Assessing Readiness of Clinical Social Workers: Using the American Board of Examiners' Conceptual Model

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Abstract

This study examined the practical use of the American Board of Examiners' (ABE) Conceptual Model for assessing clinical social work trainees' readiness to become independent licensed clinicians. At present, licensure standards including completion of supervised practice hours, attestation of competence by a supervisor, and passing a national licensure exam are the sole determinants of readiness for independent practice. The ABE Conceptual Model identifies practice expectations for clinical social work. The study analyzed their effectiveness in determining the proficiency of trainees. Nine pairs of supervisors and supervisees from Northern Minnesota used the ABE Conceptual Model in assessing trainee readiness for independent practice of clinical social work in a supervisory context. The results indicated that practice expectations of the ABE Conceptual Model assisted in determining competence of autonomous clinical social work practice. The participants reflected on the importance of having a common understanding of proficiency determination at all phases of supervision. Ancillary analysis reiterated the significance of contextual factors in effective supervision.

Table of Contents

Abstract i

List of Tables v

Chapter 1: Statement of the Problem 1

Research Questions 2

Significance of the Problem 2

Conceptual Framework 6

Social experiential learning. 6

Developmental theory. 8

Ecological systems theory 10

Operational Definitions of Terms. 11

Assumptions 13

Chapter 2: Literature Review 15

Conceptualizing Competence in the Social Work Profession. 15

Overview of the development of the social work profession in the US..........16

Critical influences: professional beginnings and challenges 19

Overview of the development of social work education in the US 20

The need for trained social workers 22

Accreditation 23

Field education: signature pedagogy 30

The development of licensure levels and requirements 32

Clinical social work as a professional title 38

Competence Assessment of Clinical Social Workers 40
Supervision requirements in the US 43
Historical overview of clinical social work supervision 44
Definitions and objectives 46
Current trends in social work supervision 48
ABE Conceptual Model of professional development 50
Chapter 3. Methodology 52
Statement of the Problem 52
Research Questions 53
Analytical Framework 54
Research Methodology 54
Participants 55
Demographic information 56
Instrumentation 58
Procedure 61
Data collection 63
Data analysis 65
Summary 67
Chapter 4: Results 68
Data Analysis 69
Descriptive Data 70
Supervision context and models 70

Results of using the ABE Conceptual Model 74

Presentation of Results 76

Practice expectations in assessing readiness 76

Most explicit practice expectation 82

ABE Conceptual Model compared to other supervision practices 88

Contextual factors influencing determination of competence 88

Summary 92

Chapter 5. Discussion 94

Participants in the Broader Context 94

Themes Identified 96

Common understanding 96

Fostering communication on a continuum 99

The influence of contextual factors 102

Recommendations 106

Limitations 108

Implications 109

References 112

Appendices 121

Appendix A. Consent Form and Questionnaire One 121

Appendix B. Questionnaire Two 129

Appendix C. Questionnaire Three 133

Appendix D. Focus Group and Interview Question 134

List of Tables

1.1 Participant Profile 57

1.2 Participant Profile: Length of Licensure and Remaining Hours of Supervision 58

2.0 Supervision Context and Model 73

3.0 Percent of Agreement between Supervisor and Combined Ratings 75

4.0 Most Explicit Practice Expectations/Items 84

5.0 Impact of Supervision Type on Proficiency and Competency Rating: overall ... 90

Chapter 1: Statement of the Problem

In 2002, the American Board of Examiners for Clinical Social Work (ABE) published a position statement outlining standards for defining competent practice of clinical social work. They identified a need “to determine reasonable practice expectations for clinical social workers at different levels of professional development” (ABE, 2002, p. 1). There is limited research on professional development standards for clinical social work. There continues to be ambiguity about the indicators, which determine proficiency at a training level verses an independent practice level. Of particular concern is the assessment of readiness for advancement of a master’s level practitioner to a more specialized clinical social worker.

There is a lack of structure in the supervisory licensure process to clarify how readiness for the field of clinical social work is assessed and measured. Assessment of readiness is further compounded because of the field’s complexity. The diversity of social work settings and fields of practice complicate determining readiness for clinical social work. Clinical social work settings are varied and context-driven, resulting in variables, which impact assessment of specific skills, knowledge, and abilities. Practice settings are too diverse and complex to have one standardized tool for assessing clinical readiness for independent practice. Creating a unified assessment tool for clinical licensees which applies to all settings and fields of practice is a challenging task.

ABE’s position statement from 2002 proposed a conceptual model, which describes standards for the competent practice of clinical social work. This model compares expectations for developmental milestones at three different stages for becoming a clinical social worker. It is unclear how the practice expectations in the ABE

Conceptual Model assist in determining readiness to become a Licensed Clinical Social Worker (LCSW).

Research Questions

This study will explore the following research questions:

- How do the practice expectations identified in the ABE Conceptual Model assist clinical supervisors in assessing readiness for a supervisees' independent practice of clinical social work?
  - Which practice expectations are the most explicit in determining readiness?
  - How does use of the model compare to a clinical supervisor's determination of readiness without using the conceptual model?

Significance of the Problem

Clinical social workers provide the majority of behavioral health services across the nation (National Association of Social Workers [NASW], 2018b). The quality of services they provide will impact the overall treatment of mental health. It is vital that the services clinical social workers provide are competent and ethical.

The professional title of clinical social worker is the most advanced level of licensed practice. In most states, LCSWs are able to provide practice independently. This means they are not required to have a direct supervisor monitoring their work, allowing them to work in private practice. Determining a clinical social worker's readiness to practice independently has long been a recognized concern within the profession. There are limited assessment standards determining readiness to be a licensed independent clinical social worker.

Once a social worker obtains their Masters of Social Work (MSW) degree, they typically must take a master's level exam to obtain licensure through the Association of Social Work Boards (ASWB). The exam is an eligibility requirement for entering the clinical training track for their LCSW licensure. Advancement to a LCSW requires that the licensee must meet additional training and exam requirements. While every state has its own specific requirements, they are generally consistent. The responsibility for certifying competence for licensure is determined by state licensing agencies.

All states across the nation determine clinical social work proficiency by the fulfillment of licensing criteria. One of the main licensing requirements is completing a set amount of supervised practice hours. Supervised practice is a period of time when a licensee is providing clinical social work under the supervision of a fully licensed clinical social worker. Typically, the licensee also must meet with their supervisor for a set amount of hours in-group or individual supervision sessions. Once supervised practice and supervision hours are complete, the licensee is eligible for the clinical level exam. The supervisor's assessment and the ASWB clinical exam are the two main assessment methods of determining readiness for independent clinical practice.

The ASWB exam is currently the main quantifiable measure of readiness to become a licensed clinical social worker. The exam is a 170-item multiple-choice exam derived from a general understanding of clinical social work. The exam content is developed from a practice analysis based on data collected by thousands of clinical social workers from a variety of different practice settings. From the data collected, ASWB identifies key knowledge, skills, and ability areas for clinical practice. This information is used to develop content areas for exam questions. A significant limitation to this

assessment method is the lack of specificity to the licensee's setting or practice. The exam questions may not be relevant to the actual work the licensee is doing in their practice setting. The exam content may be too general to make an accurate determination of competence.

Measuring proficiency by a standardized exam could result in a broad, rather than specific, assessment of clinical social work proficiency for a licensee. To compensate for this limitation, licensure has also required an attestation by a licensed supervisor. This is a qualified LCSW who has provided supervision of the licensee in training. While the attestation of a supervisor creates another competence measure, it is a subjective determination of proficiency. There are no specific measurable standards guiding the supervisor's attestation of the licensee's competence.

As a final step in the process of becoming an independent licensed clinical social worker, the supervisor for licensure determines whether the licensee is ready to practice on his or her own. Becoming a LCSW certifies that the licensee is permitted to provide services in private practice without any oversight by a more senior clinician. There are no specific measurable criteria for a supervisor to make this determination. This qualitative measure is based on the supervisor's arbitrary perspective. At the onset of supervisory process, a supervision plan is developed which is generally a description of when and how supervision will occur. This includes a description of how the supervisee will be providing clinical practice and when they will meet for supervision. The supervision plan does not typically clarify what criteria the supervisor will be using to determine a licensee's readiness to move on to autonomous clinical work.

The National Practitioner Data Bank (NPDB) is a federal repository for reports of malpractice reports and adverse actions concerning licensure. The NPDB oversees health care practitioners, including clinical social workers. Within the past ten years, reports by NPDB indicates a significant number of adverse actions being filed against clinical social workers. This national trend threatens the legitimacy of the clinical social work field. It also has important implications for the assessment of qualified and competent clinical social workers. There is no specific information indicating whether the complaints involve social work clinicians in training or Licensed Graduate Social Workers (LGSW) or, if they involve clinicians qualified to provide independent licensed clinical social work practice. Many violations involve practitioners in private practice which implies these violations are occurring largely among LCSWs.

Analyzing the nature of licensure violations can guide the process of addressing problematic practice concerns. Research about licensure violations for social work identifies several concerns with boundary violations and ethical decision-making. This information can help to guide important elements that should be focused on in supervision and in the evaluation of competence. Ultimately, assessing clinical readiness for independent practice can shape the culture of supervision within the profession and clarify assessment standards within the supervisory process.

Not only does the challenge of assessing readiness exist with postgraduate training of social workers, it also exists with assessing readiness at the graduate training level. Schools of social work are also struggling to assess and determine readiness for providing clinical social work practice. The assessment techniques schools are using to measure competence will have profound implications for postgraduate training. Having a

quality assessment measures for determining competence to provide clinical social work practice is a vital gate keeping tool for the profession. A reduction in licensure violations of clinical social workers will consequently result in competent, ethical, and quality mental health treatment.

Conceptual Framework

The conceptual framework for this study is grounded in three main theories: Social Experiential Learning, Developmental, and Ecological Systems theories. These theories provide a basis for understanding how a social worker absorbs, processes, and retains knowledge to become a clinician. Determining when a social worker is at a competent level to practice as an independent clinician is the primary focus of this study. The ABE Conceptual Model is examined as a tool to assist clinical supervisors in assessing a supervisee's readiness for independent practice. The ABE Conceptual Model utilizes a set of essential practice expectations for clinical work that the supervisor uses to assess the supervisee. The supervisory relationship is central to the assessment process and is a complex human exchange between the supervisor and supervisee. Just as with all other human relationships, it can be influenced by a larger contextual system. Cognitive, affective, and environmental processes all have an impact on the development of a clinician. This is particularly due to the emphasis on learning through modeling and self-reflection in a supervisory relationship. Each theory will be explained in relation to the research question and main principles of the theory.

Social experiential learning. Clinical social work supervisees gain knowledge by providing services under the guidance of a senior clinician. Assessment of their competence is typically based on scrutiny by the supervisor. Reflective feedback about

the supervisees' performance is provided for improvement, once integrated into the supervisee's practice and moves towards competence. The supervisor is ultimately responsible for making a determination of competence with the supervisee's clinical social work knowledge, skills, and abilities. The determination is often based on the supervisee's performance of work the supervisor has modeled to them. Supervisees learn the work by observing others and integrating what they observed into their own practice. David Kolb's (1984) Experiential Learning Theory argues that learning is a "process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping experience and transforming it" (p. 41). A clinical social worker's achievement of becoming an LCSW is a process of observation and incorporation of what they observed into their own practice. Learning in the supervisory context is primarily based on the supervisee's practice experience. Obtaining licensure is not just a matter of taking an exam to demonstrate knowledge of clinical work. Instead, a supervisee is under observation of a clinician who has mastered the essential practice expectations for clinical work. The ABE Conceptual Model explicitly describes the key knowledge, skills, and abilities required to become a competent independent clinician. The ABE Conceptual Model describes what the supervisee needs to experience, and what the supervisor must observe the supervisee do in order to become a competent clinician. In essence, it specifies the experiential learning that must occur to advance towards independent licensure. Experiential learning is at the heart of supervision for clinical social work and the research question being explored.

Social Learning Theory posits that learning occurs through observation, modeling and imitation. Albert Bandura (1977) explains,

> Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action. (p. 238)

During the 2 year period of supervision for licensure, a social worker observes and receives feedback from a more senior clinician providing services. Much of a supervisee's learning occurs through observation and practice in the field. The supervisor is a sounding board or guide for knowing whether the supervisee is accurately demonstrating particular knowledge, skills, or abilities for clinical social work. Given the nature of the supervisory relationship, social learning, and experiential learning theories are inherently a part of how a social worker develops into a clinical social worker.

Developmental theory. Supervisors are intrinsically in the role of observing the developmental process of a supervisee. Particularly due to their responsibility of determining when and if a supervisee should advance into a higher level of licensure. The profession depends on their judgment for advancement. As previously explained in the *Problem Statement*, different stages of the supervisee's development to becoming a clinical social worker are not always clearly defined causing the determination of competence can be very subjective by the supervisor. The ABE Conceptual Model attempts to articulate proficiency or practice expectations at different developmental stages of competence. Given the stages that are identified and clearly explained, the ABE Conceptual Model is grounded in developmental theory.

Psychologists, Sigmund Freud, Erick Erickson, Jean Piaget, and Lawrence Kohlberg are the pioneers of developmental theory (Overby, 2016). They have helped to describe physical and psycho-social development in a series of stages. Within each stage, people exhibit common patterns of behavior and different capacities, building on the previous stage. The concept of stage development was well established by Erick Erickson (1950) with successive levels of differentiation from childhood to adulthood. He argued that all children move thorough eight stages of development in order to become an adult. Similar to psycho-social development a supervisee also proceeds through successive stages of becoming a clinician. The ABE Conceptual Model identifies the patterns of behavior and capacities at different stages of advancement, which are necessary to become an independent clinical social worker. The descriptors for each stage clarify standards that the supervisee needs to learn for full advancement towards LCSW licensure. These learning standards or competencies also point to a developmental process occurring within the supervisory context.

The similarity between the ABE Conceptual Model and competency-based education will be discussed to further explain how developmental theory is foundational to this study. The practice expectations detailed at each stage of development with ABE Conceptual Model are similar to competency-based models in academic settings. Norris (1991) explores the philosophical foundations of competency-based education. He explains that with a behaviorist construct competence is treated as something a person is or should be able to do. It is a description of action, behavior, or outcome capable of demonstration and assessment. Students are observed in practice to determine if they are able to perform certain skills with adequacy. The ABE Conceptual Model details

necessary knowledge, skills, and abilities at different stages for a clinical social worker to achieve independent practice. Supervisors can read through each of the stages to determine if their supervisee has achieved proficiency and also to determine what they need to continue to learn for advancement. The ABE Conceptual Model essentially identifies practice expectations at different stages of a clinical social worker's professional development. Having competencies and stages of development help guide the supervisory process for teaching and learning of clinical social work practice.

Competency-based learning is foundational to the ABE Conceptual Model of assessing a clinical social worker's readiness for independent practice. Readiness in social work is grounded in comparing a supervisee's knowledge, skill, and ability to identified competencies.

Ecological systems theory. System's theory is another foundational framework of competency-based learning. In the *Australian Journal for Adult Learning*, Steve Hodge (2007) explains how the inputs of an environment are key to competency-based education as follows:

> In the language of systems theory, CBT is an 'open system', constitutionally responsive to a wide range of 'inputs'. The appropriateness and 'fit' of the theoretical components is determined primarily by the function they serve in the system rather than their inherent compatibility with each other. (p. 196)

A dynamic relationship exists between what the student or supervisee is learning and the environment in which they are practicing. As previously discussed, competency-based education is foundational to the ABE Conceptual Model. Consequently, consideration of

the context for learning is an important aspect of this study and an applicable theoretical framework.

Participants in this study will be examining a clinical social workers professional development. This will include consideration of the supervisory context or system, the developmental process of learning and the social experience of the supervisee. Developmental Theory, Social Experiential Learning, and Systems theory conceptually frame the development of a supervisee in clinical social work and the ABE Conceptual Model.

Operational Definition of Terms

The following definitions will be used throughout the dissertation:

Clinical social work practice is defined by ABE as follows:

> Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial, disability or impairment, including emotional and mental disorders. It is based on knowledge and theory of psychosocial development, behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, social systems, and cultural diversity with particular attention to person-in-environment. It shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. (as cited in Munson, 2012, p. 10)

Generalist social work practice- Generalist practice is grounded in the liberal arts and the person-in-environment framework. To promote human and social well-being, generalist practitioners use a range of prevention and intervention methods in their

practice with diverse individuals, families, groups, organizations, and communities based on scientific inquiry and best practices. The generalist practitioner identifies with the social work profession and applies ethical principles and critical thinking in practice at the micro, mezzo, and macro levels. Generalist practitioners engage diversity in their practice and advocate for human rights and social and economic justice. They recognize, support, and build on the strengths and resiliency of all human beings. They engage in research informed practice and are proactive in responding to the impact of context on professional practice (CSWE, 2015).

Signature pedagogy- "Signature pedagogies are elements of instruction and of socialization that teach future practitioners the fundamental dimensions of professional work in their discipline—to think, to perform, and to act ethically and with integrity" (CSWE, 2015, p.12). Signature pedagogy are "characteristic forms of teaching" or "types of teaching that that organize the fundamental ways in which future practitioners are educated for their new professions" (Shulman, 2005, p. 52).

Field education-is defined by the CSWE (2015) as:

> Field education is the signature pedagogy for social work. The intent of field education is to integrate the theoretical and conceptual contribution of the classroom with the practical world of the practice setting. It is a basic precept of social work education that the two interrelated components of curriculum—classroom and field—are of equal importance within the curriculum, and each contributes to the development of the requisite competencies of professional practice. Field education is systematically designed, supervised, coordinated, and evaluated based on criteria by which students demonstrate the Social Work

Competencies. Field education may integrate forms of technology as a component of the program (p. 12).

Evaluation- As defined by The National Academy of Academic Leadership in relation to their definition of assessment, "Evaluation uses information based on the credible evidence generated through assessment to make judgments of the relative value: the acceptability of the conditions described through assessment" (Gardiner, 2001, p. 1)

Assessment- "is the act of measuring student learning and involves gathering credible evidence of inputs, such as educational activities, and outcomes such as student performance, for the purpose of improving effectiveness of instruction and programs and of demonstrating accountability [Banta, 2013]" (as cited by Bogo, Rawlings, Katz, & Logie, 2014, p. 12).

Supervised practice- The supervision that is required for licensing after a social worker obtains their bachelorette or master's degree in social work. The board approved supervision must be provided by a social worker who has already obtained licensure at or above the licensure level the supervisee is seeking.

Competency-based education- "CBE is defined as an outcome-based approach to education that incorporates modes of instructional delivery and assessment efforts designed to evaluate mastery of learning by students through their demonstration of the knowledge, attitudes, values, skills, and behaviors required for the degree sought' (Gervais, 2016, p. 99).

Assumptions

In this study, it is assumed that:

1. The ABE Conceptual Model is reflective of professional development and practice competencies for clinical social workers.
2. Supervisees benefit from supervision based on a competency-based model.
3. Supervisors are able to make a determination of competence by examining practice competencies.

Chapter 2: Literature Review

This purpose of this literature review is to provide an analysis of how competency-based education originated within the social work profession and how its advancement impacts assessment of licensure for clinical social workers. The review includes early developments of the profession expanding into the educational standards that guide schools of social work today.

Conceptualizing Competence in the Social Work Profession

Critical influences of the social work profession, along with professional beginnings and challenges are discussed throughout this chapter. The historical development of social work education provides an explanation of the purpose, need, and process of becoming an accredited educational institution. Understanding the origins of professional assessment in social work has important implications for determining readiness for licensure and competent professional practice. Additionally, the review includes information about the current state of social work practice. NASW (2018b) has determined that social workers provide most of the country's mental health services. As a result, a great deal of literature related to social work is focused on clinical social work practice.

Clinical social work is the most advanced level of practice for social work. Most states have four different levels of licensure for social work practice. This includes the bachelor's level, the master's level, master's graduate in training level, and the clinical level. Clinical social work practice is the most specialized type of social work practice and requires the most extensive training of the profession. While there is a great deal of literature about assessing competence-based education in medical education, little is

known about specifically assessing readiness within clinical social work. Competency-based education is utilized by social work education at the bachelors and master's levels. Examining how master's level students are being assessed in schools of social work suggests how clinical social work supervisees in training are going to be assessed. Supervisors are likely using similar models as the schools of social work for determine readiness to become a fully licensed clinical social worker. Exploring competency-based education for social work provides us with important implications for understanding assessment of clinical social workers in a supervisory context.

The research literature examined included social work, nursing, medical, speech language pathology, and psychology. This provided a foundation to compare and contrast assessment of these fields of study because there are limited resources exclusive to clinical social work.

Overview of the development of social work profession in the US. Competence determination within the social work profession has been a controversy since the early 20th century. A clear definition of social work and the tasks involved in its work are still ambiguous. Cnaan and Dichter (2008) explain that "more than 100 years after social work evolved from its humble origins, we still lack a clear understanding as to what exactly social work is and what social workers do" (p. 278). Initially, the work was regarded as charity work and was not viewed as an occupation. The early pioneers of social work in the late 1800 and through the early 1900s were focused on ensuring settlement houses provided basic need services to the poor in an industrialized America (Knight 2005; Lubove, 1965). Jane Addams, a pioneer social worker, cofounded the US Settlement House Movement in Chicago, Illinois with the first settlement house Hull

House in 1889. Hull House was located in a poor urban neighborhood mostly populated by European immigrants. Women who lived in the home, provided volunteer services to the needy and were often regarded as "friendly visitors" (Austin, 1983, p. 358). The women volunteers were typically from the middle-to upper class who could afford spending time serving the community. The momentum of the profession progressed into a movement of scientific philanthropy (Wenocour & Reisch, 1989). Additionally, this type of service occurring within neighborhoods fostered social change through community organizing. Change was not occurring within a government context, but rather through a grassroots effort within a community system. "The concepts of community organization and group work both developed within the settlement house context" (Kirst-Ashman, 2010, p. 153). This was a revolutionary approach to social change.

Social workers during this time period often were a part of Charity Organization Societies (COS). In contrast to the empowering model of social change by the Settlement House Movement, Charity Organizations Societies adopted more of a medical model for approaching social work practice. They were steadfast in wanting to "study the problem of dependence, gather data, test theories, systemize administration and develop techniques that would lead to a cure" (Popple, 1995, p. 2283). There were significant differences in philosophical approaches to helping. The Settlement House Movement stressed people possessed the capabilities to affect their own change. Whereas the COS, argued that service providers had the answers about how to fix the ill or impoverished people. From either approach, both schools of thought agreed that skills and knowledge were necessary for providing effective help to communities in need (Breiland, 1995;

Trattner, 1999). The work of friendly visitors was beginning to shift into something more than just voluntary work. A profession was beginning to emerge.

In 1900, a social science educator, Simon Nelson Patten, coined the term, *social worker* (Munson, 2012). The friendly visitors that developed and lived in the settlement houses served a forgotten people dealing with starvation, homelessness, health problems, limited or no access to education, economic hardships, and lack of childcare while their parents worked in the factories (Popple, 1995). Additionally, social workers began establishing their work in hospitals. Ida Cannon was a pioneer medical social worker in Boston, Massachusetts hired to work under a physician in 1907. By 1915, she established the first social work department within a hospital setting and was named Chief of Social Services at Massachusetts General Hospital (NASW Foundation, 2018b). She was adamant that social workers in the medical field needed specialized training in casework and terminology. Before long she was teaching a standardized training for social workers to work in hospitals throughout her region. Social workers during this time worked in a variety of settings and in many different roles. Most were caseworkers and charity workers involved in community organizing and settlement house reform. Some viewed their work more as an organized association of philanthropists. By 1913, there were over 413 settlement houses in 32 of the 48 States in the US (Husock, 1993). Jane Addams was a prominent reformer of social issues in the US and internationally. This lead to her award of the Nobel Peace Prize in 1931. Addams set the precedence that serving people in poverty was not just a generous act by the privileged and wealthy, but a fundamental function of social justice (Knight, 2005; Smith,1995). Social workers were not only involved in social change with individuals, but also with advocacy of legislation

and larger government policy issues. Due to the varied responsibilities and roles, the purpose of the profession was difficult to define. As a result, educators, medical professionals, and philanthropists questioned if the work of "friendly visitors" could be classified as a profession.

Critical influences: professional beginnings and challenges. An influential American medical educator, Dr. Abraham Flexner, challenged whether or not social work could technically be considered a formal profession. Dr. Flexner is best known for his impact on developing standards and reforming medical education across the US and in Europe. He questioned if social work had clear and definitive skills that a person must learn. He also argued that social work did not have a solid theoretical base guiding how human issues were to be resolved within the field. In his 1915 speech at the National Conference on Charities and Corrections, he contended, "I have made the point that all the established and recognized professions have definite and specific ends: medicine, law, architecture, engineering—one can draw a clear line of demarcation about their respective fields. This is not true of social work" (as cited in The Adoption History Project, 2012, para. 5). Dr. Flexner's speech demanded clarification of the professions' aims and identity for the field of social work. He aided in conceptualizing competence for the social work profession and was an important impetus of social work's early professional development (Austin, 1983).

In 1917, Mary Richmond, who was the Director of the Charity Organization Department of the Russell Sage Foundation in New York, published one of the most prominent textbooks for the profession and education of the profession (Longress, 1995; Segal, Gerdes, & Steiner, 2004; Trattner, 1999). Her book, *The Social Diagnosis*, is a

rebuttal to Dr. Flexner's argument and provides a clear response to the casework involved in social work. She describes the theory and method involved in providing services to clients. This includes specific techniques and language used by social workers. She encouraged viewing the client within the context of their social environment. Mary Richmond transitioned what was considered charity work to a new profession-social work. She developed a scientific knowledge for practicing social work. This emphasized the importance of diagnosing a person within the context of their social environment. What was going on around the person was also significant and was necessary to take into consideration. Hence, the name of her textbook, *Social Diagnosis*. Her insistence on educating others about the practice of social work clarified there was a specific knowledge and skill set to provide quality services to clients. Mary Richmond was instrumental in defining competence for social work practice and education during the 20th century and into the 21st century.

Overview of the development of social work education in the US. During the 1890 through the early 1900s, three schools of social work emerged. In 1898, the New York School of Philanthropy developed a series of summer trainings for friendly visitors and volunteers. The Assistant Secretary of the New York Charity Society, Phillip Ayers, offered a 6 week summer training that required a publishable article. The training eventually developed into a yearlong program and was an important beginning for social work education. Mary Richmond also offered trainings as a faculty member with the New York School of Philanthropy. The summer apprenticeship trainings eventually developed into a more formal academic training. With the influence of Mary Richmond, the first school of social work focused on applied philanthropy (Austin, 1983) and had

more of a vocational approach to education. There was a strong emphasis on fieldwork experience. Students were primarily prepared for casework. The emphasis on being social change agents was secondary. Mary Richmond is noted as resisting trainings that had more of a traditional academic format. She was about practical training, rather than larger change across systems based on research or policy.

In contrast to Mary Richmond perspective on social work education, Graham Taylor established a training school for social work with more of an academic approach. In 1903, the Chicago School of Civics and Philanthropy developed a school of social work program. It was later named the University of Chicago School of Social Service Administration. The focus of the curriculum had more of an emphasis on social theory focused on research and policy change. The founders of the program were more aligned with the social work philosophy of Jane Addams. The teaching emphasized the need to survey communities in order to create social reform actions. Their principles of education focused on a commitment to public welfare and the advancement of social work practice through research by students and faculty. The pendulum towards a more academic approach to social work education was in full swing.

In 1904, Harvard College in collaboration with Simmon Female College and the head of the Associated Charities founded the Boston School of Social Work. This was the third major school of social work established in the US during this time period. With the support of Harvard, a highly regarded academic institution, the curriculum initially had more of scientific approach. The director, Jeffery Brackett, had an educational background in local government in public administration. The division of whether social work education should be more academic or practical was alive and well with the Boston

School of Social Work. Brackett is noted as struggling to keep Harvard engaged as a support of the School of Social Work throughout his career (Popple, 1978). There was often question about the program having enough of an academic focus. Harvard eventually withdrew their support of the program in 1914 when the Russell Sage Foundation was no longer willing to provide financial support to the program. At the time of their withdrawal, Mary Richmond was the Director of the Charity Organizational Department of the Russell Sage Foundation. Not only did the Boston School of Social Work lose the financial backing of an organization that supported practical casework education, they also lost support of an institution with more of an academic focus. Without having a clear definitive approach to social work education, there was a lack of foundation and stability among social work educators and their institutions.

Conflict about the definition and direction of social work education had an impact on the New York School of Social Work in 1912 as well. Samuel McCuan Lindsey resigned from his directorship due to his belief that the school should not head in a direction of being a "…training school…much more limited in scope, devoted to the development of a finer technique in a few lines of work-perhaps exclusively in a charity organization society" (Popple, 1978, p. 154). He was a proponent of a more academic approach focused on a social science and policy-based curriculum. The director of the Russell Sage Foundation challenged his approach explaining that there needed to be more of a focus on skill development. Social work education was once again losing its footing with having a clear and definitive approach to social work education.

The need for trained social workers. Mary Richmond's *Social Diagnosis* in 1917 came at an important time. It was strong rebuttal to Abrahams Flexner's criticism of

social work as a profession. Her articulation of casework provided the profession with a convincing response during a time when skill-based models for social work were needed. The first national organization of social workers called, The National Social Workers Exchange, was developed to process applicants for social work jobs. This group was later named the American Association of Social Workers and was mostly comprised of caseworkers from many different fields of practice. The need for trained social workers expanded as social welfare agencies became more established. Caseworkers were needed in the child welfare system, the schools, and also in the medical field. In 1918, Ida Cannon established the American Association of Hospital Social Worker. As a trained nurse and social worker, she identified specialized principles in training social workers providing medical casework. Not long after, Smith College created a specialized program for psychiatric social workers. There was a momentum of specializations growing and social work education was becoming more divided. By 1919, there was a total of 17 schools of social work throughout the United States and Canada. The time was coming to construct common standards of practice for educating new social workers. The Association of Training Schools for Professional Social Workers was established in 1919. This later evolved into what is known today as the Council on Social Work Education (CSWE), the accrediting body for social work education.

Accreditation. One of the leading educators that helped to develop accreditation standards for social work education was Dr. Edith Abbott. She was a faculty member at the Chicago School of Civics and Philanthropy in 1907. As with other schools during this time period, social work education was mostly focused on vocational training. By 1920, Dr. Abbott developed the School of Social Service Administration at the University

of Chicago. This advancement provided students with a more in depth educational program for social work at one of the leading colleges in the US. She eventually became the first female dean in 1924. In 1921, she wrote an influential book on the philosophy of social welfare education. During this time, the American Association of Social Workers (AASW) was working diligently on setting professional standards for the social work profession and addressing areas of concern the profession was experiencing with social welfare across the nation. Her book had important influences on the development of professional standards for this organization and other social work associations. In 1927, she became a co-founder of the *Social Service Review*, which was the first journal on social services. During this time, she also became the president of the American Association of Schools of Social Work (AASSW). This association was specifically dedicated to centralizing and standardizing social work education. In 1919, AASSW originated as the Association of Training Schools for Professional Social Workers. However, as schools of social work became more prominent, AASSW was no longer regarded as a training facility. AASSW was able to establish its role as an association. As the president of AASSW, Dr. Abbott was instrumental in setting the stage for uniformity with social work education standards just as she had done with social welfare education. In 1957, a scholar, William McMillen, wrote the following in an article published in the *Social Service Review* journal about Dr. Abbott, "...she, more than any one person, gave direction to the education required of the profession" (as cited in Sorensen, 2010, para. 10).

With the onset of the Great Depression in 1929, the presence of the social work profession was at an all time high in both the government and private voluntary sectors.

There was a significant need for social services throughout all of society due to financial hardship and basic needs being unmet. Non-profit organizations struggled to manage their traditional roles in social welfare reform based on the demand for direct care of those in need. Government organizations were also overwhelmed by the need for general social services. Many social service agencies faced bankruptcy. In light of these economic and societal changes, social workers became more influential in government administration of social welfare. Dr. Abbott's influence on social welfare and social work education shaped the way social workers were trained to respond to new demands on the profession. In 1937, Dr. Abbott became the president of the National Conference on Social Welfare. While she was an academic at heart, she also maintained the importance of teaching methods of practice that would address the needs of society at that time. She was the balance of both perspectives in social work education during a time when leadership in this area was very needed.

In 1932, the AASSW established formal accreditation procedures. This was an important milestone for social work education. While medical social workers and psychiatric social workers had some accrediting processes in place based on their specializations, a new trend in social work education was beginning. Educational standards for a more generalist practice of social work were developing. Social workers needed to know how to work in a variety of different settings. In 1937, a division occurred within AASSW. Membership became limited to just schools that offered graduate social work programs. Many felt that professional preparation was to occur at a more advanced graduate level. Formal education was viewed to be occurring at graduate level and a more generalized basic training was occurring at the undergraduate level.

This division caused many to question the accreditation standards. Several state institutions that were not graduate programs created the National Association of Schools of Social Administration (NASSA). This group was adamant about the need for more of a generalist approach to social work education at both the graduate and undergraduate levels. They did not see professional preparation to be exclusively occurring at the graduate level. Eventually, the education community became frustrated with both perspectives and accreditation authority was removed from both groups dissolving any formal accreditation process. This decision prompted the two groups to unite and determine the best way to involve diverse perspectives for setting and maintaining accreditation criteria. In 1942, a report that resulted from the two groups recommended combining the two organizations into CSWE, which was formally established in January of 1952. CSWE had a clear purpose, "to promote the development of sound programs of social work education in the United States, its territories and possessions, and Canada" (as cited in CSWE, 2018, para. 4). The purpose reflects a more general focus on social work education at the graduate and undergraduate levels, however accreditation did initially remain with just graduate programs.

In 1953, CSWE hosted the first Annual Program Meeting with over 400 attendees and published the first issue of the *Journal of Education for Social Work*. During the first several years, the CSWE focused on reviewing and forming accreditation standards, study of the curriculum and trends in social work education, and advocacy in social welfare. In 1961, CSWE placed their stamp of approval on a document that promoted a more formalized educational process in undergraduate programs called, *Social Welfare Content in Undergraduate Education*. By 1973, CSWE developed formal accreditation

standards for undergraduate social work programs. In 1974, the National Commission on Accrediting formally authorizing CSWE to accredit baccalaureate social work programs. Undergraduate programs with a more generalist social work teaching perspective were legitimized. The argument about teaching social work with a generalist approach was finally validated. In the end, CSWE determined that teaching from a generalist perspective just at the graduate level was not the answer for structuring social work education. They also did not dissolve bachelor level social work programs. A compromise was made between the differing points of view about the establishment of generalist social work education. The middle ground was a matter of supporting each other's points of view about teaching a complex profession.

During the 1970s, accreditation for social work focused on curriculum design, teaching techniques/strategies, and field experiences. Programs were required to explain teaching content and experiences in detail. For example, programs needed to detail the amount of time students would be exposed to field practicum (Bogo et al., 2014). The emphasis was on the teaching process rather than what students learned. There was a particular focus on the input of the curriculum, rather than the outcome or output of student learning. CSWE did not require schools of social work to detail the data indicating what students actually learned or how they demonstrated competence in order to earn their degree. Accreditation was in its beginning stages of establishing social work's educational process and evaluation of competence was at the brink of development.

During the mid 1970s, the buzz among social work educators was the integration of competency-based education. "Educators [Arkava, & Brennen, 1976, Clark & Arvaka,

1979; Gross, 1981] identified a range of competencies, articulated specific behaviors with indicators that reflected increasing levels of performance and urged the creation of reliable and evaluation methods of students' learning" (Bogo et al., 2014, p. 3). Some social work programs adopted this teaching approach with field practicum but did not fully integrate this into the evaluation of their full curriculum. Other schools continued to concentrate on content mastery rather than competence of practice. The emphasis was still on the input of education rather than the output. Social work education found validity with competency-based education, however there was not a definitive stance.

The trend of competency-based education was not only emerging with social work education, it also was becoming more and more prominent in other professional disciplines.

> The history of competency based programs in US higher education is distinguished by three phases: (a) innovative teacher education programs in the 1960s and beyond; vocational education programs in the 1970s and beyond; and (c) more recent programs over the last decade and a half, particularly those taking advantage of on-line or hybrid models, advances in adaptive learning technology, or direct assessment. (Nodine, 2016, p. 6)

Competency-based education was and has become a new way of understanding and justifying learning for higher education programs. Social work was not untouched by this movement. In fact, this trend helped to articulate the knowledge, skills needed for professional practice as it has done for other disciplines. Scholars in education and medicine worldwide, and in social work in the United Kingdom and Australia, were early adopters of competency-based models and have used them for many decades to

understand and define the various aspects of knowledge, values, and skills needed to practice in the respective professions (Bogo et al., 2014). Accreditation for social work education was taking on a different philosophy for determining outcomes of learning. Not only was adopting a competency based educational model aligned with other professions; it was essential to having credibility in higher education. The emphasis on the outputs of learning was a new reality for accreditation.

Throughout the time when accreditation was more focused on input and teaching techniques, students' learning was evaluated in the classroom and in a field practicum experience. Instructors were still evaluating students' conceptual understanding and this was measured by their written work (i.e., essays, examinations, and journals). Thus, Field Practicum Supervisors were the primary evaluators of a students' ability to apply social work knowledge and skills in a real-life setting. Individual social work programs developed the criteria for evaluation for the student's field learning experience. There was not a centralized way of measuring the students' ability to apply knowledge and skills for serving clients in the field. This resulted in a very fragmented evaluation of student ability in their field experience across social work programs.

> …many concerns have been raised over time in the social work literature about the ability of field evaluations to identify the differences in performance. Concerns include lack of specificity in criteria used [Alperin, 1996, Kilpatrick, Turner and Holland, 1994), the questionable reliability and validity of evaluation instruments (Bogo, Regehr, Hughes, Power & Goberman, 2002; Gurandsky & Le Sur, 2011; Raskin 1994; Regher, Bogo, Regher, & Power, 2007, Wodarski, Feit & Green, 1995], inflation of ratings and leniency bias [Sowbel, 2011, Vinton $

> Wilke, 2011], and the data used in assessment performance. (Bogo et al., 2014, p. xv)

Clearly, there are many variables that can shape how competence is measured in a field experience. The lack of a common set of criteria could result in learning outcomes that were specific to the setting, the field practicum supervisor, the instruments and the student. Recognizing these concerns, in 1981, the Commission on Accreditation (COA) for CSWE began to clarify expectations for a social work student's field experience. This included establishing standards for agency selection, criteria for selecting field practicum supervisors and student evaluation.

As social work educators grappled with the new accreditation standards for field education, more literature in social work education began to discuss the difficulty and inconsistencies in measuring student learning. There was a movement towards clarifying more concrete skills rather than abstract learning. CSWE was specifically asking schools of social work to detail how student evaluation was completed. Thus, assessment of student learning became more vital to the accreditation process. In addition, there was in influx of medical professions shifting towards competency-based education. The literature in social work education began to legitimize the use of competency-based education for the profession.

Field education: The signature pedagogy. CSWE was beginning to refine and clarify the forms of teaching and learning for social work education. In 2005, Lee S. Schulman, who is an educational psychologist from Stanford University, coined the term "signature pedagogy". This terminology was a concept that social work education eventually adopted into their accreditation standards. Schulman's article on this topic,

explained that there are forms of instruction that prepare members of particular professions. He stated, "I would argue that such pedagogical signatures can teach us a lot about the personalities, dispositions and cultures of their fields" (Schulman, 2005, p. 52). The signature pedagogy of a profession helps to frame how a student is socialized into becoming a professional. Once the forms or styles of teaching are clarified with identification of a signature pedagogy, a professional discipline creates standards for replication across institutions, programs, and contexts. Without a signature pedagogy, professions may struggle with consistency and direction for teaching and learning.

In 2008, CSWE deemed field education as the signature pedagogy of social work education. This was implemented during the introduction and publication of the *Educational and Policy Accreditation Standards* (EPAS) for 2008. They are reviewed every eight years. EPAS (2008) transitioned social work education to competency-based assessment. With field education as the signature pedagogy, there was now an expectation that competencies would be measured in the classroom and field experience. The shift was an important advancement for social work education. Field education was considered to be the essential component of teaching and learning for social work practice. Classroom curriculum needed to be centered around preparing students for the capstone experience of field work. While field or apprenticeship education has always been a highly valued component of social work education, it was never considered the backbone of social work education.

Today, educational institutions of social work have the responsibility of assessing students' competence before they are able to grant a degree of proficiency in social work. As explained in CSWE's curriculum policy, "social work education enables students to

integrate the knowledge, skills, and values of the profession for competent practice" (CSWE, 2001, p. 4). Social work competence is foundational to academia. In current social work education,

> assessment entails articulating the components necessary for effective practice and developing assessment methods that are reliable and valid and can differentiate between students who possess the knowledge, skills, values and judgment necessary for safe and effective practice and those who do not. (Bogo et al., 2014, p. xi)

The assessment models educational institutions are using inherently align with measuring competence for licensure. What schools are doing to evaluate student competence is going to have significant implications for evaluation of licensees during their postgraduate training.

The development of licensure levels and requirements. The purpose of licensure for social workers is to ensure they are qualified to provide safe, competent, and ethical practice. The national non-profit organization, ASWB, developed a *Model Practice Act* for licensure in 1997. The *Model Practice Act* details a legislative declaration for licensure.

> It is further declared to be a matter of public interest and concern that the practice of social work, as defined in this Act, merit and receive the confidence of the public and that only qualified persons be permitted to engage in the practice of social work. (ASWB, 2015, p. 3)

The legislative declaration posits licensure as a means to protecting the public by ensuring competent practice. There are a series of qualifications and requirements social

workers must fulfill before they can become licensed as a social worker. The qualifications are considered a reflection of their competence in social work practice with a specific practice skills, knowledge, and abilities. To begin understanding the how competence is determined with licensure, it is important to first explore the how licensure standards developed and the different levels that shape social work practice today.

Another important milestone in the develop of social work competence and the overall profession was the establishment of licensure. The existence of licensure helps to govern a profession and ensure competence practice. The foundation of its existence is to protect the public from unethical or unqualified practice. The official recognition of licensure was another key event that helped to establish the profession in the public sector of society. While the establishment of social work in the academic setting was vital to the profession, it also needed a formal regulatory institution within the general public.

The enactment of laws that governed social work practice first began in California. In 1945, a law was created in California requiring social workers to register with the Board of Examiners. This formality with a government institution declared who was allowed to use the term "social worker" as an occupation. The trend of licensure eventually began to take heed across more states throughout the US. In 1978, 12 state representatives established the American Association of State Social Work Boards (AASSWB). This association was focused on protecting the public, developing a professional examination to determine competence, and creating regulatory standards and resources for licensure. In March of 1979, a convention of AASSWB members was held. At this time only 18 states had some form of social work regulation. In 1983, a licensure exam for social workers was developed and implemented. By 1992, all 50 states became

members of AASSWB including Canada, which resulted in a name change to include the Canadian provinces. The new name adopted by the Association is known today as ASWB.

ASWB was instrumental in developing the *Model Social Work Practice Act*, which guides development of regulatory standards for states across the US.

> The purpose of the ASWB Model Act is simple: to provide a resource to legislatures and social work boards when addressing issues related to the public protection mission of regulating the practice of social work. Informed by a national perspective, the Model Act establishes standards of minimal social work competence, methods of fairly and objectively addressing consumer complaints, and means of removing incompetent and/or unethical practitioners from practice. (ASWB, 2015, p. 1)

The *Model Practice Act* includes guiding definitions for licensure standards and general social work competence. States are still given autonomy in creating their own specific laws for social work practice based on their own regulatory, legal, cultural, and political climates. The *Model Practice Act* promotes uniformity in language and regulation standards, however states may have different requirements to obtain licensure. While there are some similarities among states, there are mostly differences in the levels of social work licensure (Dyeson, 2004).

Each state endorses a law which defines social work practice at different licensure levels. The state also declares who is allowed to use the title at the different levels, establishes an examination board to prove competence, and sets policies regarding continuing education and disciplinary procedures once licensed. One similarity all states

have is the educational requirement to obtain licensure. The primary requirement that exists to use the professional title, “social worker” is the ownership of a BSW or MSW degree from a CSWE accredited program (NASW, 2016). This best practice guideline is set forth by the NASW, however not all states follow this standard. It may vary because of the educational opportunities for social work in a state or other contextual challenges that exist in meeting this best practice guideline. Some states only license social workers at a graduate level, while others require anyone working in the field be registered, certified, or licensed. Another commonality among all 50 states is the use of ASWB’s licensure examination. It was not until 2016, that all states used this licensure exam process.

ASWB has four different licensure exam levels: Bachelors, Masters, Advanced Generalist, and Clinical. These levels have defined the structure of licensure for many of states in the US. The bachelor’s level is the basic exam level for those who possess a bachelor’s degree. Some states require a bachelor’s degree in social work, while other states allow a bachelor’s degree in a related field (i.e., psychology or human services). Bachelor’s level social workers typically are involved in basic functions of a social worker and are typically supervised by a social worker with a higher level of social work licensure. The master’s degree level is for social workers who have just graduated from a Master’s of social work program and are obtaining postmaster’s work experience. The experience is an advanced level and can be either clinical or non-clinical social work experience. Clinical social work practice is typically defined as providing diagnostic and therapeutic services related to a mental health diagnosis.

Not all state jurisdictions use the Advanced Generalist licensure level. This level is for social workers who have a Master's degree in Social Work and have over two years of supervised practice experience in the field. Supervised practice essentially means they have been under supervision or training by a more highly licensed social worker in their practice setting. Social Workers at the Advanced Generalist level do not provide clinical services. Advanced Generalist social workers are often providing administrative or macro level social work services that affect entire communities or larger systems of care. The clinical exam level is specifically for social workers who typically have over two years of supervised practice by a clinical social worker providing therapeutic services. Some states require more supervised practice experience. Once social workers have achieved a clinical level licensure, they often are able to practice independent of supervision, such as in a private practice setting. This is the most advanced level of social work practice.

The ASWB exam is one measure of competence for determining qualifications for social work licensure. Content for the exams is based on a practice analysis study. The study is a large survey periodically completed by social workers across the Unites States to gain an understanding of what social workers do in their jobs. The results of the survey provide ASWB with an accurate picture of social work practice. This assists ASWB in developing content for the exams and ensures their categorization of licensure reflect what is happening in the field. Once this data is gathered, content areas are identified and serve as the blueprint for developing exam questions. Content outlines are developed for each level of licensure. "Each content outline is organized into content areas, competencies, and knowledge, skills, and abilities statements (KSAs)" (ASWB,

2018, para. 2). ASWB delineates clear competencies, which, "describe the meaningful sets of knowledge, skills, and abilities that are important to the job of a social worker within each content areas" (ASWB, 2018, para. 4). The KSAs "provide further details about the nature and range of exam content that is included in the competencies…. Each KSA describes a discrete knowledge component, that is the basis for individual exam questions that may be used to measure the competency" (ASWB, 2018, para. 5). Exam questions for the ASWB are based on the current understanding of what social workers are doing in the field. The exam strives to determine if a social worker has the necessary knowledge and skills to perform the work at different educational and experience levels. It also is instrumental in defining licensure levels across the US.

The ASWB licensure exam is not the only resource for structuring licensure levels. The *Model Practice Act* is another guide states also use to create regulation about licensure levels. The *Model Practice Act* only specifies three levels for social work licensure: bachelor's, master's, and clinical level. Some states follow this structural model, but not all. Much of the variance for licensure across states depends on the context of practice. This could be the funding sources, political climate about licensure, and resources for providing supervision.

Regardless of a state's licensure level structure, the ASWB exam is used for determining competence of licensure at almost all levels. Being supervised by someone with a higher level of licensure is another important requirement, but is more of a subjective measure. As a result, states significantly vary with their specific requirements. A commonality with supervised practice is that it is a longer period of time with more

advanced or specialized levels of practice. Clinical social work practice is the category of licensure that has the most intense requirements for supervision.

Clinical social work as a professional title. To begin the exploration of competence for one of the most advanced levels of social work practice, one must first understand the origins of this professional title. The echoes of Mary Richmond's *Social Diagnosis* are certainly a part of clinical social work's development. "In the past, clinical social work was referred to as casework, social casework, psychiatric social work, social treatment, psychotherapy and probably many other things" (Munson, 2012, p. 8). There was not a clear title or understanding of the work. There also was not a foundational theoretical base.

During the 1930s, many social workers were interested in psychoanalytic theory and intervention. As a result, many began training in psychoanalysis. This movement was a focus on the individual verses the person in environment perspective of social work practice. For those social workers interested in the psychosocial functioning of clients psychoanalytic focus persisted well into the 1950s. During these early years of clinical social work (social workers focused on psychosocial functioning), the practice setting was often in the hospital working under a psychiatrist. Clinical social workers during this time provided services by educating patients and their family members on mental illness, developing discharge planning, and coordinating care with other service providers (Grant, 2008). As time progressed, these social workers became highly trained and specialized in treating psychosocial functioning (NYSSCSW, 2018). When the American Association of Psychiatric Social Workers merged with NASW in the 1960s, social workers sought support from NASW for providing clinical work in a private practice setting.

Given the focus on generalist social work practice at that time, the urge for support in private practice was not supported by NASW nor schools of social work. The lack of support resulted in a group of highly trained social workers and psychotherapists in New York uniting to create their own organization in the mid 1960s. The group struggled with naming their work. Some felt they should not call themselves social workers at all, while others felt embracing psychiatric social work was aligning too closely with the psychiatric profession. After several meetings, it was determined that that term "clinical social worker" captured a general understanding of the work. Membership to this group grew and they were eventually incorporated as the Society of Clinical Social Workers in 1970.

Additional clinical social work societies began to emerge. Another developed on the west coast called the California Society for Clinical Social Work. A merge of other state organizations resulted in the National Federation of Societies for Clinical Social Work (known today as the Clinical Social Work Association). The Federation eventually began publishing a journal, which is known today as the *Clinical Social Work Journal*. They also developed their own Code of Ethics for Clinical Social Workers in 1997. The momentum of clinical social work eventually resulted in legislative advocacy to be recognized as a distinct professional title.

In 1987, ABE emerged. The main purpose of the organization then and now is to issue credentials for advanced clinical social workers with qualified education, training, and experience. The credential is another certification of competence in addition to licensure. In addition to credentialing for clinical social work, ABE advocates to strengthen high standards of clinical social work. This includes recognition within the

social work profession and overall marketplace. With the force of clinical societies and other professional associations, clinical social work growth and establishment was inevitable.

Legislation for clinical social work in the 1990s focused on receiving reimbursement by health insurance plans for the same clinical services provided by other mental health professionals. This was a trend that occurred across the nation. It also was the impetuous for clinical social workers being able to work autonomously in private practice settings. Hence today, LCSWs are able to practice independent of continued supervised practice. While reimbursement standards helped to further establish the advanced level of the profession, it did not dissolve ambiguity in defining the work. To this day, there are many different ways of describing and defining clinical social work practice.

> The definition of clinical social work has been evolving over the past three decades. This has resulted in some refinement of the definition, but also has led to some diversity, creating multiple definitions that are used by different organizations, which has resulted in some confusion [Kenemore, 1991: 83-93]. (Munson, 2012, p. 9)

The lack of a uniform definition for clinical social work has some significant implications for being able to clearly determine and assess competence. The profession does have some guiding principles for explaining clinical social work practice, however the principles result in varying contextual interpretations.

Competence Assessment of Clinical Social Workers

With a variety of conceptualizations about clinical social work, there is bound to be even more confusion about measuring and evaluating when it is occurring. This is a substantial challenge for providing supervision of professionals providing clinical social work. Supervisors of clinical social workers are inherently given the responsibility of making the determination of when clinical social work is effectively occurring. More importantly, they are charged with evaluating a clinician's readiness for independent work. The gate keeping role they hold has important implications for the profession and protection of the public from harmful or unethical practice. Clinical supervision is at the heart of competence assessment for clinical social work. Historically, across health professions such as nursing, psychology, and psychiatry, clinical supervision remains a topic to be further explored and defined. It is not just social work that is struggling with identifying a quantifiable measure of competence. In an overview of published literature about clinical supervision, White and Winstanley (2014) explain that there is mostly a description of what constitutes clinical supervision, not hard evidence to determine what works.

> Moreover, although CS (clinical supervision) is usually regarded as an essential component of contemporary professional practice (for international multidisciplinary examples see United States Department of Human Services, 2009; Australian Medicare Locals Alliance, 2013; British Psychological Society, 2010), evidenced-based guidelines about how best it should be delivered and evaluated has remained insufficient and has a historical context in which latter day developments could be earthed as remained unreported. (White & Winstanley, 2014, p. 4)

Many disciplines are in need of further exploring best practices for competence assessment of clinically oriented service delivery. In recent years, psychology has begun to explore competence assessment in supervision of clinical psychologists. Dr. Craig Gonsalvez, a professor of Clinical Psychology at the University of Western Sydney Australia, is one of the leading researchers on assessment of clinical supervisees competence. In a recent article on assessment practices of clinical supervisors, he and his colleagues examined practices of clinical supervisors. The outcome of their study stresses the need for more clear definition of competency standards as a starting point.

> These findings highlight the urgent need to develop and validate objective measures to assess competence and to outline reliable criteria with relevant behavioral anchors to identify performance that falls below competence thresholds, a view articulated by others (e.g., Gonsalvez & McLeod, 2008; Kaslow et al., 2004, 2007). (Gonsalvez, Wahnon, & Deane, 2017, p. 27)

It is evident that leading clinical disciplines are moving towards a competency-based model for measuring clinical ability in a supervisory capacity. Without clearly defined criteria, assessment of clinical work could result in leniency and ultimately incompetent practice.

Clinical supervision of social workers may fall short of providing an accurate determination of readiness for independent clinical work if there are not established definitions and criteria. Gonsalvez et al. (2017) further explain, “delivering accurate assessments is difficult without established competency standards, operationalized benchmarks, and clear normative reference points (Gonsalvez & McLeod, 2008; Kaslow et al., 2004, 2007; O’Donovan et al., 2011)” (p. 27). A competency-based model for

training clinicians in other disciplines has momentum for affecting clinical social work. This is a similar to the trend that occurred with social work education. CSWE has embraced a competency-based model. Assessment of clinical social workers will need to follow suite to have parity with other clinical disciplines.

Supervision requirements in the US. At present, assessment of competence for clinical social work practice occurs within some educational programming, however determination of being able to perform the work independently is left to licensure regulation and certification. Some MSW programs have a specialization for clinical social work; meaning students complete course work and field internship placements with a clinical concentration. CSWE requires these programs to clearly explain how the specialization extends and enhances the general social work competencies and how it prepares students for practice in the area of specialization. Programs are required to provide measurable outcomes based on their definitions at accreditation reviews. The accreditation standard can result in a variety of different training outcomes for clinical social workers. Programs are left to make their own determination of defining and measuring social work practice for their program. Ultimately, MSW students with a clinical specialization may have a varied knowledge base for clinical work.

Standards for practicing social work have been provided by the NASW in a guidebook. In this document, it explains that state laws and regulations guide competence of a clinical social worker.

> In most instances, clinical social workers are required to have: a master's degree from a social work program accredited by the Council on Social Work Education, a minimum of two years or 3, 000 hours of post- master's degree experience in a

supervised clinical setting, a clinical license in the state of practice. (NASW, 2005, p.7)

The supervision requirement is a significant component of competency assessment for social work practice. Each state has their specifications to determine constitutes supervised clinical practice. They also may have different standards qualifying someone to be a clinical supervisor. Typically, the person must have a LCSW licensure. In some states, clinical supervisors must also have specialized training in supervision, however the type of training is often not defined. Much is left up to the state to decide.

The variation of supervision standards for licensure is largely dependent on the practice setting and populations served within a state. Clinical social work in one state may look very different than another because of funding streams, human service structures, and even political climate. In Hopkins and Austin's article (2004) on "The Changing Nature of Human Services and Supervision," they explain, "In summary, the changes in human service delivery have changed the supervisory practice" (p. 8). As systems change, so must supervisory practice. This ever-changing context of social work reinforces the need for varied supervision licensure standards across the nation. Not having unified licensure supervision standards can further perpetuate ambiguity with competence assessment. Each state can have their own expectations resulting in trained clinicians with varied experiences and skill sets. Understanding how the social work profession conceptualizes clinical social work supervision is a helpful way to explore where we started and what shapes our assessment of competence today.

Historical overview of clinical social work supervision. The first mention of supervision in social work was from Jeffery R. Brackett in 1904. He is regarded as a

pioneer social work educator particularly in the field of social welfare. His publication on supervision focused on the oversight of welfare agencies, rather than the individual service provider. Brackett's interest was with "the inspection and review of programs and institutions" (Kadushin & Harkness, 2014, p. 1). There was little discussion about evaluating and supporting the providers of direct social work practice.

During 1910 through 1920, supervision developed into supporting caseworkers with increasing their knowledge and enhancing their practice skills. The focus of supervision was more on education rather than administration. Offering educational opportunities transformed the philanthropist into a social work professional. By the 1920s, there were more citations in the literature about providing supervision focused on the caseworker rather than the oversight of the agency. Explicit mention of supervision for the individual social worker was not until 1925. The social work journal called, *The Family*, included the word in their index. It was officially a term that had gained some relevancy and pertained specifically to those providing the direct service to clients.

While today's understanding of supervision did not appear in the literature until the 1920s, there is mention of a supervisory role well before 1904. The first type of supervisor in the social work profession was the role of an "agent" in the Charity Society Organizations during the 1890s. The "agent" was a person who would oversaw the volunteers or "friendly visitors" providing services to families in their surrounding neighborhoods or districts. These visitors were the first direct service social workers. The agent served as a liaison between the communities District Committee and the direct service providers. The District Committee was the Charity Organization Society's local executive. They essentially were the administrators of the services being provided to the

surrounding neighborhood. The agent was responsible for the work of the direct service providers, thus communicating administrative expectations and providing guidance to their work. During the increase of industrialization and immigration, there was a greater need for paid positions. This resulted in the development of more formalized training programs, which eventually developed into social work degree programs. The push towards supervision with an educational focus emerged as a necessary outcome of charity work. The agent was the first modern day social work supervisor. Their work embodied the purposes of social work supervision. “The three major components of current supervision-administration, education and support- were thus identifiable among the tasks assumed by the early agent-supervisor” (Kadushin & Harkness, 2014, p. 7). Supervision took root in friendly visiting and family work, eventually expanded into educational institutions. In 1911, a short course was offered for the first time by the Charity Organization Department. The intent was for agent supervisors to learn how to provide educational supervision in the field.

Definition and objectives. Given the context of when social work supervision originated, it is not surprising that administrative and educational supervision dominated the literature. Between 1920 through 1945, *Family* and *Social Casework* (the two prominent social work journals at the time), published 35 articles devoted to supervision. The first textbook on social work supervision, *Supervision in Social Casework: A Problem in Professional Education*, was written by Virginia Robinson (1936). Supervision was no longer seen as a tangential component of casework. Robinson’s text was widely used and elevated social work supervision as a specific knowledge and skill area that required educational training. She defined supervision as, “an educational

process in which the person with a certain equipment of knowledge and skill takes responsibility for training a person with less responsibility" (Robinson, 1936, p. 53). The definition of social work supervision is not without influence by the political climate and context. During the 1960s, the *War on Poverty* created an increase in social welfare programs. The emphasis of social work supervision primarily having an administrative focus was once again at the forefront of its definition. The *Encyclopedia of Social Work* in 1977 defined supervision as, "an administrative function, a process for getting the work done and maintaining organizational control and accountability" (Miller, 1977, p. 1544).

As time progressed, there was a continued fluctuation of supervision being defined with an administrative and educational focus. Charlotte Towle was an influential social work educator known for her work in examining the educational process of training social workers (NASW Foundation, 2018a, para. 1). In 1945, she defined social work supervision as being an administrative process, but with an educational purpose. There is no doubt that social work supervision was continually perceived as having an educational and administrative purpose. A third additional purpose was not fully included in the definition until 1995 and again in 2008. At this time, the expressive-supportive leadership function of supervision appeared as component of supervision in the *Encyclopedia of Social Work*. The definition clarified that administrative, education, and support are all necessary, "if the ultimate objective of supervision is to be achieved" (Kadushin & Harkness, 2014, p. 9).

Within each of the functional components defining social work supervision, there are specific short-term objectives. Educational supervision is aimed at increasing a

supervisee's knowledge to perform their work most effectively allowing them to eventually work independent of supervision. Administrative supervision is intended to provide the supervisee with a work environment that allows them to effectively do their job. Finally, supportive supervision strives to create a sense of security in their performance. They should feel good about the work they are doing. Each function has a specific focus for the supervisee, but the end result, or the long-term objective for the supervisor is integrating a combination of all three purposes. Lawrence Shulman (2010) refers to this overlapping process as "Interactional Supervision". The overarching objective of supervision is explained by Kadushin and Harkness (2014) as providing

> efficient, effective, and appropriate social work services to clients. It is towards this objective that the supervisor administratively integrates and coordinates the supervisee's work within the agency, educates the workers to a more skillful performance in their tasks and supports and sustains the workers in motivated performance of these tasks. (p. 9)

The work of a supervisor is complex and has many moving parts. It is a relational process that also must take the context of many systems into consideration. It is an art form that cannot be easily measured or captured. Exploring the models and standards of supervision that have developed in recent years is one way to begin conceptualizing and framing the work.

Current trends in clinical social work supervision. In 2012, NASW and ASWB convened a task force group on supervision standards. The outcome of their work was a document titled, *Best Practice Standards in Social Work Supervision* (NASW & ASWB, 2013). While this document has significantly helped to clarify the definition of

supervision for the social work profession, there is still ambiguity about standards for clinical social work supervision.

Dr. Carlton E. Munson (2012) is by far one of the leading authors on clinical social work supervision with the publication of the third edition *Handbook of Clinical Social Work Supervision*. The text is an extensive resource about understanding, providing, and evaluating the practice of clinical social work supervision. One of the overarching themes throughout the text is the balance of supervision as both an art and science. He explains, "the ideas of art and science played a key role in the evolution of practice theory and supervision's natural connection to this evolution" (Munson, 2012, p. 474). The art is exploring the unknown, unexplained, and unconscious of the supervisee. The science is examination of the technique and scientifically-based practice of the supervisee. Finding a balance within the complex context of social work is the challenge placed before the modern day social worker.

In 2013, Munson published another text titled, *Contemporary Clinical Social Work Supervision: A Mentoring and Monitoring Model*. This more updated text emphasizes a supportive and scrutinized role in the supervisory process. He focuses the balance of these two dichotomous tasks of clinical social work supervision. There is continued resonance of the science and art of supervision, however clarifying how a supervisee is to be monitored is further defined.

The current issues and trends in clinical supervision for social work are placing greater emphasis on competency-based assessment in the supervisory process. Other disciplines are shifting in this direction.

> Recently, emphasis on competency-based models for practitioner training in psychology and other health disciplines has greatly increased the demands on the clinical supervisor to demonstrate, in an objective and transparent manner, that all supervisor responsibilities are discharged in accordance with evidence-based practice, pedagogic principles, and/or best-practice guidelines (Falender & Shafranske, 2014; Gonsalvez & Calvert, 2014; Kaslow et al., 2007; Milne, 2010). (Gonsalvez et al., 2017, p. 21)

One of essential elements of being able to move towards competency-based assessment in clinical social work supervision will be establishing clear anchor points of learning. The emphasis on a developmental process for becoming a clinical social worker requires the balance of understanding where the supervisee is and where they are headed. Without clear distinctions, the assessment of clinical social work practice may present itself with a variety of different formats and outcomes.

ABE Conceptual model of professional development. ABE functions as a national education and advocacy organization. Their “main purposes are to issue advanced credentials to Clinical Social Workers based on uniform national of practice” (ABE, 2018, para. 2). In 2002, they published a position statement on *Professional Development and Practice Competencies in Clinical Social Work*. There was an earlier version of the paper in 1995, however the emphasis was more on generalist social work practice. The paper has “three main objectives: to identify the practice components of clinical social work; to relate professional development to practice competency; to identify the indicators by which clinical social workers may be recognized as having achieved certain levels of proficiency” (ABE, 2002, p. 1). A conceptual model for

determining mastery of clinical practice competencies is described. This includes descriptive practice expectations for professional development in clinical social work across five interrelated professional dimensions. They are as follows: professional values, professional knowledge, professional identity and professional use of self, disciplined approach to the practice environment and practice skills. Each example details behaviors that can be demonstrated and different stages of a clinical social workers professional development. The position statement is evolutionary in clearly defining anchor points of learning and professional growth. Practice expectations are described to provide a supervisor and supervisee with concrete developmental milestones indicating readiness for independent practice. While the paper provided valuable insights to clarifying the developmental stages of professional growth in clinical social work, it was never analyzed for practical use in clinical supervision of social workers.

Competency-based education in social work has a long historical development. The voice of Mary Richmond with her scientific approach to teaching social work can be heard through the demand for more concrete measurements of practice. The voice of Jane Adams can also be heard by cultivating the passion in social workers for providing meaningful community work. Through the twists and turns of challenging contexts for social work practice, there continues to be some ambiguity in training social workers for licensure. This is particularly the case for the most advanced level of social work, clinical practice. ABE's position statement provides a guide to understanding the knowledge skills and abilities that encompass clinical social work practice. A logical next step is to analyze the practical use of the competencies providing further evaluation of this valuable work to the profession.

Chapter 3: Methodology

This chapter will provide an overview of the research methodology including a profile of the participants, relevant demographic information about the participants, the instrumentation, the study procedure, and a summary of the data collection process and analysis. Reviewing the purpose of the study and the research questions will assist in clarifying the rationale for of the study design used to analyze the use of the ABE Conceptual Model. Additionally, a review of the analytical framework provides an understanding of the organization and structure of the research on the ABE Conceptual Model.

Statement of the Problem

The American Board of Examiners (ABE) in Clinical Social Work functions as a national education and advocacy organization. In 2002, they published a position statement on *Professional Development and Practice Competencies in Clinical Social Work*. A conceptual model for determining mastery of clinical practice competencies is described in their position statement. This includes descriptive examples of professional development in clinical social work across five interrelated professional dimensions. Each example details practice expectations that can be demonstrated at different stages of a clinical social workers' professional development for licensure.

At present, the discretionary measure for obtaining clinical social work licensure is based on completion of supervised practice hours, the supervisor's verification of the supervisee's competence, and passing the ASWB's clinical level licensure exam. A clinical supervisor attests that the supervisee has adequately fulfilled the supervision plan and meets professional standards to practice clinical social work independently. This

determination is based on their subjective opinion of the supervisee's competence. Use of the ABE Conceptual Model in supervision of clinical social work may provide a more detailed verification of how the supervisee has or has not achieved competence for clinical licensure at an independent practice level.

The ABE Conceptual Model is evolutionary in clearly defining anchor points of learning and professional growth for clinical social work practice. Behavioral and knowledge expectations are described to provide a supervisor and supervisee with concrete developmental milestones indicating readiness for independent practice. The ABE Conceptual Model has never been analyzed for practical use in clinical supervision of social workers. A logical next step is to analyze the practical use of ABE Model for further evaluation of this contribution to supervision of clinical social workers. Implementing the ABE Conceptual Model with supervisors and supervisees is a necessary process for understanding the Model's usefulness and accuracy in detailing practice expectations. Having clear expectations for determining proficiency is key to gatekeeping for a profession that provides the most mental health services across the nation. Ensuring competent and ethical clinical social work practice protects an already vulnerable client population group dealing with mental health issues.

Research Questions

The ABE Conceptual Model provides a series of practice expectations for proficiency at the trainee and independent clinical social work practice levels. Supervisors and supervisees completed a trail of using the practice expectations for determining proficiency. The research questions examined are: 1) How do the practice expectations identified in the American Board Examiners (ABE) Conceptual Model assist

clinical supervisors in assessing readiness for a supervisees' independent practice of clinical social work? 2) Which practice expectations are the most explicit in determining readiness? 3) How does use of the model compare to a clinical supervisor's determination of readiness without using the conceptual model? The study is a trail run of a construct of clinical social work practice. The study design was a mixed methods approach to understand the quantitative outcomes of using the ABE Conceptual Model as well as the experience of the participants with a qualitative lens.

Analytical Framework

The analytical framework for reflecting on the use of the ABE Conceptual Model is grounded in Social Experiential Learning Theory, Developmental Theory, and Ecological System Theory. From as social learning perspective, supervisees learn the work by observing others and integrating what they observed into their own practice. Supervisors view their supervisees as moving through a developmental process of learning that they observe and assess. Finally, supervisees and supervisors are in a dynamic relationship that is impacted by the environment in which they are practicing. The qualitative outcomes of the study provided one layer of understanding what it was like to use the ABE Conceptual Model. Hearing the perspectives of the supervisors and supervisees provided a more in depth layer of understanding that highlights other contextual influences.

Research Methodology

A mixed methods study explores a problem or phenomenon through multiple phases of inquiry and data collection (Creswell, 2014). Each phase is unveiling another layer of a complex system and process. The study had a series of phases for gathering

demographic information to better understand the context that shapes their supervision and practice. Then, the participants applied the ABE Conceptual model for assessment of the supervisee's proficiency to explore their social learning process. Reflecting on their experience aided in understanding how readiness is defined from different supervisory perspectives. The mixed methods approach provided a balanced and in-depth approach of using the ABE Conceptual Model.

Participants. For the purposes of this study, nine social work supervisees and nine supervisors from Northeastern Minnesota practiced using the ABE Conceptual Model and reflected on their experience. The participants were recruited by the researcher and each agreed to be a part of the study. Clinical licensure in the state of Minnesota is referred to as Licensed Independent Clinical Social Work (LICSW). This distinction is important because other states refer to clinical practice as LCSW. Previously in this paper, clinical practice has been referred to as LCSW. To discuss the data collected, clinical practice will therefore be referred to as LICSW because the context of the research was in Minnesota. The nine supervisor participants were Minnesota Board of Social Work approved LICSW supervisors. At the time of the study, they were providing supervision to LGSW licensees practicing in clinical social work. To describe that data collected, supervisor participants are referred to as LICSW and supervisee participants are referred to as LGSWs.

Some clinical supervision in Minnesota can be provided by other behavioral health professionals. For the purposes of this study, supervisor participants were only those who had a MSW and LICSW. This exclusion criteria reduced any variance with educational background and discipline. Additional exclusionary criteria was regarding

the hours of supervision completed. Supervisee participants must have completed over 100 of the 200 required hours of supervision towards their LICSW licensure. This ensured participants were at a critical point for evaluating proficiency for autonomous practice.

Demographic information. As detailed in Table 1.1, the predominate gender of participants was female (83%). The most common age range of supervisors was 35-39 (33%) and 56-60 (22%). For supervisees, the most common age range was 40-49 (55.5%). The majority of participants identified as Caucasian with one supervisee as Native American and another that identified as Multiple or Other. None of the participants had education beyond a MSW. Given the wide range of settings where clinical social workers practice, participants were asked to indicate the location where they provide services. Eight out of the 18 participants (44%) identified working in non-profit and eight of the 18 (44%) in for-profit organizations.

Table 1.1
Participant Profile

Variable	Supervisor (n=9)		Supervisee (n=9)		Total (n=18)	
	n	%	n	%	n	%
Gender						
Female	8	88.9	7	77.8	15	83.3
Male	1	11.1	1	11.1	2	11.1
Neither	0	0.0	1	11.1	1	5.6
Age						
25-29	0	0.0	1	11.1	1	5.6
30-34	0	0.0	1	11.1	1	5.6
35-39	3	33.3	1	11.1	4	22.2
40-44	0	0.0	3	33.3	3	16.7
45-49	1	11.1	2	22.2	3	16.7
50-55	1	11.1	0	0.0	1	5.6
56-60	2	22.2	0	0.0	2	11.1
61-65	1	11.1	1	11.1	2	11.1
66-75	1	11.1	0	0.0	1	5.6
Race/Ethnicity						
American Indian	0	0.0	1	11.1	1	5.6
White	9	100	7	77.8	16	88.9
Multiple or Other	0	0.0	1	11.1	1	5.6
Setting						
Non-profit	4	44.4	4	44.4	8	44.4
For-profit	4	44.4	4	44.4	8	44.4
Government Agency	1	11.1	1	11.1	2	11.1

Note. Demographic information about the participants indicates that 83% were female, the majority of participants were in the age range of 34-49, most identified their race and ethnicity as white at 88.9% and most practiced in a setting of either non-profit or for-profit at 44.4%.

Other distinct information gathered about the participant groups of supervisors and supervisees relates to the amount of time they have been licensed as a LICSW or LGSW (see Table 1.2). Of the nine supervisee participants, the average amount of time

they have been licensed as a LGSW is 1.91 years (or 23.3 months) with a Standard Deviation (SD) of 8.7 months. The average length of LICSW licensure for the supervisors was 11.3 years (or 136 months) with a SD of 57.6 months. The number of clinical practice hours supervisees had yet to complete was also collected. LGSWs obtaining supervision for LICSW licensure are required to complete 4000 hours of supervised practice experience, which is typically a 2-year process. On average, supervisees had 635 hours remaining with a SD of 445.9.

Table 1. 2

Length of Licensure and Remaining Hours of Supervised Practice

	Supervisor (n=9)		Supervisee (n=9)	
Variable	Mean	SD	Mean	SD
LICSW Licensure (range in months, 77-228)			LGSW Licensure (range 13-42)	
	136.0	57.6	23.3	8.7
Remaining Hours of Supervised Practice (range 84-1600)				
	635.6	445.9		

Note. LICSWs on average had their licensure for 136 months and LGSWs for 23.3 months. The remaining hours they had left to complete of supervised practice was 445.9 with a SD of 635.6.

Instrumentation. The measurement tool used for this study is a modified on-line version of the ABE Conceptual Model designed by this researcher. The ABE Conceptual Model details a series of practice expectations for becoming a clinical social worker at various proficiency levels for obtaining autonomous clinical level licensure also commonly referred to as LCSW or LICSW in the state of Minnesota. The on-line version of the ABE Conceptual Model served as a basis for measuring readiness of a supervisee's independent practice of clinical social work. In its original structure, the ABE Conceptual Model includes a series of grids that describe essential knowledge skills and abilities at three different practice levels. These levels are the professional

developmental milestones of becoming a clinical social worker. They are postgraduate, autonomous, and advanced. Given the focus of the study for determining readiness of autonomous licensure practice, the on-line modified version of the ABE Conceptual Model only focused on the postgraduate and the autonomous levels.

The Postgraduate level is after a social work professional has completed a Master's of Social Work degree. The assumption is that a degree alone cannot prepare a professional for autonomous work in clinical social work practice. Therefore, the professional needs to continue their clinical practice under the guidance of a clinical supervisor for approximately two years to progress to an autonomous level. The grids in the ABE Conceptual Model detail skills and abilities (also known as practice expectations) a supervisor must observe a supervisee demonstrate before advancing them to the autonomous stage of professional development.

The Autonomous competence level is when a practitioner is licensed at a LCSW or LICSW level and no longer needs the provision by a supervisor. This level of mastery assumes that the practitioner can independently decide when they may need consultation about a case or ethical concern. The ABE Conceptual Model draws comparisons between the professional abilities at each of the proficiency levels and may help to specify learning needs of the supervisee, if they are not advancing to an autonomous level. For the purposes of this study, the distinction of the proficiency levels is utilized as the determinant of readiness for autonomous practice.

The on-line version of the ABE Conceptual Model included a total of 20 practice expectations that were rated by the supervisor and supervisee at either a LGSW or LICSW proficiency level. The practice expectations were labeled as items 1 -20 and

were categorized into the Model's four different Areas of Practice including: Assessment and Diagnosis (items 1-7), Treatment Planning (items 8-12), Intervention (items 13-16), and Practice Outcome Evaluation (items 17-20). The on-line version of the ABE Conceptual Model had the participants review practice expectations and rate the proficiency level of the supervisee at either a LGSW or LICSW proficiency level for a total of 20 items. When completing the ratings, the tool also had the option of marking "not enough evidence to make a determination". This option would only be used for instances, when either LGSW or LICSW could not be chosen as a competence level.

For the purposes of the study, competency is defined as the level of mastery being rated, either LGSW or LICSW. Moreover, it is the ability and capacity for a supervisee to perform at a LGSW or LICSW level of licensure. Choosing either option essentially means that the supervisee has the necessary skills, knowledge, and ability for a LGSW level or a LICSW level. Appendix B provides a visual image of the type of questions supervisee participants answered in the on-line version of the ABE Conceptual Model.

Once a proficiency level was chosen for an item, the participant was prompted to rate the competency level for the corresponding proficiency level chosen. For example, if the proficiency level for a practice expectation/item was at a LGSW level, they would choose from a competency level of "Beginning" or "Developing". If the competency level for an item was at a LICSW, they would choose from either "Developing" or "Competent". This is because at a LICSW proficiency level, they are no longer at a beginning level.

For the purposes of this study, competency is defined as a rating of the supervisees' ability to perform at a LGSW or LICSW proficiency level. In terms of the

rating for this study, proficiency was the ability to function at a “beginning” or “developing” level for LGSW and “developing” or “competent” level for LICSW. The additional classification for competence was included as an assessment measure to help further describe the supervisee’s functioning level at a LGSW or LICSW level of proficiency. A participant choosing the competency level of “competent” for the LICSW level, signifies a readiness for autonomous practice for that particular practice expectation.

The rating of competence as either beginning, developing, or competent is not a part of the original design of the ABE Conceptual Model. However, this rating was used to gather more specific information regarding the competency level of the supervisee participants’ proficiency level. Users could provide comments as to why they gave a particular rating. This additional feature of the on-line version was to gather more information on the user’s reasoning for their ratings and written data on their process of using the tool.

Procedure. IRB approval was completed with the University of Minnesota as a first step in the process of this study. Once supervisors and supervisees participants were identified, an on-line recorded orientation was sent to them as well as letter about the study and a copy of the consent form via e-mail for their review. One they agreed to be a part of the study, they completed the on-line signed consent form, which was necessary to participate in the study. The study utilized a Mixed Methods research design including a qualitative and quantitative portion. Creswell (2013) describes the analysis of quantitative data collection followed by a qualitative approach as sequential exploratory. It is regarded “as the ‘procedure of choice’ for assessment/test instrument construction in

research contexts" (Turner, 2012, p. 68). This research design was ideal for exploring and testing the ABE Conceptual Model. The quantitative portion of the study provided measurable outcomes of using the on-line version of the ABE Conceptual Model and the qualitative portion presents information on the experiential use by supervisors and supervisee. Without their perspective, the usefulness and validity of the practice expectations detailed about clinical social work practice are unknown.

Three questionnaires were used for the quantitative portion of the study. Qualtrics survey tool was used for the questionnaires, which met the highest standards for security compliance. The qualitative portion of the study was comprised of audio and video recorded focus groups and or individual interviews. Notes were taken on the key points from the focus groups and interviews for the qualitative portion of the study. The following outlines the steps of the research procedure:

1. Questionnaire One was sent via e-mail to gather all supervisors/ supervisees' demographic information and basic information about current supervision practices.
2. The supervisor and supervisee were sent the modified on-line version of ABE Conceptual Model in the form of an on-line questionnaire (Questionnaire Two). The supervisees were asked to rate themselves on the 20 practice expectations. The supervisors were asked to rate their supervisee on the same 20 practice expectations. The rating were based on the options described in the Instrumentation section of this paper. It was also possible to provide a narrative description to justify the rating.

3. A meeting was held between the supervisor and supervisee to determine a combined rating for Questionnaire Two. This required them to have some discussion and determine a rating they both agreed on.
4. The supervisors and supervisees completed an on-line follow up questionnaire titled, Questionnaire Three. This was an opportunity to provide feedback about the effectiveness of using the ABE Conceptual Model in determining readiness for independent licensure. It also inquired about supervision practices currently used in their supervision to determine readiness for autonomous practice. The questions were mostly open-ended in nature to gather more information about their experience of using the on-line version of the ABE Conceptual Model.
5. Two qualitative focus groups were held with the supervisees and supervisors regarding the use of the ABE Conceptual model. Individual interviews were also held as an alternative option, if they were unable to attend the focus groups. Further data was gathered about their experience of using the on-line version of the ABE Conceptual Model. The questions were open-ended and provided opportunity for discussion with the other participants (for just the focus groups) and researcher (for the focus groups and interviews).

Data collection. Questionnaire One was an on-line format and focused on the demographic information of the participants. This included information such as: gender, age, race, the length of supervisory relationship, status of completing licensure requirements for the supervisee, the practice setting, and years of experience in practice for the supervisee and years of experience in providing supervision for the supervisor. Other information gathered included the focus and structure of current supervision

sessions, the designs of the supervision plan being used and identified learning needs for the supervisee upon onset of the supervisory relationship. Categories of the items were based on literature about supervision styles and type. The information gathered on the supervisory process and context could influence the outcome of using the ABE Conceptual model. Additionally, questions about current supervision practices assisted in understanding how determination of readiness is completed without using the ABE Conceptual Model.

Questionnaire Two was the actual use of the on-line version of the ABE Conceptual Model. Initially, supervisees and supervisors completed separate questionnaires rating the supervisee's proficiency and competence levels with 20 practice expectations. This initial rating was based on their individual perceptions. The on-line version also offered a narrative option for each of the practice expectations allowing the user to justify or explain their rating. Questionnaire Two was completed a second time by the supervisors and supervisees, however this second rating was based on both of their perspectives. The second rating of Questionnaire Two required a meeting between the supervisor and supervisee to discuss an agreed upon rating. They could choose more than one rating, if they could not agree on one rating and were asked to provide a narrative description for choosing more than one option.

Questionnaire Three was an on-line follow up questionnaire on the supervisors and supervisee's experience of using the ABE Conceptual Model. They provided feedback about using the Model to determine readiness for independent licensure. They were asked specific questions about the practice expectations identified in the ABE Conceptual Model including, which practice expectations were most explicit in

determining readiness. Questionnaire Three included both open-ended and multiple-choice questions with opportunities enter their own options. Additionally, questions about their current supervision practices were gathered to identify how determination of readiness is completed without using the ABE Conceptual Model. Themes and common data points were identified from the quantitative and narrative data gathered.

The fourth data set was a qualitative data gathering process from focus groups or interviews. The interviews and focus groups included guided questions specifically addressing the identified research questions. Participants were asked, what practice expectations they found to be the most explicit and other feedback they had about using on-line version of the ABE Conceptual Model. The intent of this process was to validate findings from Questionnaire Three utilizing a cross verification technique.

Data analysis. Data Analysis of this study included both descriptive and inferential statistics. Questionnaire One gathered demographic information about the participants and their supervisory process and context. Central tendencies of the data collected such as the mean and diversions such as Standard Deviation were calculated to describe a profile of the participants. A comparison of the demographic data was also made between the supervisors and supervisees to identify any specific trends in the two subgroups of participants. Descriptive information on the supervisory context and process was also gathered from the participants. The mean and SD were completed to summarize important patterns in the supervisory context of the participants. This process provided information for comparative and inferential statistical analysis with data collected on using the ABE Conceptual Model in Questionnaire Two.

Data analysis of Questionnaire Two provided information on the difference in perception by the supervisor and supervisee regarding the supervisee's proficiency and competency. Descriptive and inferential statistics were used to identify common differences or similarities in their individual ratings. Central tendencies were gathered including the mean, mode, and standard deviation. The *t*-test was also used to determine, a significant difference between the individual scorings of the supervisors and the supervisees. The *t*-test also highlighted agreement or disagreement of ratings between the initial individual and second joint rating of Questionnaire Two.

Common themes or categorical language was drawn from narrative responses provided to justify ratings or to describe discrepancies in the joint rating. A chi-square was used to identify any correlation between the scoring in Questionnaire Two and descriptive information gathered in Questionnaire One about the participants' supervisory context and process. Given the small sample size, statistical significance was difficult to determine, however meaningful tendencies were able to be identified and described.

Descriptive and inferential data analysis was also applied to data collected from Questionnaire Three. Feedback about the participants experience with using the ABE Conceptual Model is primary with this Questionnaire. Several of the responses are narrative comments describing their opinion or thoughts on the usefulness of the on-line version of the ABE Conceptual Model. They also provided information on construct and content validity of the practice expectations. This includes feedback on the use of language and clarity of the language used to describe the practice expectations. The data from Questionnaire Three aids in clarifying, if the ABE Model is congruent with conceptual understandings of clinical social work practice. Questionnaire Three most

directly addresses the research questions of the study. Questions about the supervisors' current supervision practices identified current practice expectations they use to determine readiness of a supervisee without using the ABE Conceptual Model. Also, participants are asked to identify the most explicit practice expectations of all 20 items.

Data collected from the focus groups and interviews included identification of common language, ideas, and themes identified by participants. Patterns in language, key words, and phrases were noted and summarized. The information gathered was compared the narrative data collected in Questionnaires Two and Three. Trends and patterns in the information will be described in narrative form with quotes as evidence of the themes identified.

Summary

How supervisors and supervisees experienced using the ABE Conceptual Model is best understood by a mixed methods approach. This includes analyzing the quantitative outcomes and demographic factors that influence assessment of a supervisee. The qualitative approach allowed participants to describe their story and share what impacted their process of determining readiness for clinical social work practice. The data analysis is descriptive and also identifies influential factors for determining proficiency. Supervision is no doubt a complex experience and process that involves assessment of a developmental process, examination of social learning, and the impact of environmental factors from the field. Next, the results of using the ABE Conceptual Model are presented and specific answers to the research questions.

Chapter 4: Results

This study gathered information about the use of the ABE Conceptual Model with clinical social work supervisors and supervisees in the Northeastern region of Minnesota. The ABE Conceptual Model is designed to guide determination of trainee proficiency for independent clinical practice. The specific research questions examined are: 1) how the practice expectations identified in the ABE Conceptual Model assist clinical supervisors in assessing readiness for a supervisee's independent practice of clinical social work, 2) which practice expectations are the most explicit in determining readiness, 3) how the use of the model compares to a clinical supervisor's determination of readiness without using the ABE Conceptual Model. The research questions ultimately are seeking to understand the application of the ABE Conceptual Model in a supervisory context with clinical social work trainees for licensure.

An important consideration in reviewing the results of using the ABE Conceptual Model is to examine factors which influence a supervisor's capacity to assess a supervisee. To begin, demographic and contextual information about supervision gathered in Questionnaire One will be summarized. Next, the results of the participants using the ABE Conceptual model are shared. Finally, the participants' reflection on using the ABE Conceptual model is described. This includes their reflection on how the practice expectations assisted in assessment of readiness, which practice expectations they found to be most explicit and their perception of using the ABE Conceptual Model in comparison to their current supervision assessment techniques. All data results from the questionnaires, focus groups, and interviews culminate common themes and recommendations for using the ABE Conceptual Model. The results yield some

important implications for the structure and content of supervision, when clinical supervisors are assessing proficiency for licensed autonomous practice.

Data Analysis

Data collection was completed by participants taking three on-line questionnaires and participating in focus groups or interviews. The first questionnaire gathered demographic and contextual information about the participants and questions pertaining to the format, structure, and frequency of supervision. The second questionnaire was the use of the on-line version of the ABE Conceptual Model. This was essentially a trial of using the ABE Conceptual Model in a real supervisory situation, which has never been done. All participants completed the second questionnaire twice. First to share their individual perspective and a second time with their supervisor or supervisee who was also participating in the study for a joint perspective. The ratings provided comparable information for data analysis. The third questionnaire, focus groups, and interviews provided the most direct information in answering the research questions by asking participants to reflect on their use of the ABE Conceptual Model. Understanding their experience was the overarching purpose of the study. The questions focused on feedback about using the on-line version of the ABE Conceptual Model.

Data analysis on the demographic information and on the outcome of using the ABE Conceptual Model utilized descriptive and statistical analysis such as the Mean and Standard Deviation (SD). The qualitative portion of the study gathered information from participants in focus groups and interviews. Data analysis included summarizing the key points and categorizing the information into themes addressing the research questions. An important aspect of the results indicated correlations between some of the supervisory

factors that can have an influence on assessment of proficiency and competence. Chi-square tests were completed to identify if any of the supervisory factors such as location or frequency of supervision had an impact on the ability to assess readiness. Given the small sample size, there were some results which were not statistically significant, but were meaningful to interpret. Ultimately, the correlations highlight some important factors to consider when using the ABE Conceptual Model.

Descriptive Data

Questionnaire One gathered participants' general demographic information and contextual information about supervisory practices that could influence assessment of the supervisees. Demographic information indicated that the majority of participants were female at 83%. Generally, speaking supervisors and supervisors were with the age range of 35-60, with most supervisees in the age range of 40-49. Almost all participants were of Caucasian decent with one supervisee identifying as Native American and another that identifying as Multiple or Other. All participants highest level of education was a MSW. The primary settings where participants practiced social work was either non-profit (at 44%) or for-profit (at 44%) organizations. The average length of licensure for supervisee was 1.9 years and 11.3 for supervisors. Supervisees on average had 3365 out of the required 4000 hours of supervised practice completed for obtaining Minnesota clinical licensure (see Table 1.1 and 1.2 for further statistical information in chapter 3).

Supervision context and models. While the requirements of the study excluded anyone who has completed less than 100 of the 200 required hours of supervision, there were a number of other factors to be taken into consideration. This includes information about the supervisory relationship when analyzing the data results. This specifically

refers to the frequency, format, and location of supervision. Data on the different types of supervisory models are also considered. This includes, the participants perception of their supervision having a more educational, supportive, or administrative focus. The premise is that factors of supervision could have an impact on the supervisors' ability to determine proficiency and competency of a supervisee. Therefore, knowing more about the participants' context of supervision has important implications for the outcomes of using the ABE Conceptual Model.

As shown in Table 2.0, supervisors and supervisees estimated knowing each other approximately 6 years (75.3-75.8 months). On average, they completed at least 100 hours of supervision with each other. The frequency and format of supervisor was primarily 4 hours of in-person supervision and 2-3 hours of group supervision. Eye to eye electronical media (or web conferencing) was estimated at one hour per month by all the pairs of supervisor and supervisees. Supervision by phone was rarely used. Another factor related to the format of supervision was having more than one supervisor. Only two out of the nine supervisees had more than one supervisor for licensure. The location of supervision was similar with only two supervisors being off-site from where the supervisee practiced clinical social work. If they had an off-site supervisor, the supervisor did not work for the same agency as the supervisee and provided supervision off-site from where the supervisee practiced.

Information about the participants perceptions of supervision was additional information gathered. Participants were asked to choose the most predominate type of supervision to describe their supervisory sessions. They chose from the following options and descriptions: Educational- supervision focuses on knowledge and skills of

social work, Supportive- supervision focuses developing supervisee's professional identity; exploration of strengths and areas of needed growth and Administrative-supervision focuses on work performance and/or functioning within workplace. The resounding response from both supervisors and supervisees was a supportive supervision type. Finally, participants were asked to identify if their supervision covered content on the following Areas of Practice: Assessment and Diagnosis, Treatment Planning, Intervention, and Outcome Evaluation. They were able to choose any or all of the Areas of Practice. The majority of participants indicated that all Areas of Practice were covered (see Table 2.0 for more information about the Areas of Practice). The information gathered on the context and models of supervision was analyzed using at Chi-square test to determine if these factors had any relationship with supervisees' proficiency and competency ratings. Making this comparison could provide further information of factors that influence the use of the ABE Conceptual Model. An ancillary analysis is described later in the chapter and highlights some of the meaningful correlations which were identified.

Table 2.0

Supervision Context and Model

Pair#- Sp or Se[a]	HrsSp[b]	Predominant Type of Supervision	Meeting Hours per Month: In-person	Eye to Eye Media	1:1 Phone	Group	Site	Sp>1[c]	Months Known	Areas of Practices[d]
Pair5-Sp	152	Educational	8	0	0	0	On-site		96	All
Pair5-Se	152	Educational						No		ATI
Pair2-Sp	100	Educational	3	2	1	3	Off-site		240	AT
Pair2-Se	100	Administrative	4	4	0	0		No		ATI
Pair7-Sp	100	Administrative	4	0	0	2	On-site		36	All
Pair7-Se	100	Supportive						No		ATI
Pair3-Sp	100	Supportive	3	0	1	4	On-site		132	All
Pair3-Se	100	Educational	4	0	0	4		No		All
Pair1-Sp	65	Supportive	4	0	0	4	On-site		14	All
Pair1-Se	65	Supportive						No		ATI
Pair4-Sp	100	Supportive	4	1	1	0	On-site		41	All
Pair4-Se	100	Supportive						No		All
Pair6-Sp	97	Supportive	0	0	0	4	Off-site		75	ATI
Pair6-Se	97	Supportive						Yes	52	All
Pair8-Sp	88	Supportive	4	0	0	4	On-site		24	ATI
Pair8-Se	88	Supportive						Yes		All
Pair9-Sp	100	Supportive	4	0	0	4	On-site		24	All
Pair9-Se	100	Supportive						No		All
Summary: 9 Pairs										
Supervisors										
Mean	100.2	2 Educational	3.8	0.3	0.3	2.8	7 On-site		75.8	6 All
SD	22.6	1 Administrative	2.0	0.7	0.5	1.7	2 Off-site		72.9	2 ATI
		6 Supportive								1 AT
Supervisees										
Mean	100.2	2 Educational	4.0	0.6	0.1	2.4	7 On-site	7 No	73.2	5 All
SD	22.6	1 Administrative	2.0	1.3	0.3	1.9	2 Off-site	2 Yes	73.3	4 ATI
		6 Supportive								

Note. [a]Sp=Supervisor, Se=Supervisee; [b]HrsSp= Hours of Supervision Completed Together; [c] Sp>1= More than one supervisor for licensure; [d]All = Assessment and Diagnosis(A), Treatment Planinng(T), I(Intervention) and Outcome Evaluation.

Results of using the ABE Conceptual Model. Questionnaire Two was the actual practice of using the ABE Conceptual Model. This is included as part of the descriptive data because the results of using the model do not specifically address the research questions at hand. The research questions are focused on the participants' experience of using the model, not the statistical outcomes of the participants using the model. The results do however, present some interesting differences of perception between the supervisors and supervisees and are meaningful in the study's overall outcomes and themes.

To recap, supervisors and supervisees first completed their own individual ratings for Questionnaire Two. The supervisor completed a rating for the supervisee on each of the practice expectations and the supervisee completed their own self-rating. Next, they met and completed Questionnaire Two again, but had a discussion and made a joint rating reflecting both of their perspectives. If they were unable to come to a joint decision on a rating, they could mark both ratings and provide a rationale for each rating.

With the focus of the study on the experience of using the ABE Conceptual Model, only a brief summary of results are provided. On average with the individual ratings, supervisees rated their proficiency and competence lower than their supervisor. Of the nine pairs of supervisors and supervisees, five had a high level of agreement between the supervisor's rating and the joint rating. Four out of these five high ratings were exactly the same.

Some significant trends were evident in the data pertaining to the Areas of Practice for Treatment Planning (practice expectations or items 8-12). The responses to the practice expectations or items focused on Treatment Planning indicated a slightly

higher level of agreement between supervisors and supervisees at 84.5%. While this was not significantly high, it is a trend that occurred in the results (see Table 3.0). Additionally, the results also indicted that overall scoring by supervisors, supervisees and in their joint scorings were lower in the practice area of Evaluation Outcomes (items 17-20).

Table 3.0

Percent of Agreement between Supervisor Rating and Combined Rating

Areas of Practice	Item Number							Mean
Assessment and Diagnosis (item 1-7)	1	2	3	4	5	6	7	
Frequency (out of n=9)	6	6	8	6	7	5	9	6.7
Percent	66.7	66.7	88.9	66.7	77.8	55.6	100	74.6
Treatment Planning (item 8-12)	8	9	10	11	12			
Frequency (out of n=9)	8	9	7	7	7			7.6
Percent	88.9	100	77.8	77.8	77.8			84.5
Intervention (item 13-16)	13	14	15	16				
Frequency (out of n=9)	7	8	6	7				7.0
Percent	77.8	88.9	66.7	77.8				77.8
Outcome and Evaluation (item 17-20)	17	18	19	20				
Frequency (out of n=9)	5	5	8	4				5.5
Percent	55.6	55.6	88.9	44.4				61.1

Note. The instances of agreement between the supervisors' individual rating and the rating they completed together with their supervisee were counted. The Area of Practice with the greatest level of agreement was Treatment Planning at 84.5%.

Questionnaire Two provided some useful information regarding the differences and similarities in perception shared between the supervisor and supervisee. When the supervisors and supervisees met to discuss their rating, they had a greater degree of agreement with the supervisor's scoring. The rating of proficiency and competency with ABE Conceptual Model is a matter of perception; however, several supervisors and

supervisees noted it was helpful to have a common language and description of practice expectations. This is further detailed in the results from Survey Three, the focus groups, and interviews with supervisors and supervisees.

Presentation of the Results

Questionnaire Three provided supervisors and supervisees the opportunity to reflect on their experience of using the ABE Conceptual Model. This questionnaire is by far the most direct approach to answering the research questions for this study. While Questionnaire One provided demographic information about the participants and the supervisory context, the information only provided the background information for analyzing the results. Additionally, Questionnaire Two was the practical use of the ABE Conceptual Model. In Questionnaire Three, the participants reflected on using the model and shared their perception on how it assists in assessing readiness of trainees for autonomous practice. The focus groups and interviews had similar questions from Questionnaire Three to provide more of an open-ended discussion with other participants and the researcher. There was a total of two focus groups including three supervisors and supervisees and four interviews with one supervisor and three supervisees. The results of Questionnaire Three, the focus groups and interviews will be discussed under the subheadings for each of the research questions.

Practice expectations assisting in assessing readiness. The central research question is exploring how the ABE Conceptual Model assists supervisors in assessing readiness for their supervisee to practice independently. The results from Questionnaire Three and information gathered from the focus groups and interviews presented two common themes. First, the practice expectations are assistive with determining

competence because they provide descriptive language detailing knowledge, skill, and abilities that are necessary for clinical practice. Second, the practice expectations help to foster communication about expectations. The data collected which supports these themes provides a more in depth understanding of how the practice expectations assist in assessment of a supervisee.

Participants were asked a series of closed and open-ended questions in Questionnaire Three. The questions probed whether or not the ABE Conceptual Model was helpful in determining proficiency and competency, if they would want to use it on-going in their supervisory process, and any additional information they wanted to share about its use. Participants generally felt that the ABE Conceptual Model was helpful to clarify practice expectations and giving language to the knowledge, skills, and abilities social workers should have to work autonomously. Specifically, in Questionnaire Three participants were asked if the ABE Conceptual Model was useful in learning about either their own competence or their supervisee's competence (depending on their role in the study). Seventy-five percent of the respondents (9, 5 supervisors, 4 supervisees, N=12) responded "yes" and 33% "no" (3, 2 supervisees, 1 supervisor). Participants could add a comment with their response. One participant wrote, "it helped us both to determine the areas of strength and areas in which to grow and expand". Another wrote, "it provided a useful framework for skills and competency measurement". Those who replied with "no" only had one written response stating that they already had a good understanding of their supervisee's competence without using the ABE Conceptual Model.

From the focus groups and interviews, more in-depth information was gathered. The results indicated that the practice expectations were assistive with determining

strengths as well as areas of focus for advancing supervisees' practice to an autonomous level. One participant described the ABE Conceptual Model as providing a "structured baseline" for determining proficiency and competency. He explains, "It gave a structured baseline of differentiating proficiency between LGSW's and LICSW's in an easy to follow, organized way". A supervisor shared that the practice expectations in the ABE Conceptual model shaped the direction of supervision, "It helped give me a good idea of what we can be working on before she completes her hours." Another supervisor shared, "It made me feel confident in assessing my supervisee's critical thinking skills, independence/self-reflection skills, clinical knowledge, and flexibility." The insights shared confirm that the practice expectations did assist in determining readiness as well as areas of needed growth.

Five participants in the focus groups and interviews expressed that the practice expectations in the ABE Conceptual Model helped to foster communication between the supervisor and supervisee. One participant stated, "During the survey that we took together [referring to Questionnaire Two], I learned new information that I otherwise would not have discussed with her." They also described the ABE Conceptual Model and practice expectations providing structure in conversations about the supervisee's practice. "It was a good structure for evaluation of practice more so then just talking."

Some participants commented on the potential value of using the ABE Conceptual Model throughout supervision, rather than just at one point in time. Two participants explained that it would have been helpful to have the ABE Conceptual Model at the beginning of their supervisory process to know what was expected of them as a supervisor and supervisee. One supervisor stated, "I thought it would have been

helpful to have it in the beginning of supervision. It intrigued me that I could use this to gauge my own supervisory relationship." Not only were the practice expectations foreseeably helpful to the supervisee, but also the supervisor in evaluating their supervision. A supervisee shared,

> I wish I would have had this early on and that we could have used it in the middle of my hours. By completing it with my supervisor, I found out she felt I was way more proficient that I thought she did.

The focus group and interview data revealed that ABE Conceptual Model may useful as a measurement tool at the beginning, midpoint, and endpoint of the supervision for licensure.

Some of the ways the practice expectations did not assist in determination of proficiency were also discussed in the focus group and interviews. Participants highlighted the importance language. Two participants noted that the practice expectations were not specific enough. One supervisor explained, "I had a hard time with the wording in some of them. I would have to re-read them just to grasp what they were about". A supervisor even recommended more of a scaling with descriptive language for each of the practice expectations. He explains,

> Some of them were too general. It would be helpful to have a greater breakdown of what it looks like at each level. A more thorough description of a scaling so you can clearly determine where the supervisee is and where you want them to be.

A supervisee also shared about the benefit of a scaling for each of the practice expectations. "My main point would be that I would have one statement with a range of statements. There would be like a 4-point scale for LGSW going to LICSW, and I would

choose the number." There is clearly a suggestion for further clarification of practice expectations.

Another supervisor participant described the use of the ABE Conceptual Model as "frustrating" due the verbose language and difficulty clearly understanding what types of behaviors the supervisee should be exhibiting. She shared that it would have been helpful to have more detailed examples and descriptions of observable behaviors. She overall found the language of the practice expectations to be too general and complex for making a clear determination of competence or proficiency. Based on participant comments, language in some of the practice expectations is too vague for making a clear determination. Some participants also felt that a scaling with more detailed examples would be beneficial.

Two supervisors noted that some of the practice expectations did not align in content from one competency level to the other. One example was given for practice expectation number two. The practice expectation at the LGSW level states: "Is familiar with principles of systems impacting client services" (ABE, 2002, p. 18). The practice statement at the LICSW level states: "Analyzes system barriers to client care" (ABE, 2002, p. 18). The participant explained that the first statement at the LGSW level had a completely different focus in content than the practice expectation for the LICSW. This lack of congruence prevented him from being able to make a clear determination because the descriptions were not "mutually exclusive". He explains,

> I felt like the statements for LGSW and LICSW didn't exactly correlate. For example, "familiar with principles of systems" and "analyzes". I did not see this as a continuum. Because as you become familiar you are analyzing. They are not

> mutually exclusive. Both may be true and they seem to be mutually exclusive the way they are presented. It is important that the statements are mutually exclusive. Unless I can see how these are different, it's hard to make a determination.

One of the participants felt the ABE Conceptual Model was conceptually difficult to understand, and they would have appreciated a more in-depth orientation to understanding is origination and purpose. She explains,

> It would have been helpful to have known more about the model, while we were using it and not just at the very beginning. It would have helped me understand the reason for doing the survey once by myself and again with my supervisor.

While an orientation and overview of the ABE Conceptual Model were provided as a part of the study's introduction and consent, the participant felt further information could have been provided throughout the study process to ground her understanding.

Two participants in the focus groups commented that the language used in the practice expectations could be interpreted in different ways depending on the setting of practice and the cultural context of the supervisor and/or supervisee. An example was given about language interpretation in more rural settings or with supervisors or supervisees from the Native American communities. One participant stated,

> I am wondering if people from different cultures interpret the wording in the same way I am. So, is the wording understood in the same way across cultures. Item 5- where bias comes in. There may be some very close community or family connections that might affect how a person from a different culture might understand that expectation. It would be important to consider how different cultures may interpret the wording. Having the supervisee and supervisor talking

> about wording and what it means to them. That conversation would be a beautiful way of creating and encouraging knowledge and growth with both supervisor and supervisee.

In summary, participants expressed concern about the potential for different interpretations of words used in the practice expectations. This particular participant felt that conversations about how the practice expectations were being understood could encourage knowledge and relational growth between the supervisor and supervisee. The idea of the practice expectations fostering communication emerged again.

Information gathered from Questionnaire Three, the focus groups and interviews ultimately determined that practice expectations assisted with clarifying what a supervisee should know and demonstrate at different proficiency levels. It also was repeatedly noted as helping to foster communication between the supervisor and supervisee. Several felt the ABE Conceptual Model could be used at different benchmarks of the supervisory process. Concerns about the language used in the practice expectations was described by some participants as being too general and verbose resulting in varied interpretations potentially across cultures and in different settings. A descriptive scaling was suggested to clarify expectations of measurable growth or deficit with proficiency and competence. Despite some areas where the use of ABE Conceptual Model and language of the practice expectations could be clarified, it is was overall viewed as a helpful process in determining proficiency and competence.

Most explicit practice expectations. In Questionnaire Three, participants were asked to identify the most explicit practice expectations for determining readiness of autonomous practice or proficiency. This question was asked to narrow down what

aspects of the ABE Conceptual Model are most detailed and helpful in nature. The practice expectations were divided by their respective Areas of Practice (Assessment and Diagnosis, Treatment Planning, Intervention, and Evaluation Outcomes). The participants could choose more than one item or practice expectation within of the Areas of Practice sections. As seen in Table 4.0, the practice expectation that were determined to be the most explicit based on the highest frequency were: number 19 from Evaluation Outcomes, chosen by 83% of the survey respondents, number one from Assessment and Diagnosis, chosen by 75%, number eight from Treatment Planning, chosen by 66%, and number 20 from Evaluation Outcome (chosen by 66%). Notably, there were two items (practice expectations 19 and 20) from the Outcome Evaluation section that were considered most explicit. None of practice expectations from the Intervention category were above 50% and therefore were not considered highly explicit. The mean frequency for Outcome Evaluation was the highest category at 54.1%, which indicates that participants found this Area of Practice to be the most explicit.

Table 4.0

Most Explicit Practice Expectations/Items

Areas of Practice	Item Number							Mean
Assessment and Diagnosis (item 1-7)	1	2	3	4	5	6	7	
Frequency (out of n=12)	9	6	6	6	4	5	6	6
Percent	75	50	50	50	33.3	41.6	50	49.9
Treatment Planning (item 8-12)	8	9	10	11	12			
Frequency (out of n=12)	8	6	6	6	6			6.4
Percent	66	50	50	50	50			53.2
Intervention (item 13-16)	13	14	15	16				
Frequency (out of n=12)	6	5	5	6				5.5
Percent	50	41.6	41.6	50				45.8
Outcome and Evaluation (item 17-20)	17	18	19	20				
Frequency (out of n=12)	4	4	10	8				6.5
Percent	33.3	33.3	83.3	66.6				54.1

Note. Participants identified the practice expectations they felt were the most explicit. The Area of Practice they determined to be the most explicit was Outcome and Evaluation at 54.1%.

During the interviews and focus groups, three participants explained that Outcome Evaluation was not something they often considered or discussed as a part of supervision. One supervisee explained,

> I think when [his supervisor] and I met together we reflected a lot on outcome evaluation and the importance of us evaluating our outcomes. Outcomes in terms of practice, not on supervision. The practice expectations that focused on evaluating outcomes made us consider that topic more. The entire idea was processed by having it (the practice expectation) in front of us. That was the only expectation where this happened.

For this participant, practice expectations that specifically addressed evaluation outcome emphasized the importance of this topic in supervision. He indicated that when he and his supervisee were rating practice expectations for the evaluation outcome category he realized he had never discussed this area of practice in supervision. He explains, "I have not really talked about outcome evaluation with my supervisee. Rating these items reminded me that we need to incorporate this into our supervision." While the overrepresentation of Outcome Evaluations items did not yield any statistical significance (due to the small sample size), it is a trend in the data and therefore meaningful to interpret. Participants in the focus groups and interviews confirmed the explicit nature of the items in the Evaluation Outcome category. They also shared that they may not have ever discussed competence for this area of practice without having them detailed in the ABE Conceptual Model.

ABE Conceptual Model compared to other supervisor practices. Another important inquiry in Questionnaire Three pertained to the methods of assessment the supervisors and supervisees currently use in supervision to determine proficiency and competency. This question helped to clarify how the techniques supervisors were currently using in supervision compare to the ABE Conceptual Model. From the results from Questionnaire Three, the focus groups and interviews indicated that the techniques they currently use do not compare to the ABE Conceptual Model.

In Questionnaire Three, participants were given a list of methods for assessment commonly used in supervision of social workers (case consultation, co-therapy, live observation, video recording, interpersonal process recall, role playing, and other). If "other" was chosen, the participant could enter their own response to detail the method(s)

they use. They could choose more than one response. Case consultation (at 90%, n=11, 9-6 supervisors, 4 supervisees) was the method of assessment most commonly identified by both supervisors and supervisees. Interpersonal Process Recall (27%, n=11, 3 supervisees) was the second most common method identified solely by supervisees. A total of three participants choose "other" and noted reviewing documentation and case file audits as other methods of assessment used in supervision to determine proficiency and competence. Practice expectations in the ABE Conceptual Model does not discuss performance with any of the methods of assessment the participants identified. Therefore, what the supervisors and supervisees are doing in supervision to assess readiness for autonomous practice does not compare to using the ABE Conceptual Model. They did not indicate any kind of formal measurement of proficiency. Much of how proficiency and competency is determined is based on reviewing documents and having discussions or case consultations in supervision. Their determination of proficiency and competence is more subjective in nature and does not include a clear measurement. When asked in Questionnaire Three if they would continue using the ABE Conceptual model as a method of assessment, 75% (9, N=12) said that they would continue. They also shared that it would be helpful to have a paper copy of the ABE Conceptual Model verses the on-line version.

Participants in the focus groups and interviews confirmed that the use of the ABE Conceptual Model does not compare to the techniques they often use in supervision to make a determination of readiness. One supervisor explained, "I do a weekly audit and discuss during supervision details of what I have read and the ability to make professional, ethical decisions based on the diagnostic assessment, treatment plan, and

case note". Their assessment of a supervisee is based on case documentation regarding treatment and how the supervisee conceptualizes ethical and professional issues in supervision discussions. There is not a set of practice expectations that are discussed and measured as with using the ABE Conceptual Model.

During the discussion in the focus groups and interviews, participants once again pointed out the benefit of being able to use the ABE Conceptual Model throughout their supervision. One supervisee explained, "Just having it earlier in the supervision process to track your course and then you re-check in every 6 months. The 2 years goes fast and it would be helpful to see how you are working towards your LICSW". The process of measuring progress is motioned as something they would like to do on-going. Not only were participants interested in continuing to use the ABE Conceptual Model, they also were considering ways they could implement it into the structure of their supervision. Three supervisees shared that it would be helpful to have a paper copy to use the ABE Conceptual Model verses the on-line version. One supervisor shared, "I also agree with having an paper copy to review. I would want to have it in front of me and have a paper copy verses just an on-line version. Or an option to print out my responses". When asked a follow up question about why this would be helpful, a supervisee explained, "Whenever there is a computer survey I go through it fast verses having it on paper and being able to think through it and see it".

To summarize, the ABE Conceptual Model does not compare to other assessment techniques the supervisors and supervisees were using. The majority of participants were interested in continuing to use it and had some logistical suggestions about how it could be structured into their supervision including having a paper version to reference and

process. Overall, participants reflected a positive experience with using the ABE Conceptual Mode, but provided thoughtful suggestions about how it could be improved or modified to be more efficient and effective in their practice settings and context for supervision. Due to the variety of formats and structures of supervision that exist in the field, it is important to consider how these factors could impact the use of the ABE Conceptual Model. An ancillary analysis about the contextual factors of supervision is explored next.

Contextual factors influencing determination of competence. Information about the contextual factors of supervision were gathered to identify if they had any correlations with the outcomes of Questionnaire Two. The supplementary analysis focused on whether or not there were aspects of the location, format, or frequency of supervision that had an impact on supervisors' ability to assess supervisees. While this question was not the direct focus of the study, this descriptive analysis was important to consider as a part of the participants experience in using the ABE Conceptual Model. Statistical correlations between the contextual factors of supervision and the outcomes of using the ABE Conceptual Model were completed to identify variables that impacted assessment of supervisees.

The location of supervision was one important factor to consider and did correlate with participants' ability to make a determination of proficiency. If a supervisor is "off-site" meaning they do not practice as a LICSW at the same agency where the supervisee practices, they may not have as much direct oversight of a supervisee. This could potentially influence their determination of proficiency on some items of the ABE Conceptual Model, which pertain to skills or abilities assessed by direct observation.

Some supervisors are "off-site" because the agency where the supervisee is practicing does not have any LICSWs who can provide their supervision. Two out of the nine supervisees had "off-site" supervisors. While this is not a significant number, it did have an impact on how the supervisors rated supervisees when using the ABE Conceptual Model. The off-site supervisors more frequently indicated that they did "not have enough evidence to make a determination" of proficiency in comparison to the on-site supervisors. Of the nine instances supervisors did not have enough evidence to make a determination, eight out of the nine were by off-site supervisors.

The supervisors and supervisees perception about the type and content of supervision were other important comparisons. Both factors resulted in a positive impact on the proficiency and competence ratings. Participants were asked to choose the most predominate type of supervision to describe their supervisory sessions in Questionnaire One. They choose from either educational, supportive, or administrative types of supervision. Supportive supervision was the most common type identified.

To determine, if there was any type of a correlation between the type of supervision and the ratings of proficiency and competence ratings, the Chi-square test was completed. The two variables were the competency and proficiency ratings by the supervisors and supervisees in relation to and the types of supervision chosen by the supervisors. The calculation was only applied to one practice expectation for each area of practice. Table 5.0 displays the results for item or practice expectation one regarding diagnostic assessments. For five supervisee's ratings, there was a slight correlation with their proficiency and competence and the type of supervision. Although it was not statistically significant, p =0.06, the supportive supervision type had a positive impact on

the proficiency and competence ratings in comparison to the educational or administrative types. This trend was identified only with the nine supervisee responses (see Table 5.0). In summary, the Supportive supervision type yielded higher ratings of proficiency and competence with supervisees than other types of supervision.

Table 5.0

Impact of Supervision Type on Proficiency and Competence Rating: Overall

Supervision Type	Proficiency & Competence (Frequency)				Chi-square	*p*
Item 1: LGSW: Formulates comprehensive biopsychosocial assessments using current Diagnostic and Statistical Manual under supervision. LICSW: Independently applies differential assessment and diagnostic skills and assesses clinical risk						
	LGSW-B[a]	LGSW-D[b]	LICSW-D[b]	LICSW-C[c]		
Supervisor Responses					1.50	0.47
Supportive (n=6)	0	2	2	2		
Educational + Administrative (n=3)	0	2	0	1		
Supervisee Responses					3.60	0.06
Supportive (n=5)	0	2	3	0		
Educational + Administrative (n=4)	0	4	0	0		
Combined Responses					2.63	0.27
Supportive (n=6)[d]	0	3	2	1		
Educational + Administrative (n=3)[d]	0	1	0	2		

Note. [a]B=Beginning, [b]D=Developing, [c] C=Competent, [d]Used the supervisor's responses for the Supervision Type. The Chi-Square was calculated between the participants ratings for Proficiency and Competency of Item 1 and the Supervision Type. The individual ratings for the supervisors and supervisees as well as their combined ratings are shown. Although the results were not statistically significant, *p* =.06, the supportive supervision type was likely to have positive impact on the proficiency and competence than educational or administrative types, based on nine supervisee responses.

Another comparison analyzed was the similarity between the type of supervision identified by the supervisor verses the supervisee. Three out of the nine pairs of

supervisors and supervisees did not classify the most predominate type of supervision as the same (see Table 3.0). This indicates some difference of perception about the type of supervision they are either providing or receiving. While this did not directly correlate to any of the ratings for proficiency or competence, it does speak to the difference in perception of supervision type, which may occur between supervisors and supervisees.

Another contextual factor which correlated with the ratings was the participants' classification of content covered in supervision. Participants were asked to identify, which of the following categories they felt their supervision focused on: Assessment and Diagnosis, Treatment Planning, Intervention, and Outcome Evaluation. They were able to choose any or all of the categories. The majority of participants indicated that all Areas of Practice were covered (see Table 3.0). Their classification of supervision content was then compared to their ratings of proficiency and competence for each of the Areas of Practice. The results indicated that what supervisors and supervisees perceived they covered in supervision may have been different than what they were able to make determinations about with regard to proficiency and competency. In some instances, supervisors and supervisees identified that they covered a particular Area of Practice, such as "outcome evaluation", but then when completing the items in the ABE Conceptual model that pertained to outcome evaluation, they indicated they did "not have enough evidence to make a determination" of proficiency. While this trend was not significant, the discrepancy was present in the data results. The take away is, once again, what supervisors and supervisees perceive they are doing in supervision may be different than what is actually occurring or what they are able to assess.

The supplementary analysis of the data provided some useful information about potential factors that could influence determination of competence and proficiency. The location of the supervisor could have an impact on the supervisor's ability to make a determination of proficiency and competency. Differences in perceptions between the supervisor and supervisee regarding the type and content of supervision could impact their determination of proficiency. It is evident that supervision is a complex relationship that is impacted by several factors when determining readiness for autonomous practice.

Summary

A trial of the ABE Conceptual Model with actual supervisors and supervisees provided useful information about how it can assist supervisors in making a determination of proficiency and competence. The participants concluded that the descriptive language of the practice expectations assists in clarifying what proficiency looks like at LGSW and LICSW levels, however the language may be too general. They also found that the process of using the ABE Conceptual model encourages communication about what was or was not occurring in supervision related to proficiency. In particular, they identified two practice expectations about Evaluation Outcomes to be most explicit and shared this area of practice is not a common discussion in supervision. The most common forms of proficiency assessment used by supervisors are case consultation and process recall. Participants added that documentation review was essential to supervision. Ironically, this was not a specific area of focus with the ABE Conceptual Model. The ancillary analysis of the data suggested that being an on-site supervisor can provide more opportunities for making a determination of competence. Additionally, a Supportive type of supervision can impact the self-ratings of

supervisees. Supervisors and supervisees often may have different perceptions about the type and content of supervision. While this did not appear to have direct effect on determination of competence, the different perceptions may impact what is being assessed in supervision.

The results of supervisors and supervisee using the ABE Conceptual Model concluded three common themes. First, the practice expectation identified in the ABE Conceptual Model provide a common understanding of what a supervisee should know and be able to demonstrate. However, the language used to describe the expectations may not be specific enough to the setting and context of practice. Second, The ABE Conceptual Model does foster communication between a supervisor and supervisee about expectations and that should occur throughout the supervisory process. Finally, there are important contextual factors that can influence a supervisor's ability to assess a supervisee's proficiency and competence. The next chapter will provide a more in-depth discussion of these themes and specific recommendations for on-going use and research with the ABE Conceptual Model.

Chapter 5: Discussion

The very nature of proficiency determination is grounded in having a standard or measure that rules someone in or out of meeting a particular standard. The ABE Conceptual Model is an attempt at articulating specific practice expectations for proficiency determination of a clinical social work trainee. The results of nine supervisors and supervisees in Northern Minnesota using the ABE Conceptual Model presented the benefits and challenges of having practice expectations for assessing readiness for autonomous clinical practice. At the time of data collection, nine pairs of supervisors and supervisees were at a half way point or beyond for completing the supervision requirements for clinical level licensure in Minnesota. To begin a summary of the findings, it is pertinent to clarify how the participant population compared to the overall population of social workers across the US. Next, the three themes which emerged from the data and corresponding recommendations for using the ABE Conceptual Model are discussed. Finally, recommendations and limitations of using the ABE Conceptual Model are explored as well as future research implications for supervision of clinical social work.

Participants and the Broader Context

Generally speaking, the participants in the study were reflective of the US social work population. As is the case for the broader social work profession, there were an overabundance of female participants from both groups of supervisor and supervisee participants. The average age ranges of the participants also aligned with national averages of social work professionals (NASW, 2018). With regard to race and ethnicity, the majority of participants identified as Caucasian; reflective of the Northwestern region

of Minnesota and also the social work profession in general (MSDC, 2018; NASW 2018). None of the participants had education beyond a MSW and this is typical of professionals at the graduate (LGSW) and clinical (LCSW) licensure levels. National studies by NASW (2018) and ASWB (2017) consistently show a wide range of practice setting for social work professionals with a majority in non-profit organizations at all levels of licensure. The practice settings of participants did not reflect this same trend. The majority of participants identified as practicing in non-profit or for-profit organizations. The overrepresentation of participants in for-profit organizations is not consistent with clinical social workers in the state of Minnesota (MNBOSW, 2017). While this difference did not have a direct impact on the study results, it is important to note as a significant difference from the general population of national and state social workers. Overall, the demographic profile of the participants did align the clinical social workers throughout the US. Hence, the sample population is comparable and may represent the results that would be obtained from the broader population of clinical social workers.

The extent to which the study's participants represent the clinical social work population is comparable; however, it is still important to consider factors that set the participants apart from the general population. Licensure standards in Minnesota are some of the highest across the nation. This includes the 4000 hours of supervised practice a LGSW must complete to achieve LICSW licensure status. Most states only require 3000 hours. Minnesota also requires 200 hours of supervision, 360 hours of clinical education and training, and a specified number of direct client contact hours. Not all states have these additional requirements. As is the case in all states, the supervisor

must attest to the supervisee's competence for obtaining LCSW licensure; however, the attestation is not grounded in specific measures of competence. Minnesota's high supervision standards are based on a seat time model, rather than demonstrated mastery of standards and competence. The ABE Conceptual Models presents a competency-based guide for making a determination of competence. The themes that emerged from the participants using the ABE Conceptual Model provide important implications for clinical social work supervision in Minnesota, across the US, and even internationally.

Themes Identified

Three themes emerged from the results of the participants completing the modified on-line version of the ABE Conceptual Model. First, the practice expectations identified in the ABE Conceptual Model provided a common understanding of the knowledge, skills, and abilities a supervisee should be able to demonstrate. However, participants expressed that the language may not be specific enough for all contexts of clinical social work practice. Second, the ABE Conceptual Model did foster communication about expectations between a supervisor and supervisee, and it may be beneficial to utilize at the beginning, middle, and end of the supervisory process. Finally, correlational data analysis provided some relevant information about how the contextual factors of supervision can influence a supervisor's ability to assess a supervisee's proficiency and competence. Each of these themes will be described in greater detail and supported by the literature on clinical social work supervision.

Common understanding. One of the unique and dynamic aspects of social work practice is the variety of population groups and settings where social services are provided. This is partially due to the mission of advocating and serving all sectors of a

society. Social work's mission is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW, 2018, para. 1). One of the outcomes in fulfilling this mission is that the practice of social work occurs is vast in locations and knowledge areas. The expansiveness of the field has long been recognized as creating a challenge for generalizing knowledge, skills, and abilities that should be required of clinical social workers (Munson, 2002, 2012). The challenge is even more evident with a growing trend for Integrated Behavioral Health for clinical practice. "The high prevalence of co-occurring disorders means that social workers will be working with clients with multiple mental and physical health disorders regardless of their clinical practice setting" (Becker, 2012, p. 3). Mental health services are being provided in more nontraditional settings such as schools, community centers, and in care clinics with other health professionals. Participants who used the ABE Conceptual Model reflected on the value of the practice expectations in clarifying proficiency indicators. However, they stressed that the language used to describe them may be too general for all settings and context of social work practice.

In Questionnaire Three and in the focus groups/interviews, participants provided examples of cultural and contextual situations where the language may be too general or confusing. One such example, was working with Native American populations. Tribal communities in Minnesota statistically are one of the most underserved populations across the nation particularly related to mental health and substance abuse (Tribal State Opioid Summit, 2017). These are primary areas of focus for integrated behavioral health and clinical social work practice. Other contextual examples include the practice

emphasis one type of clinical setting may have over another. For example, a clinician in private practice working with adults verses someone who is working with younger children in a school has a vast difference in knowledge, skills, and abilities to acquire. Practice expectations for clinical social work are difficult to quantify and measure when there are such significant differences across settings and population groups.

Schools of social work and ASWB, which designs the licensure exam for clinical social work practice have been faced with the same challenge of generalizing practice expectations. They have resolved this issue by surveying social workers in the field to better understand the work that they do. As discussed in the literature review, The ASWB Practice Analysis is completed every five to seven years and informs the content for the licensure exams. A survey is developed by a team of subject matter experts. In 2015, they developed task and knowledge statements about social work practice. Then, 32,000 social workers complete the on-line survey and rated the knowledge and task statements related to the job or skills that they perform. The outcome of the survey provides information for ASWB to develop a blueprint called Knowledge Skills and Abilities (KSAs). The KSAs are used for creating the ASWB exam questions at the bachelors, masters, advanced generalist, and clinical levels of social work practice.

While the ASWB Practice Analysis is helpful for verifying the knowledge, skills, and abilities related clinical social work, it still may only be gathering a general swipe of information about social work practice. Additionally, the ASWB Practice Analysis does not just target clinical social work practice and the information they learn from the survey is time sensitive. They explain, “the picture of the profession captured in an analysis has a limited useful lifespan” (ASWB, 2017, p. 3). The practice analysis is helpful in learning

the knowledge and skills necessary to perform clinical practice; however, it may not capture all practice expectations for clinical work across settings, groups, and over time. Despite this limitation, it is a thoughtful way of gathering information for content validity of their exam with a large sample of social workers.

Generalizing practice expectations for social work is no easy task and this becomes more complex with clinical social work practice. Participants in the study shared that the practice statements at the LGSW level and the LICSW did in fact create a common understanding, but they may be too general to capture the vastness of their practice. ASWB's Practice Analysis provides a model of how further research could be conducted to address this concern. Participants also suggested having a scaling for each practice statement with detailed performance indicators. More specificity presents the challenge of not being general enough. The difficulty is that performance indicators may be very setting specific. The participants suggestion is an important consideration. However, the breakdown of the performance indicators may need to be something that is completed by a supervisor and supervisee to ensure it is relevant and specific enough.

Fostering communication on a continuum. One of the most significant finds in the study was that participants experienced the ABE Conceptual Model to encourage communication about proficiency expectations. Additionally, a point repeatedly made by participants was the importance of using the ABE Conceptual Model at the beginning, middle, and end of supervision. Participants concluded that the use of the model at these stages, ultimately would have assisted in fostering communication about proficiency across a continuum of time, rather than just at the determination phase. They noted

particular practice expectations in the ABE Conceptual Model that helped to foster communication.

Participants found the practice expectations that addressed "evaluation outcome" to be the most explicit. In clinical practice, this is the work of evaluating client progress or the effectiveness of their practice at an individual or agency level. During discussion about why participants found the items on evaluation outcome to be the most explicit, they explained it was not a common area of proficiency they discussed in supervision. Some even explored how it could be further incorporated into their supervision and practice when completing the combined rating with Questionnaire Two. Using the ABE Conceptual Model at the beginning of their supervisory process may have encouraged communication about evaluation outcomes throughout the supervisee's proficiency development.

Currently, the Minnesota Board of Social Work does not clearly specify what should be discussed in supervision. The only stipulation they make is that supervision must cover certain topics, but they are not defined. Once the supervisee has completed all the required supervised practice hours for licensure a form is completed and the supervisor attests to the following: "I attest that the content of the supervision included clinical practice, practice methods, authorized scope of practice, and continuing competence" (MN BOSW, 2018, p. 3). Minnesota state statute does not define these terms and neither does the Board. The supervisor also attests to the supervisee's competence in certain content areas, but they also are not clearly defined. "I attest that the supervisee has practiced clinical social work and has demonstrated skill through practice experience in the differential diagnosis and treatment of psychosocial function,

disability, or impairment, including addictions and emotional, mental, and behavioral disorders (MN BOSW, 2018, p. 3). The supervisor is left to determine how competence with these topics will be measured and assessed. ASWB, who provides standards for licensing boards across the nation, is even more ambiguous allowing states to define competence and proficiency.

The vague terminology by state licensing boards is a common occurrence. It is up to the supervisor to communicate expectations to the supervisee. A supervisor's determination of competence is a subjective process based on the supervisor's opinion. Best practices for supervision explain that determination of competence should be a formative rather than summative evaluation (Bernard & Goodyear, 2004; Campbell, 2000; Munson, 2012; Powell & Brodsky, 2004). This is exactly the point participants made by encouraging the use of the ABE Conceptual Model throughout their supervisory process.

The Substance Abuse and Mental Health Services Administration (SAMSHA) Stresses the importance of communicating expectations in clinical supervision early on in formative evaluation.

> Before formative evaluations begin, methods of evaluating performance should be discussed, clarified in the initial sessions, and included in the initial contract so that there will be no surprises. Formative evaluations should focus on changeable behavior and, whenever possible, be separate from the overall annual performance appraisal process. To determine the counselor's skill development, you should use written competency tools, direct observation, counselor self-assessments,

> client evaluations, work samples [files and charts], and peer assessments (SAMSHA, 2009, Evaluation of Counselors, para. 7).

The participants' recognized the ABE Conceptual Model as contributory in fostering communication about expectations for clinical practice. Greater responsibility is placed on the supervisor to clarify what they expect and how it will be measured because state licensing Boards do not provide these definitions. They only list categories of content that is to be covered in supervision. The participants desire to be aware of expectations early on and throughout the supervisor process aligns with best practices for clinical supervision. The supervisor is instrumental in communication about expectations. In order to take on this role, they must first be able to clearly articulate practice expectations. Carol A. Faulkner (2014) has written extensively on competency-based supervision for psychology. She explains, "the entire process of supervision is acutely in need of understanding and developing empirical support for its components and impacts" (p. 143). The ABE Conceptual Model has articulated important components for clinical supervisors to truly embrace their role.

The influence of contextual factors. Supervision is a complex relationship and in rural communities where there is a shortage of supervisors, the relationship can become even more complex. A supervisee may need to have an off-site supervisor and, in some cases, multiple supervisors from different disciplines to fulfill the licensure requirements. The location, frequency, and format of supervision can become more varied in areas with a shortage of supervisors. Despite living in a more rural area, the participants in the study did not significantly vary with these factors; however, there were some differences that had an impact determining proficiency and competence. Statistical

analysis of their contextual factors did reveal that off-site supervision may influence a supervisor's ability to determine competence.

The format and content of supervision was another contextual factor examined. A supportive type of supervision verses educational or administrative may influence supervisors and supervisees ability to determine proficiency and competence. Perceptions about the areas of practice addressed in supervision did seem to vary between supervisors and supervisees. The areas of practice a supervisee thought was being covered in supervision was different than the supervisor's perception. The data analysis indicated that the discrepancy had a meaningful influence on determination of proficiency, particularly for supervisees. Therefore, clarification about the areas of practice to be covered in supervision are important for supervisors and supervisees to discuss because the difference in perception could affect determination of proficiency. The influence of all of the contextual factors presented were not statically significant due to the small sample size. However, they are important to consider with the use of the ABE Conceptual Model. Proficiency determination of clinical social workers is not isolated from contextual factors.

A supervisor's primary role is to attest to a supervisee's competence. If there are contextual factors which have an impact on this role, their effectiveness as a supervisor is also being compromised. The organization and delivery of supervision can influence its effectiveness. Specific research on contextual factors which influence effective supervision in social work is limited. However, other health disciplines such as occupational therapy and nursing have focused research on this exact topic for clinical supervision. Their findings indicate that contextual factors can have a significant

influence on supervision effectiveness (Edward et al., 2005; Martin, Kumar, Lizorando, & Tyack, 2016). In a narrative literature review by the *Medical Teacher Journal*, 12 tips for effective clinical supervision are presented for health professionals including social workers (Martin, Copley, & Tyack, 2014). Several of these tips directly relate to the contextual factors that impacted participants with using the ABE Conceptual Model. For example, tip six focuses on using effective communication and feedback.

Participants in the study with off-site supervision more likely indicated that they did not have enough evidence to make a determination of competence. This could be an indication that they did not receive frequent feedback about their performance in some areas of practice. The article explains, "to be effective, feedback should be clear, regular, balanced with both positive and constructive elements, non-threatening, and specific [Sweeney et al. 2001c; Cox & Araoz 2009]" (Martin et al., 2014, p. 203). A study on field education for social work also found that off-site supervision of students can be effective, but requires extensive planning and communication about performance monitoring (Zuckowski, 2016). Off-site supervision is complex and requires important attention to communication and performance monitoring.

Another tip detailed in the narrative literature review for effective supervision is the importance of reflective supervision and building a positive supervisory relationship (Martin et al., 2014). Both of these components of supervision are at the heart of supportive supervision (Kadushin, 2014). Data analysis of using the ABE Conceptual model indicated that supportive supervision had a tendency to positively impact determination of proficiency and competence. Strategies for providing reflective supervision are explained.

> Fone [2006] describes some practical strategies to assist the supervisor in facilitating reflective thinking of the supervisee. These include encouraging the supervisee to complete self-appraisal and debriefing; asking the supervisee what led them to making a decision and what they could have done differently; asking the supervisee to verbalise a sequence of thoughts and decisions; paraphrasing what the supervisee says; and encouraging the supervisee to practise verbalizing clinical reasoning. (Martin et al., 2014, p. 203)

Being able to explore a supervisee's clinical reasoning, sequence of thoughts and decisions and self-appraisal may provide a supervisor with a great deal of information about the achievement practice expectations. This may explain why there was a correlation in the data with supportive supervision.

The ability to be reflective in supervision likely requires having a positive supervisory relationship. The supervisee is encouraged to be vulnerable in their thinking and processing of events that occurring in practice. The narrative literature summary by Martin et al. (2014) explains the importance of a positive supervisory relationship.

> Empirical studies have identified that the quality of the supervisory relationship is the single most important factor for effective supervision [Hunter & Blair 1999; Kilminster & Jolly 2000; Spence et al. 2001; Kavanagh et al. 2003; Herkt & Hocking 2007; Cox & Araoz 2009; Karpenko & Gidycz 2012]. These findings have been consistent across professions including social work, psychology, psychotherapy, occupational therapy and nursing [Hunter & Blair 1999; Kilminster & Jolly 2000; Spence et al. 2001; Kavanagh et al. 2003; Herkt & Hocking 2007; Cox & Araoz 2009]. (Martin et al., 2014, p. 204)

Supportive supervision may be important to consider with using the ABE Conceptual Model and in general with proficiency determination. The literature suggests that reflective processes with a supervisee provide a window into their critical thinking skills and competence in a variety of practice areas. The supervisory relationship is foundational to creating an environment where the supervisee is able to self-assess with a supervisor and examine their proficiency in an authentic manner.

The contextual factors of significance which emerged from participants using the ABE Conceptual model suggest that frequent communication and feedback may be a challenge with off-site supervision. Nevertheless, the literature explains this can be overcome with structure and attention to performance monitoring. Supportive supervision was another significant factor, which highlighted the importance of reflective processes and an emphasis on a positive supervisory relationship. Supervision of clinical trainees is dynamic and requires a clinical social worker who is highly skilled and perceptive to contextual factors which can influence their ability to determine proficiency.

Recommendations

This study is the first known trial of having supervisors and supervisee's test the ABE Conceptual Model use with proficiency and competency determination. While the study was a modified version, it yielded some helpful information for its future use in the field. It does provide a common understanding of the knowledge, skills, and abilities a supervisee should be able to demonstrate; however, it is unclear how relevant the practice expectations are to clinical social workers. ASWB's Practice Analysis is a thoughtful approach for researching validity of their exam content. One recommendation would be

to complete a similar analysis of practice expectations in the ABE Conceptual Model. This would include reviewing the practice expectations with a panel of experts for needed modifications of language, a trial with a sample group of LCSWs and LGSWs to ensure the language is understandable. Modifications would be made to the practice expectations based on the results. The sample group would also ensure congruency between the practice expectations at the LGSW level and the LCSW level. Once the practice expectations were finalized with any needed modifications, a larger sample of LGSW and LCSW participants would be identified. Then an on-line survey with the practice expectations would be sent out to the larger sample group. The survey would ask the LGSW and LCSW participants to rate on a Likert scaling their frequency of performance and opinion on the importance for effective practice. This type of an in-depth content validity analysis may ensure the language used to describe the practice expectations is more general and relevant to clinical social work practice. The outcome may result in identifying confusing language, ensuring statements at the LGSW and LCSW are mutually exclusive and that the practice expectations are culturally and contextually sensitive.

An important aspect of the larger sample group for the study described above would be to ensure the participants were from a wide range of practice settings. This includes participants from non-profit, for-profit, government agencies. Having participants from more diverse practice settings could provide a more universal understanding of the skills, knowledge, and abilities performed in a variety of practice settings. For example, the perspective of a clinical social worker in a hospital setting

may differ greatly than a social worker in a school setting or one that works with a particular cultural group.

A second recommendation would be to encourage the use of the ABE Conceptual Model at the beginning, middle, and end of the supervisory process. This longitudinal analysis may be more helpful in determining how proficiency is measured across time and phases of the supervisee's professional development. Participants found completing the on-line version of the ABE Conceptual Model individually and then with their supervisor to be an enlightening process. This should be replicated. Offering a paper rather than just on-line version was recommended as well as a more detailed explanation of the model throughout all phases of its use not just in an orientation format.

A final recommendation is to replicate the use of the ABE Conceptual model with a larger sample size and with more diverse demographic groups. The contextual factors analyzed revealed some important trends in the data. A more expansive data set would provide more in depth analysis and likely be more statistically significance. Presenting the results of this study to ABE and the group of experts that helped to develop the ABE Conceptual Model would be timely and may offer further analysis of these recommendations. Consultation with other professional groups that are focused on competency-based education may also informative. There is no doubt that the ABE Conceptual Model is innovative and more can be learned about its effectiveness with proficiency determination.

Limitations

The major limitations of this study were the limited number of participants and the strong regional focus of the participants. These two features reduced ways in which

the data could be generalized to a larger population of clinical social workers and the statistical significance of the study. The on-line data collection may have been another limitation. This format did not allow participants to ask questions, if they needed clarification in the moment of completing the questionnaires. The researcher was available for them to contact, but not having a more immediate communication forum may have yielded different results. Participants were at times confused with the multiple phases and steps of data collection. The on-line version of the focus groups and interviews may also have been helpful to offer in person. Participants were presented with this option, if there were necessary accommodations specified, however none requested this format. Facilitation of focus groups and interviews in person and can provide more non-verbal aspects of communication that may not be as easily observed in an on-line environment.

Implications

Results of this study suggest that the practice expectations detailed in the ABE Conceptual Model do assist supervisors in making a determination of proficiency and competence. More research is needed to fully understand if the practice expectations are what clinical social workers are doing and how critical the practice expectations are to LGSW and LICSW levels of practice. This preliminary process has important implications for clinical social work practice and supervision. It essentially is establishing the foundational elements for competency-based supervision for clinical social work practice. Without this information being researched, language of the ABE Conceptual Model's practice expectations may be too general or specific to be meaningful.

Social work practice is very much influenced by micro, mezzo, and macro level systems. The political climate of our country can shift funding sources, service delivery, and the need for more of a focus on advocacy than direct practice work. Supervision of clinical social workers is not immune to this dynamic. In a chapter on the course of future research for social work supervision, a pioneer of social work supervision, Ming-Sum Tsui (2004), reiterates a point made by another esteemed expert, Daniel Harkness.

> A new or reconceptualized model of supervision would include multiple definitions of social work supervision, various, service strategies related to supervisory practice, and multiple linkages between supervisory practice and client outcomes in a variety of service settings [Harkness, 1995, 1997; Harkness & Poertner, 1989; Harness & Hensley, 1991]. In this sense, the assessment of effective supervisory practice would include measures applied to multiple sources [e.g., supervisor, worker, client, and agency]. (p. 278).

Not only must the supervisor and supervisee be examined when looking at the efficacy of supervision and proficiency determination, but we must also look at client outcomes and agency progress. The context of clinical supervision is ever changing and must be continuously evaluated. “There is an extensive body of research that shows evidence-based clinical supervision helps organizations successfully deliver evidence-informed practices, supports practitioners in their work and contributes to good outcomes for clients” (OCECYMH, 2015, p. 3). Evidenced-based clinical supervision and practice is key to understanding, if what social workers and social work supervisors are doing is meaningful to the social work mission. There is a great deal of uncharted territory when it comes to social work supervision. Ming-Sum Tsui (2004) sums up a profound

implication for future research on supervision and the use of the ABE Conceptual Model, "when we study supervision, we need to be context sensitive, construct sensitive and culturally competent" (p. 279).

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Appendix A

Consent Form and Questionnaire One

Title of Research Study: Assessing Readiness of Clinical Social Workers: Using the American Board of Examiner's Conceptual Model, Protocol #

Investigator Team Contact Information:
For questions about research appointments, the research study, research results, or other concerns, call the study team at:

Investigator Name: Joyce Strand Investigator Departmental Affiliation: Education Phone Number: 218-726-8182 Email Address: Jstrand1@d.umn.edu	Student Investigator Name: Paula Tracey Phone Number: 218-3498559 Email Address: Ptracey@d.umn.edu

Key Information About This Research Study
The following is a short summary to help you decide whether or not to be a part of this research study. More detailed information is listed later on in this form.

What is research?

- *The purpose of this study is to learn and understand the experience of social work supervisors and supervisees using the American Board of Examiners' (ABE) Conceptual Model. The study will examine the use of this Conceptual Model for assessing clinical social work supervisees' readiness to become independent licensed clinicians. Gathering information about their experience and perspective on the Conceptual Model will inform the usefulness of this tool for determining supervisee proficiency.*

Why am I being invited to take part in this research study?
We are asking you to take part in this research study because you are a supervisor or supervisee for clinical social work practice in the state of Minnesota and practice in the Northeastern Region of Minnesota. Additionally, you have provided or completed at least 100 hours of the 200 supervision hours for licensure.

What should I know about a research study?

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.

Why is this research being done?
Clinical Social Workers are the primary mental health providers acorss the nation. At present, licensure standards are the main way to determine, if a social worker is compentent to provide clinical services to the public. The ABE Conceptual Model presents a set of expectations supervisors can use to make a more measurable judgement of competence. In this study supervisors and supervisees will experience using the ABE Conceptual Model to determines a supervisee's competence. Having quality tools to determine competence for providing clinical social work practice is a vital gate-keeping tool for the profession.

How long will the research last?
The research will last 5 weeks with the participants actively engaged for approximately 120 minutes (maximum).

What will I need to do to participate?
You will be asked to complete a recorded on-line orientation to using the ABE Conceptual Model, three on-line surveys, one of the surveys will require meeting with a supervisor or supervisee and an audio and video recorded focus group or interview. The first survey is a demographic survey inquiring about the nature of the supervisory process you are involved in. The second survey is the actual practice of using the ABE Conceptual Model. The third survey is to provide feedback on using the ABE Conceptual Model. The supervisor and supervisee will complete a meeting to discuss the scoring they both provided in the second survey and to submit a final combined scoring. The focus group will be scheduled at a designated time and occur in a face-to-face on-line web conferencing format and will be audio and video recorded. Participants who are unable to attend the scheduled focused group will also be given the option of a audio and video recorded interview. The interview will also utilize an on-line face-to-face web conferencing format. The focus of the on-line focus groups and interviews will review findings from the third questionnaire and is an opportunity to offer any additional feedback about using the ABE Conceptual Model.

Is there any way that being in this study could be bad for me?
The potential risk for participating in this study are minimal, however the use of private demographic information as a potential risk. The information to be gathered is basic personal characteristics (such as age and gender) and your professional status with social work licensure and education. Additionally, if you are a supervisor you will be asked to rate your supervisee's general performance in providing clinical social work practice. The focus of information gathered for the study is regarding the supervisee's general knowledge, skill and ability to provide clinical social work practice. A supervisor discussing this information with a supervisee is a natural occurrence within supervision. Therefore, the risk of there being some slight discomfort is minimal.

Will being in this study help me in any way?
We cannot promise any benefits to you or others from your taking part in this research. However, possible benefits include: gaining a better understanding of assessing readiness for independent practice in a supervisory context, and identification of the supervisee's learning needs related to knowledge, skills and abilities of their clinical social work practice. Additionally, the supervisor and supervisee may appreciate the opportunity to share their perspectives on using the ABE Conceptual Model. The study does have the potential to inform social work educators, licensure regulators, professional associations, supervisors, practitioners and others that are invested in clinical social work supervision. The study will potentially contribute to literature in the field regarding assessment of proficiency for independent clinical social work practice.

Detailed Information About This Research Study

How many people will be studied?
We expect about 20 people here will be in this research study out of 24 people in the entire study.

What happens if I say "Yes", but I change my mind later?
You can leave the research study at any time and no one will be upset by your decision. If you decide to leave the research study before the meeting during the second survey, contact the investigator so that the investigator can inform your counterpart supervisor or supervisee who is also participating in the study that there will not be a need for a meeting.

Will it cost me anything to participate in this research study?
Taking part in this research study will not lead to any costs to you.

What happens to the information collected for the research?
The records of data collection from study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records. Study data will be encrypted according to current University policy for protection of confidentiality. The researcher will be the only one who will have access to the survey data and web conferencing recordings. Access to the web conferencing meetings will require password entry into the on-line meeting space. The focus group and/or interview transcripts, recordings and any other data will be stored in a password protected encrypted file on the researcher's password protected computer. Any hard copy data obtained such as field notes during interviews or data collection will be stored in a locked file cabinet in the researcher's campus office, which will also be locked. The researcher will destroy all data five years after completion of the study.

Efforts will be made to limit the use and disclosure of your personal information, to people who have a need to review this information. We cannot promise complete

confidentiality. Organizations that may inspect and copy your information include the Institutional Review Board (IRB), the committee that provides ethical and regulatory oversight of research, and other representatives of this institution, including those that have responsibilities for monitoring or ensuring compliance.

Whom do I contact if I have questions, concerns or feedback about my experience?
This research has been reviewed and approved by an IRB within the Human Research Protections Program (HRPP). To share feedback privately with the HRPP about your research experience, call the Research Participants' Advocate Line at 612-625-1650 or go to https://research.umn.edu/units/hrpp/research-participants/questions-concerns. You are encouraged to contact the HRPP if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide input about this research.

Will I have a chance to provide feedback after the study is over?
The HRPP may ask you to complete a survey that asks about your experience as a research participant. You do not have to complete the survey if you do not want to. If you do choose to complete the survey, your responses will be anonymous.
If you are not asked to complete a survey, but you would like to share feedback, please contact the study team or the HRPP. See the "Investigator Contact Information" of this form for study team contact information and "Whom do I contact if I have questions, concerns or feedback about my experience?" of this form for HRPP contact information.

Your electronic signature documents your permission to take part in this research. You can obtain a copy of the signed copy including the researcher's signature by clicking on this link: (weblink will be provided for generated copy signed consent form).

Questionnaire One: Demographic Information

Thank you for completing the on-line orientation and agreeing to participate in this study. The study seeks to learn and understand the experience of social work supervisors and supervisees using the American Board of Examiners' (ABE) Conceptual Model. The purpose of the survey is to gather some basic information about you and your current supervision status. There are 15 items, each with a set of responses. Please choose the response that most represents you. Once you have completed the survey you will be prompted with questions to schedule either the focus group or individual interview.

Name____

Please provide your contact information to confirm the scheduling of the focus group or individual interview.

Phone number:___________________________ OR
email:______________________________

Scheduling of Focus Group or Individual Interview

After the third on-line questionaire of this study is complete, you are asked to participate in an audio and video recorded on-line focus group or interview. Both will take place on-line using the web-conferencing software called *Zoom*. The focus group will be with other participants in the study and will last 60 minutes. The interviews will be 30 minutes long and can be scheduled at your convenience during the week of DD-DD/YYYY. Please indicate below when you would be able to attend either the focus group or an individual interview with the researcher.

Please choose one of the Focus Group meeting times or schedule a time below for an individual meeting with the researcher.

Date, Time #1
Date, Time #2

Available time to meet during the week of DD-DD/YYYY ________________________

Follow-up Questions:

1. Do you have any questions about your participation in this study?

Yes Please explain: ____________________
No

2. Is there anything that needs to be clarified regarding your participation or the study process?

Yes Please explain: ____________________
No

3. Is there anything that needs clarification regarding how the data collected will be used for the researcher's dissertation?

Yes Please explain: ____________________
No

Survey One

1. With which gender to you identify?

Male
Female
Both
Neither
I do not wish to answer this question

2. How old are you?

18-25
25-29
30-34
35-39
40-44
45-49
50-55
56-60
61-65
66-75

3. With which race/ethnicity do you identify?

American Indian or Alaskan Native
Asian/Pacific Islander
Black or African American
Latino or Latino American
White/Caucasian
Multiple ethnicity/Other. If other, please briefly describe in the space below.

4. What is the highest level of education you have completed?

Masters Degree
Doctorate
Other: ____________

5. Are you a supervisor or supervisee for clinical social work practice in the state of Minnesota?

LICSW Supervisor
LGSW Supervisee
None of the above

6. Have you completed over 100 hours of supervision towards licensure?

LICSW Supervisor
LGSW Supervisee
None of the above

7. What is the type of setting where you provide clinical social work practice?

Non-profit
For-profit
Government agency

8. Where do you provide clinical social work practice within the Northern Minnesota Region?

St. Louis County
Lake County
Cook County
Carlson
Pine
Aikin
Itasca

9. How many years of post-LICSW or LGSW experience do you have?

Less than a year
1 year or more
2 years
Over 3 years

10. For just LICSW: How many years have you provided supervision for licensure?

Less than a year
1 year or more
2 years
Over 3 years

11. For just LGSW: How many years have you been licensed as a LGSW?

Less than a year
Over 1 year
Over 2 years

12. How would you describe the supervision you provide or receive for licensure?

Educational
Administrative
Educational

13. How often do you meet for licensure supervision?

1 hour per week
2-3 hours per week
4-7 hours per month
8 hours per month

14. Is your supervisor or supervisee for licensure on-site or off-site from where you provide social work practice?

On-site
Off-site

15. How many months have you known your supervisor or supervisee?

Enter Number ________

16. How many more hours of supervised practice is required before the supervision for licensure will end with your supervisor or supervisee?

Enter Number ________

Thank you for your responses. You will be e-mailed Questionnaire Two in the coming week. Please be advised that you will individually complete Questionnaire Two and then will schedule a meeting with your supervisor or supervisee to complete the scoring on Questionnaire Two for a second time with them. Questionnaire Two is the practical use of the ABE Conceptual Model to evaluate either yourself (if you are the supervisee) or your supervisee (if you are the supervisor).

Appendix B

Questionnaire Two: Using the ABE Conceptual Model

Part A: Questionnaire Two is the practical use of the ABE Conceptual Model. For this survey, you will do the following:

If you are the supervisor, you will rate your supervisee on 20 items below.
If you are the supervisee, you will rate yourself on the 20 items below.

1. Please indicate your name and if you are the supervisor or supervisee below:

LICSW Supervisor Name: ____________________
LGSW Supervisee Name: ____________________

Practice Expectation		LGSW Level	LICSW Level
1	Proficiency	Develops confidence in having professional opinion under supervision	Asserts a professional opinion, seeking consultation when appropriate
	Competence	• Beginning • Developing	• Developing • Competent
2	Proficiency	Has sensitivity to personal and cultural issues that may influence assessment and diagnosis	Implements strategies for minimizing personal and cultural biases that may affect assessment and diagnosis
	Competence	• Beginning • Developing	• Developing • Competent
3	Proficiency	Develops understanding of use of self as change agent through participation in clinical supervision	Identifies potential professional uses of self in treatment process
	Competence	• Beginning • Developing	• Developing • Competent
4	Proficiency	Learns to engage in client strengths and resources through supervision	Independently assures client participation in establishing treatment plan
	Competence	• Beginning • Developing	• Developing • Competent
5	Proficiency	Uses clinical supervision to gain awareness of changes in views of self and client that	Remains independently sensitive to changes in views of self and client throughout the intervention process

		result from the intervention process	
	Competence	• Beginning • Developing	• Developing • Competent
6	Proficiency	Develops commitment to appropriate use of supervision and consultation in the intervention process	Uses consultation when needed to assure appropriate professional use of self in the intervention process
	Competence	• Beginning • Developing	• Developing • Competent
7	Proficiency	Accepts outcome evaluation as a method for reviewing professional use of self.	Participates independently in outcome evaluation as normative way of reviewing professional use of self
	Competence	• Beginning • Developing	• Developing • Competent
8	Proficiency	Formulates comprehensive biospsychosocial assessments using current *Diagnostic and Statistical Manual* under supervision	Independently applies differential assessment and diagnostic skills and assesses clinical risk
	Competence	• Beginning • Developing	• Developing • Competent
9	Proficiency	Formulates biopsychosocial treatment plans under supervision	Differentiates and selects treatment strategies and methods that are consistent with current biopsychosocial assessment/diagnostic standards
	Competence	• Beginning • Developing	• Developing • Competent
10	Proficiency	Engages in culturally sensitive therapeutic relationships under supervision	Applies relevant outcome-focused treatment strategies and methods and makes appropriate modifications in intervention processes
	Competence	• Beginning • Developing	• Developing • Competent
11	Proficiency	Engages in evaluation of treatment processes through participation in data collection	Uses outcome evaluation and self-study to enhance practice ability
	Competence	• Beginning • Developing	• Developing • Competent

12	Proficiency	Is familiar with standard diagnostic manual and categories	Demonstrates capacity to apply diagnostic criteria independently
	Competence	• Beginning • Developing	• Developing • Competent
13	Proficiency	Is familiar with legal and ethical parameters of clinical risk assessment	Has working knowledge of the empirical basis of clinical risk assessment
	Competence	• Beginning • Developing	• Developing • Competent
14	Proficiency	Accepts clinical supervision as a primary means of learning	Seeks supervision/consultation when needed
	Competence	• Beginning • Developing	• Developing • Competent
15	Proficiency	Understands relationship between diagnosis, treatment goals and planning	Makes treatment plans that that are diagnostically driven and outcome focused
	Competence	• Beginning • Developing	• Developing • Competent
16	Proficiency	Is familiar with theories and research about what may produce change	Has knowledge about how to engage client/family in treatment-planning process
	Competence	• Beginning • Developing	• Developing • Competent
17	Proficiency	Understands methods for involving client with the means and ends of treatment	Has increased knowledge of intervention methods and their empirical basis
	Competence	• Beginning • Developing	• Developing • Competent
18	Proficiency	Has knowledge of means to assess goal attainment	Assesses outcome progress with client
	Competence	• Beginning • Developing	• Developing • Competent
19	Proficiency	Has knowledge of social and community resources	Has knowledge of appropriate application of social and community resources to client need
	Competence	• Beginning • Developing	• Developing • Competent
20	Proficiency	Is aware of the expertise of collaborating disciplines	Conceptualizes engagement of collaborating disciplines on behalf of the client

	Competence	• Beginning • Developing	• Developing • Competent

Part B: Thank you for completing the individual scoring you completed for Questionnaire Two. The next step is for you to complete Questionnaire Two again with either your Supervisor or Supervisee. You will answer the same questions but will be submitting an agreed upon rating with your supervisor or supervisee.

1. Please indicate, who is present for the rating of this survey below:

LICSW Supervisor Name: ___________________________
LGSW Supervisee Name: ____________________________

The diagram above is listed again in the survey for Part B.

Appendix C

Questionnaire Three: Feedback on Using the ABE Conceptual Model

Questionnaire Three is an opportunity to reflect on using the ABE Conceptual Model. In Questionnaire Two you rated either yourself or your supervisee. Then you provided a rating together.

For Questionnaire Three, you will answer the following questions based on your experience of using the ABE Conceptual Model. Please answer the following questions:

1) Please enter your full name in the text box below

1. Do you feel the ABE Conceptual Model helped to determine (your or your supervisee's) proficiency as a independent clinical social worker?
   Yes Why?
   No Why not?

2. Which three practice expectations did you feel were the most explicit in determining proficiency of clinical social work practice at an autonomous level (LICSW level)?
   Please enter number of Practice Expectations from Table 1.1
   1. ____
   2. ____
   3. ____

3. What methods do you currently use in supervision to determine readiness for autonomous practice of clinical social work (LICSW level)?
Case consultation
Cotherapy
Live observation
Video recording
Interpersonal process recall
Role play
Other____________________

4. Do you think the ABE Conceptual Model would be helpful for determining readiness for autonomous practice in your supervision?
   Yes Why?
   No Why not?

5. Was the ABE Conceptual Model useful in learning more about you or your supervisee's competence of providing clinical social work practice?
   Yes Why?

No Why not?

Appendix D

Focus Group and Interview Questions

Below are the questions we will be discussing in the focus group or interviews

1. Of the Practice Expectations in Table 1.1, which do you feel are the MOST explicit in making a determination of readiness for autonomous clinical social work practice? Why?

2. What did you find to be the most helpful in using the ABE Conceptual Model?

3. What did you find to be the least helpful in using the ABE Conceptual Model?

4. If you could change something about it, what would you change?

5. Is there something that I didn't ask about that you think I should know about using the ABE Conceptual Model?