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Supervision Needs for Social Workers Providing Home-Based Treatment for Children and Families

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This is to certify that the doctoral study by

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MSW, Florida International University, 2005

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Project Submitted in Partial Fulfillment

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Doctor of Social Work

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Abstract

Social workers providing home-based therapy services for children and families face challenges that make it difficult to provide efficient and effective treatment. The purpose of this qualitative study was to explore the supervision needs of social workers who provide treatment using the home-based service delivery model. The leader-member exchange theory was used to guide the study. Data were collected from a focus group meeting with 10 master's-level social workers in Miami-Dade County, Florida. Findings from coding and thematic analysis revealed that participants' needs involved being educated on the value of the home-based model, receiving support and guidance related to their health and safety, obtaining better administrative support, having readily available assistance in handling crises, and having supervisors take a more strategic approach when assigning cases. Ongoing training opportunities, addressing concerns when voiced, and receiving regular quality supervision were recommended for helping social workers feel competent and effective in their service provision. Findings may be used to improve working conditions for social workers and improve client treatment experiences and outcomes. Improved treatment outcomes may lead to healthier individuals and family systems leading to positive social change. Organizations, administrators, and supervisors may use the findings to explore ways to best support social workers in their effort to provide treatment in the home environment.

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Dedication

This accomplishment is dedicated to my Lord and Savior Jesus Christ. I am grateful for the spirit of God that remained with me, serving as my wonderful counselor, encouraging me, and helping me push through to the end. This research is also dedicated to social workers who do the relentless work of providing home-based treatment to those most in need. When clients do not have the ability, readiness, or willingness to come to you, you go to them. Despite all adversity, limitations, and in many cases danger, you go to them. For that, I thank you for your service. Finally, this work is dedicated to my parents, Jean and Manicile Augustin. They left Haiti, their country of origin, in search of better opportunities for themselves and their children. Their decision offered me the opportunity to study and become whatever I wanted to be. I chose to be a social worker, which is not only the work I do, but who I am.

Acknowledgments

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Section 1: Foundation of the Study and Literature Review

The inspiration for this study originated from my experiences providing home-based treatment for youths and families in the community. The home-based family-centered service model is a method of service delivery to youths and families in their homes (Pecora et al., 1985). In my case and for this study, the specific service delivered is therapy. During the time I spent providing therapy services to youths in their homes, I faced many challenges and had many needs as a professional that went unmet. Although I had some success with clients, the feeling of demoralization I felt caused me to leave the much-needed work of providing home-based therapy services. As I progressed in the field, I was promoted to roles that required me to supervise social workers providing home-based therapy services. As a supervisor, I faced high staff turnover rates and poor client outcomes. Therefore, I considered this study as an investigative tool to identify and understand the needs of social workers as they provide home-based therapy services and how supervisors can best support them.

The passage of the Federal Adoption Assistance and Child Welfare Act in 1980 changed the approach professionals in agencies employed to deliver treatment to high-risk children and their families (Adams & Maynard, 2000). Under this federal policy, states are required to make reasonable efforts to preserve a child's placement at home. To adhere to these mandates, agencies have implemented family preservation programs that are most effective when executed with a home-based service delivery model. The home-based service delivery model is effective for engaging clients who are in involuntary

treatment, and it can be a less resistant avenue to address maladaptive family patterns (Cortes, 2004).

Despite the benefits of the home-based service delivery model, it comes with challenges that contribute to social worker burnout and demoralization (Cortes, 2004). Through the data obtained from the current action research project, agencies and the supervisors they employ may gain a greater understanding of the supervision needs of the social worker providing home-based services. Providing the appropriate support to social workers impacts service recipients in a positive manner as practitioner comfort levels increase (Foster et al., 2012). Section 1 of this study provides a description of the scope of the problem, presents the research questions, and clarifies the nature of the project and its significance. Furthermore, the theoretical framework, values, ethics, and a review of the professional and academic literature are included.

Problem Statement

As of January 2021, Miami-Dade County ranked seventh in the state of Florida for out-of-home care, and removed 506 children from their primary caregivers between January 2020 and January 2021 (Florida Department of Children and Families, 2021b). According to the Florida Department Children and Families (2021a), 4,321 children and young adults received services in-home, preventing the need for out-of-home care during that same period. The job of providing home-based treatment for children and families in communities like Miami-Dade County comes with several challenges for the social work professional.

Challenges that social workers face while providing home-based treatment include lack of training and experience, which places social workers providing home-based services at a higher risk of compassion fatigue and burnout than their more experienced colleagues (Macchi et al., 2016). Social workers are also at risk of burnout due to factors such as travel demands and managing heavy caseloads (Macchi et al., 2016). Unlike professionals who provide treatment in an office setting, home-based social workers are faced with isolation, feelings of inadequacy, unsafe and unpredictable environments, and unexpected distractions while conducting therapy in the home setting (Rodriguez-Keys et al., 2012). Agencies employing these social workers may experience high turnover rates due to high productivity standards that impact the quality of care service recipients receive (Franco, 2016).

Turnover rates negatively impact patient care (Ducharme et al., 2008). According to Young (2015), turnover rates weaken efforts to provide high-quality care because of unpredictability and discontinuity in service delivery. Young noted that patients remain in drug treatment longer, for example, if they keep the same clinician and experience consistency in treatment provisions. Child welfare workers were noted as having similar struggles with high turnover rates (Cyphers, 2001). Cyphers (2001) conducted a study in 43 states and found that the average preventable turnover rate of child protective service workers was 67%. *Preventable* was defined as workers who left the organizations for reasons other than retirement, death, marriage, parenting, returning to school, or spousal job move (Cyphers, 2001). Burnout, commitment, self-efficacy, and demographic characteristics were attributed to the turnover of child welfare and other human service

professionals (Young, 2015). Not only does turnover impact client treatment and outcomes, but it also has implications for the organization. In addition to the legal risks of social work turnover in social work agencies, high rates of turnover may destroy the organization's objective or intangible assets and cripple its ability to achieve its goals (Pollack, 2008).

The research is clear regarding the challenges social workers face in several service settings. The challenges faced often lead to burnout and high turnover rates. High turnover rates impact client care and contribute to organizational problems. In the current study, the supervision needs of social workers providing home-based treatment were explored so that administrators in organizations could become aware of the needs and find ways to meet those needs to avoid the preventable turnover of social workers providing therapy in homes.

Purpose Statement

The purpose of this action research project was to gather data to understand the supervision needs of home-based social work treatment providers. Using an action research methodology, I aimed to understand the supervision needs of social work treatment providers in the Miami-Dade County area. Understanding how to best support social workers who provide therapy in homes may improve outcomes for clients and yield a positive professional experience for the social worker. Further, in 2005, Lawson indicated that the research in this area was minimal, which continues to be true to date. It was my intention to add to the body of work regarding this topic and provide updated

data for further research. Findings may provide insight into the challenges and may lead to the development of appropriate solutions for home-based social work providers.

Research Question

The aim of the study was to gather data that could provide answers to the following research question: What are the supervision needs of social work practitioners providing home-based treatment? Answering this question may offer community service organizations and their leadership knowledge about the supervision needs of social work practitioners providing home-based treatment. Further, agencies and their supervisors may gain insight into how to best support their staff in delivering quality services to clients and achieving organizational goals. The process of identifying the supervision needs of social work practitioners providing home-based treatment began with clarifying the definitions to key concepts.

Definition of Key Concepts

In social work practice, several terms can be used to describe the same person. For example, in my experience as a social worker, it is not unusual for a client or other professional unfamiliar with the field of social work to identify a social worker providing home-based treatment as a counselor, therapist, case manager, or social worker. Furthermore, social work professionals provide an array of services in the home setting. Case management wraparound services and peer services are examples of services provided to families in the home. Finally, identifying who the client is in the context of this research was essential to the understanding of key concepts. Therefore, to ensure understanding of the terms used, I provide definitions of *social worker*, *home-based*

treatment, and *client*. Woodford (1999) offered characteristics of home-based family therapy from a theoretical perspective. These characteristics served as the definitions used in this action research project.

Client: Under the home-based family therapy theoretical perspective, the client is regarded as the family unit of the child or adolescent referred to receive services (Woodford, 1999).

Home-based treatment: Woodford (1999) shared that home-based therapy services are delivered in the home of the family rather than the social workers' office. For the current research project, the service provided as home-based treatment was individual and family therapy. The terms *home-based therapy*, *home-based counseling*, or *home-based family therapy* were also used to describe this concept.

Social worker: Woodford (1999) explained that home-based therapy services are provided by masters-level trained clinicians with some training, even informal, in the basics of systems theory and structural family therapy. *Social worker* was used to describe the professionals identified in this study providing home-based treatment.

Nature of the Doctoral Research Project

A qualitative action research methodology was used to answer the research question: What are the supervision needs of social workers providing home-based treatment? Action research methodology is based on a set of values that includes democratic, equitable, liberating, and life enhancing (Stringer & Aragon, 2020). Action research is a methodology that engages the voice of the people from which the research is seeking to gain information (Katwyk & Ashcroft, 2016). This systematic approach

enables participants and stakeholders to find solutions to problems they are confronted with every day (Stringer & Aragon, 2020). My role in this process was as a partner to the participants by exploring their experiences. Participants were regarded as cocreators of the knowledge being explored, which challenged traditional research approaches that reenact hierarchies based on gender, class, or race (Katwyk & Ashcroft, 2016).

A focus group is used to collect a large amount of information from a substantial group of people in a short time (Wilson, 2012). Focus groups involve combining techniques from qualitative research and group process theory (Then et al., 2014). Focus groups are used to obtain in-depth knowledge about perceptions, attitudes, beliefs, and opinions of individuals on a topic (Then et al., 2014). Through a focus group, current study participants had an opportunity to describe their experiences and present their perspectives on the issue of providing home-based therapy services (see Stringer & Aragon, 2020).

Social workers in Miami-Dade County who provide home-based services were asked questions to obtain a clear understanding of the scope of the issue and their needs pertaining to supervision. Using neutral language, I devised questions to ensure the group focused on the issue while allowing them to share their experience and perspective on their terms (see Stringer & Aragon, 2020). The data were audio recorded, transcribed, and analyzed for emerging themes and concepts.

Significance of the Study

This study was significant because it may help organizations in three ways. First, organizations may be equipped with the knowledge necessary to provide the best working

environments for social workers. Second, leaders currently providing supervision for social workers may be informed about how they can adjust their supervisory methods to best support direct care providers. Finally, supervisors and supervisees may apply recommendations and foster work environments that will lead to an increase in productivity, personal satisfaction, personal commitment, and openness to the influence of leaders, all of which are factors that impact the service delivery to consumers (see Gooty & Yammarino, 2016).

Outcomes from this action research study may provide social workers, supervisors, and organizations the opportunity to develop a better understanding of the challenges and needs faced by home-based therapy providers. Lawson (2005) addressed the gaps in training and concerns identified by home-based social workers. Lawson's work added to the progress being made in this critical but underrepresented area of the literature. Findings from the current study may also contribute to the social work body of knowledge and allow professionals challenged with the problems associated with home-based treatment to incorporate recommendations from the research in their workplaces.

Theoretical and Conceptual Framework

Leader-member exchange theory (LMX) is an influential leadership model used to predict organizational outcomes (Gooty & Yammarino, 2016). Taking a relationship-based approach to leadership, LMX emphasizes the dyadic relationship between supervisors and supervisees. With its inception in 1975, LMX has provided an alternative leadership style to vertical dyad linkage (Graen & Uhi-Bien, 1995). Graen and Uhi-Bien (1995) explained that LMX theory can be thought of in four stages.

Stage 1 is the discovery of the differentiated dyads. In this stage, managers develop different relationships with their direct reports (Graen & Uhi-Bien, 1995). When asked about their manager's behavior, different professionals offered different answers. Those with high-quality interactions articulated elevated levels of trust, respect, and obligation, and those with low-quality exchanges shared low levels of trust, respect, and obligation (Graen & Uhi-Bien, 1995). Stage 2 is focused on the relationship and its outcomes. In this stage, LMX relationships occur through a role-making process; high-quality LMX relationships have positive results for leaders, followers, work units, and the organization in general (Graen & Uhi-Bien, 1995). Stage 3 focuses on the description of the dyadic partnership building. In this stage, the offer to develop LMX partnerships should be given to all employees. Proving such an opportunity to everyone would suggest a fair process and would create more opportunities to develop high-quality relationships that would directly impact organizational capability (Graen & Uhi-Bien, 1995). Finally, Stage 4 is the expansion of dyadic partnerships to group and network levels. LMX relationships are defined not only by the dyad but also by leadership relationships among peers and teammates across organizational levels and organizations (Graen & Uhi-Bien, 1995).

LMX theory represented a parting from other leadership styles by suggesting that leaders do not treat all followers the same; instead, leaders develop different quality relationships with followers (Boies & Howell, 2006). In high-quality LMX relationships, followers are supported and encouraged, are given more responsibility, and receive more developmental assignments (Boies & Howell, 2006). Also, high-quality LMX is

characterized by leaders and followers who share beneficial and valued goals (Markham et al., 2010). In low LMX relationships, work is completed through rules and governed by contracts. Information gets communicated downward, and relationships are defined by the distance between the leader and follower (Boies & Howell, 2006).

Providing home-based services for children and families comes with unique challenges. Spending significant amounts of time in the field can yield feelings of isolation, incompetence, and burnout. The perception of the follower regarding the quality of the relationship with their leader impacts the follower's behaviors. The follower's viewpoint has been linked to several key outcomes such as higher follower satisfaction, commitment, and decrease in intent to turnover (Markham et al., 2010). Positive perceptions of support on the part of the leader create a response of enhanced performance on the part of the follower. Social workers who develop high-quality LMX relationships are nurtured toward and given the support needed to be successful (Naidoo et al., 2011). Through this leadership approach, supervisors would equip social workers with resources and provide support. The same is reciprocated, and the exchanges helps individuals feel a part of the group, which benefits both the employee and the organization (Northouse, 2016). Gooty and Yammarino (2016) discovered that applying this theory fostered work environments that led to an increase in productivity, personal satisfaction, personal commitment, and openness to the influence of leaders. As I facilitated the focus group in the current study, I applied this theory by engaging social workers in this initial exchange to explore their supervision needs while providing home-based treatment services in the community.

Values and Ethics

There are ethical dilemmas associated with qualitative research due to human participants being involved in the design (Dooly et al., 2017). Ngozwana (2018) noted that ethical issues included withdrawal from the study, anonymity, and confidentiality. The ethical issues experienced by Ngozwana were also issues of concern in the current study. The National Association of Social Workers (2017) requires that social workers engaging in research should obtain voluntary consent from participants and inform them of their right to withdraw from the study at any time without penalty.

Further, researchers should take steps to protect the participants' confidentiality by omitting information that could identify them (National Association of Social Workers, 2017). Due to the nature of focus groups, limits to confidentiality must be communicated to participants. In the current study, confidentiality was encouraged among the participants but could not be guaranteed because I could not ensure that all members of the group would adhere to it (see Sherriff et al., 2014). Participants should understand these limitations fully prior to consenting to participate (Ngozwana, 2018).

Competence is one of the six core values in social work practice (National Association of Social Workers, 2017). This current study was aimed at ensuring that social work supervisors were informed and competent in their role as supervisors for social workers providing home-based services (see National Association of Social Workers, 2017). Rodriguez-Keyes et al. (2012) noted that clinicians who work with families in their homes require supervision from competent, available supervisors. Based on the data collected from the interviews, it is the responsibility of social work

administrators to ensure that resources are available to provide staff with the appropriate level of supervision (National Association of Social Workers, 2017). Finally, should gaps in education be articulated, social work supervisors and administrators must ensure that continuing education and staff development opportunities are made available (National Association of Social Workers, 2017). The next section provides a review of the professional and academic literature regarding the topics of social work supervision and home-based family therapy.

Review of the Professional and Academic Literature

The information gathered and analyzed through the literature review provides a foundation to assist in understanding the research relevant to the supervision needs of social workers providing home-based treatment. The literature review includes the process in which the literature was gathered followed by a discussion of supervision in the social work profession. Next, the literature review focuses on the home-based delivery method and addresses the history of the method, its theoretical underpinnings, and the benefits and challenges of the method. Finally, research relevant to the supervision needs of social workers providing home-based treatment is reviewed.

Literature Review Process

The literature review commenced with the establishment of keywords and concepts relevant to the topic. Walden University's library was the primary source for obtaining literature, with PsychInfo, Sage, SocIndex being accessed most during the search process. These databases contained information about mental health and social work practice and were therefore the best to work from as sources. Keywords researched

included *home-based therapy*, *home-based care*, *home-based family therapy*, *in-home family therapy*, *community mental health*, *social work supervision*, *supervision for home-based therapist*, and *challenges for home-based therapist*.

Peer-reviewed journals from the internet and personal journals obtained via subscription through my membership with the National Association of Social Workers added valuable content. Textbooks along with local, state, and national websites were accessed for relevant data pertaining to the population served by potential research participants. Turner-Daly and Jack (2017) noted that research addressing practitioners' experiences in supervision was limited. Lawson (2005) also indicated that the literature in this area was underrepresented. Due to the limited articles published on the topic, the literature search needed to extend beyond 5 years. As resources emerged, the articles found led to additional articles appropriate for review and inclusion in the literature review. The search for literature was exhausted when the articles began to reference those articles that I had already identified.

Supervision in Social Work Practice

The term *supervision* means surveillance that derives from a realistic view of the world and relies on theories of communication and group functioning (Dan, 2017). During the Charity Movement era when volunteer friendly visitors completed social work tasks, supervision was facilitated by paid consultants who met with the volunteer (Sweifach, 2019). Kadushin and Harkness (2014) identified these consultants as the early predecessors of today's modern supervisor.

At the beginning of the 20th century, the distinction between the supervision of students and direct care professionals was established (Dan, 2017). Supervision continued to evolve with helping professionals realizing that supervision served as personal and professional support that fosters effective, productive communication among individuals working in the same field (Dan, 2017). The Association of Social Work Boards (ASWB) and the National Association of Social Workers (NASW) came together to develop the best-practice standards in social work supervision, which provide a general outline that promotes standardization and serves as a resource for issues related to supervision (NASW & ASWB, 2013). The guidelines explain that the qualifications of supervisors should follow licensing statutes and regulatory standards of each jurisdiction. These may include a current active license, a degree from an accredited school of social work, coursework in supervision, 3 year minimum of postlicensure experience, being free from sanction of the licensing board for violation(s), experience and expertise in the practice arena, and continuing education hours as required for maintenance of supervisory credentials (NASW & ASWB, 2013). Schmidt and Kariuki (2018) expressed that supervisors need training and skills in supervision to support social work supervisees because many who are promoted to leadership roles do not have the necessary knowledge to be effective supervisors.

Organizations tended to have appropriate supervision policies in place, but research findings suggested that the day-to-day practice of the supervision task did not reflect the policies (Turner-Daly & Jack, 2017). Turner-Daly and Jack (2017) also discovered that the day-to-day implementation of supervision fell short of the national

standards. Supervisor sessions focused more on case management with fewer opportunities for social workers to reflect on their practice. Time constraints and other environmental work factors contributed to the gap between organizational policy and the supervision received by social workers. Supervisors must be offered a space to practice in alignment with the national standards.

Supervision contributes to the quality of service provided because of the development and consolidation of professional competence through the supervision process (Calauz, 2017). The deeper the understanding of complex interrelational mechanisms within fields such as social work, the more necessary supervision becomes (Dan, 2017). Supervisors serve as experts in the field and are there to support social workers by providing them an outlet to communicate openly and effectively when they are confronted with challenging cases (Dan, 2017). Dan (2017) defined a *social work supervisor* as a member of the agency administrative staff who has been given the authority to direct, coordinate, enhance, and evaluate the on-the-job performance of assigned supervisees. To execute these duties, the supervisor performs administrative, educational, and supportive functions with the supervisee (Dan, 2017). Administrative duties may include staff recruitment and selection, work planning, initiating and placement, work assignment and delegation, work review, evaluation and monitoring, coordinating work, and acting as a link between parties inside and outside of the organization (Schmidt & Kariuki, 2018).

Runcan and Calauz (2011) defined *supervision* as a link between education and practice and the bridge between classwork and the realities of social work practice. The

supervisor's main objective is to ensure the provision of quality services to service recipients by the organization's policies and procedures (Dan, 2017). Morrison (1993) identified 11 principles that should be adopted to ensure the optimum functioning and training of supervisees to provide high-quality services to consumers. These principles included accepting that supervision is needed by all supervisees; the interest of the clients should come first; supervision is mandated by agency policy; supervision is culturally secured and corresponds to the participants' gender; supervision is a shared responsibility; supervision relies on negotiated agreements and conflict resolution; supervision is regulated and uninterrupted; supervision promotes competent, critical practical and responsible reflection; supervision promotes antidiscriminatory and anti-oppressive practices; supervision depends on the understanding of adult learning; and supervision supplies resources or proper counseling in matters related to culture, gender, identify, disability, religion, and age (Morrison, 1993).

To further ensure the provision of quality services, supervisors are engaged in numerous tasks, and approaches to supervision vary depending on the needs of the supervisee. For example, educational supervision includes learning activities, assisting the supervisee in finding their solutions, development of skills and attitudes, and the sharing of knowledge and experiences (Kadushin & Harkness, 2014). Supportive supervision consists of the supervisor acting as a counselor to help the supervisee face stress, and facilitates the development of coping strategies and attitudes that will foster favorable work outcomes (Kadushin & Harkness, 2014). Rankine (2019) pointed out that supervision is important because it helps to promote learning, reduces stress, and prevents

burnout. Normative supervision requires that the supervisor holds the supervisee accountable to the professional and ethical standards of the profession and work (Kadushin & Harkness, 2014). Formative supervision refers to the supervisor providing the supervisee with feedback and direction to help the supervisee become a more competent professional (Kadushin & Harkness, 2014). Restoring supervision involves the supervisor listening, supporting, and challenging the supervisee to build their toolbox by discovering new methods to help them face problematic situations (Kadushin & Harkness, 2014). These approaches promote professional confidence, maintain core values and ethics, demonstrate the value of space for social workers to reflect on their practice, develop skills, improve processes, and support the social worker in their ability to adapt to change in a variety of contexts (Rankine, 2019).

Supervision can be conducted in an individual or group format; both have their advantages and disadvantages. Individual supervision occurs between the supervisee and supervisor. During this type of supervision, the supervisor can focus on the specific needs of the supervisee using the most appropriate learning style (Kadushin & Harkness, 2014). Other advantages of individual supervision include little to no issues with confidentiality, a closer relationship with the supervisee, and time being used more effectively. Kadushin and Harkness (2014) shared that the disadvantages of individual supervision are the addiction to the relationship, higher costs, and the limitation of resources of the one supervisor. Group supervision is conducted by the supervisor and can include two or more supervisees.

Kadushin and Harkness (2014) explained that some advantages of group supervision include the ability to learn from peers, feedback from peers, and lower costs. The disadvantages are that supervisees share the supervisor, burnout of the supervisor, and lack of time to adequately review situations (Dan, 2017). In addition to individual and group supervision formats, peer supervision and the autonomous model can be used. Sweifach (2019) explained that the peer supervision model is a nonhierarchical structure in which professionals with similar credentials and qualifications supervise each other. The autonomous model is reserved for an experienced practitioner who is self-governing and not bound to the traditional constraints of traditional supervision.

Turner-Daly and Jack (2017) examined supervision of a group of childcare social workers to find out which aspects of supervision worked well and which needed improvement. Respondents reported that the following factors were not helpful: a tick-box case management approach, focusing on processes and time scales, irregular sessions that were unreliable or rushed, lack of opportunity for open discussion and reflection, oppressive leadership, and workers being left feeling down and unvalued. In contrast, helpful aspects of supervision included sessions that felt relaxed and supportive, constructive feedback that helped workers to arrive at their own decisions, opportunities for reflection and analysis, and a demonstration of genuine concern for the social worker and their personal development. Wilkins (2017) analyzed over 200 written records of supervision and concluded that records were designed more to provide management oversight of practice and accountability of the practitioner than to determine and inform the social work decision-making process.

Clinical supervision is an integral part of professionals' continued growth and development (Culbreth et al., 2004). Dan (2017) explained that supervision is a process of bilateral communication involving words, emotions, analysis, reflection, and attitude between the supervisor and supervisee. From the service recipient perspective, supervision promotes and maintains ethics in social work practice (Rodriguez-Keyes et al., 2012). Supervision is essential to the balancing of the professional's autonomy and responsibility toward the client, professional ethics, and organizational responsibility standards (Rodriguez-Keyes et al., 2012).

Working with at-risk families providing home-based care can be rewarding and challenging for the professional, and supervision is a practical method of ensuring quality services. Lack of supervision can facilitate improper practices (Rodriguez-Keyes et al., 2012). Regarding the supervision of practicum social work students, the research is abundant but pertains to practicing social workers such as those providing home-based therapy (Schmidt & Kariuki, 2018). In the next section, the history of the home-based treatment delivery model is explored.

Brief History of the Home-Based Treatment Delivery Method

Treating families in the home setting is a social work practice that dates back to the early 20th century (Woods, 1988). These friendly visitors recognized that providing concrete services in the home was beneficial to the family because it allowed families to be comfortable in their homes and made it possible for accurate observations of the family in their natural environment (Woodford, 1999). The practice of conducting home visits in the client's social environment as a way of providing services began to decline

with the influence of psychoanalysis and individual pathology theory (Woods, 1988). According to Woods (1988), social workers turned away from their roots of being friendly visitors as they joined the world of psychiatry, which viewed home visits as a diagnostic tool rather than a primary method of treatment.

Treatment eventually found its home in the office setting. Clinicians serving these families made some accommodations for families, such as adjusting office hours to evening and weekends; however, for many families, these changes were not adequate (Woods, 1988). Families who were low income and multiproblematic likely went underserved due to their inability to access treatment or remain compliant with services. Through the family preservation movement of the 1970s, critical values became significant to the child and family welfare community (Woodford, et al., 2006). These values included having children grow up with their parents, assisting families in developing self-sufficiency, using the least restrictive setting to provide services, and engaging in permanency planning for children and their families (Woodford, et al., 2006). Values such as these led to the passing of federal legislation requiring states to approach child and family services from a family preservation perspective.

In 1980, the Federal Adoption Assistance and Child Welfare Act (FAACWA) mandated that states make reasonable efforts to keep children placed in homes as an alternative to out-of-home placement (Adams & Maynard, 2000). Under the FAACWA, emphasis was placed on empowering families to be active participants in the therapeutic process while leaving the child in the home (Macchi & O'Conner, 2010). This approach allowed service providers to care for children and their families in the least restrictive

environment while providing the opportunity to address issues that were distressing to the entire family (Macchi & O'Conner, 2010). Home-based services intended to bridge the gap in traditional clinic-based services, which lacked the capacity to meet the needs of families who were at risk of children being placed outside the home, or families that already had a child placed outside of the home (Lawson & Foster, 2005).

The passing of the FAACWA escalated the need for providing home-based services as a necessary method to deliver effective treatment for serious and chronic issues facing the family (Foster et al., 2012). Families who received home-based services presented with greater needs and multiple problems that included drugs/alcohol, domestic violence, truancy, financial difficulties, assault/battery, depression, and other mental illnesses (Lawson & Foster, 2005). Clinicians working with multiproblem families approached treatment from an ecological context that considered the concrete needs of the family and the clinical needs (Lawson & Foster, 2005).

Families who receive home-based services are at higher risk than families who obtain services in a more traditional setting (Hammond & Czyszczon, 2014). Social services, juvenile justice, and other mental health providers are also likely to be involved with these families (Hammond & Czyszczon, 2014). More often, at-home interventions are implemented as a last resort and focus on addressing the immediate crisis, child abuse, neglect, reducing family violence, and preserving families to avoid out-of-home placements (Hammond & Czyszczon, 2014). Family therapy training programs have been slow to accept the trend of home-based services and continue to emphasize clinic-based approaches (Adams & Maynard, 2000). Families needing such services have much at

stake, and treatment for these families requires careful attention and supervision from competent professionals (Hammond & Czyszczon, 2014).

Theoretical Underpinnings of Home-Based Family Therapy

Social learning theory, family systems theory, crisis intervention theory, and ecological perspectives on child developmental are key theories underpinning family preservation services (Woodford, 1999). Social learning theory treats behavior as developing from an exchange between individuals and environmental factors (Bandura, 1977). Family systems theory involves structural family therapy which concentrates on ways to change the interactions of the family members by shifting their positions in the family system (Minuchin, 1974). Crisis intervention theory was developed through the work of Erikson, Lindemann, and Caplan (Pasewarl & Albers, 1972). Erickson identified eight developmental crises or turning points in one's development. Lindemann focused on transient personality disorders influenced by unusual environmental stressors and assumed that the removal of the stressor will eliminate the behavioral symptoms (Pasewarl & Albers, 1972). Additionally, Pasewarl & Albers (1972) shared that Caplan's work focused on applying public health ideas to community mental health challenges. Finally, ecological theory involves the examination of various systems, interacting reciprocally, that may impact families or individuals (Brofenbrenner, 1979). Farineau (2016) highlighted that not only does the system impact the family or individual, but they could also influence those same systems.

Home-Based Family Therapy is the delivery method for family preservation services with a theoretical perspective based upon three main characteristics. First, the

child or adolescent referred for services is the focus of treatment. Second, services occur in the home, and third, the clinician providing services is a master's level practitioner with basic training in systems theory and structural family therapy (Woodford, 1999).

Macchi & O'Connor (2010) explained that the theoretical framework that supports home-based family therapy addresses five components. The first is the family role and expectations. Providing services in the home setting allows a sense of familiarity that can enhance the participants' perception of their active and empowered role in treatment. Second, the therapeutic relationship is led by the therapist who is responsible for guiding the treatment process while empowering the family's participation and remaining responsive. Third, a focus on clinical work is mentioned through the development of meta goals. Meta goals focus on empowering families with access to resources, the generalizability of skills, and greater awareness and use of family strengths. Fourth, the environment and context of the home are used to assess and treat families. Finally, the therapists' role and expectations can be the most challenging for new practitioners. In this area, therapists are expected to have an awareness and skills to transform the home into a therapeutic space. Macchi & O'Connor (2010) concluded that training, particularly in these five components, is a key factor in the effectiveness of work with families.

The literature makes it clear that families who access home-based therapies are often in crisis. Woodford et al. (2006) explained that this state of crisis presents a unique opportunity for positive change based on the ability to reflect strength-based perspectives and solution-focused therapy.

Benefits of the Home-Based Treatment Delivery Method

Participating in treatment can prove to be a challenge for children and families at risk. Home-based counseling is an effective strategy to make treatment accessible for both voluntary and involuntary clients (Cortes, 2004). When a counselor makes an effort to reach out to families and provide care in the home, attrition is minimized (Cortes, 2004). The opportunity for developing a strong rapport with families is present (Woods, 1988). Clients who obtain services in their homes, exhibit characteristics that do not exist for clients who receive clinic-based services. For example, participants may be less defensive and feel more in control in their environment (Cortes, 2004). The motivation for treatment increases because the counselor's act of going to the client's home is regarded as a respect and appreciation of their needs (Cortes, 2004). A therapist working in the home setting communicates with the family that they are willing to immerse themselves in the family situation (Woods, 1988). Providing services in the home allows the clinician to see the reality of the home situation and observe the participants functioning in their everyday roles (Woods, 1988). Lichtenstein (2012) mentioned that providing home-based services is more ecological in that the delivery method is better for addressing clients' situations in the real-world context. Home-based services also work to eliminate barriers to service delivery.

Home-based treatment brings services to the client instead of expecting the client to go to the service. Although this expectation may be regarded as a way of determining motivation, families may have issues beyond motivation preventing them from accessing treatment. Lichtenstein (2012) notes that families may have transportation or other

logistical difficulties preventing them from accessing treatment. Caregiver mental or physical health problems, keeping regular appointments, employment or school commitments, and obtaining affordable childcare could also be barriers to accessing treatment which are eliminated by using a home-based delivery method. According to Lichtenstein (2012), factors such as poverty, neighborhood, and community influences are better addressed by providers servicing clients in the home. Home-based care also decreases non-compliance for clients who are labeled as difficult, resistant, or personality disordered (Fuller, 2004). Delivery of services in the home has been found to increase attendance and participation of adolescents and their families in sessions (Thompson et al., 2009). Fuller (2004) explained that non-compliance is typically due to poor relationships, poor rapport building, and lack of engagement. These factors are minimized with the home-based treatment delivery method.

Cortes (2004) noted a heightened possibility of change because home-based therapy makes it possible to include all members of the family. Home-based services aid in developing a more accurate diagnosis, is complementary, if not preferred, to clinic-based work and serves to increase the effectiveness of treatment and maintaining change (Fuller, 2004). In addition to having been found of value in treating emotionally disturbed children, home-based services have also been found to decrease the need for out-of-home placement for children and holds promise in the prevention of child abuse and neglect (Fuller, 2004). Home-based therapy makes it possible for families to immediately implement strategies taught in treatment in the home and allow for the monitoring and coaching of skills at the same time (Woods, 1988). The home-based service delivery

method not only benefits the service recipient but has also been found to prevent future problems for other members of the family (Lichtenstein, 2012).

Hammond and Csyszczon (2014) noted that black children were more likely to be placed in the foster care system where they are least likely to be reunited with their families or become adopted. For this reason, one could argue that black children would highly benefit from at-home services to prevent the need for out-of-home placement (Hammond & Csyszczon, 2014). Home-based services have been found to be more effective than peer groups, parent education, multi-family interventions, and individual counseling (Thompson et al., 2009). Overall, home-based treatment has been shown to improve engagement, compliance, and the therapeutic alliance (Thompson et al., 2009). The literature is clear about the benefits of home-based treatment; however, as a service delivery method it is not without its challenges for the social worker.

Current Challenges of the Home-Based Treatment Delivery Method

It has been established that there are several benefits to the home-based treatment delivery model. Social workers, however, are challenged with the delivery method in several ways. Among these challenges are the barriers to providing service to families in urban, low-income settings (Tate et al., 2014). These families are likely to present as multi-stressed families and tend to have fewer resources, language barriers, social stressors in the environment, debts, illnesses, education and employment problems as well as housing instability (Vanlawick & Bon, 2008). Those factors create an unstable living situation for clients which causes a perceived lack of control over the environment for the social worker and contributes to concerns regarding their safety (Vanlawick &

Bon, 2008). The concern for safety can also include details such as one's positioning in the home so that exits are not blocked and remain accessible to the social worker (Fuller, 2004). Feeling safe is not only a necessary factor for clients to engage successfully in treatment, but it is also critical in the social workers' ability to build the therapeutic alliance which is essential in the treatment process (Cortes, 2004).

Delivering treatment in the home can also come with managing unanticipated distractions. Distractions may include pets, pests, unfamiliar people, smoking, and unclean homes (Rodriguez-Keyes et al., 2012). Social workers are expected to provide quality treatment and manage the time and pace of the sessions, regardless of the distractions (Tate et al., 2014). Further, the travel requirements for social workers can also be a factor in delivering services effectively (Macchi et al., 2016). Social workers providing these services are likely traveling to several homes a day to provide care to service recipients. Vanlawick & Bom (2008) explains that the travel involved with the home-based treatment model of delivery can create anxiety, stress, and burnout. Another challenge faced by a home-based social worker is the lack of support.

Feeling isolated in the field is a challenge expressed by social workers. Macchi et al. (2016) explained that home-based social workers are at risk of burnout because of their lack of contact with other professionals in their agencies. Lack of contact with other professionals limits the opportunities to debrief, exchange information, consult with peers, and obtain supervision (Cortes, 2004). Rodriguez-Keyes et al. (2012) explained that even though supervisors are often on-call, social workers in the field make tough decisions while in the field and call later. The risk of burnout is also increased due to

providers being overworked and underpaid (Culbreth et al., 2004). The negative perception of the quality of life, higher rates of compassion fatigue and burnout are attributed to increased workloads (Macchi et al., 2016). Finally, social workers providing home-based treatment who are underprepared to treat children and families who present with multiple problems and mental pathology, like that found in a mental hospital setting, are also at risk of burnout (Culberth et a., 2004).

Vanlawick & Bom (2008) found that professionals working with families in the home setting are inadequately trained, with more qualified social workers working with less problematic cases. Programs preparing social workers to provide treatment are geared toward the traditional method of service delivery which is the clinic setting (Hammond & Czyszczon, 2014). Snyder & McCollum (1999) conducted a study that examined the experience of three students who were being trained to do in-home therapy after being trained in the clinic setting. All three clinicians changed their views on therapy because the home-based delivery model challenged their idealistic beliefs about therapy and professional relationships.

Home-based treatment requires the social worker to provide a variety of interventions due to the intensive needs presented by families. Social workers who lack experience or who are not adequately trained risk burnout due to the task being overwhelming and stressful (Cortes, 2004). Rodriguez-Keyes et al. (2012) noted that home-based work is high pressured, involves multiple crises daily with children at risk of out-of-home placement. Counselors have expressed concerns about professional and ethical boundaries, maintaining confidentiality, and being emotionally able to handle high

levels of crisis (Tate et al., 2014). Social workers are providing several hours of home-based services while seeing little to no change with the family situation (Macchi et al., 2016). Feelings of demoralization and ineffectiveness begin to develop for the social worker, which results in them taking a condescending educational stance toward the family and ultimately blaming the family for lack of cooperation or progress (Vanlawick & Bom, 2008).

Related Research, Methods, and Outcomes

Research highlights that among the various needs faced by social workers providing home-based care, quality supervision seems to be the most essential. That is not to say that the literature has not made suggestions as to other factors, such as, which individuals might be the most effective at this type of work. Lawson & Foster (2005) noted that therapists with higher levels of development perform better than their peers because cognitive development is linked to critical thinking, openness to conflicting ideas, and perspective taking. In any event, without quality supervision, they would lack the ability to gain the practical skills necessary to be effective. Rodriguez-Keyes et al. (2012) stressed that if home-based services are to succeed, quality clinical supervision is non-negotiable. The supervisor and supervisee relationship are parallel to that of the clinician and the client because they depend on each other to be successful. Rodriguez-Keyes et al. (2012) further explained that supervision should be specific to the situation they face and the services they provide. The goals of supervision should include improving the quality of services by maintaining high professional standards, enhancing

motivation for work, preventing burnout, promoting professional and personal development and increasing awareness of roles and responsibilities (Dan, 2017).

Rodriguez-Keyes et al. (2012) shared in their research that social workers who obtained good supervision were more likely to see strengths in their families and had the ability to facilitate collaboration and compliance with services. Although there is no current standard for home-based counselor supervision, agencies should look to adopt its guidelines governed by state regulations (Hammond & Czyszczon, 2014). Adopting and adhering to practices that support quality supervision would be in the organization's, service recipient's, as well as the therapist's best interest.

Quality supervision allows for the social worker to work to develop a professional's quality of life, reduce isolation, improve clinical effectiveness and can contribute to the improvement of staff retention (Macchi et al., 2016). Maintaining quality of life while providing home-based treatment is essential for longevity. Macchi et al. (2016) argued that regular self-care may improve a therapist's awareness of their personal needs concerning the effects their work has on their professional well-being. Self-care activities could include taking up a hobby, reading for pleasure or traveling. Spending time with family, maintaining a sense of humor, maintaining professional identity and a balance between professional and personal lives have been positively associated with counselor compassion satisfaction and a reduction in compassion fatigue and burnout (Macchi et al., 2016). Quality supervision is essential in promoting self-care activities among professionals. Supervisors of home-based therapists have a 24/7 responsibility, often dealing with critical incidents after working hours. For this reason,

Lawson & Foster (2005) recommended that supervisors should have a limited number of supervisees and a limited number of families on their supervisory caseload. As previously noted, there is no current standard for supervision with a home-based therapist, but the literature does offer suggestions.

Lawson & Foster (2005) offered guidelines pertaining to professionals required to provide supervision to home-based social workers. First, supervision must be highly valued as organizational resources will need to be dedicated to the practice. Second, supervisors should have maintainable workloads that allow them the flexibility to meet supervisee needs. Third, supervision should be developmental, considering the experience and expertise of the supervisee. Fourth, supervisors must be available to families on the caseloads when needed. Fifth, supervision should be provided by licensed providers only. Sixth, videotaping should be used as a supervision tool. Seventh, supervisors should meet with clients at the commencement of services. Finally, supervisors themselves should have the experience of providing home-based therapy. Supervision is a central element in positive outcomes all around. However, the literature also pointed to the competency and training needs of home-based therapists.

Competencies in home-based care have been called for in training programs for counselors (Hammond & Czyszczon, 2014). Lawson (2005) shared the results of a training needs assessment conducted by the Rutgers Counseling Program where counselors rated their knowledge, skills, and attitudes toward home-based counseling. The results of this study concluded that 67% had no coursework in crisis intervention, 57% had no coursework in home-based counseling, and only 36% reported that they felt

somewhat or minimally comfortable working with families. The study concluded that home-based counselors felt underprepared to provide home-based services, thus yielding uncertainty in their ability to help their clients. Crisis intervention, cultural competency, ability to assess and use family strengths, and knowledge of the person-in-environment are areas of theoretical knowledge that would need reinforcing in such a training program (Woodford & Bordeau, 2006). Lawson (2005) added that training in the family as a system, structural family therapy, family crisis intervention, family assessment, and family simulation should be provided before any commencing any home-based work with the families.

Tate et al. (2014) noted five categories of in-home counseling competence which if practiced fully, can lead to effectiveness. First, is having the necessary knowledge sets. For example, having knowledge of early childhood development and knowing which behaviors are developmentally appropriate is key to on-going assessment and treatment. Second, is conceptualizing cases to articulate an understanding of the client's experiences, recognizing behavior patterns, and how poverty may be affecting the entire family system. Third is counselor's behaviors. These behaviors include but are not limited to case management, self-care, cultural competence, and work-life balance. Fourth, is the flexibility maintained in session, which is the clinician's ability to manage multiple relationships in session and adjust to the various settings with little or no furniture and space for therapeutic activities. Finally, is the professional disposition and behaviors which, is the tendency of the clinician to be strengths-focused, comfortable in

the inner city and urban areas, and comfort receiving critical feedback. The literature provides guidance on how clinical supervision can be structured.

Group training within agencies would be beneficial. Hammond & Czyszczon (2014) explained that this format would allow clinicians to share information among themselves and learn from each other. Also, Christensen (1995) indicated that specialized training for supervisors and clinicians should be provided for support in addressing unique issues that occur in the home. Further, process evaluations should be conducted to gauge the experience of the clients and clinicians experiencing home-based therapy. Lawson (2005) mentioned that managing sessions, safety issues, utilizing the home environment, and systemic thinking should be areas of focus for supervisors.

Skill development is a vital component in learning how to serve families in the home setting. One way to accomplish this is by paring the clinician with a peer rotating as the lead therapist when appropriate. Live supervision provides a unique opportunity for supervisors to have a first-hand observation of the clinician's work and gives the ability to intervene as needed (Lawson, 2005). Culberth et al. (2004) surveyed a sample of home-based service providers to determine their current and preferred supervision practices. Respondents indicated that a combination of individual and group supervision was preferred with the frequency of the supervision taking place on a bi-weekly basis. However, Lawson & Foster (2005) cautioned that supervision should be weekly because of the intensity of the work. Further, participants indicated that receiving concrete information and homework reduced their anxiety, as well as a desire to have more discussions around legal, ethical, and boundary issues in counseling. The outcomes of

this research suggested that supervisors should have more structure in supervision and use audiotape, video recording, or live supervision in their supervisory process.

Summary

In summary, the literature is clear about the perils faced by social workers charged with providing home-based treatment. There are limited articles published on the topic and thus the literature found needed to extend beyond five years. The need for this research project is apparent as the literature reviewed does not provide adequate information on how to best support social workers with the challenges they face.

This action research project will investigate this need by seeking to understand the specific needs for supervision of the clinicians. Engaging the social workers directly in a conversation about their needs will provide insight into their experiences and offer ideas that could be used to improve the supervision of those providing home-based treatment in Miami-Dade County.

Section 2: Research Design and Data Collection

The difficulties faced in service delivery for social workers providing home-based care were presented in section 1. I explored the supervision needs of these social workers using qualitative methodology. Details of the research design, methodology, data analysis, and ethical procedures are provided in Section 2.

Research Design

A participant action research (PAR) methodology was used to collect qualitative data, and a focus group was employed to gain understanding of the supervision needs of social workers providing home-based treatment in their community. Ostaszewska (2018) described key components of PAR, which include a focus on change and addressing the needs of a group, an emphasis on collaboration, a cyclical nature, viewing participants as reflexive and competent, gathering knowledge through combined actions and efforts, encouraging a greater awareness of the situation to act, and the use of qualitative or quantitative methods. PAR creates a peer-to-peer conversation by seeking the voices of the individuals who are the focus of the investigation (Katwyk & Ashcroft, 2016). The central concept in PAR is that it is carried out with a group of people, not on behalf of that group of people (Ostaszewska, 2018). The PAR methodology inserts itself into the process of change by including action as part of the exploratory process (Katwyk & Ashcroft, 2016).

Ostaszewska (2018) identified six underlying principles of PAR, which include being grounded in lived experience, leaving infrastructure in its wake, working with people rather than just studying them, developing alternative ways of seeing the world,

addressing significant problems, and being developed in partnership. Findings from the action research are then shared with stakeholders to bring about positive change for service recipients affected most by the research issues (Fern, 2010). In following the PAR method, I took the focus group approach to answer the following research question: What are the supervision needs of social workers providing home-based treatment?

Methodology

A focus group was the primary source of data collection to assess the attitudes, opinions, and experiences of social workers who had or were providing home-based therapy services at the time of the study (see Pearson & Vossler, 2016). Focus groups are a qualitative research method that allows researchers to obtain large amounts of information from a large group of participants in a short time (Wilson, 2012). Onwuegbuzie et al. (2009) described a well-designed focus group as having six to 12 participants and lasting between 1 and 2 hours. The intention of the focus group design is to have enough participants to leverage diversity in information, but not so many that participants do not feel comfortable sharing their thoughts, opinions, beliefs, experiences (Onwuegbuzie et al., 2009).

The focus group consisted of 10 master's-level social workers in Miami-Dade County who had provided or were providing home-based treatment in the community. I moderated and facilitated the discussion and took notes (see Wilson, 2012). At the same time, the conversation was recorded for later transcription using the Zoom virtual meeting platform as a safety precaution to prevent the spread of COVID-19. The virtual platform made it possible to host all 10 participants off camera to protect their privacy.

Participants were also asked to change their screen names to assigned initials for confidentiality. I used these initials to refer to the participants during the focus group. This approach was necessary to maintain fidelity with the action research principles, which indicated that the individuals most impacted with the effort to achieve social change should be invited to participate in the study (see Fern, 2010).

Purposeful sampling was used to identify the participants who had provided home-based therapy (see Stringer & Aragon, 2020). The sample size was determined by reviewing the literature to identify a sample size used in similar research. Christensen (1995) conducted a qualitative study to explore therapists' perspectives on the provision of home-based services, and used a sample of 10 therapists to evaluate the experiences of both home-based and clinic-based family therapy. Adams and Maynard (2000) evaluated the training needs for home-based family therapy using two focus groups with sizes of 12 and 11. Both sets of researchers obtained the necessary data to answer their research questions. Based on this information, I used 10 participants in my focus group, and the duration of the focus group was 90 minutes.

As part of this action research project, I recruited social work professionals with experience providing home-based services. I used phone numbers and email addresses obtained from known colleagues and supervisors to communicate with the potential participants. All candidates received emails explaining the project. Those who agreed to participate received communication regarding the next steps via email. After finalizing the participant list, I followed the protocol introduced by Bradburn et al. (2004) to obtain informed consent and ensure all participants understood the scope of the project. I also

looked to Bradburn et al. for guidance in creating the focus group questions used to collect the necessary data to answer the research question. My research committee reviewed and approved the final focus group questions.

Prior to the focus group, I prepared ground rules to ensure that participant confidentiality would be maintained. I began the focus group by reviewing the ground rules with the participants. These ground rules included asking participants to refrain from using their full names and only using their assigned initials. Participants were also asked to avoid using any identifying information about the agencies where they previously provided or were currently providing home-based services. Additionally, participants were asked to maintain client confidentiality by not to disclosing any identifying information about the clients they served. Finally, participants were asked to mute their microphones unless they wanted to add a comment. Self-muting eliminated any background noise and further protected participant confidentiality.

After establishing ground rules, I facilitated introductions. The introductions included sharing their names using the assigned initials and confirming that they met the study criteria. Each participant was then asked to disclose whether they were currently providing home-based therapy or had previous experience providing the service. Participants were also asked to share their length of time delivering the service, population served, degree or licensed held when providing the service, and their current degree and license held. Once the participants completed their introductions, I proceeded to ask the focus group the approved questions (see Appendix).

Data Analysis

Data were collected using an audio recording via the Zoom virtual meeting platform and were later transcribed. According to Onwuegbuzie et al. (2009), this data analysis method takes the most time and is rigorous. The data analysis began with categorizing and coding (see Stringer & Aragon, 2020). I used the constructionist grounded theory approach, which is based on the premise that individuals have different perspectives of reality and the investigator's aim is to become part of the participant's world (Fern, 2010). The resulting data analysis included reviewing the collected data, unitizing the data, categorizing and coding, identifying themes, organizing a category system, and developing a reporting framework. Through this approach to data analysis, I identified the elements that composed the experiences and perceptions of the research participants. The analysis of key experiences followed (see Stringer & Aragon, 2020). This approach was used to focus on events that had a distinct impact on the participants' experience. Analyzing the key experiences included reviewing the data, identifying key experiences, identifying main features of each experience, identifying elements that composed the experience, and identifying themes (see Stringer & Aragon, 2020).

This research was qualitative, and therefore the main concern for rigor rested in whether the research was trustworthy. Trustworthiness was assessed through credibility, transferability, dependability, and confirmability (see Stringer & Aragon, 2020).

Credibility

Credibility is described as how believable the research is (Ellis, 2018). Credibility was established through prolonged engagement and offering participants extended

chances to share and explore the experiences related to their needs for supervision while providing home-based therapy. Data were collected through note-taking and audio recording, which were later transcribed. Collecting data using more than one method increases credibility because it allows the investigator to determine whether different approaches led to the same outcome (Ellis, 2018).

Transferability

Transferability was established by providing a detailed description of the circumstances, activities, and events reported as part of the study's outcome. Transferability is supported by providing a rich, detailed description of the research participants, location, context, analysis, and trustworthiness, which informs and resonates with readers (Connelly, 2016).

Dependability

Dependability, recognized as the context in which people operate, changes frequently (Ellis, 2018). In addition, dependability is recognized by focusing on the extent to which individuals can have confidence that all procedures of a systematic research process have been followed (Stringer & Aragon, 2020). Dependability in the current study was established by providing a full description of the research design and its implementation. I also provided full details of how the data were collected.

Confirmability

Confirmability, the degree to which research findings can be corroborated or confirmed (Ellis, 2018), was established by maintaining an audit trail via recording tools

and transcripts. Data collected, instruments used, and notes made available for review also confirmed the veracity of the study (see Stringer & Aragon, 2020).

Ethical Procedures

Participants received the opportunity to provide informed consent regarding the research project, which included its purpose, aims, how the results were to be used, and possible consequences of the study (see Stringer & Aragon, 2020). The Walden University Institutional Review Board (IRB) reviewed and approved the consent form and assigned the form approval number 02-28-20-0620520. The consent forms were sent via email to the participants using DocuSign, an electronic signature platform used to send documents that require review and signing. Each participant reviewed, signed, and returned the consent form before the start of the focus group. The consent forms were then saved to an encrypted flash drive device and deleted from DocuSign. These consents, and all other research documents, will be deleted from the encrypted device after 5 years. None of the participants had follow-up questions or concerns regarding privacy.

All participants received a $20 gift card to cover the cost of lunch. I could not provide lunch as previously planned due to COVID-19 limitations. The participants were also informed that they had the right to withdraw from the study at any time. None chose to withdraw. On December 24, 2019, I completed the CITI program course on ethics. This course is a requirement for Walden University student researchers.

During the approval process, the IRB raised concerns about using a focus group format instead of individual interviews. The IRB expressed concerns regarding asking

about the participants' experiences, relationships, and opinions of their supervisors. Honest negative answers would be sensitive, and this could impact the validity of the study. Participants recruited for this study were required to have experience providing home-based treatment. This could have been recent experience or previous experience. The group format allowed those who might have been removed from the role for an extended period an opportunity to recall information that they might not have been able to recall in an individual interview format. Krueger and Casey (2000) mentioned that focus groups are less threatening to many research participants, and this environment is more helpful for participants to discuss perceptions, ideas, opinions, and thoughts. Further, the choice to use a focus group was made based on prior researchers using the same methodology in collecting similar data. Christensen (1995) looked at therapists' perspectives on home-based family therapy, and Adams and Maynard (2000) evaluated the training needs of a home-based family therapist. Based on this IRB feedback, I removed the question, "Share your thoughts regarding whether your supervisor was knowledgeable enough to support you." This question was likely to elicit negative and problematic opinions. The remaining questions were more specific to the supervision process and supervision access, and would be less likely conjure negative opinions about the individual charged with providing the supervision.

Summary

Data were collected using a focus group. The interviews involved social workers who had previously or were currently providing services in the service recipients' homes. The data were collected and analyzed to identify themes from the participants' responses.

Conclusions were drawn from the collected information, and findings were established. These findings may be used to provide stakeholders with a better understanding of the social workers' experiences and may provide organizational leaders with a better understanding of how current supervision practices may or may not be helpful to social workers. The next section outlines the research findings and data analysis techniques used.

Section 3: Presentation of the Findings

The purpose of this research project was to provide understanding of the supervision needs of social workers providing home-based treatment. The information yielded from this research might improve social workers' working conditions and improve client treatment experiences and outcomes. These findings may be used to provide stakeholders with a better understanding of the social workers' experiences and provide organizational leaders with a better understanding of how current supervision practices may or may not be helpful to social workers. This project's research question was the following: What are the supervision needs of social work practitioners providing home-based treatment?

I used a PAR methodology to collect qualitative data from focus group participants and offered understanding of the supervision needs of social workers providing home-based treatment in their community. Participants were recruited using an announcement sent out via email across social media platforms in which social workers form supportive communities. The 10 participants selected provided consent to participate in the focus group, which due to COVID-19 limitations was conducted using the Zoom virtual meeting platform. The focus group was audio-recorded and later transcribed for analysis. The analysis process identified common themes. The following sections include the data analysis techniques used, the process used to validate the findings, and the themes that emerged relative to the research question.

Data Analysis Techniques

Ten social workers who had or were currently providing home-based treatment participated in this study. This group of social workers participated in a 90-minute focus group using the Zoom virtual meeting platform. The 10 focus group members shared their experiences as qualitative data regarding the supervision needs of social workers providing home-based treatment. The data were audio-recorded and later transcribed. Using a chart created in a Word document, I unitized the data to identify the discrete experiences incorporated in their descriptions to categorize the details that composed their experiences (see Stringer & Aragon, 2020). Following the unitization process, I categorized and coded the data by breaking down each question into a category and recording each answer given during the focus group. The categorizing and coding process allowed me to identify common themes related to each question posed to participants.

Providing the participants with prolonged engagement also contributed to the credibility of the data analysis. Although the participants did not need more than the allotted 90 minutes to respond to the focus group questions, they were informed that they would have ample opportunity to share their experiences. I used note-taking and an audio recording to collect data. Participants shared their experiences providing home-based treatment in detail. Transferability was accomplished by quoting the participants. Through the detailed descriptions of the participants' circumstances, activities, and services, readers of this research may be able to apply the findings in their service settings. Fully describing the design, implementation, and data gathering used in this study established dependability. The method used for data gathering was supported by

similar research (see Adams & Maynard, 2000; Christensen, 1995). Finally, an audit trail established confirmability through the recording tool used and transcripts stored for later review.

Findings

The research question addressed the supervision needs of social workers providing home-based treatment. Focus group participants responded to five questions (see Appendix). Their responses provided data that enabled me to answer the research question. The following sections include the demographic background of the participants and address their responses, which focused on their positive experiences providing home-based treatment, barriers to providing home-based treatment, professional skills needed when providing home-based treatment, communication needs with leadership when providing home-based treatment, and the supervision they experienced when providing home-based treatment.

Focus Group Demographics

The focus group comprised 10 master's-level social workers. The participants represented two major racial groups, Black and Hispanic, and their ages ranged from early 20s to late 40s. The following initials were assigned randomly to the focus group participants to maintain confidentiality: GU, CL, MC, ME, JE, HE, SIM, SH, CH, and SIC. In this paper, I replaced the initials with names. GU was replaced with Guerda, CL with Clara, MC with Michelle, ME with Melly, JE with Jerry, HE with Helen, SIM with Simon, SH with Shary, CH with Chare, and SIC with Sinclaire. The participants were asked to share whether they were currently providing or had previously provided home-

based treatment, their length of time delivering the service, their population served, their degree and license held when they provided the service, and their current degree and license information.

Guerda was a licensed clinical social worker, had previously provided home-based treatment, and was a registered clinical social work intern at the time of the study. Guerda worked with children and their families off and on for 4 years.

Clara was a licensed clinical social worker, had previously provided home-based treatment, and was a registered clinical social work intern at the time of the study. Clara worked with children and their families for 1 year on a part-time basis.

Michelle was a licensed clinical social worker providing home-based treatment with the LGBTQ population. Michelle had been working with children and their families off and on for 5 years.

Chare was a registered clinical social work intern providing home-based treatment with children and their families for 4 years.

Melly was a licensed clinical social worker providing home-based treatment with the elderly, LGBTQ, youth offender populations, and children and their families for 5 years.

Jerry was a licensed clinical social worker, had previously provided home-based treatment, and was a master's-level social worker at the time of the study. Jerry previously worked with youth offenders, juvenile sex offenders, substance use disordered populations, and children and their families off and on for 9 years.

Helen was a registered clinical social work intern who had previously provided home-based treatment with children and their families for three and a half years on a part-time basis.

Simon was a registered clinical social work intern providing home-based treatment with children and their families for 3 years.

Shary was a registered clinical social work intern providing home-based treatment with children and their families and had been doing this work for 3 years part-time.

Sinclaire was a registered clinical social work intern, had previously provided home-based treatment, and was a master's-level social worker at the time of the study. Sinclaire worked with children and their families for one and a half years.

Positive Experiences Providing Home-Based Treatment

The participant responses centered on two major themes: (a) working in the client's home environment provided better opportunities for assessment, intervention, and real-time coaching support and (b) working with clients in their homes allowed opportunities to work with multiple stakeholders.

Opportunities for Assessment, Intervention, and Real-Time Coaching Support

The participants shared that home-based treatment offered vital benefits. The social worker has the chance to effectively assess, intervene and coach in real time. Sinclaire shared "working in the home allows you to see the family dynamics more, how they respond to interventions." Clara offered "my positive experience is actually seeing the client's growth, especially in their environment…to actually get a hands-on view of

the growth." The ability to provide treatment in the home offers extraordinary opportunities to see the client's family dynamics in a way that would not be seen in the office setting.

Opportunities to Work With Multiple Stakeholders

The participants agreed that working with clients in their homes allowed opportunities to expose other family members to the benefits of treatment. Michelle shared "being able to see like, oh, therapist is not so scary, they can see what it looks like, what it actually is instead of what they perceive it to be." Family members were able to see firsthand how therapy worked, which dispelled myths about the therapeutic process. Home-based treatment also helped to reduce stigma to see their family members engaged in the therapeutic process.

According to the focus group participants, using home-based treatment provides opportunities for assessment, intervention, and live coaching of clients to use interventions as they are learned. Participants also highlighted the benefit of bringing the service to the client, particularly if there was hesitation to come into an office setting. Social workers can also include other stakeholders in the treatment process when services are provided in the home. However, the participants expressed the need for ongoing training and education on the benefits of using the home-based treatment modality and how to maximize its effectiveness. In addition to the need for more training and education, the focus group participants expressed facing specific barriers to providing home-based treatment.

Barriers to Providing Home-Based Treatment

Participants described the barriers they faced in their attempts at providing home-based treatment. Four significant themes emerged: health and safety concerns, scheduling conflicts and meeting productivity requirements, feeling disconnected from their administrators, and challenges in responding to crises.

Health and Safety Concerns

The focus group members expressed concerns about health and safety. These concerns included issues related to insect infestation in the homes, how to conduct themselves in client homes, and finding themselves in unsafe neighborhoods due to having to work late into the evening. Guerda explained

> I did not feel the agency cared for my safety. By my fourth and fifth year, I mastered how to maneuver, but I would have appreciated someone to shadow. I never did this work before; I was given a caseload and addresses and thrown out into the field. This bothered me ethically because I don't think my clients received quality therapy. I was busy worrying about my safety.

Jerry expressed

> I was working with a homicidal client who had delusions of his paramour and roommate having an affair. My supervisor told me to stay in the home and wait for a response team and to text my supervisor if I needed them.

Guerda further shared

> We needed more training, we learned some protective measures in grad school, but it does not translate the same in the field. We should have learned tips from

> the veterans like to keep your purse on you or don't bring it at all, observing the furniture set up and how it may or may not obstruct your ability to exit, or how to communicate with clients regarding their spaces to not offend them. I remembered working with a rehab facility for a short stint and told my supervisor I did not want to go into the home because it was a drug or "trap" house. No support or solution was offered. The only concern seemed to be that the person needed to be seen.

Safety is a critical aspect of the work that should be addressed during the onboarding process for therapists. For social workers to be effective in their work in client homes, they must feel that they are safe or know how to effectively handle unsafe situations that arise. In addition to concerns for health and safety, social workers were also challenged with scheduling conflicts and productivity requirements.

Scheduling Conflicts and Productivity Requirements

Where scheduling conflicts and meeting productivity requirements were concerned, the social workers expressed frustration that clients would cancel sessions after having confirmed that same day. Cancellations impacted the ability to meet productivity requirements and earning potential. Melly explained

> There is a lack of compassion from the administration. Administrators think this is easy. They think because we go to homes that we can just meet outcomes. Families reschedule, they no show and cancel a lot. Parents confirm for their children, and then the child decides they don't want to be there. This impacts our ability to meet the required productivity.

Michelle added “Getting paid fee for service is hard. You spend an hour and a half in traffic to get to a home, and the parent is not there, then you don’t get paid.” Finding logistical solutions to help social workers minimize cancellations will help them meet their required productivity and earning potential. Participants also discussed feelings of disconnection between treatment providers and administrators as a barrier.

Feeling Disconnection From Administrators

Participants generally felt there was a disconnect between what they were experiencing in the field and the administrator’s ability to understand and respond to their needs. Sinclaire shared

> Goals are unrealistic. Having to be told that you need to go to respond to a client and not knowing what you will be facing, it seems supervisors think it’s part of our learning to just figure it out instead of being taught properly how to handle a situation for the longevity of our career.

Administrators who make an effort to understand and provide solutions for the challenges faced by social workers providing home-based treatment would help them to feel connected and valued by their organizations. Finally, challenges responding to crises in the field was discussed amongst the participants.

Challenges Responding to Crises

Focus group participants gave examples of crises they experienced in the field and shared that they did not feel equipped to respond appropriately. Jerry stated “I was reprimanded for carrying mace because I was dealing with a family who the client was a

violent offender and they were slinging knives. I thought mace was appropriate to get and be safe."

The following barriers did not come up as themes; however, they were worth noting. Melly mentioned "maintaining confidentiality in the home, sometimes when the home has a lot of people, and there is no private space to meet," and Clara shared "ill-equipped or untrained supervisors. I have had experiences like others in this group, and my supervisor did not know what to do. She or [*sic*] her supervisor was not [*sic*] readily available to help leave [*sic*] us to figure it out on our own."

Health and safety concerns, scheduling conflicts, meeting productivity requirements, feeling disconnected from agency leadership, and facing challenges when responding to crises made providing home-based treatment to children and their families a difficult task for the social workers in the focus group. Their concerns were clear regarding providing home-based treatment. Social workers need supervisors to provide guidance on how to maintain their overall health and safety while in the field. Further, supervisors should help social workers develop administrative skills in appointment settings and should take their concerns to the administration. Finally, supervisors must make themselves available to social workers who are facing crises with their clients and help them navigate how to bring resolution to those crisis events.

The next section discusses the findings related to the professional skills and the experience of the participants as it related to home-based treatment.

Professional Skills Needed When Providing Home-Based Treatment

Three themes emerged concerning the skills needed to do the job. First, participants felt that they needed more training in handling various types of cases and case staffing support to determine effectiveness. Second, they stated that cases should be assigned using an approach that considers therapists' strengths. Third, they saw a need to maximize using technology when providing service. First, we will explore the need for increased training and staff support.

Increased Training and Staffing Support

According to the group, caseloads could be very diverse concerning client demographics and presenting problems or diagnoses. Melly explained,

> Training for Autism, ADHD, LGBTQ, play therapy autism, for example, you don't know how to work with this child, you ask for help and they can't help you because they don't know, but the expectation is to do the job, get it done, and meet objectives. You ask to be sent to trainings, but you got [*Sic*] to come out of pocket and pay for it. I have worked for several different organizations, and none of them provided training or support. Lots of independence, even when there is a supervisor in place, you must figure it out. This is my career, so I invest in it. But not all therapists are like me.

Concerning case staffing, participants did not feel that enough case staffing was taking place to ensure that their treatment approaches were helping the client. Guerda expressed, "Staffing cases periodically to determine if interventions I am using are working would have been helpful." Second, Melly stated,

> To do the job, you need resources. You need training, assessment skills to determine if you can effectively help this family. Many organizations are just worried about the census, and when you bring up that a client may need a higher level of care or something you are not able to provide, you are just being told to figure it out. YouTube becomes your therapy coach, you must do your own research, pay for your own training because agencies don't have funding. Many times, the organizations are being ran [*Sic*] by people who are not in the mental health profession, so they don't understand. They think, 'you are a licensed clinician, you can tackle any problem.' That is not always the case.

Michelle elaborated:

> You are unable to access refresher trainings or request a different training in alternative interventions when something is not working. Instead, you are told there is no funding or use approaches they have already trained you in. You lose clients this way. There is a lack of support, or when you try to get support, you are made to feel that the job is the way it is.

The participants also expressed the need to be more culturally competent. Michelle shared,

> As a home-based therapist, you are serving so many different types of people. I did not learn a whole lot about cultural competency in my social work program. More training and discussion about it are needed so that we are prepared for the different lifestyles we were about to meet.

In summary, participants felt that their needs as providers were not being met. Having to address the diverse treatment needs of cases they were assigned was often an insurmountable task. Administrators or agency owners maintained unrealistic expectations of the clinician's ability to provide treatment and social workers were often left to their own devices to determine treatment approaches and assess effectiveness of the interventions. The participants also shared the sentiment that cases should be assigned based on the provider's strengths. Their perspectives are discussed in the following section.

Strength-Based Case Assignments

The participants echoed each other's thoughts regarding the need to do more to assign cases more thoughtfully, according to therapist strengths. Shary mentioned, "Understanding strengths" is important for case assignment. Shary further explained, "I was thrown into working with a kid, and I hate being an inefficient therapist. It is not my goal to bring more harm." Guerda stated, "They tried to give you cases geographically, so it's based on where your home was located".

Melly, Guerda, Shary were the most vocal concerning the assignment of cases based on the strengths of the social worker. They concluded that consideration when assigning cases focused most on factors that would improve efficiency instead of considering the social workers skills sets, training and interest to ensure effectiveness. Maximizing the use of technology was another area of need that participants identified. This concern is discussed in the next section.

Maximize Using Technology

The participants felt many organizations used antiquated means of documenting service delivery and providing services. Providing appropriate technology and using technology in service delivery could save time and improve client outcomes. Michelle stated, “I was using my own technology to do the work, and often the technology the company uses is not adequate technology to get the documentation completed. Using technology as a part of interventions is important for children”. Without new ways to approach children’s treatment, the group seemed to agree that children lost attention, and treatment outcomes were adversely impacted. Michelle further explains, “these children need to see it on tv, or watch videos. Sitting and talking isn’t really beneficial for all of them. So just like technology has progressed in their lives, it should progress in therapy too”.

Social workers providing home-based treatment shared that having increased training to address their own diverse needs as well as those of the clients is essential in providing effective treatment. Additionally, they expressed that staffing support, assigning cases based on therapist strengths and maximizing the use of technology such as tablets, phones, or laptops are professional needs that will help make the work of providing home-based treatment both efficient and effective.

Making training accessible to social workers providing home-based treatment to a caseload of clients with various diagnoses is essential. Social workers should have agency funded opportunities to become certified in treatment interventions, have regular supervision and prompt feedback on their implementation of treatment strategies with clients. Assigning cases based on the social workers’ strengths will help both the client

and clinician. For the social worker, it will help mitigate feelings of demoralization and ultimately improve client outcomes. Further, administrators should ensure that they are using technology in their organizations to reduce paperwork, streamline processes, and provide the therapist with the tools they need to keep younger clients engaged.

The next section presents participant thoughts about their ability to communicate their needs to leadership when providing home-based treatment.

Communication Needs When Providing Home-Based Treatment

Participants generally agreed that they had opportunities to share their needs with their supervisors or organizations' administrators. However, four themes emerged that reduced the possibility of having those needs fulfilled. Focus group participants shared that though opportunities to share their needs were available, often no resolution was obtained, their professionalism was frequently questioned, guidance often came from inexperienced supervisors, and the impacts of cultural differences left therapists feelings that their concerns were dismissed. Presented first are the participants experienced of articulating concerns but getting no resolve.

No Resolution Obtained

Simon, Clara, and Chare agreed that they had opportunities to voice concerns but received no resolution. Clara explained, "I shared my concerns so often, I was told to stop sharing. She told me there was no point because the higher-ups were not going to do anything about it. The supervisor became tired of bringing up the concerns." In addition to no resolution being obtained, participants articulated that when they had questions or shared concerns, their professional abilities were questioned.

Professionalism Questioned

The group felt that at times when asking questions or sharing concerns their professional abilities would be questioned. Melly expressed, "your professionalism gets attacked." Attacks on professionalism included questioning of the social worker credentials or even questioning their belonging in the field. The focus group participants also expressed that when they had question or communicated concerns, at times, no resolution was obtained because the supervisor lacked the ability to assist.

Inexperienced Supervisors

If participants had a question about handling a situation clinically, five of the participants felt there was no resolution because their supervisors could not assist. Melly stated,

> Working at one agency, we did have clinical conferences where you can present cases in which you were having trouble. I was the most experienced, and when I presented, there was no feedback. No one could help. My supervisor was recently licensed with a case management background and never did [*Sic*] home-based therapy. So, no one knew what I was experiencing, and on paper, you had support, but you do not.

Having an inexperienced supervisor made it difficult for Melly to get the support she felt she needed to be effective. Having cultural differences in relation to those in leadership was also highlighted as being a challenge to communication.

Cultural Differences

One participant shared feeling marginalized and unheard due to having an identifiable cultural difference. For example, participants like Melly worked at an agency where the owners were predominately white. Melly shared, "When the administration is dominated by a certain culture group, and the direct practice professionals are people of color, it seems your voice is disregarded." In Melly's experience, she expressed that administrators did not make a conscience effort to connect with her or understand her experience and needs as a minority practitioner working with minority families.

Participants of the focus group shared their challenges when it came to communication with agency leadership. The majority of the group expressed that although they were able to share their concerns or ask questions, no resolution was realized. Participants felt that their professionalism underwent scrutiny and lack of resolutions were exacerbated by factors such as the inexperience of supervisors or cultural differences among direct service staff and leadership.

Supervisors should make genuine attempts to hear social workers' concerns providing home-based treatment and work to address those concerns to improve their ability to provide effective care. Social workers should not feel that because of their race, gender, sexual orientation, age, or any other cultural factor that their concerns will be disregarded. Administrators should be conscious of hiring supervisors who have experience providing home-based treatment and enough knowledge to provide adequate support and direction. Social workers' ability to ask questions and voice concerns is critical in their development, and their professionalism should not be questioned because they do so.

Finally, the views of the participants regarding their supervision experiences is presented.

Supervision Experiences When Providing Home-Based Treatment

The focus group participants' supervision experiences fell into three categories: no structured supervision, inadequate or inconsistent supervision, and adequate supervision. For the purpose of this paper structured supervision was described as support, instruction, and feedback occurring at a regularly set meeting time, on a weekly or biweekly basis in an individual or group format. The first group identified as having no structured supervision (Melly, Guerda, Clara, and Helen). Second were those who indicated that their supervision was inadequate or inconsistent (Sinclaire, Jerry, Shary) and the third group felt they had adequate structured supervision (Michelle, Simon, Chare).

Participants Sinclaire, Jerry, Shary, Michelle, Simon, and Chare shared that their supervision focused more on paperwork and productivity rather than treatment. Clara ended up forming her own peer supervision group and Helen hired outside supervisors. Nine out of the 10 participants shared the following about their specific supervision experience. First, we will begin with those who reported no structured supervision.

No Structured Supervision

Melly shared,

> I never had supervision. We had weekly conferences that were mandatory, but then went to bi-weekly and then, eventually stopped. The weekly conferences were not effective because the cases were so different in presentation, and peers,

> supervisors, or directors were unable to provide feedback. No real protocols were in place to meet client needs.

Clara offered,

> I had no supervision. I would ambush the supervisor after monthly team meetings about cases. No one was getting adequate supervision, so we built a network among ourselves to help each other out which was helpful because some therapists were more experienced than others, and this was helpful.

Ensuring structured supervision is essential in helping social workers feel supported and for Clara and Melly, their supervision needs simply went unmet. Other participants shared their experiences with inadequate or inconsistent supervision.

Inadequate or Inconsistent Supervision

Sinclaire stated, "My supervision was inconsistent, being constantly rescheduled on the supervisor end, which would impact client appointments." Jerry offered, "Supervision was inadequate, so I paid someone out of pocket until the agency hired someone, I felt was qualified to supervise me. I went once a week for individual and the next week for group supervision." Helen shared, "I hired someone outside the agency for better supervision." Due to inadequate or inconsistent supervision, Jerry and Helen found value in hiring supervision from outside of their agencies. Jerry and Helen were able to afford outside supervision, but what about the social workers at their organizations that could not? Those social workers would be left with their supervision needs not being met. On the other hand, three focus group members reported having adequate supervision.

Adequate Supervision

Michelle said, “I had some supervision. When I worked in the group home, there was adequate supervision (Individual), the supervisor was experienced and had a lot of clinical knowledge.” Simon shared, “I had supervision once a month, individual and group, and I didn’t like it because there was not much support.” Chare offered “My supervision was adequate, took place once per week, the supervisor was helpful, but often found myself having to find the information on my own.” Shary stated,

> I had (Individual) supervision until the supervisor passed. It was weekly, sometimes by phone, depending on the situation. After she passed, I ended up paying for supervision. The agency eventually got someone else, with no experience of home-based therapy, so I still paid for supervision.

Participants of the research study shared enlightening information about their experiences with supervision while providing home-based treatment. Participants in general fell into three categories of having no structured supervision, inadequate or inconsistent supervision, and adequate supervision.

Using the qualitative data collection, I was able to answer the overall research question: What are the supervision needs of social workers providing home-based treatment?

Social workers participating in the focus group shared a range of supervision experiences. Three participants said they felt they had adequate supervision. Of the three, one reported monthly supervision; the second reported that it was sufficient, and the third reported weekly supervision but found themselves still needing to find answers independently. The remainder of the participants shared that their supervision was

nonexistent or inconsistent. As a result, several social workers sought supervision and paid for it on their own or formed their own peer supervision groups. Supervision for unlicensed professionals providing treatment in the community is vital. In both individual and group formats. Supervision should occur weekly with a supervisor qualified to provide support, instruction, and feedback. Supervisors should make every effort to expand supervision into an opportunity beyond compliance and productivity. Moreover, they should focus on ensuring that client case reviews are taking place and social worker skills are being developed.

Summary

Social workers providing home-based treatment provided answers to five focus group questions. In answering these questions, themes emerged which highlighted their supervision needs. Meeting supervision needs of social workers providing home-based treatment centers around educating them on the value of the home-based model, providing support and guidance that relates to their health and safety, administrative support, supervisors being available to assist them in handling crises while providing home-based treatment; training, a strategic approach when assigning cases, addressing concerns that are voiced and providing regular, quality supervision by a qualified supervisor. In the next and final section, I will give the application of the study for professional ethics in social work practice, recommendations for social work practice, and implications for social change.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this study was to explore the supervision needs of social workers providing home-based treatment services. A qualitative study was conducted via a focus group. Key findings suggested that social workers need qualified supervisors who can educate them on the value of the home-based model, provide support and guidance related to their health and safety, offer administrative support, and assist them in handling crises while providing home-based treatment. Ongoing training opportunities, taking a strategic approach when assigning cases, addressing concerns that are voiced, and providing regular quality supervision were also identified as areas in need of supervision. These findings may provide insight for administrators in organizations regarding how to meet the needs of social workers who are providing home-based treatment. Improving the support social workers receive when providing services may impact how clients are served. Workers who feel they are receiving adequate supervision could see more strengths than weaknesses in the families they helped (Snyder & McCollum, 1999). The following sections focus on applicability for professional ethics, solutions for social work practice, and social change implications.

Application for Professional Ethics in Social Work Practice

Competence is one of the social work profession's core values (National Association of Social Workers, 2017). Social workers should work to increase their professional knowledge and skills to best serve clients. Findings from the current study may help guide supervisors in improving knowledge and skills of social workers who provide home-based treatment. Findings suggested social workers felt ill-equipped to

provide treatment to families. One participant shared that she did not feel that she provided quality treatment to her clients because she was too concerned for her safety. Five participants shared their thoughts regarding not having sufficient training to deal with the issues their clients have. Lawson (2005) found that home-based counselors thought they were underprepared to meet the demands of this service delivery model and, as a result, were not confident that they could help their families. Social workers should only provide services or use interventions that they are familiar with after engaging in study, training, consultation, and supervision from those competent in the interventions and techniques (National Association of Social Workers, 2017).

Participants also shared that they lacked the appropriate training to address the clients' presenting problems. Lack of training to deal with presenting problems often led participants to find solutions on their own. One participant explained that her supervisor did not have experience providing home-based treatment and was not a useful resource for her professional challenges. Due to the daily challenges social workers who provide home-based treatment face, they require supervision from competent and available supervisors (Rodriguez-Keyes et al., 2012). Supervisors who are charged with providing supervision to social workers providing home-based treatment must have the necessary knowledge and skills to supervise and consult appropriately (National Association of Social Workers, 2017).

Finally, organization administrators must ensure that adequate agency resources are available to provide staff with appropriate supervision (National Association of Social Workers, 2017). Administrators should work to ensure that supervisor workloads provide

them with adequate flexibility to ensure their clinicians' supervision needs are being met (Hammond & Czyszczon, 2014). Social work administrators and supervisors should take steps to ensure that staff training and development are made available (National Association of Social Workers, 2017). Current participants shared that not having enough training was a concern that they attempted to mitigate by seeking free searchable online tools such as YouTube or forming their own peer groups. Administrators should make every effort to ensure that social workers receive appropriate training before providing home-based treatment, opportunities to shadow more seasoned clinicians, and access to readily available supervisors who can support them while in the home providing services (Lawson, 2005). Making supervision a priority ensures that social workers are not left out in the field at risk, and clients are not subjected to substandard care (Hammond & Czyszczon, 2014)

Recommendations for Social Work Practice

Participants in the current study revealed that their supervision needs included having qualified supervisors to educate them on the value of the home-based model, support and guidance that relates to their health and safety, administrative support, and assistance in handling crises while providing home-based treatment. Additional supervision needs were ongoing training opportunities, a strategic approach to assigning cases, addressing concerns that are voiced, and providing regular and quality supervision. Through high-quality leader-member exchanges, supervisors can develop relationships with social workers providing home-base treatment that would give them an opportunity to be heard, nurtured, and supported to be successful. Participants agreed that they had

opportunities to share concerns about their work while providing home-based treatment. They also agreed that they often found their concerns were not heard or went unanswered. While engaging in high-quality leader-member exchanges, supervisees will have a chance to communicate their needs, and supervisors should work to meet those needs. As a result, supervisors would foster work environments that lead to increased productivity, personal satisfaction, personal commitment, and improved client outcomes (Gooty & Yammarino, 2016).

Qualified supervisors need to take the time to provide supervision that covers administrative, educational, and supportive functions (Dan, 2017). Supervision should be offered in individual and group formats to provide different opportunities to learn and discuss cases with a qualified supervisor and peers. According to Culbreth et al. (2004), a combination of group and individual supervision was identified among social workers providing home-based treatment as being preferred to only individual or only group supervision. Participants in this current study affirmed these sentiments. Additionally, after careful consideration of the needs of the social workers, which can be established through regular high-quality leader-member exchanges, the organization administration and supervisor should determine supervision frequency and duration. Culbreth et al. determined that biweekly supervision meetings were preferred to weekly meetings to allow time for other activities such as documentation requirements. However, Lawson and Foster (2002) suggested that supervision meetings should be weekly because of the challenges home-based therapists face. In the current study, half of the participants indicated they did not receive adequate supervision. Lack of proper supervision can lead

to social workers feeling isolated, demoralized, unmotivated, unproductive, and burned out (Dan, 2017). Further, the findings from the current study indicated supervisors should know their supervisees and their strengths. Participants shared that they would have preferred to work with cases that reflected their training and level of confidence.

Findings from this study also suggested that supervisors should address safety in the field and ensure that social workers providing home-based treatment have adequate preparation and support for providing services in the homes of clients. One participant articulated that she would have appreciated the opportunity to shadow someone who had direct experience in the field. Participants also shared examples of handling crises in the home and feeling ill-equipped to do so. Lawson (2005) stated that offering counselors opportunities to observe more seasoned clinicians would help them learn how to navigate the intricacies of the home-based treatment approach. Regularly advocating for adequate preparation, training, and certification opportunities for social workers providing home-based treatment may prove beneficial. Ensuring that social workers have sufficient preparation and training opportunities may help them to meet client needs effectively.

Administrators of an organization that provides home-based treatment need to see supervision as a core value for their organization (Hammond & Czyszczon, 2014). This can be reflected by administrators consistently engaging in high-quality leader-member exchanges with their supervisors. One current participant expressed that she brought concerns to her supervisor and was told to stop. The supervisor shared that the “higher-ups” would not do anything about it. Supervisors need to be able to address administration with the concerns of their supervisees.

Administrators need to hire supervisors who have the proper experience and the skill set to adequately supervise clinicians. Social workers who provide home-based treatment are likely to get assigned cases with various presenting issues; therefore, supervisors must be highly skilled in several treatment approaches. This will help the social workers address the diagnosis or presenting problems. Supervisors should also have experience providing home-based services to understand and be empathetic to the challenges social workers face while delivering treatment using the home-based model.

Finally, administrators should review supervisors' workloads regularly to ensure that supervisors have the time, training, and resources needed to provide supervision to social workers delivering home-based treatment. Jack and Donnellan (2010) found that supervisors considered themselves to be inadequately trained for their roles as supervisors. Specialized training should be made available to supervisors because they have a responsibility to help counselors provide home-based treatment and to manage treatment for clients in the home context (Rodriguez-Keyes et al., 2012). Supervisors have a responsibility to help clinicians address safety concerns for themselves and the families they serve, help them understand how to manage sessions in terms of pace and content, help them think systematically, and help them leverage the day-to-day interactions that can accelerate the treatment process and increase the effectiveness of therapeutic interventions.

As an advanced practitioner, I will benefit from these findings in my supervision of my supervisees. I will be more inclined to engage in high-quality leader-member exchanges to ensure that supervisees' needs are met, continually assess their training

needs, and create opportunities for them to meet those needs. Further, my supervisees will know that they can reach out to me with any need or crisis that arises while they are providing home-based treatment. Finally, I have shifted from providing individual supervision to both group and individual supervision to give supervisees an opportunity to engage and learn with and from their peers.

The transferability of this research is limited to individuals who are engaged in or provide supervision for clinicians providing treatment using the home-based model. Rodriguez-Keyes et al. (2012) highlighted that supervising home-based clinicians can be more complicated than supervising office-based clinicians. Results from this research may not translate well for supervisors who are supervising social workers in other settings. Social workers providing home-based treatment in rural areas may also have different experiences and needs that are not reflective of this study's outcomes. This study took place in Miami-Dade County, a highly populated and diverse area. Service demands tend to be high, and participants in this study came from different agencies providing the home-based treatment model in their organizations. Even though participants were from various agencies, their experiences often mirrored each other. Cities with similar demographics may find the outcomes of this study to be highly applicable to their social workers.

The outcome of this study may be useful in a broad range of contexts in social work practice. Regarding the social work core value of competence, participants felt unprepared to offer home-based treatment and reported that they lacked the appropriate supervision to feel supported in their attempts to do so. Schools of social work can use

findings from this study to better prepare social work students for working with clients using the home-based models. Lawson (2005) found that counselor trainees who were enrolled in an educational setting while training felt that they were underprepared to meet the demands of home-based counseling. Social workers engaged in policy research may use this study to encourage governing entities such as the Agency for Health Care Administration to revamp standards set for organizations regarding supervision. In this way, organizations may be more inclined to ensure that resources for adequate supervision are available.

This study addressed the supervision needs of social workers providing home-based treatment. Further research can be initiated to take a more in-depth look into the specific needs articulated by current participants. For example, participants shared that they were concerned about their safety while in the field. Future research could address what those safety concerns are. Additionally, participants shared that they would have appreciated more training in cultural competence or how to work with children diagnosed with autism. Future research could address the specific training needs that could impact the work of social workers providing home-based treatment. Furthermore, during the course of the current study, the global pandemic caused by COVID-19 impacted social workers' ability to meet in homes to provide treatment services. Researchers could examine the supervision needs of social workers providing virtual treatment services. Finally, this study focused on the social worker providing the service. Future research could focus on the needs of supervisors who provide supervision for those social workers providing home-based treatment.

In disseminating the findings from this research, I will ensure that precautions are taken to avoid the spread of the COVID-19 virus. This means following all recommended safety guidelines that include but are not limited to handwashing, wearing face masks, and maintaining social distance. Dissemination may also require using a virtual platform instead of an in-person presentation. Therefore, as appropriate to ensure safety of everyone, this study will be disseminated in two ways. First, I plan to seek opportunities to present at local and national conferences that focus on mental health services in the community to provide the research findings to interested stakeholders. Presenting at conferences will provide those interested in the home-based service delivery model with insights into the supervision needs of social workers providing home-based treatment. Audience members may include supervisors, providers, or administrators who can apply these research findings to the work they do in their organizations. Second, I plan to share this research with Thriving Minds, a governing body in South Florida responsible for managing state funding for organizations that provide mental health services in the community. These services include home-based treatment. Through sharing the findings with Thriving Minds, they may in turn share them with other organizations that could apply the recommendations from this study.

Implications for Social Change

Examining social workers' supervision needs providing home-based treatment impacts the micro, mezzo, and macro levels of social work practice. On the micro level, research findings showed that social workers are concerned about their ability to do the necessary work to achieve good outcomes for service recipients. Meeting the supervision

needs of social workers not only provides the social worker with more preparedness, support, and confidence to do the work, but it also has a direct impact on client outcomes as supervisors and supervisee rely on each other to make treatment successful (Rodriguez-Keyes et al., 2012).

On a mezzo level, administrators who make the supervision needs of social workers providing home-based treatment a priority in their organizations and apply recommendations made by this study, may find a greater level of employee satisfaction among their staff. According to leader-member exchange theory, social workers who feel heard and are supported will increase their productivity and have good client outcomes (Gooty & Yammarino, 2016). Agencies who are both efficient and effective in their work will be better situated to qualify for additional funding opportunities extending their scope of services to more communities and more families.

Finally, on a macro level, governing entities and regulatory bodies reviewing this research may create newer, more specific requirements to ensure the supervision needs of social workers providing home-based treatment are met. These entities and governing bodies provide licenses and billing authorizations to the organizations who offer home-based treatment services. Therefore, managing and regulatory bodies are well-positioned to apply the findings of this study and place more stringent requirements that can be evaluated regularly to ensure agencies comply.

Summary

In conclusion, through this action research project, I sought to gather information and inform supervisors and agencies who employ social workers that provide home-

based treatment of their supervision needs. Using leader-member exchanges, supervisors and administrators can continuously learn about the unique needs of social workers while providing home-based treatment. In this research study, participants revealed that their needs included being educated on the value of the home-based model, provision of support and guidance that relates to their health and safety, administrative support, readily available assistance in handling crises while providing home-based treatment; ongoing training opportunities, taking a strategic approach when assigning cases, addressing concerns when voiced and the provision of regular quality supervision. A review of the professional literature highlights the importance and impact of adequate quality supervision on the supervisee and client outcomes. This study affirms that message and offers insight into the supervision needs of social workers providing home-based treatment. The findings will empower organizations to implement good supervision practices that will impact social work practice on micro, mezzo, and macro levels.

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Appendix: Focus Group Questions

Study Title: Supervision Needs for Social Workers Providing Home-Based Treatment for Children and Families in the Community

Principal Investigator: Magda Demerritt, LCSW

- Introductions:
  - Degree (s) Earned
  - Time frame providing home-based therapy
  - Population worked with in the home setting

- What are some positive experiences you can share regarding your work providing home-based therapy services?
- What were some barriers you faced providing home-based services?
- What specific tools did you need to do the job, and did you have them?
- What specific skills did you need to do the job, and did you have them?
  - Did you feel adequately trained to provide the therapeutic services?
- Did you have opportunities to share what you needed to be successful in your work?
  - Who were you able to share your needs to?
  - Were your needs met?
- What was/is your supervision experience like?
  - How often did it take place?
  - Where did it take place?
  - Was it in a group format, individual format or both?
  - What was helpful regarding your supervision?
  - What was not helpful?
  - Share your thoughts regarding whether your supervisor was knowledgeable enough to support you.
  - Were there opportunities to openly share your concerns regarding your work with your supervisor?