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Background

Concern for the quality and effectiveness of child welfare supervision in Missouri has been a joint concern of the state agency and the University of Missouri-Columbia School of Social Work for some time. Twenty years ago these organizations collaborated on an intensive training project in this arena, the remnants of which are still impacting the system. Attempts to revive that initiative have since been hampered by the paucity of funds. However, when the Children's Bureau funded opportunity through the Quality Improvement Center at the University of Kentucky presented itself, both the administration of the Missouri Department of Social Services and the School of Social Work saw a long-sought-for resource to draw on to address one of the most pressing workforce needs in this state. The challenges of developing a coherent model of supervision, imparting it to staff and rigorously evaluating its impact are considerable but ones that the partners have eagerly accepted. The following paper details the model chosen, its rationale and strategies chosen for implementation.

Project Design

Clinical supervision in child welfare breaks down into two separate but interrelated areas of concern: 1) the nature of appropriate clinical practice in child protection; and 2) the most appropriate form of supervision to enhance the performance effectiveness of child protection workers. Analysis of data gathered by the Missouri Children's Division (CD) staff, the detailed literature search from the University of Kentucky Training Resource Center (UK-TRC), our own analysis of the R2P Workforce Annotated Bibliography (Child Welfare League of America, June 2002) and the UK Child Protection Supervision Survey- Results for Missouri combine to provide a framework for analyzing what approaches are best suited to addressing the needs of child protection staff to ensure that the goals of child safety, well-being and permanency are achieved in the

most effective manner.

1) Treatment Approaches

Attempts to specify the most appropriate clinical intervention in cases of family/child violence have regularly been met with a degree of frustration, chiefly because there are no conclusive explanations for its etiology. Among the causal theories offered are: psychiatric explanations, resource deprivation theory, social-situational explanations, social learning explanations and ecological perspective. Current theory and research on practice do not provide firm conclusions favoring one particular form of intervention over another but there is general agreement that situational change in a requisite component can lead to altering an abuse pattern. However, with the core concern of child safety paramount, issues related to investigation and surveillance have tended to dominate modes of intervention and supervisory emphasis. Policies governing worker behavior focus on compliance with standards designed to ensure the physical and emotional safety of the child in need of care rather than long-term behavioral change. Less attention has been paid to the service planning and delivery once the investigation and assessment tasks have been accomplished (Corcoran, 2000; Kluger, et al, 2000; Berrick et al, 1994; Berrick et al, 1997).

In Missouri CD a major quality assurance process is the Peer Record Review (PRD) system in which trained practitioners, both agency staff and outside experts, quarterly review randomly selected cases in each area of the state. The results are then fed into the Continuous Quality Improvement meetings beginning at the local level and proceeding to the state office. The data from 2001 confirm the conclusions posited above. In 92% of the cases, child safety was assured. Ninety percent of the time investigations were completed within 72 hours of an incident report being filed. However, the treatment quality assessment factors rated significantly lower. In only 51% of the cases was there evidence that a time-limited service plan had been developed and one-third contained no behav-

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iorally specific goals. In 43% of the sample there was no evidence that the families had participated in the development of the plan, confirming the feedback received from the Council on Accreditation peer reviewers.

The planning team deliberations and interviews with workers, supervisors and administrators confirm that the deficiencies noted in the PRD process are of significant concern at all levels of the organization. It is also agreed that what is lacking is a coherent model of clinical practice that can be readily taught and monitored, both through the staff training orientation and, more importantly, in the routine relationship between workers and first line supervisors. This plan proposes to address that deficit by design of a coherent treatment strategy to assist staff to partner with family members in developing treatment interventions that are strengths based, behaviorally specific, time limited, measurable and progressive. Components are drawn from several formulations including cognitive-behavioral, task-centered and crisis intervention.

2) *Supervisory Approaches*

The comprehensive literature review provided by UK-TRC well delineates the traditions of supervision in social work. This School has drawn heavily on the formulations of Kadushin, Munson, Schulman and Middleman/Rhodes in developing its Administration/Planning concentration at the MSW level. In particular the contrasts between the teaching and administrative (control) aspects of supervision have been emphasized along with the nature of the authority inherent in each. The child protective services supervisor is organizationally vested simultaneous with control responsibilities (quality, quantity and resource) and educational functions (assessing, teaching, evaluating) that require different authority bases for their accomplishment. Administrative/control duties rely on regulatory authority that is vested in the office through agency sanction. However, the educator role depends on authority of competence and it is the transaction of supervisor-supervisee, not the organization that ultimately confers it. Among all of the authorities cited above there is agreement that competency-based supervision is the most effective in all respects. However, within social work there are varying approaches to how competency and credibility are achieved.

"Apprenticeship" has long been a hallmark of professions and remains a core technique in those that rely on a traditional medical model. The supervisor is a master, the supervisee a novice in the art. The relationship is intense, analytic and tutorial. Authority of competence is assumed based on credential and/or experience but is not necessarily demonstrated or observed. The antithesis of apprenticeship is "collegial" supervision in which the supervisor assumes a consultant role with the employee as a self-directed practitioner. The techniques are suggestion, advice giving and direct influence but depend on the supervisee to initiate requests for guidance and to self-evaluate performance. Credibility depends on the degree to which the consultative content is helpful to the worker-defined problem. An alternative to these two somewhat polar positions is termed "role demonstration" supervision characterized by mutual investment, responsibility and accountability for the task. The supervisor begins as primary actor in both actual and simulated interventions and the employee assumes by successive approximation the tasks flowing from the natural course of intervention. Appropriate techniques are first modeled by the supervisor, then performed under direct observation. Each party evaluates self and others on an ongoing basis. Authority of competence is based on the supervisor's display of a range of knowledge and skills appropriate to the interventive tasks. Credibility is based on performance (Mermelstein & Sundet, 1978).

Both the internal assessments performed by CD, including the focus groups conducted as a component of the Child Welfare Accreditation process and the Missouri data from the UK Child Protection Supervisor Survey point to training needs. However, there are clearly specific priorities that both sets of data support. In the UK study, 89.6% of the respondents indicated that on-the-job-training was "very important," in contrast with 15.8% rating classroom training at that level. "Modeling good practice"(65.6%) and "providing ongoing feedback"(66.1%) were the next highest rated aspects of enhancing worker performance. "Mentoring," "modeling good practice" and "on-the-job-training" were the three highest responses to the question of what was not available or not effectively provided. As might be anticipated, these responses were

strongest among the newest workers in the agency. Since turnover rates for entry level workers routinely run as high as 21% annually, the need for these components is particularly acute.

Among the approaches to supervision in the social work literature that specifically address building clinical proficiency, those that stress a competency base clearly have the most empirical support. The evidence gathered by the CD staff and the UK research team both point to a role demonstration approach as being identified by child protection staff as both desired and needed.

The "Role Demonstration Model" of Supervision

This project will test the "Role Demonstration Model" as an appropriate one for enhancing clinical supervision in public child welfare settings. A common theme across the wide range of literature cited above is the need for the establishment of a strong and committed relationship between the supervisor and both the individual supervisees and the supervisees as a working team. The "Role Demonstration Model" is geared to the development of such a committed relationship as the basis for all supervisory activities: clinical, team-building, evaluative, and administrative.

Stages of the "Role Demonstration Model"

In working with a new supervisee, or during the initial implementation of the model within an organization, the supervisor is trained to utilize four sequential stages in the development of knowledge and skills of the worker and as the basis for the ongoing supervisory relationship. Once the base relationship is established with a worker and as that worker acquires skills and knowledge applicable to the client-worker relationship, the stages may be utilized either sequentially or discretely as needed. In addition, when gaps in skills and knowledge are identified, even with a seasoned worker, the stages of the model are used sequentially to address these needs. These are the four stages of the "Role Demonstration Model" of supervision:

1. **Observation** by the worker of the supervisor performing tasks related to the provision of clinical and adjunctive (e.g., court testimony, interdisciplinary case staffing) services to, or on behalf of, actual client systems;

2. **Cooperative provision** of clinical and adjunctive services to, or on behalf of, actual client systems by a co-clinician team of supervisor and supervisee as equal partners in the delivery of services;
3. **Observed provision** of clinical and adjunctive services to, or on behalf of, actual client systems by the supervisee with the supervisor acting as informed observer of the service delivery activities;
4. **Independent provision** of clinical and adjunctive services to, or on behalf of, actual client systems by the supervisee with clinical feedback provided from the supervisor via individual clinical case discussion and the use of the worker's team members for group consultation.

These four stages provide for the transfer, to the supervisee, of knowledge and skills related to direct practice with client systems through a stepwise progression that creates a non-judgmental environment for the worker. The stages also provide the foundational interactions needed for the worker/supervisor relationship to move away from an authority/administrative-based monitoring relationship to an educative/clinical guidance-based mentoring relationship. Such a move does not preclude the supervisor completing those tasks necessary to the administrative aspects of the supervisory role. Indeed, it is expected that the testing of the model will demonstrate that such administrative functions will be facilitated by the move to an interactional and supportive overall supervisory relationship. Because the stages of the model can be used discretely as well as in a stepwise progression, the "Role Demonstration Model" provides the supervisor the flexibility to respond effectively to many expectable team issues, including: differential pre-employment knowledge and experience, differentially difficult case assignments (e.g., a lead worker who regularly takes a specific type of case that is known to be highly complex, such as familial sexual abuse), and the introduction of new work demands (e.g., new legislative mandates on case response time) and new clinical approaches, either experimentally or as an overall clinical shift in response to new research on effective intervention

Thematic Issues in Supervision

A thorough reading of the literature provides a num-

ber of thematic issues that models to be tested should address. The themes that stand out most clearly include: 1) the incorporation of observational supervisory methods; 2) the incorporation of clinical case review processes in supervision; 3) the development of group clinical supervision processes for the work team; 4) the development of a more clinically-oriented process of individual supervision; 5) the development of critical thinking skills in the supervisees; and, 6) the development of self-reflective practitioner behavior in the supervisees. The "Role Demonstration Model" tested here encompass all these thematic issues.

Observational supervisory methods form a key component of the first three stages of the model. Use of the model in the training and initial supervision of new workers establishes a basic expectation of observation as an integral component of supervision. The initial observation by supervisees enables them to experience the process in a minimally stressful manner, thus freeing them to achieve a firmer cognitive mastery of observational supervision as a clinical tool. In a similar manner, the supervisor is enabled to achieve a cognitive and emotional sense of the stresses involved for the supervisee in the use of observational methods, thus providing a better base for using such methods. The second stage in this model provides opportunity for mutual observation during shared tasks that contribute to the development of shared meaning about the work of the organization and the tasks of the frontline worker and the supervisor. In the third stage, the supervisee experiences the value of direct observation within an already established non-judgmental relationship with the supervisor. The supervisor is better able to perform in the role of clinical observer due to the enhanced appreciation of the worker's position achieved during observation by the supervisee and the shared meaning developed in the co-operative service provision stage.

Clinical case review processes form the core of the final stage of the "Role Demonstration Model" in a number of respects. Once the supervisor/supervisee relationship has been developed via the earlier steps, clinical case review and discussion allows the interactional nature of the supervisor/supervisee relationship to continue within the context of the large workloads

that both are likely to have within the organization. The shared meaning about the expectations developed in the earlier stages and the sense of trust developed in the earlier interactions make it more likely that the worker will feel comfortable bringing clinical questions to the supervisor. The reverse outcome is also likely; i.e., when the supervisor brings clinical questions to the worker, there will be minimal negative reaction on the worker's part. The ability to model aspects of communication, role behavior, task management, goal-setting, and other clinical processes in the supervisory relationship is enhanced by the firm interactional relationship that should result from this model of supervision. The capacity of the stages of the model to be used discretely allows the worker to use the case conference to identify possible case situations in which use of other stages of the model would be helpful. The idea that at least a partial solution to a clinical case situation may be available within the supervisory relationship enhances the trust in the clinical case review.

Group supervision processes can be incorporated at all stages of the model and the potential for successful use of group processes is enhanced by the shared meaning of worker role tasks and the establishment of trust in the supervisor/supervisee relationship during the first three stages of the model. In addition, the stages of the model themselves can be used to develop skills at clinical consultation and group process among the team members. For example, the supervisor in the first stage (supervisor observed performing some aspect of the clinical work) can also present the case to the supervision team with the observing worker taking the role of group leader for that presentation. Thus, the model is applicable not only to the development of clinical skills oriented to the client system but also to group process and communication skills to enhance the potential for successful group supervision.

Increased clinically-oriented processes in the individual supervisory relationship are a natural outcome of the stages of the model. Clinical supervision is the principal focus of every stage of the model. The acquisition of new or enhanced clinical skills that work via implementation of the model will provide strong motivation for workers to pursue and accept continued use of clinically-oriented supervision. The establishment of

a truly interactional supervisory relationship founded on mutual respect, enhanced trust, and shared meaning supports the risk-taking on the part of both supervisor and supervisee that is needed in ongoing clinical supervision. The ability to return to any of the observational processes or any of the stages of the model as needed for a given case situation minimizes the potential for seeing the clinical supervision as a finished product rather than as an ongoing process.

Developing critical thinking skills is encouraged by the "Role Demonstration Model" due to the initial position of the supervisee in the role of observer and questioner. By having to develop coherent questions and alternative possible actions related to the behavior of another, the supervisee begins to develop many of the mental skills that define "critical thinking" as a process that can be applied to clinical casework activities. Although it is not possible here to address every process, we can take one process from Gambrell's (1997) definitive text on critical thinking in clinical practice as an example. A critical thinker will be able to "identify unstated assumptions." In the first stage of the model, the worker has the opportunity to see work being done and ask about what the underlying, but unstated, rationale for actions of the supervisor were. In the second stage of the model, by working together as co-clinicians, the supervisor and the supervisee must discuss, both before and after, what assumptions that have used to arrive at how they will work together and to assess how their teamwork progressed. In the third stage, the supervisor, relying now on the established interactional relationship, is free to ask focal questions about the choices of the supervisee during the observed work with the client system. This process of skill development in critical thinking can be revisited and refined due to the flexibility of using the stages in both progressive and discrete manners.

Development of the self-reflective practitioner is the logical outcome of the development of critical skills through the stages of the model. As the supervisee moves into more independent service provision, the skills directed at such critical processes as understanding alternatives, recognizing bias, and clarifying problems will move from being used to explore the supervisor's observed work or to respond to the interaction

with the supervisor to being used to examine situations as they occur in the course of clinical assessment and intervention. The continued use of clinical case review, clinically-oriented individual supervision, and clinical group conferencing with the work team, all of which are supported by the supervision model, contribute to ongoing self-examination by the worker that begins in the earlier stages of the model.

Goals of Clinical Work in Public Child Welfare

In each of the thematic areas, the "Role Demonstration Model" of supervision offers conceptual potential for positive changes in supervisory processes in public child welfare organizations. Such positive changes are also likely to affect the goals of those organizations as envisioned in the QIC prospectus: 1) increased child safety and protection; 2) increased child well-being; 3) increased positive permanency outcomes for children; and, 4) increased worker stability in the public child welfare organization. Although it must be noted that no single change at one level of the public child welfare organization can create full change in any of these organizational goals, implementing the "Role Demonstration Model" of supervision should contribute to each of them.

Child safety and protection depends upon the capacity of the child welfare worker to provide adequate assessment and intervention. It also depends upon the worker's capacity to understand the nature of risk-taking and to think about alternatives while under stressful circumstances. As already outlined, the modeling of critical thinking skills and specific assessment and intervention skills, the development of a trusting interactional supervisory relationship, an enhanced sense of shared meaning of the work, and greater emphasis on use of both supervisor and team peers for support and feedback on clinical decision-making all will contribute to enhancing both the direct work skills of the child welfare staff and their ability to trust that they can take professionally necessary actions to protect children.

Enhancing child well-being depends on the child welfare staff achieving a balanced view of the social control and the clinical intervention aspects of their work. The parallel shift from an overly

authoritarian/administrative supervisory relationship to one that is more educative/support in nature contributes to an increase in this balance in the workers' views of the clients' situations and their roles in addressing those situations. In addition, the increased emphasis on the development of clinical skills in this model of supervision, and its flexibility for adapting to new forms of empirically-based interventions, provides new and/or improved tools for the enhancement of child well-being to the frontline staff.

Positive permanency outcomes depend upon skillful clinical intervention and mobilization of appropriate supportive services. In addition to the development of direct clinical skills noted above, the model allows for the parallel development of skills in adjunctive interventions and activities. This is especially important for increasing positive permanency outcomes. Those outcomes often are as dependent upon the adjunctive aspects of the child welfare worker's role (e.g., influencing court decision-making, coordinating interorganizational communication, mediating professional disagreements related to child well-being). Because these adjunctive aspects of the worker's role are as amenable to the "Role Demonstration Model" as the direct clinical aspects, it arms supervisors with a direct tool for enhancing workers' skills and knowledge in this important area of frontline child welfare work.

Worker stability depends upon a myriad of factors including that the frontline staff feel supported and valued in the organization, that they feel a sense of shared meaning of and responsibility for the work of the organization, that they feel some degree of fairness in the administrative aspects of the organization, and that they are equipped with the necessary skills and knowledge to do the job and have access to processes that allow them to add and to maintain skills at the level they need for their work. The "Role Demonstration Model" addresses at least these issues. The stage processes allow for enhanced supervisor/supervisee interaction; greater shared meaning; addition of, enhancement of and maintenance of skills and knowledge; greater team support; and less emphasis on the social control aspects of supervision, which are often the aspects that are linked to a sense of unfairness in the organization.

The "Role Demonstration Model" and Some Conceptual Supports

The UK-TRC Literature Review makes clear that there is not a great deal of literature on supervisory models that work in public child welfare. This reflects the larger issue, previously noted in this article, that there is little evidence that any single clinical theoretical model can be successfully applied to the broad array of clientele, problems and environmental contexts with which child welfare services must deal on a daily basis. Even where research shows some potential for a specific clinical approach (e.g., Task-Centered Intervention, Solution-Focused Brief Treatment, Cognitive-Behavioral Treatment), the limitations of the studies done are so extensive that it is evident that research has only touched the surface of the complexity of clinical need in the clientele of public child welfare. On the other hand, the traditional range of literature on clinical supervision (see Holloway, 1995, for a good summary) emphasizes that such supervision should reflect a strong, single clinical orientation so that the supervision experience will carry a parallel process learning aspect to the clinical work of the supervisee. Traditional models of clinical supervision recommend an approach for which adequate theoretical models do not exist for public child welfare services.

Thus, a model to be tested for its usefulness for enhancing clinical supervision in public child welfare organizations must either assume that a specific clinical theory model will work, in spite of limited empirical evidence in support of any such assumption, or must look across current knowledge to find single constructs and concepts that support aspects of the model and that also provide at least some parallel process functions similar to the traditional single-theory supervision models. Obviously, this would mean a literature review more extensive than that which can be done within the limitations of this article. However, some key conceptual supports will be briefly reviewed here in support of this model.

Stage modeling and intervention tasks are concepts that are thematic in social service delivery literature, including family systems work (Hartman & Laird, 1983; Holloway, 1995; Gil, 1996), task-centered approaches (Reid, 1978; Epstein, 1992), social case-

work (Compton & Galloway, 1994; Tolson, 1988), and brief and solution-focused intervention (Walter & Peller, 1992; Wells, 1994; Corcoran, 1999). The "Role Demonstration Model" uses a set of discrete, describable stages with associated tasks and behaviors and identifiable learning goals. The parallel between case-work processes and the supervisory process is an important part of this model.

Social exchange and interactive supervision are both concepts that are well-supported in the human services literature and provide conceptual support for the model presented here. In particular, Shulman's (1993) discussion of the educational aspects of supervision, the use of group supervision, and the phasing of skill acquisition by new workers are congruent with the "Role Demonstration Model." The importance of interactional aspects of supervision is also supported in managerial literature on various forms of social exchange processes within organizations (Karakowsky & McBey, 2001; Cole, et al., 2002; Gomez & Rosen, 2001). The emphasis in the "Role Demonstration Model" on balancing administrative authority and clinical expertise in supervision is supported directly by the Child Welfare League of America (Rycus & Hughes; 1988).

Role reversal in stage one via observation of the supervisor in the worker role is also supported in literature from work with involuntary clients (Rooney, 1992; Ivanoff, et al., 1994; Tolson, 1988). Ivanoff, et al. and Tolson both recommend a process of "role induction" with involuntary clients that is a clinical parallel to the supervisor/supervisee role reversal in Stage One of the model. Rooney also discusses the importance of the use of Socratic questioning that is inherent in the "Role Demonstration Model" in the encouragement of the development of critical thinking. The organizational literature also provides support, particularly out of Leader-Member Exchange theory, a subset of social exchange theory, in which the term "role inversion" is used to describe supervisory processes similar to those in this model (Sherman, 2002; DeLuga, 1998). The

brief therapy concept of 'counterintuitive intervention' can also be seen as a conceptual support for the role reversal and has important parallels in clinical work (Fisch & Schlanger, 1999).

Shared meaning of the work tasks and shared understanding of organizational goals as a key need in organizational change are supported in the management (Weick, 1995) and social work education (Burstow, 1991) literature.

Educative processes that play a strong part in the model are supported by Kolb's Learning Theory, which reflects the four stages of the "Role Demonstration Model" (Raschick, et al., 1998). In addition, quality improvement studies in children's services have shown a relationship between enhanced educational components in supervision and improved quality (Kluger & Alexander, 1996). Co-learning and skill modeling are also key support concepts that can be found in the child welfare and social work education literature (Walton, 2001; Dore, 1993; Wood & Garven, 2000)

Summary

This project revitalizes a long-standing partnership to address the most pressing human resource issue in child welfare in this state. Informed by the needs assessments conducted by the Children's Division and the QIC, the joint task force of agency and School personnel has developed a model of supervision that is not only conceptually coherent and based on fundamental tenets of child welfare practice but one that is specific to the needs and aspirations voiced by the Missouri line workers and the supervisors themselves. "Role Demonstration" presents numerous challenges, including assumption of new risks on the part of the supervisors. But everyone has faith that the challenges can be met and that the risks are worth assuming because the potential impact on the quality of service to the citizens of this state is so great. Faithful execution of the model and rigor in applying the research design will ultimately prove if that faith has been well-founded.

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