionalised.

Mary went on to emphasise the importance of support to negate the risk of maternal mental health issues arising and stated that:

> This is where the strong advocacy and social justice becomes more evident in social work casework, because of the barriers these whānau face, especially if they are out of [town] and away from whānau supports.

The importance of time was also evident in the discussions relating to the paramount safety of the child. Kate reflected on having "the luxury of time" in that her service receives referrals early in the pregnancy when Oranga Tamariki is involved and this enables their service to build relationships with the women. Kate inferred that, as health social workers do not have the same investigative role as Oranga Tamariki, they are able to support mothers and whānau while working to ensure that the babies are safe from harm. Fathers did not feature much in the discussions that the participants had about supporting parents,

and women seemed to shoulder the duty of care. Often the fathers were perceived as being dangerous, disinterested, or absent by those within the MDT.

Mabel stated that some of her most challenging discussions with staff were about them needing to be person-centred and more focused on the needs of mothers. The mother who featured in Mabel's critical incident was cognitively impaired. Mabel went to great lengths to get funding approval so that the woman could be supported to care for her child, despite the cynicism of some of the staff members about her ability to parent. Mabel spent a lot of time working with ward staff to encourage them to use simple language and terms, even to draw flow charts to help a patient understand the risks to her unborn child if she did not complete regular health checks. She was strong in her assertion that the woman had a right to parent and that staff needed to spend extra time to teach and coach the woman how to care for herself and her baby.

Joan stated that people are uncomfortable with the idea of uplifting a baby at birth and planning for permanent care arrangements before the baby is born. Jo believes that in terms of giving a mother a chance to parent "we want to be able to say 'oh we gave people a chance and it didn't work out'". Lack of whānau support and support services like residential units for parents and newborn infants meant that social workers often could not guarantee the newborn infants' safety at birth. Several babies in the critical incidents were taken out of their parents' immediate care.

Kate's critical incident centred on an occasion in which Oranga Tamariki planned to issue a warrant to uplift a newborn infant in the delivery room. The risks to the newborn infant were perceived to be so high that the parents were not allowed to be left alone with their baby. Kate said that normally she would try to negotiate for mum and baby to have some time together if the baby was going to be taken into the custody of Oranga Tamariki

and she tries to ensure that the process is as therapeutic and compassionate as possible. This critical incident was significant to Kate and she needed the support of her supervisor and line manager to assist her with the ethics of the case as it was "a case that went beyond our brief as we weren't going to be able to advocate for the things that we would usually advocate for" (Kate). The circumstances required Kate to practise covertly without the consent of the mother, as the alleged risks were perceived by Oranga Tamariki to be so great that she was not permitted to be transparent around her role until the baby was born. Kate consulted with hospital management and sought their support for the plan of action due to her ethical concerns about this. She wanted managerial support to ensure that she had a fair and humanitarian approach to the risks identified by Oranga Tamariki, and a mutual plan of action was agreed to.

> [W]e had to serve the orders in delivery which for me felt like a huge compromise, like a huge injustice against their rights, it felt really ugly… [but it] had been evidenced and substantiated so you could see the risk on one hand of what had happened…yet it was still a conflict around what felt appropriate and what we would dearly like to do. (Kate)

Kate felt supported in her decision-making processes due to the ability to work collectively with supervisors, and with a supportive and engaged internal management structure. She was able to construct a carefully managed safety plan in a situation of high risk and with support felt enabled to negotiate a practice dilemma in which she had a limited sense of control.

Kim had a similar dilemma in her practice around her inability to be transparent with a caseload of young women who were likely to have their babies removed from their care at birth. She stated that, in her role as a health social worker, working with 'at risk mothers' she felt powerless to influence the outcome of who was going to be able to parent the baby.

> [Oranga Tamariki] are in the background calling the shots and telling us what to do. Because at the end of the day we actually have no call over removing that baby....You are building up this fake relationship… to get them onside, but you know in the back of your head that [Oranga Tamariki] are planning to remove that baby. So, at the end of the day they would uplift that baby and they'd call you a "Fucking liar and you lied to me, you never told me this was happening". (Kim)

This sense of powerlessness or futility is what appeared to be fuelling Kate's disillusionment and as a result, she remained in the position only for a short time. Needing to follow a process outlined by statutory authorities also aligns with the discomfort that Kate felt about her lack of transparency in the social work process with the client in her critical incident. Mary's critical incident also centred on the ethical dilemma involved with Oranga Tamariki not communicating to her about their plans to take a baby into the care of the state. This resulted in Mary having to manage the separation process on the ward while not being fully aware of Oranga Tamariki intentions; it also caused other at-risk mothers on the ward to become distressed through witnessing the separation. Mary stated that "as a health social worker you feel powerless because another agency has got it".

The participants supported patients and whānau through the legal implications of their health situations. They advocated on patients' behalf with other professionals, Oranga Tamariki, Maternal Mental Health and advised on issues such as informed consent. Mabel, in her work with a Māori whānau, gave advice about Enduring Power of Attorney (EPOA) and future-proofing care arrangements. The right to make your own decisions is a fundamental human right and Mabel was person-centred, and future focused in advocating for EPOA at this time. The EPOA process involved lots of nuances and legal considerations when collaborating with both the whānau and with other professionals to confirm the mother's ability to sign an EPOA. The whānau decided against arranging an EPOA and

guardianship, choosing to care for the mother and child informally. When considering the whānau reaction to Mabel's legal advice it highlighted how EPOA is a Western concept, which has a neoliberal emphasis on individual accountability and risk management. The whānau in the critical incident had been working collectively for years to care for the mother of the newborn and they did not feel the need for a formal process to assert this right. Consideration needs to be given to Indigenous rights and values, social work values about self-determination, and the dominance of Western norms. Māori concepts about collective decision-making and rangatiratanga within a whānau unit in these types of value-laden situations are complex for social workers to negotiate.

4.4. Practice Experiences

The participants imparted a sense of feeling separate from others in terms of their role and function. Their narratives about their critical incidents highlighted feelings of being separate from other professionals due to their distinct emphasis on patient advocacy and empowerment. When working with social workers external to health this separation of role and function was still present, due to their often-unique knowledge of bio-psychosocial dynamics impacting on patients. This conceptual category highlights the participants' narratives about feeling torn between the needs of the hospital staff or hospital processes, and the needs of the patients and their whānau. Participants also spoke about difficulties that arose in practice due to colleagues or other professionals oversimplifying complex situations and in this analytical category, the participants' voices are used to demonstrate the intrinsic challenges and demanding conversations that social workers had when addressing complexity in practice.

4.4.1 Betwixt and between

> I hold onto things like honesty, clear communication, respect, all of that. None of those are being upheld by the system. (Zenda)

The participants' narratives demonstrated a strong sense of 'being caught in the middle' within complex systems and working hard to find a compromise between polarised factions. For some of the participants, this sense of being caught in the middle also left them feeling as if they did not belong or were not able to feel fully associated with the DHB environment. Often the fractious parties involved were medical professionals and patients, with the participants intervening between them to find a compromise. Sometimes this feeling of displacement was due to the responses made by midwives, colleagues, community agencies and/or Oranga Tamariki, or the social workers feeling alone and unsupported in their judgement of a given situation.

> Parents are overwhelmed, anxious and angry over their baby's health issues and the constraints of an institution. This may require facilitation to engage other professionals who are best able to address the issues they raise – doctors, midwives, managers, kaumatua. [Oranga Tamariki] meetings are usually held in my office and they can be fraught – I see my role as supporting the parents to make the best decisions for their baby and empowering them. (Mary)

> [Oranga Tamariki were undertaking] completely unethical practice and we were feeling quite powerless and frustrated because whilst we were trying to support this separation of this mother and baby in this hospital, we couldn't really see it as being valid. I had no choice because there were legal orders that had been signed off by a Judge. So what choice did we have as a Government organisation, other than to do what they expected us to do? (Halyn)

Feeling caught in the middle was a deep-seated theme in the participants' narratives about their critical incidents as they struggled to address the social and cultural needs of the patients and whānau in a medical environment.

Myrtle spoke about her feelings of being caught in the middle when she watched the body language of a team of doctors speaking to a defensive and angry patient. Myrtle was very aware of the power imbalance between the medical staff and the patient during a ward round meeting and saw her role as "trying to balance power out by making it more of a discussion". Myrtle felt that the patient was acting defensively but recognised that she was just trying to ask questions of the doctor. In this situation, Myrtle perceived her role as working to ensure that the patient's voice could be heard, and her questions could be answered. It was apparent that the patient was not the only one feeling powerless in this situation. Myrtle indicated that she, too, felt powerlessness, stating that she was not able to facilitate the meeting due to the high-speed nature of the ward round. To defuse the situation, Myrtle spoke to the team of doctors prior to the ward round to prepare them, asked clarifying questions on the patient's behalf during the meeting and tried to "slow down the process" so that the patient's concerns could be addressed. Myrtle's position of being in the middle meant that she was focused on creating space for interaction and dialogue between two frustrated parties.

Tania spoke about being in the centre of competing forces stating that she "tried to work in a way that would keep the peace and also support my colleague, as well as advocate for my patient". Tania's quote speaks to the balancing act required by health social workers; the need for them to advocate for the patient and the difficulties involved with working to support colleagues, represent the organisation, and support Western medical frameworks – while being true to their own values. Tania acknowledged that managing these conflicting

requirements causes tension between her values, her culture, and her ability to have a professional approach.

Halyn's feelings of powerlessness and outrage about being caught in the midst of flawed processes is expressed below.

> Had this woman received social justice? Not really! Human rights? Is it the right of an organisation to work on invalid information to remove a baby from the mother. [To] not to have a plan with that woman to support her breast feeding and the nurturing and the attachment of that baby by having contact arrangements defined to her. I don't think that was right, so I think there was an injustice and I think there was a breach of human rights.

Halyn was legally mandated to support an Oranga Tamariki process that she felt was inadequately explained, and she had ethical concerns about the manner in which risk had been substantiated by an out of region Oranga Tamariki office. Given her powerlessness in this situation she took care to document events carefully. Halyn said that she liaised extensively with her local Oranga Tamariki office. Informing the Oranga Tamariki practice managers and liaison people that their responses were inadequate, and that she did not support the prescribed process as the risk assessment had been based on incorrect information.

Halyn felt powerless in this situation and subsequently relied on her positive relationships with her local Oranga Tamariki office to investigate concerns held about casework decisions. She also wrote a report to the Family Group Conference (FGC) Co-ordinator collaboratively with the midwife, to detail their shared concerns. The outcome of the FGC was that the baby was returned to the care of the mother. Halyn stated that the casework undertaken by Oranga Tamariki had a big emotional impact on her as it involved a misuse of power by another social worker from another region.

> Social workers are supposed to be trustworthy people and these people weren't acting in a very professional, very ethical manner. It was almost like this order was gained on assumptions, not on researched evidence.

Halyn also commented on the good relationship between health and the local Oranga Tamariki office, and compared it to her interactions with the Oranga Tamariki office in question:

> I did not feel that this was a respectful relationship. I did not feel that it was ethical, and I felt that it gave social work a bad reputation. (Halyn)

Kate's feelings of being caught in the middle related to the Oranga Tamariki directive to uplift a baby in the delivery room. Kate tried hard to "give some power in a powerless situation" back to the mother even though she was impelled to work under the direction of Oranga Tamariki and the police. She said that she made the best of a bad situation by comprehensively planning, consulting and debriefing in order to minimise risk, be mindful and act humanely in an ethical dilemma.

> Maternal mental health didn't really give a shit anyway and [Oranga Tamariki] said 'well that's not a care and protection issue – we just care about whether she is co-sleeping with this baby or not. (HG)

The critical incident that HG is referring to in the above quote refers to an experience she had with a group of professionals who were not prepared to collectively address issues of risk due to neglect, deprivation and maternal depression. HG felt caught in the middle between Oranga Tamariki, community social service providers, and the DHB's maternal mental health service. HG expressed concerns about specialised service providers pushing back work onto community agencies who were not able to adequately address complex and specialised issues of mental ill health combined with child neglect and deprivation. For HG,

her feelings of being caught were related to the paramount needs of the children involved. HG voiced strong concerns about the ethics of who is left to assess and manage risk and provide appropriate psychological support. HG expressed frustration about the DHB's maternal mental health service gate-keeping service users and not providing holistic care to those who met the service criteria. HG stated that maternal mental health left her "holding the baby". HG, in turn, relied heavily on community support workers as a way of managing her heavy workload. She expressed frustration that these community workers were poorly paid women doing social work tasks without the training or support. Despite this dissatisfaction, HG spoke with pride in the good service she was able to provide with these community workers "while we were waiting for the cavalry – maternal mental health, which didn't arrive, we just did some good work together". Like HG, Jo also reported difficulties with getting maternal mental health services to remain involved with the woman portrayed in her critical incident. Ideal practice for Jo was about working collaboratively and communicating effectively, pragmatically stating that no one service can manage a multitude of complex issues.

Feeling caught in between was not always a negative for the participants. For instance, for Jo being in the centre of situations related to her feeling caught between midwifery staff and Oranga Tamariki staff. Jo is the sole health social worker in her MDT and works alongside community services and Oranga Tamariki. She believes that, as a health social worker working with newborn infants, she is well placed to provide midwifery staff with the support and advice they need to manage risky social circumstances. Jo expressed concerns that Oranga Tamariki social workers do not always acknowledge the expertise that Midwifery staff have with antenatal care and can ignore their advice to the detriment of the baby's health needs. For Jo being caught in the middle between health, Oranga Tamariki

and community services was an advantage. Jo feels that health social workers are better informed about previous care and protection alerts than community social workers. She believes that, through working alongside medical professionals, health social workers can attend to bio-psychosocial needs and access at-risk women who are normally reluctant to engage with social workers. Being betwixt and between was perceived by all to be a place full of contradictions.

4.4.2 Challenging practice

One of the biggest challenges for the participants was being subjected to the derogatory comments made by other staff about patients. Concerns about the way that staff spoke about patients and whānau was a prominent topic in the phase one interviews:

> Nurses and midwives just absolutely love complex social situations – they sort of make a meal of it – and they sit round and discuss it and it's all totally unprofessional, but that's what they actually do so I guess in some ways I don't tell everybody everything. It is a need to know basis, because actually I do not want the women's dirty washing to be discussed round the nurses' station. (Mary).

Mary felt that this action was needed in order to protect the patients' privacy and to respect the patients' dignity. The following statement highlights her integrity, her motivation to empower patients and her need to be true to her own values:

> … as far as I'm concerned, I'm protecting the women. How can I be saying to her I need to empower you and all this sort of carry on and yet allowing tittle-tattle to be going on. (Mary)

In the except below, Halyn is expressing her frustration about judgments made about patients and in particular a Māori mother who was suffering from a significant health issue:

Kelly: You were saying it's more than racism?

Halyn: Oh yeah…judgemental – judging her. Because I had a doctor say to me "basically she's a drug user and a prostitute and she's hooked up with a bad crowd and everything, so what more could you expect." [huh] I mean her healing is not going well. She is immune suppressed, and things like that. To me that was such a judgemental comment because actually this woman has got the most amazingly generous heart and she's kind and she's giving. But they don't see her for that – they see her for drugs, prostitution.

Kelly: They're not seeing the real person?

Halyn: They're not seeing the real person – they just see like a few key words and they then put a label, they stereotype/stigmatise that person.

Participants appeared to take responsibility for the negative labels and sarcastic ways their colleagues used to speak about patients. In response to this kind of behaviour, they would try to model good practice. They worked to engage the staff in conversations in which they would try to humanise the patient, hoping to enable the staff member to see beyond the demanding or disagreeable behaviour that they thought a given patient was exhibiting. Other participants spoke about in-service training that they conducted on the dynamics of power and workshops on person-centred practice to modify the behaviour or culture within the ward or service. Myrtle tried to address this behaviour in hospital committees and forums as well.

Mabel stated that some of her most challenging discussions with ward staff were about them needing to be person-centred and more focused on the needs of mothers. Mabel reflected on the experience of having to reframe ward staff's thinking to get them to assist a woman with an intellectual disability to parent. Stating that she did "absolutely everything in my power to empower and strengthen them [mother and whānau] to be able to care for their own". Mabel stated that, due to the commitment to teaching her how to care for herself and her baby over several weeks, the woman was able to take her baby home and that the staff appreciated this success. Mabel talked about having multiple

conversations with staff to reinforce best practice and acknowledged that conflict occurred with staff because hospital systems and processes are set up for 'normal' people, therefore diversity and difference can be perceived as problematic. Other types of judgements that the participants had to address were due to assumptions made about service provision and the right to service provision.

Sally also had concerns about ward staff staying focused on their need to provide a service to all people regardless of the decisions that they make. She felt that patients were treated differently due to their social circumstances, giving an example of patients on periodic detention. She expressed strong concerns about staff labelling patients, stating that it is important to stop the labelling because other staff can be slow to question whether the negative label is accurate or deserved. Sally believes that systemic support is needed from 'upper management' to shift perspectives and generate cultural change. Sally reflected on this issue stating, "it is my ever-hopeful belief that if people knew different then they would be different". This statement of hope alludes to a global belief in social change, as in this instance she is referring to change needed in other professionals, rather than change in patients or service users. The participants' view of their work meant that they often acted like a social conscience within their working environment, strategising to achieve social change or a more ethical working environment through reflective questioning and guided discovery.

4.4.3 Māori experiences of racism

Both Mary and Myrtle stated that patients who are perceived to be 'rough' or 'too loud' were often offside with staff, were judged by staff and talked about in a derogatory way. Mary stated that ward staff would comment that patients would be getting "special

treatment because they were Māori", and that the staff struggled at times to meet the cultural needs of patients. Mary felt that the patients were grouped into two categories – 'Lion Red' and 'Chardonnay' by some members of staff. Myrtle expressed concern about the patient being labelled by staff as "the naughty ones in that room" and was troubled by the level of sarcasm used by some ward staff when describing patients that were labelled troublesome.

At the time of the interview, Myrtle expressed disbelief at some of her colleagues' behaviour and asked for advice on how to handle prejudiced behaviour. Myrtle said that she got into arguments with staff about the sarcastic way in which they discussed patients and felt that she was labelled a 'bleeding heart', in her attempts to address labels such as 'naughty' that were assigned to patients. Myrtle stated that the two women labelled naughty in her critical incident were Māori, had been on the ward for only 2-3 days and were already aware of the judgements. She recalled an incident that she felt was unwarranted, in which security had been called, and she felt that the women's behaviour had been misrepresented. Myrtle said that the women felt stereotyped and asked her "is it because I am a Māori that I am being treated like this?" Myrtle did not state how she replied to these patients but did acknowledge the impact of what she called 'personal racism' on these women. Myrtle asserted that Māori women seem to be more likely to receive negative attention from ward staff and linked this injustice to the impact of colonisation and Māori health statistics. When questioned about the impact of racism on her, personally, Myrtle indicated that she gets angry, frustrated, and argumentative with people, and states that she is channelling this frustration into research. Sally had similar concerns about staff racism stating that Māori receive different treatment based on negative assumptions:

> …it's this judgement that we need to stop them from getting pregnant, judgements on whānau if they've got tattoos… (Sally)

Sally linked negative judgements about Māori to them being overrepresented in negative statistics about health, crime and education. She stated that the judgements are overarching and are "universally applied until proven wrong", and states that the "culture of middle to upper class hospital workers" perpetrates this racism. Like Myrtle, she is aware that Māori patients are aware of the judgements and perceptions about them, expressing the following concerns:

> Families can feel that judgement, and I've had families not even wanting to come onto the ward because of the judgement they feel, and so then it re-oppresses the whānau, it re-oppresses and reinforces them that they are not coming up onto the ward either with the baby. So, it can get into quite a negative cycle, some of the whānau are stronger so they might try and have a stand against something but then they can be labelled as difficult…and then that reinforces people who treat them as if they're difficult. (Sally)

To counteract this, Sally emphasised the importance of valuing peoples' stories and working to help staff avoid making judgements in order to protect patients from "negative labels which then can become self-fulfilling prophesies". For Sally it is about being able to *"*look at the bigger picture and go 'why is that? – because of the history, because of what's happened, how can we help prevent that?' Actually, we're almost redoing that [oppressing, colonising] to families because we are judging them and putting them in a box."

4.4.4 Negative working environment

The negative working environment experienced by some of the participants was made worse by issues of trust and having to work hard to belong. These experiences left them feeling demotivated and devalued. Social work, as discussed earlier, provides a

secondary psychosocial focus to the medical model. The participants spoke about having to work hard to earn their place within their specific DHB setting and that social workers were mistrusted by some professionals. Some participants referenced having to prove themselves by *"passing the test"* and having won the trust of medical staff. Mary spoke about how she nearly gave up her job due to the divisions and difficulties that existed between the midwives and the lack of professional respect for social workers when she first started. Mary said that the ward staff "hated social workers…I think they'd had a couple of bad experiences in their eyes with my predecessors." Mary spoke of her initial experiences of being bullied by ward staff and the pressure put on her by them to practise social work in the manner that they wanted her to when she first started working for the hospital.

> Then I had [ward name] who thought I was absolutely useless, hopeless and didn't know what to do. They were obviously that used to telling other social workers what to do and the other social workers leaping up and doing it – well, that wasn't my style. I'd say, "if you've got sufficient concern you do the ROC [report of concern]". I even used to say that to one or two of the paediatricians that would come in and say "well, I think you need to do a ROC". And I would say, "in my assessment, I don't think I do, but you feel free to do it." None of them ever did it. But you know, I was not going to be the dumping ground in doing ROCs when actually I didn't see the need for them. (Mary)

Mary stated that it took two to three years to gain the trust of the ward staff, to prove her place and to stop other professionals from telling her what to do.

> The first year was hideous, the second year I started to get my feet under the table and the third year it was sort of sweet as and it's been fine ever since. I mean, they just go along with what I say now. They may very well mutter behind my back. (Mary)

Although some of the participants such as Alice felt that they were well supported by their MDT, they noted that they were not well supported by the wider organisation. Halyn was left to pick up the work of a social worker on leave for six months; this meant that her caseload doubled, and she had to employ a system of case prioritisation. Halyn wrote a formal letter to her managers detailing her lack of capacity to cover the workload and safely manage risk. She requested support as she was unable to respond to all referrals and informed management that "the DHB had put me into a position of risk and that they needed to take ownership of that risk"' Halyn said that as a result of the letter she received "some additional support" and spoke of the personal costs to her due to the stress of managing two caseloads, as well as break-down in relationships through her inability to receive referrals in situations of significant risk:

> …the cost from that for me has been tiredness, obviously…stress, definitely, and not feeling like I can relax, even in the time that I have to myself in the weekend. That's definitely been a big issue, dreaming work, waking up thinking work. (Halyn)

Alice stated that she feels that within her organisation compared to the medical professionals that "social work is the least important" inferring that the social workers' in-tray is filled with "the shitty jobs". Hierarchies between different professionals were apparent in the participants' narratives, with the participants often expressing feelings of being devalued, which made it harder for them to make systemic change when they felt it was needed.

Problems with hierarchy existed outside of the DHB environment as well. For instance, Jo stated that her local Oranga Tamariki office teased her about being 'high maintenance.' Jo said that she will challenge decisions that she feels are not right and speak

to Oranga Tamariki supervisors to express her concerns. When reflecting on her ability to get her professional assessment heard by Oranga Tamariki Jo stated that:

> I just have no power, so I just advocate, but quite often my advocacy works…I wouldn't probably fight as often if I thought it was never going to work, but I think sometimes just by discussing and going through the risks and being logical about it you can actually work through it and get to a place where you can agree. Sometimes if they pull rank I've just got to say "ok" because I've also got to work constantly with [Oranga Tamariki] (Jo).

Jo will contest Oranga Tamariki decisions that she is uncomfortable with, but is very aware of her boundaries and the importance of maintaining good professional relationships with colleagues from other agencies.

Kim felt a sense of powerlessness in the work that she did with young pregnant women, stating that, while she was supporting them through their pregnancy, the level of risk was such that they were unlikely to be able to parent their baby.

> You build up this fake relationship with the girl – get them onside and then you know the baby's going to be removed. (Kim)

Kim stated that she would get on well with the young girls and try and be genuine in her relationships with them, but despite her best efforts the girls would start to disengage. Kim felt an incongruence between the work that she was doing, and the likely outcome of the baby being removed from the mothers' care. A result of this incongruence was that she lost the motivation to continue in the role.

4.4.5 By Māori for Māori

Many of the participants linked their concerns about Māori being over-represented in negative health statistics to their experiences inside a Western health system. Some of

the New Zealand European participants were very aware of issues around cultural competency and acknowledged the impact of cultural difference. Jo, commenting on her role, working with mainly ethnic populations stated, “it’s really funny having a middle-aged Pākehā woman doing what I do”. She spoke about being very conscious of being culturally appropriate and consulting cultural support workers. Jo also expressed concerns about the midwifery service being very European. These concerns mirrored those mentioned by Sally about the need for social work practice to be by Māori for Māori:

> We do have a lot of Māori whānau come through. As part of my social values I really value biculturalism and the treaty and like to learn te reo. I want to be really appropriate in my work with Māori whānau, and I think for me at the end of the day, I’m still not Māori…although I can do the best that I can within that situation. (Sally)

Sally talked about the need to move beyond platitudes and tokenism, and how, as an organisation, social work service provision needs to be by Māori for Māori. She expressed concern for rural Māori whānau coming into the hospital to receive treatment not available in their hometowns – acknowledging how they are separated from their community and culture at a time of huge stress. Sally appreciated the need for procedures and regulations around limiting visitor numbers with babies needing intensive care, but acknowledged that the clash of culture can leave a lot of Māori whānau feeling judged during a traumatic life event.

Tania raised issues about issues of people of her ethnicity also being judged negatively due to cultural differences. She spoke about immigrant people reacting indignantly to the tone used by doctors towards them when they have followed cultural practices rather than the standards drawn by Western medicine. Tania acknowledged the offence caused by cultural wisdom and ancient practices not being respected, leaving her

feeling torn and conflicted between her own cultural knowledge and the standards set by the DHB. Tania stated that, due to incidents in which mistakes have been made by immigrant people to the detriment of their health their cultural knowledge is often disregarded:

> When you mention cultural tradition people start rolling their eyes in MDT's because most of what I deal with now are issues with delay in presentations. [Families] use massage so if they don't know it's a fracture, they'll massage it anyway because that's a tradition that they're going to carry on. (Tania)

4.4.6 Social worker as educator/consultant

With respect to the judgements about patients by medical professionals, it appears that the participants had a strong educational role in assisting staff to critically reflect in order to develop an increased understanding of the structural issues that patients were facing.

> Sometimes they [medical staff] will make a really judgemental statement based on one little interaction they've had with the family, or something they've heard or something they've seen. When we add context to that because we engage with the person and get to know more about their life story, then they'll go "oh, ok, that's really sad" and they totally rethink it. We are able to do that quite a lot, because they just get snippets of things, but we actually spend time with the person and get the whole story and then we lay that in a way that they'll understand and then we do get some shift that way. (Sandra)

> I think I'm an educator about how families might be feeling, like I think sometimes other disciplines can be a bit quick to judge, whereas we can give a bit of context to the situation that maybe they're not focused on because they might be focusing on feeding…while the baby's our client we're kind of looking at a wider ecological perspective, so we might have a bit more context to the situation, so that we can educate maybe not to jump to conclusions and maybe advocate for parents. (Sarah)

> I do see it partly as a role to be an advocate for the patient or the client that I'm dealing with…I think that in so doing, you are educating the staff. You are educating them to think beyond what they have in their sight. To actually expand their thinking to be just a little bit more compassionate or a little bit more sensitive or not to be so confronted if somebody says something that seems really awful to them. (Halyn)

Work with newborn infants can be traumatic due to the vulnerability of newborn infants and women at this critical life stage. Many of the participants spoke about the work that they do advising and debriefing non-social work staff due to the emotional reactions that they have to their work. Sarah felt that the work that she does supporting staff is recognised on the ward, but not necessarily by the 'social work department' as it is not quantified in any way.

Jo described her role as a community health social worker with newborn infants as an advisory role, where the midwives come to her for advice and support on how to best manage risk. Jo believes that her role has *"opened a can of worms"* as she is inundated with complex cases and expressed frustration about the level of support that the midwives need. Jo stated that she works in isolation as the sole social worker in a big team and feels that she is not being fully supported via funding for increased and much needed social work services. Jo's pragmatic solution to this is her decision to train the midwives that she works with to be "more like social workers". Jo indicated that when she started her role, she was able to do home visits and work intensively. She stated that now due to the high caseload she is "more of a consultant and a navigator" only getting involved if the women "absolutely decline all other social work and then I manage to wangle my way in". Jo believes that she is poorly remunerated for the complexity of her work given the advisory service that she offers other professionals and believes that she holds a lot of responsibility and accountability should something go wrong in her service.

4.4.7 Supervision and support

Working with newborn infants and their whānau is specialised and often autonomous work. It requires a complex understanding of the health and wellbeing needs of women and babies, as well as understanding care and protection processes, legal requirements and the dynamics of risk assessment and management in a health setting. Often the participants were working independently in their role, were required to have a significant amount of expertise, and reported issues with the level of support they received from their employer. Kim stated that she was only given one day's training to assist her with the specialised care and protection processes when she started the health role with newborn infants and that, as a result, the first couple of months in the role were very trying.

Many of the participants spoke about managing high workloads and working in stressful circumstances with very complex cases. HG stated that she was seeing up to 30 clients a week and her interventions were supposed to be brief; however, she asserted that "with mums and babies it usually wasn't ever brief unless I could hook them up with some really good support". Participants acknowledged the impact of the heavy caseloads on their ability to be resilient and provide a holistic service. Some of the participants also commented on the range of work that they do, stating that stress was placed upon them because they would be at times moving between a patient recovering from a stillbirth to a patient who is neglecting their newborn baby's needs. The contrast between cases was perceived to be very difficult, with one participant stating that she may only have a brief walk down the corridor to reflect and debrief before being juxtaposed into an extremely different situation that can trigger a completely different set of emotions.

Ethical concerns were raised by participants about the impact of being supervised by their line manager:

> [Internal supervision] is a little bit incestuous…there's so much gossip that goes on. I do trust the supervision relationship, but I also wouldn't want someone to feel burdened by issues within the team that they're already in. (Sarah)

Sarah stated that this type of supervision is useful in terms of case management, but that, if you have issues with your team leader, then you may end up raising the issues with your peers who are also impacted by being in the same team. The cost of external supervision was seen to be a barrier. In some cases, due to the cost, peer supervision arrangements were negotiated instead.

One participant stated that she has never had a decent supervisor since she has been with the DHB. Due to issues regarding identification, I have chosen not to name the participant, even though she indicated in the interview that she would stand by her statements if her comments were linked to her and would challenge the organisation to do something. She expressed dissatisfaction that, in situations when she is dealing with complex decision-making around case work and feeling torn and conflicted, she receives poor supervision and feedback, stating that the "big issues get swept under the carpet". This participant is supervised by her team leader and stated that if the critical incident event was happening now that she would probably not even discuss it with her team leader and would go straight to the DHB lawyer instead. This participant receives her support from ward colleagues and debriefs with individual social workers due to a lack of confidence in her team leader/supervisor's ability. This participant states that, *"in the social work department it's absolutely toxic"* and describes the environment as "dangerous, disgusting and damaging". When asked how she stays safe in this environment, the participant stated that she does not associate with the social work team unless she has to.

Sandra stated that she felt that issues discussed in a social work supervision forum did not stay confidential to the group, resulting in a lack of trust and willingness to participate in what should have been a supportive discussion. The participants saw informal peer supervision as being a vital support system, utilised daily on an ad hoc basis to assist with decision-making and reflection on complex situations.

> We'll do a difficult piece of work – you'll come back in and go "guess what now", and then we'll have a discussion and you'll get loads of ideas from everyone else. You will get reassurance that you've done absolutely everything that you can – you'll get some ideas about things you could have done – things you might want to do differently. We really, really look after each other over here. (Sandra)

4.4.8 Feeling disillusioned

> It causes me ongoing distress that it is my perception that lip service is given to social workers, they are not valued and are easily overridden by "nurse" type processes. That nursing staff can come in and completely overturn social work initiatives without even the decency to discuss the reasons why. I am disillusioned with social work in health and feel that perhaps if integration of secondary and primary service occurs then social workers will be able to take more control of their profession working in a community environment where, in my opinion, social work serves the community best. (Mary)

Mary's quote illustrates a strong sense of disenchantment with health social work. Mary has practised social work for a long time and seen many changes in health, as well as in social work. She spoke with pride about the community initiatives that she has developed over the years, and the systemic changes that she was able to make within the community and DHB when working alongside a ward manager who understood and valued her social work knowledge. Mary is coming close to the end of her social work career, a career that she is

proud of and her commentary was full of concern about the ability for health social workers to hold their place within the medical model.

> Gradually the edges of social work are been nibbled away and it seems everyone can do social work – until they get in a pickle and then scream for help. (Mary)

Many of the participants expressed concerns of being dominated and felt worn down due to the need to 'fight' to make change, and at times the participants' narratives reflected those of someone going into battle:

> I have to go put my boxing gloves on and go fight; fight surgeons, fight health professionals, fight for transport for her – nothing was easy. (HG)

The participants generally seemed to enter into social work due to a sense of wanting to 'help' or address injustice. There was an undercurrent of weariness in the way in which they spoke about their practice and their ability to achieve both the patient-related goals, and the aspirations they had for the service in which they functioned.

> There's a lot of challenges in this place, the more I talk about the more I think why do I like it? (Sandra)

The chapter so far has provided an explanation of the three category headings, *Practice vision, Work expectations* and *Practice experiences.* To develop these categories further, the next section of the chapter considers the category headings alongside the ecological perspective and pertinent literature relating to health social work. As previously acknowledged, the purpose of introducing this literature at this stage is to progress the emerging knowledge about how values support and inform health social work practice. This discussion, based on the critical incident findings, will serve to situate the research before introducing the phase two findings.

4.5. Discussion of Phase One Findings

In order to begin to develop further understanding about the three broad headings that arose out of the critical incident findings, it is important to consider constructions relating to social work practice and the concept of health. The discussion below contains an examination of these constructions alongside the ecological perspective; and considers how the findings relate to the social determinants of health. The role of health social workers is explored in alignment with some of the guidelines that relate to health social workers. Further consideration of some of the pressures that are affecting health social workers in Aotearoa New Zealand is then provided in light of the participants' experiences and feelings.

Health social work with newborn infants naturally aligns with an ecological perspective. This is due to multiple systems and professional perspectives informing and impinging upon practice situations within health social work. As the phase one and two data were being analysed, it became increasingly apparent in the participants' narratives that the complexity of health social work was predominantly navigated by the participants through consideration of systems in action. The participants demonstrated an ability to apply a critical analysis to issues of power and mandate within interrelated systems. An ecological perspective is entrenched within social work thinking and the participants' narratives served to emphasise the perspectives' ongoing validity and relevance. Given the complexity inherent in health social work with newborn infants, the ecological perspective was utilised as a body of knowledge that helped to refine, support and scaffold the emerging theory during the write-up of the discussion.

The theoretical base of social work has developed and refined systems perspectives and ecological thinking since the 1970s. An ecological perspective provides social work

practitioners and researchers alike, with an understanding of multiple perspectives. This comprehension of complex systems enables social workers to grapple with constructivism. As the ecological perspective was employed to support the write-up of the discussion, an explanation of the perspective is provided in this discussion section. The ecological perspective was not utilised as an overarching theoretical perspective in the manner that symbolic interactionism was; however, when it was applied, the perspective enabled further development of the theoretical categories when considering literature related to the place of values in health social work practice. The next section of this chapter is designed to explain how the ecological perspective has relevance to constructions of health social work and how it was used to further develop the principal analytic categories.

4.5.1 Employing an ecological perspective

An ecological perspective uses the metaphor of ecology to encourage social workers to focus on the centrality of people in their environment, concentrating on transactions both within and across systems (Dubois & Miley, 2019; Healy, 2014; O'Donoghue & Maidment, 2011). This perspective provides social workers with a way of understanding people within the context of their whānau and wider social environment, in order to better comprehend how individuals, whānau, communities, and organisational systems interact and adapt to their wider social and cultural environment (Healy, 2014; Payne, 2014). An ecological perspective integrates interpersonal therapeutic work with practice that intervenes with whānau, communities and wider social agencies (Payne, 2014). This integration is done through focusing on how social and physical environments interact with personal factors, to understand how interventions can engender individual and environmental change (Connolly & Harms, 2015).

Healy (2014) refers to “three waves of systems perspectives – general systems theory, ecosystems perspectives and complex and chaos theories” (p. 115). General systems theory focuses on wholeness and causality to understand “interactions and adaption through elaborating the core concepts of emergence, open and closed systems, boundaries, entropy and steady state” (Connolly & Harms, 2015, p. 63). It can be difficult to discern the difference between general systems theory and an ecological perspective, as they hold very similar premises and basic assumptions. Teater (2014) asserts that an ecological perspective was developed by social workers in order to move beyond the use of non-human terminology and assessments of systems.

The metaphor of ecology encourages social workers to seek sustainable change through improving transactions from within and across systems (Healy, 2014). Complex and chaos theories allow for ambiguity and have been developed from systems theories in reaction to the way in which social problems and environments are located in incredibly complex systems (Connolly & Harms, 2015; Healy, 2014). Health social work is located in a crisis-ridden complex ecology, so these theories will assist in comprehending behaviour, reasoning, and the interplay of interaction within the DHB environment. Systems theories highlight the importance of non-linearity as the relationship between cause and effect is often non-proportional. Complex systems are also useful with understanding resilience within people, communities and environments (Connolly & Harms, 2015). All three waves of systems theories will contribute to understanding value demands in health social work practice; however, the ecological perspective will be used as the central frame of reference to further develop the principal analytical categories.

Gitterman and Germain's (2008) life model of social work practice is perceived to be the leading theoretical account of the ecological perspective (Healy, 2014; Payne, 2014; Teater, 2014). Gitterman and Germain's (2008) ecological life model of social work practice is a collaborative approach designed to empower through improving the fit between the individual and their environment, as well as working to intervene to make the environment more suitable to people's needs (Besthorn, 2013). Beckett and Horner (2016) state that Gitterman and Germain's (2008) ecological life course model differs from systems theory in its values-based orientation, as the ecological perspective works to assist people to adapt to their social world while making it incumbent on society to recognise and adapt to differing needs. It is therefore an anti-oppressive approach to practice, addressing issues of discrimination and oppression by accounting for issues of diversity and difference (Teater, 2014).

From a life model approach, stress is perceived as being due to a discrepancy between an individual's needs and ability to cope, and the environment within which that individual resides (Dubois & Miley, 2019). Gitterman and Germain (2008) drew on these ecological concepts to explain the theoretical foundation underpinning the ecological perspective contained within their life-model approach of social work practice:

1. Ecological thinking and reciprocity of person-environment exchanges
2. Person:environment fit, adaptedness, and adaption
3. Habitat and niche
4. Abuse or misuse of power, oppression, and social and technological pollution
5. The life course
6. Life stressors, stress and coping
7. Resilience and protective factors. (p. 51)

Bronfenbrenner's (1979) ecological systems theory was a forerunner to the person-in-environment and life course perspective (Gitterman & Germain, 2008; Sable et al., 2012). Connolly and Harms (2015) state that Bronfenbrenner (1979) outlined four layers of interrelated context to demonstrate how human development occurs within a social environment. These layers are the micro, meso, exo and macro systems, which are placed within a chronosystem to demonstrate the context of time. Thinking across these layers of interconnected systems enables social work practice to focus interventions throughout the micro to macro continuum, allowing for a range of interventions from interpersonal work to wider macro issues around advocacy and policy work (Connolly & Harms, 2015).

One of the key factors that an ecological perspective provides is a lens through which to see how a person resides within an environment. This lens sensitises health social workers to "team and organisational issues, community processes, and macro-level policy while they simultaneously attend to the intra-psychic and interpersonal need of individuals and families" (Gardner & Werner, 2012, p. 512). Socio-political and economic adjustments impact upon the health social worker and the individual receiving the social work service. They also impact upon the layers of systems stemming up from the individual, to the whānau, to the whole of society (Germain & Gitterman, 1986). The health of individuals and communities is determined by wide-ranging factors, stemming from genetics and behaviour, to broader socio-economic, cultural and environmental factors. Understanding these factors involves comprehension of complexity and systemic interactions that impact upon patients and the way practice is conducted.

An ecological perspective allows a holistic consideration of complexity that privileges individuals' experiences within the DHB context. Fook (2016) stated that the term

intersectionality is useful to consider the ways in which the "different dimensions of inequalities (most commonly associated with race, class and gender categorisations) can intersect and interact in ways that compound the experience of social disadvantage" (p. 103). Within this research, the concept of intersectionality is useful to extend beyond fixed social categorisations among groups to illuminate how interacting social factors and power differentials impact upon people, and to better understand causal complexity (Hankivsky et al., 2010; Mohanty, 2018; Teater, 2014). An ecological perspective recognises the myriad of interrelated influences that affect people, enabling an active recognition of intersectionality and complexity dynamics. This recognition of complexity can be equally applied to the analysis of the support needs of patients and whānau, and the needs of health social workers and other professionals or communities that interact within the wider DHB system.

A critique of ecological perspectives is that, while it provides multifactorial explanations about complex situations, it does not give direction on how to prioritise information or how to intervene (Healy, 2014; Payne, 2014). Another critique of systems thinking is that there is a risk that social workers could simplistically focus on the person, whānau, group or community adapting, rather than taking social justice action for systemic change (Payne, 2014). A key strength of an ecological thinking is the perspective's ability to recognise complexity, and it is this strength that makes the perspective so worthwhile when applying it to the complex nature of health social work. Healy (2014) credited systems theories with providing a form of systemic analysis on interactions across and within multiple systems, such as whānau, friendship groups, community systems, organisational systems, social policy structures, and socio-cultural systems. This process of analysis and way of framing individual and community wellbeing allows for a wider understanding of how to improve adaption between individuals and their social environment. In light of the

above criticisms, it is important to note that the focus on fit between individuals/groups and their environments would be inconsistent with social work values if it did not include analysis and action points about pressure to conform, structural injustice and misuse of power (Healy, 2014; Payne, 2014). Germain and Gitterman (1995) assert that, within an ecological perspective, attention is given to issues of coercive and exploitative power that create and sustain oppressive conditions like poverty or institutionalised racism. Having clarity about the dynamics of oppression and discrimination enables and extends social workers' ability to empower and, through consciousness raising, invoke societal change (Germain & Gitterman, 1995).

An ecological perspective can illuminate situations of structural inequity and oppression, creating opportunities for action for change. An example of this is how feminist groups have used systems perspectives to demonstrate exploitation of women's work within family systems functioning (Healy, 2014). A balance is needed between a systemic focus on the uniqueness of individual, groups and situations and the interactions between and within systems (Healy, 2014). Time pressure, fragmentation of services and specialisation of health social work practice has made it more challenging to bridge the micro–macro practice divide (Austin et al., 2016). Given the complexity of health social work practice, an ecological perspective allows for a critical consideration of how value demands are experienced and negotiated across the differing layers of intersecting systems in practice.

4.5.2 Constructions of social work practice

Social work practice is hard to define due to the diversity that exists within different scopes of practice – resulting in a sense of intangibility about what social work is. Clark

(2000) asserted that social work is the “most contentious” of all helping professions, and that practice is located over the “fault lines of controversy of social values” (p. 2). This societal ambivalence may be, in part, due to the way in which the media portray a distorted depiction of the social work profession, especially in relation to issues about child protection and risk management (Beddoe et al., 2017; Lonne & Parton, 2014; Warner, 2013). These factors combined can lead to a sense of misunderstanding or ambiguity about the nature of social work practice, making it necessary for social workers to have a clear understanding of their professional mandate which is founded on the profession’s values.

Over the past 30 years, social work values have been affected by neoliberal policies and practices in Aotearoa New Zealand, and these changes have resulted in a contested professional identity (Hyslop, 2013a). Ross (2014) stated that social justice and human rights are a binding force in Aotearoa New Zealand social work practice but believes that, without a strong professional identity social workers could be vulnerable to following organisational mandates regardless of their fit with social work values. Social work practice reflects and responds to changes in society and societal values.

Social work practice intervenes at junctures that involve both the public and private domains of individuals, whānau, groups and communities. The knowledge base of the profession spans across the psychological to the political. Social workers negotiate issues of safety, equity and justice through considering how the lives of those that they work with are impacted upon in terms of their immediate environment, ecosystem and structural influences. Clark (2000) contends that social workers deal with the societal issues that most people prefer not to think about. As social work practice is located within challenging environs it is essential that practice evolves in reaction to the changing socio-economic, cultural and political landscape. Social workers are obliged to be both resilient and

responsive so as to effectively meet the changing needs and circumstances of the communities with whom they work – as well as adapt to changes in social policy and organisational obligations in which they function.

Bisman (2004) considers social work knowledge, values and skills, alongside the history of the profession in order to gain understanding of the state of social work professionalism, and asserts that grounding the profession in its moral core will secure the future of social work. Lymbery (2001), like O'Brien (2011b), Bisman (2004), and Mullaly (2007) challenge the profession to be engaged politically and socially, stating that there needs to be a strong professional voice. O'Conner et al. (2003) asserted that "the choice for workers is not whether there is an ethical dimension to their work, but whether or not they explore these dimensions" (p. 200). They claim that the profession is demoralised; in order to overcome this, they believe that social workers need to recapture radical social work practice and have clarity about their role and how they can maximise client participation. These authors locate social work values as being important to maintaining social work as a distinct profession in a managerial environment of multidisciplinary working, with blurred boundaries between professional groups.

It was evident in the participants' narratives that they appeared to analyse situations relating to practice in terms of micro, meso and macro influences intuitively. The participants' critical incident narratives demonstrated that they often acted as educators within their teams. The participants would often take a lead role in understanding psycho-social issues impacting upon patients and their whānau and providing a critically reflective account to team members about how the realities of patients' lives were impacting upon their health, and their health choices. The participants' professional identities were not a

natural fit with other health professionals within their MDTs, and they needed to be resilient in practice to have their professional voice heard.

4.5.3 Constructions of health

The term, *health,* itself is a contested concept, and cognizance about social workers constructions about *health* provides a platform to consider the work that health social workers do. The World Health Organisation constitution defines *health* as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (World Health Organisation, 1948 para, 1). This definition of health was ground-breaking at the time, as it went beyond physical health to include mental and social dimensions of health (Huber et al., 2011). The prevailing attitudes about health and wellness changed in alignment with this definition. Health is now increasingly defined with regard to functioning, rather than a medicalised view that focuses on the absence of illness or fighting against disease (Petrakis & Lethborg, 2018).

Gross inequalities in health outcomes led to the World Health Organisation launching a Commission on the Social Determinants of Health in 2003 (Marmot, 2005). The term *social determinants of health* refers to any nonmedical factors that have an impact on health (Stanhope, 2018). Nonmedical factors relate to social inequalities or adverse environmental, cultural, political or economic conditions that disproportionately influence health outcomes, including neighbourhood and environmental conditions, issues of class, discrimination, social exclusion, and restricted ability to access employment and education (Craig et al., 2013; Spector, 2019). McLeod and Bywaters (2000) asserted that health inequalities are a key focus for social workers for the following three reasons:

- It is unjust that people should suffer unnecessarily due to inequalities that are socially constructed
- The social control function of social work means that social workers are implicated in the production and maintenance of inequalities
- Life expectancy and the chance of people experiencing a serious illness is linked to social circumstances; social workers have the professional knowledge and skills to advocate for systemic change to ensure equity in health.

The need to diagnose the underlying causes of illnesses, with attention to social factors, alongside concerns about the dehumanisation of patients within hospitals was a powerful motivation for social work to become originally established within hospital settings (Stuart, 2005). An ecological perspective allows for greater clarity of understanding about the differing layers of impact that the social determinants of health have in order to direct social justice action (Craig et al., 2013).

In the critical incident narratives, people needed the participants' services when they were at a crisis point in their lives, which was often due to vulnerability brought about through ill-health, violence, social inequality and related adversity. The participants acknowledged their professional power and protective responsibilities in these types of risk situations. However, the participants did not explicitly acknowledge that health social work could be perceived as a form of social control through the monitoring of safety and compliance (Burman, 2004). The participants paid close attention to micro and macro issues regarding social inequalities and poor health outcomes, and this focus is a key point of difference between them and other health professionals (Petrakis & Lethborg, 2018). Finn and Jacobson (2003) asserted that "attention to context entails an appreciation of the emotional, cultural, and physical surroundings of our work" (p. 70). In the critical incident

narratives, it was evident that the participants employed an ecological perspective of individuals and their whānau to holistically assess needs, manage risks, and plan discharges (Landau, 2001). The participants appeared to try to structure their interventions to buffer negative bio-psychosocial factors that affect the individuals and whānau that they worked with.

4.5.4 The role of health social workers

In Aotearoa New Zealand, social workers have been engaged in the delivery of healthcare since its establishment (Beddoe & Deeney, 2012) and, over time, the role of social workers in health has changed considerably (Coffey, 2018; Staniforth et al., 2014). Beddoe and Deeney (2012) asserted that, in the 1970s, health social workers consolidated their professional identity, and positioned themselves as social reformists. This involved a movement away from a psychoanalytic practice approach to a more sociologically informed approach to practice that accounts for the social context of the patient. Beddoe (2013) stated that social work in Aotearoa New Zealand has traditionally made links between health and social inequalities. The knowledge base of social work practice means that health social workers are uniquely placed to consider the needs of the patient in the context of their whānau and wider ecology (Haultain et al., 2009).

Health social workers define themselves through a macro-level focus on the social determinants of health; concentrating on how the socio-cultural and economic determinants of health impact upon the person's ability to manage their illness (Beddoe 2017). Health social workers' ability to understand the social determinants of quality care creates opportunities for social work to take a lead role in transitioning people between differing levels of care, managing risk, and supporting culturally appropriate and community

based care (Coffey, 2018). Health social workers are advocates who are pivotal to safety planning for hospital discharge, as they are a crucial link between the health needs and the social worlds of the individual and their whānau (Foster & Beddoe 2012).

The National DHB Health Social Work Leaders Council and ANZASW (2018) have constructed the following scope of practice to demonstrate the diverse activities and client-centred issues that health social workers can encounter:

- Bio-psychosocial assessment
- Risk assessment, safety planning and risk mitigation
- Bio-psychosocial interventions
- Crisis intervention
- Responding to trauma
- Interventions to protect vulnerable people
- Complex problem solving
- Socio-legal issues and ethical decision-making
- Advocacy in relation to social justice and inequality/stigma
- Therapeutic social work practice (group work, therapy, counselling)
- Grief and loss intervention, and support
- Discharge planning
- Leadership collaboration and professional supervision
- Research and education
- Health promotion, preventative and early intervention. (p. 6)

Through analysing the critical incident narratives, it is apparent that the participants' work reflected the types of responsibilities, tasks, and assessments that this list represents. What was also pleasing to see is that many of the participants were also engaged in research about social work practice; this representation in continuing education and research may not necessarily be indicative of the wider health social work population.

4.5.5 Guidelines to health social work practice

To appraise the unique Aotearoa New Zealand context of practice, consideration will be given to the following definitions and classifications, the IFSW (2014) 'Global definition of

social work', the SWRB (2017b) 'Practice of social work', and the joint National DHB Health Social Work Leaders Council and ANZASW (2018) overview of the 'Aotearoa New Zealand health social work scope of practice'. These three documents provide the most prominent current definitions of practice relevant to the context of health social work in Aotearoa New Zealand. These documents sit alongside professional codes of ethics, codes of conduct, practice standards and legislation, informing health social work practice in Aotearoa New Zealand.

The IFSW (2014) 'Global definition of social work' promotes the importance of collective action and macro perspectives, shifting the emphasis away from social work intervention that is focused on individualised approaches to practice (Ornellas et al., 2018). The IFSW (2014) global definition demonstrates a shared aspiration to work towards social justice and achieving human rights. Social work practice is context-specific (Palattiyil et al., 2018) and therefore, it is important to consider how the bicultural nature of social work practice influences social workers in Aotearoa New Zealand (Crawford, 2016; Walker, 2016). The SWRB acknowledges the IFSW (2014) global definition, but also defines the 'Practice of social work' in Aotearoa New Zealand as:

> Establishing collaborative relationships with clients and their communities to overcome barriers and obtain support, based on an understanding of their history and the personal, spiritual, whānau, social, and cultural meanings of who they are and what they want to achieve....The assessment and evaluation of client situations and needs incorporating analysis of structural, cultural, social and economic issues using indigenous, social sciences and humanities knowledge, social work theories, skills, strategies and interventions. (SWRB, 2017b, p. 7)

This definition of the 'Practice of social work' is set out by the SWRB to illustrate what social workers do, and incorporates key elements of the IFSW (2014) definition. When comparing

the IFSW (2014) definition to the SWRB (2017b) 'Practice of social work', it is apparent that the SWRB definition neglects to openly acknowledge social justice action, and that social work is an academic discipline, involving professional practice (Re-imagining Social Work Collective, 2017) . Given the profession's focus on advancing social justice and human rights, this lack of clarity is significant. A later SWRB (2017a) document titled 'General scope of practice' strengthens the social justice imperative of social work within this SWRB definition of the practice of social work and includes the need to advocate in relationship to injustice, poverty and inequality. This strengthening of the social justice imperative by SWRB is encouraging as it lessens the divide between their definition of social work practice and that of the IFSW (2014) global definition.

The National DHB Health Social Work Leaders Council and ANZASW (2018) report on the '*Aotearoa New Zealand health social work scope of practice'* aligns with the IFSW (2014) definition of social work and the SWRB (2017b) definition in the 'Practice of social work' but also extends these definitions by specifying that health social workers conduct bio-psychosocial assessments and interventions. The 'Aotearoa New Zealand health social work scope of practice' document recognises that health social workers assist people and their whānau to be self-determining, safe and to manage the social effects of their ill health or disability, and the associated life changes. Aside from listing the IFSW (2014) global definition of social work and including "advocacy in relation to social justice and inequality/stigma" in the scopes of practice list, the main body of the document does not directly mention social justice action or the activist component of social work. The document does, however, state that the principles of Te Tiriti o Waitangi are to be used to address inequalities present in the health sector. In sharp contrast, the IFSW (2012) 'Policy on health' asserts that human rights and social justice are the two principal values that

frame social workers' understandings around health provision, and the right to equity in social conditions.

Boehm's (2013) research into social work values concluded that social workers aspire to incorporate professional values into practice due to the perceived importance of values in ethical decision-making. These findings are consistent with the participants' aspirations to achieve social change and empowerment in situations of inequity. The social justice foundations of the social work profession encapsulate a commitment to work for equity, to reduce the impact of negative social determinants, insufficient resources, and issues of racism and discrimination. These foundations were evident in the way that the participants aspire to practise social work, striving to ensure equity of outcome for all, working to ensure that people are empowered to be active decision makers in their treatment plans, and that their voice was heard in the decision-making process. Kim's disillusionment about violence against women and her perceived inability to inspire social change and enhance safety factors for the women and newborn infants that she worked with resulted in her changing roles. A couple of the other participants also said that they were considering resigning as their managers were likely to change the scope of their role in a manner that might change the nature of their practice. The participants valued the freedom to be creative in practice, responding to issues in accordance to their professional assessments of needs and risk.

Health social workers are concerned with health chances and health experiences (IFSW, 2012). Health chances relate to a person's ability to stay healthy and live a long life, without having their health or wellbeing unfairly impacted upon due to socio-economic, political or environmental factors. Health experiences relates to people's experiences of combating illness or of adapting to a life with illness. For health social workers this means working to ensure that people have access to healthcare, that they can negotiate treatment

decisions, or have services to manage their illness at home (IFSW, 2012). This means that health social workers have traditionally worked to confront inequalities, to improve people's access and experiences when using health services, and to challenge institutional and social policies to advocate for system change to reduce the impact of the social determinants of health (Salerno et al., 2018). The focus of the National DHB Health Social Work Leaders Council and ANZASW (2018) 'Scope of practice of health social workers' is on advancing individual wellbeing, rather than having a strong focus on addressing the social determinants of health. This emphasis is contrary to the social justice and human rights values of the profession. This altered focus by the Allied Health Social Work Leaders is clearly reflected in the tensions that the participants felt in practice.

4.5.6 The challenging nature of values in practice

The participants reported severe difficulties with trying to make systemic change to the communities that they served. These systemic challenges were experienced both within the DHBs that they worked for, and in the communities that they engaged with. Clark (2006) stated that standard social work ethics are based on liberal individualism which prescribes a minimal approach to a welfare state and requires an impartial standpoint. Contending that this requires 'value neutrality', which is hard to maintain in practice as the social work role can involve value judgements, educational features and modelling of a virtuous character. In 2006, Clark asserted that this requirement to be virtuous was starting to be recognised in the requirements for professional social work registration. In Aotearoa New Zealand, this was evident in the establishment of the Social Workers Registration Act 2003 'Fit and proper' criteria that set out the requirements of what it means to be a 'fit and proper' social worker. Clark (2006) advocated for attention to social work character as well as technical

skill and supports professional registration that addresses issues of character and attributes when determining competent professional practice.

All professions exhibit value preferences that inform practice. Theories themselves contain values that naturally align with a certain style of practice (Rossiter, 2005). Professional values do not sit in isolation from societal values, therefore professions can be perceived as accepting the sanctions that are imposed on them in the form of societal responsibilities and legislation (Hepworth et al., 2010). Clark (2006) claimed that, when values are expressed in practice, they are not neutral or independent of personal beliefs, but are subjectively based on the locality and norms of the community in which they are expressed. Social work in Aotearoa New Zealand tends to be legitimised by the state, with the state providing funding for a large proportion of the workforce; conceptions of welfare generally reflect governmental priorities and values. Clark (2006) contended that, in practice social workers and other welfare professionals are required to be personal exponents of individual liberalism, so therefore they need to personally commit to the neutrality of values.

Shardlow (2009) asserted that a focus on professional values in practice will help social workers achieve their humanitarian goals, as values serve to mediate between practice that is procedural in nature and creative practice. Ferguson (2008) expanded on this by asserting that neoliberalism has reduced the level of discussion about social work values within social work education relating this to the reconstruction of social work as an 'ethically neutral task'. The focus that this research has on values allows for a consideration of the deeply seated beliefs that the participants had about the way in which they function within the realm of health social work. The research concentrates on the participants' beliefs about what it means to practise with integrity, scrutinising their practice intentions,

the way that values inform their approach to their work and their reactions to the workplace demands placed upon them. The participants' values were not-one-size-fits-all, they were not truly universal, as they were influenced by their own personal socio-cultural context and belief system; however, there were more commonalities than differences. The commonalities were evident in their beliefs about client-centred transparent practice and how they strived to be courageous in practice.

A key finding of the phase one research process was that the participants' work centred on advocacy for the patient and their whānau within both the DHB system, and in other, related, systems. The participants envisaged the patient and their whānau holistically, from an ecological perspective and worked within the meso-system to help the patient navigate their way through their DHB journey. To work within the meso means that they are working between the patient, their family, their community, their workplace, their social networks, their schools, and the DHB. Social workers are well positioned to respond to the needs of the communities that they work with, to advocate for resources, and to develop community initiatives. The implications of working within the meso is that social location becomes very important (Ruben, 2013). Practice within the meso-system within health social work involves multidisciplinary teamwork and that requires the ability to integrate knowledge about organisational and team dynamics (Waldrop, 2006).

Health social workers employ knowledge about team processes and boundaries so that scarce resources can be effectively advocated for and utilised. For the participants, their ability to achieve results, especially in relationship to health inequities, are restricted if the line manager is not social work trained, and the other professionals that they interact with to achieve results do not hold an exosystemic view of situations (Ruben, 2013). McLeod and Bywaters (2000) asserted that, even though health social workers are well placed to

address social problems that undermine health, they face persistent issues of underfunding and discriminatory practices within the hospital system. For the participants, the lack of resources and engagement of others with the social realities of patients and their whānau hindered their ability to activate social change.

The participants occupied the middle ground, between the other health professionals and the patients and their whānau. The participants undertook control of this middle ground through creating space for client voice and challenging assumptions held by colleagues about patients, or the nature of social work practice. The participants expressed feelings of discouragement and disillusionment about power imbalances but remained hopeful about their ability to enact social change. Staller (2018) believed that social work researchers rarely enquire about how faith, hope and courage inform social work practice. What the phase one findings have demonstrated is that both hope and courage inform the way that values are enacted within health social work practice. The participants strived to remain hopeful, and be courageous under quite adverse working conditions, and the phase two interviews continued to explore the way in which courage and bravery sits alongside values, motivation and vocation.

The explanation of the three broad category headings drawn from the phase one critical incident data has now all been covered in the earlier sections, and the discussion following this has served to situate the research before considering the phase two findings. The aim of this research was to develop substantive theory about how values support social work practice, and to discern further knowledge about how value demands are experienced and negotiated. The critical incident narratives provided valuable insight into how the participants negotiated value demands in the field of health social work practice. The guided discovery approach allowed the space needed for the participants to critically reflect on an

incident that occurred within everyday practice. The element of critical reflection moved the interview on from a simple tale about practice, to a situated analysis which attends to issues and patterns of power inherent in social interactions and institutional processes (Taylor, 2013).

CHAPTER FIVE: PHASE TWO FINDINGS

5.1. Overview

This chapter presents the findings from the second phase of data collection. The phase one interviews had a strong focus on what the participants do in practice through concentrating on the participants' behavioural and emotional reactions to their practice encounters as a way of gaining initial insights into how values are experienced and negotiated in practice. As illustrated in Figure 6, the emphasis in the specific research question for phase two is on the word *understand*. The focus of the phase two interviews was on the perceptions of the participants when critically considering their collective action in terms of their understandings of the impact of values and value demands on their professional practice.

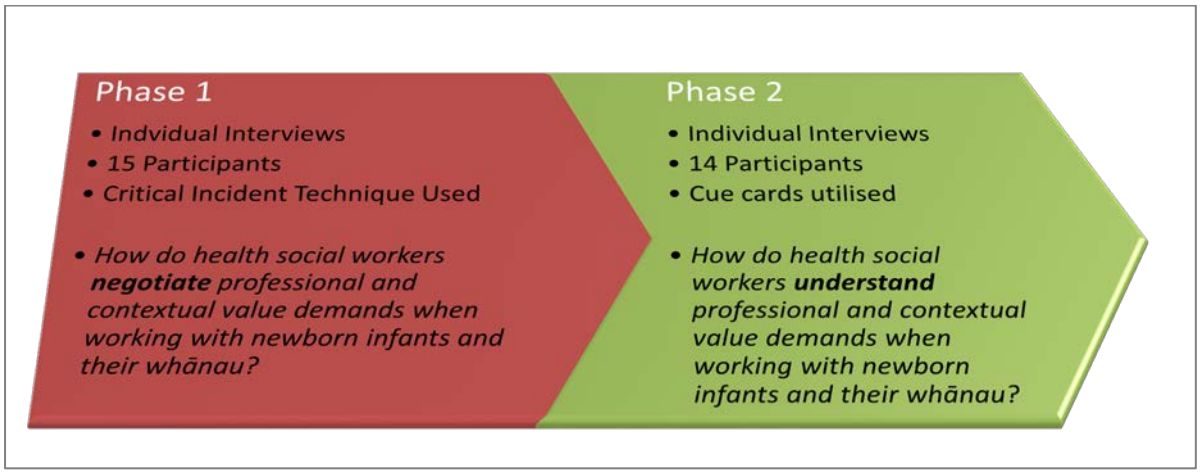


Figure 6. Data-collection process.

The cue cards formed a visual stimulus from which to extend the participants' reflections by incorporating specific information about the way in which the participants collectively experience and negotiate values. This process of critical reflection on the cue card statements generated further considerations about how values support and influence

health social work practice. This chapter presents the breakdown of the conceptual categories that emerged in phase two of the research process. As explained earlier, the phase one findings are presented in Chapter Four under these three analytical categories: *Practice vision, Work expectations,* and *Practice experiences.* When grouping and analysing the phase two findings the same three analytical categories were utilised to form the framework for coding in the NVivo project. This allowed information about how the participants experience and negotiate values in health social work practice to be traced and iteratively developed in a synthesised manner across the successive research phases. Figure 7 illustrates the sub-categories drawn from the phase two findings, which will be examined and clarified throughout this second findings chapter.

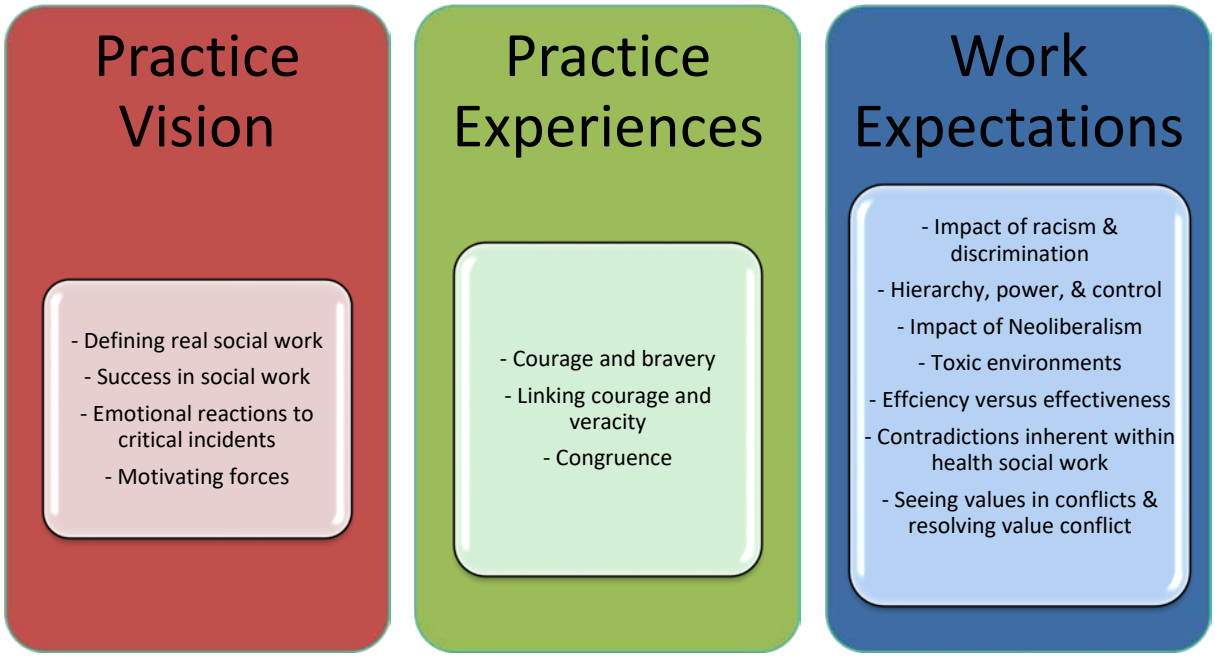


Figure 7. The three conceptual categories.

5.2. Practice Vision

The first of the three conceptual categories from the phase one findings is *Practice vision*. The specific point of interest that was explored in the phase two interviews

pertaining to the category *Practice vision* was the place of hope alongside motivations. To explain this further, the participants' dialogue in the phase one interviews was that they were motivated to be social workers in order to generate social change. The participants acted as the conscience of the ward/team, they worked hard to educate colleagues about psychosocial needs, and to create space for other professionals to understand the patients' reality. This work put them in the position of being the 'challenger', and as a source of power to patients who were finding it difficult to navigate the ward environment. The participants had hope for positive societal change, as well as systems changes within their immediate practice environment, and saw themselves playing a part in the change. Also, the participants also spoke about feelings of being disillusioned, triggered by events, and at times they felt despondent about societal issues and the systemic changes needed.

In the first findings chapter, the information listed under *Practice vision* relates to the ideals and values located in the participants' statements about the critical incident. This analytical category also conveys information pertaining to why the participants chose to be social workers, their aspirations, hard lessons learnt, and the motivating forces behind their client-centred view of success. As illustrated in Figure 8, the data analysed from the phase two interviews under *Practice vision* are further broken down and presented within this chapter under sub-categories titled: *Defining real social work; Success in social work; Emotional reactions to critical incidents;* and *Motivating forces.*

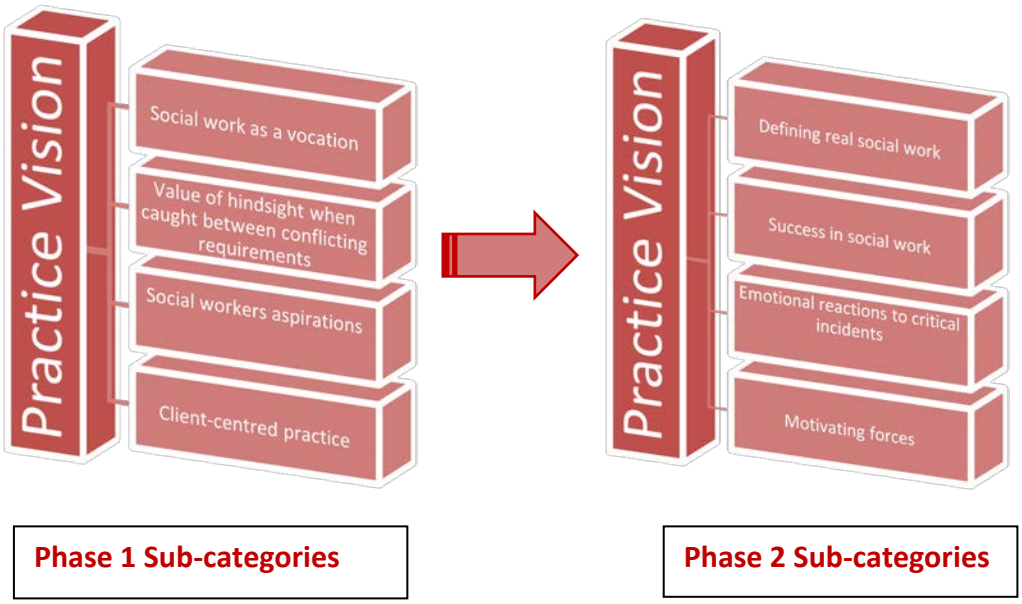


Figure 8. Sub-categories for practice vision.

5.2.1 Defining real social work

Defining social work is complex (Rode, 2017). The participant interviews highlighted that there are many misunderstandings about what social workers actually do. HG stated that "people think social workers are going to come in and take their kids or come in and something horrible is going to happen". In the phase one interviews, a prominent theme was that intensive social work conducted over a longer period of time allowed for 'real' social work to be done. As an opening question to the second interview, the participants were asked 'What is REAL social work to you?' This question was asked as a way to explore what the participants valued about social work and to probe further into their ideals about social work practice. In response to this question, the participants said that *real* social work is hard to define but acknowledged that social workers themselves have a shared understanding of what social work is. Alice's description of what real social work is summed up many of the participants' statements:

> REAL social work is about recognising that I have a very short time with clients…. it's about recognising that level of support [needed] to guide, to advocate, to empower on some level, to link people with supports….guiding them through a difficult period with resources, supports and counselling

In health social work there was a strong sense of having to wrestle with shaping practice to the fast 'conveyor belt' nature of the hospital admissions and discharge cycles. Alice uses the word *recognise* twice in the quote above, it is difficult to know who needs to recognise these issues around her work pressures – is it herself recognising these challenges, her organisation, or perhaps her colleagues? Either way, the quote reflects the need for recognition of these core components of health social work practice.

The critical incidents' narratives indicated that the participants found that a longer period of client engagement allowed a sense of increased satisfaction due to being able to practise in a more holistic fashion. The participants repeatedly commented that their most memorable work experiences were with the patients and whānau that they work intensively with through complex situations. The least satisfactory aspects of social work practice were reported to be tasks such as checking benefit allowances, allocating resources, and brokering services with other agencies. The participants conceded that these types of social work tasks are necessary, but concerns were also raised about the de-skilling of professional practice if these tasks become the core component of day-to-day work.

Joan spoke about how she saw real social work as prioritising home visits late into the afternoon, but the result of this would be that she would still be at the office until 7.30pm conducting her administrative work to meet organisational requirements. The choice to prioritise home visits over office tasks demonstrates a high level of commitment to the patients. It is questionable if these types of work habits are sustainable in the long term,

and they could increase risk of fatigue or burnout. Joan saw the administrative tasks associated with working in a big organisation as something that gets in the way of real social work. The participants expressed frustration about the time-consuming nature of administration tasks; however, they generally concluded that administration tasks are also real social work, because it is an essential function of practice. Another significant source of frustration was the amount of time spent on risk assessment and then the brokering on of work to others outside of the DHB context, in accordance with their risk findings.

Real social work was perceived by the participants to be about building relationships, about helping people, without muddling up the agencies' expectations and need for certain deliverable outcomes. In summary, it can be concluded that real social work is more than assessing risk; it is about therapeutic conversations, building rapport, establishing trust, exploring perceptions of need, and putting in place a meaningful intervention that balances the organisations' need against the patients' needs, in a compressed, time-limited environment. The next interview question in the phase two interviews built on the participants' considerations of real social work by asking them to consider what success was in social work practice. These first two interview questions were designed to be icebreaker questions to allow the participants to consider some of the key points of their critical incident and to lay the foundation for further exploration into how values are collectively experienced and negotiated.

5.2.2 Success in social work

In the phase one findings it was evident that the participants perceived success to be achieved by the participants though the quality of relationships that they had with people. Qualities linked to success were honesty, respect, and the ability to establish trusting

relationships with patients in a time-limited environment. The concept of success was further explored in the phase two by contrasting notions of success with what the participants had to say about real social work. This was done to get the participants to begin to reflect on whether success is defined by the organisation or defined by internal perceptions of good social work practice. The table below summarises some of the key statements made by the participants when they considered what success meant to them in terms of their health social work practice.

Table 2.

Considering Success

Considering success	
Tania	In relationship to the critical incident Tania achieved success through being able to address issues pertaining to colleagues' behaviour appropriately.
Sandra	Sandra believes she achieved success through being able to go beyond the requirements of a task to establish rapport, and resolving issues pertaining to hospital processes. In her example, Sandra acted as a mediator and advocate, helping the woman navigate hospital protocols and assisting staff to understand the emotional impact that the specific ward rule in question had on the woman.
Joan and Kate	Joan and Kate both defined success in terms of overcoming systems-related barriers put in place by midwives and the organisation, or being able to prolong treatment and delay discharge.
Jo	Jo expressed pride in the fact that she feels that she really knows the women that she works with and links the level of engagement to some of her success in practice.
Myrtle, HG, Kate and Halyn	All saw success as patient empowerment, with the patient feeling heard, less frightened and more able to cope. This process of empowerment was often done through normalising experiences, in order to begin to seek solutions.
Jo, Sarah, Sally and Joan	All considered success primarily in terms of trust, with some of them linking success to issues of dignity, worth, respect and positive change. "success means trust, if someone trusts you enough to tell you things that potentially they've never told anyone else, that's success for me…and good outcomes for families" (Sarah).
Alice	Perceived success as being a relative term, with social workers defining success through their code of ethics, organisational expectations and policies.

Sarah and Zenda	Acknowledged that success involves hard decisions, as success from a social worker's perspective might be achieved through making sure that the child is safe, whereas the whānau may disagree with the intervention approach and associated outcome.
Mary	For Mary, success is achieved when the client understands what is going on in their life and can find a pathway through. Mary believes that social workers are not always around to see the success that their intervention has propagated. Mary saw success in terms of empowerment, stating that it is the social worker's role to "help them look at options, to sow the seeds, and give them some tools to keep the weeds out, and water the garden so the seed will grow into a crop, which they will reap further down the line".
Mabel	Success was being able "to leave the door open for [people], even if it's not with you, with somebody else if it raises stuff with them".

In summary, the table above illustrates how success was defined by the participants in terms of professional and relational factors, and by elements external to themselves. The participants perceived success to be achieved incrementally and over time – this caused issues for the participants, as they believe that, as an organisation, the emphasis is on moving people through the DHB system quickly.

5.2.3 Emotional reactions to critical incidents

> I would say being a social worker in an MDT is like being married to ten different husbands, who all have different needs and wants, that may or may not have anything to do with the client and they're all important now and you've got to stand back and figure out what's really going on and who is most important. The other part of that is we're containing not only the client's distress, but the family's distress and often the staff's distress – so we've got to contain all of that, and manage that, before we get to manage our own distress. (Mabel)

The critical incidents engendered strong emotions for the participants, who used words such as 'haunted', 'triggered', 'torment', and 'regrets,' to describe what they felt to be an impact of failing in practice or a failing in process. The emotive language used to describe the critical incidents highlights the emotions the participants felt when they had

not achieved ideal practice. I used the phase two interviews to explore the participants' emotions further, through contrasting the participants' aspirations to do their very best for the patients, against the issues with funding, lack of time, space and resources. This process was designed to consider the participants' ability to be resilient in such a fraught practice environment. Given that the participants appeared to try hard to control variables that were often outside of their jurisdiction, I wanted to know more about how these high aspirations linked to their professional values.

When questioned about these feelings of needing to do better, Sandra spoke about how she had to be very focused on professional boundaries to ensure that she did not take action to make herself feel better, at the expense of the patient. Due to the intensity of emotion that she felt regarding the critical incident, Sandra got an alternative social worker to do follow-up work with the patient when she was readmitted, to ensure that the patients' right to privacy was respected. Myrtle thought that perhaps social workers feel that they have more influence over outcomes then they actually do, and therefore get disappointed in themselves when things do not go to plan. Myrtle felt that her sense of frustration was heightened due to her acute awareness of inequality and her need to make a difference. Kate said that she tries to use situations where things do not go to plan as a way of grounding herself in the patients' reality, as a lesson to reflect on how patients can experience issues of power and voice. Kate stated that these experiences are "a reminder… to remember what it's like to be in that position, to experience some helplessness, some powerlessness". Sally linked these feelings to social workers' motivation to wanting to only do good and do no harm. She said that practice conditions are not always ideal, and at times, there are no supervisors available for support. Sally acknowledged that, due to the nature of care and protection work, she often knows that the outcome of her social work

intervention is going to have negative elements. Sally said that in these moments she is aware of wanting to do the best that she can, while managing the risk of being scapegoated by the DHB if something goes wrong in a practice review. This type of commentary was common throughout the participant interviews, and it speaks to that of a punitive environment in health social work, in which social workers are not experiencing a 'just culture.'

Halyn stated that anyone working in critical situations struggles with these types of emotions and needs to accept that it is not possible to be working at your optimum all the time. Halyn made the link from these types of feelings to the need to maintain self-care strategies, stating that "over time social workers learn that resilience is about coping". Halyn believes that a key to resilience in practice is the quality of the relationships that you have with your colleagues and the team dynamic. This statement indicates that Halyn does not see resilience as being an individual trait, but something that relates to the structure of the team, the workplace dynamics and collegial relationships. HG highlighted the importance of supervisory conversations when feeling strong emotions, stating that "you've got to have a way to make peace with your ideal practice and your actual practice, because I think there will be gaps" Kate stated that some of her work is really "rewarding and incredibly privileged". When questioned, Kate explained what she meant by this, she reflected on the rewards of being there for people during traumatic experiences. Kate indicated that, for her, success is ensuring that whānau are supported well within the ward environment, and she appears to feel humbled by her involvement with whānau at this time. Kate links these feelings to her motivation to continue practicing social work and feels successful when she manages to "take the sting out of" a trauma.

Social work as a vocation and experiencing success in practice were both motivating forces behind the work that the participants do. The participants were focused on what success meant for them, in terms of good social work practice, rather than the ideals of the DHBs that they worked in. They were also pragmatists, in that they had shaped their professional practice to the fast-natured realities of the wards and the various practice environments that they worked in. They appeared to have adapted their practice to the communal norms and standards of their inter-professional teams while still managing to maintain their own professional standards about what real social work should be within that environment.

5.2.4 Motivating forces

The phase one interviews examined why the participants wanted to become social workers, in order to consider the values that underpinned the participants' practice vision. In the phase two interviews, more time was spent considering the participants' motivation to practise social work and their expressed need to make a difference was explored further. As advocates, the participants were often able to achieve extraordinary things. The participants' motivation to help others did not sit solely within the confines of their caseload, and they recognised the power that they had through their professional skill base to make a significant difference in people's lives. The participants acknowledged that their initial motivations to practise social work have not changed over time, but aspects of their practice may have. The participants acknowledged that, over time, they have become less easily swayed by others and clearer about their professional role within health.

For the participants, being a social worker appeared to be woven into the fabric of their being; it had become a substantial part of their identity. In the phase one interviews,

all but one of the participants saw social work as their vocation. When considering her motivation to practise social work, Myrtle acknowledged that "I think I'd find it quite difficult to do another type of work and feel satisfied." Participants gave examples of things they had done to assist patients, staff and others around them, which made them feel triumphant, and allowed them to feel successful and able to make a difference. They gave examples of their success stories that they had achieved through their advocacy, such as securing free flights through the National Airline for whānau to see a dying baby or advocating in writing with a governmental department to have a substantial tax debt waived.

The phase one findings included a quote from Mabel "only but for the grace of God go I", the participants spoke a lot about how they would struggle to cope if they had to deal with the circumstances that some of the whānau that they worked with were coping with. This sense of empathy and ability to consider life from other people's perspectives remained a strong theme in the phase two interviews. Some of the participants stated that their views of social justice stem from their upbringing. They thought that they view the world through an empathetic lens, and it is apparent that they are motivated to work towards equality of opportunity for service users. Zenda stated that because of this need for fairness she gets frustrated when people have deterministic thinking about peoples' past behaviours, and she upholds the core social work belief that people can change. Halyn reflected on watching her mother being disempowered by whānau violence and believes these experiences have laid the foundation for her to be active in women's rights. Halyn stated that:

> I feel that my practice in working in women's health and the rights of women, and the protection of women is very congruent to me as a person…and it hurts me when I see women disempowered. I want them to dig in and find their strength.

For some of the participants, the power that they had to define their role, the success that they achieved in practice, and their ability to be creative within their role were the key reasons that kept them motivated. Sarah noted that:

> Compared to Oranga Tamariki where you daren't sneeze without speaking to your supervisor first, I can do whatever I want over here. So, if I was actually [practising] without integrity, and I was poisonous, and I was meeting my own needs. I've got a free range to do that.

This level of freedom also reflects the trust that DHBs place in the professionals that they employ, as trained registered professionals they are expected to be able to make good judgements and work independently in practice. In the phase one findings it was evident though, that, while the DHB accorded them the independence and trust as a professional, their non-social work colleagues did not always do the same.

Sarah then went on to state that she has really high standards that are informed by her values, her work ethic and a need to fight for what she believes is right. Sally's response to the question about what motivates her social work practice was "this is people's lives, and I want to do the best I can for their lives". Many of the participants made statements akin to what Sally said about her motivations in practice; they recognised the limited social work resource that their DHBs were funded to provide and worked hard to make a difference. Most of the participants practised as independent professionals, and this was something they valued about health social work practice. The participants worked under a high trust model within their DHBs, and they expressed satisfaction that this trust enabled them to adapt to the varied work that they needed to respond to, be innovative in their practice, and practise in accordance with their values.

5.3. Practice Experiences

The second of the analytical categories to be presented is *Practice experiences*. The key feature of this conceptual category is the way in which participants considered courage alongside veracity in their professional practice. The participants spoke about issues of power in both phases of the interviews; they reflected on experiences of feeling powerless, as well as the power gained. The participants gained power in practice through critical reflection, systems critiques, from holding onto a strong social work identity and having a resilient social work voice within their organisation. Challenging was a salient theme that emerged from the phase one interviews, with the participants challenging professionals to be more client-centred and open-minded. They also challenged systems and other professionals about issues relating to bullying and professionals oversimplifying risk-laden situations.

The phase two interviews were used to explore the impact on the participants of the work that they did to address issues of hierarchy within the medical model. The phase two interviews examined the impact on the social workers of the negative labelling of patients. This second round of interviews progressed understanding about how the participants experienced and negotiated issues of racism and discrimination. The interviews provided the scope to further consider the work that the participants did to become trusted members of their medical teams. The research findings illuminated the links between the participants establishing trust within their practice environments and them being able to hold onto their professional power and practise authentically within this space. Considering that the participants are professional practitioners, trust should not be something that needs to be so hard won.

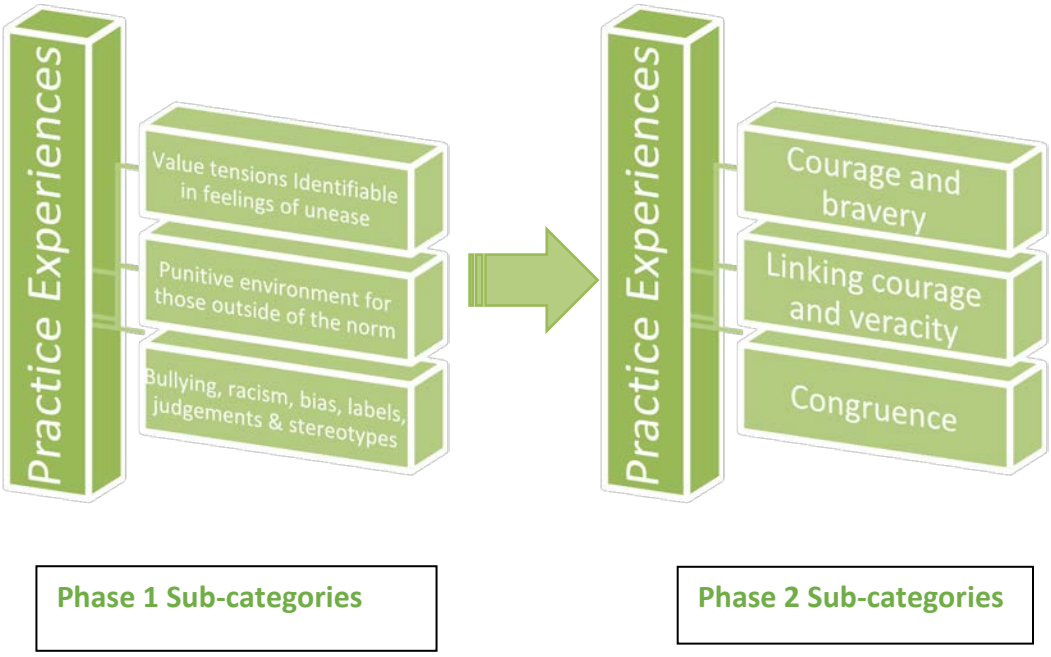


Figure 9. Sub-categories for practice experiences.

5.3.1 Courage and bravery

Courage and bravery were salient themes in the phase one interviews. The need to be courageous was attributed to the way that the participants felt that their practice mandate was at times at variance with the DHB practice environment. These feelings of incongruence resulted in them feeling conflicted and to challenging workplace norms. HG stated that conflict:

> …thrives when there's secrets, lies, and dark corners; and things that aren't spoken. If you can shine the light…maybe you become a casualty of the light, but actually when that [conflict] has to be taken into account, no longer can that fester and grow, and more of us have to step up and say "no, that is not ok".

During the phase two interviews, the participants were all asked this question: 'How does courage and bravery sit alongside values, motivation and vocation?' In reply, the participants generally perceived that they use courageous conversations to enable decisions

that were congruent with their values and practice motivations. In response to this question, Zenda stated that she uses “the principles of justice to make decisions”. Hayln spoke about not having a choice and finding that she had to speak up to advance women’s rights, even if that meant speaking out about DHB management practices. The participants saw courage and bravery as part of their everyday lives and considered themselves courageous in practice. The participants spoke about dealing with violence and referred to situations such as being in whānau meetings with people who had threatened to kill them. They reflected on practising under the threat of violence, giving examples of situations such as having the police on standby with tasers in the next room, in case they were needed.

Alice stated that health social work “takes a hell of a lot of courage” due to the hierarchical structures that underpin the medical model. Alice believes that doctors sit at the top of the hierarchy. The participants spoke about doctors managing the medical risks, while social workers are often the sole psycho-social voice managing social risk factors. They spoke about the fear that this sometimes induced, and the confidence that they needed to have to assert their professional opinion. Tania stated that, compared to working with a violent whānau, she needs a lot more courage to speak out against another colleague. Tania stated that if it is in the best interest of the patient, then she will speak out against a colleague, despite the risk to her reputation. Tania acknowledged that no one wants to be perceived as the person who makes trouble for colleagues.

Repeatedly, the participants referred to working with adversity, using the language of violence with words and phrases such as ‘fighting’, ‘casualty’ and ‘going into battle’. When discussing these types of difficulties, they are not referring to their work with patients and their whānau, but with colleagues, hospital systems, and management. The participants

had a heightened awareness of systems issues, which they linked to politically driven managerial techniques informed by neoliberal perspectives – alongside issues with hierarchy that exist within the medical model. The energy that the participants expended fighting these 'battles' clearly exhausted them, frustrated them, but also highlighted to them the importance of their professional view and voice within a hospital environment. Due to this sense of 'battling' for issues of respect, fairness, equity and participation, the participants' social justice focus and voice within the medical model enabled them to have clarity about their professional values in practice. HG stated "I don't think we ever really think about what our values are until our values are tested. We might say we are an ethical practitioner, but we don't really know what that means until we find ourselves at that ethical edge."

The conflicted practice environment also sits outside of the hospital due to differences in the professional focus between health social workers and Oranga Tamariki social workers. The participants spoke about the statutory power that Oranga Tamariki has, stating that "the Oranga Tamariki social workers remit trumps [ours]" (Sandra). Kate, Halyn and Mary expressed concerns about the way that Oranga Tamariki is not always transparent in their processes, citing issues of consent, continuity of process, and use of coercive power to compel action. The participants expressed frustration about the lack of consultation with parents and support for them, asserting that parents have a right to be part of the decision-making process and a right to understand what is about to happen to them. The language of violence was used when speaking about the working relationship that the health social workers had with Oranga Tamariki. For example, when Sandra spoke about a patient that she was supporting, alongside Oranga Tamariki social workers, she said "there is going to be a turf war" to ensure that her professional judgement regarding risk levels was listened to

by them while the baby remained in the hospital. When reflecting on the conflict that the different professional imperative places on social workers, two of the participants stated, without prompting, that they could clearly envisage the different values underpinning the role conflict. If questioned directly, more of the participants would have been likely to be able to discern the value demands too, given their ability to be clear about how values were experienced in practice. The participants spoke a lot about the way they had a stronger focus on maintaining the integrity of their relationship with the parents compared with Oranga Tamariki social workers whose focus was perceived to be more concentrated on the risk-assessment process that underpins statutory care and protection social work.

Joan contemplated the impact of "social workers battling management, the wider MDT battling social workers" and feeling like you "never knew where you stood or were with anyone". The impact of persistent wrangling with colleagues meant that Joan felt like she had to constantly build rapport and trust to win people over, with a lot of time and energy devoted to proving oneself and creating space for relationships to grow. Conversely, honest transparent conversations are often courageous conversations, and these conversations were had with colleagues, and patients and their whānau. Joan stated that:

> …having courageous conversations with people, going to those places people generally don't go or asking the questions people are too scared to hear the answer to, and there's a sense of, not necessarily pride, but there is a sense of like we can do this in a sensitive, respectful, dignified way.

Joan's quote portrays a sense of pride in the skill base of the profession; she acknowledges the courage that social workers have every day in the difficult situations that they address with people during times of trauma or crisis. While having these transparent conversations

the participants reiterated the need for social workers to have established rapport, trust and be acutely aware of the possible consequences of their words.

5.3.2 Linking courage and veracity

Through listening to the participants' dialogue, it became apparent that the participants felt that if they are being true to themselves, then they felt that they could be courageous and work to ensure that their professional opinion was heard. This level of courage involved being truthful in their approach to others, and the participants being transparent in their practice. Kate stated that she finds honesty in professional practice removes barriers and finds care and protection practice where, occasionally, information is withheld from the parents due to safety concerns for the baby most difficult. Jo also puts a lot of weight into being honest and feels that at times she can be too transparent. Jo stated that, when introducing herself to new patients she tells them that she will be completely honest with them until she feels scared. Jo said that people usually laugh when she says this, but she corrects them and reiterates that she will tell them everything she is doing unless she fears telling them. Jo said that she does not think she is courageous in practice but wants people to be clear about what to expect from her, and what her limits are.

A Scottish study into how newly qualified social workers (NQSWs) navigate practice found that "honesty, openness, empathy, respect and anti-discriminatory practice emerged as professional values NQSWs felt most able to demonstrate" (Grant et al., 2017, p. 51). This demonstrated ability to be honest in practice may be a social work practice norm, but it still takes moral courage. Some of the participants did not want to label their work as being courageous or brave, stating that it is just part of the job. But Zenda observed that being brave and courageous was part of her everyday life. Zenda stated that the process of being

involved in this research has helped her realise that, in her work to empower others, she is congruent in both her personal life and her professional one. Kate stated that she is not courageous in her personal life but agreed that she is courageous in her professional life. Kate felt that she has a calm, gentle and kind approach to challenging people, and asks guidance from a higher power to help her in difficult situations.

Sandra stated that she is not often courageous for herself at work but stated that although she has "taken on senior management a few times", it was more for the benefit of the whole department or team. Sandra thought it would be quite hard to stand up for solely her own interests, and when she reflected on this, she was surprised by her reaction, stating: "I actually find that quite hard, which is weird because I say I've got all these skills, why wouldn't I use them for myself?" Sandra noted that "it's important that you are always truthful, honest and transparent, because that's the best way to avoid those massive guilt trips that can go on for years." Stating that honesty is the best policy, as she would rather deal with the consequences immediately than have to worry after the fact. Mary felt that colleagues are frightened of her due to her ability to speak her mind and challenge practice. Mary stated that she finds this opinion of her incongruous as she does not like conflict and believes that she is incurring a personal risk through speaking out about controversial issues. Mary likened her courage to speak out regardless of who she was speaking out to as *'*stupidity*'*; she then stated that "you take a lot of personal risk in social work, and the risk is losing your job, your reputation, your profession".

Sandra believes that many people in her social work team have a similar level of integrity to her; she also stated that there are some that she would not trust. Sandra felt that being truthful with some colleagues could place her into a position of "being bullied,

dictated to, and things happening to you, rather than with you". Sandra reasons that conflict arises when you know that you need to have courageous conversations to uphold your values and professional boundaries, but you lack the courage to speak out and take action. Sandra believes that she sees this type of conflict all the time in the social work team, and that she sees social workers sitting back and putting up with unsafe situations.

The link between courage and veracity was evident; however, there were also times in the phase one interviews when the participants talked about using deception due to differing opinions on risk. I used the phase two interviews to explore how, in environments that are perceived to be punitive and full of distrust, social workers do not always stand up for their professional opinions, choosing instead to take covert action to achieve what they believe to be the best result. Alongside of this were management structures that did not fully understand professional social work practice, and a need for line managers to micromanage decisions around risk or, more specifically, interactions with Oranga Tamariki. Many of the participants pointed out that, due to DHBs' internal policies on child protection, all suspected abuse must be reported. At the time of the interviews, the participants perceived that Oranga Tamariki risk thresholds were rising, and they felt that the result of this was that a lot of the reports of child abuse or neglect were not being fully attended to. Mabel's frustration about the lack of action by Oranga Tamariki is evident in this statement: "we will report it, but it goes nowhere, so how many times do you have to report it before it becomes an issue? And we don't report lightly". The participants expressed huge concern about the uncertainty about the changes being made to Oranga Tamariki and what upcoming legislation will mean for children in need of care and protection. They also expressed concern about how the health social workers will be resourced if Oranga Tamariki were to become devolved.

When questioned, other participants clearly remembered situations in which they manipulated information pertaining to child protection issues to achieve action by Oranga Tamariki. The participants would contact Oranga Tamariki and subtly imply that the baby is medically ready for discharge a week or so in advance of the true timeframe. The participants justified this type of deception stating that Oranga Tamariki "needed a bit of fire under their belly just to get them moving" (Alice), and would also assert that a hospital is not a good environment for a baby. If you frame this type of action in terms of social justice and empowerment, it is possible to perceive that the social workers used this tactic to gain power, and were acting as the voice of the baby, as the baby needs to be settled in a stable home environment. Alice took a consequential approach to this type of action despite acknowledging the action to be "faulty and inappropriate', stating that 'I actually think it is okay. I think it is how we operate in this world, it's for the greater good"' Consequential thinking like this always needs close attention to how the utilitarian concept of 'greater good' is defined; in supervision is important to be aware of these types of conceptions. There is often no immediate right or wrong in these types of scenarios that link back to the greater good; they are frequently high stakes situations that are laden with dilemmas, and as such, critical reflection will assist with making the unconscious conscious.

Regarding managing risk, Joan spoke about her manager directing her to take an unwise course of action, about feeling unable to persuade her line manager that the action was unsafe despite her best efforts. As predicted, the situation deteriorated, and Joan felt that she carried the blame for the ill-advised course of action. Joan believes that, because of this experience, she is now quicker to defend herself, and less trusting of managers. Joan also spoke about no longer being hesitant to speak to hospital hierarchy about risk situations, having learnt the importance of liaising directly with hospital lawyers about risk

situations for vulnerable patients in situations of conflict. Another participant employed an employment lawyer to assist her with unfair Human Resources processes driven by her line manager. One of the participants demonstrated the capacity to get legal advice to advocate for a Disability Commission investigation into a complaints process about a misdiagnosis. Mediating on this matter was something that took significant professional courage as she put herself against professional colleagues at another DHB; when reflecting on the courage that it took the participant stated: "I thought fuck it, this is really bad…I just thought no, fuck you, I'm not ashamed of doing this, you guys fucked up and you know, the least you can do is say that". For this participant, having the health professionals acknowledge this mistake to the patient was vital to achieving redress for the patient involved. This type of thinking presents social justice as a restorative process, seeking recognition and balance.

Some of the participants spoke about survival strategies of being passive or being strategic in the choice of which 'battle' to fight, or how covertly they dealt with a particular issue. The impact of heavily established workplace norms made it tricky to be the lone voice challenging. Sandra observed that because some norms were so entrenched that people would just leave rather than try and fix the problem. However, one participant noted that social workers at her DHB were becoming more political and assertive about challenging workplace directives. Noting that "people are now starting to come forward and complain about things, using Human Resources more, using the [union] more."

A participant spoke about times in which efficiency was prefaced over effectiveness due to staff shortages. She spoke about the tactics that her team had to try and challenge management about the staff shortages that they faced, stating that they would "personally invite people to different meetings to verbally persuade and advocate for the staff". Due to

staff shortages and overwhelming workload, their social work team developed a complexity rating so that they could prove to senior leadership the type of work that they were having to prioritise and complete. The participant said that this process enabled a conscious decision that patients and their whānau with lower risk situations were not going to receive a social work service. She then reflected on the efficacy of this, as these patients can then resurface with more issues later. She gave an example of this, citing an experience in which she gave a patient deemed to be 'low risk' a form to fill out, without conducting an assessment. Later, she then had to visit the patient's house and found them living in substandard conditions, without the cognitive capacity to complete the form given previously. This participant stated:

> …sshh, don't tell the boss…when we had restrictions on how many home visits we would do, I would just slip out and go and do a few extra visits, or do a few extra things, and just hope that no one would notice. I guess from a health and safety point of view that's appalling, but when you know the situation that somebody is going to continue living in, you can't not do anything about it.

When considering efficiency versus effectiveness, this participant said that the decisions that she made around doing:

> …an extra home visit or taking a client to WINZ or whatever it was that I was doing that I felt like I shouldn't be doing, it was because I knew that it wasn't necessarily an efficient use of time, but it was an effective use of time and if I'd been audited then actually the work that I did would be valued.

She justified these actions by saying that the work would be valued as, in the incident that she was referring to, her actions prevented an unsupported woman and her newborn baby from being discharged homeless.

Many of the participants acknowledged that they set high standards for themselves and recognised that their values and work ethics inform the standards that they set for themselves. Sarah said that she fights for what she believes is right and feels that she has done a lot of communicating with her team and other people within the organisation to ensure that professional standards are met. Sarah stated that, as social workers within the DHB, "we've been so isolated from one another because we've lost rooms, we've lost space, we're working really in isolation under a lot of risk." Sarah believes that social workers across wards need to connect to reduce isolation and tries to arrange events to ensure this happens, asserting that, despite the isolation, she is not disillusioned.

Issues with hierarchy and bullying were a common theme within the participant interviews. Some participants were concerned about newly qualified social workers' ability to hold onto their social work mandate, and not be dictated to about the needs of the DHB as opposed to the needs of the patients. Two of the participants reflected on experiencing manipulation and emotional abuse in their first social work positions. One participant reflected on the experience of being a 'young social worker' in a large hospital and resigning from the job after a few years of work due to issues with bullying and intimidation from social work colleagues. She stated that, as a novice social worker, she was "…still being pruned and shaped; and I felt intimidated, I felt scared, and I felt like I was being judged." She believes that, as a beginning social worker, she felt that her professional values were still developing, and now that she is an experienced practitioner, she is more 'abrasive' and less likely to be influenced by others. Due to this negative experience, the participant was so disillusioned she nearly left the social work profession completely, but after a short period of 'healing' she realised that she had "become a social worker for a reason" and returned to the profession. Mabel acknowledged, too, that now she is an experienced practitioner she is

less influenced by the ward staff but noted with amusement that she had trainee doctors trying to tell her how to do her job. Mabel's response to these trainee doctors was:

> What, get off! I don't tell you how to be a doctor, don't try and tell me how to be a social worker thank you. Don't tell me I need to go and xyz, when actually I know how to do my practice, thanks.

One participant talked about having a sense that management tried to make social workers vulnerable through deliberately rotating them through positions and wards, to keep them busy and unable to stand up to bad management practices. The participant stated that:

> I'm at the top of my game over here, so I'm pretty confident and competent at what I'm doing, so I'm not nervous about stuff, which allows me cognitive space to think things through about what they're [management are] saying, whereas if they can blind people with science or you've just walked into the job you don't know any different.

The participants believed that one cost of standing up for your values in social work practice or within a health setting could be that you would be disciplined if you did not manage the process well through being technically competent in your processes. Sarah cited an experience of being reprimanded in a public forum for speaking out about what she believed were deficient processes underpinning a hospital employment issue. Joan felt that the managerial issues were endemic, and that there was no point in speaking out, as there were so many conflicts and bullying tactics going on. She witnessed people in senior leadership fighting amongst themselves in front of junior social workers and believed that to take a stand against the aggressive behaviour would end up with her appearing naïve or "some sort of Pollyanna type" person. Joan also said that through observing these types of conflicts, she believed that people's values were made visible when they were in conflict

with others. Joan stated that “what was interesting is that some of the values didn’t necessarily contradict each other, but the way that they were advocated for caused conflict.”

Alice believes that due to her years of social work experience she can quickly identify conflicting values contained within practice dilemmas but acknowledges that sometimes she is just too busy and therefore less likely to “see the forest for the trees”. The participants indicated that, during times of dealing with too much pressure, they are unable to conduct the big picture thinking that is needed to envisage values at play. The pressure can make them feel disillusioned and tired of battling management and systems. They indicated that, when under pressure, talking with supportive colleagues, an effective manager or supervisor assists them to see the bigger picture to refocus on what they believe to be the important aspects of their practice.

Alice thought that success in practice was about integrity, commitment, responsibility and adhering to your values and ethics to maintain professional credibility. In complex situations of conflicting values, Alice believed that good supervision helped her maintain her practice, so that she could continue to feel credible and successful in her work. Alice indicated later in her interview that, in order to have power in practice to advocate for patients, she had to feel credible. She described being credible in terms of having evidence to justify her statements, knowing that her notes are clear and detailed, debating issues with colleagues to come to a point of agreement and having good communication with everyone involved.

Sally stated that when she starts to feel exhausted by day-to-day practice, she consciously steps back, becomes more mindful and considers the need for personal and

professional development, to focus on her goals and what needs to be done. Some of her goals related to creating a healthier team dynamic, or developing assessment tools, and were often related to improving wider systems within the hospital environment. Sally believed strongly in the place of hope within social work, the belief that things can change is central to her motivation for practice. Sally said that her sense of hope dwindled the most when she felt that the negative elements of the ward culture were not changing, and that when she lost hope, she momentarily could not see the point in continuing to practise social work. Sally explained this by saying:

> If you don't have hope for things to be better or different, why would you take the risk? Why would you put yourself out there? Why would you be transparent as being part of being courageous? Why would you even be courageous if you had no hope….there is no point.

The participants viewed the hospital management as needing to take responsibility for shifting negative workplace dynamics that they had experienced within the hospital. At a grassroots level, they tried to react to issues that occurred in front of them but given that some of the bullying and toxic behaviour existed with some of the management hierarchies, they felt that they had limited ability to be successful in generating positive change. Sally was most concerned about the racism and bias that existed on some of the wards stating that the "bureaucracy actually creates really negative culture amongst some of the staff on the ward around their job and that will actually have a negative flow-on impact to patients, and so management has to answer to that as well." Kate stated that all staff need support to manage the vicarious trauma that they witness through working in a hospital. Kate believed that hospital management are responsible for ensuring that workplace supports are in place, so that all staff respond appropriately to patients and whānau all the time. Kate

believed that all hospital staff need to be taught how to use peer supervision processes effectively and noted that the debriefing services that the social work teams provide to nurses are not always effective due to shift workers being unavailable to attend.

5.3.3 Congruence

> I am a person that if I feel really strongly about something, I'll just keep at it. I feel like I'm quite a strong advocate for families. I will let a lot of things slide but when it comes to things really core issues, I will just keep going. I will just keep being that annoying person, all the time, but I don't care what people think about me because it's for the great good. (Sarah)

When asking the participants about whether they feel congruent in practice, many of them acknowledged that they are feeling disillusioned and beaten down by the system. Mary talked about being sick of fighting management. Mary said that when she does come into work without her normal 'passion and verve', she feels guilty and experiences a sense of personal failure. Mary stated that lately she has been noticing that because she is feeling tired, that she is more likely to comply with management and take a path of least resistance. The participants believe that it is harder to take action for social change now, with one participant stating that:

> It's not like the old days where you'd go to the local MP and start getting them to start making a noise. If you do anything like that, you actually get hauled up and your disciplined for it because you're not allowed to do things like that these days; which I've done in the past, but that's seen as a risk [now]. You're not allowed to write to the Chief Social Worker of Oranga Tamariki when you've got real concerns about what's been happening with something to do with their babies and processes and that is because that's a risk to the DHB and it's not putting the DHB in a good light.

Mary said that she believes that the radical element of social work is not so evident now because people are worried about mortgage repayments if they lose their jobs. This sentiment is confirmed in Kate's statement where she states that she is tempted to speak out about issues of homelessness and the lack of resources available but admits feeling gagged because of "really strict policies in the hospital. If I'm unemployed I'm not helping anyone, so I wouldn't make that move."

Two participants were not working as social workers at the time of the phase two interview. Both participants stated that they had recognised that they needed a break due to feeling burnt out, that they had lost the ability to be resilient in practice. One participant said that that because she was burnt out, she was not practising social work adequately, stating:

> I want to be passionate about it [social work], I want to be loving it, I want to have all the hope and have the courage, and have all of that to do really good social work, and if I'm in the space where I'm not able to do that then that's not congruent, and you need to step out, re-energise, and get back so that you are doing great social work that is congruent with who you want to be and what you think social work should be.

Joan feels congruent in practice, able to maintain the core values of what she believes social work to be but acknowledges that, when under pressure, her practice may vary. Joan also stated that:

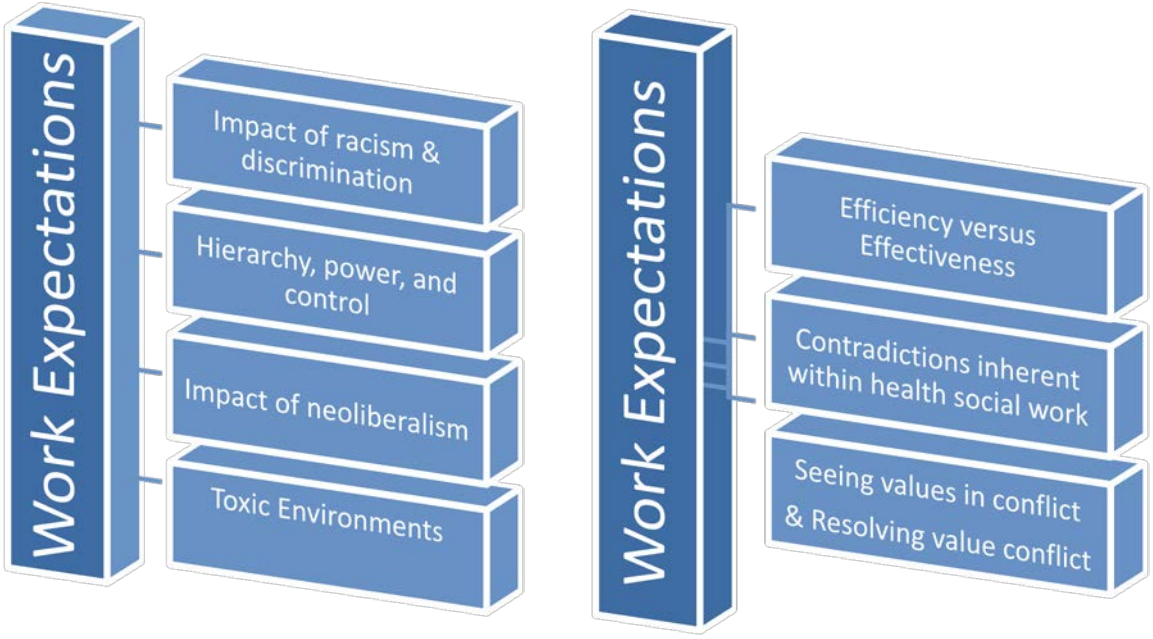
> …hope is one of those reasons why I'm still a social worker, and why I haven't moved on. I'm sure I could find a lovely job in IT or administration somewhere, and it would probably be as boring as hell, but you don't do this work if you don't believe that things could be better, and will be better, there's no point.

Alice said that “hope lies eternal in the human breast”, and she sees the social workers’ role as inspiring hope in patients, supporting them or subtly engineering situations so patients can see that there is some hope in their situation.

5.4. Work Expectations

The analysis developed under this third and final analytical category relates to the way in which power is managed within health social work. The feelings of power that the participants had, and the way in which they experienced other systemic issues relating to power. The participants were encouraged to reflect further on the expectations that the health sector has about how social work is practised within DHBs. Conceptual categories that emerged from this segment of the phase two interviews related to neoliberalism. Illustrating how neoliberalism shapes resource allocations and conceptions of risk, how risk to DHBs’ professional reputation can be a key driver of social work action; and subsequent restrictions that inhibit social work decision-making due to the way that risk is managed and resourced. The participants described a toxic hierarchical environment within health, in which their practice is under immense pressure to be compliant to the organisation, due to feeling powerless, and the fear of receiving a bad review, or punitive threats of discipline. The phase two interviews were used to explore how the participants practised with courage and creativity, given the way that their practice is situated within such a hierarchical environment.

Phase 1 Sub-categories



Phase 2 Sub-categories

Figure 10. Sub-categories for work expectations.

5.4.1 Impact of racism and discrimination

A prime example of the types of organisational issues that the participants were challenged with are the coded and analysed statements made by the participants pertaining to racism and discrimination. It was evident right from the start of data collection that issues of institutionalised racism have had a substantial impact on the participants. Racism and discrimination were prevalent themes in the phase one interviews, with social workers spending a lot of time educating other staff members about other people's reality and working to counterbalance issues of racism and discrimination. When questioned about issues of institutionalised racism or class in the phase two interviews, the participants acknowledged that racism within health systems is a significant problem that they often try to rectify. There was a strong thread within the phase one findings of the participants challenging issues of racism or discrimination, with participants acting as the social conscience of the MDT team to try to ensure safe access to health services for all.

Attention was given in the phase two interviews to the participants' feelings that anyone who sat outside of supposed norms was more open to judgement from the medical staff. Kate felt that this attitude related to the workload that health professionals struggled with, stating that compassion fatigue feeds into some of the judgments made, as anyone who needs more support can be then perceived to be exhausting. A few of the other participants felt that the middle classes, and older first-time mothers also get judged for asking too many questions, or for wanting to be in control of decisions made. Sandra felt that ward norms around class and race do not affect her ability to adhere to her professional values because the ward staff "[expect] me to challenge and I usually can get things the way they need to be. Sometimes it's just a bit more of a challenge and I need to

think outside of the box". Joan stated that young teenage mothers can express feelings of vulnerability due to judgements made from health professionals about their age. Sally talked about the work that she does to support parents who are reluctant to come up to the ward to visit their baby because of feelings of being judged and unsafe. Kate, alongside a few of the other participants, also spoke to the importance of documenting the patients concerns, to change the way in which people got treated within the ward environment.

The sole Māori participant said that racism affects her values in practice by making:

> …it harder, because I think it can wear you down. It can make you more vulnerable as well, and I think you need to be aware of when it is happening. You need to surround yourself with good social work colleagues.

This participant felt that she maintained her resilience in practice through having open conversations with people and surrounding herself with like-minded practitioners. The participant of Polynesian heritage stated that she believes racism is subtle on the ward, and that she hears comments from other staff such as "oh, not that Māori family again" or "don't tell me Tongan or Samoan or something". This participant stated that her strategy to deal with issues of racism is to speak up immediately in that moment to reflect their comments back to them, so that they are held accountable for what they have said. The participant said that the consequences of this type of challenge is that the particular staff member never makes racist comments in front of her again.

I asked the participants how they would respond to the Māori patient who asked the participant in her critical incident if it was because she was Māori that she was being treated punitively. The participant who reported this in her critical incident felt that the patient was effectively asking her if the unfair treatment she was experiencing was because due to

racism. Most of the participants said that they would explore the incident further with the patient and encourage her to make a complaint if that is what they thought the problem was. Myrtle acknowledged that challenging this type of behaviour made her feel less resilient, but that she would try and find allies as a way of gaining support in situations of conflict. Joan stated that in these types of situations, "you've got to choose your ally, or you've got to choose the side of the fence you are going to go on". Some participants said that they would also speak to a trusted senior manager, and many of the participants also said that they will challenge racist behaviour, while a few stated that they may not always challenge directly.

Mary reflected that she believes *"*racism is always ignorance*".* She then reflected further and contradicted her earlier statement, stating that despite mandatory training on cultural competence that she thinks "some people choose not to change. I think that's just a sad fact of life". Most of the participants said that they would document the patient's query, but some of them said that they would be less direct in their notetaking, in that they would not explicitly name the nurses involved, stating instead that the patient feels judged. All the participants spoke about their duty of care towards the patient, and many commented on their role as being the intermediary person between the patient and the ward. One participant spoke about recently having "a rude awakening" when she recently realised that she had been repeatedly misunderstanding cultural issues relating to Māori patients. The participant stated:

> …many people, myself included have got to be shown the same thing umpteen times before it sinks in, and they [Māori] don't talk because actually a lot of them are shy and they need to get to know you first and trust you.

Joan spoke about the need to have care when responding to patients' complaints about racism, due to the detrimental consequences that are likely to occur if she said to the woman "yes, it is, it's because you're Māori." Joan stated that, in her experience, Māori women will not make comments like this unless there is substance to them. Joan asserted that it is unlikely that the staff member concerned is going to see the error of their ways, and that management would need to be involved. Joan believes that it is not simply just a matter of doing the honest thing and moving on, because that can have some detrimental effects for everyone involved.

Most of the participants believed an honest and cautious approach is needed in these types of situations, so that the women's access to future healthcare is not compromised. However, a couple of the participants wanted to address the issue head on, and overtly challenge the team culture. An example of how they would do this is detailed in what HG states that she would say to the MDT: "hey guys, I'm noticing that actually there seems to be an attitude among the staff which seems to be biased at best, racist at worst, and we have to get on top of that. It's not ok". Halyn spoke to a recent experience of observing and openly challenging racist behaviour by a nurse towards a social work colleague. Halyn said that she informed the nurse that she thought that the underlying issue behind her behaviour was racism and threatened to report her if it happened again. HG summed up the need to challenge racism by concluding that if you are "in any job where you are there doing a service, the very least you can do is be kind to people. If you can be effective, awesome, but be kind as well."

5.4.2 Hierarchy, power and control

I think it is part of our team, our team culture, we are always almost mining for opportunities to balance out that power. That's pretty much our ethos. (Kate)

The participants frequently referred to issues of power in their interviews, signalling both individual experiences of power, and the transmission of power within systems. The attention given to balancing out power to ensure that women have a fairer chance to be successful or heard really illustrates the adversarial conditions that some women experience while accessing maternity services. In the quote above, Kate is talking about the culture of her social work team which is committed to focussing consistently on patient empowerment. The participants were very aware of the power that they wield as DHB social workers, and how their choices and actions could make a substantial difference to improve the lives of those they worked with.

Jo provided reflection about a midwife reporting to her that a violent woman from a very tough whānau had said that Jo was a "tough bitch". Jo said that she had gained this reputation because this woman had "seen me in Housing NZ, in a place she was disempowered and couldn't be powerful, her way of being empowered was to punch people in the face, whereas she suddenly saw the power of talking to somebody". Jo reflected on her ability to advocate successfully for patients at governmental agencies such as Housing NZ, because she represented the DHB in those spaces. Jo openly acknowledged the power and status endowed on her through her professional role and socio-economic background when she stated in an ironic tone that "middle aged white ladies wield a little bit of power in those situations you know, I hate to say it, carrying a DHB badge. Again, those systems of power".

The participants were conscious of their ability to make a difference, and the power that they wielded through their professional role. Most of all, the participants appeared to value their professional focus on advocacy and social justice. The participants expressed a strong sense of responsibility towards the people on their caseload. This sense of responsibility often meant that they were critical of themselves when they were not able to use their professional power and standing achieve the results that they wanted for the patients. “I think we are hard on ourselves because you want to do your best for families, and I guess make social work proud as well. You want at least one profession who sticks up for people” (Sarah).

The participants exhibited dichotomous thinking in relationship to how they spoke about power. In some instances, they narrated situations where they had power to generate change, for both patients and within systems. At other times, they spoke of being completely without power and having to remain passive in order to hold their place within the ward or MDT. An example of acknowledging this sense of powerlessness is portrayed in Sally’s reflections about “hard lessons learnt” about having a “limited sphere of influence” in terms of addressing staff misconduct. Sally said that in the past she has made things worse for patients by trying to rectify issues through directly confronting staff with “strong personalities”.

Sally said that she now tries to help “families through these tumultuous waters of the ward and the ward culture, without necessarily being able to change that culture”. Sally is not completely passive within these types of situations, as she uses education as a means to shift the ward culture slowly, as an alternative to generating immediate and direct change. Sally now overtly teaches patients how to avoid having negative judgements made

about them, and how to communicate effectively with ward staff. Alternatively, Kate recalled incidents of staff judging patients based on their ethnicity, with assumptions about drug use attached. In these instances, Kate chose to take a position of power, challenging the staff members' assumptions through requesting them to justify the evidence on which they based their assumptions.

Jo talked about her approach of systematically challenging unjust situations when she came across them. Jo also commented on seeing other experienced social workers being "completely railroaded" or "becoming obsolete" because of their inability to speak their minds within professional meetings. She spoke about how cultural norms around respecting those senior to you affected some Pacifica social workers in that some very competent social workers are silenced and unable to challenge others effectively. Jo also spoke about breaching cultural boundaries, and the challenges of learning that sometimes it is more powerful to stay quiet when working with a group of Pacific Island people so as not to cause offence. Mary stated that, because of her reputation in challenging other staff members about unprofessional conduct, she feels that she is closely watched by senior managers. The participants all appeared to be focused on helping the patient navigate their journey through the wards in order for them to feel safe and not judged by staff. The participants all had their individual style of working to achieve this level of support for patients, with some confronting issue directly and others taking a more covert approach to challenging staff and systems.

The level of power that the participants had within their organisation often directly correlated to the years of experience that they had in social work practice or to the strength of the social work team within the DHB that they worked in. "We've got a very weak social

work service in this DHB. There is no sense of leadership, the professional advisor is really bullied, and her role is getting watered down" (Mary). It appeared to be that if the social work service was service-led rather than department–led, then the professional identity and voice of the social work team were not as strong. Jo expressed frustration as the social work pay scale did not reflect her level of expertise or contribution to DHB managerial systems. She stated that the work she was doing was technical specialised work, that she was acting as a consultant, advising other health professionals and developing practice pathways, and this left her feeling used.

5.4.3 Impact of neoliberalism

The social work profession was founded on principles of social justice, human rights, empowerment and fairness. In the phase two interviews, participants were asked what they thought about the word *still* in the following quote "social justice and empowerment are **still** the foundations of social work practice". I was curious as to why the participant needed to emphasise the word *still* so much. I wanted to know if it was because social norms around what social work practice have shifted or if it was more to do with issues of social service resourcing and the apparent holes in the 'welfare safety net' that promoted citizenship and equal participation in Aotearoa New Zealand society.

The participants were very aware that growing inequality, the impact of increasing poverty, and the shortage of adequate housing was contributing to increasing complexity in their caseloads. They looked to a shift away from neoliberal policy generated by the current government to engender systemic change. They were concerned about both the blaming of individuals stuck within a poverty trap, or within violence, as well as being concerned about the culture of blame that sits within the DHB environment when things go wrong. A

participant stated that she has worked in the same job for years now, and in that time her "workload has more than doubled in numbers, and probably quadrupled in terms of complexity". Mabel reflected on issues of growing inequality and poverty:

> …we are working now in environments that are hugely impacted by a growing poverty cycle where people feel helpless, hopeless, lack resources, and lack resilience. We are working in environments that are cut back past the belt buckle in terms of their budgets and so everything gets slimmed down; social workers are part of the workforce that gets slimmed down. We are also working in a political environment where our Government of current times thinks anybody can do social work.

The participants spoke about unfair situations for whānau, in terms of risk management, with women disclosing risk situations to midwives and then promptly being reported to Oranga Tamariki. The result of the report to Oranga Tamariki often meant that women asking for help and support (due to issues with addictions or violence) were liable to be placed under a statutory risk assessment process because of their appeal for help. The participants reflected on the impact of the risk-averse approach that organisations adopt when being propelled by neoliberal thought. Mabel acknowledged that social workers are under incredible pressure because of the emphasis on risk in a compressed, pressurised practice environment.

The participants also thought that the way in which the media report social work practice, highlighting all the negatives also contributed to the pressure that social workers feel to be risk averse in practice. The participants had a strong sense of responsibility. They need to be considering the wider systemic issues as to why they are not achieving required outcomes as an individual social worker. The problems that they faced in practice in achieving the goals that they had for specific patients, or the goals that the DHB expected of

them, are difficult to achieve because of the complexity of social issues that the patients were experiencing. These social issues also need to have a critical feminist critique applied to them, the way in which mothering, and childhood is constructed and construed in society.

The participants felt that they were not able to consistently provide adequate coverage to the teams or wards that they worked with. They noted that replacement staff were not provided for situations of social work leave, and at times people were not replaced when they resigned. This meant that the participants were often covering other people's workload and they felt this had an impact of wider perceptions of the social work service across the DHB. They acknowledged that staffing shortages affected their feelings of self-efficacy: "practice changes when you don't have the time to invest in each family that you're working with…. At the time the message was efficiency but then afterwards the critique was on effectiveness… you're always kind of balancing this sense of almost business risk and personal risk" (Joan).

There was a general acknowledgement that neoliberal ideology has had a powerful impact on the way that social workers view their work, and that the social work profession has lost some of its critical edge. Mabel stated that:

> …all aspects of social work now are being driven by social policy and Government, rather than [social work] influencing social policy and Government, like it was in the 1970s. People do not have the time and the energy to be out there being vocal and political like they were.

Myrtle felt that in the 1980s, the social work profession started to lose sight of the principles of social justice and empowerment; however she believes that social justice is still the foundation for social work practice. Joan believed that while social work practice is different

to what it was in the 1970s, she did not believe that social workers had lost that sense of social justice and empowerment. Perhaps the strategies for social justice action have changed. Zenda stated, "social justice doesn't have to be about protesting…I personally don't subscribe to protesting….I'd be more inclined to do things like getting the MP or someone like that behind my cause if I needed to. Lobbying is what I'm more into".

Myrtle believed that social work's "power is in our knowledge and expertise, I think that's [still] strong, and I don't think we realise it though…. we need to be more creative about finding our voice". Mabel also reflected on the need to be for social workers to be a united front, ready to stand up for the profession, stating:

> How much do you battle? How loud do you make your voice? How fast on the treadmill do you run? Sometimes you have to create a space to stop and reflect, and do that as a group, and that's actually really hard when you're working in an environment that doesn't allow for that.

Sandra spoke to her frustrations about a management system that was not responsive to the views of social workers, stating that "management are so oppressive…. [you] tell them that's not the best way and that there is another way they're just 'oh no, we're in control' and they will not bend no matter what you do."

The phase two interviews took place in 2016, at the time the participants expressed a growing sense of unease about the transition from CYFs to Oranga Tamariki. The participants were vocal in their dissatisfaction with the way in which child protection services were under-resourced, in the inability of the service to retain experienced staff, and the pressure that their Oranga Tamariki colleagues withstood at work. Sarah reflected on the impact that health social workers were experiencing due to the changes that were happening in Oranga Tamariki, stating that there had recently been:

> …quite a big shift in how Oranga Tamariki do things, they take on less, and it seems like they have a huge staff turnover, so you have a massive amount of new people who don't know much. It feels like you're having to explain an awful lot just for what I would say is a really basic service, for an assessment of a family, and individual social workers at Oranga Tamariki that have just really really worrying practice, and [you] minimise your concerns potentially because they're under so much stress.

The participants widely acknowledged that if they could devote some time to the whānau who have "borderline care and protection issues" they would be able to prevent a lot of harm from occurring. Sandra stated that, for these types of at-risk situations, Oranga Tamariki would determine the whānau behaviour to be below their risk threshold and nothing would change. Oranga Tamariki social work staff were perceived by the participants to be forced into reactive practices due to issues with staff resourcing. HG likened Oranga Tamariki social work to surfing a big out-of-control wave, stating that in her local office they need 15–20 social workers but that they have around six staff. She felt that Oranga Tamariki social workers are really fighting disillusionment owing to the reactionary practice that they have been forced into due to understaffing. The participants felt that they were in a privileged position compared to Oranga Tamariki working conditions.

HG stated that the Oranga Tamariki social workers themselves are worried that they are just removing children from their homes, because they do not have time to do anything other than that, and the children are not safe where they are. The participants spoke to their feelings of frustration due to knowing that severe violence and neglect were taking place within some whānau and feeling that Oranga Tamariki social workers were not taking reasonable steps to protect the children. At times they depicted situations in which they passively accepted the assessment of risk conducted by Oranga Tamariki, acknowledging the value conflicts involved, and the need to stay collegial. Sandra said that she accepted that

the “Oranga Tamariki social workers’ remit trumps mine.” The participants acknowledged that within the health environment they had the specialised knowledge. They felt that their position as health social worker enabled them to have a clearer window into the lives of these at-risk children, especially as subsequent children were born, and worked hard to stay credible and collegial with Oranga Tamariki staff.

The participants noted that they could see values being made visible through the types of conflict that they had with Oranga Tamariki social workers, due to the differing needs of their respective organisations. Many of the participants expressed concern about the way in which social work practice currently has such a strong focus on assessment and brokering-on of work. They felt that they were constantly assessing and were quite worried about whether there was provision for Oranga Tamariki or NGOs to undertake the social work follow-up that patients needed post-discharge. The participants stated that, alongside the pressure that Oranga Tamariki staff were under, many community agencies have closed, or have a reduced level of capacity to provide services. The participants expressed grave concerns about the length of waiting lists for newborn babies, giving examples of newborn babies sitting on a 20-week waiting list to be seen. Sarah emphasised that many community agencies have got:

> [C]losed waiting lists, so you can’t even refer to them, so that feels really uncomfortable because you can’t set families up for the supports that they need and also deserve because everyone is just overloaded…so I think there are really big implications for us in how we respond and how we refer on, or don’t refer on because there’s no-one to refer on to.

Many of the participants were hopeful about a change of government in the 2017 election. Mabel stated that it would be good to:

> …have a Government that actually has some compassion for the people, rather than being all about making money, and rather than having this individualised thing [focus] where it's more [about] total responsibility, because there's a lot of people out there that don't have the resources to be responsible. Where is the hope?

After the 2017 election a Labour-led, New Zealand First and Green Party Coalition was formed, the new Prime Minister, Jacinda Ardern, Leader of the Labour Party publicly acknowledging that neoliberalism has failed the country, resulting in poor outcomes for employment, poverty and housing. The Labour Party has historically critiqued the underfunding of the health system when not in the seats of power, although it was been noted that the 2018 budget has a stronger focus on tackling urgent hospital building repairs, rather than investing in health services (Espiner, 2018).

Similar to the Prime Minister, the participants also perceived that the pervasive neoliberal ideology underpinning Aotearoa New Zealand's social services has failed to protect vulnerable patients. They indicated that neoliberal funding practices have too strong a focus on accuracy in risk assessment and risk management, and services being contracted to do very specific types of work. These types of funding regimes have resulted in a social service sector that has everyone brokering services on. They questioned who is actually doing the work – semi-skilled field workers, perhaps 'Aunty Āwhi.' The term *Aunty Āwhi,* in this context refers to a woman without a professional qualification, who helps, assists, or supports people in need.

Three participants spoke negatively about their perceptions of their respective local Children's team, believing that the team had a lack of social work expertise, and a poor ability to effectively manage and understand risk. Non-social work staff in community agencies such as Family Start were perceived to be ill-equipped to handle the complexity of

issues that whānau face to due to issues of violence, addiction and lack of housing. One participant specifically expressed concern about public health nurses being appointed as Lead Professionals, without the ability to handle to complexity of risk in child protection, particularly with reference to issues of neglect. When Sandra reflected on this issue, she stated that other professionals focused on the 'temporary fix' and not the reasons why these whānau are immobilised or unable to provide the care. To her the temporary fix was the food parcel, budgeting advice or some specialised equipment.

Sandra stated that the early intervention is great in theory, but that budgets and social work roles are needed to support the intervention.

> It is my belief if we engage early with women when they're pregnant and actually address the social issues or work in a collaborative way to have resolved a lot of those issues before the baby is born then we can cave better outcomes for babies. That's the ultimate overview of it, and then you get the complexity…the problem is you throw in the complexity of women that have huge addiction issues, huge family violence issues, huge property issues that you can't address in nine months. Then you're fighting for babies to get uplifted, you're fighting for them to stay with their mother (Jo).

Joan stated that, at the beginning of 2016, the media reported a New Zealand politician stating that:

> …social workers go to social work school and get brainwashed to think that people can change, and I was like "well, what else are you going to do, you can't spend your days thinking that everyone is going to stay the same forever because that's going to diminish your hope for anything if nothing else will."

The participants had a strong sense of their values and how their values apply to their social work practice. These values appeared to be central to their professional identity

and the values informed their understanding of how they expected other social workers to practice. They appeared bemused at times that social work values were not universally prioritised by other professionals, as illustrated in Sarah's statement:

> …all of us share the same strong values about the patient being the centre [client-centred], fairness and equality; that other professions just don't seem to value. I find it really astonishing because it's my core value that everyone should be treated fairly…but other people just don't see it that way. I find it really hard to make sense of it. It just seems like people just don't have empathy, and I do think values come through in conflict.

Neoliberal ideology promotes individual achievement and venerates competition. In a compressed environment with scarce resources, this can feed into issues of negative comparisons being made, and competition between staff. Jo talked about the lack of support that she has in practice from management and believes that this lack of support sometimes equates to not doing "what you know is right, you do what is expected of you"' Jo then stated that "it is weird that our system does not really support you, even other social workers sometimes tend to throw each other under the bus, because no one wants to be in trouble. No one likes to be that person having the finger pointed at them."

A participant reflected on a manager who she felt was egotistical and a bully, stating that this manager was "known as a roadblock" because she liked to get the credit for developing resources. The participant felt that this manager was threatened by other people's initiatives and found it hard to accept that other people could conduct independent projects. Another participant spoke about feeling extremely offended when she was informed by her social work manager that "we don't provide a Rolls-Royce service". Sarah reflected on the severity of risk, and the potential for a baby or its mother to die because of lowered staffing levels and increased referrals. Sarah said that the service they

provide is basic, but they try to respect the patients, and respond to need as it arises. Sarah said that she feels that there is a culture of bullying within social work management and stated that "the social work department expect us just to do the minimum and I don't think that's right, because if a family needs something I feel obligated to at least look into it for them".

5.4.4 Toxic environments

> I feel like we're just carrying too much risk and potentially a woman or a baby could die, and it might take that for people to realise just how important we are as part of that whole journey. (Sarah)

The social workers acknowledged that they did not feel that DHB management valued their work because the nature of their clinical work was not congruent with the medical model. The participants all spoke clearly about how health can be a toxic environment for social workers. Through discussions about values in this research project the participants noted that the conflicted nature of their work environment made their values visible in their everyday practice. They saw values their values in action when they perceived a lack of empathy in their colleagues, and they saw their values as being what drives them in situations of conflict to continue to advocate for patients and their whānau.

> I am what I am, I believe what I believe and unless you've got a really good rationale, you're not going to change what I believe, and so when that awful management team, who are so oppressive do things that I know are not okay I challenge. (Sandra)

In contrast, Tania stated that she often feels like she disregards her clinical wisdom about what needs to be done in order to adhere to DHB protocols, especially in relationship to child protection issues. To clarify this assertion, Tania stated that she has to work to specific

standards, and that community referrals have to fit certain funding criteria. Tania felt frustrated that she is unable to assist people who have been declined support from community services and was concerned that she did not have time to locate alternative community support services. Tania asserted that this leaves the patients feeling a sense of hopelessness, and at times, they question the point of receiving a referral to hospital social work services. In these instances, all Tania felt that she could do was apologise and document their issues; as well as be a listening ear and someone for them to vent their frustration on.

> I feel that maybe I could have done some follow-up in the community with them in regards to whether the Police are continuing to be involved, Victim Support be involved, just to make sure that they've got some of those supports in place, although with my case-load I can't really, because there's always new stuff coming in and we're always told we work acutely. (Tania)

5.4.5 Efficiency versus effectiveness

> When the shit hits the fan, you don't call the ghostbusters, you call the social workers to come and fix it up. (Mabel)

Participants spoke about complexity in terms of having to consider the safety of the baby with issues such as incest or ethical issues around surrogacy. Alice considered the difficulties of practice in terms of often needing to approve the discharge of vulnerable babies due to bed shortages while not knowing the full extent of the concerns held for the babies. For Alice, being effective in practice involved documenting risk carefully and getting the right balance between efficiency and slowing discharge processes down. Sally demonstrated both her enthusiasm for practice and her frustration about limited time frames stating, "I'm really passionate about early intervention and really passionate about

more the relational side of things, and I'm not saying you can't do that in a short time frame, but sometimes having a bit more time is more helpful.

Joan noted in her phase two interview that a lot of her social justice action is done on a micro level, with individual patients, rather than addressing more collective issues. In essence, Joan was questioning the effectiveness of the work that she does, and she stated that lately she has had a growing need to become involved in collective social justice action outside of formal work. Joan believes that she does not always get the opportunity for social justice action within her health social work role, however, Joan gave plenty of examples in her interview of social justice action such as laying complaints with WINZ and liaising with senior management from the Ministry of Social Development in relationship to patient advocacy. Joan stated that, within the DHB, she feels that social work's "value is measured by the number of people we see and the number of XYZ issues that we resolve, rather than on changing society and changing the way our workplace functions for our families".

5.4.6 Seeing values through conflict

It is important to consider how value conflicts are resolved, and the information contained here explains how the participants reacted when they could conceptualise value conflict and the steps that they took to resolve it. The participants appeared to be able to see values in practice through reflecting on situations of conflict. When asked how they work to resolve value conflict, the participants would do so through examples; explaining a conflict situation, then considering action, behaviour and choices made in terms of rights, ethical principles (duty and consequences, utility, virtues). Through this process of explanation they were able to identify values at play at the heart of the conflict. When Zenda was interviewed, about situations of conflict, she was puzzled about how to resolve

the underpinning value conflicts that can reside within a situation of tension. Zenda questioned how to resolve value conflicts when you identified them, stating "then what do you do? How does that help you improve that interaction?" Given Zenda's line of questioning in the interview it felt that, to her, resolving the underpinning value conflict could be a complicated process that she was unsure how to handle. These issues relating to value conflict will be considered further in the next chapter as they are key to how social workers in health experience and negotiate values in practice.

5.5. Bringing All the Threads Together

The critical incident technique allowed for an examination of the day-to-day realities of health social work. It also allowed for the platform of experiences described within the narratives to be iteratively developed in subsequent interviews to uncover additional abstract concepts about how values are experienced and negotiated. Charmaz (2014) asserts that "interview conversation may elicit the participant's reappraisal of a taken-for-granted discourse and its social foundations" (p. 85). Conducting the phase two interviews allowed for the reappraisal of experiences contained within the critical incident narratives. Charmaz (2014) instructs grounded theorists to follow the emergent leads, and keep gathering data on these leads, so as to avoid constructing analysis around standardised categories. The phase two interviews generated further discussion and critical reflection about value pluralism, hierarchies and competing demands.

The participants' voices brought together a diverse commentary about the state of health social work practice with newborn infants and their whānau, in Aotearoa New Zealand. The interview narratives captured practice at a particular point of time, between November 2014 and November 2016. These interviews were prior to the establishment of

Oranga Tamariki (changed from CYFs), and before the title of social worker became protected. Their collective narratives and reflections provided a lens through which to view constructions of health social work practice realities within that time period – illustrating the issues that the participants grapple with, and the conditions under which they work.

In the participants' interviews it was evident that they valued honesty and respect in their work with patients, as well as in their work with other professionals. The participants demonstrated these values through striving to be transparent in the work that they did. They worked hard to ensure that they collaborated with the patients and whānau and endeavoured to address issues of power in their practice. Power relations were frequently problematic in relationship to the participants' interactions with colleagues, and in the treatment of patients by other professionals. The participants perceived principles of partnership and the right to equity in service provision to be integral to their work and laboured to realise these principles in their work with colleagues and for the individuals and whānau that they worked with.

Value demands were prevalent within the participants' critical incident narratives. The categories that arose out of the participant interviews centre around the participants being caught in the middle of prevailing forces within a complex practice environment. The participants worked hard to manage this complexity, striving to control this middle ground, to ensure that the patients' rights were upheld, and that the patients' voice was heard. The participants took significant steps to negate the impact of judgements and assumptions made by non-social work colleagues about patients. The participants perceived the judgements made by colleagues to be due to a lack of appreciation or understanding of the patients' social situation, and they worked to educate their colleagues about the socio-economic realities that the patients faced in their day-to-day lives. This sense of being in the

middle, between the patients and staff was often seen as being a lonely place. This perception of isolation is made worse by the fact that social workers were often the lone voice actively challenging systems, racism and discrimination, as well as team and/or organisations' norms. The participants, who managed to be part of a strong team, whether it be a team of social workers, an MDT, or a ward team, were more empowered to speak out against injustice and ensure that the social work perspective was firmly entrenched within the team culture.

CHAPTER SIX: DISCUSSION

6.1. Overview

This discussion chapter brings together the key points from the research conducted about the place of values within health social work practice. The participant interviews provided a clear vantage point through which to critically consider how values are experienced and negotiated in practice. The discussion is designed to augment the emerging theory drawn from the consecutive phases of interviewing through further exploration of the two principal analytic categories: *Contextual complexity* and *Controlling the middle ground*. The categories do not stand independently of each other, they are interrelated, and together portray the way in which values are experienced and negotiated. This chapter positions these categories in relationship to social work literature containing concepts surrounding complex working environments, practice aspirations, power, mandate, and professional voice and identity. This exploration is designed to develop further understanding about value demands through considering values in relationship to how the participants worked to control the middle ground in a complex practice environment.

Symbolic interactionism was the overarching theoretical perspective employed for this research, while an ecological perspective was utilised to further develop the theoretical categories when writing the discussion sections. As a social work researcher focused on social justice issues, there is a natural tendency to be attentive to reciprocal relationships between people and their wider personal, cultural and societal environments. Researching an abstract concept like values in practice involves an examination of the differing layers of interactions across and within the social systems to understand how meaning about values is generated.

Charmaz (2005) states that social justice researchers need to make "explicit connections between the theorized antecedents, current conditions, and consequences of major processes" (p. 8). An ecological perspective stimulates thinking that allows this level of analysis through a concentration on connectedness, context, and interrelated systems. This type of systems thinking about complexity is becoming more prevalent in child protection social work. Munro (2020) states that her third edition of *Effective Child Protection* has been significantly changed to adopt a more holistic view of practitioners working within systems to address issues of complexity associated with child protection. This change in emphasis is congruent with the findings represented in the principal analytical categories that will be discussed in this chapter. These categories signify the developed theory that places importance on how health social workers working with newborn infants and their whānau are located in the middle ground. Within this middle ground, they are buffeted by complex systems; their work is often misunderstood, and they work in relative isolation from other DHB social workers.

The scaffolding of the grounded theory refinement as it emerged through the different stages of category development is depicted in Figure 11. Represented in the first arrow are the broad headings that were explained in Chapter Four (Phase One Findings). The conceptual categories that developed from the initial analysis of the phase two interview data are illustrated in the middle arrow; these categories were explained in Chapter Five (Phase Two Findings). The final arrow in the diagram depicts the two principal analytical categories, *Contextual complexity* and *Controlling the middle ground.* These two principal conceptual categories slowly crystallised during the process of data analysis, and they will be discussed in more detail within this current chapter.

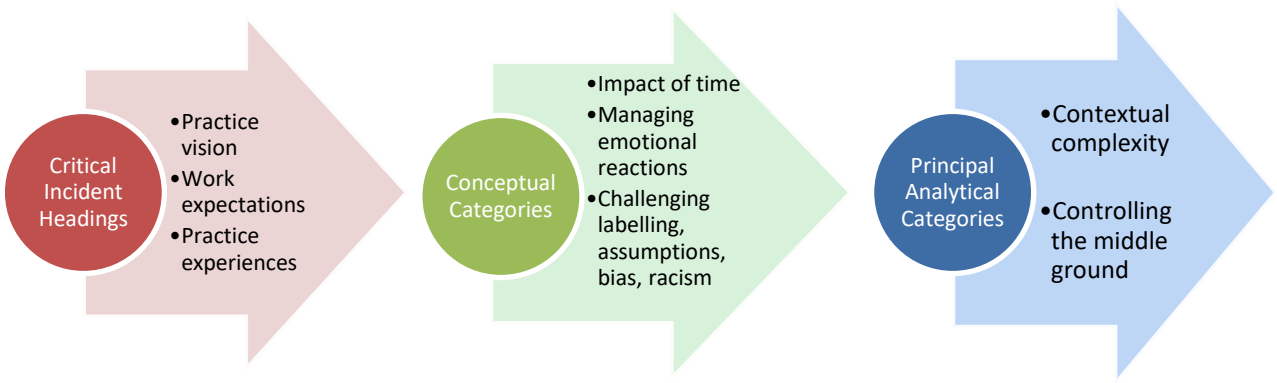


Figure 11. Stages of category development.

To begin this chapter, the principal analytical category *Contextual complexity* is examined through further consideration of the key elements of the backdrop to current health social work practice in terms of what the participants had to say about their experiences. Social justice is then defined as the primary organising value within this research and then Māori health outcomes are considered in relationship to social justice. The principal analytical category, *Contextual complexity,* sets the scene for understanding the tone that characterises *Controlling the middle ground*. The impact of time, challenging practices, and the emotional landscape of practice comprise the three key conceptual categories that are then investigated to further explain the place of values within health social work practice. The literature used within the discussion is designed to extend the participants' commentary, to generate further understanding about the grounded theory analysis regarding how values are experienced and negotiated in practice.

6.2. Contextual Complexity

The principal analytical category, *Contextual complexity,* speaks to the intricacies involved in health social work practice. In the introductory chapter, attention is given to the context of health social work to explain the circumstances and conditions underpinning

practice. In the first findings chapter, the pressures facing health social workers are explored. Consideration of the current practice backdrop will be provided to further locate the developing theory within the complex landscape of health social work practice with newborn infants. To round off the discussion about contextual complexity, social justice is defined as it relates to social work practice and Māori health outcomes. The literature and research reviewed elucidates the analytical category through illustrating the societal problems that health social workers respond to in their work with newborn infants and their whānau.

6.2.1 The landscape of practice

Health social work with newborn infants occupies a contradictory practice environment in which the participants are required to resolve thorny problems in settings laden with shifting realities. The participants' decision-making in child protection often felt 'as clear as mud', with many layers of competing values and requirements at stake. These problems exist due to uncertainty, with conflicting standards and differing risk thresholds existing for professionals or organisations. For the participants, these difficulties were further compounded by a lack of relevant services and resources, or quality whānau support provisions for those in need. These problems are then further exacerbated by issues of poverty and power related to oppression, alienation, discrimination, and violence, which can be experienced at individual and structural levels. The participants' work was often misunderstood, and a significant amount of energy was exerted to gain the trust and confidence of other professionals.

Within the DHB context, social justice functions as the primary organising value that underpins social work practice, allowing the participants to clearly differentiate themselves

from other professionals through their motivation for intervention (Stewart, 2013; Taylor et al., 2017). Social justice, as an organising value, limits practice that penalises individuals for the unjust circumstances that they might find themselves in, allowing an increased focus on endeavouring to account for the impact of inequity and deprivation. Since the 1990s, neoliberal ideology that promotes technocratic approaches to managing complexity in social work practice have held increasing sway in health service delivery (Beddoe & Maidment, 2014). Schön's (1983) quote below speaks to the impediments that health social workers face when advancing the well-being of newborn infants:

> In the varied topography of professional practice, there is a high, hard ground, where practitioners can make effective use of research-based theory and techniques, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society while in the swamp are the problems of greatest human concern. (p. 42)

It is easy to make sound technical decisions about certainties, but with vulnerable newborn infants, there can be great uncertainty, unknowns, risks and multiple agendas; even the term *vulnerable* isolates and stigmatises. In order to understand the way that values inform and influence practice, attention to the practice environment is vital. Values and their associated commitments prevent social workers from becoming mere technicians who provide social support (O'Leary & Tsui, 2019). In Aotearoa New Zealand, health social workers take a key role within hospitals in leading and facilitating decision-making about newborn infants in need of care and protection. A technical rational approach to practice focuses on the professionals' problem-solving processes (Schön, 1983); however, social work is so much more than naming, framing and resolving objective problems.

Featherstone, White and Morris (2014) state in their opening pages of their text on re-imaging child protection that:

> Social workers are charged with entering the lives and moral worlds of families, many of whom have routinely experienced disrespect, and have longstanding histories of material and emotional deprivation. In entering such lives, social workers share with those they encounter universal experiences of loss and disappointment. However, there are additional issues that arise in the course of doing such a job involving the making of decisions that bring pain and hurt as well as joy and support with consequences that can endure for generations. This dual mandate (often known as care and control) is one to be treated with humility and seriousness. (p. 1)

These two quotes are consistent with the findings from this research into how value demands are experienced and negotiated within health social work with newborn infants and their whānau. Social workers practise in the swampy lowlands where it is messy, with many value-laden contradictions and unpredictable risks. Values inform a significant part of the equation within social work practice and decision-making, as they create the foundation from which practice is formed and the lens from which to view what needs to be achieved.

Health social work with newborn infants is crucially important as protection and advocacy can be needed to ensure safety and well-being, and social justice values act as a guide within these stressful and complex circumstances. Value pluralism, combined with the often intractable and unbounded problems that social workers face, means that values cannot always clearly demonstrate a path to achieving success. Moral choices are essential within this space. These choices involve a process of knowing-in-action (Schön, 1992) that requires reflexivity about value conflict and organisational influence as practice unfolds.

Health social work with newborn infants is to be valued and appreciated for its complexity, and it also needs to be understood by both the professional community and the general public. The participants often felt that their role and practice were misunderstood and underappreciated. Health social work with newborn infants involves assisting women and their whānau at the start of a significant change, at a time of new life, with bourgeoning opportunities, challenges and risks. The feelings of loss, disappointment, pain, hurt and joy that Featherstone, White and Morris (2014) reference in the last quote are very much experienced by health social workers as they work alongside whānau at this crucial time.

In 2019, as this research project neared completion, social work practice involving protecting newborn babies from risk situations has been particularly under the media and political spotlight. There have been widespread objections throughout the country about Oranga Tamariki social workers removing Māori babies from the care of their mothers, protest campaigns throughout social media and on the steps of parliament. These protests were initially sparked by a Newsroom video (Reid, 2019) titled 'Taken by the state: NZ's own taken generation' which featured an attempt to take a newborn infant from a hospital ward into the custody of the Chief Executive of Oranga Tamariki. The documentary centred on the high incidences of Māori babies being taken into custody. Health social workers are intensively involved in these processes. They are situated in the middle ground supporting the mother and whānau, protecting the vulnerable newborn, advising DHB managers, and facilitating the actions of Oranga Tamariki social workers as they carry out their legal obligations.

As a result of the media documentary, the Chief Ombudsman announced a wide-ranging investigation into newborn babies being removed from their whānau (Office of the

Ombudsman, 2019). This public discontent is predominantly centred on concerns about racial profiling of Māori newborn infants and an inability of the state to support whānau to parent (Peacock, 2019). The findings of a review of practice report regarding the events publicised in the documentary prompted the Chief Executive of Oranga Tamariki, Grainne Moss, to issue an apology, and there are several iwi-led investigations into Oranga Tamariki under way.

The failure to vigorously implement the recommendations made in the Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare (1988) Pūao-te-Āta-tū report has also been subject to ongoing criticism (Hollis-English, 2012; Williams et al., 2019). Boulton et al. (2018) lay part of the blame for this on "a lack of government funding to truly implement the legislation and poor social work practice" (p. 2). Underfunding of statutory care and protection social work services has had a direct impact on the quality of service provision. This situation has been further complicated by the overwhelmingly high workloads that Oranga Tamariki social workers have (Office of the Chief Social Worker, 2014), which has a limiting effect on supporting whānau to care for their children. Māori children are significantly affected by the systemic issues within child protection practice; and health social work practitioners work in tandem with Oranga Tamariki services and other professionals to resolve these issues and protect these children.

Social workers are bound by the legislated environment in which they practise, and their decisions are shaped by the environment in which they are located (Taylor & Whittaker, 2018). While not undermining the dire concerns about the numbers of Māori children in the care of the state, it is also important to consider that social work practice in Aotearoa New Zealand is situated in a society that has, in its totality, tolerated child poverty, housing insecurity, violence against women and children, and institutionalised racism. This

societal apathy has an impact on social workers' ability to protect those at risk of harm and provide meaningful resources to whānau who are trying to ensure the safety and wellbeing of their loved ones.

Not all the work that the participants did concerned care and protection issues, but a significant amount of the participants' time was spent working collaboratively with whānau, health professionals and Oranga Tamariki to ensure the safety and wellbeing of newborn infants. Child protection social work is emotionally intense for everyone involved: the children, the whānau, the community, the professionals, and the wider public. Child protection social work can attract high-profile media attention due to the serious consequences at stake and the intensity of emotions when child maltreatment is suspected. The public outcry over the media documentary referred to above is just one example of many that pushes social workers into the media spotlight in a way that is beyond their control. Social workers' ability to speak to the truth of their practice decisions and experiences is limited by the ethics of confidentiality. Social work practitioners are reliant on the goodwill of their organisations, and the professional community, namely ANZASW, to protect their reputation. It is hard to have a 'just culture' in social work, and blame promotes risk-averse practice due to the significant harm or even death that can occur (Featherstone, White & Morris, 2014). Issues of ethnic inequalities within this mix place greater responsibility on health social workers to work towards systemic change to address the disproportionate representation of Māori and certain ethnic groups (Keddell & Hyslop, 2019a).

Health social work practice with newborn infants involves complex interactions with whānau who may feel unfairly targeted, have heightened emotions and much to lose. This

work had a powerful impact on the participants. This difficult work takes place in an organisational culture where social work is secondary to the medical model. True recognition of health social work practice that incorporates the lived experiences of dealing with complex risk situations that are intensely emotional amidst restrictive organisational and time constraints is needed (Ferguson, 2017). As the participants have demonstrated, their workloads are embedded in complex risk situations with high stakes. They work in a resource-poor environment with people who are often without hope due to poverty or marginalisation, and to work in this milieu takes courage and resilience. This work needs to be sufficiently supported and respected through social policy designed to empower holistic practice and cultural responsiveness. Support through management structures that promote 'just cultures', and through adequate resourcing for quality supervision and continuing professional development is also needed.

6.2.2 Defining social justice

In this research social justice has been positioned as social work's primary organising value, as it was the overarching value to which the participants referred. As a primary value, social justice places the profession in solidarity with people in poverty, people who are marginalised and suffering oppression and discrimination (Banks, 2014). Social justice is a value that encompasses many other values. Social justice is referred to in literature as both a singular value and as a category comprising many types of related values. Value pluralism means that in situations containing ethical dilemmas there is a sense that values compete for primacy. The participants emphasised the value of social justice as a way of indicating their overarching goal; therefore, perhaps the term *social justice* can be perceived as indicating both social justice as a value and the participants' practice goals in relationship to

values. Social justice as a goal links into the aspirational nature of values, centring social work values on the participants' beliefs about what is "worthy or valuable in a social work context" (Banks, 2012, p. 8). Due to the primacy of social justice within this research, the following section will explain the term in relationship to both this research and to social work practice.

The practice of social work is difficult to define, which means that the practice of social work can be co-opted and redefined (Hyslop, 2012). An example of this is the way in which neoliberal ideology has influenced social policy and organisational norms, and therefore the professional practice that is located these organisations. Some of these changes have been good (Beckett, 2014); for instance, increased accountability and safeguards to manage risks and protect the public such as the SWRB (2018) 'Fit and Proper' policy. Market-oriented values within social service provision do not necessarily equate to better outcomes (Reisch, 2014). The participants had deep-rooted complaints about the time they spend on risk management and compliance. The social work participants in Hyslop's (2018) Aotearoa New Zealand based research into neoliberalism and identity voiced similar concerns, with accountability measures being perceived as forcing the prioritisation of increasing data input over face-to-face engagement.

Just as social work is a contested profession (Ferguson, 2008), social justice is a contested concept that lends itself to multiple interpretations. Social justice is interpreted differently by individuals, groups of people, cultures and according to political convictions, and there is no widespread universal agreement on what the term means. Gallie (1964) states that, from a Liberal-Individualist standpoint, social justice is focused on rewards distributed being proportional to effort or merit within a free market. A Socialist-Collectivist

perspective asserts an emancipatory approach to social justice that is more focused on the rights of people's humanity (Gallie, 1964), with distributions being made on the basis of differential needs. For the participants, Te Tiriti o Waitangi is a source of power to work towards equity in health outcomes (Ahuriri-Driscoll, 2016). Recognitive models of justice utilise Te Tiriti o Waitangi to promote transformative practice that is centred on self-determination to overcome structural disadvantages and achieve collective rights (Humpage & Fleras, 2001).

Social justice as a concept cannot be fully understood without some consideration of the social, economic and political position of the person or group using the term (Heaney, 2009). As a contested concept, the term *social justice* can be captured to advance political and social agendas, especially in the state-sponsored environment in which social work practice is often located. When people talk about social justice, it is important to clarify how they theorise social justice (Parvin, 2018). Care is needed to be sure of the way that the term has been claimed to elucidate the meaning behind its usage. Understanding the way in which contested terms such as social justice are used can be critical in situations containing ethical dilemmas, as choices are devised according to interpretations of what is socially just or fair (Heaney, 2009).

There is a lack of clarity about how the dynamic concept of social justice informs the actual practice of social work (Hudson, 2016; O'Brien, 2011b; Taylor et al., 2017). Contemplating social justice involves a consideration of (in)justice, with its associated themes of fairness, equity, equality, opportunity, access, respect and tino rangatiratanga, alongside issues of poverty, health inequities, oppression, marginalisation and social exclusion (Hodgetts et al., 2010). Rawls (2001) conceives of justice as fairness, with a focus

on fairness representing equal fundamental rights and liberties, along with opportunities to ensure the ability to participate (Freeman, 2019). Rawls' notion of social justice is not compatible with a society premised on individual gain (Craig, 2002).

The participants' conceptions of social justice appeared to mirror Rawls' conception of social justice as fairness, as it is primarily centred on the belief in equal economic, political and social rights and opportunities. Hyslop (2012) argued that "social work has been significantly emasculated within the rubric of the neoliberal political era: an era which privileges modernisation at the expense of tradition, individual over collective interests, and places economic value before social development" (p. 405). Social work as a profession strives to connect the dots between personal problems and structural issues that perpetrate inequality, discrimination, oppression and exploitation. In an unequal world, gender and racialised inequality remain a central focus when considering experiences of social injustice (Rummery, 2018; Solomos, 2018). The IFSW (2018, pp. 4-5) 'Global Social Work Statement of Ethical Principles' states that promoting social justice means: challenging discrimination and institutional oppression; respecting diversity; working to ensure equitable access to resources; challenging unjust policies and practices; and building solidarity. The IFSW encourages social workers to use their knowledge base to actively speak out against injustice, and to formulate policy for preventing injustice and social change. Overall, the participants aspired to do this, but were often confounded as to how to achieve change in a meaningful and sustained manner at a macro level given the competing claims on their professional time.

O'Brien (2011a, 2011b) asserts that social justice is the "heart of social work" and that it is "alive and active" in social work practice in Aotearoa New Zealand. O'Brien (2011a)

utilised the following definition by Craig (2002; 2018) to capture the essential elements of social justice that relate to social policy and the politics of social justice. Craig (2018) defined the concept of social justice in social work as:

> …a framework of political objectives, pursued through social, economic, environmental and political policies, based on an acceptance of difference and diversity, and informed by values concerned with:
>
> - achieving fairness, and equality of outcomes and treatment;
> - recognising the dignity and equal worth and encouraging the self-esteem of all;
> - the meeting of basic needs, defined through cross-cultural consensus;
> - maximising the reduction of inequalities in wealth, income and life chances; and
> - the participation of all, including the most disadvantaged. (p. 6)

Craig's (2018) definition has been updated since his early definition of social justice in 2002, to highlight the importance of developing a cross-cultural understanding of basic needs. This update is designed to help avoid imposing dominant cultural constructs upon other more marginalised groups. Social justice is multifaceted and there is no standardised measure of equality or well-being. Craig (2018) advised that it is important to evaluate justice with regard to the most significant and relevant aspects of life. Craig (2018) asserted that the "different dimensions of justice are interconnected: distribution and recognition, recognition and voice, and justice in public and private spheres should be mutually reinforcing" (p. 6).

Craig (2002) explained that social rights are centred on the right to basic standards of living, such as health and housing, while political rights are focused on the right to vote or participate in political activities. Social and political rights provide a balance against civil rights, which afford legal guarantees, protect property and freedoms. Craig (2002) stated that civil rights reinforce the functions of a market economy, while social and political rights

challenge inequalities driven by free-market ideologies. Craig (2002) extended the concept of social justice beyond civil, political and social rights, and asserts that a social justice approach requires working towards getting governments to confront the inequities of market-driven systems.

To conclude this section on social justice it is good to keep in mind Banks' (2014) perception of “radical social justice” as it aligns with Craig’s (2018) definition of social justice, and the way in which work for social justice has been envisaged within this research project:

> Social workers need to take seriously the social justice agenda contained within international and other definitions and descriptions of social work as being about working for equality of outcomes and challenging unjust policies and practices. We need to be alert to the variety of formulations of social justice (such as the more liberal reformist focus on equal opportunities) and hold onto a conception that embraces a call to challenge the five faces of oppression as identified by Iris Marion Young (Young, 1990, p. 41): exploitation, marginalisation, powerlessness, cultural imperialism and violence. (Banks, 2014, p. 19)

Young (2018) used the term *five faces of oppression* to systematise the meaning behind the concept of oppression. She highlights that groups are not oppressed in similar ways or to the same extent, but that “all oppressed people suffer some inhibition of their ability to develop and exercise their capacities and express their needs, thoughts, and feelings” (Young, 2018, p. 50). The way that the participants strived to ensure that rights are attended to, their attention to practice that is fair and transparent affirms the place of social justice as a primary organising value within social work practice.

6.2.3 Māori health outcomes

Given the level of concern that the participants had about the uneasy fit between Te Ao Māori and DHB services, this section of the discussion concentrates on the impact this cultural incongruence has on Māori health outcomes. The challenges that the participants had in practice often related to issues of racism, bias, and assumptions made about people who sit outside of hospital service norms. Sitting outside of the norm can result in being stereotyped as 'other' or 'deviant' by a more dominant group or culture (Young, 2018). For Māori, one of the challenges of being 'other' results in inequitable health outcomes, which will be further explored in this section.

Phelan et al. (2010) conducted research into the fundamental causes of health inequalities. They concluded that reducing health inequality is done through creating health policies that diminish the health advantages that those with access to socioeconomic resources have. The logic is that resources such as money, social connections and other forms of power provide a degree of protection against negative health outcomes – and that distributing socioeconomic resources more fairly across the population should decrease health inequalities. What these types of conclusions do not perceptibly do is account for how cultural difference can significantly impact upon people's experiences within the health system, through differences in cognitive styles, customs, spirituality and language (Durie, 2011). The way that people experience illness is socially constructed; and embedded with cultural understandings that impact upon their identity and the way in which health outcomes are managed (Conrad & Barker, 2010). Through reflecting upon repeated instances of traditional healing methods being disvalued by medical staff, some of the

participants expressed grave concerns about how cultural misunderstandings marginalise and impact upon access to health services and treatment outcomes.

Social inequalities and health outcomes are intrinsically interconnected (Fish & Karban, 2014). Health inequities, like poverty, sit along racial lines within Aotearoa New Zealand, and are a legacy of the ongoing trauma of colonisation (Dale, 2017; Reid et al., 2014; Ware et al., 2017). The Human Rights Commission (2012) acknowledges the correlation between institutionalised racism and health outcomes, asserting that structural discrimination occurs through the advantages that dominant groups hold through systematically privileging and maintaining their rules and practices over less dominant groups. The Human Rights Commission (2012) stated that "significant and deep-seated ethnic disparities in health and well-being continue to afflict New Zealand, and there is a good amount of research examining these disparities in relation to structural discrimination" (p. 18). This situation continues today, with the United Nations (2019) Universal Periodic Review report stating that, in Aotearoa New Zealand "the impacts of colonization continued to be felt, through entrenched structural racism and poorer outcomes for Māori" (p. 2).

Compared to other New Zealanders, Māori, alongside Pacific people, are more likely to experience poorer health status (Crichton-Hill, 2018; Harris et al., 2012; Pack, 2018). Fritzell (2014) asserted that having good health is perceived to be one of the most important life spheres, therefore making the goal of reducing health inequities even more profound. Fritzell (2014) stated that it has been demonstrated that health inequity is closely related to social inequalities, through comparing the health status of groups at either

extreme of the social ladder. Systematic differences in health outcomes for diverse groups are therefore unfair and unjust.

One of the findings of the Perinatal and Maternal Mortality Review Committee (2018) report was that "babies of Māori, Pacific and Indian mothers were less likely to receive an attempt at resuscitation and less likely to survive to 28 days" (p. 21). With mortality review report findings like this, it is unsurprising that Harris et al.'s (2012) research into racial discrimination in Aotearoa New Zealand found that the prevalence of racial discrimination experienced can pervasively impact health outcomes. Came and Griffith (2018) framed racism as a "wicked health problem" stating that "social and health inequities are rooted in a history of systems of racism that cut across institutions and levels within institutions" (p. 186) within Aotearoa New Zealand. The Waitangi Tribunal (2019) inquiry into the health services and outcomes indicated "persistent, systemic problems" with Māori having the worst health outcomes of all ethnic groups.

Houkamau (2016) stated that implicit biases can endanger the interactions that Māori have within the health system. To resolve health inequities and to make hospitals a safer place, cultural safety programmes are perceived as being one way to work towards ensuring that Māori and other ethnic groups' health rights are recognised, and to address issues with institutionalised racism (Health Quality & Safety Commission, 2019). Reid (2011) asserts that, to minimise health inequity action is needed in the following areas:

- minimising material deprivation in society;
- eliminating the over-representation of Māori in low socioeconomic areas;
- minimising the effects of exposure to chronic stress;
- eliminating racism and discrimination;

- and eliminating the severe stressors that occur at vulnerable times in life. (p. 46)

Giving birth is a vulnerable time for whānau. Reid's (2011) action points can reduce the interplay between cultural misunderstandings, the ongoing process of colonisation and associated issues of powerlessness that the participants witnessed. In an ideal world, if society were committed to these action points, the role of the participants in health social work would change drastically. They would be able to concentrate on issues of grief and loss related to unavoidable health outcomes, rather than constantly reacting to health issues that are the result of violence and the associated stressors that are derived from poverty, trauma and alienation.

6.3. Controlling the Middle Ground

Controlling the middle ground was the other principal analytical category that emerged through the course of this research. The category became increasingly salient during further analysis about the impact that time has on shaping practice. *Controlling the middle ground* depicts the way in which the participants challenged labels, stereotypes, assumptions, bias and racism, keeping issues of poverty central to practice decisions, and how they managed the emotional landscape of practice. Health social workers visualise clearly the link between social needs and health, recognising the essential requirement for health policy and funding to effectively address the social determinants of health. Through practice, they witness the consequences of ill-health and risk to wellbeing brought on through poverty, housing insecurity, addiction, violence and trauma, alongside issues of discrimination, negative stereotyping, institutionalised racism and other types of systemic inequalities pertaining to group differences. Health inequities differ from health concerns in that they can be rectified with the right social and political will (Fish & Karban, 2014).

Through the discipline's human rights approach to practice, health social workers can speak out in solidarity to address the sometimes seemingly intractable task of reducing unjust health inequities (Ferguson et al., 2018).

The action exhibited and stances taken by the participants within their roles at their respective DHBs was value laden, with values being distinguished relationally within a broader social, cultural and political context. The participants were able to clearly identify instances of value tension, reflect on action taken and decisions made in terms of social work's core purpose, and wider systemic and political issues. They did not speak of being impartial in practice, but instead spoke in terms of being disrupters 'rattling cages' or keeping a 'low profile' to avoid negative attention while trying to achieve their social justice goals. Alongside these premeditated reactions to practice situations, the participants worked to ensure the safety and wellbeing of newborn infants, and women and whānau. The participants acknowledged the perennial challenge in social work practice as to how social workers can invoke change along the micro to macro continuum. The question of how systemic change can be advanced is not an easy one to resolve. Focusing on value demands experienced in the middle ground can signal further strategies for resolution through considering ways to strengthen professional identity and professional voice in practice.

The category, *Controlling the middle ground,* can only be truly understood through an appreciation of the other principal analytical category, *Contextual complexity*. The phrase the 'middle ground' conveys the space that the participants occupied between the medical practitioners, other professionals, organisational systems and the patients. The concept of the middle ground relates primarily to the context in which the health social worker encounters the patient. The category, *Controlling the middle ground,* allows a panoramic

account of the situations and circumstances in which social workers are conscious of their reactions to experiencing value demands. Health social workers align themselves with patients to work collaboratively with them as advocates and key supports, while also balancing the respective accountabilities that they hold to their multidisciplinary relationships, and the systems that underpin professional practice.

For some people and their whānau, the DHB environment can be daunting and confusing, a place where they feel unheard, misunderstood, and without power. Māori especially are more likely to experience differential treatment and institutionalised barriers when accessing health services. These experiences result in an increased likelihood of unresolved health needs (Houkamau et al., 2017; Rouland et al., 2019). Houkamau (2016) asserted that, due to time pressures, pain or fear, misunderstandings can develop between patients and DHB staff; acknowledging also that for Māori being exposed to bias is an additional stressor. In the participants' critical incidents, issues of cultural misunderstandings when working with Māori were extremely prevalent. The participants laboured to ensure that those who sat outside of dominant population groups felt safe within the DHB environment. They adopted an intermediary role, working with patients to improve the relationships between them and those they encounter within their DHB journey, taking a systemic approach to improving opportunities for voice and self-direction.

This recognition of social work being located in the middle ground is not unique to this research. Howe (2014) acknowledged the middle ground in relationship to the pressures that occur through social work being located between the individual and society. Howe (2014) stated that "social work is an occupation forged in the heat of the middle ground. It arises out of the tensions between society as it struggles with matters of care on

the one hand and issues of control on the other" (p. 4). The conceptualisation of the middle ground within this research goes beyond the well-established tension between care and control functions of social work. In this research, *Controlling the middle ground* pertains to how the participants managed themselves within the health hierarchy, the strategies they used to engender systemic change, to advocate and empower patients and their whānau. It is also about the issues of bullying, racism, and discrimination experienced within their practice environment. When the participants were faced with these types of issues or a toxic practice environment, the conceptual category *Controlling the middle ground* relates to the different coping mechanisms that they used in order to persevere. These coping mechanisms involved the participants adopting adaptive strategies that ranged from taking a position of continual challenging to passivity and disillusionment.

The myriad of tasks performed by health social workers are often not sufficiently acknowledged or recognised due to their non-medical nature (Auerbach & Mason, 2010; Judd & Sheffield, 2010; Lloyd et al., 2002). Proctor et al. (2002) asserted that, as social work is a poorly understood profession, it needs to clearly communicate service goals and objectives. Proctor (2017) recalled publicity campaigns that claim "nurses save lives" and asserts that social workers need to provide evidence of their effectiveness through demonstrating outcomes similar to these types of campaigns, in order to be appreciated for the effective solutions and results that they achieve. Steketee et al. (2017) conducted a systematic review into health outcomes and the cost of health social work services in the United States. They found that, while social workers are perceived to be an integral part of the healthcare system, their specific contribution to improving health outcomes and cost-containment are not realised. The social work profession's person-in-environment framework and unique skillset, particularly around addressing the social determinants of

health, hold promise for improving health outcomes, reducing social costs, and providing economic savings.

When Carol Meyer (1983) developed the ecosystems perspective, she expressed concern that as a profession social work does not have clarity about what they can do in practice (Johnson, 2012). Meyer felt that social workers needed to be better at articulating what they can achieve through their employment: "Social work succeeds in ameliorating some of the toxic effects of racism, poverty, sexism, and ageism, Meyer argued, but does not have the resources to rid society of these 'isms'" (Johnson, 2012, p. 241). This assertion reflects the practice realities of the participants. Health social workers in Aotearoa New Zealand do not appear to have the resources mobilised to campaign effectively and collectively across the wide variety of 'isms' that they come up against repeatedly in practice.

The participants worked in complex, crisis-ridden situations to promote responsive environments that support people's wellbeing and social functioning (Germain & Gitterman, 1996). The adaptive strategic aspect of the category *Controlling the middle ground* allows a discussion about how the individual participants and their teams functioned, and how they held onto power in constructive ways in order to control the middle ground. At an earlier stage when this category was being developed, it was nearly labelled *Accommodating the middle ground* due to issues with passivity that the participants demonstrated within the medical model and its associated hierarchies. Upon further analysis, the *accommodating* aspect of this category was rejected, because the participants were not often categorically passive or subservient; instead, they chose their battles and were often very strategic in how they did this. This demonstrates a long-term plan, where social justice as a primary

organising value remained a target to be achieved, alongside self-preservation. Often the participants worked over a long period of time to establish rapport and gain trust in order to gain respect and therefore power, so that their voice was heard within the DHB space.

6.3.1 Māori health outcomes in the middle ground

The conceptual category, *Controlling the middle ground,* signifies the way that social workers can be at variance with the DHB environment and are often challenged by conflicting requirements within that space. The overarching purpose of social work as outlined in the IFSW (2014) definition of social work is "social change and development, social cohesion, and the empowerment and liberation of people" (para. 1). Consequently, social work practice cannot truly be described as impartial as it is embedded in values aimed at achieving these fundamental and prescribed goals (Banks, 2012; Reamer, 2013). This puts into question notions of objectivity. If health social workers are centring their practice on helping the most marginalised in each situation, and that person or group of people are exhibiting behaviours that impact negatively on others, then, in these types of situations, value dilemmas occur and conflict is likely to erupt. It is evident from the participants' narratives that value-related conflict occurred most often within their practice due to issues over scarce resources and, at times, professionals blaming patients for their situations or health needs.

Within the social constructionist paradigm, reality is viewed as being constructed through interchanges between people who are situated within their socio-historical contexts (Priya, 2019). The lived experiences of Māori within DHB services was central to understanding how values are experienced and negotiated within the Western medical system. Considering power, within society and within organisational systems, is central to

understanding socio-historical interchanges. For example, health social workers are critically aware of Māori struggling with how Western constructions of whānau impact upon how they access and effectively utilise health services and welfare provisions (Haultain, 2011). The participants' narratives demonstrated that cultural misunderstandings are prevalent in mono-cultural environments embedded with competing needs, heightened emotions, and conflicting motivations between health professionals and the patient/s. An example of this is Māori whānau wanting to be ever-present supporting patients on the ward, while other patients who are sharing the same space need quiet periods of time without visitors, or when a newborn infant's visitor numbers are limited in SCBU due to risk of infection. For social workers in these types of situations there is a tension between accounting for difference, aiming for equity, ensuring risks are minimised, while also ensuring that people's competing needs are meet. Correcting the imbalance of power means that Māori worldviews and perceptions of the requirements to achieve wellbeing need to be actioned within both the DHB context and the wider ecology.

Social workers can clearly envisage the connection between inequality, inequity and health service provisions that are culturally incongruent with Māori (Pihama et al., 2017). The participants talked about the difficulties of addressing racism that often was subtle and presented as a series of microaggressions or deficit theorising. Deficit theorising can result in health professionals pathologising observed behaviour and having low expectations of patients to manage their health needs; this, in turn, can create a downward spiral, or a self-fulfilling prophecy of failure (Bishop et al., 2009). The participants noted that health professions were more likely to pathologise Māori through perceiving them to be 'exhausting' or 'threatening'. These perceptions, when they occurred, were formed because of 'difference'; for instance, because of the importance of whānau and the concomitant

large number of visitors on a crowded ward. Another example includes being unconsciously blamed for being more likely to present with health issues that were linked to social circumstances relating to poverty and housing insecurity. To counterbalance these issues, it was evident that the participants took time to engage with patients and whānau, and to explain honestly why protocols and systems were in place. The participants worked towards being inclusive of other ways of being within dimensions of DHB culture that could be compromised in a manner that did not unduly impact upon the healthcare of others. They also invested considerable time having honest conversations with colleagues and other professionals to work towards enhancing ways of responding to cultural needs, and to increase understanding and overall responsiveness to difference.

6.3.2 The impact of time

The first salient theme to be explored in the phase two interviews related to the fact that the critical incidents described by the participants were primarily about a piece of work that was conducted over a long period of time. Being able to work in a sustained, holistic fashion with a person while they were in hospital was perceived by the participants to be a luxury that provided them with the opportunity to conduct quality social work. When viewing health social work in terms of a contextual perspective, the DHB context generates a range of constraints and opportunities that contributes to a set of organisational behaviours (Beltrán-Martín et al., 2017; Johns, 2006). Time is of the essence in health social work due to the constant pressure to move people on through the hospital, to make way for more incoming admissions. The use of terminology such as 'incoming admissions' denotes the dehumanising of people being admitted into hospital, and signals some of the organisational and resourcing pressures that impact on DHB systems, staff and patients.

Given the pressure to react to constant casework and treatment needs, a key tension for health social workers is finding the time for preventative work and to work towards social reform. With technological advances in medical procedures (and the resultant escalating costs), there has been increased pressure on Allied Health professionals to accurately measure the effectiveness of their practice (Berkowitz et al., 2019; Nilsson, 2007). Foster and Beddoe (2012) conducted research into Aotearoa New Zealand health social workers who attend to the healthcare needs of older people. They expressed concern that, due to managerial imperatives of reducing the average length of stay, social workers' sole function has become primarily focused on discharge planning, with little time left to address social issues.

Time pressures can create value conflict between professional and organisational values within a hospital setting (Heenan & Birrell, 2019; van Heugten & Gibbs, 2015a). Postle (2007) stated that value conflict occurs:

> [W]here the context for social work appears to privilege the need to process work as fast as possible, constantly aware there are always far more people needing services than there are staff to work with them or resources to meet their needs. (pp. 253-254)

This conflict in values is especially true for health social workers who support patients in crisis situations, which are often complex and laden with risk (Lloyd et al., 2002). Alongside this complexity, it was evident in this research that the participants were required, due to the fast-moving nature of hospital practice, to not only make decisions quickly, but to also broker on services to other professionals outside the hospital. Haultain et al. (2016) conducted research into health social workers in an Aotearoa New Zealand maternity context. Their research also emphasised the importance of time to avoid reactive practice.

Haultain et al. (2016) assert that manageable caseloads and attention to workload management is vital given the complexity of need, and that time is needed to develop quality relationships and shared understandings.

Time shapes decision-making about relationships and engagement in health social work settings (Kerson et al., 2016). As a result of the time-pressured nature of practice, the participants appeared to be very adept at establishing quality relationships and trust quickly with patients in this fast-paced environment. The ability to do this was evident in the person-centred manner in which they interacted with patients and whānau, demonstrating an unconditional regard for the patient, and an authentic interest in working collaboratively (Corey, 2005; Howe, 2009). This person-centred approach to practice is congruent with Māori cultural values. Rogers (1978) interpretation of congruent practice that is empathetic and reflects unconditional positive regard represents the Māori values of pono (truth), aroha (love) and whanaungatanga (valuing kinship, connections and belonging) in action (Davies & Eruera, 2008).

The participants generally acknowledged that *real social work* involves putting aside personal assumptions and perceptions of a situation and working alongside people to empower them. This patient-centred approach to practice was perceived to be incongruent with the medical model at times, and the participants spoke about this type of practice being unanticipated by nurses and midwives when it occurred. This may be because the participants were often focused on reacting to crises as they occurred with little time for intensive work, so that when truly collaborative, planned, person-centred practice occurred, members of the ward or wider team did not foresee it. Murphy et al. (2013) asserted that social work practice tends to be more 'relationship-based practice' rather than person-

centred. They questioned if the essential element of 'self-determination' within person-centred practice can be realistically achieved due to wider utilitarian goals driving the level of service provision and risk management processes within health and social services.

The person-centred approach to practice can be engaged to assist adaption between a person and their environment via increasing self-understanding and self-acceptance (Sheafor & Horejsi, 2008). If practice is primarily centred on adaptation, this is a concern, as 'the personal is political' within social work practice. In keeping with social justice as a primary organising value, practice is not about adapting to unfair environments. Social work practice goes beyond the exploration of the unconscious processes of patients to engender change. Murphy et al. (2013) cautioned against the use of terms such as *person-centred social work*, stating that social work is "state-centred" as the state often imposes obligations on people. These obligations can limit the potential for self-determination, especially within statutory social work.

Collaborative practice that is strengths-based and solution-focused is central to child protection practice, but red flags can also be raised around notions of empowerment. This research was not structured to specifically resolve the question of whether health social workers buy into notions of individual responsibility. However, it was noted that, very occasionally, the participants referred to getting patients to "take responsibility for their situation". Working to get people to take ownership of their problems is valid, but notions of ownership of problems align with neoliberal conceptions of 'blame' if the individual is not achieving or responding constructively to issues in their lives. Many times, in the history of the profession, social workers have worked as agents of social control, and care is needed with the concept of empowerment. Critical analysis about power and oppression moves

practice beyond notions of individual capability or resilience. Critical analysis in practice encourages reflection about structural issues that disproportionately burden individuals and groups in society, resulting in these individuals and groups having a loss of hope or belief in change.

The participants acknowledged that, due to the short engagement timeframes, they needed to be clear about their purpose and refer on to services external to the hospital. It was apparent that health social workers working with premature babies were more likely to develop quality social work interventions, as the baby and whānau frequently stayed connected to the ward for several weeks. This time allowed for deeper engagement to explore and work to resolve identified problems. The participant whose role it was to support women throughout the length of their pregnancy stated that, given the complexity of the social issues, “huge addiction issues, huge family violence issues, huge property issues” that the level of work needed can not necessarily be achieved in nine months. Working with these types of trauma-related issues can evoke a sense of helplessness and a feeling of powerlessness. There is a need for staff to consciously work to support each other in an environment with well-established boundaries to reduce the risk of secondary trauma and staff retention issues (Birmingham et al., 2016). Short-term and long-term goals are needed to empower and overcome issues of grief, loss and instability. For the health social worker this means being collaborative, responsive and supportive in practice (Birmingham et al., 2016).

A few of the participants commented on the cultural constructs that relate to time, when working with Māori. Māori look to the past to view the future, and time is needed to acknowledge iwi and whānau connections, and for whākawhanaungatanga before practice

can begin (Tuhaka, 2003). Ruwhiu (2013) stated that, as a practice principle, whākawhanaungatanga means viewing "a client as a whānau and you are whānau to that client" (p. 134). This concept of whanaungatanga can extend across professional relationships as well, with obligations to be mutually supportive (Kenney, 2011b). For Ruwhiu (2013) the process of becoming whānau in a professional working relationship is paramount, and it is done through time spent on "healing engagements". Tikanga then serves as a guide to support the professional boundaries of practice and collegial relationships. Tikanga is nuanced and complex, which means that, for the participants (and everyone), developing understanding about tikanga is a life-long journey.

Hollis-English (2015) stated that tikanga concepts such as whākawhanaungatanga are vital to the way that Māori social workers practise with clients and in the way that they approach practice within their organisation. With time being of the essence in social work, hegemonic practices that reinforce Western cultural norms around time can unconsciously become the default. Having time for quality engagement would benefit people of all cultures, as Kupe-Wharehoka stated, "the holistic practices and beliefs of Māori are universal, and do not belong to just one people but to all" (2000, as cited in Kenney, 2011a, p. 133).

The participants believed that more success could be achieved if social workers are enabled to engage early with women in their pregnancies, as they would then be able to address the social issues before the baby arrives. The participants were pragmatic about the need to refer work on to other professionals, as illustrated by Mabel's comment that success in social work was being able "to leave the door open for [people], even if it's not with you". When completing these referrals, the participants worked hard to reassure the

patients that someone else would be assisting them, and to build trust in the follow-up that would take place due to the referral process.

The participants expressed concern about the constant cycle of assessment and brokering work. They worried about who is actually able to do the work needed once the women and newborn babies were discharged. Their concerns related to a retraction of community services linked to neoliberal funding practices that focus on funding for a narrow range of specific tasks, and accuracy in risk assessment and risk management. The participants felt concerned that they and other types of social services are only able to respond to a narrow range of specified need and wondered who is actually doing the work. Some participants felt strongly that it was semi-skilled and low paid field workers, 'Aunty Āwhi' who was left trying to support whānau with very complex needs. This is of concern too, because of the 'gendered, raced and classed' nature of this low paid and highly demanding 'care' work, and a feminist analysis is required to give voice to the common experiences and gendered dimensions of this devalued work (Orme, 2013; Tronto, 1993).

The participants who worked in areas where Children's Teams were functioning also raised concerns that social work expertise was not optimised in these MDTs. In these types of MDT, they questioned the ability of other professionals to effectively manage and understand risk without some members of the team having acquired social work's unique knowledge base to provide a foundation for analysis. To conclude this section, it is useful to consider Keddell's (2017) words of caution in her review of CYF that relate to the concerns that some of the participants held about the devolution of CYF before it became Oranga Tamariki:

> The expectation that market mechanisms can provide the full range of required services through third party contractors reflects a commitment to the reduction of the role of the state, and a faith in market-like arrangements to deliver the various types of services required. Whether or not this can meet the needs of prevention of child abuse and neglect is questionable, because market drivers of supply, demand and profit are unlikely to be responsive to the range and complexity of human problems encountered in the child welfare domain. (Keddell, 2017, p. 6)

6.3.3 Political discourses shaping the agenda?

Payne (2005) asks the question, "who sets the agenda?" in relationship to social work theory. This question is relevant to the challenges faced by health social workers because whoever sets the theoretical tone, by implication, sets the backdrop for day-to-day practice. Health social workers need to quickly build an ecological perspective about the professional and interdisciplinary networks that they are aligned to, and have clarity about patterns of authority and to whom they are responsible (Kerson, 2005). Payne (2005) states that there are three arenas of social construction: the political-social-ideological arena, the agency-profession arena, and the client-worker-agency arena. These arenas interact with each other and collectively influence social work practice through competing constructions (Payne, 2005).

The political-social-philosophical arena is formed from social policy that has arisen from political and social debates that often unfold through the media. These policies set the purpose and the function of social service agencies. The participants commented on the dangers of not responding to child protection related risks adequately. They were also very aware of negative perceptions that are held by some of their colleagues about social workers removing infants from their whānau unnecessarily, as illustrated in the quote from Joan below:

> I think a certain group of midwives that I worked with felt that social work was there to kind of come in and mess up families, be intrusive and cause anarchy on the wards, and just be generally difficult in families' lives.

In child protection practice the incidences of death reviews and outcomes of inquiries can set an emotionally charged moral tone to these debates, which can polarise and vilify social workers and organisations (Warner, 2013). An example of this can be clearly seen in the outcome of the documentary about the Hawkes Bay hospital uplift mentioned earlier in the chapter. Oranga Tamariki have clearly not protected individual social workers whose practice was recorded in this documentary. Their actions have been reviewed as part of a practice inquiry, and clearer media statements could have been made about the collective nature of decision-making within Oranga Tamariki and the systemic pressures that are known to exist within the governmental ministry.

Another outcome of the widespread dissatisfaction due to the media attention about the events surrounding the Hawkes Bay hospital documentary has been a reported increase in threats and violence towards Oranga Tamariki social workers (Robson, 2019). Threats of harm to social workers are, in part, a reflection of the way that sections of society views social workers and the inadequate resources put in place by organisations and public policy to value and protect the workforce. Hunt et al. (2016) research into child protection workers encountering violence highlights the societal and economic costs through the resultant health issues and absenteeism experienced by child protection social workers. They assert that policy and practice changes are needed, and that children cannot be adequately protected if social workers do not receive better organisational support and supervision (Hunt et al., 2016). These assertions apply to the participants as well as to Oranga Tamariki social workers due to the role that health social workers with newborn

infants take in the assessment and management of risk protocols when protecting infants from potential incidences of child maltreatment.

Payne (2005) states that the agency-professional arena represents the agencies and organisations that employ social workers, alongside of the professional associations and trade unions. These bodies and employers shape the way that social work operates in practice and interacts with the political-social-philosophical arena to lobby and influence the drafting of policy. For social workers in Aotearoa New Zealand, it is the professional association and the unions that predominantly represent social work's voice (Ross, 2014; Warner, 2013). In Aotearoa New Zealand, child abuse tragedies have led to political events that have resulted in policies that enforce an authoritarian approach to practice that emphasises systems of surveillance rather than agency support (Beddoe, 2014; Joy & Beddoe, 2019). Payne (2005) asserts that the agency-worker-client arena is the most important, as it provides the immediate context of practice within a set of prescribed roles.

The theoretical tone underpinning child protection practice in Aotearoa New Zealand has been predominantly been set in reaction to child deaths as the result of maltreatment in a neoliberal political climate. As Keddell and Hyslop (2019b) noted, that "despite efforts to develop a child welfare orientation, particularly in response to Indigenous Māori concerns relating to disproportionality, the policy orientation remains broadly protectionist" (p. 4). The public's opinion appears to be shaped by the tone of the media responses and the political arena in which these tragedies have been debated. Māori whānau are often perceived as the site of increased risk, and the responses to this risk and tragedy have become increasingly punitive with increased likelihood of children being removed rather than whānau being supported (Keddell, 2017). The social investment approach to children

positions them as vulnerable victims whose rights need to be protected from their irresponsible caregivers, thus minimising the significance of the relationship between children and their whānau (Keddell, 2018; Lonne et al., 2016).

A child-focused policy orientation that utilises a social investment approach to emphasise children's rights needs to be applied cautiously by social workers and their organisations. This approach, when combined with neoliberalism, can result in removing children from their whānau, to rescue them, without supporting whānau to optimise their parenting (Lonne et al., 2016). In terms of what this social investment child-centred discourse means to health social workers, it is evident from the participants' narratives that there is a concentration within DHBs on rigorous risk prediction and risk management. When the media and political spotlight focuses so intently on high-profile child protection situations, it is unsurprising that organisations like DHBs become very focused on their staff being procedurally correct to minimise the risk of undue criticism and negative publicity.

When considering why health social work is challenging, it is evident that political discourses are powerful, shaping policy and reinforcing particular value-based approaches to practice within DHBs (Ware et al., 2017). These discourses shape practice and divert attention away from social work's professional understanding of the importance of strength-based relationships to manage risk. Durie (1985) provides a perspective of how Māori perceive health, stating that it is conceived in terms of the needs of the community, while a Western view of health emphasises personal health issues and socio-economic inequalities. Health is perceived holistically within Te Ao Māori, highlighting the connections between the four cornerstones of health: spiritual, physical, psychological and whānau (Durie, 1985; Warbrick et al., 2016).

Critical theories which help to examine factors that exclude and marginalise are unlikely to be congruent in a neoliberal practice environment. Within a neoliberal perspective, there is a concentration on locating solutions through the strengths that individual clients hold, with only surface-level regard for diversity and difference, and the importance of the collective. Having clarity about the theoretical base that underpins practice is necessary. The profession's values are reflected in the way that social workers make sense of situations; however, the theoretical knowledge that we apply is shaped and bound by the context in which practice is located.

The Social Work and Health Inequalities Network (SWHIN) asks the following questions: How relevant are health related performance objectives to Indigenous cultures? How do social workers demonstrate their conviction to honour Indigenous knowledge? How does practice change when it is focused on restoration for those marginalised by ongoing processes of colonisation? (Ka'opua et al., 2019). These questions raised by SWHIN demonstrate the challenges facing health social workers globally. One way does not fit all. Health social workers are driven through their value base to develop partnerships and practice that advance the wellbeing and knowledge of Indigenous people and all people who are marginalised. To reduce marginalisation and to resist hegemonic discourses, many of the participants recognised that Indigenous health perspectives need to be made more visible. This visibility needs to be increased within wider health practices and within social work's knowledge base (Ka'opua et al., 2019).

6.3.4 Keeping poverty on the agenda

Along with the question of 'Who sets the agenda?', another significant question to be reflected upon when considering values in social work is: 'Is poverty central to the

practice agenda?' Poverty is a fundamental social justice issue affecting social work practice. It is so central to day-to-day practice that it can be normalised by the profession (McCartan et al., 2018). The established link between poverty and child maltreatment can be perceived as being stigmatising, which can further reduce social workers' ability to recognise the part that poverty plays in increasing risk of harm (Morris et al., 2018). Anti-oppressive approaches provide a multifaceted reflexive lens to enable social workers to consciously resist 'culture of poverty' discourses. Some of the participants recognised their own privilege and, on the whole, it was apparent that they reject discourses that construct people as being individualised active agents trapped in poverty due to self-perpetuating behaviours which make them a burden on the state (Fook, 2012; Lonne et al., 2016). Morris et al.'s (2018) research into how social workers discuss the socio-economic circumstances of children in need of care and protection found evidence of a detachment in practice from poverty-related issues. They surmised that this could be due to practice being unduly influenced by organisational culture that focuses on risk management in a manner that is detached from issues of deprivation.

Bywaters et al. (2019) advocated for social work practice that strengthens connections between people's "private and public worlds" to reinforce the profession's role in "shaping and managing the conceptions of families', parents', and children's lives in the context of profoundly unequal societies" (p. 6). This type of anti-oppressive approach is widely appreciated within social work practice. However, as Morris et al. (2018) state, "poverty is the wallpaper of practice: too big to tackle and too familiar to notice" (p. 370). Health social workers can easily become overwhelmed by issues of poverty and become immobilised. For the participants, poverty was linked to issues of complex need. McLaughlin et al.'s (2017) research into social justice action in child welfare practice found that

experienced social workers employed a systemic approach to practice, working collaboratively with clients to address social justice issues, and were able to link individuals' experiences to structural issues. These findings mirrored how the participants were able to express their views about the way in which they positioned social justice issues as being structurally located. Workload issues related to time and resources were the key limiting factors to enacting social justice action. Morris et al. (2018) state that:

> There is a complex interplay of professional values, private reactions, and public expectations, structural and systemic forces that result in ethical and practice dilemmas. Critical to addressing these dilemmas is interrogating the disconnection between abstracted understandings and practice actions. In order for social work to move forward in addressing child welfare inequalities, an extended knowledge of the relationship between poverty and harm must be developed, alongside robust frameworks that engage with conceptual understandings of shame, suffering, and the consequences of inequality. (p. 371)

For the participants, poverty was linked to the bread and butter of practice, the growing issues with social housing shortages had become normalised. With clarity, the participants appeared to comprehend the consequences of "shame, suffering, and inequality" (Morris et al., 2018, p. 371). External to the participants' immediate work environment, their voice and critical understandings about the impact of poverty on newborn infants and their whānau did not appear to be heard, although some of them may be involved in external community development outside of their work, or within their professional associations, or have a social justice voice through their contributions to social work research. Bradshaw (2018) states that, in "developed states", under neoliberal policy environments, there is no conclusive resolve on what the correct balance between the responsibilities of family, the responsibilities of the market or the state when it comes to

supporting children out of poverty. Newborn infants and children in Aotearoa New Zealand are not being fairly treated in terms of redistribution of resources, with growing inequality increasing vertical injustice (St John & So, 2017). Social work values require the profession to speak out about injustice and mobilise community action to improve the adequacy of incomes and housing. For the participants it appeared to be very difficult to do this when they are immersed in a pattern of responding reactively to repeated risk-laden crisis situations that involve immediate and overwhelming need, while also being limited by issues of confidentiality.

6.3.5 Emotional landscape of practice

The emotional landscape of practice category refers to many of the emotional hardships that health social workers experience, whether due to issues of emotional fatigue, mistrust, or derived from the vicarious trauma of working with the immediate effects of violence. The information in this section is centred primarily on how professional identity is influenced by the nature of the relationships that the participants had with others and the emotional demands of attending to complex societal issues in what are often fraught systems.

Banks (2016a) refers to 'ethical emotion work' within professional practice as the emotions linked to:

- caring for others;
- respectful practice;
- feelings of compassion, empathy, guilt or shame.

Banks (2016a) differentiates between emotions and feelings, stating that emotions contain a more reflective element, combining affect and cognition; while feelings such as pain are

more immediate and can be more engrossing. The participants demonstrated a very clear 'ethic of care' when reflecting on elements of their practice. With hindsight, they were very hard on themselves for things that had gone wrong in practice, even though they were pragmatic about the restricted, fast-paced nature of health social work practice. The participants described feeling buffeted by macro-level changes that they had limited control over. They were conscious of the limits of their power, but still expressed feelings of guilt when they were not able to provide an adequate service or broker an appropriate resource. Value based practice invokes strong emotions, with individuals often making extraordinary efforts to maintain their practice standards (Gordon, 1965). The participants experienced strong emotions when outcomes in practice were not what they had anticipated or desired. These emotions are, in part, evidence of the value-informed nature of their practice and their aspirations to achieve social work's foundational goals in practice.

Social housing and homelessness has become an increasingly 'wicked problem' (Johnson, 2017), and the participants strove to pragmatically resolve these types of issues with limited resources in an environment of contracting social services. The work took an emotional toll on them when challenging situations deteriorated and harm occurred. The participants worked hard to gain the trust of their colleagues within their ward or DHB service. Harrison and Smith (2004) asserted that "trust can only become active between individuals who base their relations on commonly shared norms" (p. 376). As the only non-medically trained health professionals within the MDT, the participants often had to vigorously defend their risk-related practice decisions and spoke in a language of 'battles and challenges' regarding their work with other professionals. Beddoe (2017) has noted that within health social work, military metaphors that invoke a battlefield are employed to

describe health social work practice. Trust is necessary when the outcomes of interventions cannot be certain (Harrison & Smith, 2004). Social work practice with at-risk newborn infants involves great uncertainty due to the many complex and interrelated variables, therefore a high level of trust is needed between members of an MDT when assessing and managing risk.

The category *emotional landscape of practice* articulates the emotional labour that health social workers undertake in order to attain the basic requirements of what they needed in practice to achieve social justice. It is important to note that other medical professionals within the DHB are under similar stress due to the emotionally demanding nature of their work (Chambers & Frampton, 2016). In a report by the Association of Salaried Medical Specialists (2019) it was reported that the health workforce is expressing "nothing less than desperation about the increasing pressures to cope with hospital workloads", and that "there is a palpable sense of dread among members of what's in store next winter when hospitals are at their busiest" (p. 1). This sense of being emotionally overwhelmed is symptomatic of a health system that is overloaded, with services stretched. Health professionals nationally are under increasing pressure, are susceptible to burnout, and are struggling to remain resilient (Chambers & Frampton, 2016).

> If we can't be kind we shouldn't be in our job, some social workers are just tired, they've done it for a long time and it's difficult [to have] a compassionate eye. (HG)

This quote from HG speaks to the challenges of being emotionally competent in health social work practice. As established, the DHB is a fast-paced practice environment where health social workers are having to react with immediate effect to multiple crisis-ridden and trauma-laden situations as they unfold. The quote above speaks to the need to remain emotionally available in practice – despite workplace pressures. Kindness often involves

prioritising the needs of others first, and the participants found it hard to be kind to themselves under the workload pressures that they faced due to the complexity of needs and the sheer volume of work. The value of imparting a sense of genuine respect can be hard to uphold with patients in time-limited practice environments. The requirement to be kind and respectful is challenged further by the complexity of the different layers of systemic need and vulnerability that newborn infants and their whānau can face.

Feminist theorists Fisher and Tronto define 'care' as "a species of activity that includes everything that we do to maintain, continue and repair our 'world', so that we can live in it as well as possible" (Tronto, 1993, p. 103). Being kind or caring from this perspective is ongoing as it is "both a practice and a disposition" (Tronto, 1993, p. 104). Caring involves a commitment to making the needs and concerns of others the foundation for action. Beddoe (2017) acknowledges the concept of social workers occupying the middle ground, stating that health social workers' identity is "forged in in-between spaces, performing actions that may be unappealing to others, or which may fall between their understood roles" (p. 129). Unfortunately, as previously recognised, care work is often "gendered, raced, and classed" (Tronto, 1993, p. 112). Social work is about respectful caring, a vocational commitment to care about inequality, human rights and social justice. It is not surprising then that the profession is also gendered and, in Aotearoa New Zealand, has historically struggled to be recognised alongside other registered professionals. Social work as care work is devalued.

Holistic assessments conducted by social workers can be viewed with suspicion by other hospital professionals and given the decreasing length of hospital stays they are becoming harder to complete (Wilson, 2019). The participants expressed frustration that

perceptions about their efficiency and effectiveness was linked to their visibility on the wards rather than the outcomes that they achieved. The Office of the Chief Social Worker (2014) workload casework review demonstrated that social workers dealing with child protection issues have a considerable amount of desk time, conducting the reporting and administration processes behind their risk assessments. Some of the participants felt that to be perceived as being effective they had to be visible on the wards. Joan stated, "I've seen people play that game in hospital social work. I've seen social workers wandering around looking like they're busy and they're not busy, but it is about maintaining your visibility and networks". Social workers are the professional minority within the DHB environment and, while Joan was critical of social workers who 'play the game', she also acknowledged that the underlying purpose of doing this was networking and relationship building.

When considering the future of the social work profession, Lavalette (2019) asserts that "we do not need to be defensive. We should be much more assertive about what we do right, and open to the idea that we can improve some aspects of our activities" (p. 1). Lavalette's (2019) words are true in relationship to Joan's comments above, as they link to the work that the participants had to do to build trust so that their colleagues would have faith in their practice. Non-social work colleagues developed understanding of social work processes through situations of collaborative working. It could easily be argued that the time spent networking on the ward is a strategic tactic that health social workers use to gain some control of the middle ground, for them to gain place and space on the ward so that their professional input, when it is vitally needed, is heard and respected.

Lavalette's (2019) comments about not being defensive when there is a perceived lack of success are important. When a critical point is reached in practice, care is needed to

not also have a crisis in confidence in the social work project. The participants indicated that, in the current funding climate, success in practice is becoming more difficult to obtain, resulting in social workers having to try harder to achieve a good result. Remembering also that success was overwhelmingly defined by their own internal perceptions of success in social work practice, these perceptions are aligned with professional prescriptions of holistic collaborative practice to achieve predominantly patient-centred goals.

Krumer-Nevo (2015) asserts that the combination of neoliberal policy and new managerialism “leads to the abandonment of the ethical aspect of social work practice, the individualisation of social problems and the othering of poor people” (p. 1805). It is simpler in practice to focus on empowerment than social change, as empowerment lends itself to individualised interventions that rely less on intervening with structures and wider social processes (Ashcroft et al., 2017). Perhaps also, making a difference through individualised interventions at a micro level provides a more instant feel-good factor rather than a hard slog towards wider systemic change with little hope of immediate gains.

Mantle and Backwith (2010) conducted research into alleviating poverty through social work practice. They concluded that social workers being closely connected to the community is the best way to ensure effective practice through a prevention and empowerment approach to community action. O'Donoghue (2015) asserted that health services in Aotearoa New Zealand are in the midst of devolving from hospital into the community. Healthcare contracts are becoming increasingly focused on primary level support that can involve social workers being based at general medical practices and speciality clinics. O'Donoghue (2015) believed that the challenge for the profession is:

> …specifying what social work practice involves at the tertiary, secondary and primary health care levels. For health social workers in hospital-based services the challenges include: increasing demand and decreasing resources within the sector; discussions regarding the regionalisation of services; an aging population; the increasing prevalence of chronic diseases; and the rising prevalence of mental ill-health. (p. 2)

The Association of Salaried Medical Specialists (2019) stated that the trend of shifting resources from the hospital to community health services will result in more emergency care patients as more resources are needed in the community. This assertion is especially true for the more economically deprived Māori and Pacific populations who struggle to access general practitioners. A key contribution that social workers can make to primary healthcare teams is providing outreach to communities that struggle to access medical care, to increase the likelihood of early intervention. Social workers in primary health help to move practice beyond technical prescriptions into a more relational and holistic approach (Ashcroft et al., 2017).

The category *emotional landscape of practice* also refers to the impact of working with violence to minimise the risk of maltreatment primarily for woman and children. Pregnancy can provide a unique opportunity for intimate partner violence intervention (McMahon & Armstrong, 2012). Hospital social workers are confronted with the impact of the violence and tasked with taking action to protect women and their newborn infants. Resilience is needed to work alongside of these women and their whānau to remain effective. A mixture of creativity and caution is needed to engender trust so that these women are open to reaching out for assistance at this time (Crichton-Hill, 2010). It is emotional work that can often go wrong, and it is important that the professional social work knowledge gained from maternity social work practice is utilised to advance social policy. Felitti et al. (1998) assert that their research into exposure to childhood

maltreatment established a “strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults” (p. 245).

The consequences of maltreatment and adverse childhood experiences are recognised as being felt throughout the lifespan (Felitti et al., 1998). This knowledge about the impact of adverse experiences places additional responsibility on society to safeguard and protect children. Appropriate and timely intervention into adverse childhood experiences can reduce the impact of abuse and reduce the risk of ongoing trauma (Walsh et al., 2019). Māori are over-represented in family violence statistics (Dobbs & Eruera, 2014; Family Violence Death Review Committee, 2017). With the right support and political motivation, child maltreatment is not irrevocable within a society. Using the words of the Second Māori Taskforce on Whānau Violence, it is important to dispel “the illusion (at the collective and individual levels) that whānau violence is normal and acceptable” (Kruger et al., 2004, p. 5). The Second Māori Taskforce on Whānau Violence asserted that:

> Violence is the language of the powerless. The presence or absence of violence is indicative of the state of wellbeing or dis-ease of whānau, hapū, and iwi. Whānau violence is a labyrinth because it is often housed inside imposter tikanga. (Kruger et al., 2004, p. 9)

It was evident that, overall, the participants worked to give emphasis to the findings of the Second Māori taskforce (Kruger et al., 2004), and to achieve the goals of Pūao-te-Āta-tū (Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare, 1988). They worked hard to avoid reacting to risk of violence in a manner that positioned the needs of the mother or the whānau against the needs of the newborn infants. It was apparent that they held the paramountcy of the child central, while striving to understand the structural issues and lived realities surrounding the newborn infant and

their whānau and to prevent harm to everyone (Haultain et al., 2016). This work took an emotional toll on them.

Pack and Brown's (2017) writing about Australasian health social work practice with gender and sexual minorities asserted that social workers' emancipatory approach to practice can model an anti-oppressive stance for other professionals. This assertion was also true for the emancipatory anti-oppressive approach that the participants took while occupying the middle ground. It was evident in the way that the participants viewed their possible responses to being approached by a Māori woman about experiencing racism through the actions of ward staff. Not only did the participants consider confronting and challenging the racism directly with colleagues, they also took time in practice to have guided conversations to widen other people's worldview to alternative social realities.

Many of the participants also said that they would take significant care with recording woman's complaints to avoid the person being targeted by staff. Some of the participants acknowledged that it was a delicate balance between effectively challenging instances of staff misconduct and ensuring that the person making the complaint was not at risk of feeling alienated from DHB services. The participants all stated that they would take some sort of action to testify to the woman's adverse encounters with staff. Hyslop's (2018) research into health social work in Aotearoa New Zealand reported that health social workers worked to record patients' social history well in medical notes in order to humanise them within the clinical hospital system. Similarly, Cairns et al.'s (2017) research into the ethics of sharing information in health records found that social workers managed inter-professional tensions by accurate recording of events that presented the events neutrally in order to minimise misunderstandings.

These findings reflect the participants' voice and intentions within this research. The participants demonstrate a need to take social justice action to change and challenge systems, while still trying to manage the multiple emotional responsibilities of conducting these types of challenges. Social workers' integrity can be invoked in situations of value conflict and courage is needed to resist the pressure to follow unethical agency norms (Banks, 2016b). The role of the health social worker complements the medically trained staff within the DHB environment. Social workers' person-in-environment approach to practice means that social workers focus on the patients' understanding of their health and social needs, alongside the support that they will need upon discharge. Maramaldi et al. (2014) assert that, through the health social workers' unique skillset, they can take a lead role in addressing psychosocial issues and tensions, which allows other team members to concentrate on medical needs.

It was apparent that the participants worked within the confines of the economic and policy constraints of the hospital system, and they remained cautious about denying people's social realities or oversimplifying complex situations (Kerson & McCoyd, 2013). The participants demonstrated that they were very aware of how patients and whānau are located within the culture of the ward or DHB service. They worked hard within micro- and meso-level systems to carefully navigate patients through the stressful situations and tried to give voice to their concerns. The participants strived to educate other professionals about the patients' social realities that were impacting upon the way that they received services. Alongside this emotional complexity, they also worked to build professional relationships with their colleagues so that their actions and risk-related decisions were respected and trusted. It was noted by some of the participants that anyone who sat outside of the ward

or service norm were perceived as problematic, thus providing the participants with the imperative to establish the trust and respect of their colleagues.

Hood (2018) stated that "complexity in social work is often about relationships" (p. 4). Social workers concentrate on relationship dynamics, dealing with patterns that the dynamics sets and, as they do so, they become part of the very dynamic that they are trying to influence (Hood, 2018). Kerson (2005) stated that many of the systemic issues that health social workers face are "related to location, access, authority, and change; turf conflicts, teamwork and interdisciplinary, intra, and interagency work" (p. 52). McLaughlin et al. (2017) believed that experience in practice may allow social workers the time and confidence to integrate anti-oppressive approaches to their practice and influence relationships through developing their voice about social justice issues. Hyslop's (2018) research into identity in social work within Aotearoa New Zealand led him to conclude that:

> Social work occupies an intermediate location. The stances adopted to facilitate the tasks required in this territory – juggling, balancing, bridging – generate particular kinds of awareness and particular skills/knowledge – flexible presentation, managing uncertainty, tolerating ambiguity, standing in more than one world. (p. 27)

It was evident that professional socialisation occurs in hospitals through the development and maintenance of professional values and identities. These shared professional values and identities are generated through common experiences and accepted understandings of problem resolution processes (Evetts, 2013). A conclusion of the research was that developing professional values is complex and highlighted the importance of encouraging social workers to incorporate values and ethics into their day-to-day practice in order to promote ethical competence. The participants interviewed for this research found that, with time and experience in practice, they were better placed to maintain their

identity and chosen practice stance. This stronger sense of self as an experienced social worker allowed them to feel resilient as they were more congruent in practice and less influenced by domineering colleagues when put in situations of competing values.

CHAPTER SEVEN: CONCLUSION

7.1 Overview

This final chapter brings together the key points from the research, moving full circle to reflect on the learnings gained through the research project in alignment with the stated objectives. This research set out to explore the situations and circumstances in which health social workers are conscious of their values, to explore how value demands are negotiated, and to describe value demands in terms of their perceived influence on day-to-day behaviour and professional identity. The critical incident technique combined with the reflective analysis on the cue card statements produced significant detail about how values inform the participants' professional identity. The data gathered visibly illustrated how values support day-to-day practice within health social work, and the way the participants utilised value-based thinking to unpack value demands.

The participants' use of critical thinking enabled them to tacitly apply an ecological perspective to complex situations to perceive the connections between interrelated systems and structural issues. The participants' reflexive approach to practice allowed them to speak confidently about the place of values contained within their critical incidents. Given the reactive nature of practice it would be challenging for the participants to apply this level of thought, insight, and analysis about the place of values within day-to-day practice. With good use of supervision and sound managerial and collegial support, this level of critical analysis and reflexive thinking about values can be used to bolster value-based decision-making and their professional identity in health practice.

Within this concluding chapter, consideration is given to how values support a reflexive approach to practice; the influence of other professionals on values; the importance of difficult, value-based conversations; and commentary is provided concerning how values can sustain social work practice. The participants' collective practice narratives illustrated an approach to practice that was reflexive and considered situations from an ecological perspective. The participants also placed great value on an honest, transparent approach to collaborative practice. The participants demonstrated resilience in practice in the way in which they strived for fairness when upholding competing rights and obligations.

This chapter begins with an explanation of the salient factors that have been found through this research to be associated with the way that values are experienced and negotiated. The concept of *kaiwhakatara* (conscience-prickers) is introduced within this chapter, and then later on the concept of *pā whakawairua* (replenishing and strengthening workers) is also introduced to further consider how the participants addressed the challenges of value-based practice. Neoliberalism and the status of whānau have been identified as significant factors that shape values throughout this thesis, and subsections are included in this chapter that collate the findings in terms of these two important, but quite disparate, influences. The chapter then concludes with considerations about the implications for practice and research from this study, the limitations of the research, and its contribution to social work knowledge.

7.2. Experiencing and Negotiating Professional Values in Practice

This research has presented information about how health social workers working with newborn infants experience and negotiate values. The subjective experiences described by the participants only allow a partial view into their reality but are a valuable

source of knowledge when endeavouring to understand how values are experienced, and how social workers respond to injustice in practice. The ecological perspective and symbolic interactionism provided a framework to elucidate the way value demands are experienced and negotiated. These perspectives demonstrate how power resides within transactional processes and are useful to gain a more critical understanding about the influence of ethnicity, race and gender within practice (Ungar, 2002). The theoretical perspectives provided understanding about the way that the participants behaved in their critical incident, drawing attention to how the participants derived meaning about values through their interactions with the people and systems that they encountered (Blumer, 1986).

The knowledge base of the profession, alongside professional values, helps social workers discern the nature of presenting problems, with attention to their roles and responsibilities, and the associated skills and intervention approach needed (Trevithick, 2008). As such, social work education and professional development is designed to develop and maintain a critical understanding of role and purpose within complex and interrelated systems. Healy (2014) acknowledges that "some social work theorists argue that recognition of the systemic character of human problems and the need for intervention to improve the interaction between the client and their broader environment distinguishes social work from other human service professions" (p. 115). The term *frame reflection* is used by Schön (1983) to explain how different professional groupings have distinct ways of framing an event or incident in practice. The different frames used to reflect on practice can result in conflict as distinct professional groupings may give primacy to different aspects of the situation, or the facts relating to the event (Leigh & Laing, 2018). Banks (2016a) places importance on framing when discerning ethical issues, to develop a collective understanding about the rights, responsibilities and risks within a given situation. When working with

colleagues, frame reflection can assist with developing a conscious collective understanding about risk and the various value-based tensions at stake.

Some of the participants described situations of feeling powerless, at the bottom of the medical hierarchy and disenfranchised within a risk averse environment. There are many contradictions within health social work, and it was evident that, while these participants expressed feelings of disillusionment about the place of social work within the health system, they also expressed a considerable amount of pride in the professional knowledge, values and skillset. This sense of professional pride was linked to social workers' demonstrated ability to work creatively, to make a difference and to be resilient in practice. The social work toolkit was perceived to be good and sound, but the DHB systems in which it was located were, at times, perceived to be problematic. Some of the participants thrived in their roles within the DHB and felt that they were valued team members; however, they still had issues with the way that social work services were managed and located within the wider ecology of the DHB. Through analysing the participants' discourses, it was evident that the role of social work sits uncomfortably alongside other professionals. DHB managers and MDT members frequently did not appear to share the same understanding as the participants over the role and function of health social work, and this led to health social workers feeling unsupported in their roles.

It is apparent through conducting this research that values, decision-making, and professional competence are all interwoven. Values, whether they are consciously acknowledged or not, influence decision-making, while expertise is needed to ensure that sound decisions are made in complex situations. Schön's (1992) assertion that value conflicts are recognised as being central to professional practice applies even more so to the

complex social justice and human rights mandates underpinning social work practice. The influence of other professionals alongside managerial agendas can be hard to resist and can insidiously undermine social workers' capacity to practice in accordance with the profession's value base.

An ecological perspective was used by the participants in their critical incident analysis to deconstruct the power of competing discourses that privilege professionals and professional services over the marginalised people and communities that they serve. The participants questioned normative assumptions about the systemic behaviour of professionals within the DHB setting (Ungar, 2002). Kerson (2002) states that a concentration on ecology enlarges the focus to include adaptations to change, as well as the interdependency between people, institutions, and culture as they interact both between, and within, interlocking systems. Value-based thinking complements an ecological perspective, creating a lens that informs social workers' knowledge base, enhancing their ability to critically understand situations and circumstances, and how to intervene safely, effectively and according to need. The challenge of value-based decision-making resides in the management of bias, assumptions and issues of transference. A reflexive approach to applying knowledge to situations and circumstances, according to purpose and needs helps to illuminate points of difference between personal, professional and organisational values. This knowledge base also helps social workers to discern other frames of reference and value positions that the people that they are working with might hold.

7.2.1 Kaiwhakatara

The participants demonstrated critical analysis about how interpersonal issues played out within teams. This analysis was evident in the way that the participants guided

colleagues to develop more holistic understandings of the pressures that patients were facing in situations of conflict. The critical incident narratives and subsequent analysis established that the participants often acted as kaiwhakatara. Ruwhiu et al. (2016) define kaiwhakatara as "mentors who are not scared to address difficult things that are often left covered up or unspoken – conscience-prickers!" (p. 88). Ruwhiu et al. (2016) use the term *kaiwhakatara* to refer to significant people who surround you that demonstrate brave thinking linked to social justice action and who then influence the way that you think, your own decision-making and subsequent actions.

The participants often adopted the role of the social conscience of their MDTs, addressing difficult value-laden issues and endeavouring to educate other professionals about the psychosocial needs of the people using the DHB services. For some of the participants, it is evident from the way that they spoke about their interactions with their teams that they were perceived by some of the team as kaiwhakatara. For these participants, they were able to act as a source of information, a 'critical friend', or as a mentor on psychosocial issues. For other participants, the insights that they shared, or the challenging nature of their conversations were not always appreciated or welcome. It is important to point out that professionals from other disciplines are likely to take on this advocacy role as well within multi-disciplinary health teams. It is highly improbable that the participants were the only ones acting as kaiwhakatara within their services, but the point of difference is that, for social workers, empowerment and advocacy is a primary function of their role.

The participants' narratives revealed a high level of objectivity and reflexive practice. The participants demonstrated an ability to intuitively critique interrelated systems and hold

onto a bird's-eye view of practice. This may be because the process of the interview narratives allowed for that measure of distance; but the way that the participants functioned as educators with their colleagues to create space for increased understanding about the patients' reality demonstrates a level of knowing-in-action. Rights-related values such as human dignity and liberty involve abstract thinking, and are not always easily perceived in everyday social work practice (Connolly, 2013). Schön (1992) assumed that competent practitioners know a lot more than what they articulate, as knowing in practice is often tacit. This statement is true of how the participants negotiated the value demands highlighted in their critical incidents. They exhibited an intuitive knowing-in-action that was linked to their social work identity and motivation to assist the people that they encountered in practice.

7.2.2 Neoliberalism

The influence of the neoliberal paradigm has been referred to extensively throughout this research due to the power that it holds over the ability for health social workers to realise their professional values in everyday practice. Some of the fundamental ways in which neoliberal policy and practices have held sway over the participants are now summarised. Neoliberal thinking is evident in the devaluing of the ethic of care, and the way in which professional status and pay is gendered. Neoliberal thought promotes the individualisation of social problems. This has resulted in the 'othering' of people who are marginalised. This has a utilitarian impact, with people located outside of dominant groups becoming invisible with their needs less likely to be met, and an increased chance that they will be blamed for their social circumstances and inability to compete within the market-driven economy.

For social workers in practice, neoliberalism encourages a propensity for them to focus on individual empowerment rather than advocacy for social change, as the layers of structural disadvantage can become normalised or too big to address meaningfully. Neoliberal policy influences the way that risk is interpreted, assessed and managed, with an emphasis on individualised blame but also creating risk-reporting structures that demand an adherence to technical procedures. The way that risk is envisaged from a neoliberal standpoint also encourages the view of children as 'social investments' to be protected and have their rights safeguarded. This can result in a disconnection between the rights and needs of children from their whānau, and a 'rescue and remove' orientation towards child protection. This orientation places pressure on the participants to report every concern to Oranga Tamariki. This is a form of defensive practice that can skew the view of the newborn infants' whānau, emphasising deficits that, on some levels, are contrary to the strengths-based language promoted in child protection practice. The 'rescue and remove' orientation does not adequately account for circumstances of structural disadvantage and experiences of marginalisation that are impacting upon people's ability to safeguard and nurture their children. Another impact of neoliberalism is that, within health social work practice, perceptions of efficiency and effectiveness are being increasingly linked to targeted outcomes prescribed through ministerial contracts rather than a focus on professional standards and goals.

All of this points to various layers of restriction placed upon social workers in practice to adhere to prescribed standards and procedures in order to be technically correct and safeguard the rights of infants. There is a decreased emphasis on the art and craft of social work, which allows social workers to respond in alignment with their professional wisdom. Professional wisdom is gained from social workers' training and practice

experience, and also comprises their values, ethics, theoretical knowledge, and understanding of evidence-based practice. In the often chaotic and complex situations that quickly unfold, social workers need the freedom to follow their values and professional standards to achieve social justice outcomes for the people with whom they work, while still attending to organisational obligations.

7.2.3 Sustained by Values

This thesis has explored the contextual complexity that health social workers encounter within the *middle ground* to consider how values are experienced and negotiated within an often misunderstood, high-stakes environment laden with contradictions and risks. O'Leary and Tsui (2019) asserted that "social work originates from values, it is part of our social values, social workers work for values and is sustained by values" (p. 1328).

The participants expressed frustration about the inability to carve out time for social justice action. Jansson (1994) believes that, at different points in the history of social work, the profession's value preferences need to be revived and reaffirmed as new generations of professional leaders replace those who have retired. The Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare (1988) released the Pūao-te-Āta-tū report at a critical juncture for the profession – a time to take stock and reflect on the way in which the profession aligned itself with tangata whenua and the government. With the amendments to the Oranga Tamariki Act 1989, the current inquiries into Oranga Tamariki, the revised ANZASW (2019) Code of Ethics, and the changes brought about through the Social Workers Registration Legislation Act 2019, the social work profession in Aotearoa New Zealand is once again at a critical juncture.

Critical reflection on systems and understanding of how change can be evoked is one of the strengths of the profession, and we need to employ that knowledge on ourselves as a professional group. Self-care, resilience and resistance are essential. Attention to the social identity of social work and unity through a strong professional voice will empower us as professionals, our non-social work colleagues and most importantly, the communities in which we work.

A key finding of this research has been that health social work is about advocacy for patients within various systems, with the health social workers functioning as navigators through the system. The participant narratives created a picture of health social workers working within the 'meso', between the patients and their surroundings; envisaging the patient from an ecological perspective. To do this, the participants sought to create and strengthen connections between individuals and systems within their immediate environment, while also being acutely aware of the influence of external systems that were impacting on the patient or situation. A recurrent theme within the data was that the participants were persistently seeking the freedom to practise in a collaborative, authentic, person-centred, holistic manner that allowed patients to actively participate in decision-making, to access required resources, and resolve their identified issues.

The participants spoke in the language of 'battling and fighting', working to illuminate patients and situations from the lens of the people involved and their social reality and constantly challenging other professionals to appreciate the social realities and situations in which the patients are located, so that their specific needs and circumstances are not disregarded. This challenging involved acting as kaiwhakatara; being the conscience of their MDTs and educating other professionals about the dangers of oversimplifying social realities. This atmosphere of challenge resulted in the participants feeling both wary and

wearied, yet there was faith and pride in the practice skills, knowledge base, and values of the profession. More importantly, their expressed pride in their successes and in their professional skillset also empowered the participants to remain courageous in practice and appeared to help sustain their hope for achieving equity and justice on behalf of the people that they assisted in their work.

The participants were very humble about the work that they did, but often felt a disconnect between them and the health-oriented practice environment. Social justice is an overlapping practice concern across allied health and medical professional groupings, as evidenced through the various professional codes of practice (Vanidestine & Aparicio, 2019). Social work is secondary within a DHB, which as an organisation is primarily focused on resolving medical issues rather than directly addressing aspects of social well-being. In comparison to other helping professions, social work's mission is historically grounded in social justice values (Reamer, 2013). Regardless of the setting, health social workers are tasked with providing a critical, holistic, person-centred perspective to patients' needs within a wider MDT (Beddoe & Pockett, 2018; Cleak, 2019).

In their work, health social workers deal with complex and daunting human and social problems beyond issues such as physical ill health, mental health, and addiction. In the opening pages of her text *Ethics and Values in Social Work*, Banks (2012) repeatedly cites Jordan's (1990) commentary that "moral issues haunt social work" (p. 1). Jordan (1990) then goes onto state that "… social workers stalk moral problems" (p. 1). This concept of feeling haunted by complexity and actively seeking out ethical problems, speaks to the participants' convictions, courage and emotional resilience in the face of adversity and their acceptance of working with complexity. Hyslop (2016) asserted that social workers (in

comparison to other professional groups) "are afforded a direct view of the human consequences of structural disadvantages" (p. 9). Not only are they well placed to reinterpret for others the impact of economic inequalities and social injustice, health social workers are also the primary professional grouping tasked within the DHB system with dealing with the oppressive impacts of poverty, homelessness, social isolation, discrimination and violence. As social workers witness the impact of social policy, they need to have a loud, clear collective voice influencing future policy directions to provide pragmatic solutions to social inequities. This includes the promotion of on-going measures to address racism, discrimination and to build cultural competence, especially in relationship to Te Ao Māori and tikanga.

In Ruwhiu et al.'s (2016) writing about borderland engagements in social work practice in Aotearoa New Zealand, they introduce the concept of *pā whakawairua*. According to Ruwhiu et al. (2016) pā whakawairua refers to "refilling, replenishing and strengthening" (p. 87) workers for engagements at the border. When Ruwhiu et al. (2016) introduce the concept of pā whakawairua, they do so to explain how Māori social workers engage at the border as Te Tiriti o Waitangi partners, referring to the:

> …cost of continually giving, sharing, challenging, dealing with conflict, negotiating and often carrying the onus of responsibility of an entire people is draining, one's own wellbeing (states of ora) reservoirs are left in either a vulnerable or depleted state. (p. 87)

Within this explanation, pā whakawairua "signals places and spaces of safety where our values and beliefs resonate and vibrate" (Ruwhiu et al., 2016, p. 88). As always, I tread carefully here as I am mindful of appropriating Te Ao Māori knowledge, constructs and metaphors, and I use them with the support and guidance of the Kaitiaki of this thesis to

avoid misinterpretation or misappropriation. A step that I have taken to stay true to Ruwhiu et al.'s (2016) meaning and intent is to quote their work to explain these concepts, and not try and interpret them from a Pākehā worldview.

The concept of pā whakawairua, alongside kaiwhakatara, was introduced by Ruwhiu et al. (2016). The concepts have great relevance in terms of the experiences of the participants. The processes contained within these constructs are the descriptions that I have located to speak to the support needs of health social workers when walking through the tenuous world of health social work. The participants' critical incident analysis spoke to the fact that they were constantly "continually giving, sharing, challenging, dealing with conflict, negotiating" (Ruwhiu et al., 2016, p. 87). The difference is that, for the all but one of the participants were not doing so as tangata whenua, so the cost of engagement as a Treaty partner is not soul deep. Given the fact that the emotional toll on health social workers was found to be so significant within this research, I feel the need to adopt the concept of pā whakawairua to illustrate the importance of sustaining ora (states of wellbeing). Ruwhiu et al.'s (2016) words are used here to explain how this is done:

> Ora reservoirs can be revitalised by immersing ourselves in healthy natural environments, or directly from influential significant others who are our role models, mentors, kaiwhakatara, inspirational leaders, "go-to people", or loved ones, etched in our memories for their humanistic love, kindness, support, social justice, brave thinking and behaviours; or simply due to the fact that they have touched our lives, our thinking, and left an indomitable positive impression woven into and influencing our paradigms, decision-making and actions. (p. 88)

Attention to sustaining ora is needed, beyond supervision, especially for newly qualified social workers who are having to examine their feelings about complexity in value demands for the first time in professional practice. To end this section on being sustained by

values in practice, Gupta's (2018) thinking is congruent with the analysis underpinning this research project. In the closing paragraph of the article, "Punishing the poor? Child welfare and protection under neoliberalism", Gupta (2018) stated:

> Child protection raises complex moral and political issues which have no one right technical solution. Practitioners are asked to solve problems every day that philosophers have argued about the last two thousand years… Moral evaluations can and must be made if children's lives and wellbeing are to be secured. What matters is that we should not disguise this and pretend it is all a matter of finding better checklists or new models of psychopathology – technical fixes when the proper decision is a decision about what constitutes a good society. (p. 6)

7.2.4 Valuing Whānau

Ungar (2002) asserts that social work practice uses an ecological perspective to emphasise the importance of context, with attention to power and privilege to enhance culturally sensitive practice. The participants' view of the patients enabled them to see the patient as an individual, as a member of a whānau, their place within their community and as a person with a distinct culture. They strived to understand how the people with whom they worked were embedded within their whānau, community and the societal influences that impacted upon them (Ungar, 2002).

Germain and Gitterman (1995) believe that "reciprocal transactions between people and their environment support or inhibit the ability to adapt" and that "people and environments must be viewed as a unitary system within a particular cultural and historical context" (p. 816). The concept of emergence is used in systems thinking to explain how the whole is perceived to be more than the sum of its parts (Connolly & Harms, 2015). This concept is important as values within social work are perceived to be part of the collective

identity, and should not be seen in isolation, but rather through the interplay across a range of situations and contexts. Equally, the concept of emergence applies to Indigenous constructions of whānau as, within Māori culture, individuals need to be perceived and firmly located within the context of whānau. As Ruwhiu et al. (2016) asserted, "the wellbeing of individual Māori can be brought about by focusing on the collective whānau" (p. 86). Blank et al. (2015) draw attention to the fact that whakapapa in the context of ethical decision-making in risk situations is about the quality of relationships and the quality of processes that have been employed to support relationships. In order to ensure the wellbeing of newborn infants and to support their whānau, significant amounts of time are needed to ensure that quality engagement and consultation with whānau are adhered to. This assertion is true for engagement with whānau, hapū and iwi from the micro to the macro level, as the same principles apply.

In the analysis conducted throughout the course of this PhD project, it has become increasingly evident that the construct of whānau is vital to the way in which social work practice is conducted in Aotearoa New Zealand, and maybe even internationally through other similar concepts. I have taken great care in the introductory chapters to explain what whānau means, justifying the importance of whānau within the overall research question. I have defined whānau in terms of what it means to me, my own worldview, and my own upbringing, and have been reflexive about how my personal understandings of whānau have influenced this research.

In the participants' dialogue about the patients (the mother and the baby) they instinctively looked to the strength of the whānau, considering how the whānau was embedded within its community and societal influences – the resources, the strengths, the

solutions, the problems, the areas that they needed support in, and the threats that existed within the whānau. The participants thought about the way that systems interacted within the different units of the whānau, and how the whānau sat within the DHB framework. They were also very aware of how their colleagues' constructions of whānau impacted upon the interactions with the women, the babies and their whānau within the hospital unit/ecology. The participants' political analysis of colonisation, oppression, discrimination, racism, institutionalised racism and alienation was applied to the concept of whānau. Whakapapa is central to identity, whānau is central to identity.

Through considering the concept of whānau in this manner, and the journey that the analysis took throughout the research project, it has become apparent that 'whānau' in itself is a value, and that the participants value the importance of whānau. Banks (2012) refers to social work values as a "range of beliefs about what is regarded as worthy or valuable in a social work context" (p. 8). Without fail, the participants looked to the strengths of the whānau to nurture the newborn infant or protect vulnerable people from harm. Whānau were seen as the source of the solution, although often too the source of threat, harm or violence. Concepts of whānau are socially constructed and can differ greatly between individuals and professionals alike. An ecological perspective, however, considers the impact of whānau across the many layers of systems that influence and surround newborn infants – considering too, the perceptions of the whānau themselves and how different members of the whānau engage with the child.

This recognition of the importance of whānau within child protection practice is not new or unique. Smith and Reid (2000) referred to whānau as a principle that is an:

> ...integral part of Māori identity and culture. The cultural values, customs and practices which organise around the whānau and "collective responsibility" are a necessary part of Māori survival and educational achievement. (p. 10)

The importance of focusing on collective whānau is recognised in health and social service strategies through Whānau ora policies. Whānau ora is an approach to social service delivery that focuses on outcomes for the whānau rather than intervening at an individual level (Moore, 2014). Ruwhiu et al. (2016) asserted that "what Māori are saying about whānau ora is that it means healing our whakapapa, protecting it and creating a pathway into the future that is positive and empowering" (p. 86).

The recognition of the importance of whānau is also embedded in the principles of the Oranga Tamariki Act 1989, with the original emphasis of whānau as lead decision makers. Internationally, similar recognition is a social norm on one level, despite the commonality of an authoritarian child protection orientation that exists in England, the United States and Canada (Gupta, 2018). Social policy in Aotearoa New Zealand also adopts a child-focussed orientation that individualises children, emphasising the rights of children, and perceiving their wellbeing in terms of social investment for the future (Keddell, 2018). Addressing issues of poverty and inequality should be an essential part of the social work role when working humanely with vulnerable infants and deprived, marginalised whānau (Featherstone et al., 2018). Lonne et al. (2016) stated that:

> All societies rest on the value that family is the best place to raise a child. Therefore attempting to keep families together is an ethical imperative, and failure to do so means there is something at fault with the system that does not provide the necessary supports and opportunities for families to raise children. Most often the main contributing factor to families struggling to raise children lies in social inequalities, which is one reason why people from poor and marginalised social

classes tend to be overrepresented in the child protection and family welfare system. (p. 133)

Highlighting the importance of whānau has a synergy with a relational approach to child protection. This approach rejects the individualisation of problems and the blaming of parents, framing problems instead as coping difficulties (Lonne et al., 2016). A focus that concentrates solely on child maltreatment ignores the violence of inequality. In the midst of the complexity of child protection practice, health social workers need to directly assess and address the risk of maltreatment, liaise with the whānau and Oranga Tamariki social workers about child maltreatment concerns, maximise whānau engagement, and also not lose sight of the whānau experiences of inequity, alongside issues of class, race and gender (Keddell, 2015).

Featherstone, Morris and White, (2014) stated that after enduring decades of neoliberal policy and rising inequality, the importance of family support is gaining recognition. A relational approach involves the practitioner employing a respectful, trusting, empathic, hopeful, positive, person-centred approach to collaborative engagement, with an over-arching social justice goal (Lonne et al., 2016; Reimer, 2017). Featherstone et al. (2018) assert that the current model of child protection practice needs disrupting. They state that the "current child protection story" follows this type of formulation:

- The harms children and young people need protecting from are normally located within individual families and are caused by actions of omission or commission by parents and/or other adult caretakers.
- These actions/inactions are due to factors ranging from poor attachment patterns, dysfunctional family patterns, parenting capacity, faulty learning styles to poor/dangerous lifestyle choices.

- The assessment of risk and parenting capacity is 'core business' and interventions are focused on effecting change in family functioning.
- Developing procedures, expert risk assessment and multi-agency working are central to protecting children. (Featherstone et al., 2018, pp. 6-7).

Family violence deaths have between the period of 2009-2015 in Aotearoa New Zealand have been shown to demonstrate how:

> …multiple forms of oppression based on race, gender and class (colonial, structural, institutional and interpersonal) intersect and shape how violence is experienced by people, their families and whānau. Those living with the most harmful levels of family violence are also often experiencing multiple forms of disadvantage and discrimination. (Family Violence Death Review Committee, 2017, p. 11)

In Aotearoa New Zealand, 80% of child abuse and neglect deaths involve children under the age of five years (Family Violence Death Review Committee, 2017). As a society we need to become better at talking about the root causes of child maltreatment, we need to rethink the role of the state, and develop a relationship-based approach to child protection that is supportive of whānau (Featherstone et al., 2018; Gupta, 2018). Featherstone et al. (2018) have developed a social model to strengthen child protection practice that not only tackles the causation of maltreatment, but it rethinks the role of the state, to develop a form of relationship-based practice that is collaborative, and a "dialogic approach to ethics and human rights in policy and practice" (Featherstone et al., 2018, p. 6). This would involve a whānau support orientation to child protection practice where a key consideration is on restoration, to address social inequities that make it harder for children and families to flourish within their communities.

7.7. Implications for Practice and Research

It was evident that the role of the social worker is often misunderstood with resultant issues of mistrust for other professionals, patients and the public. Social workers hold a relatively unique position within the DHB, predominantly focusing on social need and working across multiple systems to assist patients. Continued discussions need to be had across micro to macro domains to educate colleagues, service users and the public about the values of social work so as to increase clarity across all of society about the purpose of social work practice. The place of values in social work needs to be continually debated and reflected on, especially by social workers. Having value-based discussions to enhance decision-making processes in complex situations will assist social workers to have clarity about their role and function. Patterns of conflict due to value demands need to be understood as they signal areas in which professional identity and voice can be strengthened.

Ross (2014) believes that more attention needs to be given to the question of "who advocates for the advocates' and considers the place of unionism in strengthening social work voice" (p. 4). Values in social work practice are not exercised in isolation from societal influences and they reflect the stresses and challenges on social work environments and practice. At the turn of the century, Lymbery (2001) argued that social work is under pressure due to neoliberalism and that social workers need to develop a stronger sense of purpose, in order to have more control over their future, and be more able to serve the people and communities that they work with. Over time, this pressure has intensified with the tenets of neoliberalism affecting most aspects of everyday practice, and there is growing

recognition through research that issues of racism experienced at individual and structural levels are increasing in many countries (Craig, 2018).

There is an increased drive within Aotearoa New Zealand to have health social workers attached to district nursing teams, midwifery teams, large doctors' clinics, and private accident and emergency centres. This call has been ongoing and appears to be gaining momentum, and it may save health dollars through decreased hospital admissions – especially in relationship to violence, neglect, anxiety and depression. Health social workers hold a unique subset of knowledge relating to biopsychosocial issues, when compared to Oranga Tamariki social workers, Women's Refuge workers and other groups of community based social workers. The participants generally acknowledged that time is needed to get out into the community to do preventative work. They reflected on the professional satisfaction that they felt when they were able to be a lynchpin between home and the hospital services. They demonstrated that they are well positioned to mobilise whānau support, to act as advocates and navigate people through complex situations involving interrelated systems. Having health social workers functioning more outside of the confines of the hospital campus could reduce the sense of value conflict experienced by health social workers. Currently, health social work appears to be predominantly reactive, crisis-oriented work that involves brokering on work and not knowing outcomes. Research into the efficacy of having health social workers in primary health settings to allow for increased engagement and resolution of unmet need would be beneficial, as support could be more holistic, and over time.

Utilising the critical incident technique to examine situations of conflict is a valuable way of providing insight into the different values at play in a given situation. Considering

conflict in terms of the values at stake provides another lens through which to reflexively examine situations of tension and disagreement, or situations in which social workers are feeling a lack of congruence between the work that they are doing and their professional values. The critical incident technique allows practitioners to see to the heart of the issue. This could also be particularly useful when considering the option of whistle-blowing due to moral distress, to allow social workers to feel like they have followed their conscience and stayed true to their values, and to avoid colluding with unethical practice (Banks, 2012).

Figure 12 illustrates how considering conflict in terms of the values at stake could be structured to inform decision-making and courses of action in complex situations.

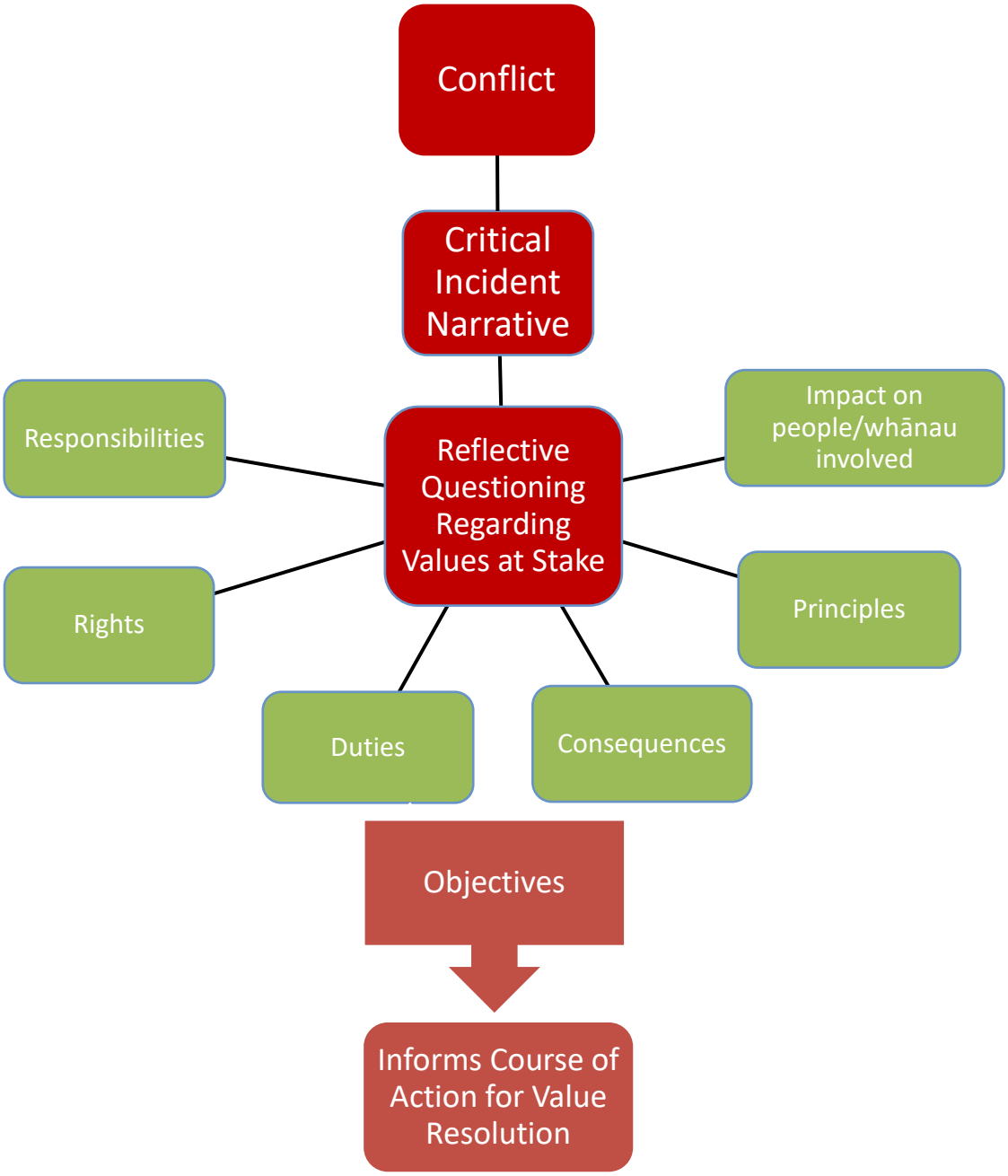


Figure 12. Reflective questioning informing value resolution.

Value demands were often experienced due to the breach between work expectations and the participants' aspirations for practice. This had a flow-on effect regarding the way that the participants perceived their professional identity and the strength of their professional voices. Reconsidering the three broad category headings developed from the phase one interviews *(Practice vision, Work expectations* and *Practice*

experiences) it was evident that *Work expectations* was a powerful common denominator. Within the critical incident narratives, work expectations shaped the participants' practice vision, their practice experiences and subsequently their identity. When work expectations are a central driving force, then the organisations mandates could unduly impact the profession's identity and voice which, in turn, may alter the participants' aspirations about what was possible in future practice. Work expectations appeared to shape professional identity more when the participants were first becoming established in their health social work role. The result of this is that social workers' values may become consciously/unconsciously aligned with the values of the organisation rather than those of the profession and more research into this would be useful to clarify support needs during career transitions. It is an ethical obligation to uphold the values of your employer; however, using a decision-making framework such as that depicted in Figure 12 could reduce the risk of work expectations becoming the overriding influence and give clarity about the value-based nature of practice. The participants pushed back against negative work expectations through practice experience, through supportive management structures, and the support of quality supervision and colleagues.

7.8. Limitations

In keeping with a constructivist methodology, the research relied on the participants' accounts of events and there was no perceptible reason to gain independent observations to verify their accounts. It is evident through contemplating the difficult realities of the participants' practice that they managed to continue to strive in practice to address the needs of the patients in front of them. This contemplation is predominantly linked to the qualitative information given about their critical incident narratives. The critical incidents

were chosen by the participants because they were salient for them in practice, and it is uncertain if this level of commitment is universally applied to each person that they encounter in practice.

When poverty and issues of austerity have become the bread and butter of child protection practice it can become soul destroying to keep on tenaciously addressing the herculean task of resolving issues of poverty within micro-level practice, let alone having the energy or the time to address the macro-level issues. The cost of not engendering systemic change at some higher level could result in burnout or disillusionment which is hard to measure or research within the ebb and flow of day-to-day-practice. This research explored values in practice in part through considering the participants' constructions of 'success' in practice. Future research into burnout and disillusionment within day-to-day practice would advance understanding about this, looking further into social workers' perceptions of the drivers of 'success'. Utilising tried and tested success strategies could enrich and support workforce development and retention, alongside a group approach to strengthening social work's professional voice and identity.

What is true in one moment of time will not likely endure. Social work values represent our deep-seated beliefs about bi-cultural practice in Aotearoa New Zealand, but the culture of social work is not static and change occurs over time, and with it so do our beliefs about social justice (Craig, 2018). This research involved an analysis of the narratives and critical reflections of 15 health social workers across several DHBs within Aotearoa New Zealand. The data that was gained was rich and full of detail about the realities of health social work practice; however, it was gathered from a relatively small cohort of health social workers at a specific point of time. While the group had some elements of ethnic diversity,

they predominantly represented a Pākehā female workforce, which is reflective of the nature of the current health social work workforce.

Given the significant issues with institutionalised racism witnessed and experienced by the participants it would have epistemic value to repeat aspects of this research with a cohort of Māori, Pacific or other ethnic groups of social workers. Mohanty (2018) asserts that "knowledge gained from the subjective, identity-based struggles of subordinated groups – women, workers, gays and lesbians in a heterosexist social structure – is indispensable for a richer, more nuanced conception of universalist ideals and values" (p. 426). Gathering a clearer social account linked to distinct ethnic and gendered identities would help advance understanding about strategies that Indigenous, Pacific, and other ethnic and diverse groups of social workers employ to navigate and support people of their culture within the DHB. There is further learning to be gained from them about their specific professional support needs and successes in practice in line with their social identity.

Understanding how values support social work practice directly correlates with understanding social workers' professional motivations, aspirations and identity, alongside how they can be supported through supervision, within their workplace, management systems, and through their professional organisations and unions. More research on the subject of how values can support social work practice is needed to consider how the findings resonate particularly with health social work practice and child protection practice, alongside other fields of social work practice.

7.9. The Final Word

In the introductory chapter of this thesis, I introduced my motivation to research social work values in terms of my reflections about the experiences I have had in practice

and as a social work lecturer. The research question then crystallised when supporting social work students through field placement and then, taking them through a social justice, ethics and law paper involved watching them wrestle with matching their BSW learnings to the experiences they had on field placement. Time was spent supporting them to maintain their enthusiasm for social justice action given their observed realities of practice while on field placement. Beckett and Horner (2016) asserted that "academic social work always runs the risk of becoming decoupled form social work itself" (p. 231). This assertion resonates as social work education needs to prepare students for the realities of social work practice. It is evident that the practice environment that I emerged into as a newly qualified social worker has changed greatly and has become more challenging due to increasing inequality and a retracted social welfare safety net.

In the rough and varied terrain of professional social work practice, the profession's values are an anchor to sustain, hold and unite practitioners through the lifetime of their career. They are the source of the profession's identity globally. For social workers in Aotearoa New Zealand, the bicultural nature of our values is a standpoint, a source of power that we need to increasingly articulate in order to speak back to organisational and social policy imperatives that are not in the best interests of the people that we serve, and also not in the best interests of our profession. It was evident in the narratives of the participants that the powerlessness that some people felt when receiving services from DHBs was mirrored in the experiences of the participants as they tried to navigate these people through the DHB service. Social workers speak of the power of solidarity to invoke social change and need to remember that this power applies to themselves as practitioners too.

Our acknowledged professional values are a manifestation of our commitment to, not only the people and communities that we work with, but also to each other as colleagues. Moral courage was demonstrated by the participants when working with complexity and value conflicts, and as a result of considering their actions when asked to give feedback on the draft of the ANZASW (2019) Code of Ethics, I requested (among other things) in an email to the ANZASW Chief Executive that the following statement be included "We support colleagues/groups/communities when they are being courageous and striving for change, believing in the power and protection of collective action." This statement is now incorporated within the ANZASW (2019) Code of Ethics under the value of Mātātoa. In environments where power is unequal, a balance can be found through solidarity, using professional associations and unions as sources of strength and voice. In a small way, this sentence has become part of this research's future contribution to the aspirations for social work practice in Aotearoa New Zealand.

Social work in Aotearoa New Zealand has now become a registered profession requiring a four-year course of study to reach the professional requirements at an undergraduate level. In these four years, social work students learn theory, read the latest research, practise the skills that underpin professional practice, all while being socialised into the profession. This process of socialisation is vital, allowing students to learn how to be critically reflective in the way that they absorb new knowledge and experiences, so that they can envisage the wider systems and structures at play. The profession's values create the lens through which to view society, to see systems and discern the impact of societal systems on the individuals, whānau and communities that we as a profession collectively serve. Wisdom and a strong sense of identity is needed to hold fast to one's values, to have the confidence to stand tall alongside one's convictions, and it is my hope that the

profession's social justice values will continue to be the centrifugal force that underpins and provides a buttress to social work practice in turbulent times.

When completing this thesis, I was predominantly working out of an office at the University of Waikato Windermere Campus in Tauranga in a building named after the late Dr Maharaia Winiata. It seems fitting to conclude this thesis drawing upon his words and wisdom in a whakatauākī written by him, and permission has been given from Ngai Tamarawaho to use Dr Maharaia Winiata's words within this thesis.

Ina aro atu te oranga ki nga mea pai, ka rere te wairua, ka taea nga mea katoa.

When our lives and heart are attuned to good things, life is clear, the spirit flows freely. Everything is possible.

Dr Maharaia Winiata

The value foundations of the social work profession are our 'good things' and, in practice, in order to remain resilient, we need to remain attuned to them. They represent the profession's central purpose and for many practitioners their natural alignment with the profession's values is what led them to become, and remain, a social worker.

The social justice passion for committing to the profession needs to be sustained and nourished. Ruwhiu et al.'s (2016) concept of pā whakawairua provides the reminder that social workers need to immerse themselves in "places and spaces of safety, where our values and beliefs resonate and vibrate" (p. 88). Embedding the protective concept of pā whakawairua into social work education and practice is important, especially for newly qualified social workers who are traversing the neoliberal social work practice landscape for the first time. The participants expressed feelings of being wary and wearied in practice, due to constantly battling systems. Having kaiwhakatara that are internal and external to the organisation that social work professionals work for will be a source of strength and

resilience. Kaiwhakatara will help to bring about the strong sense of identity needed to resist injustices. Unity is needed to increase a sense of professional belonging that, in turn, will increase professional capacity, confidence, skillsets, and knowledge.

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APPENDIX 1: Ethics Approval Letter

Office of the Vice-Chancellor
Finance, Ethics and Compliance

UoA logo

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UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

30-Sep-2014

MEMORANDUM TO:

Assoc Prof Christa Fouche
Counselling, HumServ & SocWrk

Re: Application for Ethics Approval (Our Ref. 013036): Approved

The Committee considered your application for ethics approval for your project entitled **Realising Values: Experiencing congruence and incongruence in Health Social Work with newborn infants and their families..**

We are pleased to inform you that ethics approval is granted for a period of three years.

The expiry date for this approval is 30-Sep-2017.

If the project changes significantly, you are required to submit a new application to UAHPEC for further consideration.

If you have obtained funding other than from UniServices, send a copy of this approval letter to the Research Office, at ro-awards@auckland.ac.nz. For UniServices contracts, send a copy of the approval letter to the Contract Manager, UniServices.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals. If you wish to do so, please contact the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

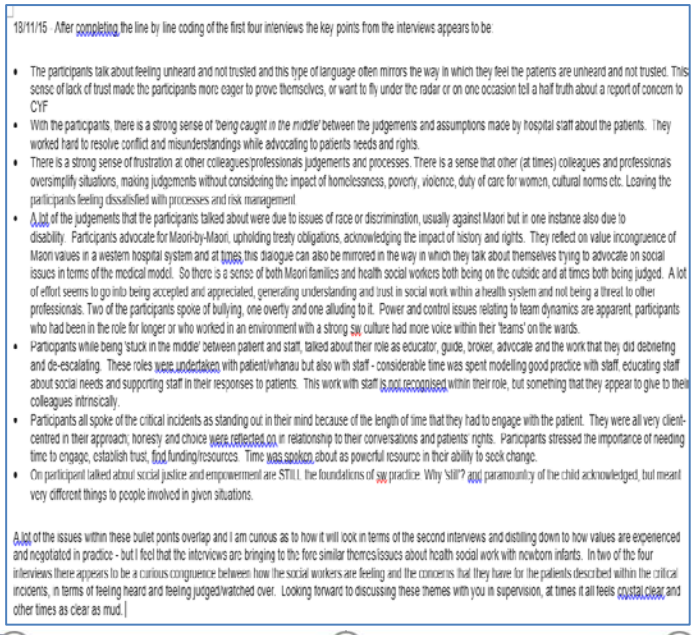
Please quote reference number: **013036** on all communication with the UAHPEC regarding this application.

(This is a computer generated letter. No signature required.)

UAHPEC Administrators
University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Counselling, HumServ & SocWrk
Dr Carole Adamson

APPENDIX 2: Coding And Memo Images



18/11/15 - After completing the line by line coding of the first four interviews the key points from the interviews appears to be

- The participants talk about feeling unheard and not trusted and this type of language often mirrors the way in which they feel the patients are unheard and not trusted. This sense of lack of trust made the participants more eager to prove themselves, or want to fly under the radar or on one occasion tell a half truth about a report of concern to CYF
- With the participants there is a strong sense of 'being caught in the middle' between the judgements and assumptions made by hospital staff about the patients. They worked hard to resolve conflict and misunderstandings while advocating to patients needs and rights.
- There is a strong sense of frustration at other colleagues/professionals judgements and processes. There is a sense that other (at times) colleagues and professionals oversimplify situations, making judgements without considering the impact of homelessness, poverty, violence, duty of care for women, cultural norms etc. Leaving the participants feeling dissatisfied with processes and risk management
- A lot of the judgements that the participants talked about were due to issues of race or discrimination, usually against Maori but in one instance also due to disability. Participants advocate for Maori-by-Maori, upholding treaty obligations, acknowledging the impact of history and rights. They reflect on value incongruence of Maori values in a western hospital system and at times this dialogue can also be mirrored in the way in which they talk about themselves trying to advocate on social issues in terms of the medical model. So there is a sense of both Maori families and health social workers both being on the outside and at times both being judged. A lot of effort seems to go into being accepted and appreciated, generating understanding and trust in social work within a health system and not being a threat to other professionals. Two of the participants spoke of bullying, one overtly and one alluding to it. Power and control issues relating to team dynamics are apparent, participants who had been in the role for longer or who worked in an environment with a strong sw culture had more voice within their 'teams' on the wards.
- Participants while being 'stuck in the middle' between patient and staff, talked about their role as educator, guide, broker, advocate and the work that they did debriefing and de-escalating. These roles were undertaken with patient/whanau but also with staff - considerable time was spent modelling good practice with staff, educating staff about social needs and supporting staff in their responses to patients. This work with staff is not recognised within their role, but something that they appear to give to their colleagues intrinsically.
- Participants all spoke of the critical incidents as standing out in their mind because of the length of time that they had to engage with the patient. They were all very client-centred in their approach; honesty and choice were reflected on in relationship to their conversations and patients' rights. Participants stressed the importance of needing time to engage, establish trust, find funding/resources. Time was spoken about as powerful resource in their ability to seek change.
- On participant talked about social justice and empowerment are STILL the foundations of sw practice. Why 'Still'? and paramountcy of the child acknowledged, but meant very different things to people involved in given situations.

A lot of the issues within these bullet points overlap and I am curious as to how it will look in terms of the second interviews and distilling down to how values are experienced and negotiated in practice - but I feel that the interviews are bringing to the fore similar themes/issues about health social work with newborn infants. In two of the four interviews there appears to be a curious congruence between how the social workers are feeling and the concerns that they have for the patients described within the critical incidents, in terms of feeling heard and feeling judged/watched over. Looking forward to discussing these themes with you in supervision, at times it all feels crystal clear and other times as clear as mud.

Name	Sources	
considering success for doctors, midwives, nurses, dhb, Maori whanau	3	9
Social Worker Achieving Success, being appreciated, sharing confidence in swker	2	4
experiencing change	2	3
making connections	2	2
patients sharing confidence in social worker	1	2
swker considering success	4	10
swker trusting others	1	
Swkers Feelings	0	
acting defensively	3	4
feeling pre-occupied	2	2
swker dissatisfied with processes	4	9
swker feeling burdened	2	2
swker feeling caught in the middle	1	2
swker feeling concerned by staff judgements	5	22
swker feeling demoted or undervalued	2	6
swker feeling dominated	2	4
swker feeling frustrated and or angry	4	10
swker feeling humble	1	2
swker feeling ironic	1	2
swker feeling lucky	1	2
swker feeling misunderstood	2	3
swker feeling nervous	1	2
swker feeling unsure about how to respond or proceed	2	2
swker feeling worried or concerned	2	3
Systems Issues	0	
challenging environment	4	9
identifying dilemmas	4	7
poor process	2	4
reflecting on the medical model	2	2
swker advocating or not	2	4
swker feeling cautious when describing issue	2	4
swker noticing trends	4	18
swker noticing patient trends	3	5
swker recognising system issues	6	25
'wasting resources'	1	1
Team	0	
reflecting on supervisors role	3	6
swker de-escalating or debriefing	1	1
swker defining their team	3	8
Values	0	
Paramountcy of Child, expressing a bottom line	2	5
recognising personal and professional congruence	2	4