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Evaluating a Social Work Supervision Model in a Real-World Child Welfare Setting

Carol H. Smith, LMSW; Regina Russell, MA, MEd; and Martha M. Giddings, PhD

Within the public child welfare system, tragedies such as the death of children are no longer seen as private losses to be addressed on a need-to-know basis. With the emergence of electronic communication, news of these tragedies spreads quickly into the public domain and emerges on the front page of newspapers or on television's breaking news along with graphic crime scene footage. News reports have a similar format, and once the incident moves into the public domain; a chain of events often is set into motion. Questions are raised, families grieve, organizations reel, and blame is directed, dissected, and deflected. In the wake of the finger pointing that usually follows, the state often decides to enact tough new policies, politicians call for child welfare reform, attorneys threaten, and agencies reorganize. Meanwhile, an ever-deepening malaise settles over professionals who remain deeply troubled and deeply committed to the search for better ways to protect the nation's children.

Whereas these problems are depressingly familiar and even predictable, the frequency of these crises presents public child welfare with a pressing need to develop more innovative and empirically-based solutions to reduce the occurrence of these senseless deaths. The following article is not intended as a critique of caseworkers, supervisors, or child welfare administrators. Advocates of the field of child welfare know about the long hours, constant crises, hard work, and dedication of employees who work with families dealing with stressful events on a daily basis. The following article represents a call for child welfare practitioners and social work educators to collaborate in an effort to examine whether the supervisory structure of child welfare organizations can be made more responsive to severe family distress through the provision of consistent and clinically-oriented oversight.

Renewed attention in the literature is being given to the use of clinical supervision as a tool for responding to these challenges in public child welfare (e.g., American Public Human Services Association [APHSA], 2005; Collins-Camargo & Groeber, 2003; Diwan, Berger, & Ivy, 1996; Ellett, Ellett, & Rugutt, 2003; Ellett & Millar, 2001; Gleeson, 1992; Jayaratne & Chess, 1984; Samantrai, 1992). Previous research indicates that supervision has been used as a way of meeting professional development needs of workers through the acquisition of practice knowledge (Diwan, Berger, & Ivy, 1996; Gleeson, 1992). Supervision also has been seen as a way of reducing worker stress and offering increased protection for clients (Texas Department of Human Resources, 1982).

Defining a specific type of supervisory model that is likely to be most effective in a child welfare practice environment is particularly daunting. Despite the number of clinical models that are used commonly in social work supervision, some contain vague language, global descriptions of behavior, and ambiguous long-term goals and outcomes. Many supervisory models are difficult to teach, replicate, evaluate, and few contain a structured method of implementation (Giddings, Cleveland, & Smith, 2006). Importantly, there are few models that have been tested empirically.

The intentional application of professional supervision in child welfare is likely to have some sort of impact on participating caseworkers as well as on their beginning career development. Likewise, application of a model from within the organization is likely to have

Carol H. Smith, LMSW is the Director of the Title IV-E Program at Valdosta State University

Regina G. Russell, MA, MEd is the Admissions Coordinator in the Division of Social Work at Valdosta State University.

Martha M. Giddings, PhD is a Professor and Director in the Division of Social Work at Valdosta State University

some sort of impact on the organization itself. The current article outlines an innovative clinical supervision model, describes how the model has been used in a real-world child welfare practice setting, and provides a beginning evaluation of the model's effectiveness. Conclusions about the evaluative data received as well as implications for further use of the model and its impact on a child welfare organization will be addressed.

The Integrative Supervision Model (ISM)

The ISM was developed in 1983 by a social work professor who developed a single method of preparing beginning Master Social Workers (MSWs) for advanced social work practice and simultaneously preparing them for clinical licensure (Giddings et al., 2006). The ISM is designed to provide supervisees with a comprehensive review of the social work knowledge base and to facilitate their integration and application of the knowledge base, values, and skills into professional clinical practice. The model also helps to teach MSWs to supervise the practice of others.

It is important to recognize that the ISM focuses on case conceptualization from a professional social work perspective rather than an agency perspective. This supervisory orientation directs attention to the professional development of MSWs rather than the administrative role of monitoring agency tasks (Giddings et al., 2006). One noteworthy aspect of the model is that it provides a highly structured method of conducting clinical supervision that requires a standardized, repetitive way of approaching case studies and processing case information. The provision of a definitive supervisory structure is helpful in attempts to replicate and evaluate the model.

The ISM attempts to build on the knowledge and skills that MSWs develop during their graduate education and to assist them in refining their integrative skills as they engage in advanced social work practice (Giddings et al., 2006). As defined by the model, supervision is comprised of four phases which can be expanded or condensed according to the length of time available for supervision. Four critical elements of the ISM are emphasized differentially in each phase: clinical practice skills, supervision skills, group dynamics, and self-reflection.

The following is a brief description of the goals and tasks implemented during each of the four phases of the ISM (Giddings et al., 2006; Giddings, Cleveland, Smith, Collins-Camargo, & Russell, in press).

Phase 1. Goals include increasing supervisee confidence; increasing knowledge and comfort with professional case presentations; acquiring new knowledge based on previous education and experience; beginning a process of reflective learning; increasing integrative skills. Specific tasks that are implemented in Phase 1 include a structured, oral presentation of a child welfare case that is developed according to specific instructions using a standardized case study template. Phase 1 lasts until phase-specific goals are reached. Typically, each of the supervision group members has at least one opportunity to present a case formally, and most have additional opportunities. Clinical supervisors are expected to model empathy, genuineness, and warmth in order to facilitate a positive group climate in which trust and honest communication can emerge.

Phase 2. Goals include: increasing the professional knowledge base; enhancing the ability to write case studies from a holistic perspective; facilitating a higher quality of skill performance; increasing the level of group participation; increasing practice skills; and increasing reflective practice. Phase 2 tasks include preparation with written case studies rather than oral, using a structured case study template in which attention must be given to

appropriate grammar, spelling, content, clarity, and correct use of professional terms. Participants must identify theories and intervention models that fit the particular case situation and they must attend to issues of values, ethics, policy, legal, and diversity related to that case. In Phase 2, beginning attention is given to a review and understanding of group process (e.g., Garvin, 1997). Supervisors are expected to assist group members in managing conflict in the group constructively, leading to the emergence of new leadership patterns and negotiated group goals.

Phase 3. Goals include: a continuing focus on empowerment, group process, the ISM, and reflective practice; enhanced knowledge of theories, practice models, and clinical skills; demonstration of increasing autonomy and competence; beginning provision of supervisory feedback to peers. Phase 3 tasks call for a continued emphasis on written case studies and the introduction of the role of responder for each case presentation. The responder must construct a response to the formal case study by submitting a written critique of the study, addressing all aspects of the case and evaluating the presenter's strengths and areas needing improvement. In regard to other Phase 3 tasks, increased attention is given to mastery of specific theories and practice models that can be used to explain the case along with recommendations for specific case interventions. Supervisors are expected to focus on the empowerment of group members, emphasizing increased member autonomy, and an emphasis on the acceptance of commonalities and differences among members.

Phase 4. Goals include: increasing mastery of practice knowledge and skills; increasing competence in practice and group participation; increasing self-reflection and evaluation of self as a social worker; increasing ability to articulate a philosophy of practice; increasing self-reflection and evaluation of the work of others; increasing ability to engage in independent, professional practice; preparation for termination.

Among the Phase IV tasks are further emphasis on knowledge and skills learned in previous phases, provision of evidence of supervisees' competence through the use of conjoint interviewing with the supervisor or presentation of interview tapes, attention to facilitation of supervisees' leadership in the supervision group and attention to advanced group processes. Supervisors are expected to begin to relinquish the facilitator's role as the group begins the termination phase of the group (Giddings et al., in press).

Based on previous use of the ISM by social work faculty, the model was deemed to provide an effective mechanism for meeting the needs of multiple levels of MSW staff members including administrators, supervisors, and caseworkers. The model is adaptable for multiple supervisees in one organization or for individuals in multiple practice environments. The ISM is implemented by experienced and trained clinical supervisors in groups of 4-6 members. Advanced social work skill acquisition and refinement are targeted (Giddings et al., in press).

The ISM in the Supervision Project

Social workers and researchers were presented with the opportunity to develop and implement a program to provide clinical supervision for MSW employees in public child welfare. This project was viewed as both a way 1) to provide high quality clinical supervision to career MSWs in child welfare and 2) to test the effectiveness of the ISM in a real-world practice situation.

The Supervision Project was initiated by a state public child welfare agency for the purpose of enabling its employees to pursue clinical licensure. The agency demonstrated its

commitment to professional education through a training grant designed to support the ongoing educational development of its MSW employees. Funding for the unique pilot program was provided by the State of Georgia Division of Family and Children Services (DFCS) and represented a collaborative effort between the organization and the Valdosta State University Division of Social Work. The project provided a unique opportunity for implementation of a standardized model of supervision across the state and for evaluating the utility of the ISM.

The Supervision Project was made available to all MSWs across Georgia who were employed by the DFCS. Based on worker response, supervision groups were geographically constructed so as to reduce participant travel time. Group supervisors were chosen to minimize child welfare worker travel, but many participants had to travel a significant distance in order to attend scheduled supervision meetings.

Project Sample

With approximately 200 MSWs employed with the agency, all were invited to participate in the pilot project. By the end of the first four months of the project, 23 MSWs had volunteered. Interestingly, volunteers were not beginning-level caseworkers, but rather, they held leadership positions in DFCS, had been employed at least five years, and sought clinical licensure. Participants included a county director, program administrator, program consultant in Treatment Services, Social Services Treatment Specialist, two Education and Training Specialists, Foster Parent Liaison, seven Social Services Supervisors, and eight Social Services Case Managers. Five participants were promoted to supervisor and two were promoted to training specialist during the first three phases of the project. Among the original participants, 13 worked in rural counties and 10 worked in urban counties. Six individuals withdrew from the project because of time constraints, illness or family illnesses, or other personal reasons, leaving a total of 17 MSW participants.

Three supervision groups began approximately at the same time, and two additional groups were added several months later. Employees were given time off during their work week in order to attend supervision which facilitated project participation. Phase 1 lasted approximately two months, Phase 2 lasted about four months, and Phase Three lasted approximately nine months to one year. There were minor variations among the groups in regard to the timing of the phases due to employee holidays and difficulties in scheduling meetings.

Since each MSW employee also had an assigned DFCS Supervisor, project staff contacted all work supervisors and informed them about the project and invited their participation in the project. DFCS work supervisors are assigned by the agency to evaluate and assess the performance of each employee. DFCS Supervisors were asked to attend the initial orientation meeting as well as all other meetings, and the project director made periodic telephone calls and visits to each DFCS Supervisor's agency to keep them informed about the project and to seek their feedback on project outcomes through the data collection process.

Five licensed, clinical social workers (LCSWs) were hired initially to provide clinical supervision for MSW participants. These LCSW Supervisors were selected on the basis of their extensive clinical experience and knowledge and practice experience with children and families and public child welfare. These individuals were trained to implement the ISM with their assigned groups of MSWs. In order to participate in the project, LCSW Supervisors had to agree to implement the ISM as the sole supervision model in their groups. According to feedback from LCSW

Supervisors, use of the ISM represented a significantly different way of conducting supervision than they typically utilized. In an attempt to standardize implementation of the ISM, project staff provided eight hours of training for LCSW Supervisors plus two additional three-hour training sessions for follow-up as well as periodic telephone contacts by project staff.

Approval and consultation for implementing the ISM Supervision Project was sought from the state social work licensure board since it included hours of both individual and group supervision. The Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists approved implementation of the ISM supervision method so that participants received one hour of individual supervision when they made formal case presentations. The remainder of supervision hours was classified as "group" supervision. The timing and scheduling of supervisory sessions was left to the discretion of supervisors and group members.

Evaluation of the ISM
Method

Data was collected from three key groups: MSWs employed by DFCS who participated in this pilot project, DFCS Supervisors of participating MSW employees, and Licensed Clinical Social Workers (LCSWs) who were hired to supervise the MSWs. Both qualitative and quantitative data were collected at the end of each of the first three phases of the project which spanned a 15-month period. Data from the two supervision groups that started late were not included in the current data set. Evaluation surveys were posted on-line in order to enhance the convenience of data collection and to ensure respondents' anonymity. Anonymity provided obvious benefits to employees and supervisors, although the process did not allow for follow-up with non-responders and prevented tracking individuals across phases.

Three types of data were collected: 1) tracking data for each case presented during the supervision groups; 2) quantitative survey data from MSW Participants, DFCS Supervisors and LCSW Supervisors collected at the end of each project phase; and 3) qualitative data collected from all three groups after each project phase. Although members of each group were surveyed at the end of each phase, survey responses at the end phases one (P1) and two (P2) were less extensive than responses at the end of phase three (P3).

As with all new and complex projects, unanticipated difficulties emerged, particularly at the beginning. P1 was quite short, and the evaluation was focused on making sure the groups were functioning adequately. During the evaluation of P2, there were some issues with ensuring participant access to the online surveys. Phase specific data from P1 and P2 were used to evaluate whether the goals of each phase were met. However, the majority of the current analysis will focus on data collected from the evaluation of P3. This survey was the most extensive, presented no computer access problems, and provided a good foundation for evaluating the overall project.

Surveys from all three phases included a group of questions intended to assess the overall project as well as phase-specific goals (Part A). Questions in Part A were structured according to a 5-point Likert Scale which ranged from 5-Strongly Agree to 1-Strongly Disagree. Some questions were constant over the three phases and some were added or removed based on the specific goals of that phase. All surveys also included a series of open-ended questions to elicit comments and qualitative feedback about various aspects of the project and the individual phases (Part C).

Phase 3 surveys included an additional set of questions (Part B) in which each respondent was asked to rate her or his skills and abilities at the

beginning of the project and then to rate the same set of skills and abilities at the end of P3. Although this method was not a true pre-test/post-test format, it allowed the researchers to assess "perceived change" over the course of the project. MSW Participants, DFCS Supervisors, and LCSW Supervisors were asked to use a 7-point scale (7=very high to 1=very low) to estimate skills and abilities at the project's beginning and then to rate the skills and abilities after the completion of P3.

Response Rates

MSW Participants were asked to provide feedback about the overall project, evaluate phase-specific goals, and estimate their own change. Although there were 17 participants in the Supervision Project, two groups had not reached Phase 3 by the time of the evaluation and data analysis. Ten of the remaining thirteen MSWs responded to the P3 survey representing a 77% response rate. DFCS Supervisors were asked to evaluate their perceptions of their supervisees' overall participation in the project and to evaluate specific increases in professional knowledge and skills. The response rate for DFCS Supervisors in P3 was 42% (5 of 12 DFCS Supervisors responded). Similar questions were administered to LCSW Supervisors including questions to evaluate the overall project goals, phase-specific goals and perceived change in supervisees' skills and abilities during the project. All LCSW supervisors responded to the P3 survey (n=3).

Results

Case Tracking

Using MSW Participant data, all cases that were presented in supervision were tracked. MSWs were asked to provide information on the total number of DFCS cases that received supervision per phase, family composition, and type of problems that were in evidence (see Table 1). During the project year, a total of 84 cases were supervised with a reported case membership of 126 adults and 147 children.

Table 1. Cases & Issues Discussed through Phase III of Supervision Group

Total FAMILY cases presented	84
Total ADULTS presented	126
Total CHILDREN presented	147
Substance Abuse Issues	25
Abuse/Neglect Issues	50
Family Violence Issues	15
Mental Illness Issues	44
Joblessness Issues	11
Homelessness Issues	10
Other Issues *	40

* (e.g., developmental issues, intergenerational foster case, delinquency, medical issues)

When supervised cases were examined by problem type, the following were identified: substance abuse, child abuse and neglect, family violence, mental illness, joblessness, homelessness, and other cases involving developmental disabilities, intergenerational foster care, delinquency issues, etc. Cases typically reflected multiple problem types. These included child welfare cases that were exacerbated by the co-occurrence of serious mental health, substance abuse, and other life-threatening human problems.

Supervisees spent an average of five hours per case which included in-depth assessment and supervision activities related to preparation of the case, presentation, discussion, and follow-up on specific interventions recommended in supervision. Thus, approximately 420 total hours of case monitoring was provided to DFCS. Participants confirmed that they selected some of their most difficult cases for supervision. Although the authors cannot demonstrate that the additional 420 hours of supervision improved

client services, they contend that the increased level of supervisory oversight was likely to have been beneficial in regard to the caseworkers' ability to respond effectively to these cases and select appropriate interventions for these families.

Phase 1 and 2 Evaluations

The Phase 1 evaluation was conducted within the first two months of the project and involved administration of quantitative and qualitative on-line surveys as well as the implementation of focus groups for all MSW Participants and LCSW Supervisors. Each DFCS Supervisor was contacted individually by project staff in order to elicit their feedback on the project and their supervisee's participation.

There were two overarching reasons for the structure of the P1 evaluation. One reason was to determine how well the project was being implemented, to identify emergent problems, and to determine how each cohort of participants evaluated the project. It was of particular interest to determine whether MSW Participants felt that the Supervision Project was a worthwhile use of their time, whether the project offered them increased levels of support, and whether the ISM had enabled them to meet specific project goals such as increasing their confidence, their ability to make professional presentations, and their ability to use a holistic approach to cases.

The second reason was to troubleshoot and make changes in the structure of the project, if necessary. Data from LCSW Supervisors and DFCS Supervisors were used to confirm or contradict Participant responses and provide a fuller picture of the project. The overall response was very positive and necessitated only a few minor adjustments in terms of logistics and clarifications. For example, one such change occurred early in Phase 2 when MSW Supervisees in one group complained that their Supervisor missed a supervision meeting, was late frequently, and did not return their telephone calls in a timely manner. After exploring the problem, project staff dismissed the LCSW Supervisor and dispersed participants among the other supervision groups. Because of the critical role played by LCSW Supervisees in the project, this staffing change resolved the issue.

At the end of P2, qualitative and quantitative on-line surveys were used in addition to focus groups. As in P1, the second evaluation was used to track project implementation and to assess whether MSW Participants had met Phase 2 goals. Results confirmed once again that the project was perceived quite positively by participants, and both MSW Participants and LCSW Supervisors perceived that participants were approaching their cases holistically and were applying new levels of knowledge and skills to their caseloads. Both stated that the quality of the group presentations had improved, and the MSWs were actively involved in group supervision. The number of DFCS Supervisors' responses was quite low, exacerbated in part by computer access problems. Project staff continued to contact all DFCS Supervisors periodically using agency visits and electronic mail to elicit feedback.

By the end of P3, the project appeared to be going well, and the ISM was being administered relatively consistently across groups. At this time it was determined that the P3 evaluation should focus on the project's impact on participants, whether participants perceived that they could apply what they were learning to their cases, and whether they perceived changes in themselves over the first three project phases. Focus groups were not scheduled at the end of P3.

MSW Participant Data

Results of participant responses to the P3 survey can be seen in Table 2. Of the ten respondents, 100% strongly agreed that project participation

Table 2. Participant Evaluations of Supervision Project

	% Strongly Agree or Agree
Participation in a supervision group has been a worthwhile use of my time as a DFCS employee.	100%
My understanding of educational and supportive supervision has increased.	100%
I have found that the support provided by my LCSW Supervisor has been helpful to me as a DFCS employee.	100%
The support that I received from my peers (in the supervision group) has been helpful to me as a DFCS employee.	100%
I have been able to apply ideas from my supervision group directly to my DFCS caseload/ DFCS job responsibilities.	100%
I have been able to identify specific clinical skills that are being used by other group members.	100%
I have increased my knowledge of effective supervision techniques with colleagues.	100%
I believe that the Supervision Project provides needed support for DFCS employees.	90%
I have felt supported by my immediate DFCS supervisor to continue my participation in the Project.	90%
I feel more confident about my ability to present a case.	90%
I find having an opportunity to examine cases holistically has assisted me in managing my DFCS caseload/DFCS responsibilities.	80%
My understanding of group process has increased because of my participation.	70%

10 responses out of 13 Participants; 77% response rate.

was worthwhile, that their understanding of educational and supportive supervision had increased, and that their LCSW supervisor's support and peer support had helped them as DFCS employees. Further, all strongly agreed that they were able to apply ideas from their supervision group directly to their caseloads, that they were able to identify specific clinical skills that were being used by other group members, and that they had increased their knowledge of specific supervision techniques with colleagues. Overall, they appeared to be quite positive about the value of the project and their acquisition of new skills and knowledge.

MSW Participants' responses to Part B provided an assessment of the perceived level of change due to participation in the supervision group. Using two-tailed, one sample t-tests, the mean level of participants' perceived change was examined. As shown in Table 3, there was a statistically significant change in participants' perceived levels of professional knowledge and skills by the end of the third project phase. On each of the questions asked, participants perceived a significant increase in their level of professional knowledge and skills, and judging from the size of the mean differences, many of the changes were striking.

Questions that focused on acquisition of specific practice skills were clustered at the top of the table (where participants reported the most change). Interestingly, most of the changes that clustered at the bottom of the table (where participants reported the least change) related to workplace issues with no direct relationship to the goal of increasing professional clinical knowledge. Examples include participants' satisfaction with DFCS support and their quality of interaction with DFCS supervisors

Qualitative data were used to better understand changes in participants' professional knowledge and skills as a result of using the ISM. Open-ended questions also addressed whether the changes were applicable to

participants' child welfare responsibilities. MSW Participants described strong, positive responses to the project and described both internal and external changes in themselves in regard to their professional development.

A number of themes were apparent in the MSWs' qualitative data. These themes included the acquisition of new knowledge and skills (e.g., more knowledge, a holistic perspective, improved assessment and clinical skills, better DSM-IV skills); affirmation that they were conducting their job responsibilities differently (e.g., challenging, educating other staff, confronting clients, better ensuring child safety); affirmation that they perceived more self-confidence (e.g., in relation to managing cases, making case-related decision); affirmation that their actions had resulted in a higher level of client protection; and a sense of perceived support from their LCSW Supervisors and their fellow group members.

LCSW Supervisor Data

All three of the LCSW Supervisors participated in the P3 evaluation for a 100% response rate. The combined qualitative and quantitative data provided a good picture of this small population. In examining their responses to Part A of the survey (Table 4), there was strong agreement that MSWs' knowledge of the specific advanced practice skills had increased.

They were in full agreement that participants' DSM-IV skills had increased, that supervisees were able to provide increasingly accurate feedback to one another on case presentations, that supervisees' were better able to engage in

Table 3: Participants' Self-Assessments Before and After Completion of Supervision Project

Estimates are based on a 7-point scale (1=very low … 7=very high)	Estimate BEFORE	Estimate AFTER	Mean Change
Knowledge of theories and practice models	3.80	5.60	1.80
Ability to use theories and practice models with cases	3.80	5.60	1.80
Ability to use the DSM-IV to assess cases	3.90	5.70	1.80
Satisfaction with my professional development at DFCS	3.60	5.30	1.70
Ability to participate in supervision group	4.80	6.40	1.60
Ability to deal with complex cases holistically	4.60	6.10	1.50
Self-confidence in regard to clinical practice	4.20	5.70	1.50
Ability to assess clients accurately	4.80	6.20	1.40
Ability to present cases in writing	5.20	6.60	1.40
Ability to provide clinical feedback to colleagues	4.50	5.90	1.40
Quality of interaction with your LCSW Supervisor	4.75	6.10	1.38
Ability to assist coworkers with their own cases	4.70	6.00	1.30
Ability to present cases orally	4.70	5.90	1.20
Ability to self-reflect in relation to cases	4.80	5.90	1.10
Satisfaction with the support I receive at DFCS	4.20	5.20	1.00
Satisfaction with my overall work environment	4.30	5.30	1.00
Satisfaction in helping clients	5.10	5.90	.80
Quality of interaction with your DFCS Supervisor	5.33	5.70	.33*

10 responses out of 13 Participants; 77% response rate.

**Based on a Two-Tailed One-Sample T-Tests, all mean change scores are significant at the .05 Level except "Quality of Interaction with DFCS Supervisor which is significant at the .10 level*

Table 4: LCSW Supervisors Evaluations of Supervision Project

	% Strongly Agree or Agree
The Supervisees' knowledge of the DSM-IV has increased during Phase III.	100%
The Supervisees have provided increasingly accurate feedback on case presentations to one another during Phase III.	100%
The Supervisees have increased their ability for self-reflection during Phase III.	100%
The Supervisees have increased their ability to approach cases holistically during Phase III.	100%
The Supervisees' ability to apply Theories and Models to practice has increased during Phase III.	66%
The Supervisees have increased their understanding of group process during Phase III.	66%

3 responses out of 3 LCSW Supervisors; 100% response rate

self-reflection, and that supervisees were able to approach cases holistically. One supervisor responded "neither agree or disagree" when asked whether supervisees had increased their ability to apply theories and models to practice. Another responded "neither agree or disagree" in regard to whether supervisees had increased their understanding of group process.

Data from Part B as seen in Table 5 show that LCSW Supervisors perceived a strikingly high level of mean change among MSWs from the beginning of the project to the end of P3. Because there were only three supervisors who, in essence, represented the entire population, tests of significance were not appropriate. However, the level of perceived change was even larger than changes as assessed by the MSW Participants themselves. Among these experienced practitioners and supervisors who clearly were qualified to evaluate progress or lack of progress in their supervisees over the course of the project, this group reported the largest mean differences. For example, in assessing change in participants' ability to deal with complex cases holistically, a 3.33 point mean change (on a 7-point scale) was reported over the course of the project.

Qualitative data from LCSW Supervisors confirmed the quantitative results that emerged from Parts A and B of the survey. Overall, the qualitative comments in regard to the project were extremely positive. The themes that they presented included the perception that MSWs have become more skillful consumers of critical case information, they were more confident in all elements of communication regard their cases, and they were more confident in dealing with their professional peers and in regard to responding to professional reports (e.g., psychological and psychiatric evaluations).

DFCS Supervisor Data. The low response rate from DFCS Supervisors was important since only five of twelve supervisors responded to the on-line survey at the end of P3. The five supervisors who responded to Part A (See Table 6) presented positive responses about their workers' participation in the Supervision Project. Approximately 80% to 100% of DFCS Supervisors strongly agreed or agreed that the project was worthwhile, that their supervisees had applied clinical skills, theories, and practice models to their practice, that they were providing a more holistic approach to cases, and that they could assist their coworkers. Further, 80% of the group believed that the project provided support for MSW employees. On the whole, this small

Table 5. LCSW Supervisors' Assessment of Participant Skills Before and After Completion of Supervision Project

Estimates are based on a 7-point scale (1=very low . . . 7=very high)	Estimate BEFORE	Estimate AFTER	Mean Change
Ability to deal with complex cases holistically	3.33	6.67	3.33
Ability to use the DSM-IV to assess cases	2.33	5.33	3.00
Self-confidence in regard to clinical practice	2.67	5.33	2.67
Ability to participate in supervision group	4.00	6.33	2.33
Ability to assess clients accurately	3.67	6.00	2.33
Ability to assist coworkers with their own cases	4.00	6.33	2.33
Ability to provide clinical feedback to colleagues	3.67	6.00	2.33
Quality of interaction with you as LCSW Supervisor	4.67	6.67	2.00
Ability to present cases orally	4.33	6.33	2.00
Knowledge of theories and practice models	4.33	6.00	1.67
Ability to use theories and practice models with cases	4.00	5.67	1.67
Ability to self-reflect in relation to cases	4.00	5.67	1.67
Ability to present cases in writing	5.00	6.33	1.33
Satisfaction in helping clients	4.33	5.67	1.33

3 responses out of 3 LCSW Supervisors; 100% response rate

group of supervisors seemed supportive of their MSW supervisees.

Table 7 reflects DFCS Supervisor perceptions of the level of change that they perceived in their workers at the beginning of the project and at the end of P3. Questions in Part B assessed MSW supervisees' skills that were linked with project objectives, DFCS Supervisors' interactions with the worker, and the worker's perceived level of satisfaction in helping clients. There was little perceived change found in the data in Table 5. Compared to the large mean differences that emerged in MSW Participant and LCSW Supervisor data, the differences were quite small. Apparently, these DFCS supervisors perceived little or no change in their MSW Supervisees. Due to the small sample size and inability to confirm whether the responding sample was representative of the entire group, significance tests were not appropriate. However, data suggested that even supportive DFCS Supervisors did not perceive much change in MSW skills and abilities as a result of supervision project participation.

The low response rate confounded the results since it was likely that only the most supportive group of DFCS Supervisors chose to complete the survey. Verbal feedback from MSW Participants suggested that a number of DFCS supervisors exhibited what they labeled as "benign neglect" in relation to the supervision project. Although their DFCS Supervisors allowed them to participate, they expressed minimal interest in the project or outcomes.

Table 6. DFCS Supervisors Evaluations of Supervision Project

	% Strongly Agree or Agree
Participation in a supervision group has been a worthwhile use of my employee's time as a DFCS employee.	100%
I believe that my employee has developed a more holistic or comprehensive approach to understanding her/his cases.	100%
I have seen my employee apply clinical skills learned in supervision directly to her/his DFCS caseload.	80%
I have seen employee apply Theories and Practice Models learned in Phase III to her/his cases.	80%
I believe the Supervision Project provides needed support for DFCS employees.	80%
I have seen my employee use techniques and skills to assist their coworkers in responding to her/his cases.	80%

5 responses out of 12 DFCS Supervisors; 42% response rate

Low response rate also might be indicative of some unique problems faced by DFCS Supervisors. DFCS Supervisors might not have had clinical social work training and might not understand the purpose and goals of clinical supervision. They also might lack a clear vision of specific ways in which advanced social work skills and knowledge could benefit either the organization or the day-to-day functioning of the unit.

Compared to the extensive qualitative data provided by the two other project groups, DFCS Supervisors provided only a limited amount of feedback. Overall, the qualitative comments were less positive than the Part A quantitative data implies. The most positive qualitative responses tended to confirm the presence of strong MSW employee-DFCS Supervisor relationships. There was evidence of respect on the part of some of the supervisors for their supervisees as well as support for the supervisees' professional development. However, there also was an indication that some supervisors had ongoing concerns about their MSW supervisees that were not articulated.

The following comments affirmed the variation in responses of DFCS Supervisors in regard to their worker's project participation:

"No real changes have been made as a result of her participation in the group. However, I have found myself assigning her some of the harder cases involving clients with mental illness."

"Time management is a factor, as this employee is not compliant with documentation and face-to-face contacts"

"My employee has always been gifted and familiar with policy and practice issues."

"Participation has given an enhanced assessment and understanding of issues thatdrive families. She seems to be more confident in providing direction and promoting next steps with case

Table 7. DFCS Supervisors' Assessment of Participant Skills Before and After Completion of Supervision Project

Estimates are based on a 7-point scale (1=very low . . . 7=very high)	Estimate BEFORE	Estimate AFTER	Mean Change
Ability to assist coworkers with their own cases	5.60	6.40	.80
Ability to deal with complex cases holistically	5.40	6.00	.60
Ability to assess clients accurately	5.80	6.40	.60
Ability to provide clinical feedback to colleagues	5.40	6.00	.60
Quality of interactions with you as DFCS Supervisor	5.80	6.20	.40
Ability to present cases orally	5.80	6.20	.40
Ability to use theories and practice models with cases	5.40	5.80	.40
Ability to present cases in writing	6.20	6.20	.00
Satisfaction in helping clients	6.00	6.00	.00

5 responses out of 12 DFCS Supervisors; 42% response rate

managers/supervisors who do not shareher knowledge base."

Perhaps the most striking qualitative finding was the overall lack of data from this group. This deficit was problematic particularly because it suggested that DFCS Supervisors were much less committed to and involved in the project.

Conclusions

In examining results of the current study, it is important to emphasize that the ISM was implemented and empirically tested in a large state child welfare organization. The sample size was small, and consequently, study results cannot be generalized to other settings. Researchers, however, attempted to balance the small sample size by developing multiple sources of data in order to strengthen the validity of the evaluation. Importantly, it cannot be determined from this data whether use of the ISM would offer the same results to supervisees in other practice settings.

As is true with most social work field research, establishment of empirical controls was not practical. Instead, the value of the project relates to the fact that it was implemented in a real-world practice setting. The project itself was impacted both internally and externally by factors that were beyond the control of researchers including communication problems that arose among participants and their specific DFCS county offices, technology problems which interrupted some participants' access to the web-based survey instruments, establishment of project policies that were designed to address emergent problems rather than proactive policy making, and periodic, realistic concerns of whether funding for the project would be continued so that participants could have time to complete their licensure.

Even with these constraints, there are three important conclusions that can be drawn from the evaluative data collected during this project. First, the provision of outside supervision based on the ISM encouraged a more comprehensive review and clinical approach to some child welfare cases. Second, data suggest that the Integrative Supervision Model was successful in promoting advanced social work knowledge and skills as defined in the model's goals. Third, MSW Participants and LCSW Supervisors were very supportive of the program and reported large increases in advanced social work skills and abilities,

whereas DFCS Supervisors were generally supportive, but saw fewer tangible benefits.

Differences in the results of the three project groups also appear to be important, particularly the strength of the LCSW and MSW responses which tend to confirm one another. Overall, MSW Participants report a consistently high level of satisfaction with the project, and they perceive that use of the ISM has resulted in a significant level of improvement in their professional knowledge and skills. Their LCSW Supervisors concur, and they report even greater changes in supervisees' knowledge and skills. The lack of change perceived by DFCS Supervisors is extremely important, and perhaps is one of the most important findings of the study.

Implications

Results of this study suggest that the ISM is a supervision model that can be systematically integrated into a professional development program for career MSWs in large child welfare organizations. The strong, positive feedback about the model provided by the participating MSWs and LCSW Supervisors offers evidence that there are significant and relevant gains in social work clinical practice skills that can be accomplished through use of the model. However, the project also draws attention to the fact that more effort must be given to the process of integrating advanced social work knowledge and skills into the culture of public child welfare organizations. The ISM was developed to facilitate the acquisition of advanced clinical skills for professional social workers. The model did not focus on how these skills could then be translated back into specific agency responsibilities and tasks.

Work supervisors in this project perceived an extremely low level of change in their supervisees in comparison to the other two groups. Responses by the work supervisors underscore the need for a targeted, internal organizational response to the process of advancing the professional knowledge and skills of social workers. Although the state child welfare organization in this study is to be commended for seeking out and funding a project for enhancing advanced practice skills for MSWs, there was less clarity about ways in which more highly trained social workers could "fit back into" the organization and their jobs.

One change that should occur within the organizational culture is that work supervisors must be taught to identify, use, and evaluate the advanced skills of MSWs. Importantly; it is the work supervisors who are responsible for conducting performance evaluations of their MSW Supervisees. If such a pivotal group perceives little or no change in MSW Supervisees' acquisition of professional knowledge and skills during the project, then changes that have been confirmed by MSW Participants and LCSW Supervisors receive no "official" organizational sanction. This is particularly problematic because there may be no new positions in the organization to which these MSWs can advance, limited financial rewards, and few changes in status or responsibility. In essence, there may be no well-defined role within the organization that can sustain the skills and needs of cohort of highly-trained, licensed professionals who have the ability to engage in advanced social work practice.

Beyond supervisory responses in the agency, efforts must be given to providing expanded opportunities for MSWs to use their new levels of expertise within public child welfare and to be rewarded for their increased professional knowledge and skills. Further, MSWs also must be taught how to better integrate their professional skills within the organization itself, and how to advocate for themselves and educate supervisors, program managers, and directors about their new skills and knowledge that can assist the organization. Both MSWs and child welfare administrators must struggle with the

critical issue of expanding organizational roles for professional social workers so that enhanced knowledge and skills can be reflected in enhanced opportunities to use these skills, career advancement, and financial rewards.

The success of the ISM and the Supervision Project in increasing the professional skills of MSW employees can be undermined if there is not a subsequent attempt to better integrate advanced job responsibilities and the organizational culture. It is even possible that the lack of fit between MSWs and the child welfare work environment may increase to the point that MSWs who already have demonstrated their career commitment to child welfare may find that they have no viable contribution to make to the organization.

Supervision Project Update: By end of the first 12 months, initial feedback from MSW Participants, DFCS Supervisors, and LCSW Supervisors remained positive. This feedback made its way to the state-level DFCS administrators who were able to recommend approval for continuing the pilot program for another year. After a hiatus in which continued funding was uncertain, a smaller contract was provided so that Phase 4 could be implemented. Unfortunately, no new MSWs have been allowed to begin the program. The research team plans to give attention to the issue of employee-organization fit in Phase 4 of the Supervision Project and to track the career paths of MSW employees who have completed the Supervision Project.

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