

An Evolving Paradigm of Supervision Within a Changing Health Care Environment

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ABSTRACT. As hospitals attempt to decrease their costs to survive in today's health care market, they are implementing resizing strategies that promise greater efficiency. A by-product has been the elimination of many management and supervisory positions. A self-administered questionnaire was sent to a stratified random sample of 750 hospitals (yielding a 46% return rate) to study the types of supervisory models being utilized and the factors associated with their differential use. While concern is expressed about the erosion of clinical supervision, the data suggests that the majority of social workers are receiving supervision from a social worker [*Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com> © 2001 by The Haworth Press, Inc. All rights reserved.*]

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INTRODUCTION

Cost-containment and the privatization of health care with an emphasis on for-profit markets are leading to sweeping changes (Salmon, 1995; Sherrill, 1995). Managed care and capitated methods of financing are reducing the revenue flowing into the health system. Hospitals are decreasing their costs to remain competitive in the marketplace, producing a differential impact on access to and quality of services. Restructuring, resizing, and rightsizing are organizational strategies to achieve systemic change (Berger, 1993). A byproduct of these strategies has been the elimination of many management and supervisory positions within hospitals.

Traditionally, in hospital social work departments, management roles reside with executive (e.g., director, associate director, assistant director) and supervisory leadership. Supervision is associated with two main functions: clinical supervision aimed at improving skills in the delivery of clinical services to clients, and administrative supervision that focuses on organizational accountability. In a traditional hierarchical organizational structure, leadership often incorporates both functions simultaneously, such as ensuring that resources are available to meet the clinical demands of care, complying with regulatory and hospital expectations and mandates, and supporting the professional development needs within the department. As management and supervisory positions are eliminated, both the corporate administrative and clinical service delivery systems and functions are impacted. This latter issue is the focus of this paper. As supervisory positions decrease in response to cost-containment strategies, concern over the availability of clinical supervisors raises questions about the potential erosion of clinical competency.

Supervision in social work is a building block to effective practice and professional growth and development. It is identified as key factor in job satisfaction as well as high quality service delivery (Itsui & Ho, 1997; Harkness, 1995). Professional social work organizations are challenging the efficacy of reductions in management and its impact on clinical practice. An exploratory study by NASW (1993) cites concern over the reported erosion of social work supervisory positions, concluding that professional development will suffer. Ross (1992; 1993) and Munson (1998; 1998 Editorial) speak to similar concerns on the changes impacting hospitals and social work departments. Ross expresses her concern that clinical issues are being addressed through mechanisms that she asserts are ineffective, such as peer consultation, group dis-

cussions, and team meetings. Munson (1998) points to managed care as a primary cause in eroding social work autonomy, including the area of social work supervision. If clinical supervisory functions decrease or are eliminated as a responsibility of management, clinicians may find themselves unprepared to develop, implement, and maintain activities related to professional development and identity, unless effective alternative models for clinical supervision are implemented. However, there are no rigorous empirical studies that support or refute these claims of erosion to clinical supervision, or examine the impact of differential supervisory models on social work performance and quality of patient care.

The Society for Social Work Leaders in Health Care (SSWLHC) and the National Association of Social Workers (NASW) commissioned a national study to examine the impact of changes in the health care arena on social work structure and practice in hospitals settings for fiscal years 1992 (FY 92) and 1994 (FY 94) (Berger et al., 1996). The primary focus of the study was to examine: (1) the changes occurring in hospitals and social work departments; (2) strategies being utilized to achieve organizational change; and (3) the impact of these changes on social work, particularly in the area of clinical practice. To address this last issue, one component of the study examined changes in "clinical supervision" for social work staff. The University of Michigan School of Social Work sponsored the FY 96 follow-up study.

Data will be presented in this paper on three models of clinical supervision used by respondents (i.e., traditional, peer, and non-social worker models), and the changes that occurred in supervisory practices over a three-year period, FY 92, FY 94, and FY 96. Three research questions guided this endeavor: (1) What models of supervision are being utilized in social work departments in hospitals?; (2) how have these supervisory models changed?; and (3) has the use of peer supervision become a more prevalent model?

LITERATURE REVIEW

Tsui and Ho (1997) delineate five models of supervision used within social work agency settings: casework, group, peer, service delivery team, and autonomous models. A formal supervisory role in which a hierarchical relationship exists between supervisory and supervisee characterize the casework and group model. The casework model, the most common approach, utilizes one-on-one supervision. Group mod-

els are the next most common model, and are often used in combination with individual models. While they use a formally designated supervisor, the supervisees play a greater role in the educational process than with the casework model. Peer supervision has no formally designated leader and uses a case consultation format in which all members share equally in the responsibility for learning. Peer supervision can be conducted within a group or tandem (Watson, 1973) format. The team model combines the leader's role as educator and coordinator for team activities, though all activities of the team are more self-directed. The leader serves as a facilitator rather than a hierarchical supervisor. Finally, the autonomous practice model is particularly relevant to advanced practitioners. Practitioners assume responsibility for their professional development, and may draw on a variety of clinical supervisory approaches (e.g., peer, consultation, group supervision).

A debate over the efficacy of these various approaches to social work supervision permeates the professional literature. It centers on such issues as: what is the function of supervision within the social work profession? (i.e., clinical versus administrative) (Munson, 1983; Brashears, 1995; Shulman, 1982; Harris & Allison, 1982); which models of supervision are most effective? (Schreiber & Frank, 1983; Kadushin, 1992; Harris & Allison, 1982); what should be the structure of supervision in terms of length and frequency? (Kadushin, 1992; Veeder, 1990; Baretta-Herman, 1993; Rabinowitz, 1987); and what skills are necessary to do supervision? (Kadushin, 1992; Munson, 1983; Perlmutter, 1990). Others have emphasized the importance of view appropriateness of supervisory models along a continuum of need (Caroff & Mailick, 1980; Schulman, 1992; Berkman, 1996; Christ, 1996; Mailick & Caroff, 1996). As a practitioner's expertise increases, or job-functions change, differential use of supervisory models occurs in response to defined learning needs. Much of the debate related to social work supervision has primarily been internally driven, evolving from professional issues and priorities.

Health care today is throwing this debate onto a new platform: one influenced by economic and political factors external to professional domains (Berger, et al 1996; Berkman, 1996; Christ, 1996). Cost-saving mandates in labor-intensive industries typically produce reductions in management levels within the organization (Gibelman & Schervish, 1997). This has been the case for middle-, and upper-man-

agement positions in health care, where work redesigns often challenge the need for supervisory roles by pushing decision-making down organizational levels closer to patient care (e.g., self-, or shared-directed teams). Restructuring reduces management positions through vertical integration (i.e., removing levels of management) or horizontal integration (i.e., reducing management by combining departments and/or staff under a single manager) (Berger, 1993). The move to “product-line” and “programmatic” structures are a special case of horizontal integration. Rather than merely keeping departmental structures in place with new leadership, departmental structures are dismantled. Staff is decentralized, combining disciplines and resources under a single, unifying structure, led by a generic manager. The “program” is organized to provide services in a more multidisciplinary, coordinated, and client-focused process. Services are combined within a single program, rather than sending patients to separate, unique departments that are often organizationally and/or geographically separated. For example, a “Heart Program” might co-locate nurses, social workers, cardiologists, heart surgeons, physical therapists, respiratory therapists, etc., into one organizational grouping. Another example involves coordinating activities related to a set of functions (e.g., Patient Management Services that might combine social work, chaplains, financial counselors, patient relations, discharge planning, etc. into cross-functional service teams). Epstein (1973) first identified bureaucratic decentralization as a major factor in moving away from more traditional, hierarchical models of social work supervision. A potential downside of decentralized and flattened structures that reduce and/or change supervisory roles is the potential de-professionalization of professional services and loss of professional identity and role.

Gibelman and Schervish’s (1997) study of supervisory positions within the NASW labor force further document the impact of these trends. They report that the proportion of NASW members citing supervision as their primary or secondary function has decreased between 1991 and 1995, with a relatively low number of supervisors in the private sector.

While adjustment to organizational realities can be an important impetus to change, it may not be the only justification for developing alternative models for supervision. The professional literature includes discussions of the efficacy of peer models of clinical supervision over

more traditional hierarchical models (Tsui & Ho, 1997; Marshack, 1996; Richard, 1992; Watson, 1973; Bruggar et al., 1962).

Peer supervision can be viewed as a poor compromise to high quality supervision as supervisory roles disappear (Ross, 1992, 1993). Some social work scholars and practitioners encourage greater use of peer supervision, questioning the appropriateness of the traditional one-on-one model of social work supervision, especially for experienced practitioners. A major concern in the literature is the potentially negative impact of hierarchical supervision on the worker by fostering dependency (Fizdale, 1958; Beatmen, 1964; Rabinowitz, 1987; Schreiber & Frank, 1983; Veeder, 1990; Richard & Rodney, 1992; Barretta-Herman, 1993, Christ, 1996). When supervision is mandated beyond legal and/or professional requirements, it may be interpreted as the worker is not competent or capable of making appropriate decisions without continued oversight by a more experienced clinician. It perpetuates hierarchical power structures that could prevent workers from becoming empowered practitioners who take responsibility for their own education and to teach others.

Barretta-Herman (1993) encourages the use of a group format for competent practitioners, so that the supervision becomes a forum for skill development and knowledge exchange that minimizes the isolation of practitioners. Group modalities form a continuum from formal supervisory groups in which a "supervisor" serves as the leader, to more informal approaches as characterized by peer group approaches. Peer supervision is most often employed using group formats. The clinician's responsibility and accountability for continued professional development are emphasized with group formats, and the "we/they" paradigm between staff and management often diminishes. Brasher (1995, p. 696) states, "When the work group is defined as a collective of interested parties, the usual tensions brought by issues of control and power, 'we' versus 'they,' and the supervisor as outsider are reduced." Formalized group models can provide the setting and structure for accountability for clinicians' decision-making. These are critical skills for clinicians moving into decentralized structures, such as program management, working within self-directed teams that place more decision making at the clinical level of practice, and/or practicing within managed care environments.

Another advantage of group supervision is its relationship to adult learning theory (Schreiber & Frank, 1983). Traditionally, supervisory

assignments are made based on one's location within the organization. For example, as an oncology social worker, the practitioner would be assigned to the supervisor in oncology based on substantive knowledge of oncology practice rather than the fit between the worker and supervisor's learning and teaching styles. While this type of assignment can be efficacious to skill development in the earlier stages of one's clinical development, it does not recognize that variations in learning style may inhibit growth when restrictive supervisory assignments have the potential to limit options for maximizing learning. Group formats are likely to produce an array of learning and teaching styles that are capable of resonating with one's own learning needs.

Group supervision can also improve "customer" satisfaction if it emphasizes clinical content. As management and supervisory staff decline, the supervisory session is likely to over-emphasize administrative issues. This shift from clinical to administrative oversight can produce negative outcomes for clients if no time is made available for clinical problem solving. Harkness and Hensley (1991) report that client-focused supervision actually improves customer satisfaction with outcomes. It promotes communication of new clinical information to encourage clinical growth and development among the members, producing more effective clinical practitioners.

While group supervisory approaches can offer many advantages, it may not be a panacea. Implementation of group supervision is challenging, with many potential barriers to success. This is particularly true for peer groups where there is no formal leader who is responsible for learning. Members of supervision groups need to develop skills in the areas of leadership, conflict management, effective communication of feedback, and group behavior if the group is to be successful in promoting profession development. While the group format allows for greater representation of knowledge, and cross-fertilization of ideas, care should be given to avoid what Janis (1972) describes as "group think." This is particularly important with peer approaches. Individuals tend to select people with similar perceptions when seeking supervision. This preference, combined with the need for harmony and cohesiveness within the group, can distort decision-making and problem solving. Unless norms and skills are developed within the group to manage conflict, the negative influence of "group think" can destroy the value of this modality. Peer groups must encourage the exploration and evaluation of opposing viewpoints in order to facili-

tate diversity and cross-fertilization to facilitate growth among its members (Richard & Rodway, 1992; Schreiber & Frank, 1983; Abrahamson & Mizrahi, 1996).

The move to a more empowered workforce does not obviate the need for accountability and responsibility to their colleagues, the system, and to patients. The authors do not suggest that total professional autonomy, as evident in the traditional medical model, is the ultimate goal. History has shown that "total autonomy" can lead to incompetence, professional arrogance, and mistakes (Mizrahi & Abrahamson, 1986). Safeguards to ethical and high quality practice need to be built into any system.

METHODOLOGY

An exploratory/descriptive survey design was used (refer to Berger et al., 1996 for a more detailed description of the methodology). The FY 92/94 data collection occurred in 1995, and the FY 96 data collection occurred in 1997. A standardized, self-administered survey instrument was specifically developed for use in this study. The questionnaire was pre-tested with several hospital-based social work departments, and examined for content validity by leaders in the field of social work practice in health care settings. The questionnaire was revised again for the FY 96 follow-up study. More detailed questions relating to hospital activity and financial information were eliminated, and the questions addressing social work supervision were refined to obtain more descriptive information on the supervisory process.

The same data collection process was used for the original (FY 92/94) and follow-up (FY 96) studies. The questionnaire was mailed to the same stratified, random sample of 750 hospitals drawn from the membership list of the American Hospital Association, in which social work services are provided within their organization (3,700 hospitals met this criteria). Three mailings were conducted. A total of 340 usable questionnaires were returned in the FY 92/94 study, yielding a 46 percent response rate, and a total of 311 usable questionnaires were returned in the FY 96 study (42 percent response rate). The small difference in response rates would ensure comparability between samples, but several questions in the FY 96 questionnaire asked for information about FY 94. These questions were compared with the questions asked in the FY 92/94 survey to determine if there were

significant differences in responses. Analysis indicated there was no significant difference between the two samples.

A series of questions specifically addressed the clinical supervision of social workers. Respondents were asked, "How has the clinical supervision for social work staff been handled, responding for both FY '92 and FY '94?" Three separate approaches to supervision were given, including traditional supervision, social work peer supervision, and supervision by a non-social worker. "Traditional" supervision was defined as one in which a senior social worker formally has responsibility for providing supervision. "Peer" supervision was defined as an individual or group format, in which there is no formal supervisory personnel. "Non-social work" supervision occurred when an individual who did not hold a social work degree served as the formal supervisor. Respondents were asked to indicate whether or not each model was in operation for both of the fiscal years indicated. This was done in order to determine whether or not more than one model of supervision was in operation, and if these models changed over the two-year period of analysis (FY '92 & FY '94). As described earlier, the FY 96 questionnaire utilized a similar set of questions, but expanded traditional and peer approaches into individual and group formats. This resulted in respondents reporting on the use of five different approaches to supervision rather than the original three questions. In order to facilitate comparative analysis with the FY 92 and FY 94 data, individual and group models associated with traditional approaches were collapsed into "traditional" approaches, and the individual and group peer models collapsed into "peer" approaches. Chi Square was used to measure change in the use of supervisory models over the three fiscal-year period. The rejection level was set at $p = .05$.

FINDINGS

Supervisory Models

Table 1 shows the number of respondents indicating the use of a particular supervisory model for each of the three fiscal years. Traditional models of supervision represent the most frequent model, though it decreases significantly in between FY 92 to FY 96. A peer

approach is the second most common model of supervision. While peer supervision appears to have grown in FY 94, this trend dissipates by FY 96, with peer supervision showing an overall decline from FY 92 levels. Although the overall numbers reporting the use of supervision by non-social workers is small, there is a significant increase in its use over each of the three fiscal years.

Analysis continues with the use of multiple models of supervision concurrently. Since respondents answer separate questions for each model, different combinations of models could be analyzed. Table 2 shows the incidence of solo models versus combination models (e.g., peer and traditional, traditional and non-social work). Solo models of supervision are most common for each fiscal year, with its greatest use in FY 96. Only about one-third of the hospitals used a combination of supervisory approaches in FY 92 and FY 94, dropping to slightly more than a quarter of the respondents by FY 96. However, these changes over the three fiscal years are not statistically significant.

Table 3 provides a more detailed picture of the various types of models reported for both solo and combination, noting that changes

TABLE 1. Frequency of Respondents Indicating Use of Supervisory Models

Supervision Model	FY 92 (N/%)	FY 94 (N/%)	FY 96 (N/%)	X ² (df = 2)
Traditional Social Work	273/82%	270/80.4%	218/74.1%	X ² = 6.332 P = .042
Peer Social Work	117/35.1%	132/39.3%	92/31.4%	X ² = 4.276 P = .118
Non-Social Worker	40/12%	54/16.1%	56/19%	X ² = 5.981 P = .050

NOTE: The columns and rows do not add up to 100 percent because it represents only the "yes" responses, and participants could indicate use of more than one model simultaneously.

TABLE 2. Incidence of Solo Versus Combination Models

Supervisory Models	FY 92 (N = 319)	FY 94 (N = 323)	FY 96 (N = 279)
Solo Models	207 64.1%	216 67.7%	201 72.0%
Combination Models	116 35.9%	103 32.3%	78 28%

X² = 4.338, df = 2, p = .114

TABLE 3. Frequency of Combinations of Supervisory Models

Supervisory Models	FY 92 (N = 319)	FY 94 (N = 323)	FY 96 (N = 279)
Traditional Only	174 54.5%	159 49.2%	148 53.0%
Traditional and Peer	86 27.0%	89 27.6%	52 18.6%
Peer Only	19 6.0%	21 6.5%	24 8.6%
Traditional and Non-Social Work	5 1.6%	6 1.9%	11 3.9%
Peer and Non-Social Work	4 1.3%	5 1.5%	9 3.2%
Non-Social Work Only	23 7.2%	27 8.4 %	28 10.0%
Traditional and Peer and Non-Social Work	8 2.5%	16 5.0%	7 2.5%

$$\chi^2 = 21.071, df = 12, p = .049$$

over the three fiscal years is significant at the $p = .05$ level. “Traditional only” shows a steady decrease between FY 92 and FY 96. The combination of “traditional and peer” shows a slight increase by FY 94, but drops dramatically by FY 96. “Peer only” models show a steady but small increase over the three fiscal years, as did “tradition and non-social work,” “peer and non-social work” and “non-social work only.” The use of all three models slightly increases from FY 92 to FY 94, but drops below FY 92 levels by FY 96 .

A final area of analysis focuses data collected from the FY 96 follow-up study, where data specific to individual versus group formats is examined (see Table 4). While data is reported in tabular style, each row represents a separate question (i.e., respondents indicated whether or not each of these approaches is being used). Traditional one-on-one supervision is the most prevalent model, with respondents fairly evenly split between traditional group supervision and both forms of peer supervision. These findings were found to be highly significant, indicating that they are not likely to be attributed to sampling error.

TABLE 4. Format for Social Work Supervision in FY 96

SOCIAL WORK SUPERVISION	YES	NO	χ^2 (df = 1)
Senior Social Worker Provides Individual Supervision	174/59%	120/41%	$\chi^2 = 9.92$ P = .002
Senior Social Worker Provides Group Supervision	66/22%	228/78%	$\chi^2 = 89.26$ P = .000
Peers Provide Supervision on an Individual Basis	46/16%	248/84%	$\chi^2 = 138.79$ P = .000
Peers Provide Supervision Within a Group	60/20%	234/80%	$\chi^2 = 102.98$ P = .000

DISCUSSION

While concern is expressed about the potential danger to clinical social work supervision in this tumultuous health care environment, the data does not suggest that this is occurring as of FY '96. Over 80 percent of the respondents indicate that traditional supervision is in use for the first two fiscal years of the study, and over 70% in the last year. However, FY 96 marked a significant drop in this model of supervision. Solo rather than combination models of supervision are more likely to exist, with the traditional model of supervision still dominating solo models (as noted in Tables 2 and 3). This is consistent with the findings from Greenspan et al.'s (1991) study of other social work settings, in which 81% reported supervision within the traditional format. Clinical supervision by a social worker is clearly evident in the data.

However, as management personnel decrease in numbers and expand their scope of responsibility, social work programs in hospitals are only making small, but some significant shifts in their approach to supervision. Departments are increasingly utilizing a variety of supervisory models within the hospital setting, including solo and combinations of models. Traditional models of supervision are beginning to erode, while non-social work supervision experiences a significant increase over all three years of the study (see Table 1). As social work management positions in hospitals decline (Berger et al., 1996), traditional models of supervision may become more difficult to effectively

implement. What will emerge to fill the gap in clinical supervision in light of this decline?

The growth of supervision by non-social workers is setting off alarms for many practitioners and leaders. The use of non-social work supervisory models is still relatively small, but its growth is significant (see Table 1). In FY 92, only 13 percent of the respondents reported its use either in solo or in combination with others models. By FY 94, this grew to 16 percent, and FY 96 saw another increase to 19 percent. As hospitals increasingly adopt programmatic structures, and implement matrix models of management, there may be even greater use of non-social work supervisors. This trend needs to be monitored both in terms of its growth and its impact on social work practice and professional identity.

Peer supervision experienced an increase in use from FY 92 to FY 94, but dropped again in FY 96 below FY 92 levels. It is unclear why the trend reversed itself in FY 96, even though traditional models of social work supervision also declined. While some of the decline in traditional approaches might be accounted for by the slight increase in non-social work models, it does not sufficiently address how supervision is being handled. It opens up concern that a large number of social workers could be receiving no supervision. Unfortunately, the data could not effectively capture this information. It would be an important question to address in future studies.

CONCLUSION

The data from this hospital study suggests that the move to alternative supervisory models is slowly evolving in response to a changing health care environment, as Epstein (1981) hypothesized. As hospitals move to leaner management structures, the number of managers will decline, and their roles become more generic (i.e., cross-departmental managers with responsibility for multiple departments/programs). The issue of appropriate and effective clinical supervision becomes a real and important concern for social work practitioners in health care settings. How do these changes influence the mix in functions for the manager/supervisor? Is the function of clinical supervision incorporated into these new roles, and if not, what alternatives are being designed and implemented to address these needs? Supervision by clinically experienced social workers holding formal roles, as supervi-

sors, are likely to be even less feasible in the future, which could produce a sense of clinical isolation for practitioners if there are no alternative models.

The erosion of clinical development could become a reality if social work departments continue to depend on more traditional approaches to clinical supervision, particularly one-on-one models. There does not appear to be a commensurate growth in other models of social work supervision such as group or peer approaches that could moderate the negative impact on clinical and professional development. In the past, social workers have received clinical development from the organization. While options for clinical development exist externally, social workers have not had to depend on these, nor are they likely to choose this option because of the additional time and financial burdens it creates. The responsibility to ensure quality practice by assisting staff with professional development may no longer be the sole responsibility of the institution. Hospitals have a responsibility to ensure quality services to patients through support mechanisms for professional development. However, as resources decline, social workers will be called upon to assume greater responsibility for steering their own professional and skill development, and in seeking the resources necessary to accomplish this. It is interesting to note that Gibelman and Schervish (1997) distinguish clinical supervision from traditional social work supervision as, “. . . (1) not necessarily agency-based; (2) does not concern practice within an agency context; and (3) focuses on the dynamics of the client situation and the work of the social worker in that regard.”

Group or peer models of supervision may be alternatives that allow clinical development to proceed within the institution without reliance on more expensive one-on-one or external models. For example, peer supervision may be a model that allows clinical social work supervision to thrive in this changing environment. The move to peer supervision need not be a purely reactive response. It offers one solution to the reality of organizational change in health care facilities, while preserving the importance of professional supervision to clinical growth and development, and practice accountability. It has the potential to encourage a more empowered professional, who is better able to function effectively in an environment characterized by increased decision-making and responsibility at the clinical levels of the organization. It could also contribute to greater accountability through continu-

ous quality improvement, creating structures and process that promote clinical growth and professional support. Finally, group structures for supervision, both traditional and peer, can provide a forum in which a response for the collective formulation of political and professional agendas. It can promote professional values of advocacy and social change, while maintaining professional identify. More research is needed to test the efficacy of these models

This is the time for social workers to begin exploring and thinking about alternative approaches to clinical development. Practitioners will need time to explore, learn, experiment, and evaluate the different approaches as to their implications for practice. For example, to achieve optimum benefits from peer and/or group supervision, adaptation needs to be thoughtful with sufficient attention to the details of implementation. Adequate time is necessary to implement training and ensure the involvement of staff in developing the mechanisms for group norms and operations. Evaluation of the process and outcome of group and peer methods is paramount. The profession needs to build a body of experiential learning as it moves in this direction. Comparative, experimental, and longitudinal research is needed to evaluate the process, outcome, and efficacy of alternative supervisory methods.

Future research on the efficacy of alternative supervisory models is greatly needed to examine the impact on social work practice and professional development, both in terms of skill acquisition and professional identity. More in-depth study of supervisory models is needed to guide practitioners. Ideally, a prospective analysis could shed greater light on the efficacy of various models of supervision. Greater attention needs to be given to the differential quality and effectiveness of supervisory models, particularly as they relate to professional development and clinical practice. Questions about non-social work supervision can address the following: What are the qualifications of the individuals performing the supervision? Where does the supervisor sit in the organizational hierarchy? What is their supervisory philosophy and method? What is their understanding of social work profession, including training and roles? If used in combination with other models, what percentage of the social worker's time is spent with the non-social worker? What is the content of their supervisory session? Do social workers supervised by non-social workers perceive their clinical supervision to be a problem? Do they seek clinical supervision

from social workers outside the system, or informally from colleagues within?

The development and implementation of alternative models of supervision requires change not only in the framework of the social work thinking, but also a full commitment from the organization. For example, in relation to peer supervision, unless the system is prepared to address the cultural and structural changes necessary to facilitate a move to this supervisory model, effective implementation can be compromised. A hospital that has a decentralized structure, such as a programmatic structure, may need to address issues of authority when supporting peer supervision of social workers, as this could be threatening to the program administrator. The organization would have to demonstrate a commitment to the utility and efficacy of peer supervision in order to commit the time and resources to make this a successful endeavor. This organizational commitment will probably require advocacy on the part of social work staff and leadership.

Alternative supervisory models will also need to be supported through social work education and research. Most schools assign students to one supervisor throughout their field placement. This establishes a paradigm for supervision that rests solely on one approach to clinical growth and development. Schools of social work can begin exploring the use of group formats in learning, and include differential field instruction models to augment the one-to-one model of field instruction (Livingston, Davidson, & Marshak, 1991; Marshak & Chernack, 1996), as well as exploring the new skills that may be needed to prepare beginning practitioners for alternative approaches to supervision.

Differential models of social work supervision continue to be an important professional concern. While issues internal to the profession have historically driven this debate, the external economic and political pressures impacting health care, as well as other social service agencies, are elevating this issue to greater heights. The use of consultants and external reviews of social work departments are increasing in hospital settings (Berger et al., 1996), and this has the potential to shape supervisory models within health care settings. Change in social work management structures may also influence the use of alternative supervisory models, even though the traditional model continues to dominate. More work is needed to create innovative alternatives to

traditional supervisory models, and to test the efficacy of these models on social work practice and professional growth and development.

BIBLIOGRAPHY

- Abrahmson, J. S. and Mizrahi, T. (1996). When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. *Social Work*, 41, 270-281.
- Barretta-Herman, A. (1993). On the development of a model of supervision for licensed social work practitioners. *The Clinical Supervisor*, 11 (2), 55-64.
- Beatman, F.L., (1964). The training and preparation of workers for family-group treatment. *Social Casework*, XLV, April.
- Berger, C. S. (1993). *Restructuring and Resizing: Strategies for Social Work and Other Human Services Administrators in Health Care*. (Chicago: American Hospital Association).
- Berger, C. S., Cayner, J., Jensen, G., Mizrahi, T., Scesny, A., Trachtenberg, J., (1996). The changing scene of social work in hospitals: A report of a national study by the Society of Social Work Administrators in Health Care and the National Association of Social Workers. *Health and Social Work*, 21 (2), 167-187.
- Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work*, 41, 5, pp.541-551.
- Brashears, F. (1995). Supervision as social work practice: A reconceptualization. *Social Work* 40 (5), 692-699.
- Bruggar, T., Caesar, G., Frank, A., et al, (1962). Peer supervision as a method of learning psychotherapy. *Comparative Psychiatry*, 3, 47-53.
- Carroff, P. and Mailick, M., with Fields, G. (Eds.). (1980). *Social work in health care services: An academic practice partnership*. New York: Prodist.
- Christ, G. H. (1996). School and agency collaboration in a cost conscious health care environment. *Social Work in Health Care*, 24, 1/2, pp. 53-72.
- Epstein, L. (1973). Is autonomous practice possible? *Social Work*, 18, 5-12.
- Ezera, I.P., Lazar, A. (1994). The administrative and educational functions in supervision: Indications of incompatibility. *The Clinical Supervisor*, 12 (2), 39-56.
- Fox, R. Guild, P. (1987). Learning styles: Their relevance to clinical supervision. *The Clinical Supervisor*, 5 (3), 65-77.
- Frizdale, R. (1958). Peer group supervision. *Social Casework*, 39 (8), 443-450.
- Gibelman, M and Schervish, P. H. (1997). Supervision in social work: Characteristics and trends in a changing environment. *The Clinical Supervisor*, 16 (2), 1-15.
- Greenspan, R., Hanfling, S., Parker, E., Primm, S. (1991). Supervision of experienced agency workers: A descriptive study. *The Clinical Supervisor*, 9 (2), 31-42.
- Harkness, D. (1995). The art of helping in supervised practice: Skills, relationships, and outcomes. *The Clinical Supervisor*, 9 (2), 31-42.
- Harris, D. V. and Allison, E. K. (1982). Performance management and professional development as separate functions of supervision. *Health and Social Work*, 7 (4), 283-290.
- Kadushin, A. (1992). *Supervision in Social Work*, 3rd Edition. (New York: Columbia University Press).

- Livingston, D., Davidson, K., and Marshack, E. (1991). Education for autonomous practice: A challenge for field instructors. *Journal of Independent Social Work*, 4 (1), 69-82.
- Mailick, M. D. and Caroff, P.(Eds.) (1996). *Professional social work education and health care: Challenges for the future*. New York: The Haworth Press, Inc.
- Marshack, E. F. and Chernack, P. (1996). Alternative teaching approaches in field education: Responding to changes in service delivery. Paper presented Annual Program Meeting, Council on Social Work Education, Washington D.C., February 1996.
- Mizrahi, T and Abrahamson, J. S. (1985). Sources of strain between physicians and social workers: Implications for social workers in health care settings. *Social Work in Health Care*, 10 (3), 33-51.
- Munson, C. E. (1983). *An introduction to clinical social work supervision*. New York: The Haworth Press, Inc.
- Munson, C. E. (1998). Societal change, managed cost organization, and clinical social work practice. *The Clinical Supervisor*, 17 (2), 1-41.
- Munson, C. E. (1998). What next? Trends in psychotherapy supervision. Special Section. *The Clinical Supervisor*, 17 (1), 95.
- NASW Hospital Social Work Reorganization Survey, Report to the Board, October, 1993.
- Perlmutter, F.D. (1990). *Changing hats: From social work practice to administration*. Silver Spring, MD: NASW Press.
- Rabinowitz, J. (1987). Why ongoing supervision in social casework: An historical analysis. *The Clinical Supervisor*, 5 (3), 79-90.
- Richard, R., Rodway, M.R. (1992). The peer consultation group: A problem-solving perspective. *The Clinical Supervisor*, 10 (1), 83-100.
- Ross, J. (1992). Clinical supervision: Key to effective social work. *Health and Social Work*, 17 (2), 83-85.
- Ross, J. (1993). Redefining hospital social work: An embattled professional domain. *Health & Social Work*, 18 (4), 243-247.
- Salmon, J. W. (1995). Perspective on the corporate transformation of health care. *International Journal of Health Services*, 25 (1), 11-42.
- Schreiber, P. & Frank, E. (1983). The use of a peer supervision group by social work clinicians. *The Clinical Supervisor*, 1 (1), 29-36.
- Sherrill, R. (1995). The madness of the market. *The Nation*, 260, 45-46+.
- Towle, C. (1963). The place of help in supervision. *Social Service Review*, 37, 403-415.
- Tsui, M and Ho, W. (1997). In search of a comprehensive model of social work supervision. *The Clinical Supervisor*, 16 (2), 181-205.
- Veeder, N.W. (1990). Autonomy, accountability and professionalism: The case against close supervision in social work. *The Clinical Supervisor*, 8 (2), 33-47.
- Watson, K. W. (1973). Differential supervision. *Social Work*, 8 (3), 37-43.

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