

**CLINICAL SOCIAL WORK PRACTICE IN A CHILD WELFARE SETTING:
BARRIERS AND POSSIBILITIES**

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BY

CARMEN THIVIERGE HONORS BSW

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AUTHOR:

Carmen Thivierge
H.B.S.W. (Laurentian University)

SUPERVISOR:

Dr. James Gladstone

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ABSTRACT

Despite the vast research available in child welfare services, little has been written about the fit between clinical social work practice and child welfare work. When the field emerged from the prescriptive and intrusive practices of the Ontario Risk Assessment Model (ORAM), it ushered change towards Differential Response (DR), a strength-based, client-inclusive model that relied heavily on the skills of clinical social work practice, thus making it necessary for the field to reevaluate service delivery and the philosophy surrounding risk and protective services to children and families.

Through the use of qualitative interviews, this study examines the experiences and perspectives of five child welfare supervisors as they support the implementation of clinical practice through competing demands and a child welfare mandate whose mission is to protect children.

An analysis of the participants interviews reveal experiences mixed with successes and obstacles as it examines factors which are likely to increase or decrease the engagement of clinical practice in a child welfare agency. The main areas identified include case load management, delivery of services, support for front line workers and philosophy of the agency.

The study supports the need for further research in this area to inform policy development, training considerations and service delivery processes in effort to further support the implementation of clinical practice in child welfare work.

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INTRODUCTION

“The last 20 years have witnessed a growing cacophony of heated debate about the most appropriate policy paradigm for thinking about and delivering children’s services” (Parton, 2009, p. 715) in child welfare work.

The field of child welfare has experienced dramatic shifts in philosophy and service delivery. While the child welfare mandate of safety for children has remained consistent, notions of risk and best interests of the child have been influenced by the political, economic and historical contexts of the time.

The shift from the Ontario Risk Assessment Model (ORAM) to Differential Response (DR) and the Transformation agenda brought with it a move towards focus on implementing clinical social work practice in child welfare work. With ORAM, clinical skills and social work theory took a back seat to directive and prescriptive practices that focused on reducing risk. DR invited a resurgence of clinical skills and focused on a strength-based philosophy that supported least intrusive approaches and family preservation. As the field of child welfare has embraced clinical practice, it has also experienced competing demands and significant barriers with its implementation.

Clinical practice within a child welfare setting presents challenges for front line workers who must balance client work with administrative demands. How to do this effectively and efficiently, and whether or not this is even possible, is the focus of this study. I will examine the experiences of five child welfare supervisors and explore their definitions of clinical practice and the barriers and possibilities of engaging in clinical practice in a child welfare setting.

LITERATURE REVIEW

There is a wealth of child welfare literature examining child maltreatment and the delivery of child welfare services. The degree to which the government becomes involved, the extent to which policies and procedures are applied and how risk to children is defined, depends largely on outside factors which influence or shape child welfare practice.

In the eighties child welfare emphasized least intrusive interventions and the preservation of the family. The mid nineties ushered in reform which emphasized a low tolerance for risk and intrusive practices that valued safety over preserving families. By 2005 Transformation held promise of a balance between managing risk and preserving families. The reform and Transformation eras demanded different skills and expectations from workers.

In a review of the available literature on clinical social work practice in child welfare work, three areas of research are relevant to my study. These include the paradigm shifts in child welfare practice, clinical approaches to social work practice and to child welfare work and clinical practice in general and clinical supervision in a child welfare setting.

First, literature addressing the paradigm shifts and the political forces influencing these shifts was explored because it provided information about how these shifts have shaped the way child welfare work is viewed and practiced. The shifting values determine the predominant views of risk and tolerance for risk to children. During the Ontario Risk Assessment Model (ORAM), tolerance for risk was low and workers were

obligated to follow strict procedures. During Transformation the tolerance for risk increased and clinical skills became necessary to do the work. Examining the literature related to the shifting values provided an understanding of the challenges with implementing clinical practice in a child welfare environment. Second, an examination of the literature on clinical practice in child welfare gave insight into how clinical practice can be implemented in a child welfare setting and the challenges facing implementation. Finally, a review of literature on clinical supervision provided information on how supervision is viewed in child welfare and the significant role it plays in influencing the clinical practice of front line workers.

a) Child Welfare and Shifting Paradigms

British researcher Eileen Munroe (2004) described the culture of child welfare in the seventies and eighties to be representative of a time where there were few regulations and no Ministry standards guiding the profession. Workers were autonomous and used intuition and empathy to guide their practice. Worker judgment and individual discretion were encouraged and there was minimal paperwork and no standardized assessment tools. Documentation involved free narratives of client involvement. Services were delivered in a least intrusive manner and family preservation guided decisions. Clinical skills of empathy, empowerment, client engagement, rapport building and others were emphasized as good examples for practice. However, it was challenging for workers to give a clear account of their objectives for service and their methods or theories used in practice. Munroe described this era as a time in which there was no consensus on what

entailed good or effective practice. There was no clear knowledge base guiding the profession and no standardized frameworks from which to understand the work. Child welfare professionals were self-regulating and deemed to be the experts.

By the mid-nineties, the face of child welfare began to shift. It was influenced by three major outside pressures; the emergence of the ‘risk society’ as described by Beck (1992), political pressures to reduce government spending in social services and media backlash to reports of child deaths in Ontario (Dumbrill, 2006).

The ‘risk society’ was a term that emerged in the 1990s. Beck (1992) and others described it as encompassing the notion of a society concerned about its future and safety resulting from becoming an industrialized nation. If risk could be anticipated, it could be mitigated by way of intervention. A number of authors have contributed to discussions on risk relating to child welfare. There is consensus that the emphasis on risk of harm and managing for risk in child welfare is largely influenced by the shifting political and economic conditions of the time (Beck, 1992; Anglin, 2000; Scourfield & Welsh, 2003; Schwabe, 2004; Knoke & Trochmé, 2005; Sidebotham & Heron, 2006).

By the mid nineties research in child welfare placed emphasis on reduction of risk to children or risk avoidance. Further, the research describes how political and media pressures to make the field of child welfare more accountable to the people led to the inception of “reform”. Reform introduced a prescriptive practice to child welfare, emphasizing risk reduction and standardizing services (Dumbrill, 2006; King, Leschied, Whitehead, Chiodo and Hurley, 2003; Anglin, 2002). Practice tools were introduced and

these tools assessed for risks and offered little emphasis on the assessment of strengths of families (Ontario Association of Children’s Aid Societies, July 2002).

Case load sizes increased under reform (Trocmé, Fallon, MacLaurin and Neves, 2003), and child welfare costs almost doubled (Ontario Association of Children’s Aid Societies, Jan. 2006). High and low risk cases followed strict investigative or forensic approaches with little attention to case-specific needs, cultural considerations or less intrusive measures. While ORAM was intended to increase accountability, credibility and standardize approaches, it also introduced higher potential for adversarial and coercive relationships with families. Monroe (2005) writes that in Britain the new public management system, similar to ORAM in Canada, reduced worker autonomy and promoted tighter managerial surveillance. Emphasis was placed on performance targets and processing tools rather than client engagement and relationship building.

By the early half of 2000, “Transformation” was being considered to offset the high cost of child welfare spending and to promote more family inclusion in caring for children. Transformation, as described by Dumbrill (2006) was seen as a necessary measure to lighten the financial burden of the government as it increased individual accountability and choice. Families would become empowered to look after themselves and there would be a higher tolerance for risk where safety factors could be identified like support systems or services. Families’ strengths and safety factors were emphasized as being important to decrease concern for risk. Transformation encouraged workers to use their clinical skills and judgment and there was a shift back towards clinical practice that better supported client’s needs. Initiatives like Differential Response (DR)

(Differential Response Committee, Sept. 2004) introduced alternative approaches to practice based on a family's circumstances. Assessments and intervention under transformation promised family and child-focused approaches with more time for client contact. It encouraged collaboration with community services and families, and allowed for greater emphasis on client capacity for change through a more reflexive clinical practice.

However, the balance between meeting clinical objectives and achieving compliance to legislative, policy and Ministry requirements became challenging. The Ontario Child Protection Standards (Ministry of Child and Youth Services, Oct. 2006) and the Ontario Child Protection Tools (Ontario Child Welfare Secretariat, Oct. 2006) introduced child protection standards which both streamlined the work but also imposed time lines and practices initiatives that were sometimes in conflict with client's needs.

Dumbrill (2006) cautioned that Transformation was, “another swing of the pendulum” which focused on “strengthening the agencies that serve families, rather than strengthening families themselves” (Dumbrill, 2006 p.11). Transformation raised the question of whose needs are being served, the clients' or the organizations'; and what takes precedence when it comes to meeting clinical practice objectives versus achieving administrative expectations?

This challenge is described by Green and Tumlin (1999) who looked at efforts in Washington DC to introduce clinically based practices in child welfare. The barriers they describe include an intrusive and involuntary child protection mandate, stringent time lines, work load demands, staff training needs, worker turnover, funding cuts and

legislative pressures. The authors further note that the expanded role in child welfare to provide increased support services and increasing demands on a worker's time, strain agency capacity.

Research by Courtney (2000) who examined the experiences of children removed from their families, outlined concern that child welfare interventions and decision making about families, have largely excluded the input and experiences of the families. Courtney reported that families “... have little to say about what they are subjected to” (Courtney, 2000, p. 745).

Smith and Donovan (2003), report that organizational demands place pressure on workers to “deprioritize their work with parents” in order to meet standards (Smith & Donovan, 2003, p. 558). The authors studied the impact of child welfare policies on the daily practices of case workers through interviews of front line workers. The findings suggested that administrative requirements and policy demands place a significant strain on the ability for workers to carry out clinical work. The competing demands they described include documentation, meeting deadlines and ensuring clients comply with services even where the services may not be the best fit for the needs of the family. Smith and Donovan noted that workers were forced to develop service plans with families that were often “constructed to reflect ‘outsiders’ expectations rather than the evidence-based or family-centered strategies demonstrated to be the most effective practices for helping families...” (Smith & Donovan, 2003, p. 560).

Wells (2005) describes the importance of achieving a balance between developing good clinical practices and balancing administrative demands. Wells' area of research

involved giving support and guidance to caseworkers despite the challenging nature of the work. He identified gaps between policy initiatives and practice objectives. Wells noted that the competing service and policy demands produce tensions in which organizations needed to “maintain accountability and predictability and, at the same time, also be flexible enough to adapt to changing external situations” (Wells, 2003, p. 1184/5). Wells notes that front line workers need “the equipment, supplies, training, and time ... to do their jobs” (Wells, 2003, p. 1187). He also found that workers could work more efficiently with families when they assumed “lighter caseloads” (Wells, 2003, p. 1187). Wells noted that similar findings have been reproduced in other health and human service settings. He suggested that reducing case load sizes may increase worker efficiency and effectiveness with families.

With a shift towards a family-centered approach and clinical focus to child welfare work, Dumbrill notes the need to “develop a better understanding of the dynamics that drive the child welfare pendulum” (Dumbrill, 2006, p.12). Similarly, Anglin (2002) cautions that child welfare authorities need to examine the nature of the changes implemented through Transformation to learn from past mistakes and to ensure that the field is able to manage the change and what may result from this. The authors imply that the pendulum may swing yet again to introduce more change. This is not to imply that the change will be positive or negative, rather that change of any nature will bring disruption or unforeseen consequences as workers in the field shift their practice and philosophies to accommodate the change.

Anglin sees transformation as a step in the right direction in balancing safety considerations, children’s developmental needs and supporting families. He notes that “what appears to have been lacking is the understanding, conviction and commitment at the highest levels necessary to initiate and sustain such a truly transformative process” (Anglin, 2002, p. 253).

b) Clinical Social Work Practice in Child Welfare

Since the inception of Transformation in 2006, the field of child welfare has been organizing itself around using various clinical models of practice and evidence-based research to inform service delivery. The research and knowledge base regarding the implementation and effectiveness of clinical social work practice continues to grow as the field of child welfare embraces the clinical framework for practice.

Clinical social work practice is described by Ferguson (2003) as the concept of best practice where the focus is on engaging service users, advocating on the client’s behalf, establishing empowering relationships and conducting longer-term therapeutic work that encourages growth and autonomy over one’s life.

Further, Simpson, Williams and Segall (2007), define clinical social work practice as having “the broad goal of restoring and enhancing biopsychosocial functioning of individuals, couples, families and groups through prevention, diagnosis and treatment,” (Simpson, Williams & Segall, 2007, p.4). While the knowledge base for clinical practice varies, the authors note that clinical practice must include “professional ethics and values, biopsychosocial development, psychopathology, psychodynamics, interpersonal

relationships, environmental determinants and clinical methods,” (Simpson, Williams & Segall, 2007, p.4). The authors also discuss the notion that a clinical approach to practice will encompass opportunities for supervision, education, research and evaluating the effectiveness of practice. Also inherent in a clinical approach to practice is a commitment to preserving the dignity of the individuals involved and helping them in a collaborative fashion as opposed to implementing “...a series of techniques performed on an objectified client,” (Simpson, Williams & Segall, 2007, p.4). This is a concept that is challenging for child welfare given its intrusive and non-voluntary mandate.

Simpson, Segall & Williams (2007) and Goldstein (2007) further acknowledge the importance of social work education in clinical learning and achieving excellence in clinical education. Goldstein (2007) highlights several important areas in clinical learning which include developing a complex understanding of client’s problems which refrain from pathologizing them or ignoring the impact of their social environment; a consideration of the client’s strengths, attention to self esteem and identity issues, a commitment to ethical conduct and social justice; a commitment to critical thinking; and gaining field experience.

Bellefeuille and Schmidt (2006) note that as a specialized area of social work practice child welfare work poses challenges for clinical practice described above. Employers who deliver child welfare services are “... under tremendous pressure to address inadequacies in the system and to keep up with growing demands,” (Bellefeuille & Schmidt, 2006, p. 4). The authors identify that budget constraints, limited resources and high and more complex cases pose challenges to educating social workers in doing

child welfare work. Education may mean the difference between whether child welfare workers can become critical thinkers or whether they will follow direction without question. The authors view the relationship between university educators and the child welfare Ministries to be pivotal to developing a work force in child welfare able to deliver clinical practice in child welfare.

Some clinical approaches introduced into child welfare work with families include interventions like Brief Solution Focused Therapy. Here the focus of intervention is on finding solutions instead of examining the problem that warranted child welfare intervention. The approach does not focus on the past, but instead, focuses on the present and future (Dumbrill, 2007; Iveson, 2002). The concept of ‘solution-focused’ can be adapted to suit the needs and situation of the family.

Further, Transformation in child welfare has introduced the need for a family-centered and strength-based approach. The clinical frameworks underlying this approach are client-focused. They support relationship building techniques and working with a client’s resiliency and strengths. Strength-based approaches recognize that clients may feel stigmatized or oppressed or they may blame themselves or others for the dysfunctional patterns in their lives. A strength-based approach looks for success and builds a client’s self-esteem by validating what is working well in the client’s life (Brun and Rapp, 2001; Saleebey, 2006). The ‘Signs of Safety’ is one such framework developed by Turnell (1999) that emphasizes what is working well for a client over what is not working well and how to achieve the best outcome for the client.

Authors such as Black & Lobo (2008) and Barankin & Khanlou (2008) introduced resiliency in child welfare work. This approach encourages families and children to bounce back from challenge and diversity and enables them to better cope with stress. It calls on workers to be empathetic, understanding and sympathetic to the feelings of their clients. It is work that requires time to support positive growth and improved mental health.

Ruch (2005), Maiter, Palmer & Manji (2006), and Altman (2008) write about the need to strengthen the worker/client relationship believing that a positive alliance can occur within child welfare despite the adversarial and often complex nature of child welfare practice. Relationship building uses the skills of caring, empathy, and non-judgment can be beneficial in the helping role. Further, Ruch (2006) describes a case discussion model of practice that encourages taking time to ‘do the thinking’ before the doing in order to allow for critical reflection and analysis.

Taking time to do the thinking and to be critically reflective is a significant challenge in child welfare practice. Munroe (1999) expressed concern in which child protection workers are quick to make judgments or conclusions on few facts and slow to revise their thinking when new evidence emerges. Munroe (1999) concludes that child welfare workers can consciously strive to avoid quick judgments by adopting a more critical approach to their work. Clinical social work practice invites an opportunity for reflection and input from other sources including families.

The concept of family inclusion is supported by McLaughlin (2009) who completed a study looking at how advocacy strategies in mental health supported a

socially just approach to clinical practice. Her research discovered that “clients benefitted from increased opportunities and reduced barriers and stigma” (McLaughlin, 2009, 63). Respecting individual needs of vulnerable clients, calls on workers to challenge themselves to be open to multiple interventions.

In her work on psychoanalysis and social work, Goldstein (2009) discussed the need for workers to be aware of how their own values, background, beliefs and differences impact on their clinical work. She promotes respecting diversity and recognizing that workers need to challenge themselves to see a client’s situation through the client’s lens and for workers not to be influenced by their own deeply embedded personal experiences. Goldstein states, “we do not know what we do not know” (Goldstein, 2009, p. 12). This requires workers to adopt a clinical approach in which they are open, sensitive and willing to share with and learn from the client.

c) Clinical Supervision in Child Welfare work

Research on supervision in child welfare has not been widely available over the past decade. The available literature addresses the administrative aspects of supervision. Only recently has there been attention paid to research in clinical supervision. A review of the relevant literature during the ORAM or reform years in child welfare refers to supervision in child welfare as being prescriptive. Workers deferred to the expertise or authority of their supervisor for guidance and direction (Ministry of Children and Youth Services – Child Welfare Secretariat, 2005 and 2006). Supervision ensured workers carried out the organizational mandate, delivered services effectively and performed their

jobs adequately. (Dill & Bogo, 2009). Dill (2009) cites Kadushin who described the administrative function of supervisors to be “selecting and orienting workers, assigning cases, monitoring, reviewing, and evaluating work, and serving as social agent, advocate and buffer within the organization ...” (Dill & Bogo, 2009, p. 88).

Berg (2003) noted that the field of child welfare once held a belief that in order to be a good supervisor you needed to have the same skills that created a competent or experienced worker and therefore supervisory training involved modeling former supervisors who modeled their predecessors. Berg noted that this significantly limited the growth and development of supervisors. With an expanded supervisory role and the transition to a strength-based approach to practice, supervisors have been challenged to move beyond the deficit-finding and problem-solving approaches once expected in child welfare work. Supervisors in child welfare are challenged to be teachers, mentors, coaches, negotiators, team builders and community relationship builders who encourage networking and liaison work with families (Berg, 2003).

Shulman (2006) saw the importance of a good working relationship between the supervisor and worker. Elements of a good working relationship included a positive rapport, trust and caring. He viewed the supervisor and supervisee roles as interactional where both contribute to the outcome of supervision. He stated that supervision can “influence the development of a positive working relationship with the supervisee, and this working relationship is the medium through which the supervisor influences the practitioner,” (Shulman, 2006, p. 24).

Shulman saw the “parallel process” as being important in the supervisory relationship. He believed that, “the way in which the clinical supervisor interacts with the supervisee models what the supervisor believes is at the core of any helping relationship,” (Shulman, 2006, p. 26). This may influence the workers’ interactions with their clients. Shulman identified three important core skills for a supervisor which he has obtained through years of research. These include articulating the workers feelings, communicating the workers views to higher levels of the agency and allowing the worker to express their negative feelings. He found it was important for workers to have their needs met so they could meet the needs of their clients (Shulman, 2006).

Dill (2007) conducted focus groups to explore the supervisory relationship in child welfare. Key findings included the importance of the supervisor’s role in promoting a worker’s skill development, self-reflection and critical thinking. Dill identified the need for supervisors to receive education relating to role modeling, peer focused learning or supervision that promotes a supervisor’s critical thinking. Similar to Shulman’s findings, the concept of a parallel process was found by Dill to be a key area for growth and development (Dill and Bogo, 2007).

Further in her published findings, Dill (2009) identified that supervision involves administrative, clinical and educational components that are interwoven and are not separate from one another. Dill also noted a need for organizations to shift from a culture that supports risk management strategies to one that embraces aspects of clinical and educational objectives. This requires organizational leaders to “shift the focus away from a predominantly administrative and accountability-based work environment to a more

balanced client focused perspective” where continuous professional learning is valued and encouraged (Dill and Bogo, 2009).

The concept of ongoing professional development of supervisors was found by Strand & Badger (2007) to be key in developing a clinical consultation model for child welfare supervisors to support their role as educators and mentors to front line staff doing clinical practice. Dill (2009) emphasized the need for further research in supervision in child welfare to build knowledge and promote competence gained from ongoing professional development. Dill also noted that as mediator between the front line worker and the administrative leadership, supervisors have influence and “in many respects hold the key to moving the child welfare field forward” (Dill and Bogo, 2009, p. 102).

In Summary

The above literature review highlights how child welfare organizations moved away from a ‘child protection model’ (Parton, 2009) that supported assessing for risk to a ‘child welfare model’ (Parton, 2009) that supported strengths-based approaches, family inclusion and family preservation. Though Transformation in child welfare has paved the way to clinical practice, the literature highlights concern that service delivery in child welfare requires a careful balance between meeting administrative expectations and satisfying the needs of the family.

Research on clinical practice in child welfare is relatively scant and is an area that can benefit from further study. The clinical approaches described above, when applied to a child welfare setting, require time, opportunity for reflection and evaluation and support

at higher levels of management to deem it a priority. While research suggests that clinical practice is helpful to the development of client growth and capacity building, the effective delivery of these services requires workers to have the skills and time to achieve best outcomes for their clients through the development of a therapeutic relationship (Brun and Rapp, 2001; Shulman, 2006; Black and Lobo, 2008; Altman, 2008 and Dill and Bogo, 2009).

Over the past decade, there has been limited research into the area of clinical supervision and client outcomes in child welfare services. Bogo and McKnight (2006) cite the downsizing and cost-cutting measures of some organizations as factors contributing to the decreased interest in supervision of clinical practice. However, the authors advocate for the need to conduct further research in this area. The research supports the view that supervision is critical to the professional learning and clinical development of front line workers.

Building on this literature and analyses of data from qualitative interviews of five child welfare supervisors, I hope to add to the available research on using clinical social work practice in a child welfare agency. I will be exploring the experiences of these front line supervisors through the following questions: What factors increase or decrease the likelihood of engaging in clinical social work practice in a child welfare agency? And, what changes might be helpful to further advance the engagement of clinical practice in a child welfare agency?

METHODOLOGY

a) The Qualitative Design

I undertook a qualitative study to explore clinical social work practice in a child welfare setting as experienced and understood through the lens of front line child protection supervisors. The qualitative approach to research allows for the exploration of themes and for meaning to be derived from the context of the information gathered in an open ended interview style (Kreuger and Neuman, 2006). This enabled me to focus on the participants' unique experiences without trying to prove a theory or hypothesis.

Further, the qualitative design approach relies on interpretive and critical social science to examine the participant's experiences as it follows a non-linear path (Kreuger & Neuman, 2006; Neysmith, 1995). This approach allows for the researcher to explore case situations and the context of the participant's experiences and to explore deeper truths to make sense of their realities (Greenhalgh & Taylor, 1997). It is an approach which emphasizes that there is not a single truth, but rather there are multiple perspectives and this brings validity to the experienced reality (Mays & Pope, 2000). In this study the opinions and ideas of the front line supervisors will form the basis of the data. The concept of what constitutes good evidence is described by Neuman (1997) as being the opinions of the participants who have direct experience. It is the direct experience of the front line supervisors in this study that formulates an understanding of how clinical social work practice is experienced in a child welfare setting. In this study

the supervisors were able to share their descriptions of problems or successes encountered in implementing a clinical approach to child welfare work.

b) Recruitment Strategy and Study Sample

I recruited participants from among front line supervisors of Children's Aid Societies in Southern Ontario. I either called or emailed service directors to request participation of their front line supervisors in my study. Each of the directors was provided with an electronic copy of my Letter of Information/Consent (Appendix A). They were asked to forward the information to interested participants. Interested participants then contacted me by email or telephone. I communicated with the participant by email or telephone to answer their questions and to provide them with further details of the study.

In selecting participants, I placed no restrictions on age, gender, culture or race. I used “participant selection” as described by McQueen and Zimmerman (2006) so that I could choose a population familiar with my research topic (i.e. child welfare supervisors). I also employed the use of “convenience sampling” (Kreuger & Neuman, 2006, p.209) in which recruitment continues until the desired number of participants are reached. There was a very slow response to my recruitment efforts, but eventually I was able to recruit 5 participants.

My sample consisted of 5 child welfare supervisors across 4 agencies in Southern Ontario. There were 4 females and 1 male participant. Their educational backgrounds ranged from 1 BSW graduate to 4 MSW graduates. Their experiences in the field of child

welfare ranged from 10 years to 25 years. They were all front line child welfare supervisors whose current positions included 2 intake supervisors, 1 Crown Ward supervisor and 2 family services supervisors. The participants were Caucasian and their ages appeared to range from the late thirties to the late fifties.

c) Ethical Considerations

In undertaking this study I was able to ensure the confidentiality of the participants by recruiting from child welfare agencies other than the one for which I work, thereby avoiding risk of persuasion or biased results (Martin & Marker, 2007; Peled & Leichtenritt, 2002).

Participants were identified by a code (i.e. P1 for Participant 1, P2 for Participant 2, etc) in the audio tapes and transcripts. The names and contact information of the participants, including their signed consents, were kept separate in a locked filing cabinet in my home and stored separately from the data. Only I had access to the identities of the participants. This information was not disclosed to anyone.

I obtained the participants consents in writing as per the Letter of Information/Consent (Appendix A) to allow me to tape and transcribe the interviews. The participants were free to decline to answer any questions or to end the interview at any time. This being a voluntary study, management in the agencies in which the participant worked were not told of the individual's participation. None of the participants withdrew from the study.

The location of each interview was chosen by the participant. Each had the discretion to end the interview at any time if he or she felt uncomfortable proceeding. While none of the participants ended the interview, one did ask for the tape to be turned off at one point in the interview process. The participants were advised that no identifying information would be included in the final report.

Ethics approval was obtained from the McMaster University Research Ethics Board (MREB) before embarking on this study.

d) The Data Collection Process via Interviews

Data were collected through interviews. I used an interview guide to focus the discussion but I also allowed for other areas to be explored which were not covered in the question guide. Four of the interviews were conducted at the participant's place of employment. One interview was held at an alternate office so that the participant could further ensure confidentiality. The interviews lasted on average between 60 to 90 minutes.

I reviewed the consent process with each of the participants and obtained their written consent to be interviewed and for the interview to be recorded as well as transcribed. I also obtained their consent to take written notes. Thus, all of the interviews were recorded on tape and all were later transcribed by me to ensure confidentiality, accuracy of the transcribed information and it enabled me to become very familiar with the data.

I began each “semi-structured interview” (Rubin & Babbie, 1993) with an introduction about myself and my research project. The semi-structured and in-depth interviews I conducted followed a general guide as per Appendix B which offered a framework for discussion; however, this process allowed for deviations from the scripted questions to encourage more of a conversational flow and to allow for probing. Therefore I was able to explore issues relevant to the participant as well as make further queries generated from the participant’s responses.

In the data collection process I was mindful of the “personal and intellectual biases” (Mays & Pope, 2000. p.51) that I might bring to the study. Since data are being filtered through my lens, I needed to identify and understand my prior assumptions and experiences which have led me to study this topic. I have considered my social location (Lasala, 2003), my relationship to the participants and any power relationships that may exist which may have relevance to the participants’ free sharing of information. By interviewing other front line supervisors like myself, I avoided power relationship issues that might have occurred if I had interviewed front line workers or clients. Other supervisors were similar to me in social location (i.e. race, educational background, employment) and we shared in the use of terminology and language used in the field of child welfare. In this respect having first hand knowledge of terminology used in the field was an advantage as an interviewer in generating questions and expanding on concepts the participants discussed.

By being aware of my social location and biases, it alerted me to how the data collection process can be skewed through my filters and inferences to derive meaning

that was not intended by the participant. I took care not to impose my judgments and biases on the participants and made every effort to allow the participants’ experiences to speak for themselves without censoring or editing their opinions, (Horwath, 2007).

In the interview process, I used a scripted question guide (as per Appendix B) but I also allowed for participants to ask questions and express alternative viewpoints which were not covered in the interview guide. Open-ended questions on broad themes as described by McQueen and Zimmerman (2006) allowed for data that can be analyzed for patterns and themes. The prepared questions I used were designed to highlight the more apparent themes and issues which I felt were relevant to this study and which were guided by the literature. I encourage a conversational flow to the interview in order to allow participants to share as much detail as they could about their experiences and to allow for issues important to them to emerge.

e) The Data Analysis Process

My data analysis began with a coding process which allows for data to be fragmented and named in effort to define and derive meaning from the data. Initial coding (Charmaz, 2006) was the first phase of my analysis process which allowed me to examine individual transcripts to study fragments of data. I used ‘line-by-line’ coding as described by Charmaz (2006) which allowed me to “see the familiar in a new light,” (Charmaz, 2006, p. 55). Given that I spent twenty years in child welfare, it was important for me to disengage from the content of the data in order to be open to new ideas that

might not be apparent if I were merely to focus on searching for themes. Line-by-line analysis allowed me to focus on key words and phrases or patterns.

I also made use of ‘incident-by incident’ coding. Charmaz (2006) describes this process as useful to “aid you in discovering patterns and contrasts” (Charmaz, 2006, P. 55) in the data. By looking for similarities and differences within interviews and across interviews, I was able to introduce an analytical process to explore categories. The constant comparison process “stimulates thought that leads to both descriptive and exploratory categories.” (Lincoln & Gaba, 1985, p. 341).

I looked for major categories that emerged from the data. I labeled the categories (e.g. barriers to clinical practice) and broke them down into sub-categories (e.g. administrative barriers, performance barriers). This process of open coding “brings themes to the surface from deep inside the data (Krueger and Neuman, 2006, p. 438), and allowed me to explore the data without drawing conclusions or making assumptions about what the data might mean.

In the second phase of the coding process I moved towards more ‘focused coding,” (Charmaz, 2006). This process was helpful to consider larger chunks of data and how they may fit together. Axial coding (Krueger and Neuman, 2006) is one type of focused coding I used to make sense of the data. By reviewing each of the five transcripts several times and looking for connections between main categories to highlight patterns, I was able to make linkages between categories and develop new questions arising from the data. The process of axial coding helps examine content to identify reemerging patterns and wider themes or issues emerging across the data.

f) Limitations of the Study

This study has presented some limitations. Given that the study sample utilized a type of convenience sampling, the participants involved may not necessarily be representative of the general population of front line supervisors from across Ontario. As well, the study sample was somewhat limited in its diversity and geographic location in that all of the participants were from a southern Ontario child welfare agency. It would have been interesting to obtain data from participants in northern Ontario communities to see if additional themes or issues emerged.

In undertaking this study, I approached it from the perspective of an “insider” (Lasala, 2003) and while this may support an advantageous position for formulating questions and having first hand knowledge and experience of the subject matter being studied, it also positions me with a bias that may have entered into the coding process without my knowledge despite my efforts to remain objective and unbiased.

Despite the limitations noted, however, this study offers a contribution to research into the area of clinical social work practice in a child welfare setting in which there has been little written in this area. This study may serve to stimulate dialogue and discussion for further research and practice development in this area.

FINDINGS

This study began by looking at how participants defined clinical practice. The participants' data then revealed some main themes related to the factors that increased or decreased the likelihood of engaging in clinical practice in a child welfare environment. These themes include the following: 1. Case Load Management, 2. Delivery of Services, 3. Support for front line workers and, 4. Philosophy of the agency.

These main areas were examined in terms of barriers (factors decreasing the likelihood of engaging in clinical practice) and enablers (factors increasing the likelihood of engaging in clinical practice). Each of these main areas was broken down into categories and subcategories to further identify factors that support or hinder engagement in clinical practice.

The participants viewpoints will be presented as P1=Participant one, P2=Participant two and so on. While the participants included 1 male and 4 females, each will be referred to with the feminine pronoun to further protect the confidentiality of all of the participants.

Part I:

PARTICIPANTS' DEFINITIONS OF CLINICAL PRACTICE

Overall, participants defined clinical social work practice in terms of outcome goals and measurements. They felt that the ultimate goal of clinical practice was to

influence positive change with the individual or families. Anything that was reactionary or unplanned was not viewed as being clinical.

The participants' views of clinical practice included four key themes which distinguish clinical practice from other types of intervention. These key areas included the use of goal setting, clinical skills, the use of theories to inform practice and the ability to measure outcomes.

P1 felt that clinical social work practice has become more prominent in child welfare over the last two years. While P1 felt that she always used clinical skills in her work and with her staff, she felt that defining it is “... one of those things that’s hard to put into words.” P1 further stated “...the goal is enhancing and maintaining the physical, mental, emotional and social functioning of individuals and families.” She stated that she would take it a step further in her role as a supervisor “...to help maintain these things with my front line staff because they’re the ones out there doing the work ... I try to use a clinical aspect to my supervision style.”

P1 further identified the need to supervise staff by encouraging them to use clinical skills and different theories to facilitate change with clients. She identified that “the change is your measurement,” to determine the effectiveness of clinical practice.

P2 defined clinical social work practice as “... the application of a method or a methodology to a situation and the ability to measure the outcome of that methodology ... once its been implemented.” She further identified that methodology could include, “... a theory, a practice, [or] a system ... that is actually planned and concrete as opposed

to a reactive approach to something; and then being able to measure whether that has been successful or not.”

In contrast, P2 described an approach which would not be clinical to include responding to situations in an unplanned or reactionary way, “... in which there is really no thinking about outcomes, no thinking about variables, no thinking about factors or systems. It’s more or less how do we correct this or how do we fix this ... without encompassing a broader picture or a broader view of the situation.”

P3 believed that clinical practice supported the growth and development of clients through the application of theories. She felt that as a supervisor there was an aspect of using clinical skills to “... helping our workers with managing and balancing their life with the work and ... stressors that they have.” P3 discussed the parallel process as an important aspect of mirroring for workers what you would like them to use with clients.

P4 supported the view presented by P1 with respect to enhancing client functioning. She also supported the view expressed by P3 in that clinical practice as a front line supervisor encompasses supporting the front line worker “... towards increasing their ... skills, increasing some of their capacities ... and their knowledge, their confidence ...” in the work they do with families.

P5 defined clinical practice in child welfare as involving, “... thorough, accurate and informed assessment of ... individuals and the families and ... a continuous process of assessment and reassessment and a collaborative approach as much as possible ... to assisting the family in applying a variety of interventions to making the changes that will result in the outcomes that we need.” She identified enhancing the functioning of the

family and the individual to enhancing and maintaining their “physical, mental, emotional, social functioning ...” as aspects of good clinical work.

Part II:

BARRIERS – Factors Decreasing the Likelihood of Engagement in Clinical Practice

1.) CASE LOAD MANAGEMENT

The participants identified that managing a child welfare case load presented challenges with engaging in clinical practice. These challenges or barriers included functions like maintaining standards, time constraints and response time, and managing high caseloads (see Appendix C). The participants identified a number of factors in each of these areas which they believe impedes the likelihood of engaging in clinical practice.

A) Maintaining Standards

Maintaining standards in child welfare is central to the work and allows for evaluation of practices and procedures. Standards are in place to safeguard liability and increase accountability. A number of participants described how the pressure to maintain standards in child welfare directly impacts a front line worker’s ability to carry out effective clinical practice.

I. Rules and Rigidity

Many of the participants found that the rules that guide child welfare work left little room for the flexibility and creative thinking necessary in clinical practice. P3

described case load management to be “administrative-heavy” and the standards guiding the work are based on “best practice” initiatives which P3 believed was a hard thing to live up to and wondered if it was a reality. P3 provided the example of the 10-day rule for completion of a file transfer from an Intake to ongoing family services. This requires the internal transfer meeting between the intake worker and the ongoing family services worker and the external transfer meeting with the two workers and family to be completed within ten days.

P1 believed ministry standards are “... very rigid ... and they’re not very amenable to clinical.” This point was also illustrated by P5 as she discussed the “permanency rule”. This dictates that children in care of the Society under the age of 5 years must move on to a permanent living arrangement after one year and two years for children over 5 years of age. The intent of the permanency rule was to make sure children are not left in limbo. P5 points out that though this may have advantages, it’s restrictive for parents who are “... making change and ... need a bit more time.”

P2 believed that fifty percent of child welfare work “... is the standards and the ... rules and regulations that create the rigidity ... so it’s sort of a hybrid system in many ways.” P2 suggests that the flow of the clinical intervention is disrupted by the rules which block it.

II. Accountability and Liability

Some participants identified accountability and liability as significant factors which interfere with the flow of clinical practice. Accountability refers to ensuring

standards are met and outcome goals of the agency are achieved. Liability refers to taking responsibility for some action when something goes wrong. In child welfare, accountability and liability are often maintained by adhering to Ministry rules and standards to ensure procedures are followed. P5 believed that “... the degree to which we ... have to be accountable, sometimes very much interferes with the flow of the clinical part.” In other words, achieving standards meets the accountability frameworks, but it may not necessarily be what is best for families.

Fear of liability often drives decision making. P1 stated, “... my very first thought [when I started in child welfare was] they really make us cover our asses ... that’s really what it [the Ontario Risk Assessment Model - ORAM] was about ... liability...” P1 noted that when the worst case scenario happens and a child dies, regulations and standards change to accept less risk. Further P1 stated, “You don’t want to think outside the box because if somebody dies how do you explain that?” P1 described the need to cover all of the bases because you will never escape the liability issue and this will ultimately impact on work with families.

P2 supports this notion and stated that “... the system is largely liability based and ... is often times more focused on protecting itself from blame than it is in actually instituting some measurable change.” She explained that generally families and communities work with children under the notion of risk management which entails weighing the variables and factors that plan for safety. In contrast, child welfare work often practices risk avoidance in order to ensure safety.

B) Time Constraints and Response Time

Some participants believed that time constraints and rushing to meet standards by imposing a fast response time created barriers to clinical practice. Time constraints pose challenges to building therapeutic relationships with clients because it restricts the time needed for reflection, planning and assessing the effectiveness of these plans and making adjustments where necessary. Administrative responsibilities and documentation were two key areas that were shown to emphasize these themes.

I. Administrative Responsibilities

The need to maintain consistency, integrity and accountability in an organization rests with the administrative body that must ensure that key controls are in place. In child welfare work, these controls relate to policies, procedures and standards that aim to secure the effective and efficient delivery of the child welfare mandate. There are times, however, when these administrative responsibilities are in conflict with clinical objectives.

P2 identified that time was a significant factor in implementing clinical practice; specifically, that the process of clinical intervention could not be rushed so that the next task could be accomplished. She stated that “...there’s not enough room sometimes to be more clinical with clients; to be a little bit more innovative, a little bit more exploratory in a way we would want to ...” Similarly, P3 stated that “in order to do good clinical work, the reality is you need time. And, we seem to ... be trying to negotiate ... client contact with administrative work, with supervision.”

Further, P5 explained that relationship building with clients is essential to clinical work and cultivating the worker/client relationship takes time. She expressed concern about a lack of time and stated, “I think ... the administrative, people tell us that [workers are] spending maybe 30% ... of their work time on direct... contact.” She went on to explain that “when there’s a crunch, meeting the deadlines and having the administrative part done ... [is the priority].” Stringent time frames sometimes require workers to put in extra hours to complete their work. P5 believed that the child welfare system does not allow for the worker to adjust the time needed on a case as the case situation warrants it.

II) Documentation

Documentation was identified by the participants to be particularly daunting and participants believed it took away from time needed to engage in clinical practice. The documentation referred to included case recordings, case notes and court documentation.

P2 explained that the volume of recording is substantial. As a Supervisor of a Crown Ward unit of children in care, P2 found that her workers are overloaded with the requirements of documentation.

[My workers] have anywhere from 17 to 19 [cases] which doesn’t sound a lot but the other aspect of workload which I should address is the recording piece. The amount of recording and documentation you have to do based on the contact ... is so daunting that it’s almost like a 60:40 equation where 60 per cent of your time is recording and 40 per cent of your time is with ... actual people. I would even say it’s more 70:30.”

P4 found that with the former risk model of practice (i.e. ORAM) it affected clinical practice in that “... there was so much time on paperwork. They didn’t give as much emphasis on spending time with the families in that clinical kind of aspect.” The risk assessment form under ORAM “...took maybe three hours to complete ... [and] was a lot of documentation you had to do for each interview with the families. That really took away from time spent with the families.” P4 suggested that workers need time to re-learn how to interact with families and adjust recording to reflect this work.

Some participants believed that court requirements added to the tremendous workload involving paperwork. With court generating additional paperwork, there is time needed to complete the extra work and there is less time to spend with families. P5 stated the following:

When I have workers in my office and I’m signing off on 10 hours of over time a week ... it’s all reasonable. They’re overworked ... Like when they’re saying, but I had to cancel this because I had to be in court here, and the 7 day was due yesterday.”

P5 believed that the thing that drives the need to spend so much time on court work is to establish credibility, often at the expense of client engagement. P5 explained that “... there are some [case] notes that I think that are longer because we want to make sure that there’s enough in them ... for court.”

The other aspect of court documentation that P5 referred to is the manner in which work is structured. Court work becomes a priority and because of this other work suffers so a worker can attend to the needs of court. P5 stated that this “... causes us to ... have less time to spend [with clients] and [this causes us to] lose the flow sometimes with the clinical part.”

C) High Caseloads

As child welfare work embraces a more clinical approach to service delivery, the demands on a worker's time is increasing and managing high case loads is becoming a daunting task to ensure standards are met and clients' needs are addressed. On average, participants believed that a case load of 14 would be more conducive to implementing clinical practice but they also believe that case complexity needs to be taken into account.

P4 explained that workers are always working at their max without any breaks in the work load. She believes that high case loads place pressure on workers to meet time constraints in order to get everything done. P4 stated that case loads should be lower than they are. She stated that “... when they're at 14 they're at their cap. When you're at your cap, you're ... maxed ... So you go beyond your cap and it's hard to manage.” P4 further explained that when case loads are lower this creates another dilemma. She stated that “...with the case loads going down, funding goes down, and ... we've had more cuts; not cuts of workers in terms of letting people go, but through attrition ... People leave and their positions and don't get replaced ...” She points out that lower case loads don't necessarily mean a reduced work load.

Coverage was another factor identified to increase workload. When workers are not available to tend to their cases for reasons of court, absences or leaves, coworkers must bridge the gap, thus increasing their work load and offering clients only crisis coverage in most cases.

2. SUPPORT FOR FRONT LINE WORKERS

The participants believed that the level of support offered to front line workers including worker skill and training needs, supervision, high turnover and funding issues all played major roles in enabling or creating blocks for workers to do their jobs and to implement service within a clinical framework.

A) Worker Skill and Training Needs

A number of the participants identified that some workers lacked the skill needed for clinical practice and were in need of training. Training and skill level were identified to be important aspects of clinical practice. However, the participants discussed how training takes time and the need to train competes with the need to have workers out in the field meeting with the families.

P2 stated that “... in certain departments or aspects of child welfare, there’s a lack of training, there’s a lack of awareness; and so you get ... a lack of clinical decision making.” Without sufficient training for workers, clinical skills will be lacking.

P5 noted that training for both new hires and more senior staff meets with many competing demands for a workers time. She stated that, “... we want people to ... go to training to ... increase their skill and their ability to use their skills but the other side of that is that their work is still waiting for them.” Workers are expected to complete the work without first receiving the proper training. Further to this, P1 spoke about the time needed to train new staff who may be out of the office two or three out of five days a week for a number of months. New staff cannot carry full case loads and the cases they

carry go unattended when they are in training or receive only crisis coverage. Unattended cases or cases receiving only crisis coverage do not receive the benefits of clinical intervention that is client focused and engages the feedback and participation of the clients, because in these situations only the bare minimum of service is provided.

P1 noted that when child welfare shifted its practice to include a more strength-based approach to the work, there was an absence of training in this new area. P1 explained that Differential Response (DR) was fully implemented by spring of 2007 and that now in 2009 there has been no formal training offered in strength-based practice.

We got ... all the computer training, how to do the new modules, how to make sure we know when we are in compliance and all of the liability pieces of it. We got it ... shoved down our throats quite quickly. But there's been no clinical training with respect to implementing the strength's based practice.

Therefore, the challenges with acquiring clinical skills through training have been identified by the participants to be significant barriers to implementing clinical practice.

B). Supervision

Generally participants viewed their roles as supervisors to be messengers and promoters of clinical practice. P5 believed that, "... if you have supervisors who discount the importance of clinical stuff, ... in your writing and in your thinking, then it's going to drop out of people's practice and out of their consciousness." The work becomes more about meeting standards than about improving the quality of life for families.

As well, the fast pace nature of child welfare work requires supervisors to be available to front line workers on an ongoing basis and this leads to what P1 termed as "doorway supervision." Doorway supervision involves workers providing quick

descriptions of situations often excluding details of interactions and family dynamics, and usually ending with directives to implement reactionary approaches to the work which is detrimental to establishing good clinical practice.

P3 found there was little time for having wider clinical discussions with workers, “...because you’re so focused on ... getting information about the safety...” Safety is the paramount reason for child welfare intervention and because of this, clinical discussions involving other aspects of the case gets put aside during supervisory discussions. P3 also found that certain front line workers trained in the risk assessment model (ORAM) were having a difficulty in making the transition to a more strength-based and client-focused approach to their work. She also noted that supervisors who have been trained in the risk model “... supervise their team from ORAM [and] the difference in the supervision style is very evident...” as they are “... very intrusive ... [and] less ... clinical.” Therefore, if supervisors aren’t familiar with what clinical practice entails or how to implement it, they will not be able to support their workers in developing a clinical approach to their work.

C. High Worker Turnover

Some participants identified high staff turnover to be a barrier to engaging in clinical practice. High turnover creates vacancies often requiring existing staff to cover. New hires who fill these vacancies require training and orientation to do the job effectively and they are often unable to carry full case loads. As existing staff assume extra work, their time spent on their own cases is reduced. New hires or covering workers

may experience challenges with clinical skills like client engagement and relationship building as families have difficulty adapting to the change of workers.

P1 described how sick leaves and high turnover create additional work for staff left behind. This additional work load causes workers to spend less time with their families. P1 expressed concern that vacancies were not covered in a timely manner and this placed pressure on other workers for coverage. She stated, “I had a worker off from October until February and I didn’t get a get a replacement”. P1 explained how this creates a problem for implementing clinical practice because a worker’s case load increases to cover the vacancy.

...the Ministry has a job to do. At the Ministry level its business ... But ... we’ve talked before about ... how [we] can ... alleviate some of these barriers ... [W]e need to have people ... go into these four months sick leaves who are just floaters. You know or go into these maternity leaves because I can’t remember the last time we had a worker in place before somebody went off on maternity leave ... we work in a field where there’s someone pregnant every other month.

P1 points out that vacancies must be covered off by existing staff and this creates tension for the workers who have their own case loads to manage and their time is spread thin.

According to P3, “...turnover has a huge impact on clinical work with our families ... I would love to have a team that is consistent and stays ... three to four years, 10 years...” She notes that the short term stay in the profession has a direct impact on service delivery since worker changes are a significant factor in decreasing the likelihood of engaging in services as there is no consistency and this jeopardizes relationship building efforts.

P3 further stated that doing clinical work requires knowing the job well and having the time to engage with clients.

...you have to really do this job for a good two years before ... that consolidation happens; and because there's so much to learn. And I think, unfortunately, when you're here less than two years, you don't get that, you don't get that exposure, you don't get that consolidation. And, when people come back [from leave] ... it's almost like you have to start from scratch.

P4 found turnover of staff to be a significant complicating factor to service delivery problems and engaging families. She described how workers were leaving on a monthly basis and as a result tension among workers was very high resulting in a team of relatively newer workers who all require training and mentoring. Though vacancies are eventually replaced, P4 explained that, "... they are newer workers and they need training ... so they're not carrying a full case load." This means existing workers must assume extra work which interferes with the time needed to engage in clinical work.

D. Funding

Another area of support for workers is funding. Adequate funding will support having sufficient staff and resources and allow workers time for client engagement. Funding restrictions will result in a reduction of staff and services. This will tend to increase the work load for staff and a higher workload will result in less time to engage in clinical practice with families.

P4 discussed funding problems. She stated that, "...funding is a huge barrier ... We're funded ... based on case numbers." As a result of this funding formula, when case numbers are low there is less funding and staff cuts are sometimes the result. P4 expressed concern that a reduced case load doesn't necessarily result in a reduced work load for staff. P4 explained that, "... despite funding ... you might spend three hours [with a family] ... in crisis. You're not going by the hour really. You use more [time]

than you’re allotted.” Therefore, the complexity of cases and time needed to work with a family are not factored into the funding formula.

P5 expands on the notion of case complexity. She explained that where there is a lot of complexity in cases, the extra time needed to manage the case is not taken into consideration.

... Workers feel that they’re not supported because they still have 18 cases like everybody else. So we’re saying you do great work ... we like what you’re doing, you got this case because you got the skill set to handle this; but you know what, there’s three more behind.”

With focus on case load numbers driving funding, P5 worries that the funding formula misses the need for workers to spend additional time with families during critical points in the life of a case.

3. DELIVERY OF SERVICES

Delivery of services in child welfare was seen by the participants to be a key area for promoting clinical practice. Three areas of service delivery were seen to be problematic and which created barriers to engaging in clinical practice. These included the perceptions of CASs held by clients and the community, worker’s skepticism about their work and the child protection mandate involving involuntary services, a risk avoidance philosophy and an often reactive and crisis oriented approach to the work.

A) Client & Community Perception of the CAS

The acceptance and perception of CAS work by clients and the community was believed by participants to interfere with the relationships between worker and client and

the agency and community where these perceptions were seen to be negative. Tensions in these relationships were believed to have a negative impact on the worker’s ability to engage the client in a clinical or therapeutic relationship.

P1 felt that a huge barrier to the clinical relationship between a worker and a client was that clients will typically reject the CAS as the helper. P1 described hearing a worker saying, “... I don’t know how to engage these people ... the clients are saying ... just look in my cupboards and get out.” She stated that workers are asked to use their clinical skills with clients and often clients are resistant and distrustful of CAS and will ask the workers “what do I have to do to get you out of my life.”

P4 identified that the conflict between the agency mandate to protect and the clinical objective to engage with clients and to work with their strengths is a difficult fit. P4 stated that the disjuncture comes in where “... the goal of the agency ... is not the same as [the family] and they may not want you involved with them but ... you ... still [need to] ... develop a relationship with the family.”

P1 further identified that community professionals sometimes view CAS in a negative light. She stated that the “... the community has an idea about what we are all about as well. They don’t wanna engage with us. That can be changed, but it’s not going to happen over night. It frustrates the workers.” Rather than being seen as helpers and facilitators with families, P1 worried that CASs and child welfare workers are perceived by some community professionals as being more disruptive than they are helpful.

P3 talked about observing a lack of support for CAS work by community services and she felt the need to educate the community about what the CASs are trying to

accomplish. If community professionals view the CASs in a negative light, this will ultimately be translated to the client and this will interfere with a front line worker's ability to engaging in clinical practice.

B) Worker's Skepticism

Participants noted that the move from ORAM to DR was not without its problems. As the field experienced a paradigm shift, a change in basic assumptions and philosophies about how child welfare work should be viewed and practiced, workers were transitioning from a risk-based philosophy to a strength-based philosophy. For some it was an easy transition; for others it was a challenge to call upon clinical skills that were long dormant or absent. The participants shared their views and experiences of the effects ORAM and DR had on clinical practice and the challenges faced with implementing DR.

P1 believed some of her workers don't feel free to engage in a relationship with clients because the service is about the agency agenda and not the client's agenda. Therefore workers believed that clients feel betrayed and manipulated. P1 explained she has been frustrated to hear her workers say things like, "...oh well we're never going to be able to make changes like it's never going to happen they [the clients] are just going to keep blaming us." P1 further felt that the move towards Differential Response and a strength based approach to working with families was viewed by some workers with skepticism. She has heard workers say that management will "...just ... roll something else out and we're going to have to be explaining things all over again ... We're just

going to learn how to get really good at doing this and then they’re just going to change it again.”

P5 attributed much of the negative feelings workers have about their work to be due to ORAM. The risk assessment model did not support clinical practice and was very prescriptive. Its focus was on looking at deficits and eliminating risk. P5 believed that ORAM caused a lot of damage to the relationship people had to the work as child welfare workers.

I think we probably lost a lot of good people who were disillusioned. It would be interesting to look at the turnover rates ‘cause I think people who came in as social workers during ORAM who felt a very big connection to the clinical value base and who wanted to do clinical practice, I think probably there were a lot of them who found you couldn’t sustain that.

P3 believed when ORAM came in CASs “...became very much of a policing agency with a risk focus, moving away from ... trying to find some balance [in the work].” P3 stated that ORAM, “moved [child welfare work] off the clinical spectrum. So ... now we’re trying to bring it back. And now you have to retrain everyone that we trained for ORAM ...” She added that implementing clinical practice has been more difficult for people trained in ORAM.

P5 stated that child welfare is finding it hard to recover from ORAM because “...people who have only worked in that time have had more of a struggle to embrace ... transformation.” With shifting philosophies from ORAM to DR, workers are left wondering how future shifts will affect their work with clients.

C) Protection Mandate

The involuntary and intrusive child protection mandate was cited by participants to be a huge barrier to client engagement. Focused on avoiding risk and often necessitating reactive and crisis oriented work, the child protection mandate was seen as an obstacle to the relationship building aspect of clinical practice.

I. Involuntary Service

The involuntary nature of child welfare services was seen to create barriers to clinical practice in child welfare work largely because the intrusive mandate of the agency tends to impose change or goal outcomes on clients that may be unwelcome or which may differ from the goal(s) of the client. Therefore the agency agenda would take precedence over the client's agenda and this can be counterproductive to developing a therapeutic relationship with a client who feels forced to implement change which he or she does not feel is necessary.

P1 believed that the authority versus the helping role is a difficult barrier to overcome in clinical practice. She stated that most workers enter the field to help empower clients and help them to find their strengths and their self worth; but P1 explained the following:

.... ultimately ... the point may come when [as workers] you have to make a decision for a parent about their child. And all of your clinical and strength based stuff goes out the window ... So it's really hard ... we're pushing to build these relationships, get to know your clients. But it's a really fine line because ... you may have to bring them in line.”

P1 stated that the involuntary nature of the services requires clear boundaries and she believed that despite the move towards transformative practice, CASs are, in many ways “policing agencies” and that “... at the end of the day if you still have to apprehend, you still have to apprehend.”

P2 explained that voluntary services imply that the client has an agenda that sets the tone and pace for service. She points out the tension with involuntary services by suggesting, “If a person walked into a counselor’s office and every interaction was based on the counselor declaring I want to talk to you about [a certain issue]; that counseling wouldn’t last very long.” Here P2 suggests that the agency’s agenda is not a good motivator for client engagement.

P4 believed that true clinical practice is something that is “... guided by the client” She stated that even in a voluntary situation where a client is coming to you, developing positive working relationships with clients involves being respectful and clear about your role. P4 noted that it takes much effort to achieve a positive rapport and when a worker has certain expectations of a family, “the families don’t necessarily want [CAS] involvement. And the practice [becomes] defensive-driven.”

Simply put, P5 stated, “... because we deal mostly with ... involuntary clients ... we have challenges in establishing therapeutic relationships that others don’t. [We] see people who are troubled, who aren’t gonna get help ... by their own choosing.” In this respect, P5 notes that engaging in clinical practice becomes very challenging.

II. Reactive and Crisis Oriented

Some of the participants stated that the reactionary and crisis oriented nature of child welfare work decreases the likelihood of engaging in clinical practice when there is little time to build relationships and plan for services.

P1 stated that “... workers get frustrated because we’re a very reactive profession ... which makes it kind of difficult to really hone in on ... your clinical skills and your practice.” When a family is in crisis there is a tendency for workers to find a quick solution to the problem in order to reduce the risk to the child. The reactive and crisis oriented nature of the work also interferes with workers plans. P1 noted that “... one phone call on Monday morning can throw [a worker’s] whole week into a tailspin.” As a result other families are impacted and do not get the services because they are not in crisis and their home visit by the worker gets postponed.

P2 viewed child welfare agencies to be somewhat clinical organizations. She noted that “... there’s a piece of child welfare that in some ways has to be reactionary in terms of safety issues.” She explained that “...at the front end there’s a system built into place where it’s a little bit more ... reactive, and [there is] more of a need to address something in a very rapid and ... concrete way.” Client engagement becomes problematic when the system is reactionary.

P5 concurred that “sometimes the need to get things done speedily in our work prevents us from examining [issues] and prevents ... discussion,” to address the immediate concern.

Part III:

ENABLERS – Factors Increasing the Likelihood of Engagement in Clinical Practice

1.) CASE LOAD MANAGEMENT

The participants discussed how managing a child welfare case load from a clinical framework is easier to promote when consideration is given to case load size and complexity; when there is support from management; when there is encouragement to implement alternative practices which engage clients and when there is a more clinical orientation to the supervision process.

A) Case Load Size and Complexity

Participants noted that reduced case loads promote increased opportunities to engage in clinical practice as there is less pressure on workers to manage a high volume of work. Allowing time to review complex cases and plan for strategic interventions support the potential for greater clinical engagement with families because workers are not running from one case to the next.

P1 suggested that lowering case loads to 14 would increase opportunities to engage in clinical work. She also felt that the development of a “floater team” would be beneficial to “fill in the gaps” when vacancies occur so the workers are not overloaded. Ideally P1 believed that with lower caseloads and the right resources, “... you can do beautiful clinical work.”

P2 believed that lower case loads would increase the potential to engage in good clinical practice.” She has seen how lower case loads can increase time for client contact.

She believed that if you want to make a difference in people’s lives you have to get to know them. P2 believed that ... the success of ... some counselling [is] because it’s all about interaction.” Increased client time allows for the potential to establish these important therapeutic relationships.

P5 discussed how having tolerance for a range of case load sizes based on complexity would be beneficial to supporting client engagement. She stated, “ ... if you’re at the lower end [in terms of case load size] it’s because you’ve got some intensive work going on with one or two families” P5 believed that this kind of case size flexibility would require “support at the funding level,” and would allow for workers to adjust completion of case load demands to better suit a client’s needs.

B) Support from Management

Participants have noted that management is encouraging clinical practice with a strengths-based focus that requires client engagement, goal setting and the use of various theoretical approaches to assist clients. This is contrary to past practices in which the focus of service was to ensure safety and avoid risk. This approach typically involved meeting administrative responsibilities rather than ensuring client oriented objectives. As well, providing training and having a higher tolerance for flexing rules and time frames were additional factors participants noted as efforts management has made to support clinical work. This supports clinical work because training will enhance a worker’s clinical skills and the flexibility to compromise some rules gives priority to clinical objectives and client work.

P2 explained that when she entered child welfare prior to ORAM she implemented clinical practice in her work and there was neither support nor resistance for the way she worked with families. She noted that ORAM’s inception restricted some of these clinical approaches but that DR offered “...a greater sense of permission ... a greater recognition around ... [clinical practice] being a viable method of looking at families and looking at situations.”

The need for training specific to enhancement of clinical skills has become a priority for many agencies. P5 stated that her agency is supportive of ongoing professional development. She believes there has been a steady move towards training and of integrating training into practice. She stated that agencies, “...support workers ... to have opportunities to continue their professional development,” and there is increasing support for this type of training to include clinical practice training.

Further, P2 believed that management supports engagement in clinical practice by showing a higher tolerance for bending rules to support the best plan for a client/family.

P2 explained the following:

Because you’re dealing with human beings ... and because every situation ... is different ... there’s an ability to ... look at five different methods and methodologies ... and often times there’s a subtle resistance to ... adopting a system that is global like this should work for everybody. So that’s one of the strengths of the system, the flexibility within it, the whole notion of assessment means gathering information and to find that information in a clinical way.

Management was viewed by participants as becoming more supportive in allowing for a diversity of approaches for implementing practice and child welfare work was thereby becoming less of a policing function and more of a therapeutic intervention.

C) Supervision

All of the five participants identified supervision to be a key factor in encouraging workers to implement clinical practice in the management of their case loads. Specific to supervision, the role of the parallel process and mentoring as well as the skill level of the supervisor were identified to be the main themes.

P1 perceived her role as a supervisor to be an opportunity to look for ways to get her staff on board with a clinical application to child welfare work. She supports her staff in making client visits a priority and will extend time lines for recording requirements. She believes that, “... from a service level [workers] are not going to have [their] recordings up to date all the time ... so I give them a 45 day window.” Allowing for this extension is one of the ways in which she supports her workers and makes space for client engagement and more clinically oriented discussions of families.

Further, the issue of documentation was seen as an opportunity to engage in what P5 referred to as “professional writing”. Professional writing could support clinical practice as it has the potential to offer descriptions of clinical work conducted with clients. P5 explained that, “...part of your writing is ensuring that you’re getting those clinical things in there. And you have to know how you’re filtering those first.” She believed that “...the degree to which people have clinical skills would be the degree to which they would ... write more detailed information...” Therefore, clinical practice helped to sharpen skills which could be translated into the written documentation.

P2 believed that a significant component of supervision was to mirror good practice for the workers. She stated, “... you have to mirror the relationship you want the

workers to have in the community and if you micromanage and if you're too authoritative ... then you're going to create a worker who is going to mirror that and take that behaviour out into the homes of people.” P3 expressed a similar viewpoint as she felt that as a supervisor she works with her team in the same manner as she would like them to work with clients. She referred to this as a “parallel process.”

P4 drew from her personal experience with good mentors who believed in clinical practice. She felt that the mentoring role is very effective to building an atmosphere that supports clinical work. P5 expanded on the mentoring concept and stated, “...that whole mentoring piece enables ... workers to have a larger repertoire of skills and knowledge that they're applying to every family ... So it is the teaching but it's also shadowing...” She goes on to explain, “...there's a very big parallel process between our clinical work with families and individuals and our work with our staff.” The supervision process was seen by participants to use training, mentoring, and modeling to promote good clinical practice.

Further to the issue of supervision and its ability to further the implementation of clinical practice, P1 felt that having skilled and trained supervisors in child welfare was essential to this process. As well, P3 felt that at her work place they have a strong supervisory group who come from a variety of experiences. She stated that the supervisory group brings “... clinical skills and ... social work theories,” to help inform their practice.

P5 discussed the importance of the supervisor being open to learning. She stated that, “... if you have supervisors ... that are open to ... continuous learning through their

career ... you can even model learning together,” and this created an openness to embrace clinical practice.

2. PHILOSOPHY OF THE AGENCY

A philosophy encompasses a set of beliefs, ideas and values. Specific to child welfare, the philosophy guiding child welfare work took a dramatic shift in 2006 as the field transitioned from a child protection model (i.e. risk focused and deficit-based) to a child welfare model of practice (i.e. risk management and strength-based). The participants describe this shift as a positive move towards engaging in clinical practice. The key areas they identified with respect to supporting the engagement of clinical practice included the strength-based approach, managing for risk and the implementation of Differential Response.

A) Strength Based Perspective and the DR Framework

As the child welfare field moved away from a deficit-based model with focus on risk avoidance to a strength-based approach involving client feedback and opportunities for considering various theories to inform practice, this increased the potential for engagement in various clinical interventions.

P1 believed that Differential Response was a significant factor contributing to support for clinical practice. She stated that she likes the concept of, “... Differential Response with respect to building a therapeutic relationship between ... yourself and your families... engaging [clients], and talking about [their] strengths.” She stated that

the previous philosophy under ORAM typically told a family how to raise their children and clients did not respond well to that.

P2 sees a strength based practice as inviting opportunities to learn from research and to incorporate different ideas into the work. She referred to research that speaks to the strengths and resiliency of children under very challenging circumstances.

We focus on ... all the harmful effects of abuse, and we need to do that because we need to know how to address it. But then we look at the kids who have successfully managed some very difficult times, very horrendous situations with strengths and ... we don't ask the question how did you do that? What strengths did you exhibit? ... How was it that what happened to this other child devastated them; what happened to you ... didn't have the same impact? What is it about you that allowed you to ... navigate through this difficult time?

Here P2 points out that researching resiliency and why children do well in difficult circumstances is an opportunity to learn more effective service delivery as we strive to replicate with other families what is working as we implement the clinical process.

Many of the participants expressed a level of comfort with DR and the strengths-based approach to practice because they identified that they worked in a similar manner before the implementation of ORAM. The participants noted that they used similar mapping strategies and approaches but there was no name given to these approaches at that time. Some of the participants feel they have come full circle to the clinical practice they once implemented.

One of the participants, P2, felt strongly about the need for child welfare work to take a risk management approach to the work as opposed to risk avoidance approach. She felt that this has been possible with the implementation of Differential Response and strength-based practice. P2 stated, “I’m of a belief that risk to children needs to be

managed ... not avoid[ed].” Further, P2 explained how a risk management philosophy supports clinical work. She stated, “....if you’re talking about risk management and you’re looking at factors and variables and resiliency then there’s a lot more room for clinical practice, there’s a lot more room for theories, for approaches, for looking at research.”

P1 stated DR is a framework for practice that reintroduced clinical practice to child welfare work and supports a philosophy of risk management. Further, P3 stated, “I think that we are making some strides in that direction [of being clinical agencies] ... Our agency now is looking at ... the Signs of Safety [model],” which supports DR. As an example of this P5 stated that, “Our current model [DR] does allow for some more intensive work on the front end. So even just having the initiation of service first month in ongoing now acknowledges something that wasn’t acknowledged say even three years ago before that. So that’s a start.”

The strength based perspective and the DR framework allows for assessments, alternative approaches, client involvement and feedback that was largely absent under the prescriptive practice of ORAM, thus better supporting engagement clinical practice.

3. DELIVERY OF SERVICE

Service delivery in child welfare has shifted over the years to support the philosophies of a Differential Response model. DR’s clinical objectives are its strength-based and collaborative approaches which promote client inclusion as discussed previously. The success of DR requires workers to have a wide range of clinical skills

which includes a solid knowledge base, the ability to formulate assessments, and an ability to build relationships with clients and communities for optimal engagement in clinical practice.

A) Worker Skill

Participants identified the skill level of the worker to be an important factor in their ability to carry out clinical practice, in terms of their assessment skills, knowledge base and relationship building efforts.

P5 noted that workers who are able to identify the assessment frameworks they apply to their work are better able to replicate successful interventions with families and apply their assessment skills and clinical knowledge to further their clinical practice. She stated that supervisors and workers carry assessment frameworks around in their heads and workers can improve their assessment and writing skills to better inform their practice. She stated, “we have to be really skilled at identifying, naming, recognizing those little bits of change. Because ... it may not be a whole lot of the particular programs we offer, that makes the change, [but] it’s the naming, acknowledging, validating, catching that first little bit of change that leads to the hope that [clients] can ... change.”

P5 further identified that increasing a workers knowledge base was an additional factor that support good clinical practice. Child welfare deals with a diverse population with multi-level needs. Therefore, she saw the need for workers to be trained in a variety of areas. This would mean that a worker should learn about mental health, child development, drug use and more. She explained that a worker who has, “... a high level

of clinical skill ... [will] try and engage a client ... to facilitate change ... using their knowledge of conflict resolution ... to get closure of a case faster than if [they are] not taking a clinical approach...” She also felt that it was important for workers to look for opportunities to work with the client’s agenda and what they need. She explained that, “There may be layers of work and we may be doing different things at different times [but] need to meet our responses on what [the client] is ready to work on.”

P2 stated that, “...one of the key components ... of clinical practice is relationships ... the ability to build a relationship with someone, a professional relationship, [and] a supportive relationship ...” She explained that some of her best work as a front line worker came out of the relationships she had developed with her clients. She provided an example of what a relationship building opportunity might look like. She stated that she would take time to get to know the client and ask them about their lives as per the following:

To ask them how they’re doing, to drop in and not on a purposeful visit necessarily, but to drop in and talk to them without having to say I got a complaint or I’ve heard this, or I’m here because; just to say can I meet with you just to see how things are, just to drop in and to form those bonds ... And when you form those bonds, people become more receptive because they see you in a different light and then ... you have a lot more ... opportunity for clinical practice, for introducing ideas to people that they’re more receptive to.

P2 described the importance of client engagement and relationship building to achieving good outcomes for families. If we’re looking at better outcomes we have to ... be more clinical. If we’re looking at making significant, long lasting change then slow change is permanent change. So then we have to take a more clinical, a more well-paced approach ... to resolving some of the issues that our families are dealing with.

P3 believed that there should be more time allowed for visiting with clients. She stated that clinical work is, “...all about engaging and being out there and meeting your families and having time.”

Participants also believed that having the skills to mobilize the community resources to get them on side with child welfare work would enrich the clinical process. P1 felt that the idea of community capacity building was important to clinical practice, “...because it would ... alleviate some of the pressure on [CASSs].” Additionally, P4 believed that the development of resources both internally and externally would support prevention work with families and increase client engagement for an improved working relationship. She stated the following:

If we do more preventative work within the community or expand that role so it's not just ... reactive, and [give] families ...options [and] ...more concrete supports [such as] counseling, food vouchers, resources ... to address their needs ... [then] .. [we are] not just involved when things happen.

Finally, P5 discussed the need for child welfare agencies to develop community partnerships. She believed that, “...we could have more effective clinical social work practice by having better partnerships with our community providers, or other service providers. Collaborative efforts, therefore, would enhance case planning and increase service delivery to better support clients through the clinical process.

DISCUSSION

This study set out to examine the experiences of child welfare supervisors and their front line workers in carrying out clinical social work practice in a child welfare agency. The key areas explored included the participants’ definitions of clinical practice, barriers which decreased the likelihood of engaging in clinical practice and enabling factors which increase the likelihood of engagement in clinical practice. From these three areas, a number of themes emerged which included case load management, support for front line workers, delivery of services, and the philosophy of the agency. These three key areas and the emerging themes identified in the findings are explored further below.

Definition of Clinical Practice

While there is limited literature describing the nature of clinical social work practice in a child welfare setting, participants’ in this study defined clinical practice based on their experiences and understanding of how it relates to their work. Their definitions identified the use of clinical skills such as assessing, facilitating and planning; the establishment of goals; the use of theories to inform practice; and the measurement of outcomes or change. This description offered by the participants was consistent with themes noted in some of the literature that defined clinical practice, (Ferguson, 2003; Goldstein, 2007; Simpson, Williams and Segall, 2007).

Simpson, Williams and Segall (2007), noted that inherent in the definition of clinical social work practice is the need for workers to have clinical skills. As well, the goal oriented nature of clinical practice was viewed by participants to be pivotal to

clinical work as it set the stage for measuring client outcomes and change. The Registry of Clinical Social Workers refers to the diagnostic function of clinical practice and its prevention and treatment objectives (Goldstein, 2007).

Absent in the participants discussions of clinical practice was reference to the clinical process about how clinical practice is implemented and the actions, procedures or methods used to carry out this practice. Clinical process involves the actions taken to achieve the goals. It can involve the collaborative process between the worker and client (Simpson, Williams and Segall, 2007) or the approaches and interventions utilized in the process such as strength based approaches (Brun & Rapp, 2001; Turnell & Edwards, 1999) solution focused therapies (Iveson, 2002; Dumbrill, 2007), and resiliency approaches (Barenkin & Khanlou, 2008; Black & Lobo 2008), to name a few.

While participants supported the use and importance for clinical practice in child welfare, they noted that there have been few or no discussions at their agencies of what defined clinical practice or how it differed from non-clinical practice. Since the field transitioned from a child protection and risk focused model to a child welfare and risk management model (Parton, 2006) participants felt the field was ill prepared to adopt the new system and there was inadequate training for front line workers to accommodate the changes. A number of the participants described how change to a more clinical practice was “thrust” upon everyone without much thought to its implementation or its impact.

Interestingly, participants believed that goals centering on meeting standards and the reactive and crisis oriented nature of the work were not seen as being clinical while client-centered objectives, strength-based approaches, engaging with and building

relationships with families and reflecting on the work, were viewed as being more clinical in nature.

Generally the former Ontario Risk Assessment Model (ORAM) was viewed as not being clinical because it was prescriptive, reactive and dismissed the input of families in the planning process and disregard the use of theories to inform practice. The current Differential Response model (DR) was viewed as being more clinical because it encouraged the use of strength-based approaches, evidence-based research to inform practice and the use of a “theoretical knowledge base that is central to all clinical social work education,” (Simpson, Williams and Segall, 2007, p. 7)

Undoubtedly, further work at the agency level to define and clarify clinical social work practice would help to set the stage for a deeper understanding of the fit for clinical practice with child welfare work and how to implement it and maximize it’s usefulness in light of the many constraints and challenges with its implementation.

Barriers Decreasing Likelihood of Engagement in Clinical Practice

There were common descriptions among participants that identified barriers to clinical practice. These barriers related to case load management, the support offered to front line workers and the delivery of services as described below.

Case Load Management

The issue of case load management was seen as a significant barrier to clinical practice because managing cases is subjected to the rules and regulations guiding child

welfare work. Maintaining standards was seen to play a key role in creating barriers for workers to implement clinical practice in the management of their cases because it impacted on time allotment and meeting administrative expectations that might be in conflict with the client’s needs or goals.

Where there was tolerance for deviation from standards and allowances made for flexibility of timelines or paperwork and a greater tolerance for managing risk, there was generally a greater likelihood of implementing clinical practice into the work. Where there were instances of fear of liability, inflexible rules, permanency considerations and rigid documentation requirements, this decreased the likelihood of engaging in clinical practice. The pressure to rush through case transfers to meet time lines, the rigid standards and the emphasis on accountability tended to interfere with the flow of clinical practice according to participants.

The pressure to meet administrative requirements and policy directives was noted by Smith and Donovan (2003) to be a significant factor compromising a worker’s ability to engage in clinical practice. This notion is supported further by Green and Tumlin (1999) who identify the intrusive child protection mandate, time constraints, high work load demands, untrained workers and funding cuts as just some of the factors which pose significant barriers to implementing a clinically based practice.

Research speaks to the fact that work load pressures to meet standards, causes worker’s to deprioritize their work with families, (Courtney, 2000; Anglin, 2002; Smith and Donovan, 2003; and Altman, 2008). Further, Altman (2008) notes that “role overload” leads workers to struggle to be available for their clients. Paper work, court

dates, meetings, and other tasks make it difficult to help parents because there is “too much case work” (Altman, 2008, p. 54).

Support for Front Line Workers

A number of participants believed that the emphasis on clinical training and education of child protection workers should start as soon as possible upon entering the field and that existing practice training needed to be richer in clinical content. This concept is supported by Bellefeuille and Schmidt (2006) in their research on social work education and child welfare practice. The authors note that child welfare is a complex field full of challenges and they believed that child welfare employers and educators need to examine content of education to better prepare workers to enter the field.

A second aspect of skills, training and knowledge base involved the participant’s belief that supervisors needed to be skilled in clinical work and model good interaction. With proper skills, supervisors can recognize and nurture the skill and individual strengths of workers. Conversely, supervisors who focus on a worker’s deficits and do not nurture their strengths may jeopardize the worker’s engagement in clinical practice.

Until recent years, supervision in child welfare has been inadequate to support clinical practice. Participants noted that “doorway supervision” or quick consultations that bypass clinical discussions and reflection was not conducive to supporting clinical practice. The participants identified that if supervisors discounted the value of clinical work, workers will tend to do the same. This threat is real when supervisors are on overload and demands on their time force supervisory discussions with workers to be

focused on safety issues and meeting standards. This concept is consistent with Strand and Badger’s (2007) findings that the administrative focus of supervision, like ensuring paperwork and accountability issues are addressed, has been given priority over client contact and clinical discussions of direct service to clients.

Another aspect of support to front line workers included the issue of funding. Participants discussed how funding to child welfare agencies can hinder engagement in clinical practice. They believed that the funding is not adequate to support the changes brought forth by the Transformation Agenda and DR. The current Funding Framework (Ontario Association of Children’s Aid Societies, 2002) in child welfare is dependent upon case volume where numbers drive funding.

Complex case work or additional work like court work or coverage work is not recognized in the funding framework. When case loads are down, funding is reduced despite work loads being heavy. Additionally, participants outlined the need for support services and cultivating community partners as key factors in supporting a solid clinical practice in the field and these efforts require funding to establish these services. Some participants worried that without a comprehensive review of the funding framework, the ability of workers to adequately address the needs of their families will continue to be compromised.

The issue of funding inadequacies was consistent with research described by Bellefeuille and Schmidt (2006). The authors described the tremendous pressure placed on administrators of child welfare agencies to address inadequacies in the system and to

meet growing demands of the work. The authors described how budget constraints result in inadequate resources to address the needs of complex family systems in child welfare.

The Ontario Association of Children’s Aid Societies (OACAS) progress report of 2002 spoke of the need for the funding framework to allow for greater flexibility and to take into account the unique needs and circumstances of the individual agencies. Their follow-up report in 2006 noted that the new funding model under Transformation and DR continued to be inadequate to incorporate the changes recommended and these funding deficiencies ultimately impact the support available to front line workers.

The paper argued that initial financial investments in prevention programs and the development of community resources to support child welfare work will ultimately reduce the need for intrusive or reactive child welfare intervention in favour of a more reflective and clinically based approach.

Delivery of Services

The participants noted that in delivering services to clients there were a number of blocks encountered. The top three areas noted included the perceptions of CASs by clients and the community, worker’s skepticism and lack of faith in the system and the intrusive protection mandate and crisis oriented nature of the work. In keeping with this concept, Altman (2008) noted that parents expressed difficulties with interacting with child welfare professionals in clearly understanding their roles and functions. She also noted that many parents mistrust child welfare services and do not feel that the system is helpful or on their side.

This concept is developed further in the research by Dumbrill, 2006 who examined parent's experiences of what it is like to be on the receiving end of child protection services. He found that workers and policy makers need to be aware of the impact that the use (or misuse) of power has on the worker-parent interaction. Some parents noted fear of the worker and agencies' power and made claims of being misunderstood.

Typically, parents or caregivers come to the attention of child welfare agencies, “...through a judgment of their failures as caretakers, with goals too often selected and imposed on them by the child welfare system” (Altman, 2008, p. 56). Therefore services in child welfare are often involuntary, reactive and driven by a crisis situation that necessitated CAS involvement. If the parent or caregiver does not wish to engage in services this poses significant challenges to the engagement and relationship building process characteristic of clinical practice.

The participants noted that workers have expressed feeling negative about their work when they believe that clients have preconceived notions of CAS and that as workers they feel they cannot make a difference. This negative perception and skepticism affect a worker's ability or desire to engage in the clinical process.

The participants also noted that workers are feeling frustrated that the changes in child welfare have been dramatic and they are reluctant to fully immerse themselves in a new practice as they believe that something new is just around the corner. It is challenging to realign a value base (i.e. from risk based to strength based) and to make the shift with the uncertainty of further changes pending.

This skepticism is similar to Camilleri's (1999) research on social work and its search for meaning as he writes about “a crisis in confidence affecting not only sponsors of social work but social workers themselves” (p 25). Camilleri reviewed conflict with the managerial nature of social work and a reevaluation of what constitutes social work practice. He concluded that reestablishing a solid value base in social work requires a practice approach and is about “developing a language of practice which provides for a recognition of the skilful activity of the work and the ‘empowering’ of both the recipient and practitioner ...” (p.37).

Further, the participants have identified that the intrusive child protection mandate and the reactive and crisis oriented nature of the work make it difficult for workers to hone in on clinical skills. The concept of the child protection mandate conflicting with servicing families according to their needs is consistent with numerous researchers who have written about these competing demands (Anglin, 2002; King, et. al, 2003; Dumbrill, 2006; Parton, 2006; Altman, 2008; Dill, 2009; and others). Often when a worker is obligated to make a decision for a parent affecting the safety of a child in which that parent may not be in agreement, this will decrease the likelihood that the client will engage in a therapeutic relationship with the worker.

Enabling Factors Increasing the Likelihood of Engagement in Clinical Practice

There were common descriptions among participants that identified factors which enable clinical practice. These enabling factors related to case load management, the philosophy of the child welfare agency and the delivery of services as described below.

Case Load Management:

A number of participants discussed how there is a greater sense of tacit permission from upper management and the Ministry in implementing various approaches or practices to managing child welfare case loads which would not have been possible under the prescriptive model of the ORAM. Some participants noted that the ministry standards allow for greater flexibility with respect to compliance and this facilitates the process of allowing time for more client contact.

Participants expressed a high degree of comfort with using DR and its support of greater client engagement and relationship building approaches. They discussed how DR promotes an increased tolerance for risk or a redefining of risk. As the focus has shifted from looking for deficits in a client to looking for strengths, the capacity for implementing clinical practice became opened to more theoretical approaches which could be incorporated into practice that supports client change.

Unlike ORAM, the DR model promotes client involvement, feedback and client participation as being central to the transformation agenda. One participant noted that you can't do the job under the new transformation framework without clinical skills. They identified the need to develop relationships with people and the ability to facilitate change is dependent upon client engagement and relationship building success.

Further, just as certain aspects of supervision were identified to be barriers to clinical work, other aspects of the supervision process were seen to increase the likelihood of engaging in clinical practice. Supervision was seen by the participants to be a key area which could promote and support clinical social work practice in child welfare

and serve as the bridge between front line workers and upper management. Supervisors play an important role in the training and development of front line child protection workers. A number of participants referred to the parallel process (Berg, 2003; Shulman, 2005; Dill and Bogo, 2007) as an opportunity to transfer skills and knowledge by mirroring good interaction with the worker who can then use these skills with their clients. This requires supervisors to be well trained in clinical practice.

Berg (2003) identified the need for more training for supervisors, indicating that generally supervisor training in the past has consisted of modeling former supervisors. One participant noted the need for supervisors to remain open to continuous learning, to be open to listening to workers, to be available to them, to help them put a theoretical context to their work; to help them look at assessment frameworks and to keep theory alive in their process of establishing a clinical practice.

Philosophy of the Agency

The participants discussed how the philosophy of a strength-based approach and Differential Response (DR) contributed to supporting clinical practice as it promotes practices and approaches geared to engaging with clients and supporting them in change by allowing them more input into the planning process. Working collaboratively with clients and building relationships, therefore, was seen to increase their participation with services and create conditions in which they will be more likely to achieve positive change and not require child welfare services in the future. The concept of collaborative work between worker and client is supported by research as helping to increase the

likelihood that clients will engage in services with more successful outcomes (Maiter, Palmer & Manji, 2006; Ruch, 2006; Mykota, 2008; Altman, 2008).

Delivery of Services

Many of the participants discussed how clinical work with families in child welfare required the support of community partners to bridge service gaps. These community partnerships were thought to move clinical work with families forward as better community partnerships were believed to lead to more effective clinical practice. This concept is supported by Altman (2008) who found that workers identified the need to have the support of community based services in effort to more effectively engage with families. Further, Altman (2008) found that parents in her study discussed how reunification efforts with their children were compromised by not having appropriate and available resources or services.

The skill of relationship building efforts and supporting the clients with what they are ready to work on can facilitate change even where the clients may not have chosen to interact with CAS and will lead to better outcomes. Client engagement establishes an agreement between the client and worker to work together. Altman (2008), reports that client engagement is a process that “...creates an environment of warmth, empathy and genuineness that enables a client to enter into a helping relationship and actively work towards change” (p. 43).

Further, Altman (2008) presents evidence which supports the importance of client engagement in the helping process in child welfare. She refers to research which has

shown that client engagement will result in a decrease in referrals to court, an increased likelihood that parents will maintain custody of their children, a higher likelihood that parents will be reunited following a separation and greater likelihood that parents will participate in treatment planning (p. 44).

Further to the issue of improved service delivery is the support of management as it embraced organizational change. This is a process which involves a restructuring in the mission or functioning of an organization and is often a fundamental or radical reorientation in the way an organization operates (McNamara, 2008). Usually the change is a strategy to accomplish an overall goal and it typically meets with resistance as people are afraid of the unknown or they don't understand the need for change (McNamara, 2008). In order to facilitate the process of organizational change, McNamara (2008) discussed the best way to do this is for the organization to sustain communications with its employees, offer training and ensure that the organizations top level of management, including the board and executive are involved in the process.

Participants in this study noted that child welfare organizations underwent a radical change with the implementation of Transformation and DR. Though the implementation of organizational change is continuing to present significant challenges, participants' noted that support from upper levels of management for clinical practice is growing and there is much enthusiasm and support from management for implementing clinical initiatives. At the same time, participants further noted that workers who were motivated, enthusiastic and invested in embracing clinical work were more likely to gain

support in introducing clinical approaches to their work as upper levels of management saw value in these clinical approaches.

As upper levels of management and front line workers engage in a symbiotic process of showing energy and inspiration for clinical practice, this filters through the system as workers inspire supervisors and managers who in turn inspire workers to continue the clinical work. When workers are supported and feel validated in what they do, this encourages them to be more creative in their work and embrace the clinical process. Likewise, supervisors and managers become motivated to support and promote clinical initiatives.

Implications for Clinical Practice in Child Welfare

Central to the issue of clinical practice in child welfare under the current philosophy of the Transformation Agenda, is the need for agencies to develop the conditions that promote such clinical work to be undertaken. This is an enormous task as it involves establishing a careful balance between ensuring the mandated obligation of keeping children safe while also engaging and empowering parents and care givers, who may have harmed their children, to continue in their parenting role. The enormity of the task of successfully achieving this balance cannot be underestimated.

In examining the barriers and possibilities of engaging in clinical practice in child welfare, the findings based on the participant's responses suggest that while considerable efforts are being made by upper levels of management and the Ministry to engage in clinical practice, just as many barriers halt the process of the flow of clinical work.

With a need to rebalance and refocus child welfare work to be more supportive of families and children, there is also emphasis on the need for more collaborative work and engaging families and communities.

Interestingly, in the participants’ discussion of the ideal setting to promote clinical work, the discussion of funding did not play a major role. This suggested that there may be an acceptance or a tacit understanding that because so much emphasis has been placed on funding restrictions and cut backs that any discussion of redesigning or increasing funding would be futile as funding changes are not likely to be implemented. It is interesting that one participant noted that increased funding at the front end to promote preventative services may reduce the financial burden that may result from the absence of services necessitating children coming into care.

The participants also discussed the importance of the culture of the agency in implementing clinical practice. Participants believed that having the right kind of culture within the agency was a significant factor contributing to the support and implementation of clinical practice. Some participants, for example, noted that where there is a greater sense of permission from management to incorporate alternative practices and manage for risk, there is a greater likelihood for engagement in clinical practice.

The crucial element of ‘time’ factored prominently into the discussion to increase capacity and promote conditions for clinical work. Many suggestions were made to increase availability for client time which included more expedient replacement of workers to fill vacancies, possibly via the implementation of a trained floater team ready to fill in the gaps; reduced work loads by case reduction, streamlining documentation and

accounting for case complexity; and greater flexibility and review of Ministry standards that are more conducive to and compatible with the goals of the transformation agenda.

One further and very important concept identified as a contributing idea to supporting clinical work in the field is to involve clients at higher levels of the agency to participate or have input into policy development and input into services affecting them. Taking the opinions of the families and workers into account and allowing them to be involved in policy planning was believed to be beneficial in increasing the successful outcomes of clients. A qualitative study conducted by Dumbrill & Maiter (2003), explored the feasibility of having clients help design and evaluate child protection services based on their experiences. The study found that parents' participation and progress with services was improved when parents and workers were directly involved in the planning and service designing and implementation process.

Overall, the participants relayed messages of hope and support for clinical practice to evolve and permeate the child welfare system. Participants saw the paring of clinical social work practice and child welfare intervention as “a necessary fit”, “a challenging fit”, “a tense marriage”, “a tough fit” and “a tricky dance”. But each of the participants recognized a place and need for clinical practice in the field. The power/authority role, the safety/empowerment objectives; the client contact versus ministry requirements and the building of relationships with clients who are often involuntary or resistant to services are not mutually exclusive in relation to one another; instead, these tensions require thoughtful and deliberate balance to ensure the successful implementation of clinical social work practice in child welfare work.

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Appendix A

Letter of Information /Consent

Clinical Social Work Practice in a Child Welfare Agency: Barriers and Possibilities

Student Investigators: Carmen Thivierge
Graduate Student: Master of Social Work
905-522-1121 Ext 6170 (work)

Student Faculty Advisor: Dr. James Gladstone
School of Social Work
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 23786

Invitation to Participate & Purpose of the Study

If you are a child welfare supervisor managing a team of front line child protection workers, you are invited to participate in a research project examining clinical social work practice in a child welfare setting.

The goal of this study is to develop a better understanding of how child welfare supervisors and their front line workers manage the tensions between the demands of their clinical practices and the administrative requirements.

Procedures involved in the Research. What will happen during the study?

As a participant in this study, you will complete one 60 minute interview. I will conduct the interview at a time and place of your choosing. With your consent, I will take notes and tape the interview so it can be transcribed to accurately reflect your views.

I may ask you questions like the following: In what ways does your agency support clinical practice? In what ways does your agency create obstacles to clinical practice? Do you consider child welfare agencies to be clinical organizations? What do you see as being helpful to bridge the gap between clinical practice objectives and administrative expectations? As we talk, the questions I ask may change slightly based on our discussion and you will have an opportunity to provide information you feel may be relevant.

Potential Benefits. What good things could happen if I participate?

Your information will contribute to developing a better understanding of implementing clinical practice in a child welfare agency and thoughts for improvements. This

information could also be useful at the management and Ministry levels. Your feedback could help guide policy recommendations for practice. It could also influence discussions to promote change to better support clinical social work practice in child welfare agencies.

Potential Harms, Risks or Discomforts: Will anything bad happen during the study?

It is not likely that there will be any harm or risk associated with this study. Some of the discussions may make you reflect on situations or experiences that have created a strong emotion for you. This may cause some upset or discomfort. You may feel frustrated as you relay information about challenges and tensions you have encountered in your work. You may also worry about how others will react to what you say.

You are not obligated to answer any questions that make you feel uncomfortable. Your participation is voluntary and you can choose to skip questions or to end the interview at any time. You are in control of the process. If you decide that you need further support or assistance, I will provide you with contact phone numbers where someone will be able to help you. I do not anticipate that you will be exposed to any risks other than those you may encounter in the normal course of your day in chatting with co-workers about your work experiences. I describe below the steps I am taking to protect your privacy.

Confidentiality: Who will know what I said or did in the study?

Your identity will remain confidential. Your privacy will be respected. Your name will not be used in the study and I will not include any data which may allow you to be identified. I will be using code names to identify the participant's. The information I obtain will be kept in a locked filing cabinet in my home. Only I have access to this cabinet. When the study is completed, all tapes, notes and transcripts will be destroyed. I will change any information that you provide which could reveal your identity.

Information about the Study Results: Study Debriefing

If you are interested in the study results, please let me know at the time of the interview and I will forward you an electronic PDF summary. I expect the study to be completed by November or December 2009.

Information about Participating as a Study Subject

If you have questions or require more information about the study, please contact me, Carmen Thivierge, at 905-522-1121 Ext 6170 or email me at thiviecc@univmail.cis.mcmaster.ca. You may also contact my research advisor, James Gladstone at (905) 525-9140 ext. 23786.

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

CONSENT

I have read the information presented in the information letter about a study being conducted by Carmen Thivierge of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time.

I acknowledge that I have been given a copy of this form.

I agree to participate in the research study by participating in the interview. Further, with respect to

1) Audio-taping the interview:

- a) I agree to the audio-taping of the interview; _____ or,
b) I prefer that the interview not be taped _____

2) Note taking by the interviewer.

- a) I agree to notes taken during the interview: _____ or,
b) I prefer not to have notes taken _____

Name of Participant

Date

Further, I acknowledge that I would like to receive a summary of the research results and provide the following contact information for receipt of this document:

Signature

Thank you but I am not interested in receiving a summary of the research results
(Check here) _____

Appendix B

INTERVIEW GUIDE

Clinical Social Work Practice in a Child Welfare Agency: Barriers and Possibilities

These interview questions form the basis of the questions to be asked. However, they may vary slightly depending on the content of the information provided by the participant.

1.) How long have you worked in child welfare? What is your background in clinical social work practice? What position do you currently hold?

(Probe for the type of service the participant provides, their clinical experience and general work history)

2.) How do you define clinical social work practice?

3.) Do you consider child welfare agencies to be clinical organizations? In what ways are they clinical and in what ways are they not clinical. Please explain your answer.

(I am probing to see how participant views the nature of the child welfare agency. Do they separate clinical work from child welfare work? What are the strengths and barriers presented by agencies in carrying out clinical work?)

4.) Tell me what your thoughts and experiences are about the fit between clinical social work practice and child welfare work?

(I will probe for the participant's ideas about how clinical practice and support to clients can be achieved in child welfare work that is largely intrusive, involuntary and imposes significant administrative expectations)

5.) What conditions at your agency enable you and your front-line workers to apply clinical skills? Please explain.

(I am looking for what promotes clinical work and the strengths the agency offers to promote client-centered work. What are the things that support clinical objectives of client support, advocacy, empowerment and autonomy?)

6.) What conditions at your agency serve as barriers to you and your front-line workers in the use of clinical skills? Please explain.

(As in number 5 I am looking for what interferes with carrying out clinical work. Where are the barriers? How does the participant or their front-line workers define and

experience them? What is their perception of how the client may be experiencing the service?)

7.) Do you feel child welfare agencies should be clinical settings? Why? Why not?

(What are the participant's thoughts about the work they and their front line workers perform? Child welfare agencies have shifted from imposing prescriptive practice to encouraging a more worker autonomy. The shift from a deficits based or risk focused approach to one of strengths-based has called for the need for more clinical skills. How are the participant's and their front-line workers adapting to the changing approaches to practice?)

8) In the ideal child welfare setting, what would you and your front-line workers need to carry out your work that is not presently available? Alternatively, if the agency presently provides you and your front-line workers with everything you need to carry out the work, describe what these supports would be?

(I am probing for a description of the participants ideal work environment in their child welfare agency. Ideally, how to they perceive themselves and their front-line workers being best supported to carry out their work. Is their focus more risk-based or strength-based? Do their front-line workers respond better to an autonomous work environment or do they prefer more direction? Do the participants support clinical practice and do they feel it is possible in a child welfare agency?)

9) Assuming that we are trying to promote clinical social work practice in child welfare work, describe the top three changes you would make and why?

(What would make clinical social work practice more effective in child welfare agencies based on their experiences and those of their front-line workers?)

10) Do you have any questions for me based on our conversation?

(I want to give participants the opportunity to pose any questions that have emerged for them as a result of participating in the conversation. It would be helpful to know if the conversation was beneficial to them in any way in helping them to focus their thoughts or express their ideas.)

Appendix C

BARRIERS OUTLINE

Factors Decreasing the Likelihood of Engagement in Clinical Practice

1.) CASE LOAD MANAGEMENT

A) Maintaining Standards

- I. Rules and Rigidity
- II. Accountability and Liability

B) Time Constraints & Response Time

- I. Administrative Responsibilities
- II. Documentation

C) High Case Loads

2. SUPPORT FOR FRONT LINE WORKERS

A) Worker Skill & Training Needs

B) Supervision

C) High Turnover

D) Funding

3.) DELIVERY OF SERVICES

A) Client and Community Perceptions of the CAS

B) Worker's Skepticism

C) Protection Mandate

- I. Involuntary Service
- II. Reactive and Crisis Oriented

Appendix D

ENABLERS OUTLINE

Factors Increasing the Likelihood of Engagement in Clinical Practice

1.) CASE LOAD MANAGEMENT

A) Case Load Size and Complexity

B) Support of Management

C) Supervision

2.) PHILOSOPHY OF THE AGENCY

A) Strength Based Perspective and The DR Framework

3.) DELIVERY OF SERVICE

A) Worker Skill