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Narrative summary of the evidence review on the supervision of social workers and social care workers in a range of settings including integrated settings



Evidence review on the supervision of social workers and social care workers in a range of settings.

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Introduction

This report is a review of evidence from research literature accessed by the Social Care Institute for Excellence (SCIE) through systematic searches for a research briefing, a SCIE practice enquiry and a seminar of practitioners and people using services (see 'Technical notes' at the end of the report). Studies were subject to systematic screening, data extraction and quality appraisal. The report provides a compendium of evidence to inform the practice guide, with summary evidence statements. Evidence and descriptions of studies are repeated in different sections of the report to ensure that each section is comprehensive in itself as a review of all relevant evidence.

The superscript *** after a reference denotes a study with stronger strength of evidence. The superscript ** denotes a study with moderate strength of evidence. The superscript * denotes a study with weaker strength of evidence. These quality assessments took into account both methodological quality (for a study of this type) and relevance. Quantitative studies were called 'small scale' if they had a sample size smaller than 100.

Regularity of supervision, time taken and ad hoc support

What is the practice?

In a UK survey of workers in integrated adults health and social care services, practitioners reported that each supervision session most commonly lasted one hour and took place monthly (Lambley and Marrable, 2012**). In a small-scale survey of local authority children's services workers in England, most practitioners reported that supervision sessions lasted on average between one and two hours, and took place monthly (Holmes *et al*, 2010**). A few workers said that their supervision sessions occurred less frequently than once a month or were carried out on an ad hoc basis. In a study of home care workers in Northern Ireland, some staff said in focus groups that supervision was infrequent or had never occurred, but the majority of workers in the small-scale survey said that they always or usually had all the support they needed from their supervisor (Fleming and Taylor, 2007**).

In UK case studies of integrated adults health and social care services (Lambley and Marrable, 2012**), and in a small-scale survey of local authority children's services workers in England (Holmes *et al*, 2010**), **informal/ad hoc supervision** was available in addition to scheduled supervision sessions. These were not necessarily provided by the practitioner's own supervisor, but sometimes by another senior member of staff or by peers.

What happened as a result of the practice?

There is mixed evidence on whether the amount of supervision predicts positive outcomes. In a cross-sectional study of social workers and health professionals in integrated mental health teams in Australia, the **hours of supervision per month** was a predictor of the perceived impact of supervision on clinical effectiveness (as reported by supervisees) (Kavanagh *et al*, 2003***).

However, in a nationally representative cross-sectional study of child welfare workers, although **more than two hours of supervision** was positively related to job satisfaction, the relationship was not statistically significant at the 0.05 level (Barth *et al*, 2008***). There is also evidence from an intervention study that the amount of supervision did *not* predict the level of critical thinking among workers following an intervention to introduce critical thinking skills through group supervision for supervisors (Lietz, 2008**). There were mixed findings from a longitudinal study (no response rates reported) on whether the amount of time spent with supervisors predicted whether the worker stayed in his or her job (Scannapieco and Connell-Carrick, 2007*). These three studies cover child welfare workers in the US.

In a US intervention study of child welfare workers, **supervisor availability** was a predictor of the level of critical thinking among workers following an intervention to introduce critical thinking skills through group supervision for supervisors (Lietz, 2008**). In a cross-sectional study of social workers and health professionals in integrated mental health teams in Australia, the reported **availability of the supervisor and the**

self-efficacy of supervisees to obtain effective supervision were predictors of the perceived impact of supervision on clinical effectiveness (as reported by supervisees). Self-efficacy was also a predictor of supervisees' job satisfaction (Kavanagh *et al*, 2003***).

What do people think about the practice?

In a survey of workers in UK integrated adults health and social care services (Lambley and Marrable, 2012**), a small-scale survey of home care workers in Northern Ireland (Fleming and Taylor, 2007**) and a small-scale survey of local authority children's services workers in England (Holmes *et al*, 2010**), most practitioners said they received the **right amount of supervision**. Some said they would **prefer fortnightly sessions** to monthly or less frequent sessions. In the small-scale study of home care workers in Northern Ireland, workers said they would find **regular supervision** useful, **for example, weekly contact with their supervisor** (Fleming and Taylor, 2007**).

There is good evidence from four qualitative/descriptive studies and a survey that workers wanted an **'open door' to their supervisor** and/or **ad hoc/informal supervision when needed** (Lambley and Marrable, 2012**; Bogo *et al*, 2011 a,b**; Holmes *et al*, 2010**; Fleming and Taylor, 2007**; Kavanagh *et al*, 2003***). These studies cover practitioners in integrated adults health and social care services in the UK, local authority children's services practitioners in England, home care workers in Northern Ireland, social workers and health professionals in integrated mental health teams in Australia and social workers and other professionals in interprofessional mental health teams in Canada. Specifically, in the study of home care workers in Northern Ireland, some workers said they would like **better communication** and **responsive out-of-hours contact arrangements with their supervisor for support in emergencies and crises** (Fleming and Taylor, 2007**).

Will it work in day-to-day services?

There is good evidence from three qualitative studies (Lambley and Marrable, 2012**; Bogo *et al*, 2011 a, b**; Bourn and Hafford-Letchfield, 2011**) and two quantitative surveys (Holmes *et al*, 2010** – small-scale; Kavanagh *et al*, 2003***) that **high or fluctuating workloads, downsizing in organisations/cutbacks in staff** and the **availability of a supervision partner** can be barriers to spending time on supervision or keeping to scheduled appointments. In one qualitative study, there were tensions between the different functions of supervision due to constraints on time (Bourn and Hafford-Letchfield, 2011**). These studies cover practitioners in integrated adults health and social care services in the UK, social worker supervisors studying for a Master's degree in England, social workers and other professionals in interprofessional mental health teams in Canada, social workers and health professionals in integrated mental health teams in Australia and practitioners in local authority children's services departments in England.

In case studies of two UK integrated adults health and social care services, supervisors reported that they were allocated time to deliver supervision. They were then **closely monitored** to ensure that they were delivering this time, as supervision was a **management performance target** that had to be delivered (Lambley and Marrable,

2012**). In the remaining two case study organisations, there was a **commitment to supervision** (cultural expectations that supervision was taking place). However, respondents reported that it could be less of a priority when workloads were high.

The supervision relationship and emotional support

What is the practice?

In a qualitative study of social worker supervisors studying for a Master's degree in England, supervisors used various strategies to promote a positive relationship, give support and enable supervisees to express feelings of anxiety which sometimes connected with working with specific people using services (Bourn and Hafford-Letchfield, 2011**). These strategies included **active listening**, **'emotional attuning'**, **encouragement**, **humour**, **support for work well done** and **facilitating reflection**. They combined with the supervisor's awareness of self and of the emotional impact of the work on the supervisee. Supervisors also used **depersonalised language and jargon** to 'contain' anxiety and to divert discussion away from expressing feelings.

What happened as a result of the practice?

A small-scale evaluation of a US intervention, the Integrative Supervision Model, recorded positively reported outcomes (Smith *et al*, 2007**). The model introduced **clinical supervision – focusing in a structured way on specific people using services, and including emotional support to supervisees, such as modelling empathy and warmth** – to social workers, who could themselves be supervisors. The positive outcomes recorded included understanding of supportive supervision, more self-confidence, clinical practice outcomes and outcomes for people who use services (as reported by workers). The intervention was delivered to 17 Master¹ Social Workers in child welfare services. It was evaluated through survey questions on outcomes as perceived by 10 participants and their clinical and administrative supervisors following the intervention. However, it is not possible to disentangle the impacts of the emotional component of the intervention on clinical practice outcomes or on outcomes for people using services.

There is good evidence from one US intervention study (Lietz, 2008**), one meta-analysis of mainly US studies (Mor Barak *et al*, 2009**) and one Australian cross-sectional study (Kavanagh *et al*, 2003***) that **positively perceived relationships and/or positively perceived interpersonal communications between supervisors and supervisees** are predictors of:

- the level of critical thinking among workers, following an intervention to introduce critical thinking skills through group supervision (Lietz, 2008**)
- the perceived impact of supervision on clinical effectiveness (Kavanagh *et al*, 2003***)
- job satisfaction (Kavanagh *et al*, 2003***)
- a range of positive and negative staff outcomes (Mor Barak *et al*, 2009**).

¹ Master Social Workers are a type of licensed social workers in the US i.e. a post/ seniority grade, rather than a qualification/ course.

These studies cover child welfare workers, social workers and mental health workers in the US, and social workers and health professionals in integrated mental health teams in Australia.

However, in a longitudinal study of new US child protection workers who had just completed core training (no response rate reported), there were mixed results (Yankeelov *et al*, 2009*). The supervisee's **sense of attachment to the supervisor** was a positive predictor of staying in the agency, but supervisees' overall satisfaction with their relationship with their supervisor was *not* related to staff retention.

There is mixed evidence on whether the **supervisee's perception of support from their supervisor** (not always clear that this is specifically emotional support) predicts positive outcomes, although a meta-analysis of studies (Mor Barak *et al*, 2009**) suggests that it does.

There is evidence from one meta-analysis of mainly US studies (Mor Barak *et al*, 2009**), one US longitudinal study (Maertz *et al*, 2007**) and four US cross-sectional studies that the supervisee's perception of support from their supervisor is associated:

- with a range of positive/negative staff outcomes (Mor Barak *et al*, 2009**)
- *negatively*, with intention to leave their job (Maertz *et al*, 2007**; Simons and Jankowski, 2007**), staying in public child welfare work (Maertz *et al*, 2007**; Dickinson and Perry, 2002**) and job stress (but not 'depersonalisation') reported by workers (Boyas and Wind, 2010***)
- *positively*, with emotional exhaustion reported by workers (Boyas and Wind, 2010***); job satisfaction (Landsman, 2008***; Simons and Jankowski, 2007**), perceived organisational support (Landsman, 2008***; Maertz *et al*, 2007**) and organisational commitment (Landsman, 2008***; Simons and Jankowski, 2007**).

These studies cover a range of US children's services workers (including child welfare workers), social workers, nursing home directors of social work (not all licensed social workers) and mental health workers.

However, one US longitudinal study (Scannapieco and Connell-Carrick, 2007*) (no response rates reported) and five US cross-sectional studies showed no relationship or ambiguous/mixed results between perception of support and:

- intention to leave their job (McGowan *et al*, 2009**; Jacquet *et al*, 2008**; Strolin-Goltzman *et al*, 2007***)
- leaving their job (Jacquet *et al*, 2008**; Scannapieco and Connell-Carrick, 2007*)
- 'depersonalisation' reported by workers (Boyas and Wind, 2010***).

These studies cover a range of US child welfare workers.

One longitudinal study of US children's services workers showed that perceived supervisory support interacts with the relationship between perceived organisational support and turnover. Supervisory support was a more important predictor if perceived organisational support is low (Maertz *et al*, 2007**).

There is evidence from one cross-sectional study of Australian social workers and health professionals in integrated mental health teams that **expressed empathy for the supervisee, supervision strengthening confidence and supervision offering safety to the supervisee to express self** (all reported by supervisees) were predictors of job satisfaction, and also of the perceived impact of supervision on clinical effectiveness (Kavanagh *et al*, 2003***). In a US longitudinal study of new employees in child welfare – who were mainly career starters (no response rate reported) – the **supervisor’s role in facilitating enthusiasm about the job** (as reported by supervisees) was a predictor of whether the supervisee stayed in or left their job (Scannapieco and Connell-Carrick, 2007*).

There is evidence from one small-scale cross-sectional study of US family support workers and their supervisors in family visiting services that **supervisees’ sense of rapport with their supervisor** was a positive predictor of their job satisfaction, but was *not* related to their burnout. However, in the same study, **supervisors’ reported identification with supervisees** was a *negative* predictor of supervisees’ satisfaction with job security. Supervisors’ sense of rapport did *not* predict burnout of supervisees (Mena and Bailey, 2007**).

What do people think about the practice?

There is strong evidence from six qualitative studies that supervisees and/or supervisors find **the relationship between the supervisor and supervisee, and the emotional and supportive functions of this relationship**, important (Lambley and Marrable, 2012**; Bogo *et al*, 2011 a, b **; Bourn and Hafford-Letchfield, 2011**; Holmes *et al*, 2010**; Morazes *et al*, 2010**; Gibbs, 2001***). This includes:

- influencing positive outcomes for people using services (as reported through workers) through a greater sense of confidence and ‘safety’ among practitioners (Lambley and Marrable, 2012**)
- whether the supervisee stays in his or her job (Morazes *et al*, 2010**).

These studies cover child protection workers in Australia, workers in UK integrated adults health and social care services, social worker supervisors studying for a Master’s degree in England, local authority children’s services workers in England, social workers and other professionals in interprofessional mental health teams in Canada and US child welfare social workers with a Master’s degree who had been on an apprenticeship.

In a qualitative study of Australian child protection workers (Gibbs, 2001***), staff **felt valued and cared for** in important supervision relationships (also ‘valued’ in Lambley and Marrable, 2012**). A few workers associated having a valued supervisor with staying in their job, and inadequate supervision with feeling poorly supported in the organisation. They said that supervision could evoke negative feelings. In a qualitative study of US child welfare social workers with a Master’s degree who had been on apprenticeship, some workers associated lack of support from the supervisor with leaving the public child welfare field (Morazes *et al*, 2010**). In a study of home care workers in Northern Ireland, workers wanted **extra time and support available in a crisis** (Fleming and Taylor, 2007**).

There is evidence from these same qualitative studies on the conditions and processes that workers think are necessary or helpful in providing emotional support. In two

qualitative studies of practitioners in integrated social care and health services in the UK and Canada (Lambley and Marrable, 2012**; Bogo *et al*, 2011 a, b**), professional workers wanted a **'safe' emotional climate** in supervision in which to:

- talk about their subjective work experiences and sensitive and vulnerable aspects of their work
- reflect on their feelings, cultural and gender biases, identity, 'use of self' and personal struggles as a clinician.

In two qualitative studies, staff in Australia and the US said that they wanted supervision to **respond to or buffer stress and high workloads** (Morazes *et al*, 2010**; Gibbs, 2001***). In two UK studies, practitioners mentioned that they wanted to **'debrief', 'offload', discuss or reflect on the emotional impact of their work, including their work with specific people who use services** (Lambley and Marrable, 2012**; Holmes *et al*, 2010**). At least three studies mention **respect and/or trust** (Lambley and Marrable, 2012**; Bogo *et al*, 2011b **; Morazes *et al*, 2010**).

One UK study discusses **counselling services or other forms of support** made available through supervision, and the importance of a **quiet, confidential space** for supervision (Lambley and Marrable, 2012**).

Task assistance, practice discussions and longer-term professional development

What is the practice?

In a small-scale survey of local authority children's services workers in England (Holmes *et al*, 2010**), and in a qualitative study of supervision sessions supervised by social workers studying for a Master's degree in England (Bourn and Hafford-Letchfield, 2011**), there was a **dominance of the managerial/administrative role** (eg directive, task and target-focused, managerial surveillance, case planning). This was sometimes to the detriment of a supervisee's (social worker's) need for reflective discussion, emotional support and professional and individual needs. In a small-scale survey of home care workers in Northern Ireland, nearly all workers reported that they could discuss issues with their supervisor that arose with their clients (Fleming and Taylor, 2007**).

However, in a survey of workers in UK integrated adults health and social care services, the majority of staff said they had **supervision for performance** (eg progress and achievements), **development** (eg identifying training opportunities) **and professional/personal support**. However, only about half the practitioners said they had supervision 'for clinical practice' (Lambley and Marrable, 2012**). Non-professionally qualified staff tended to say they had management supervision, whereas professionally qualified practitioners tended to say they could access both management and professional/clinical supervision. Examples were given in the case studies of:

- **formal quarterly reviews and written personal development planning** for each supervisee
- **evaluating the progress of people who use services** against the delivery of care plans, which were reviewed at agreed intervals.

What happened as a result of the practice?

There is mixed evidence on whether 'task assistance' predicts positive outcomes, although the balance of evidence, including one meta-analysis of studies (Mor Barak *et al*, 2009**), suggests that it does.

Evidence from one meta-analysis of mainly US studies of child welfare workers, social workers and mental health workers suggests that supervisors **giving 'task assistance' (advice/guidance, feedback, training and coaching)** is related to positive and negative outcomes (Mor Barak *et al*, 2009**). It also suggests that the effect of this is greater than for the impacts of social/emotional supervisory support and the quality of supervisory interpersonal communication.

There is evidence from two longitudinal studies of US child welfare workers who were mainly career starters (no response rates reported) that supervisors **facilitating the supervisee's learning** (Scannapieco and Connell-Carrick, 2007*) or **the amount of guidance and information** (Yankeelov *et al*, 2009*) (both reported by supervisees) were predictors of workers staying in their job. There was correlational evidence from one cross-sectional study of social workers/health professionals in integrated mental health

teams in Australia that the **priority of time spent on discipline-specific skills** (but *not* generic skills) was a predictor of the perceived impact on clinical effectiveness, but *not* of job satisfaction (Kavanagh *et al*, 2003^{***}). The extent that **supervision teaches new skills** was a predictor of both job satisfaction and the perceived impact on clinical effectiveness.

However, one US longitudinal study of new child welfare workers at the time of a class action lawsuit against the agency (Faller *et al*, 2010^{**}), and a US cross-sectional study of child welfare workers who had experienced an organisational intervention to improve turnover while the survey was conducted (McGowan *et al*, 2009^{**}), showed no statistically significant relationship between similar guidance/information variables (reported by supervisees) and turnover.

Also, in two longitudinal studies of US child welfare workers who were career starters (no response rates reported), workers' reports of:

- **hours spent with their supervisor in 'on the job' training** (Scannapieco and Connell-Carrick, 2007^{*})
- workers' perceptions of **supervisors' attitudes towards workers' training** (Yankeelev *et al*, 2009^{*})
- **perceived quality of work assistance from the supervisor** (Yankeelev *et al*, 2009^{*})

did *not* predict retention.

There is mixed evidence on the impact of structured practice/clinical discussions about specific people using services, but intervention studies that are not controlled suggest that they do predict positive outcomes.

Evaluations of US interventions that introduce different forms of **structured case-focused clinical supervision** to workers (who could themselves be supervisors) in child welfare services had positively reported outcomes (Collins-Camargo and Millar, 2010^{**}; Smith *et al*, 2007 – small-scale). These included self-efficacy and confidence, professional development, clinical skills/practice outcomes, outcomes for people who use services (as reported by workers) and interagency outcomes (Collins-Camargo and Millar, 2010^{**}). These interventions were:

- (i) the Integrative Supervision Model, delivered to 17 Master² Social Workers in child welfare services, and evaluated through survey questions on outcomes perceived by 10 participants and their clinical and administrative supervisors following the intervention (Smith *et al*, 2007^{**})
- (ii) structured clinical casework supervision projects implemented in the public child welfare agencies of four different US states, and evaluated through focus groups with participants midway and at the end of the intervention (Collins-Camargo and Millar, 2010^{**}). [Note – there was also quasi-

² Master Social Workers are a type of licensed social workers in the US i.e. a post/ seniority grade, rather than a qualification/ course

experimental evaluation of the interventions described in Collins Camargo and Millar, but these papers were not accessed for the research briefing.]

One US intervention focused on **introducing critical thinking skills in review of 'cases' through group supervision** for child welfare workers (Lietz, 2008**).

Evaluation of this 'supervision circle' project found improvements in the level of critical thinking in supervision (as reported by workers). There was a greater increase among group supervision participants, although no statistically significant increase among the small sample of 47 child welfare managers who had experienced the initial training. This intervention was evaluated through before/after survey data, including a question asking whether the respondent had participated in the group supervision.

Evaluation of a US state-wide organisational intervention that included **clinical supervision and case review** was reported as having positive outcomes. These included improved retention of workers, supervisor effectiveness, team effectiveness and job satisfaction (Renner *et al*, 2009*). However, the evaluation used descriptive time series data in which the changes were not consistent over the time period. There were also other changes over the same time period, and so the data is difficult to interpret.

However, there is evidence from one small-scale cross-sectional study of US family support workers and their supervisors in family visiting services that:

- supervisors' reports of the **client focus during supervision** were:
 - a *negative* predictor of supervisees' job satisfaction (in the areas of policy/procedures and the human relations aspect of supervision i.e, less client-focused, more job satisfaction) but
 - *not* related to supervisees' burnout (Mena and Bailey, 2007**)
- supervisees' reports of the client focus were *not* related to supervisees' job satisfaction or to their burnout, but the nil results reported could be due to the small samples.

What do people think about the practice?

There is evidence from two qualitative studies of practitioners in integrated adults health and social care settings in the UK (Lambley and Marrable, 2012**) and Canada (Bogo *et al*, 2011 a, b**) that supervisees want supervisors to have:

- **expert up-to-date theory/practice knowledge** (both studies)
- **clinical intervention skills for specific client populations** (Bogo *et al*, 2011 a, b**).

This is so they are able to teach new models and skills in professional practice. This also applies to those supervisors not from the same professional background as supervisees. These supervisees wanted **systematic discussions about individual cases with people who use services**, and **broader clinical discussions**.

Three UK qualitative/descriptive studies in the UK and Canada refer to supervision needing to support **specific decisions about people who use services** (Lambley and Marrable, 2012**; Bogo *et al*, 2011a**; Fleming and Taylor, 2007**). In the UK study of workers in integrated adults health and social care services, workers reported specific

outcomes for people who use services following discussion of individual 'cases' in supervision (Lambley and Marrable, 2012**). In the small-scale study of home care workers in Northern Ireland, workers wanted information about their clients and consideration of their views when professional staff made decisions about care (Fleming and Taylor, 2007**).

However, in a qualitative study of children's services workers in Canada (Gibbs, 2001***), a study of children's services workers in England (Holmes *et al*, 2010**) and a qualitative study of practitioners in integrated adults health and social care settings in the UK (Lambley and Marrable, 2012**), workers did not want **case planning or task-focused supervision or 'lists'** at the expense of emotional support, constructive challenge of practice, decision-making or longer-term professional development. Children's services workers in England said in focus group discussions that they did want to **prioritise work** in supervision (Holmes *et al*, 2010**). In a UK qualitative study of workers in integrated adults health and social care services, **accessing training and development** through supervision was considered important for all workers to support good practice, staff retention and career progression (Lambley and Marrable, 2012**).

Involvement of people who use services in supervision (based on views expressed at a seminar and in two focus groups)

What is the practice?

In a UK study of workers in integrated adults social care and health settings, there was little **direct involvement in supervision of people who use services** (Lambley and Marrable, 2012**). One case study site involved people who use services in group meetings with staff that linked to supervision. Their input into supervision was generally at the discretion of individual workers. None of the paperwork (eg policies) provided to the research team required direct feedback in supervision from people who use services.

What happened as a result of the practice?

There was no evidence on outcomes from the involvement of people who use services in supervision.

What do people think about the practice? Will it work in day-to-day services?

In a UK study of workers in integrated adults social care and health settings (Lambley and Marrable, 2012**), and at a seminar of practitioners and people who use services, they wanted their **concerns to be heard** in supervision. They wanted to **feed back examples of good and bad practice or events to those who worked with them**. They had not experienced supervision leading to the changes they would like to see happen. Additionally, they were concerned that decisions were made about them in supervision without their participation.

At the UK seminar of practitioners and people who use services (not a research study), participants suggested that supervisors could consider how to involve people who use services in supervision, especially in **structured practice discussions and decisions about their care**. Examples were through **regular group meetings** (also in Lambley and Marrable, 2012**) and **written feedback**. Supervisors should consider how this involvement could be:

- **empowering, non-threatening and emotionally ‘safe’** for people using services
- **sensitive to the power relationships that** exist between staff and people who use services.

For the supervision of workers who have a high caseload, it may not be practical to include all people using services.

Reflection and critical thinking

What is the practice?

It wasn't always clear from the research papers whether 'reflection' meant reflecting on practice, or in terms of the worker's feelings about their work (emotional support).

In a study of UK workers in integrated adults health and social care settings, workers said that clinical and professional supervision for professionally qualified workers was seen as a process of **in-depth reflection**, with supervisors providing '**challenge**' and '**support**' for their work (Lambley and Marrable, 2012**). However, in supervision sessions supervised by social workers studying for a Master's degree in England, there was a dominance of the managerial/administrative role. This was sometimes to the detriment of a supervisee's (social worker's) need for reflective space (Bourn and Hafford-Letchfield, 2011**).

What happened as a result of the practice?

Evidence from intervention studies (not controlled) is consistent with positive outcomes from reflection and critical thinking in supervision.

Evaluation of one US intervention found improvements in the level of critical thinking in supervision (as reported by workers) (Lietz, 2008**). The 'supervision circle' intervention focused on **introducing critical thinking skills in review of 'cases' through group supervision as a form of training** for 47 child welfare managers. It then cascaded the critical thinking training through the organisation to supervisors of frontline child welfare workers. The evaluation found a greater increase in the level of critical thinking among intervention participants. However, there was no statistically significant increase among the small sample of 47 child welfare managers who had experienced the initial training. This intervention was evaluated through before/after survey data, and included a question asking whether the respondent had participated in the group supervision intervention.

Evaluations of US interventions (Collins-Camargo and Millar, 2010**; Smith *et al*, 2007** – small-scale) that introduce different forms of **structured case-focused clinical supervision** to workers (who could themselves be supervisors) in child welfare services, including **reflection/critical thinking**, had positively reported outcomes. These included more self-reflection and critical thinking, clinical skills/practice outcomes, outcomes for people who use services (as reported by workers) and interagency outcomes. These interventions were:

- (i) the Integrative Supervision Model, delivered to 17 Social Workers in child welfare services, and evaluated through survey questions on outcomes as perceived by 10 participants and their clinical and administrative supervisors following the intervention (Smith *et al*, 2007**)
- (ii) structured clinical casework supervision projects implemented in the public child welfare agencies of four different US states, and evaluated through focus groups with participants midway and at the end of the intervention (Collins-Camargo and Millar, 2010**).

However, it isn't possible to disentangle the impacts of the reflection component of the interventions.

What do people think about the practice? Will it work in day-to-day services?

There is good evidence from three studies (Bogo *et al*, 2011 a, b^{**}; Holmes *et al*, 2010^{**}; Gibbs, 2001^{***}) that supervisees want, or note the absence of, reflection on practice, including '**identifying blind spots**' (Bogo *et al*, 2011b^{**}). These studies covered children's services workers in Australia and in England, and social workers and other professionals in interprofessional mental health teams in Canada.

In qualitative UK studies of workers in integrated social care and health settings (Lambley and Marrable, 2012^{**}), and of social worker supervisors studying for a Master's degree in England (Bourn and Hafford-Letchfield, 2011^{**}), workers or supervisors said that performance review or recording in supervision could interfere with the '**space**', **openness and honesty** required for discussion and reflection.

Feedback and recording in supervision, including performance review

What is the practice?

In a UK study of workers in integrated health and social care settings, clinical and professional supervision was associated with supervisors providing '**support as well as challenge**' to professionally qualified workers (Lambley and Marrable, 2012**). There was also **reciprocal feedback** between supervisor and supervisee, for example, supervisees giving feedback to supervisors, and raising organisational issues and barriers (also Bourn and Hafford-Letchfield, 2011**). **Performance issues** were raised and often dealt with in supervision.

In a qualitative study of social worker supervisors studying for a Master's degree in England, supervisors used **positive reinforcement, encouragement and support for work done** as strategies to manage anxiety in supervisees' work and to establish a collaborative relationship (Bourn and Hafford-Letchfield, 2011**). However, the administrative and managerial roles of the supervisor, including '**managerial surveillance**' and **performance measurement**, could dominate in supervision over space for reflection and emotional support.

There was also descriptive evidence on the **recording of supervision**. In the UK study of workers in integrated health and social care settings, some respondents used a structured format that was outlined in a **supervision pro forma** (Lambley and Marrable, 2012**). The supervisors used this format to guide the supervision meeting. Most supervisors adapted the delivery of the questions and the order they were asked in to individual workers. Supervision records were also used to provide information for re-registration purposes for professional workers. In one organisation, records were kept of **formal quarterly reviews and written personal development planning** for each supervisee.

In a study of social worker supervisors studying for a Master's degree in England, supervisors **made notes** during supervision on their laptop. This sometimes diverted them from providing space for communication, reflection and emotional issues (Bourn and Hafford-Letchfield, 2011**).

What happened as a result of the practice?

Evidence from intervention studies (not controlled) is consistent with positive outcomes from feedback in supervision. However, it is not sufficiently strong to say that there is good evidence for this.

Evaluations of US interventions that introduced different forms of **structured case-focused clinical supervision** to workers (who could themselves be supervisors) in child welfare services had positively reported outcomes (Collins-Camargo and Millar, 2010**; Smith *et al*, 2007** – small-scale). The supervision included a **360 evaluation of supervisors including by supervisees** (Collins Camargo and Millar, 2010 **) and giving **supervisory feedback to supervisees** (Smith *et al*, 2007**). Outcomes included better feedback between supervisees (reported by intervention supervisors in Smith *et*

al, 2007**), greater openness to feedback from supervisees, clinical skills/practice outcomes, outcomes for people who use services (as reported by workers) and interagency outcomes. These interventions were:

- (i) the Integrative Supervision Model, delivered to 17 Social Workers in child welfare services, and evaluated through survey questions on outcomes as perceived by 10 participants and their clinical and administrative supervisors following the intervention (Smith *et al*, 2007**)
- (ii) structured clinical casework supervision implemented in the public child welfare agencies of four different US states, and evaluated through focus groups with participants midway and at the end of the intervention projects (Collins-Camargo and Millar, 2010**).

However, it isn't possible to disentangle the impacts of the feedback and the 360 evaluation components of the interventions.

What do people think about the practice? Will it work in day-to-day services?

There is evidence from two qualitative studies that supervisees want, or note the absence of, **feedback, 'support for work done' and/or evaluation of their work** (Bogo *et al*, 2011a **; Gibbs, 2001***). However, there could be tensions between open honest feedback and the supervisee wanting to appear competent (Bogo *et al*, 2011a **). These studies cover child protection workers in Australia and social workers and other professionals in interprofessional mental health teams in Canada.

In a study of social workers and other professionals in interprofessional mental health teams in Canada, supervisees specifically valued **reciprocal feedback between supervisors and supervisees**. This feedback included their concerns and suggestions for improvement, and feedback to the supervisor on their role (Bogo *et al*, 2011 a, b **). One supervisor in a study of workers in integrated health and social care settings in the UK appreciated **positive feedback from their supervisee** (Lambley and Marrable, 2012**).

There is good evidence from supervisees and/or supervisors in four qualitative studies that there can be an **over-emphasis on performance review, recording, productivity, time management, managers' lists and/or checking** (Lambley and Marrable, 2012**; Bogo *et al*, 2011 a, b**; Bourn and Hafford-Letchfield, 2011**; Gibbs, 2001***). These studies cover child protection workers in Australia, workers in integrated adults health and social care services in the UK, social worker supervisors studying for a Master's degree in England and social workers and other professionals in interprofessional mental health teams in Canada.

However, there is a balance to be struck, as staff also wanted:

- feedback and evaluation of their work (Bogo *et al*, 2011 a, b**)
- a link between supervision and **internal and external accountability systems**, and the **recording of decisions about people who use services** (Lambley and Marrable, 2012**).

Organisational support for supervision

What is the practice?

In a qualitative study of social work supervisors studying for a Master's degree in England, the organisational and managerial roles of the supervisor, including '**managerial surveillance**' and **performance measurement**, sometimes dominated in supervision (Bourn and Hafford-Letchfield, 2011**). Supervisors used various strategies (eg humour, ironic apologies and distancing) to mediate between the organisation and the supervisee, and to gain compliance with the implementation of unwelcome procedural changes. They were aware of power relationships.

In a study of workers in integrated adults social care and health settings in the UK, some supervisors **acting as leaders** understood the role of supervision in the wider goals of their organisation. They **took supervisees' concerns outside supervision** (Lambley and Marrable, 2012**). There were examples of organisations having a **cultural commitment** to supervision taking place, and formally monitoring the time spent on supervision. Two organisations had a **management performance target** for this.

What happened as a result of the practice?

There is mixed evidence on whether supervision interventions implemented in organisations lead to positive outcomes at the level of the organisation.

Evaluations of US **supervision interventions implemented by child welfare organisations** showed positively reported organisational and interagency outcomes (Collins-Camargo and Millar, 2010**; Renner *et al*, 2009*; Lietz, 2008**). These included:

- an increase in the level of critical thinking in supervision among workers (Lietz, 2008**) following a critical thinking intervention through group supervision
- reduced turnover (Collins-Camargo and Millar, 2010**; Renner *et al*, 2009*)
- better intra-agency and interagency working (Collins-Camargo and Millar, 2010**)
- increased peer support and enhanced teamwork (Collins-Camargo and Millar, 2010**)
- an increased evidence-based learning culture within organisations (Collins-Camargo and Millar, 2010**)
- an impact on people who use services (as reported by workers) (Collins-Camargo and Millar, 2010**).

These interventions were sometimes delivered as training for managers and/or supervisors, and then cascaded through the organisation to supervisors and/or workers.

However, in an evaluation of a US intervention that introduced **structured case-focused clinical supervision** to social workers (who could themselves be supervisors) in US child welfare services, participants' administrative supervisors reported fewer benefits of the intervention than clinical supervisors and participants (Smith *et al*, 2007**

– small-scale). The administrative supervisors worked in the participants' agencies and were responsible for their performance management. The clinical supervisors delivered the intervention. Participants reported less change on outcomes related to caseload or workplace issues (eg agency support) than on outcomes related to clinical practice. The intervention did not appear to affect their reported interaction with their agency (administrative) supervisors. There was a poor response rate from agency supervisors in the evaluation of the intervention.

What do people think about the practice?

In one study in integrated social care and health settings in the UK, workers wanted **supervisors to act as 'leaders' and to take their concerns outside supervision** (Lambley and Marrable, 2012**).

In one survey of social workers and health professionals in integrated mental health teams in Australia, a lack of **support from the supervisee's director or line manager** was seen as a problem by 19 per cent of the professional workers (Kavanagh *et al*, 2003***).

In the UK study in integrated social care and health settings in the UK, workers wanted a **quiet confidential physical space** for supervision (Lambley and Marrable, 2012**).

Organisations having a supervision policy and/or supervision agreements/contracts

What is the practice?

In the surveys of workers in UK integrated adults health and social care services (Lambley and Marrable, 2012**), and local authority children's services department managers (Holmes *et al*, 2010** – small-scale), workers or local authority managers said that **supervision policies and procedures** were largely in place. However, not all staff were aware of them (Lambley and Marrable, 2012**). In the practice enquiry (Lambley and Marrable, 2012**), **supervision contracts** were also commonly used. In a case study site in the qualitative part of the practice enquiry, supervision policies and procedures **dovetailed with human resource policies**.

In the same study, while most staff were not able to choose their supervisor, some could **ask for a change of supervisor** (Lambley and Marrable, 2012**). One organisation used **staff profiles to try and match people to a preferred supervisor**. There were examples of organisations **formally monitoring the time** spent on supervision. Two organisations had a **management performance target** for this. None of the paperwork provided to the research team required **direct feedback from people who use services** for use in supervision.

What happened as a result of the practice?

Evaluation of a US state-wide organisational intervention, which included a **supervisory strategic plan to support supervisors** and to implement a range of interventions, was reported as having positive outcomes (Renner *et al*, 2009*). These included improved retention of workers, supervisor effectiveness, team effectiveness and job satisfaction. However, it isn't possible to differentiate the impacts of having a policy from the impacts of the interventions implemented as part of the policy. The evaluation used descriptive time series data in which the changes in worker retention were not consistent over the time period.

In one cross-sectional study of social workers/health professionals in integrated mental health teams in Australia, supervision being **governed by a fully specified contract** (agreement between supervisor and supervisee) was a predictor of perceived impact on clinical effectiveness, but was not related to job satisfaction (Kavanagh *et al*, 2003***).

What do people think about the practice?

In a survey of social workers and health professionals in integrated mental health teams in Australia, a lack of **supervision guidelines** was seen as a problem by 24 per cent of the professional workers (Kavanagh *et al*, 2003***).

Group supervision

What is the practice?

In a UK survey of workers in integrated adults health and social care, most formal supervision was 1:1. There was also **group or peer supervision**, including **informal team supervision** in one case study site (Lambley and Marrable, 2012**). In the qualitative part of this study, senior practitioners in one site used group supervision, called a 'seniors' meeting'. All service managers participated in the meeting, and practitioners such as GPs or nurses were invited if input was needed. There were case discussions and decision-making relating to individual people who use services, but their direct involvement in the meeting was not reported in the practice enquiry report. Any outcomes could be fed into formal supervision.

What happened as a result of the practice?

Evidence from intervention studies (not controlled) is consistent with positive outcomes from group supervision, but is not sufficiently strong to say that there is good evidence for this.

Evaluation of one US intervention found improvements in critical thinking (Lietz, 2008**). The 'supervision circle' project focused on introducing **critical thinking skills in review of 'cases' through group supervision as a form of experiential training** for 47 child welfare managers. It then cascaded the intervention through the organisation to supervisors of frontline child welfare workers. The evaluation found improvements in the level of critical thinking in supervision (as reported by workers), with a greater increase among group supervision participants. However, no statistically significant increase was found among the small sample of 47 child welfare managers who had experienced the initial training. This intervention was evaluated through before/after survey data, including a question asking whether the respondent had participated in the group supervision. However, it isn't possible to disentangle the impacts of the group supervision component of the intervention.

Evaluations of US interventions introducing different forms of **structured case-focused clinical supervision** to workers (who could themselves be supervisors) in child welfare agencies had positively reported outcomes (Collins-Camargo and Millar, 2010**; Smith *et al*, 2007** – small-scale). These included:

- outcomes for people who use services (as reported by workers)
- peer support or consultation within supervision groups
- learning skills from other group members
- better feedback between group members
- clinical skills/practice outcomes
- interagency outcomes.

However, in Smith *et al* (2007**), only 70 per cent of participants reported that their understanding of group process had increased, compared with between 90 and 100 per cent agreeing that other types of changes had taken place.

These interventions included **group supervision** (covered group dynamics and conflict in Smith *et al*, 2007**) and '**learning laboratories**' (supervisors learning supervision skills in a learning cycle in group supervision with peer consultation and support in Collins-Camargo and Millar, 2010**). They were:

- (i) the Integrative Supervision Model, delivered to 17 Master³ Social Workers in child welfare services, and evaluated through survey questions on outcomes as perceived by 10 participants and their clinical and administrative supervisors following the intervention (Smith *et al*, 2007**)
- (ii) structured clinical casework supervision projects implemented in the public child welfare agencies of four different US states, and evaluated through focus groups with participants midway and at the end of the intervention (Collins-Camargo and Millar, 2010**).

However, it isn't possible to disentangle the impacts of the group supervision components of the interventions on clinical practice outcomes or outcomes for people using services.

What do people think about the practice?

In a qualitative study of social workers/other professionals in interprofessional mental health teams in Canada, some practitioners participated in **group supervision in teams**. They valued **supervisors who promoted cohesion and facilitated discussion and problem-solving** (Bogo *et al*, 2011b**).

^{3 3} Master Social Workers are a type of licensed social workers in the US i.e. a post/ seniority grade, rather than a qualification/ course

Training for supervisors

What is the practice?

In a survey of workers in integrated adults social care and health settings in the UK, nearly all supervisors reported that they had **access to specialist training in supervision and supervision techniques** (Lambley and Marrable, 2012**). Training topics included:

- poor performance
- coaching
- supervision skills
- non-verbal behaviour
- communication skills
- case and clinical supervision
- appraisal training
- national vocational occupational training and accredited management training.

In contrast, social worker supervisors studying for a Master's degree in England in a qualitative study said that most supervision training was **'on the job'** (Bourn and Hafford-Letchfield, 2011**).

In a qualitative study of social worker supervisors studying for a Master's degree in England, supervisors **watched their supervisory performance in audiovisual recording**, and then reflected on it (Bourn and Hafford-Letchfield, 2011**).

What happened as a result of the practice?

Evidence from intervention studies (not controlled) is consistent with positive outcomes from supervision training for supervisors, but is not sufficiently strong to say that there is good evidence for this.

Evaluation of one US intervention found improvements in critical thinking (Lietz, 2008**). The 'supervision circle' project focused on introducing **critical thinking skills in review of 'cases' through group supervision as a form of training** for 47 child welfare managers. It then cascaded the intervention through the organisation to supervisors of frontline workers (child welfare workers). The evaluation found improvements in the level of critical thinking in supervision (as reported by workers), with a greater increase among group supervision participants. However, there was no statistically significant increase among the small sample of 47 child welfare managers who had experienced the initial training. This intervention was evaluated through before/after survey data, including a question asking whether the respondent had participated in the group supervision.

Evaluations of US interventions introducing **different forms of clinical supervision** to workers in child welfare services, **including training for supervisors (covered supervision skills and how to implement the clinical supervision model)**, had positively reported outcomes (Collins-Camargo and Millar, 2010**; Smith *et al*, 2007** – small-scale). These included:

- understanding of the educational role of supervision
- knowledge of supervision models and techniques
- other positive supervision outcomes
- an increased learning culture within the organisation
- clinical skills/practice outcomes
- outcomes for people using services (as reported by workers).

One mechanism appeared to be that the group supervision training for supervisors could model a strengths-based approach with supervisees, who could then model it for people using services.

These interventions were:

- (i) the Integrative Supervision Model, delivered to 17 Social Workers in child welfare services, and evaluated through survey questions on outcomes as perceived by 10 participants and their clinical and administrative supervisors following the intervention (Smith *et al*, 2007**)
- (ii) structured clinical casework supervision projects implemented in the public child welfare agencies of four different US states, and evaluated through focus groups with participants midway and at the end of the intervention (Collins-Camargo and Millar, 2010**).

Evaluation of a US state-wide organisational intervention, which included **basic supervisor training and clinical supervision training**, was reported as having positive outcomes such as improved retention of workers, supervisor effectiveness, team effectiveness and job satisfaction (Renner *et al*, 2009*). However, the evaluation used descriptive time series data in which the changes for worker retention were not consistent over the time period. There were also other changes over the same time period (key agency/local political context), and so the data is difficult to interpret.

It isn't possible to disentangle the impacts of the training components of the interventions on clinical practice outcomes or outcomes for people using services.

What do people think about the practice?

In a UK study of workers in integrated adults social care and health settings in the UK, some supervisors said they wanted more training (Lambley and Marrable, 2012**).

Specific topics requested included:

- performance management (especially in relation to under-performing staff)
- conflict management
- service modernisation
- models of clinical supervision
- coaching
- group work
- action learning.

In a survey of social workers and health professionals in integrated mental health teams in Australia, 15 per cent of the professional workers reported insufficient training for supervisors as a problem (Kavanagh *et al*, 2003^{***}).

In two qualitative studies of workers in integrated adults social care and health settings in the UK and Canada, practitioners said that their supervisors needed **up-to-date knowledge and skills to help them guide supervisees in their professional practice** (Lambley and Marrable, 2012^{**}; Bogo *et al*, 2011 a, b^{**}).

In the qualitative study of social worker supervisors studying for a Master's degree in England, supervisors valued the **opportunity to watch their supervisory performance in audiovisual recording, and then reflect on it** (Bourn and Hafford-Letchfield, 2011^{**}).

Supervision of personal assistants note (based on views expressed at a seminar and the project advisory group, ie, not research evidence)

At a seminar of practitioners and people who use services (not a research study), and at the project advisory group, participants made the points that **personal assistants should receive supervision**. However, this needed to be **funded**, and people using services might need to have **training** on how to act as supervisors. If not directly supervising personal assistants, people using services should provide key input into their supervision.

Discipline-specific supervision

What is the practice?

In a UK survey of workers in integrated adults social care and health settings, the majority of practitioners who were professionally qualified said that they had a **supervisor from the same profession** (Lambley and Marrable, 2012**).

What happened as a result of the practice?

In one cross-sectional study of social workers and health professionals in integrated mental health teams in Australia, the **priority of time given in supervision to discipline-specific skills** (but not generic skills) were predictors of the perceived impact of supervision on clinical effectiveness, but not of job satisfaction (Kavanagh *et al*, 2003***).

What do people think about the practice?

In a cross-sectional survey of social workers and health professionals in integrated mental health teams in Australia, **finding discipline-specific supervisors** was seen as a problem by over 20 per cent of the professional workers (Kavanagh *et al*, 2003***).

In qualitative studies of practitioners in integrated adults social care and health settings in the UK and Canada, practitioners valued their supervisors having a **good understanding of their role** (Lambley and Marrable, 2012**; Bogo *et al*, 2011 a, b**). In the Canadian study in which practitioners had a programme manager as their supervisor, not necessarily from their professional background, practitioners missed the connection to their own discipline (Bogo *et al*, 2011 a, b**). They valued supervisors who tried to **understand the frameworks and values of their specific professions**, and **spoke in their professional language**. They wanted **profession-specific meetings** as well as supervision.

Different career stages

What is the practice?

In a small-scale survey of local authority children's services department managers, all but two of the surveyed authorities reported that **supervision was held more frequently** (eg fortnightly or weekly) **for newly qualified staff** (Holmes *et al*, 2010**). In a qualitative study of social work supervisors studying for a Master's degree in England, supervisors tended to use **a more consultative style with experienced staff** and a more directive approach with less experienced staff (Bourn and Hafford-Letchfield, 2011**).

What do people think about the practice?

In a qualitative study of social workers and other professionals in interprofessional mental health teams in Canada, practitioners considered that the focus and content of supervision **should vary according to the practitioner's career stage** and how long they had been employed in a specific agency (Bogo *et al*, 2011b**).

Costs to inform recommendations

A small-scale study of local authority children's services departments in England and their frontline workforce concluded that the unit cost of a supervision session lasting 1.5 hours was £87 per frontline social worker (Holmes *et al*, 2010**). If the frequency of supervision sessions was increased to fortnightly (from monthly), this would be an annual increase in costs of £1,217 per worker. For a referral and intake team with five social workers and three family support workers, this would be an additional annual cost of £9,408. These calculations were based on a 'bottom-up' methodology that included a time use survey of 54 frontline practitioners in nine local authorities.

In a UK study of integrated adults social care and health settings in the UK, three of the four case study organisations did not separately calculate the cost of supervision as it was seen as an 'integral part of working roles' (Lambley and Marrable, 2012**). Where a calculation was made, they multiplied the supervisor and supervisee's hourly rate by the time taken for supervision, but did not always take into account organisational overheads. In one of the case study organisations, the following supervision costs were calculated:

- Supervision for team leaders as four days per annum, a total of 7 per cent downtime, which cost the community support services subsidiary £478.98 per person annually.
- Supervision for senior support workers as three days per annum, a total of 6 per cent downtime, which cost the community support services subsidiary £217.18 per person annually.
- Supervision for support workers as three days per annum, a total of 6 per cent downtime, which cost the community support services subsidiary £190.23 per person annually.

These calculations of costs did not take into account the benefits of supervision, for instance, increases to output, improved outcomes for staff and people who use services, retention of staff and improvements to efficiency at work.

Technical notes – inclusion criteria and the strength of evidence

Notation for studies

***** stronger** strength of evidence, taking both methodological quality (for study of this type) and relevance into account

**** moderate** strength of evidence, taking both methodological quality (for study of this type) and relevance into account

*** weaker** strength of evidence, taking both methodological quality (for study of this type) and relevance into account

Inclusion criteria

This narrative summary is based on:

- The empirical research papers selected for the SCIE research briefing on supervision. These were included in the research briefing if they met defined criteria, in particular that they:
 - included quantitative or qualitative evidence on the effectiveness of and/or outcomes from supervision of social workers and other social care workers (any setting)
 - were published from 2000 onwards
 - were peer-reviewed journal articles or research reports
 - were in countries with developed infrastructures.

They excluded studies where the only outcome was the relationship between supervisor and supervisee.

- The SCIE practice enquiry (Lambley and Marrable, 2012).
- A seminar of practitioners and people using services, held to inform the supervision practice guide.

Research briefing studies are included in the narrative synthesis reported in this summary if they:

- Relate to specific aspects of supervision, ie, not just overall or composite quality of supervision or satisfaction with supervision
- Are from the UK (regardless of strength of evidence)
- Are meta-analyses, intervention or longitudinal studies or include specific economic evidence (regardless of strength of evidence)
- Are qualitative non-UK studies if they are of strong *** or moderate ** strength of evidence (based on quality and relevance)
- Are cross-sectional non-UK studies if they are of strong *** or moderate ** strength of evidence (based on quality and relevance) and meet the following criteria:

- sample size greater than 150, unless a census study of a defined population
- response rates of 45 per cent or greater
- use multivariate analysis for outcomes data (only the findings on outcomes from multivariate analyses in these studies are used in the narrative summary).

Furthermore, studies are only included under the heading 'What is the practice?' if they are UK studies.

Quantitative studies are called 'small scale' if they have a sample size smaller than 100.

Strength of evidence

There is little intervention evidence in the papers accessed for the research briefing.

The few intervention studies are methodologically weak in showing any causality, and are all of US child welfare workers. The outcomes are as reported by supervisors and supervisees, rather than being independently measured. None of these evaluations uses intervention and comparison groups (a 'controlled trial'), but instead are based on:

- before/after data (Lietz, 2008)
- change reported by supervisees and supervisors at one point in time following the intervention in a small-scale evaluation (Smith *et al*, 2007**)
- descriptive time series analysis (Renner *et al*, 2009*)
- qualitative evidence on changes (reported by supervisors and supervisees) (Collins-Camargo and Millar, 2010**),

all of which introduce confounding factors.

These complex interventions each incorporated several components such as:

- clinical practice
- individual supervision
- group supervision
- emotional support
- training
- clinical supervision
- 360° feedback
- 'learning laboratories'.

As there was little reported in-depth qualitative evidence focusing on intervention mechanisms, it is difficult to attribute positive outcomes to specific intervention components. There was also quasi-experimental evaluation of the Collins-Camargo and Millar interventions, but these papers were not accessed for the research briefing or this narrative summary.

There is qualitative evidence from studies on the experiences and perspectives of supervisors and supervisees. However, this is not a comprehensive review of these studies because the research briefing criteria included qualitative studies only if they

referred to reported outcomes of supervision. The practice enquiry is the only research study to report the views and perspectives of people who use services, but is restricted to integrated and joint adult social care and health settings.

There is no strong evidence on outcomes for people using services, or on outcomes for workers that are defined by people who use services.

Therefore, none of the recommendations reflect 'promising' or 'proven' good practice (see Appendix 2 of Fisher and Rutter, 2011).

Many of the studies are for specific populations, often child welfare workers in the US for the cross-sectional and longitudinal studies.

So supervision practices are either unproven, or somewhere between 'unproven' and 'promising'. The evidence base is:

- intervention evidence from non-controlled studies
- qualitative evidence from supervisors and supervisees
- multivariate correlational evidence from longitudinal and cross-sectional surveys.

Most of these studies have specific localised populations in one state or county of a country or in one or more agencies. Therefore it is unclear whether the evidence applies to the wider population of social workers or social care workers in the UK.

Strictly speaking, according to SCIE guidelines (Fisher and Rutter, 2011), recommendations should not be made at all, based on this weak evidence base.

Therefore recommendations have been made using the language of 'could', 'may want to consider' and so on.

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Narrative summary of the evidence review on the supervision of social workers and social care workers in a range of settings including integrated settings

This report is a review of evidence from research literature accessed by the Social Care Institute for Excellence (SCIE) through systematic searches for a research briefing, a SCIE practice enquiry and a seminar of practitioners and people using services

The report provides a compendium of evidence to inform the practice guide, with summary evidence statements. Evidence and descriptions of studies are repeated in different sections of the report to ensure that each section is comprehensive in itself as a review of all relevant evidence.

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