



# **SUPERVISION MANUAL**

**A GUIDE FOR ALL MANAGERS  
(THE SUPERVISORS) & STAFF  
(THE SUPERVISEES)  
AT  
THE CHILDREN'S AID SOCIETY  
OF BRANT**

---

---

## TABLE OF CONTENTS

<b>INTRODUCTION</b> .....	1
<b>A. AGENCY POLICY</b> .....	2
1. General Considerations about Clinical Supervision.....	2
2. Motivational Factors in Clinical Supervision.....	3
3. The Definition of ‘Manager’ .....	4
4. The Requirement of a Strengths Perspective in all Agency Supervision .....	4
5. The Mutual Exploration of Hopes and Fears with children and their families.....	5
6. The Parallel Process.....	5
7. Clinical Supervision and Transformation .....	6
8. Various Clinical tools to Assist Supervision.....	6
9. Casenotes Written by Workers in Clinical or Ad Hoc Supervision.....	7
10. The Sharing of Responsibility for the Transition to Clinical Supervision.....	9
<b>B. THE FUNCTIONS OF SUPERVISION</b> .....	9
1. Job performance.....	9
2. Job Definition and Role Clarity.....	9
3. Training and Education .....	9
4. Evaluation.....	10
5. Motivation and Support.....	10
6. The Expected Service/Administrative Director Approaches to the use of Supervision .....	11
7. The Connection of Clinical Supervision to the Annual Staff Evaluation Process.....	12
8. Resolving Professional Disagreements.....	12
9. Limitations on Case Discussions.....	12
10. The Use of Child Welfare in Ontario: Developing a Collaborative Intervention Model .....	12
<b>C. TYPES OF SUPERVISION:</b> .....	12
1. Individual Clinical Supervision .....	12
2. Team Supervision .....	13
3. Peer Consultation .....	15
4. Group Consultation .....	15
5. Ad-hoc or Informal Supervision .....	15
6. Supervision for All Non-case Carrying Team Members .....	16
a) Support Staff Supervision .....	16
b) Protection Support Worker Supervision .....	16
c) Workers in the Child Development Unit .....	16
d) Supervision for Lawyers.....	16
7. Conclusions .....	17
<b>D. THE SUPERVISION AGREEMENT</b> .....	17
1. The Frequency of Supervision:.....	17
2. The Setting: .....	18
3. Direct Observation:.....	18
4. Documentation (supervision and consultation:.....	18
5. Caseload Reviews:.....	19
6. Dealing With Topics of Diversity and Anti-Oppression .....	19
7. The Supervision Agreement .....	19

<b>E. THE CLINICAL SUPERVISION AGREEMENT FOR ALL BRANT CAS SUPERVISEES AND MANAGERS</b> .....	21
<b>APPENDIX 1: THE SIGNS OF SAFETY AND THE OLMSTED COUNTY MODEL</b>	23
Protection Planning Discussion for Individual/Team or Peer Clinical Supervision Outline based on the Agency’s Protection Planning Conference OUtline .....	23
<b>APPENDIX 2: ADDITIONAL GENERAL CONSULTATION AND SUPERVISION QUESTIONS FOR WORKERS</b> .....	24
a. For both new and ongoing Child Protection/child care cases (From Clinical Supervision M6A): .....	24
b. Transforming supervision, encouraging critical thinking tips for moving beyond case description (from mcmaster course).....	24
c. A model for critical thinking (adapted from bogo & vayda itp model and taught in the mcmaster clinical supervision course for managers) .....	24
<b>APPENDIX 3: SPECIFIC SUPERVISION REQUIREMENTS RELATING TO THE AGENCY’S DIFFERENTIAL RESPONSE POLICY AND PROCEDURES</b> .....	26
1. D.R.3.8 Supervision and Review of Cases .....	26
2. Requirements of the Minstry Differential Response standard #12 .....	26
<b>APPENDIX 4: SELF CARE AND PROFESSIONAL DEVELOPMENT PLANNING</b>	28
<b>APPENDIX 5: DECISION MAKING IN THE SOCIETY</b> .....	29
1.6.1 Decision Making in the Society .....	29
1.6.2 The Collaborative Problem-Solving Process.....	31

**Clinical Supervision Committee Members**

Lee Ann Marshall, Management Assistant  
 Adelaide Cordeiro, Management Assistant  
 Karen Perrin, Child Development Unit Worker  
 Barbara Mayo Melara, Central East Team Manager  
 Bob Pittman, Specialized Services Manager  
 Catherine Andreasen, Central West Team Manager  
 Denise Morton-Sayles, West Brant Team Manager  
 Sally Rivers, Aboriginal Services Unit Manager  
 Sarah Robertson, New Beginnings Team Manager  
 Terry Arnold, Permanency Services Unit Manager  
 Elizabeth Capitano, Legal Counsel  
 Iona Sky, Community Development  
 Lana Brasher, Worker  
 Leigh Savage, Worker  
 Natalie Chambers, Worker  
 Natalie Dixon-Judah, Worker  
 Trish Silverthorne, Worker  
 Bruce Burbank, Director of Services  
 Andrew Koster, Executive Director  
 Paula Loube, Executive Assistant

## INTRODUCTION

Beginning In the spring of 2008, seven social work managers, six front line social work staff, three support staff in various roles and services, an agency lawyer, a director of services, and the executive director held a series of meetings to develop a set of policies and procedures for a clinical approach to supervision. It was intended to mandate how supervision would be delivered to all staff employed by the Brant CAS. Each group represented their constituency and had been chosen or volunteered for their committee role.

Over the course of six meetings the group discussed ideas and concerns from various perspectives. What began as an outline from the Child Welfare in Ontario: Developing a Collaborative Intervention Model Phase 2 material, which provided a proposed, a generic policy and procedures manual for CAS agencies (see below), expanded as various constituencies presented their thoughts. The role of the Executive Director was to ascertain that indeed there would be a policy and procedure manual on how supervision would be conducted for all staff and then to address the group dialogue and resubmit updated versions of the initial document. The first part of the final product provides the philosophy and underlying intents for the philosophy followed by actual procedures that are expected to be universally adapted by all individuals and teams at the agency.

In addition to the original document and the committee member ideas, there was adherence to the expectations that flowed from the Ministry's Transformation Agenda and the outline envisioned by a number of Collaboration participants from various CAS agencies and from various Schools of Social Work who developed that project's clinical supervision section.

These required policies and procedures contain specific principles and ideas from the OACAS Clinical Supervision Module 6A and a Clinical Supervision Course held for CAS Managers at four participating CAS agencies by McMaster University School of Social Work. One major inclusion was the outline of the proposed supervision agreement. It was hoped that all of this excellent reference material would facilitate an additional 'transfer of learning' opportunity for

managers who had taken these training modules and university courses.

Additional material was submitted by committee members including an article by Jeffrey K. Edwards and Mei-Whei Chen, entitled Strength-Based Supervision: Frameworks, Current Practice and Future Directions: A Wu-wei Method. The article provides further powerful descriptions of clinical supervision. The word supervisee has been substituted for the word 'covisee' which is used in the article has been substituted in these passages in order to maintain consistency with the terminology used in this procedural manual.

- Strength-based supervisors must model the very values that we wish the supervisees to exercise with their clients.
- We often begin supervision by asking what supervisees feel they have succeeded in doing, and encourage them to repeat those behaviors in similar situations. Starting the supervision with an emphasis on supervisees' strengths and successful interventions is more likely to make supervisees feel more capable. Even when the counseling outcomes seem unsuccessful, the supervisor can still look for supervisee's underlying good intentions . [and] help supervisees learn to accept that "what they felt as being a mistake is just a chance to learn more about clients" (Merl, 1994, p. 51).
- In addition, we [ask] the supervisees to remember past successes in dealing with similar issues or feelings. Then supervisees are more able to create their own solutions by recouping past solutions (Marek, Sandifer, Beach, Coward, & Protinsky, 1994).
- In strength-based supervision, not only do we focus on supervisee's competence, but the language used to talk about clients is also competence-based.
- We strive to avoid using pathological labels about clients that might silence the expansion of client possibilities (Bobebe, Gardner, & Biever, 1995).

- We encourage supervisees to identify strengths and assets in their clients.
- We ask about unique outcomes (White, 1989) where clients have been successful in defeating problems. This type of supervision enhances supervisees working with clients. It helps supervisees develop an alternative clinical schema basis on success and competency (Wetchler, 1990). As Cantwell & Holmes (1994) state: "As client competencies improve when affirmed and problems drop away, so too do therapist competence expand when tagged and accepted" (p. 45).
- We promote a supervision that shifts away from scientific objective detachment towards interactive transparency.
- We take advantage of those precious moments to share "own humanity, life-story and professional journey" (Cantwell & Holmes, 1995, p. 38), or "share with supervisees our initial struggles in learning new ideas and accepting feedback" (Selekman & Todd, 1995, p. 22), and initial confusion when learning a strength-based model. The transparency in our humanity also paves the way for us to take a "not-knowing" position.
- We leave room for doubt or rejection; we reflect in a hypothetical way (Merl, 1995). Through such a curious posture, we convey interest and a need to know more (Anderson & Swim, 1995). Furthermore, this unassuming humanity makes room for supervisees' expertise and competencies.
- In our attempts to be humble and transparent, we acknowledge the power we have in the evaluative position.
- We agree with Turner and Fine (1995) who stated that "we need to be very clear and up-front about the power we have accepted as part of our supervisory position and about our responsibility to work within specific guidelines" (p. 63).

## **A. AGENCY POLICY**

### **1. General Considerations about Clinical Supervision**

Clinical supervision represents a goal-directed, contractual and inter-personal process and relationship between each staff member and his/her manager. It has jurisdiction over most aspects of the worker's or staff person's job responsibility, performance and performance evaluations. It also influences the provision of services that each employee provides that are within the agency's prescribed mandate and mission.

As a result of its importance to the protection of children and appropriate service delivery to families and communities regardless of the employee's specific role, the supervisory process will lead towards the professional growth and development of the individual.

Clinical Supervision, which includes critical thinking, reference to theory and the application of best practice, are crucial to these goals. The values and approach that are articulated in M6A on clinical supervision are incorporated into the policies and procedures on supervision. In turn this necessitates that, as knowledge and performance of a supervisee increase, a corresponding level of shared decision-making in the management of individual cases should occur. This is not new but is currently articulated throughout the OACAS Management Training Modules (M Series) and the McMaster University Course on Clinical Supervision. Portions of these training programs are included in the appendix. The fact that this training has been provided to various non 'social work' managers as well enables the agency to move towards a clinical supervision approach in a more universal manner.

This policy and procedure is also intended to provide a clear definition of supervision and the manner in which it is operationalized throughout the Society regardless of individual roles and functions. Supervision and its application are critical components within an organization and are primary vehicles for communication and a collaborative approach within the agency's system. At risk children and their families will be the beneficiaries in a parallel process.

Agency philosophy and policies should have a direct influence on how all staff in the organization conduct business with children, families and their co-workers. It is also important that the agency code of ethics is followed as well as those codes outlined for various professional groups within the organization whether they are social workers, lawyers or accountants. It is crucial that we all uphold and live by these principles of practice within our workday. It should also be the basis of supervision, team supervision and group problem solving.

It will assist in eliminating informal interference on case decisions, gossiping and inappropriate judgments made on occasion by other staff unrelated to the specific case management responsibilities. It will help eliminate situations that can be common place in all organizations yet are poisonous to the environment and can cause grievous harm to those who participate and to the recipients.

Traditionally, clinical supervision has been confined to social work staff dealing directly with children at risk and their families. At the agency it has been determined that the clinical approach should be used with all staff whether they deal directly with children and families or not. Each employee in order to feel fulfilled requires the following:

- Meaningful discussion on their present functioning and career development
- Acquiring the necessary training to enhance their competence and to aspire for other work experiences as an employee
- Sharing ideas and work related feelings in privacy with someone who can offer undivided attention
- Debriefing in safety where needed and to be aware of the possibility of vicarious trauma (actual therapy is not provided in supervision)
- Learning how to talk to children, clients, foster parents or other staff in other departments when required to deescalate or to collaborate.

- Developing diplomacy skills in dealing with external and internal complaints or concerns
- All staff in community based locations require opportunities for input and dialogue in terms of their role in the team and the community in which they are located
- Engaging in the appropriate discussion of diversity, comfort zones and other related issues within and external to the agency
- Exploring best practice procedures provided by peers in team supervision and peer consultation
- Providing honest feedback on what is required for professional growth after the employee has sought and been unsuccessful in other job opportunities within the organization

All of these topics should be potential discussion points in the supervision of all staff. All staff share universal Maslow motivators.

## **2. Motivational Factors in Clinical Supervision**

As indicated in the Child Welfare in Ontario: Developing a Collaborative Intervention Model (Phase 1 Position Paper), the motivational level that the supervisor is operating at will likely influence all but the most confident and resilient staff. By the same token, a worker operating out of Maslow's level two, will not be able to make concerted efforts to engage their clients if they are staff who actually have case management responsibilities. This is explained in the figure below outlining Maslow and Hertzberg's principles that are currently taught to supervisors in the OACAS M3 training module.

## Comparing Maslow's Hierarchy of Needs with Herzberg's Satisfiers

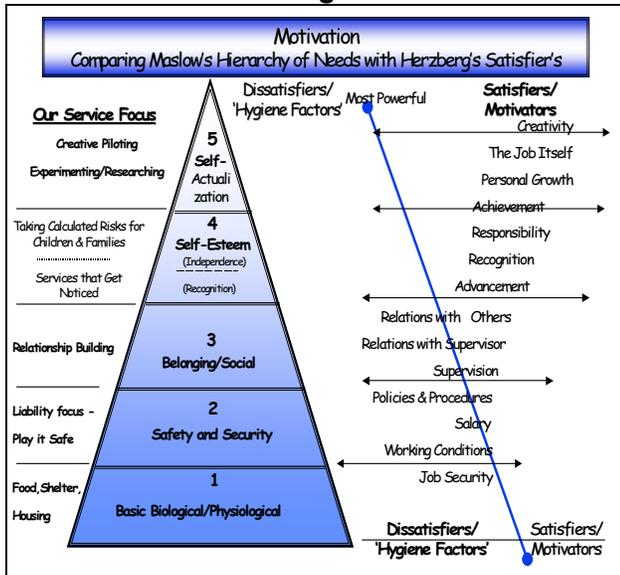


Figure: Rocci Pagnello, 2005

### 3. The Definition of 'Manager'

The term "Manager" applies to any staff person who manages, evaluates and assigns work to others. For service managers, this is consistent with the Differential Response procedures 3.15 on Staff Supervision which defines the role. Differential Response 3.5 also states the following:

'Every manager shall provide a program of supervision for the staff responsible to him/her for the following purposes':

- to provide a forum for review of the staff member's work
- to ensure that standards are being met, and where they are not, to approve deviations or develop a plan for remediation
- to evaluate and develop each worker as a skilled professional to the maximum of his/her potential; and
- to support the worker in carrying out his/her duties.'

### 4. The Requirement of a Strengths Perspective in all Agency Supervision

In the OACAS Clinical Supervision Module, the 'strengths perspective or the 'strengths-based approach' is a way of looking at individuals and families and their circumstances, that is diametrically opposed to how most child protection professionals, and all helping professionals have been oriented to help families.

Very simply, the strengths perspective is about mobilizing clients' strengths (their talents, knowledge, capacities and resources) so they can achieve their goals and have a better quality of life on their terms. The concept is simple, but to practice from a strengths perspective is hard work because we must shift our thinking from problems and deficits defined by the worker, to possibilities and strengths identified in a egalitarian, collaborative relationship with clients.

The 'strengths' perspective values health over disease, accomplishments over failure and resources over deficits, [however] "...this is not a perspective of naive optimism or superficial wishful-thinking...Life's brutalities and pain are accorded due respect and soothing balms are applied where possible...such adverse experiences, are not however, given "master status" [and considered to be] the most significant aspects of a person's life...rather...the strengths perspective fills in the gaps of the theories that emphasize defects, providing balance and relation to the various dimensions of lives." As well, Saleebey (2006) said, "the central dynamic of the strengths perspective is the rousing of hope, of tapping into visions and the promise of the individual, family and the community. Circumstances, bad luck, unfortunate decisions, the harshness of life lived on the edge of need and vulnerability...may smother these [but] it is the flicker of possibility that can ignite the fire of hope" ((Saleebey, p. xiv). "

The development of the strengths perspective represents a significant paradigm shift for social work and other professions. It is more than an 'add-on' to traditional pathology-based, problem-solving paradigms within which an assessment of strengths is used to overcoming barriers and obstacles to achieving goals. The strengths perspective is a 'frame of mind' that once integrated into our core, changes how we view children, adults, families and communities.

In order for front line workers to make the shift from a pathology-based, problem-solving paradigm to a strengths based paradigm, while at the same time making child safety paramount, supervisors must embrace the shift and in the process of doing so learn the lexicon or the language of the strengths perspective and become skilled in reinforcing thinking and 'doing' within a strengths-based framework.

## 5. The Mutual Exploration of Hopes and Fears with children and their families

This approach includes an understanding of the mutual hopes and fears of both the worker and their respective client families. Informed clinical supervision that explores all of the factors associated with collaboration with clients (children and/or their families) allows this process to occur.

**Figure 1: The Hopes and Fears of Parents and Workers**

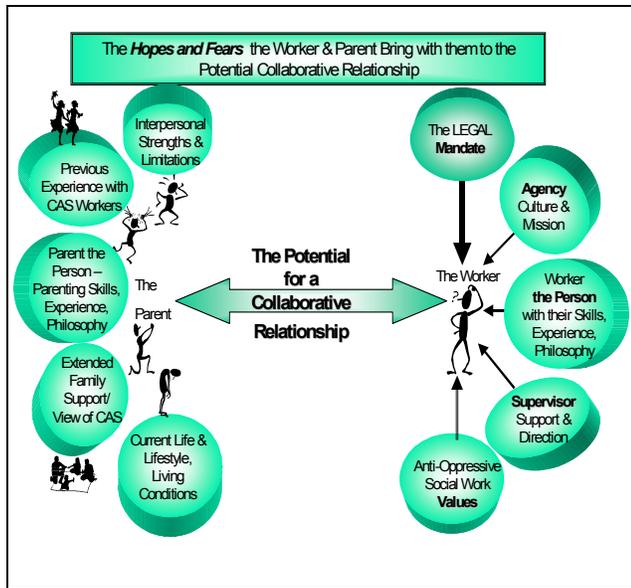


Figure: Rocci Pagnello, 2005

## 6. The Parallel Process

It has been discussed in the field whether a supervisor has a therapeutic role in helping a worker address issues that may be affecting the extent to which the worker is able to fulfill his or her function? The agency confirms the position taken by Munson, Shulman, and Kadushin on the subject. All three have written extensively on social work supervision. They take care to point out that a supervisee is not a client of the supervisor and therefore supervision should not become a therapeutic relationship. According to Shulman, "It is absolutely essential that this relationship not happen and that the work of supervision remains focused on helping staff members carry out their work-related tasks", Shulman, 1999, p. 6-7.

However, many researchers believe that the nature of the supervisor-supervisee relationship and the manner in which the supervisor and supervisee interact is replicated in the field between the worker and his or her clients. Shulman (1999)

refers to this as a parallel process. Supervision should start where the worker is at just as managers would want their workers to similarly begin their relationship with children and their families - the safety and wellbeing of children not withstanding.

The Child Welfare in Ontario: Developing a Collaborative Intervention Model Phase I Position Paper goes on to indicate *'that there is a reciprocal parallel process at work in crisis situation for both. If the worker can rise above their own work pressures and demands and attune to the parent – meeting them at their level, then there is an opportunity to potentially forge a trusting relationship. When a parent's homeostasis is disrupted, crisis theory indicates there is a window of opportunity for change. Crisis theory would likely suggest that when a parent is in crisis, hurting, terrified etc. the support they get at that time would promote a bond to those who helped them work through the problem. If we miss that window, the opportunity to facilitate long-standing or real change in the relationship may be compromised until the next crisis occurs. Could an analogous process take place in the worker/ supervisor relationship? Our workers deal with clients who are chronically in crisis and emotional pain. The issue of 'compassion fatigue' and the fear of not keeping up with demands of the job are evident from time to time with even our most competent staff. If a worker is feeling unsafe, insecure or somehow in emotional pain or discomfort and the agency and/or supervisor ignores that state, the opportunity to forge a stronger relationship and model collaborative work may be lost.'* (p. 193)

**Figure 2: Crisis Window for Change**

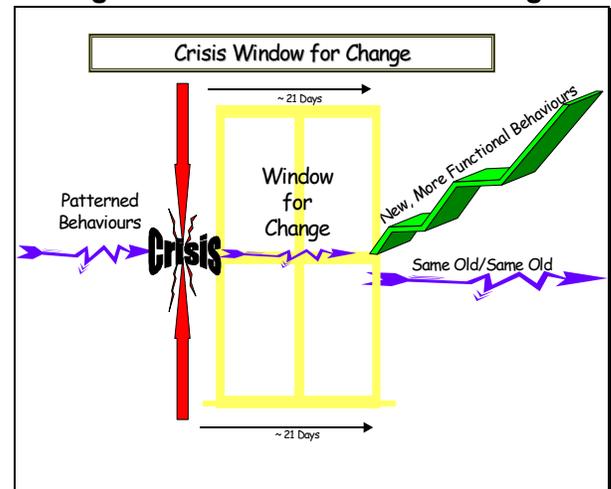


Figure: Rocci Pagnello 2005

Clinical supervision of all agency staff should include this exploration - not only for better service to clients - but equally important for the wellbeing of the supervisee.

## **7. Clinical Supervision and Transformation**

Child Welfare Transformation necessitates a shift in the philosophical approach to practice. Within the previous Ontario Risk Assessment Model, there was a forensic, risk and deficit focused intervention for front line staff that emphasized both the child protection supervisor and front line worker should keep within prescribed guidelines and timeframes in adherence to strict accountability mechanisms. Within that particular climate, supervision of child protection cases became a mechanical review of cases, documentation requirements, deviations and an oversight of the risk assessment tool. The dialogue between supervisor and worker was scripted accordingly and dependent upon caseload size or case complexity, supervision would consist of the review of each case on the worker's caseload. In this environment, the focus remained on risk assessment, risk management and compliance. As a result, the language of supervision was shaped accordingly.

Today, it is important to reinforce a collaborative philosophical stance to how supervision is deployed. For Transformation initiatives to be effective, supervision should include such concepts as 'critical thinking', theory, and best practices service delivery to children and their families. It needs to confirm that child protection services can be delivered in culturally appropriate ways to diverse and marginalized communities while still protecting children.

Under the present changes in Transformation, the renewal of clinical practice is not a bureaucratic exercise. While it should be insightful and dynamic and still have time for the administrative parts of supervision. Often 'Administrative' supervision deals with ensuring that deadlines are met while 'clinical' supervision is concerned with 'what's going on with cases?'

In many agencies administrative supervision has been 90% of supervision. Under Transformation and the practice of sound clinical supervision this is unacceptable. All parties involved in supervision practises will now have to redefine

their individual roles. All agency staff will need to think about what they are bringing to the table in supervision, not just as a manager but as a supervisee. Supervision is a reciprocal exercise - beginning with children and their families and ending with the Board of Directors.

It is hoped that once the new strength based language is completely incorporated into regular agency dialogue and in supervision, there will be an increase in comfort level in speaking to clients in a more inclusive manner. The use of appropriate clinical supervision will be a major factor in changing culture, language and our approach to clients and each other. For the tools outlined in Transformation to be most meaningful, we need to develop our skills through clinical supervision. This includes how to complete the tools collaboratively with the family, to understand what the tools are telling us, how to integrate this information into our assessment, and how to review the tools in order to evaluate progress that may or may not have been achieved.

The Supervision contract found later in this document will then become the outline and agreement for behaviour. It will model in supervision the way workers will want to interact with their clients.

## **8. Various Clinical Tools to Assist Supervision**

As the agency becomes more familiar with the new tools for Differential Response there will be further benefits to the process of clinical supervision. Anticipated areas of enhancement include:

- Discussion about critical analysis of safety and risk factors, dynamics and strengths of the family, protective factors and how these aspects can be incorporated into the service plans.
- Incorporation of the various assessment tools into practice – what are these tools telling us about the family? About the child? How can these tools be used to help us recognize progress? In child community family service teams, discussions regarding the critical analysis of safety factors and dynamics will use the Signs of Safety format

and the Olmsted Model of case conferencing children at risk. A copy is in the appendix.

Previously, workers and managers have been pre-occupied with outputs and have never incorporated information gathered in supervision. The tools may assist this process by facilitating a deeper discussion about the family/child; providing a starting point to understand where the family/child is at and an opportunity to develop interventions and goals using the tools to inform our practice. Clinical Supervision will help ensure we incorporate tools and information gathered through tools. Some specific examples of tools and their use include:

- AAR is a comprehensive document created in collaboration with the child and foster parent which should be used to inform the plan of care. The AAR can assist us in recognizing specific areas that require growth, the strengths of the child, and to identify progress in the child's over development while in care. As part of clinical supervision, the CSW and Manager can use this assessment tool to really understand the needs of the child, develop the direction for case planning, and to assist to keep perspective of the child's progress.
- ONLAC can be used to determine the degree of success that a child is achieving while working to the goals outlined in the model.
- Audits – The compliance in service plan area provides a logical progression to better client engagement and sets stage for working relationship with client. In a case/month to audit we would have a greater opportunity to really reflect as to what the audit is telling us in terms of clinical supervision.
- ADR and Differential Response follow the logical flow of working towards collaborative agreements with children and families.

Through supervision, we need to develop our skills in completing the tools collaboratively with the family; understand what the tools are telling us; how to integrate this information into our assessment and how to review the tools to evaluate progress. This includes working with

the strengths of the individual - presenting what the clients are saying - and working together to identify strengths or coming to a plan. Ideally we can shift our thinking from risk adverse to risk tolerant. This approach will accentuate the clinical use of various assessment tools.

Ultimately for front line workers, clinical supervision will include a related process in which the supervisee and manager learn to accommodate information (action plan) and plan follow up. Even though it may be initially contentious the exploration of best practice and worker feelings of apprehension, will provide a more consistently clear path for what is needed to resolve case management options. This does not mean that most managers and workers are not engaged in this exploratory process but this procedure will make it more universally accepted by others now that it is agency mandated.

### **9. Casenotes Written by Workers in Clinical or Ad Hoc Supervision**

According to the Brant CAS, (DR policy 3.12 Case Recording) workers are required to ensure that "Case notes should be taken to record all activities on a case, including but not limited to 'Supervisory consultations and discussions, including ad hoc consultations'. However, the manager is responsible for signing off on case notes written by the worker in supervision.

This supervisory signature should be added to a worker's case note where there is an Agency or Ministry Standard requiring Supervisory approval for an aspect of case decision-making. It may also occur where there are approvals of departures from child protection standards, agency policies and procedures including extensions of timeframes require supervisory signature."

Supervisory signature is also required on child protection case documentation submitted by the worker at the completion of a safety assessment, conclusion of an investigation, a formal case review, an override on a risk assessment, case transfer or case termination. When supervision is occurring "ad hoc" by phone or e-mail, the manager may request that the caseworker document the supervision in his or her case notes and sign later.

## **The Process**

With the expectations and the time limitations placed on workers and supervisors in the Child Protection Standards, there can no longer be the rote supervisory review of each case and the implied unattainable "knowing" of each risk facet in each case. Instead, there must be a structured decision making process where the worker and supervisor agree on which cases will be reviewed in each clinical supervision period. This requires the courage to manage the anxiety created by the "letting go" of the current need for some supervisors to know everything and document it all.

However, mandatory supervisory reviews of case decision points can also occur in ad hoc encounters as a case develops. It can also occur in set periods of time each week that the supervisor/manager is encouraged to set aside for the potential case reviews brought forward by various team members.

Best practice dictates that for ease of review and for coverage purposes the title of the case note written by the worker should be "Consultation with Manager". The Supervisor/Manager may also confirm this on a computerized case recording if available.

## **Manager Initiated Case Notes**

Managers may decide to produce their own case notes in some contentious situations or where there is risk of agency liability. This may be done by signing, dating and handwriting the information using the carbonated supervisory case note or relevant electronic case notes.

There should always be a separate note for each case discussed as any disclosure or warrant will be for particular people or family. These notes may include but not be limited to:

- Information about the case situation as provided by the worker
- Decisions or plans made in response to this information
- Timelines for actions or response
- Review of plan from previous information (if a topic of supervision)
- Frequency of the worker's contact with the family, noting date of last contact, next expected contact, and any missed or cancelled contacts

- Family and Child's strengths and needs assessment

## **Legal Considerations**

Both parties to the supervision should remember that if their documentation relates to a case, decision making, effectiveness of service to that person or family etc., it is subject to disclosure. It is important to think about what one wants disclosed before writing it down. A Society would have an obligation to disclose supervisory notes related to case files. In addition, notes in a worker's case file that say – supervisor says to (apprehend/not apprehend) because (set out reason) are clearly going to be disclosed as part of the worker's file. We are also speaking of the manager's notes on a case that include the client's actual names – they are always subject to a disclosure order or warrant although the local practice may not be to request them. As a result they should be complete and accurate.

## **Exceptions to Disclosure**

The Clinical Supervision Agreement articulated in this document concerning a worker's professional development; strengths and weaknesses; skill augmentation; updates on projects; training needs or progress on performance goals would not ordinarily be subject to disclosure.

To ensure this probability, these items should be kept in separate file folders by both the supervisee and supervisor (manager) to assist in the accuracy of their supervisory process. Under no circumstance should this documentation include the names of client children, adults or family members. This would make the agreement and other areas potentially subject to a case disclosure application.

As a general rule, it is not the file that determines whether the document is subject to disclosure but the contents of the document. This is similar to the fact that it is not the title "solicitor-client" that protects a document but the content of the document being legal advice. Periodically, the supervisor and supervisee should ensure that the case file information is not accidentally mixed into a worker's supervision folder and that information meant for the supervision folder does not end up in a case file.

## **10. The Sharing of Responsibility for the Transition to Clinical Supervision**

All staff, regardless of role, should know that there is a strong sharing of responsibility as the agency moves to a clinical approach to supervision. Under transformation, front line workers and managers share a revitalized emphasis on relationship focused, strength based assessment and re-assessment. In order to maximize child safety and wellbeing, the clinical supervision of child protection work must include the following:

- An opportunity for critical thinking
- Reference to a relevant theoretical base
- Knowledge of Research-based, Best Practice in similar situations
- Active reflection, questions and hypotheses by both the Supervisor and Supervisee about the case
- The articulation of the dynamics in the situation
- The hoped-for outcome for the child
- A determination of the degree of worker's knowledge and ability to perform tasks in order to contract on the amount of direct supervisor intervention in the case (directing, coaching, supporting and delegating as defined with other worker assessment tools in OACAS Management Module M#3).

This progress is supported and confirmed within the agency since an enhanced supervision model will assist in keeping children safe while providing more appropriate services to families and their communities. Clinical Supervision is seen as an expected requirement for supervisors and managers. Therefore, it is advocated for and insisted on by senior staff.

This approach requires time to evolve into a natural approach to supervision practice. The agency must articulate in its contract with staff a commitment to the shared accountability and liability inherent in this new approach. As Munro (1996) stated, "Senior management needs to

ensure that time for thinking and supervision is valued and protected from competing demands."

Supervision is now a shared responsibility with the agency. It is endorsing the move to clinical supervision and a collaborative approach to children, families and communities as articulated under the various Transformation Initiatives of the Ministry.

## **B. THE FUNCTIONS OF SUPERVISION**

The functions of supervision will include the following:

### **1. Job performance**

As Kadushin mentions, administrative supervision "is a process that implements organizational objectives. It is a process of defining and attaining the objectives of an organization through a system of coordinated and cooperative effort". Specifically it can ensure the adequate performance of the job according to prescribed legislation and defined agency standards. This is the primary function of the supervisory process and is designed to help workers provide ethical, collaborative services to clients while still emphasizing child safety. It includes advocating and providing for the provision of adequate resources. Appropriate support and direction provided to staff is also a 'parallel process' to how front line workers will facilitate effective decision-making with their children and families at risk.

### **2. Job Definition and Role Clarity**

Administrative supervision ensures through the collaborative supervisory process, a clear mutual understanding of the agency's mission; relevant legislation with its regulations' agency standards and the tasks to be performed. In addition, each person's role in relation to their colleagues and the aspects, which contribute to a 'collaborative' agency culture and environment, must be clarified within the context of the supervisory relationship.

### **3. Training and Education**

A critical component of supervision is assisting employees in increasing their professional knowledge and understanding in order to improve their critical thinking, theoretic base and professional practice skills. This activity is crucial at all stages of the supervisory relationship, from the introduction of a new worker to the child

welfare field to the ongoing challenges facing senior management.

This includes what is traditionally known as 'clinical supervision' although in the Society's interpretation it also includes a comprehensive approach to interactive process itself. Kadushin states that it is "the teaching of knowledge, skills, and attitudes necessary for the performance of clinical social work tasks through the detailed analysis of the worker's interaction with the client" and is "...a situation in which a more experienced professional oversees the work of a less experienced professional with the objective of helping that person develop greater adequacy in professional performance" (Kadushin, 2002, p. 129)

Specifically this means that:

- Educational supervision provides the knowledge and skills required to do the job and is concerned with the cognitive aspects of the work - with increasing worker effectiveness through upgrading knowledge and skills.

Managers must have solid theoretical grounding, be skilled in application techniques and strategies and transmit this in a supportive, non-threatening manner or have access to the knowledge that the supervisee needs. Wherever possible the manager should be up-to-date on current research findings, attend training where applicable and be well read on their area of expertise.

#### 4. Evaluation

In order to ensure that effective service is provided to the community, it is essential that ongoing and regular evaluation of staff performance is an agency commitment. The evaluative process should be as objective as possible and should include input from the employee and his/her supervisor. Evaluation within a managerial relationship should endeavour to determine the extent to which the employee is achieving the requirements of his/her job responsibilities as defined by the organization. This process should be directly linked to the training and educative component of supervision, in order to ensure ongoing employee learning and performance improvement.

A "team" evaluation of a manager may become evident or complaints are received about the lack of supervision by a manager:

- There will be a need for parallel processes
- How to control information addressed in discussion by a particularly dominant team member
- Who is feedback solicited from?

#### 5. Motivation and Support

The OACAS M6A reminds us that 'A supervisor is a manager in implementing administrative supervision, a teacher in implementing educational supervision, and an *'adjustment counsellor' in implementing supportive supervision.*' (Overhead #6, Kadushin, 2002)

This means that:

- Supportive supervision is about helping supervisees deal with job-related stresses.
- Supportive supervision is concerned with the effective aspects of the work - with increasing worker effectiveness through decreasing stress that interferes with performance while increasing motivation and intensifying commitment that enhances performance.
- Supportive supervision provides the psychological and interpersonal context that enables the worker to mobilize the emotional energy needed for effective job performance and obtain satisfaction in doing their job.
- Supportive supervision "relieves, restores, comforts and replenishes...but also inspires, animates, exhilarates, and increases job satisfaction...supportive supervision makes the difference between joyless submission and eager participation - between playing notes and making music."

The value of supportive supervision should never be minimized. In a large-scale study of the training needs of 1500 child welfare supervisors and direct services workers, 'identifying and lessening worker stress' was identified as among the very highest of priorities.

Other common stressors include confusion and anxiety about their role and responsibilities; feelings of disillusionment, disappointment and disenchantment with the client population served; too many cases with too little time for each one;

and organizational instability from constant restructuring, staff turnover, etc. There is also the stressor of a supervisee having feelings of powerlessness in being able to affect positive change: within the organization, with clients, and/or within the supervisor-supervisee relationship.

Conversely common de-stressors include recognition for work well done; conferences and training workshops that offer opportunities for growth and provide a break from the day-to-day monotony of the work; flexible work schedules. Once in a while and after extensive dialogue and problem solving it may also be alleviated by re-assignment to another area. It could also help where there is an appropriate balanced reduction in caseload stresses through review, re-assignment and re-prioritization. Research reported in Kadushin (2002) identifies several benefits of supportive supervision and include the following:

- Reduction in worker anxiety about their ability to do their jobs
- Lower levels of burnout
- Higher levels of overall job satisfaction
- Better over-all outcomes for clients

Recognizing the stresses and pressures related to the provision of child welfare services and the supportive aspects of the supervisory relationship are most important. In assisting employees in adjusting and coping with job related stresses, the manager is ensuring that staff members are emotionally prepared to provide effective service to the community. The ongoing positive motivation of staff members is also seen as a crucial element in an effective managerial relationship.

The stronger and more positive the relationships are among directors, managers, workers and staff, there are fewer opportunities for oppression.

## **6. The Expected Service/Administrative Director Approaches to the use of Supervision**

Directors have a powerful role and responsibility in making the society culture. It should be remembered that the physical layout of a building that allows for direct and frequent contact between the various levels of management and staff persons can enhance the

positive culture of an organization and enhance the parallel process.

Directors should encourage managers to have open discussions with staff concerning the core elements of practice. This discussion along with support will help foster and encourage the process of change and provide a map for each worker to accomplish this.

- Effective Communication and engagement with individuals family groups and community partners
- Assessing what needs to change and how this can be accomplished
- The effective use of authority that focuses on safety and solutions.
- Asking the questions which need to be asked and challenging staff in a supportive way.
- The case manager will require active support and supervision as each situation evolves and develops. Set backs or impasses may occur which will require new approaches and different strategies.
- The development of team building and group process that allow the sharing of skills and knowledge of other staff.

Supervision needs to nurture relationships between manager and worker in a non – threatening manner. Both parties - whether they are managers or workers - should know what supervision is supposed to look like and prioritize it.

Directors reinforce these priorities. Directors are expected to deal with their managers in a parallel manner to the expectation that they have for the managers themselves. Managers should receive the same kind of supervision that will be in place for workers. Clinical supervision for managers needs to be consistent and reinforce what is to be provided to workers; parallel processes at all levels of the organization. Any disruption of this parallel process in the hierarchy of the agency at any level can adversely affect collaborative interventions with children and their families on

an individual basis and the consistency of its application across the agency.

### **7. The Connection of Clinical Supervision to the Annual Staff Evaluation Process**

The Annual Evaluation shall reflect that the Clinical Supervision Agreement has been reviewed but is not attached to the evaluation. The Annual Evaluation shall have a “tick” box to indicate that Individual Supervision has taken place as agreed to in the contract and/or the minimum standards outlined in this policy have been attained. If this has not occurred, reasons should be provided.

Directors will meet or respond to staff persons who have indicated specific issues or concerns that have been written by them into their annual evaluations. This could involve further joint discussion and problem solving with both the specific staff person who raised the concerns and that person’s manager.

### **8. Resolving Professional Disagreements**

It should be remembered that professional disagreements can go through a conflict resolution process outlined in the Agency’s Philosophy manual. Either party may also wish to initiate a protection-planning meeting for resolution. Both would provide additional 3rd party input that can sometimes be a vehicle for positive resolution when there is disagreement. Unresolved conflict festers.

Staff persons in professional disagreement are also encouraged to utilize a more informal process that really involves both parties obtaining a respected 3rd party opinion without the formality of the Concurrent Permanency Meeting or conflict resolution. This process can also help deal with issues resulting from shifting expectations and roles.

### **9. Limitations on Case Discussions**

There are some restrictions on the discussion of case sensitive or staff related issues. Confidentiality of case sensitive information is a staff requirement outlined in Agency Policy and Procedures. Case issues can be legitimately discussed only within a clinical supervision framework, team supervision, team debriefing or in a case-planning meeting. If there is any disagreement or concern on the handling of a case, individuals directly involved in any aspect

of a specific case can refer to the case and conflict resolution processes mentioned previously in this document.

Staff should also keep in mind that gossip may be the result of anxiety or the need to project responsibility for something that may not have gone well. It could also be connected to differences’ in beliefs about how to deal with families. It could arise from differences in how individuals view “other’s” performance in their position. It could also be simply a frustration about lack of consistency in practices. Criticism related to the handling of cases by peers is not appropriate in any informal forum.

The types of supervision and peer consultation that will be outlined in the next section will become powerful forums for reinforcing that gossiping about case situations can be damaging to the emotional environment of staff. Managers can reinforce how this can be addressed appropriately and/or how staff may remove themselves from situations that make them feel uncomfortable.

### **10. The Use of Child Welfare in Ontario: Developing a Collaborative Intervention Model**

There are a number of articles in the clinical supervision section of the Child Welfare in Ontario: Developing a Collaborative Intervention Model that can help articulate various issues of supervision such as the inherent power differential and ways of working with it. There are several hundred articles of a clinical nature including many aspects of work with children and their families which may be used during supervision. Many of the articles and research documents originate from Ontario sources and other CAS contributors.

## **C. TYPES OF SUPERVISION:**

There are several ways in which supervision can take place:

### **1. Individual Clinical Supervision**

This model of supervision is consistent with the emphasis on supervision as a goal-directed, contractual, interpersonal relationship. This style of supervision is the primary model used within the organization because it recognizes the importance of one-to-one communication and the ability to risk and expose job-related

weakness within the context of the supervisory relationship. It is consistent with the ethics of social work as defined by the CASW and/or the agency's own code of conduct.

The agency acknowledges that supervision may be more of a stressor for new staff who are more vulnerable to power imbalances. In 2008, the agency's 'diversity Committee' dealt with these issues in their report and recommendations, submitted to the Board of Directors. The report should be required reading for all new staff. The agency also acknowledges that there will need to be a clearer differentiation between interpersonal and case decision resolution processes. These will be available in a renewed format by August of 2008 and available for review in the agency's Human Resources Manual.

The purpose of this practice model illustrates the need for a different and more effective approach to practice that is not restricted to the measurement of risk in families. This approach should use strategies that promote an atmosphere of collaboration between child welfare agents and families and community resources. Case managers should be trained and supported by their managers in key areas of practice that include the following:

- Inviting and including parents, children and extended family members in a process to build partnerships and collaboration
- Promoting strength based and solution focused interaction and discussion
- Recognizing the strengths and the resources that extended family members offer
- Advocating together, rather than in isolation, for solutions and change
- Action goals, which address all the issues such as poverty and power imbalances between families and other, sanctioned social agents.

#### Skills Required

- The ability to engage with individuals on an individual level with the goal to develop helping relationships based on trust. This will require an investment of time using face

to face contact in a safe and neutral atmosphere.

- Group work skills that can establish boundaries and maintain balance among the participants with the purpose of finding solutions rather than blame.
- Community resources should be considered and utilized when needed. Dependency of agency resources should be avoided.

## **2. Team Supervision**

Team supervision should be considered as a mandatory supervision option for all service teams when deemed appropriate for case resolution, task refinement, morale factors and staff development. In fact, the more the agency sets up clear universal structure and parameters for information sharing, case presentations and task issues, the clearer this role will be. Team supervision, as a method of sharing knowledge, will benefit individual staff members by providing an atmosphere of shared accountability and mutual support. In general the committee concluded that:

- Team meetings are an excellent forum for the promotion of team morale and team building, which are important elements in the development of a healthy workplace culture.
- In team supervision discussions may occur on agency philosophy and policies, our conduct with families and coworkers and how the team can uphold or live by these principles of practice within our workday. (This conversation could spill over to individual supervision as identified goals and could be classified as inter-personal/professional development).
- Team discussion to enhance morale and spirit, as poor morale and spirit can negatively impact our families.
- A regular review of the team philosophy and whether it is practiced would indicate that people/units aren't "walking their talk." During these discussions, workers could give examples on how they live by this practice in their work with co-workers and families.
- This is a process that needs to include AOP, as this is a fluid process. Everyone deserves

kindness, even when they slip up. People are not meant to carry shame for slipping up.

The OACAS M6A training identifies some advantages of team supervision:

- Group supervision saves time, and ensures consistency in the transmission of administrative information
- Group supervision makes it possible to utilize a variety of teacher-learning experiences (e.g. use of videos, role plays, etc.) that if used in individual sessions would be too time consuming and would not allow for cross-sharing
- Group supervision can be a source of emotional support for workers where successes can be celebrated, and sorrows and disappointments reframed
- Group supervision provides workers with an opportunity to see the work of others and provides them with a basis for comparison
- Group supervision is more comfortable for some who are intimidated in one-to-one session
- Group supervision encourages interdependency within the work unit and helps the team to develop cohesion;
- Group supervision enables the supervisor to observe and experience the worker in different kinds of interactions and relationships
- Group supervision is sometimes a better medium within which to influence worker behaviours
- Group supervision provides workers with an opportunity to see the supervisor model group interaction skills
- Group supervision provides an opportunity for multicultural learning

It also highlights potential disadvantages:

- Group learning needs take precedence over individual learning needs

- Group sessions sometimes stimulates a sibling-type or peer rivalry that distracts from the objective of the session
- Group supervision may be intimidating for new staff members
- Group supervision allows workers to abdicate certain responsibilities that they would be held responsible in one-to-one supervision

### Team Supervision Involving Specific Cases

The goal of team supervision is to help facilitate the integration of clinical tools into practice and enhance individual confidence and decision-making. It is regarded as a mandatory team activity across the agency. Within this expectation are the following parameters:

- The case for discussion should be brought forward by the case manager for the purpose of acquiring assistance or demonstrating certain case challenges.
- The case manager maintains control of decision-making responsibility
- Team presentations will be given with a clear structure using Building Safety & Strengthening Families Practice Framework
- Although there is a set structure, the discussion is encouraged to be full, frank and comprehensive to enable appropriate and thoughtful decision making
- Although there may be varied, useful suggestions, the ultimate decision making remains with the case manager and the manager. Team supervision is not to be team decision-making
- Case decisions are documented by the decision makers and then signed off by the manager where required
- White Boards assist to provide a “visual” of the discussion, alleviate the need for minutes or notes of the discussion and to provide reinforcement of the Building Safety & Strengthening Families Practice Framework;
- The discussion/dialogue that takes place in

team supervision is not to be compartmentalized nor exclude certain issues but the issues themselves are to be addressed in a clinical fashion

- There is to be a transition phase of one year with the expectation that at the end of the one year period team supervision will be fully implemented
- Assistance to teams may be provided to ensure that implementation is ultimately successful
- Team supervision requires a safe environment and good management

Other team members such as unit assistants and protection support workers need to participate and contribute to team supervision as full professional colleagues. This ensures that they are considered part of the team decision-making process. They can be helpful in their role as well as more effective and efficient in their positions.

### **3. Peer Consultation**

When the case manager's manager is not present but the worker requests input from other team members or workers, this is referred to as 'peer consultation'. Usually the consultation is structured into regular meeting times either before the manager arrives or at the end of a team meeting. It may also occur when a manager is not available to participate. The case for discussions should be brought forward by the case manager needing assistance.

Peer 'consultation' is the preferred terminology since supervision implies decision-making. In this case the manager retains the responsibility for final decision-making in keeping with the relevant case management standards and their role in regard to the particular worker and agency expectations.

It is usual to stay within a team to ensure it can become a vehicle for group solidarity and team building. It is easier to ensure confidentiality and to keep peer consultation from moving into gossip. The team is able to provide adequate and current information to the consultation process. Having said this, on occasion, other specific, scheduled gatherings of staff with

similar functions may discuss cases where all may gain knowledge.

Peer consultation is optional, yet it may be applied to all teams across the agency where there is a need.

### **4. Group Consultation**

This model of consultation involves a group of staff with similar job responsibilities meeting (eg. several lawyers or protection support staff or unit assistants). It is particularly helpful in a group setting to address issues of common concern or where common training needs can be met. This model is not intended to replace individual supervision but rather as an option for front line staff and for staff development.

Strong supervision may minimize the need for "informal supervision" by providing a venue for resolution, positive discussion and healthy discussion and even disagreement. It is recognized that there is a need to ensure that behaviour within the work place meets with the cultural expectations of the Society.

### **5. Ad-hoc or Informal Supervision**

This form of supervision involves the many unplanned but necessary contacts between front-line staff and their managers during the day. The manager and his/her staff members should develop a clear understanding of when this type of consultation is appropriate and required. Development of clear expectations is essential to avoid interruption of other supervisory sessions or managerial tasks and to promote a sense of control and planned response within the organization.

Ad-hoc supervision can be very important in meeting standards and for freeing up of formal supervision time for other necessary discussion. If a manager and a front line worker discuss a case and a manager gives an authorization or a confirmation for actions required by standard or regulation, then there is no need to have that case automatically discussed in formal supervision. The worker would have made a case note on the approval or discussion and it would then be submitted to 'e-forms' and reviewed by auditors at a later time if required.

It is simply not a good use of formal supervision time to go through caseloads to ensure that a

protection case, for example, is reviewed every six weeks. When the average caseload size is considered, there is insufficient time. It is better to concentrate on those cases that either the worker or the manager believes should be discussed in formal supervision time. In addition, many cases at intake would have required several supervisory decision points to have been reached and confirmed within a six week period without a need for them to be further discussed in supervision where there is not a necessary focus. E-forms allows for managers to check on the supervisory input status of all protection cases when they access the data base.

## **6. Supervision for All Non-case Carrying Team Members**

This is an important area that has not received sufficient attention and is often ad hoc. It includes various staff including legal support, unit assistants, information technology, accounting, clerical workers, child care and all other unique job descriptions. Various requirements for supervision and consultation are outlined below. This is not all inclusive and the supervision for specific individuals and their managers will be negotiated using the supervision agreement outlined in this policy and procedural manual.

### **a) Support Staff Supervision**

In the development of this section, surveys were sent out to all support staff. After further committee discussion it is recommended that unit assistants receive supervision at least eight times per year and that mandatory attendance occur every three months at the unit Assistants Group networking group (a peer consultation forum). This group will share information about processes and training. It will also assist in the development of agency standards relating to the various support staff roles. When discussing mutual concerns, the group will be goal oriented and solutions focused.

### **b) Protection Support Worker Supervision**

Protection Support Workers may have different schedules in combination with group supervision opportunities. This will include four times minimum per year for each type of supervision. Also, there are four peer consultation opportunities where all Protection Support Workers will participate.

### **c) Workers in the Child Development Unit**

Staff provided input to some specific ingredients for their set supervision times.

- CDU supervision is often specific to the job description and the various roles and responsibilities of each worker within a diverse unit in various community settings.
- Staff require equal opportunities for training related to their current practice assignments. This puts an onus on both the supervisee and the manager to investigate future training/educational opportunities such as site visits to similar programs.
- The code of ethics will be reviewed annually at a team supervision session.
- The current scheduled monthly supervision is sufficient - however additional supervision will be provided to help support staff deal with difficult situations that may arise in the various community locations.
- The styles of supervision will include direct observation by informal unscheduled program site visits by the manager.
- Peer support is seen as a specific, viable method to encourage new members of the team

### **d) Supervision for Lawyers**

To meet the supervision needs of lawyers, peer consultation and group supervision (if legal manager is present) is to be considered the primary modality. This supervision and/or consultation would be actualized via regular counsel meetings. Such meetings shall take place so that there can be a regular exchange of information between counsel, discussion of case files or relevant issues and consistency in respect to processes and decision making.

Lawyers have specific training issues that cannot always be met through in house or OCCAS training programs. The Society acknowledges this need and will provide opportunities for counsel to attend training required to maintain and augment their skills.

Although, there is a predominant view that lawyers may engage in peer consultation or

group supervision as a primary modality, the lawyer with carriage of file retains decision-making responsibilities. In addition, regular meetings between the legal manager and an individual lawyer will be held when the issues for discussion require employee privacy or specific organizational considerations that are not conducive to a group discussion.

## 7. Conclusions

The agency is actively strengthening and encouraging the wider use of team and group supervision along with peer consultation. Strengths-based practices are to be reinforced regardless of the specific modality. Clinical supervision and team/group consultations can be a vehicle for moving the entire culture of the agency to a new level. It is not just about cases but it is about the positive meetings of two or more people in dialogue with each other in a strength based process.

One important outcome of both peer consultation and team supervision is to provide a diversity of opinion as team members come to the table with various backgrounds and perspectives. The challenge for staff in these modalities is to not digress into 'group think'. It should also be a safe environment to challenge one another in respectful way. When staff engage in these processes they need to make it a formal priority and have set expectations for how they are used, instead of seeing the options as simply an informal exchange of ideas.

These modalities can also facilitate the transfer of ethical values. How the agency introduces and implements supervision procedures to both managers and to staff that they supervise will be directly related to how successful the agency is in the end in creating this desired culture.

Supervision within the agency represents a blend of administrative, evaluative, education and support components. The clear intent - consistent with the agency's defined purpose - is to provide quality child welfare services to the community. Supervision is provided by recognizing the importance of the employee and manager mutually working together to meet the accepted and recognized purposes of the supervisory process. The relationship that needs to be built and nurtured between a worker and a manager cannot be legislated but must be

continually worked upon. In order to do so there needs to be recognition of a power imbalance and the need to develop safeguards.

It is the responsibility of the agency through ongoing orientation to ensure that staff is familiar with the processes that can help to ensure that their concerns about supervision can be recognized. These include the following scenarios that may need to be addressed in any transparent, strength-based organization:

- What happens if there is a problem between a worker and a manager
- What is a safe place for addressing case work and personality conflict issues so that staff persons know with some certainty that they will not suffer a negative consequence if enforcing a right to supervision and need to have concerns resolved. It is recognized that there are union and conflict resolution processes in place that are viable options. There will be opportunities for team feedback on supervisor performance evaluations (to be finalized in the summer of 2008).

## D. THE SUPERVISION AGREEMENT

The following section outlines some areas for discussion and then concludes with the introduction of a 'contract' signed by participants involved in the (clinical) supervision. This form will be adapted to all staff in light of their various agency roles. It will also address the following specific ingredients required along with the actual supervision.

### 1. The Frequency of Supervision:

Individual supervision sessions for all staff are to take place on a regular planned basis. Both participants are expected to set aside planned times that are protected for this purpose. Checking emails, making phone calls or other people interrupting the supervision is not allowed. Managers and staff should make arrangements for coverage of their regular duties to ensure supervision is not disrupted. Supervision times like other meetings can be subject to illness, holidays or by crisis situations which will negate the attendance or even the emotional involvement of one or both parties. Having said this, cancelled supervision should always be rebooked and replaced at the time of

cancellation whenever possible. It should always be remembered that 'ad hoc' supervision does not replace the formal set scheduled times. An 'open door' policy by managers should be deployed whenever possible due to such things as stress, child protection issues and other issues often faced by staff. The limits are contained in the degree of urgency and those aspects negotiated in a team setting with the individual manager.

Planning times should be six months in advance with the assistance of various team staff. This approach will assist both the employee and his/her manager in viewing supervisory sessions as a valuable resource in the provision of effective and efficient services to the community.

The frequency of individual supervision may vary depending on the nature of the job and the individual needs of the staff member. When hiring a new staff, supervision should be weekly depending on the experience of the staff and continue in this manner for a minimum of the first eight weeks. For other front line workers, the minimum regular individual supervision time shall be no less than once per month. In those months where there is another form of supervision or a set peer consultation, this could be extended into the next month if both agree. Employees, both those with benchmark or alternate qualifications with little or no experience require more scheduled supervision time than those with demonstrated competence. The OACAS M3 Management Training is a guide to this assessment of a worker's need for guidance.

Supervision should allow time for managers to ensure compliance and alignment with agency requirements. Group and team supervision should be held on a regularly planned basis. Although group and team opportunities for case and/or task consultation are mandated agency wide practices, the intervals between these modalities will vary from every two weeks to one month in frequency. As indicated previously, some groups of workers may substitute individual supervision times for mandated group consultation, which will take place a minimum of four times a year. These will include unit/legal assistants, Child Development Unit workers, and Protection Support Workers.

## **2. The Setting:**

It is preferable for supervision sessions to be conducted in a quiet, private setting that is conducive to open and honest consultation. "Hallway supervision" is not encouraged as this setting fails to respect client and worker confidentiality and is not conducive to effective planning and decision-making. In some agency situations, separate office locations such as interview or conference rooms should be booked in order to reduce any existing distractions.

## **3. Direct Observation:**

At times, it is appropriate for the work of staff members to be reviewed and evaluated directly by his/her manager. This form of supervision allows the worker immediate and accurate feedback regarding skills directly related to their job responsibilities. Managers may join with workers in engaging clients both in the office and out in the community. This is beneficial for all but it needs to be done in an organized, respectful fashion so as not to be intimidating to any of the various parties.

## **4. Documentation (supervision and consultation):**

All managers are encouraged to use the prescribed agency format to record supervision discussions and decisions, i.e. electronic supervisory case note or carbon pages.

Supervision notes as they relate to case decisions will be signed and dated by the manager. The supervision notes should reflect both the clinical notes related to work tasks and case decisions. The frontline caseworker will document clinical case notes separately for inclusion in the case file. Both formal supervision and ad hoc case supervision should be documented when important decisions and changes in case direction are made (according to provincial recording requirements).

Informal notes or e-mails may be kept by both parties for the purpose of enabling both workers and managers to focus on the issues that they are working on in supervision. They are not to be considered part of any official case record. White boards are available with headings for the Signs of Safety and Olmsted model approach to case discussions. These are available for each manager and their service team. Peer

consultation does not require notes as part of the case documentation.

Finally, in order to build an atmosphere of trust, supervision issues addressed simply for worker benefit and training do not belong in case files. In some instances notes may be taken for later recollection by both the manager and supervisee. Please see 'Ad hoc supervision' for other information on the retention of case notes that will be part of the case file for the purposes of maintaining provincial case work standards.

### **5. Caseload Reviews:**

Managers and child protection workers will review every child protection case and every child in care case together on a regular basis, and at least once every six weeks (see appendix 4). Managers will randomly request updated information from workers regarding cases not identified for discussion by the worker. Supervision is continuous - if an issue is discussed during an initial supervision then the follow up activity is reviewed for progress at the next supervision session.

### **6. Dealing With Topics of Diversity and Anti-Oppression**

The following section references portions of the Phase 1 Collaboration Paper on Diversity and Anti-Oppressive Practice.

Anti-oppressive practice (AOP) is based on a commitment to social equality and social justice. AOP involves not only identifying barriers but also working in ways to eliminate them. The concept of power is seen as being central to this equation. Inherent in our relationships with one another are power imbalances, which are based on age, class, ethnicity, gender, geographic location, health, physical ability, race, sexual preference and income.

Managers and staff will be expected to engage in thoughtful discussions about his/her relationship with each another, his/her team, the families whom we serve, our community partners, the larger systemic relationships, policy, and the larger social context

Managers and staff will regularly review the Vision and Purpose statements of the Children's Aid Society of Brant and the Diversity and AOP Committee.

Managers and staff will engage in a critical self reflective dialogue about cultural competence, social inclusion, empathy, and social justice issues.

**Cultural Competence:** Refers to an ability to interact effectively with people of different cultures. Cultural competence is comprised of four elements: a) an awareness of one's own cultural worldview b) attitude towards cultural differences c) knowledge of different cultural practices and worldviews d) cross cultural skills.

**Social Inclusion and Social Exclusion:** Social inclusion ensures all citizens the opportunity and life chances for individuals to achieve a basic level of well being. Social exclusion refers to the inability of people to fully exercise their social, cultural and political rights as citizens.

**Empathy:** Refers to the ability to put oneself in someone else's shoes and imagine what it is like to be in their skin. It is expected that empathy will be enhanced through clinical supervision.

**Social Justice:** It is understood that collaborative child protection agencies work with families and communities to advocate for social justice.

**Social Location:** Refers to a person's position in a social system which reflects a world view. It is crucial that one critically reflects on one's world view so that one is able to assess how it affects his/her understanding and his/her actions.

### **7. The Supervision Agreement**

The proposed supervision agreement is intended to be a fluid starting point and is not intended to define or bureaucratize the worker/management relationship. It is not exclusive with respect to issues for supervision. It is intended, however, to ensure that all managers and all workers start with the same supervisory expectations and initial framework for their relationship. There are however certain principles:

"What" is consistent but "how" is flexible  
Mutual expectations to be clear—needs to set up a two way street of what worker needs from manager and what manager needs from worker

Confidentiality issues need to be clear. What is case management and what is for the overall performance of the worker need to be clear and not co-mingle

The Supervision Agreement needs to be contracted and then reviewed as part of the performance review annually and amended as required. It should be reviewed upon team transfer and at any other time, upon request by either party.

The Agreement defines the **Learning, Setting** and **Context**. The agency promotes and encourages an effective learning environment that addresses the clinical needs of all staff and the development and enhancement of these skills. Structured supervision, through a learning agreement, should be developed for each staff member and their manager.

:

The Learning Agreement should identify and outline the separate aspects of supervision

- Definition and role clarity
- Orientation
- Evaluation
- Training and Education
- Motivation and support
- Administrative (vs. clinical)

Types of learning arenas should also be considered:

- Direct individual supervision
- Observation in groups
- Theoretical (literature, research, articles, manuals)
- Workshops, conferences, courses, training
- Observation with other professionals (planning meetings)
- Observation with clients

A number of learning teaching styles can be used in the supervision process. Each manager and staff person should discuss what styles best suit their dispositions and what methods can best be used to enhance learning. Some approaches may include any of Directive observation, Analytical, Theoretical, Experienced based, Reflective, Interactive, Evaluative, and Individual rather than group modality.

## **E. THE CLINICAL SUPERVISION AGREEMENT FOR ALL BRANT CAS SUPERVISEES AND MANAGERS**

(Electronic Version: When completing sections of this agreement please ensure it is consistent with the expectations outlined in the accompanying Supervision Manual. If a handwritten version is preferred please ensure that enough space is provided prior to print-off.)

**Worker Name:**

**Manager Name:**

**Meeting Day:**

**Time:**

AM  PM

**Meeting Frequency, please elaborate:**

**Have the “supervisee” and “supervisor” discussed in detail (individually or as a team) the various expectations outlined in the clinical approach to supervision manual prior to the completion of this supervision agreement.**

Yes  No

**If no, please provide a detailed explanation.**

### **OUR PROCESS (Define the following in the context of Clinical Supervision)**

**Feedback** (How will feedback on work performance and the supervisory process be provided by the manager and by the supervisee?)

•

**How will we handle disagreements in terms of clinical supervision issues?**

•

**Power / Responsibilities** (How will we define our professional relationship in terms of a clinical approach to Supervision? Who is responsible for what?)

•

**Diversity and AOP** (Are there issues that either party can initiate and discuss regarding response to clients and/or colleagues that have diversity or anti-oppression issues as expressed in the Position Paper on Diversity & Anti-Opressive Practice, 2008.)

•

**Place for Supervision** (Where will clinical supervision be located normally?)

•

**Style** (What approach will be used by the participants and why? What is the level of development [directing, coaching, supporting, etc.] of the supervisee and the corresponding supervisor approach?)

- 

**Crisis Situation** (How will we deal with them when there is supervision planned? What does the supervisee expect from their supervisor when they are in a crisis situation?)

- 

**Agenda Setting** (Order of items for supervision including urgent topics, worker environmental scan, case consultation, learning development, connection to annual goals from the performance evaluation, other topics for discussion, feedback to the session)

- 

**Methods** (What additional modalities will be deployed in the employee receiving formal Supervision; role playing, literature review, OACAS Collaboration Project CD, attending employee appointments, video tapes, etc.?)

- 

**Performance Appraisal** (How will it connect to Supervision? All staff persons will provide in a tick box on the performance appraisal whether formal supervision has occurred and what the frequency has been. Career development discussions should be included in the annual performance appraisal.)

- 

**Confidentiality** (It is important that both parties refer to the accompanying Clinical Approach to Supervision Manual and that only required notes are taken in order to develop a atmosphere of mutual trust.)

- 

**Worker Objectives for Supervision and Development:**

- 

**Manager's Comments and Additions to Worker Objectives:**

- 

Today's Date:

Review Date:

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Based on the form designed by Sheila Sammon (McMaster University, Autumn 2007) and adapted to all staff involved with supervision with a manager at the Children's Aid Society of Brant

**APPENDIX 1: THE SIGNS OF SAFETY AND THE OLMSTED COUNTY MODEL**

**PROTECTION PLANNING DISCUSSION FOR INDIVIDUAL/TEAM OR PEER CLINICAL SUPERVISION OUTLINE BASED ON THE AGENCY'S PROTECTION PLANNING CONFERENCE OUTLINE**

**NAME OF CHILD(REN):**                      **D.O.B:**

**NAME OF PARENT/CAREGIVER:**

**PURPOSE / FOCUS OF CONSULTATION:** *(What is the worker/team looking for in this consult?)*

**DANGER / HARM** *(Detail re: incident(s) & pattern history)*

**SAFETY** *(Strengths demonstrated over time or pattern/history of exceptions or past coping/functioning)*

**CURRENT RISK FACTORS** *(List neglect or abuse factors that score 1+ in Family Risk Assessment)*

**STRENGTHS / PROTECTIVE FACTORS** *(Resources/capacities with the family, individual or community)*

**COMPLICATING FACTORS OR SITUATIONAL STRESSORS** *(Conditions/behaviours that contribute to greater difficulty or vulnerability for this family)*

**WORKER'S ESTIMATE OF PRESENT LEVEL OF SAFETY GIVEN THE DANGER & SAFETY INFORMATION** *(0 means recurrence of situation or worse abuse/neglect is certain and 10 means there is sufficient safety for the child to close the case)*

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<input type="checkbox"/>										

**AGENCY GOALS** *(What will the Agency need to see occur in order to be willing to close this case?)*

**FAMILY GOALS** *(What does the family want generally and regarding safety and what are they willing to do to meet these goals?)*

**DECISION REACHED / NEXT STEPS**

## **APPENDIX 2: ADDITIONAL GENERAL CONSULTATION AND SUPERVISION QUESTIONS FOR WORKERS**

### **A. FOR BOTH NEW AND ONGOING CHILD PROTECTION/CHILD CARE CASES (FROM CLINICAL SUPERVISION M6A):**

1. What does the client want?
2. What are the signs of success that you think are important? Describe in detail.
3. What has been accomplished toward these goals so far?
4. How will clients/we know they can achieve these goals?
5. Who will do what, when, where; how will we achieve the next steps?
  - List past successes — exceptions?
  - Where does the client feel he/she is on the scale of 1 to 10 toward achievement of goals?
6. What is the confidence/investment level to achieve the goals?
7. How will we know when the client has achieved a level of success that warrants case closure?
8. What did we learn from this case?

### **B. TRANSFORMING SUPERVISION, ENCOURAGING CRITICAL THINKING TIPS FOR MOVING BEYOND CASE DESCRIPTION (FROM MCMASTER COURSE)**

- Contracting for supervision that is more than descriptive is an important first step in establishing clinical supervision. A model contract is attached. In our case the agency has incorporated the McMaster model of a supervisory agreement.
- For specific critical thinking case decisions ask questions such as the following:
  - "what are the most important facts?"
  - "what do I need to know to be helpful in this case discussion?"
  - "what do you want to get out of this conversation?"
- One suggestion to help the worker practice this exercise is to use an egg timer and contract for how much time will be allotted for the initial description of a case in supervision.
- After hearing the description the Supervisor/Manager can facilitate discussion and show that the worker has been heard by providing a summary of what she/he now knows about the situation
- Next ask "how do you interpret what is happening in this situation?"
- Said differently, the Supervisor/manager uses the same skills that he or she would use with a service user/ client to focus a discussion
  - "Let me summarize what I understand about the situation so we can move on to the analysis"
  - "Sorry to interrupt, but I think I get the basics of the situation, let's move on"
  - "Sounds like you have gathered a lot of important information, let's see
  - What sense we can make of this so that you can go away with a plan"

This leads to [A Model for Critical Thinking](#) (Adapted from Bogo & Vayda ITP Model and taught in the McMaster Clinical Supervision course for Managers). Please see below....

### **C. A MODEL FOR CRITICAL THINKING (ADAPTED FROM BOGO & VAYDA ITP MODEL AND TAUGHT IN THE MCMASTER CLINICAL SUPERVISION COURSE FOR MANAGERS)**

1. **Description:**
  - Listen to the description of the situation.
  - What happened?
  - Who said what?
  - What did the worker say/do?

Who was there?  
What did others say/do?  
Listen for an understanding of client's location/workers lens.  
How does the client's social locations affect the situation?  
Physical environment?  
What are workers strengths?  
What are clients strengths?  
What is the worker's assessment?

**2. Reflection:**

What meaning does this situation have for the worker?  
What are the worker's feelings?  
Assumptions about the situation?  
How does his/her social location affect her/his understanding and her/his actions?

**3. Consider and integrate:**

What knowledge does the worker bring to her/his understanding of the situation?  
How does she/he incorporate the client(s) knowledge?  
How does the worker understand the impact of poverty? Racism?  
Structural factors affecting the clients?  
How does the worker address/ work with her/his power/ authority/ responsibility?  
What are the service users' strengths?  
How do these strengths relate to the current situation?  
How does this family relate to various communities?  
What supports does it have?  
What knowledge/ theory does the worker use to understand the situation?  
(developmental, structural, family, crisis etc)  
How can this situation be viewed / understood holistically?  
What knowledge/ theory did the worker use to guide her/his actions?(solution focused, feminist, narrative, cbt, structural etc.)  
Any social work values considered?  
How does the worker understand his or herself in this situation?  
How does the worker navigate power? Privilege?  
Is the worker aware of how her/his feelings, experiences, affects how she/he relates to the family?  
What are other possible understandings of the situation?  
What worker strengths are demonstrated here? How? Why?

**4. Plan:**

Focusing on service user's and worker's strengths what does the worker plan to do next?  
If developing a goals and an action plan, how can the family be part of this?  
How will the family and the worker know that the goals have been met?

**5. Repeat 1-4 as Necessary as Case Evolves**

<sup>1</sup> Bogo, M., and Vayda, E. 1998. The Practice of Field Instruction in Social Work: Theory and Process. 2<sup>nd</sup> ed. New York: Columbia University Press.

## **APPENDIX 3: SPECIFIC SUPERVISION REQUIREMENTS RELATING TO THE AGENCY'S DIFFERENTIAL RESPONSE POLICY AND PROCEDURES**

### **1. D.R.3.8 SUPERVISION AND REVIEW OF CASES**

All cases are reviewed with a supervisor on an ongoing basis within the context of a regularly scheduled supervision session at least every month during an investigation, minimally once every six weeks during on-going child protection service and prior to case closure or investigation discontinuation. Higher risk or more complex cases are reviewed with a supervisor more frequently. Supervisory approval is required for all departures from the Ministry Child Protection Standards, agency policies and procedures and protocols (OACAS accreditation Standard 3.8). The review focuses on the implementation of the Plan of Service, the progress made by the family and re-assessment of risk. The following must be reviewed with a Manager whenever they arise on a case:

- A Child and Family Strengths and Needs Assessment
- A Plan of Service
- A new referral on an open case
- Court applications and reviews
- Case transfers and closings
- A decision to depart from standard procedure
- Reducing contact with an abused child living at home
- A report to the Child Abuse Register
- A request for expungement from the Child Abuse Register
- Criminal charges laid against a client
- Admission of a child into care
- Concerns about the actions of another Agency
- Recommendations for the referral of the family for a Parenting Capacity Assessment
- Critical Incidents in the case (threats by the client to the worker, death of any member of the family, threats of suicide, new partner moving in, birth of a baby, or addition of new members to the household such as a grandmother)

### **2. REQUIREMENTS OF THE MINISTRY DIFFERENTIAL RESPONSE STANDARD #12**

1. The child protection worker is the case manager and it is not intended that every case decision requires consultation with a manager. Any decision that affects the safety or permanency of a child is made in consultation with, or reviewed and/or approved by a manager prior to implementation.

2. All case-specific consultations, reviews, approvals, decisions and rationales are documented in case notes by the worker.

3. All cases are reviewed regularly in scheduled supervision sessions:

- at least once a month during an investigation
- at least once every six weeks during ongoing services
- prior to case closure or discontinuing an investigation
- cases with higher degrees of risk are reviewed more frequently.

4. The following decisions are reviewed with and/or approved by the manager:

- Depending on the knowledge and skill of the worker and the risk and complexity of the referral, the worker may consult with the manager about the disposition of the referral and response time
- Depending on the knowledge and skill of the worker and the complexity of the case, the worker may consult with the manager about the investigation plan
- The worker safety plan (when required) is reviewed by the manager prior to starting the investigation
- A new or revised Safety plan is assessed and approved by the manager before it is implemented
- When no safety concerns are present, the Safety Assessment is reviewed with the manager on the next working day
- The verification decision, decision about whether the child is in need of protection and the case disposition are reviewed at the next regular supervision meeting prior to completion of the investigation. This review includes a comprehensive case review and analysis.

- Any departures from the Standards, agency policies and procedures, including extensions of timeframes
- Overrides on the Ontario Family Risk Assessment
- Placement of a child in Kinship Service or Kinship Care, or in a CAS placement

5. The manager provides ad hoc supervision when decisions must be made quickly to ensure the safety of a child.

6. The manager's signature on case documentation at the conclusion of an investigation, formal case review, transfer or termination indicates the manager's approval of:

- The thoroughness, accuracy and quality of the work
- The accuracy of the worker's assessments
- Appropriateness of decisions and plans
- Effectiveness of casework
- Quality of written documentation

**Procedure:**

1. Each manager supervising direct service social work staff shall establish a schedule of case review sessions with the minimum frequency as follows:

- After-hours workers, once every month;
- Family Services Workers and Children Services Workers, twice per month; and
- Intake Workers, once per week.

2. The manager shall establish a rotation list for the review of the worker's cases according to the needs and urgency of the case.

3. The focus of case review sessions shall be to assist the worker in assessing the case, developing a plan for intervention, and ensuring that the plan is carried out according to Agency policy and practice and sound clinical principles.

4. The manager shall maintain a record of each case supervised. The record shall focus on plans made and the implementation of plans.

5. Each manager shall provide an opportunity for clinical skill development within the team once per quarter. This time may include listening to tapes, carrying out live observation, reviewing relevant research, etc.

6. Managers of direct service social work staff shall be available to staff outside of regularly scheduled supervision sessions, to provide emergency supervision, provide assistance to the worker in carrying out difficult assignments.

7. All correspondence with clients with the exception of routine communications (e.g. confirming an appointment, enclosing a copy of a court order) is to be signed by the case manager and manager.

8. All correspondence by managers is to be signed by a Service Director.

## **APPENDIX 4: SELF CARE AND PROFESSIONAL DEVELOPMENT PLANNING**

### **(From the OACAS M6A Clinical Supervision Module)**

**Self-care** begins by being self-aware. **Self awareness** refers to our capacity to perceive our responses to other persons and situations realistically and to understand how others view us. **Self awareness** is an exercise in self reflection...a process during which we 'stand outside of our self and look in'. **Self-care** is about taking care of our 'whole' and its components in healthy ways and being tuned in to our body, mind, heart and soul. **Self care**, from a wholistic perspective, means being tuned into and tending to the needs of the four components that comprise our whole: physical, mental/intellectual, emotional/social, and spiritual. **Self-care** is another term for 'self management'.

#### **Our Whole:**

- Within the physical component: consider your degree of comfort and happiness in your physical self and surroundings at home, at work and in your community
- Within the intellectual / mental component: consider the level of stimulation and satisfaction you receive from work, colleagues, supervisees, friends, and in leisure and professional development activities
- Within the social / emotional component: consider the extent to which you feel valued and a sense of belonging in your family group, in your community, and among your professional peers
- Within your spiritual component: consider the extent to which you make meaning of the world around you and the ways in which you do this

#### **The factors within the four quadrants that contribute to holistic wellness:**

**1. Physical stressors** refer to those factors or circumstances that affect not only our physical self (body) but also our physical environment. For example, commuting long distances on treacherous roads can be physically exhausting; working in an office that is drafty, poorly lit and in a state of disrepair can be another cause of stress. Fear for one's physical safety can also be a source of stress.

**2. Mental / Intellectual stressors** may include: engaging in work that is not intellectually challenging (boring), or, its opposite: too intellectually demanding.

**3. Social / Emotional stressors** may include: work-related demands that extend into one's family / social life (no time for family, friends, leisure activities); feeling that one's behaviour is constantly being scrutinized (if living and working in one's home community); and fear of rejection from one's family and friends (as a consequence of trying to help).

**4. Spiritual stressors** may include: feelings of hopelessness and despair about the people one is trying to help and their circumstances; confusion about your own cultural identity; fear resulting from religious teachings; the absence of faith or belief in the inherent goodness of people (as a consequence of too few successful outcomes); not enough time for self-reflection and restorative / rejuvenative activities to revitalize one's spirit.

Most people do not know they are 'out of balance' until the components of their whole begin to break down. For many individuals, this imbalance or a pervasive sense of unwellness has 'crept up on them' and existed for some time. As a result, the 'whole' has developed patterns or ways of sustaining itself and these patterns or habits are difficult (but not impossible) to change. Stressors are subjective: what causes one person to feel stressed or unbalanced may not be stressful for another. There is no 'right or wrong' in terms of what causes us to become stressed; rather, it is our individual experience and the ways in which we do or do not cope with the event or circumstance that is important.

## **APPENDIX 5: DECISION MAKING IN THE SOCIETY**

(The following excerpts are taken from the Brant Philosophy Manual and are to be deployed when there are decision-making differences of opinion that may arise in teams. This may also be used for professional case decisions arising from the Supervisory process. In those situations, the first step would be #2.)

### **1.6.1 Decision Making in the Society**

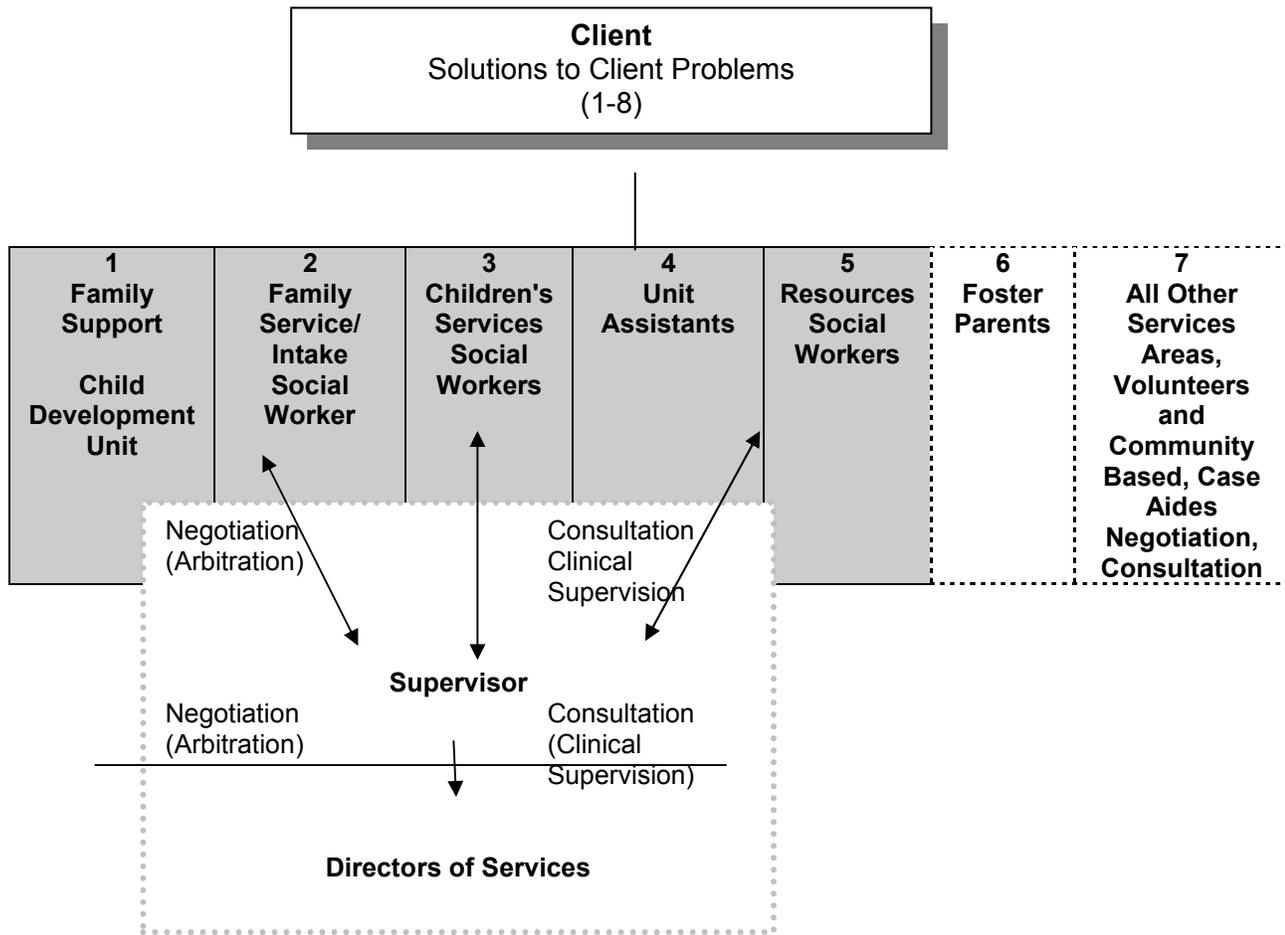
One of the most specific implications is that each professional described in the concept of team, is provided with an equality of professional relationship, as well as an autonomy to do the specific tasks that are defined within their individual role descriptions which are outlined in other Agency Manuals. Their professional decision-making is only limited by the 9 areas which are listed on the following page. All nine areas are defined within either this manual or in other related agency policy manuals. It is hoped that with this focused and defined framework for each professional to operate, that the client, who is placed on top of the chart, will receive the most efficient and also the most responsive service.

Where more than one professional is involved in decision-making due to an overlap of case or function responsibilities, each begins the consensus process on an equal footing. If consensus cannot be reached, a set manner of managerial input will help to resolve the client or agency issue.

1. Manager attempts to resolve issues where more than one professional (example, The Society social worker and unit assistant) cannot reach a consensus decision by themselves in an area which involves the functions and roles of both.
2. If any of the team members does not agree with the arbitrating decision of the supervisor, they will abide by the decision unless they initiate an appeal to their Director of Services.
3. The Executive Director is the last internal right of appeal if the arbitration of the particular Director of Services is not agreed to by any of the principals involved in the process.

The opinions of other individuals, departments, foster parents, and community professionals are to be considered in the service to clients. As such they are vital adjuncts to the concept of team and should be actively involved in the decision-making process as it relates to their specific roles in the delivery of service.

Finally, the Collaborative Problem-Solving Process which is outlined in this section is also to be considered in the professional process of finding solutions to client and agency challenges.



## Child Welfare Decision Making and Responsibility

### Limitations to all Roles:

1. Agency Philosophy of Service
2. Legislation and MCYS regulations
3. Individual job descriptions of all professionals to allow autonomy within that role
4. Negotiation and resolution of differences of professional opinion
5. Any action which impacts on other service areas must be negotiated
6. All team members are equal in terms of their right to perform their particular described duties
7. Management (supervisors, Directors of Service, etc.) are consultants, arbitrators, and on occasion, people who allow compliance to legislation and to related standards
8. Agency policy and procedure
9. Union contract

## 1.6.2 The Collaborative Problem-Solving Process

PROBLEM-SOLVING STAGES	BEHAVIOURAL SKILLS NEEDED	BLOCKS TO EFFECTIVE GROUP FUNCTIONING	POSSIBLE METHODS
Problem definition Climate setting Expectation sharing	Attending behaviour (verbal & non verbal) Empathy Clarification of others statements Encouraging	Ambiguity about the problem Statement of problem is too general	Problem census Data collection from within and without Sensing groups
Problem diagnosis	Acknowledging receipt of message Reflection-testing for accuracy	Over rigorous Defining too vague an issue	Helping trios Force field analysis
Idea generation	Self-disclosure Spontaneity	Too early evaluation Reliance upon authority Lack of trust Lack of listening to each other	Brainstorming Wish list
Exploration and evaluation of alternatives	Reality testing Probing open-ended questions Confronting Problem-stating Harmonizing	Lack of experience Too hasty decision Straw voting False standards of expertise among members Attaching ideas to persons (becomes personalized)	Decision group Staff meeting Helping trios Role-playing Force field analysis of each alternative
Action planning Decision-making Deciding on solution	Summarizing Developing criteria for decision-making Testing for consensus	Voting Polarizing Mixing policy and action groups Lack of involvement of appropriate people Absence of decision-makers	Defining points of agreement & disagreement Skill-building in collaborative skills Voting
Planning how to carry it out	Initiative Risk-taking	Failure to pin down responsibility	Task groups on various aspects of the decision
Implementation	Informing others of the results of decisions and activities	Lack of involvement Lack of specification of mechanics Incorrect diagnosis	Work groups
Evaluating	Come back to first step	Evaluation not built in from the beginning Developing a process which isn't tied to clear goals	Sub-groups Fishbowl
Terminating	Valuing of the process Expressing the common vision of the group To be in the here and now	Cynicism, Nay-saying Unable to be optimistic	Work team

\*Training and Development Journal - Alice C. Sargent

- pbl