

University of Iowa School of Social Work and
The National Resource Center for Family Centered Practice

In partnership with the
Iowa Department of Human Services

“Committed to Excellence Through Supervision”



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Committed to Excellence in Supervision

Module III: Case Practice Domain

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**The National Resource Center for Family Centered Practice
University of Iowa School of Social Work**

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Meet the Training Staff and Presenters

LISA D'AUNNO, J.D., has 23 years of child welfare experience as an attorney, clinical professor of law, trainer, and program administrator in Michigan and Illinois. As Director of Best Practice for the Office of the Inspector General, Illinois Department of Children and Family Services in Chicago, she managed the implementation of a number of interdisciplinary field tests to improve practice with families, including projects to integrate child welfare and substance services, increase non-custodial fathers' participation in child welfare services, implement concurrent planning with relative caregivers, and integrate family meetings into practice. Lisa has taught law and social work at the University of Chicago School of Social Services Administration as well as child advocacy at the University of Michigan Law School. As an attorney, she represented parents and children and prosecuted a number of complex termination of parental rights cases. Over the years, Lisa has trained over 8,000 social workers, lawyers, and judges in subjects including legal aspects of child maltreatment, courtroom skills, liability in human services, and interdisciplinary decision-making.

PHILIP E. EWOLDSSEN (MDiv, MA) has conducted training for the National Resource Center for Family Centered Practice for many years, in Iowa as well as nationally. He has been a clinical therapist for over ten years with Hamilton Center, Inc. located in Indiana, working with a broad range of clients (children, adolescents, adults, couples and families). Previously Mr. Ewoldsen worked for the Charter Hospital of Terre Haute, Indiana, and for Four Oaks, Inc. in Cedar Rapids, Iowa. In addition to clinical work, Mr. Ewoldsen has extensive experience in staff consultation, supervision and training, and advocacy/public education services with direct service and management personnel. Mr. Ewoldsen will serve as a workshop trainer for the *Committed to Excellence Through Supervision* training program.


DIANE FINNERTY, MS, is Director of Training and Adjunct Lecturer for the University of Iowa School of Social Work's National Resource Center for Family Centered Practice. In this position, Diane develops and coordinates educational programs for social service, non-profit, and business organizations throughout the United States. Ms. Finnerty has been the lead curriculum developer for the *Committed to Excellence Through Supervision* training program and will be the lead trainer for Modules I and II. Diane has served as a consultant with the University of Iowa's Human Resources Division working with managers and campus leaders on issues related to organizational effectiveness. Prior to coming to the National Resource Center, Diane served as Diversity Resources Coordinator in the University of Iowa's Office of Equal Opportunity and Diversity, which is charged with overseeing the implementation of institution-wide diversity initiatives and civil rights education. Diane has a strong professional background with years of experience working in domestic violence, sexual assault intervention and prevention, and community-based health services.

PATRICIA C. GILBAUGH, Ph.D. Candidate, LMSW, is a Research Assistant for the National Resource Center for Family Centered Practice. As a former Court Appointed Special Advocate (CASA) Program Coordinator, she developed administrative and report writing skills in the child welfare services area of social work practice. She continues to practice by conducting family and school environment assessments while participating in a number of policy committees at the state level. Her research interests include permanency issues, ASFA legislation, and foster youth with special needs. She has over 15 years of combined experience in child welfare and supervision practice.

BONNIE MIKELSON, ACSW, LISW is an experienced consultant, trainer, and therapist, currently in practice with Mercy Psychiatric Services of Central Iowa in Des Moines. She received her M.S.W. From the University of Iowa in 1977 and has specialized in the areas of family therapy, mental health, teaching, training, and supervision. Ms. Mikelson's years of experience as a trainer includes curriculum development and revision for NRC and other organizations, as well as presentations at state and national conferences for family development, child abuse and neglect, community action, workforce development, state welfare and child protection. Ms. Mikelson's areas of expertise include welfare to work, family development, family support, supervision, management, systemic consultation, health and wellness for workers and managers, and curriculum development for specialized trainings.

Supervision BINGO

Your Name _____ Service Area _____

A person who has been a DHS supervisor for over 20 years.	Someone who uses an effective technique for engaging “advanced professional” workers.	Someone who has worked for a boss they greatly respected.	Someone who has had to fire a supervisee.	A person who has supervised someone who has gone on to be a supervisor.
Someone who has worked in a private agency before coming to DHS.	A person who has received a compliment about their supervision from a supervisee. What was it?	A person who supervises staff in more than three locations.	A person who has had a former staff member return to thank them.	A supervisor who has a supervisee who would make an excellent supervisor.
Someone who supervises staff who are more clinically trained than s/he is.	A supervisor who has been a DHS caseworker.		Someone who has been supervised by an oppressive boss.	A person who supervises someone who is excellent at cross-cultural work with families.
A person who was born in the community in which they now work.	A person who has less than one years supervisory experience.	A person who has challenged a racist assumption made about a family by a supervisee.	A person who serves on a local community task force or civic committee.	A person who supervises in a geographic region that is different than you (e.g., rural, if you’re urban).
A person who plans to retire in the next two years.	Someone who is currently orienting a new staff member.	Someone who implemented a new practice since the last training in Pella. What?	A supervisor who employs strategies for self-care. What?	A supervisor who has mentored a terrified worker into a competent practitioner.

Have other participants sign their name and Service Area in one box until you have “Bingo” or all boxes are filled

Learning Objectives

Module III: Case Practice Supervision

Following this training, participants will be able to:

- A. Define IDHS case practice supervision.
- B. Identify the goals, functions, developmental process, structure, tasks and skills of case practice supervision.
- C. Use supervision and the supervisory relationship to promote the values, principles and standards of child welfare practice.
- D. Use strength-based, reflective supervision to implement the IDHS practice model.
- E. Articulate the ethics of case practice supervision and implement strategies to address dilemmas that arise (e.g., informed consent, confidentiality, self determination).
- F. Implement or update a supervision program (e.g., formats for delivery, techniques, tools, values communication).
- G. Train and coach staff to integrate new information and skills into their practice.
- H. Adapt supervisory interventions to supervisee developmental stage, skill level, learning style, and culture.

~ Conceptual Model of Supervision ~

Theoretical Foundations	<ul style="list-style-type: none"> ▪ Systems ▪ Developmental ▪ Adult Education ▪ Social Justice
Guiding Principles	<ul style="list-style-type: none"> ▪ Competency-based ▪ Strength-based ▪ Outcomes-driven ▪ Culturally Competent ▪ Reflective ▪ Stewardship of Resources ▪ Organizational Development ▪ Individual Development
Context	<ul style="list-style-type: none"> ▪ Legal ▪ Economic ▪ Social ▪ Technological ▪ Political ▪ Ethical ▪ Organizational
Purpose of Supervision	<ul style="list-style-type: none"> ▪ Support mission of organization ▪ Ensure quality of services ▪ Foster staff professional development ▪ Contribute to the on-going vitality of the organization
Domains of Responsibility	<ul style="list-style-type: none"> ▪ Case/Clinical Supervision: Responsible for the oversight and development of social worker competence and the quality of service delivery. ▪ Human Resources: Responsible for obtaining and maintaining a qualified, productive workforce and supportive work environment. ▪ Public and Community Relations: Responsible for representing the agency to the public and in the community. ▪ Safety and Well Being: Responsible for ensuring staff safety and well-being before, during, and after performance of the job.
	<ul style="list-style-type: none"> ▪ Administration: Ensuring an effective work environment

Supervisory Functions	<p>that supports organizational goals, values, and policies.</p> <ul style="list-style-type: none"> ▪ Education: Facilitating the acquisition and application of organizational and professional knowledge, values, and skills. ▪ Consultation: Using professional knowledge to advise and guide practice. ▪ Counseling: Identifying and responding to the psychosocial needs of staff. ▪ Evaluation: Systematically assessing staff processes and products.
Domain-specific Competencies	<p>Competencies: The categories of ability that are necessary to fulfill the responsibilities of the job in the following domains:</p> <ul style="list-style-type: none"> ▪ Human Resources ▪ Case Practice ▪ Public and Community Relations ▪ Safety and Well-being
Content	<p>The “knowledge”, “values”, and “skills” that make up social work competencies.</p> <ul style="list-style-type: none"> ▪ <u>Knowledge</u> <ul style="list-style-type: none"> ○ E.g., Agency Practice Model; Domain Theory; Case Management ▪ <u>Values</u> <ul style="list-style-type: none"> ○ E.g., Safety, permanency, and well being for children and families; Cultural Competence; Family-centered; Strengths-based ▪ <u>Skills</u> <ul style="list-style-type: none"> ○ E.g., Documentation; Design Supervision Program; Staff Recruitment and Interviewing; Conflict Negotiation , Teaching
Process	<p>The ways in which supervision is carried out.</p> <p><u>Supervision Program</u></p> <ul style="list-style-type: none"> · Supervisory Relationship · Developmental Process of Supervisor and of Supervisee · Teaching/Learning Strategies · Formats · Tasks/Activities

Values and Beliefs That Guide Good Child Welfare Supervision*

- All staff have strengths.
- Staff can make well-informed casework decisions when they are supported in doing so.
- Staff involved in decision making are likely to have better case outcomes than staff who have decisions made for them.
- Solutions generated by the caseworker or collaboratively are more likely to succeed than those generated by the supervisor alone.
- All staff can develop greater competence when education and training are provided.
- Cultural competence is key to understanding staff and the choices they make.

* Adapted from IDHS, *Child Welfare Practice in Iowa*, Participants' Handouts, p.24

Supervisor Competencies in the Case Practice Domain

For use with the Developmental Planning and Support Tool

1. Uses supervision and the supervisory relationship to promote the values, principles, and standards of child welfare practice and a practice culture that is family-centered, strength based, and solution focused.
2. Supervises staff in implementing IDHS's practice model (e.g., engaging family members and service teams; functional assessment; family team meetings; service planning;; implementing plans; accessing services; working with independent providers and provider agency staff; monitoring progress and adapting services with on-going safety assessment and planning; closing cases, documenting practice, using technology).
3. Provides training/education to enhance competence of staff.
4. Coaches staff in documenting case management (e.g., writing assessments, family case plans, safety plans, case notes, court reports, progress reports, referral letters).
5. Evaluates the clinical/casework performance of staff.
6. Interprets program rules and regulations for staff to inform casework decisions.
7. Adapts supervisory interventions to supervisee developmental stage, skill level, learning style, and culture
8. Manages legal risk of practice and supervision (e.g., direct and vicarious liability, confidentiality, full disclosure and informed consent, supervision programming, supervisory competence, staff competence and case assignment, use of consultation, documentation of supervision, written policies and procedures)
9. Establishes a protocol for managing crisis situations (e.g., suicide and suicide attempts, threats by clients, witnessing disasters and violent events, personal crises of supervisees)
10. Demonstrates culturally competent supervision and develops cultural competence in staff
11. Counsels impaired staff whose professional judgment may be adversely affected.
12. Provides mentoring to further staff career development
13. Stays current on issues facing child welfare such as substance abuse and current drugs, mental health and psychiatric conditions, abuse and violence, and safety and risk assessment methods, neurobiology and trauma, treatment modalities.
14. Establishes and maintains working relationships with referral networks.
15. Monitors available resources (fiscal and programmatic) and maximizes their effective allocation.
16. Implements a supervision program (e.g., orientation, formats for delivery, scheduling, tasks, techniques, staff development, criteria and process for evaluation of staff).

IDHS Case Practice Supervision

Case practice supervision in the Iowa Department of Human Services is a formal process of professional support and learning which enables individual child welfare practitioners to:

- Develop knowledge and competence in determining underlying causes of child and family symptoms.
- Identify, recommend, and evaluate effective treatment strategies.
- Assume responsibility for enhancing their own child welfare practice knowledge and skill.
- Enhance child safety, permanence, child well-being, and family stability through informed analysis of all information relevant to an individual case.

Iowa DHS's case practice supervision is designed to support the child welfare Model of Practice through the following strategies:

- Focused case supervision
- Full case reviews (written review of compliance, internal and external reports, attention to critical case decision points, examination of how well the caseworker has analyzed and synthesized all information and components of the cases)
- Stuck case conferences
- Record reviews/Record Audits
- Specific clinical problems
- Peer consultation
- Live practice oversight (joint home visits, participation in FTM's, observation in court or other meetings) followed by de-briefing and coaching.
- Clinical supervision tools such as the *Guide for Reflective Practice*.

Supervisor Skills in the Case Practice Domain

Administration Skills in the Case Practice Domain

- Establishing policies, procedures, and norms.
- Ensuring adequate documentation of casework and supervision.
- Selecting and implementing supervision strategies.
- Setting agendas.
- Troubleshooting cases
- Managing caseloads.
 - Assigning cases
 - Matching case requisites with social worker developmental level and skills

Education Skills in the Case Practice Domain

- Reflectively exploring caseworkers' cognitions, perceptions, actions, and reactions.
- Explaining and conceptualizing case material, strategies, and/or interventions.
- Evaluating and interpreting significant information, events, and processes.
- Prescribing/formulating tactics and interventions.
- Describing, demonstrating, and modeling interventions.
- Identifying areas for continued professional development and providing in-service and other opportunities

Consultation Skills in the Case Practice Domain

- Reflectively exploring case information and casework decisions, strategies, and plans.
- Affirming caseworkers' personal and professional competencies.
- Encouraging and accepting autonomous behavior
- Providing suggestions and options.
- Directing caseworkers to specialized resources.

Counseling Skills in the Case Practice Domain

- Exploring affective reactions, beliefs, assumptions, and attitudes.
- Recognizing and acknowledging unexpressed anxiety, anger, etc.
- Questioning discrepancies between and among feelings, thoughts, beliefs, and actions.
- Pointing out discrepancies between expectations and performance.
- Normalizing unrealistic expectations and defusing anxiety
- Recognizing impairment and addressing necessary action with the social worker.
- Encouraging structured self-care activities.

Evaluation Skills in the Case Practice Domain

- Identifying and affirming strengths and indicators of new knowledge and skill
- Accepting limitations of developmental level

Guidelines for Supervision Program

A “Supervision Program” is defined as *the deliberate, systematic, formal commitment to providing comprehensive documented case practice supervision*. Reasons for implementing systematic supervision program include: increasing staff competence, decreasing risk to clients and staff, limiting liability, and increasing efficient use of supervisor time. The following guidelines were adapted from Haynes, Corey, & Moulton (2003).

- Establish an explicit supervision program that incorporates professional standards
- Maintain and ensure consistent compliance with written policies
- Use multiple methods of supervision
- Evaluate and monitor staff competence
- Provide regular training for line staff
- Be available for supervision consistently
- Document all supervisory activities
- Keep up to date on ethical and legal issues affecting practice and the profession
- Keep up to date on clinical practice
- Seek consultation from colleagues when needed
- Consult your agency’s legal counsel preventively
- Maintain trusting relationships with supervisees

Developed by IDHS Subcommittee, 2/06

Two Supervision Models Compared

Traditional Remediative Supervision	Strength-Based Reflective Supervision
Focuses on what's wrong	Focuses on successful strategies
Relies on "Super"-vision	Encourages "Inner"-vision
Fosters reliance on supervisor	Fosters staff self efficacy and autonomy
Hierarchical in supervision	Emphasizes collaboration in supervision
Give directives	Teaches (transfers K & S) and mentors
Provides structure for compliance	Provides structure for staff development
Evaluation primarily summative	Evaluation both formative and summative
Uses evaluation primarily for accountability	Uses evaluation primarily as basis of development plan
Uses investigative language	Uses reflective language

Characteristics of the Reflective Supervisory Relationship

Reflection means the process of stepping back from daily, intense hands-on work to take time to wonder what the experience really means about the families and ourselves. Through reflection, we “examine our thoughts and feelings about the experience and identify interventions that best meet the family’s goals for self-sufficiency, growth and development.” (Parlakian, 2002).

The **reflective supervisory relationship** is the foundation for reflective supervision, a “*relationship for learning*” (Fenichel, 1992) that has the following characteristics:

- | | |
|--------------------------|---------------------------|
| Trust | Systemic |
| Respect | Participatory |
| Collaboration | Shared power |
| Strengths and Resilience | Reciprocal expectations |
| Safety | Outcome focused |
| Thinking and Feelings | Structure and consistency |
| Empathic | |
| Nonjudgmental | |

Seven Phases of a Reflective Supervision Session

The following model illustrates parallel process with worker- family interactions. Being asked for one's opinion -- and listened to -- assists the worker with reflective listening and collaborative action planning with families.

1. Preparation—clear mind, phone calls and interruptions on hold, comfortable setting
2. Greeting and Reconnecting—brief personal chat
3. Opening the Dialogue and Creating the Agenda:

Sample opener: “How has this week been for you?”

Creating the agenda: “What’s on your mind? What would you like to focus on?”

4. Gathering Information—gather details as you listen; wait, don’t jump in
5. Formulating Hypotheses—collaboratively share hunches about what might be happening, what might be helpful: “ I wonder about...” ; hypotheses are generated as open, tentative explorations
6. Considering Next Steps—clarify further, begin collaborative problem solving by asking worker how they might approach next family contact; share own experiences that relate; stay open regarding potential outcomes
7. Closing—express appreciation for specific aspects of work done; confirm next meeting

Adapted from Gilkerson, L. Reflective supervision in infant-family programs:
Adding clinical process to nonclinical settings. *Infant Mental Health Journal*. Vol. 25 Issue 5, 424-39. (2004).

Supervision of Ethical Practice Scenario

Nancy is the supervisor of a team which includes Juanita, four other case managers, and an open position which has been unfilled for four months. Of the five supervisees, Juanita is the least experienced. She has also been the least resistant to accepting case reassignments after the sixth member of the team resigned to go back to school. As a result, Juanita has a caseload of 80 families, whereas Nancy's other supervisees are carrying about 70 a piece.

Juanita is assigned to be the ongoing worker for Beatrice and her two daughters, Karen, age 4, and Sheila, born six weeks ago with a positive blood toxicology for opiates, which Beatrice admitted was heroin. It was Beatrice's first contact with DHS. Beatrice had a high school diploma and a spotty but positive work history. She worked as a housekeeper for a local motel until two months before the baby was born, when she developed complications and she and Karen moved in with Beatrice's mother. Karen's physical and social development is consistent with her chronological age and she seemed generally well-cared for. Beatrice's mother was willing to let Beatrice and her children continue to live with her and to provide support. However, both Karen and Sheila were placed in foster care. Beatrice appeared to be quite upset by the girls' removal and said she "would do anything to get them back".

Juanita's child was sick on the day that Beatrice's Family Team Meeting was scheduled, so the meeting was cancelled. Subsequently, Juanita developed her case plan using her standard formula for case plans involving substance abuse: substance abuse evaluation and treatment and parenting classes for Beatrice, play therapy for Karen.

There are two substance abuse treatment programs in Friendly County: Program A offers a combination of intensive outpatient treatment and methadone maintenance for treating heroin addiction, Program B is ideologically opposed to treatment medications and relies on group counseling and AA/NA meetings. Recently, Nancy (supervisor) presented results of a national study of substance abuse treatment effectiveness at a brief in-service. According to this and other studies, cognitive-behavioral treatment plus use of treatment medications such as methadone or naltrexone was shown to be significantly more effective in treating heroin addiction.

Because Juanita's brother kicked his drinking habit with AA only, Juanita questioned the results of the study. When she stopped by Beatrice's house to drop off the written treatment plan (Beatrice wasn't home), Juanita left a piece of paper with the names of both programs and decided to let Beatrice choose for herself. When she checked back with Beatrice, Beatrice told her that she chose Program B because her friend with a drinking problem said the staff was not judgmental. Three weeks later, when Juanita visited Beatrice's home, she learned that Beatrice went to Program B for an assessment but didn't begin the recommended treatment. She encouraged her to get started on treatment and also gave her information about local AA meetings.

Shortly thereafter, Juanita received a job offer from the social work department of the community hospital. She gave two weeks notice and during that time was unable to meet with Beatrice and the girls. Her cases went uncovered except for emergencies for three more weeks until the new hire, Michael, could be oriented. When Michael finally met Beatrice, he learned that she had moved out of her mother's home and into an apartment with her new boyfriend, Joe, whom she said she met at AA. One of the things that had really made sense to Michael in new worker training was the danger of continuing to add in new requirements to a case plan. Since the original allegation concerned substance abuse only, Michael reasoned that it was not necessary to assess Joe. Happy to hear that Beatrice was attending AA, Michael wrote in his case notes that Beatrice was complying with her case plan.

A month later, DHS received a report of suspected child sexual abuse by Joe of his own biological daughter. In addition, a drug screen on Beatrice was positive for opiates. Upon talking with Michael and reviewing his case notes, Nancy (supervisor) became concerned about his ability to handle his caseload. She felt partly responsible because she had not given Michael more supervision, so rather than giving him critical feedback she just decided to reassign a number of his cases and "start fresh" with the cases that remained. A court review hearing on Beatrice's case is scheduled for next Monday. Nancy decided to take the file from Michael and attend the hearing alone.

Scenarios for Strength-based, Reflective Supervision

A) Placing Children with Relatives

An assessment worker with 5+ years of DHS experience has gone out and determined that the children are not safe in their current placement. The extended family is nearby and is involved with the three children who are all preschool age. The worker is recommending foster care which is her normal pattern. She states that she doesn't want to use the relatives because, "The apple does not fall far from the tree." How would you help the worker see options that are unavailable because of her bias? How would you talk about the consequences of her apparent bias?

B) Perceiving Risk to Children from Domestic Violence

An assessment worker with 8 years experience has gone out on a Domestic Violence call. The two preschool children were not present during the incident in which the mom received a red mark on her face from a slap. The worker does not express concern for the children's safety to the supervisor.

C) Role of Social Worker

Belinda is a 15 year veteran of the agency and has spent most of her career as a CPW. Belinda primarily views her job as finding abuse or not. You note that she utilizes law enforcement frequently on her first contacts with families. You see how it compromises her ability to engage the family and do a thorough assessment. Belinda maintains daily contact at lunch with DEA and is proud of her connections to law enforcement through family & marriage (her husband and brother work for the Sheriff's Department). How do you go about getting to these issues?

D) Continue Case or Close Case

Sasha and Malachai were removed from their mother's home due to Mom's admitted drug use. The children were placed in foster care. After some initial reluctance, Mom successfully engaged in substance abuse treatment services and has been discharged. The children were returned to her care after 6 months and Mom has remained clean and sober. Six months have now elapsed and the SWCM is contemplating recommending to the court that DHS end its involvement with the family. However, Mom has not fully disengaged from some of the known meth users with whom she used to party. None of these folks are in the home, but she does maintain occasional contact with Rick, the father of Sasha. Rick is a known drug user & hangs out with the unsavory scoundrels. Your SWCM is on the fence about her recommendations. How can you help the social worker think through whether to continue or close the case?

E) Approaching Cases Through Deficit or Strength Assessments

Andrew is a SWII with 5 years experience at DHS. He is seeking assistance with the Jones family. Through the years Andrew has had several complicated cases involving families with drug-affected children and parents struggling with chronic substance abuse issues. He is seeking consultation from his supervisor in regard to the Jones family which includes John, long-term paramour (age 30); Christy, biological mom (age 28) and siblings Cody (age 9) and Charity (age 3), biological child of John and Christy. Andrew reports that following a 5-month period of sobriety, John and Christy have relapsed twice in 18 months. The recent relapse resulted in a founded assessment for denial of critical care/failure to provide supervision. The case file reflects that when both parents are sober the family functions successfully. During the initial stages of the consultation, Andrew voices his frustration and states he is struggling with how to proceed. Andrew indicates that he believes that the adults will not be successful with their rehabilitation. He questions whether the children need to be removed and if concurrent planning should begin. Andrew states that given his experience with drug-affect families and this family's relapse history, he is unable to identify strengths.

F) Transitions and Case Closure

The current worker is the 5th for a family whose case has been open for 7 years. The judge has recently ordered a determination of permanency. At the time of the judge's order, the 2 youngest children were in foster care and the two oldest were placed with the paternal grandmother. The mother, 26 years old, has a diagnosis of major depression, but is not taking medication. She does self-medicate with alcohol. PTSD with borderline traits has been ruled out. Mom has been ordered into therapy but only goes intermittently. Mom is also involved in an on and off relationship that involves domestic violence.

The oldest child, 9 years old, is attached to mom and her siblings' grandmother. This child, who is a product of rape, has a history of taking care of Mom and the younger children. Mom has a special attachment to her oldest son, 7 years old, who is named after his father. The youngest two children, boys 5 and 3 years old, are attached to mom. The worker is struggling to decide what is best for the children. Previous plans have focused on the domestic violence and helping mom be independent. Mom has made some positive changes. She has her own apartment, continuous employment for four years and periodically goes to therapy. The worker is struggling with providing a recommendation to the court that is in the best interest.