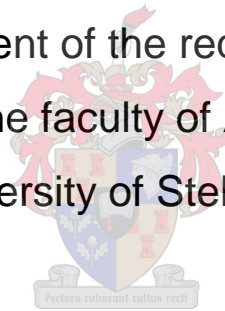


**THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE
DEPARTMENT OF HEALTH, WESTERN CAPE: SOCIAL
WORKERS' EXPERIENCES**

BY

ESTELLE SILENCE

Thesis presented in fulfilment of the requirements for the degree of
Master of Social Work in the faculty of Arts and Social Sciences at
the University of Stellenbosch



SUPERVISOR: PROF LK ENGELBRECHT

March 2017

DECLARATION

By submitting this dissertation electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

March 2017

Copyright © 2017 Stellenbosch University

All rights reserved

SUMMARY

The profession of social work originated in the 19th century in England, as a means to address social deterioration caused by poverty. Supervision was used as a means to teach lay persons how to perform social work tasks, hence the reason why some experts in the field question the need for its continuance, as social work is a profession implying that once you qualify as a social worker you no longer need a more experienced person to guide your practice.

The practise of social work is however governed by an ethical code of practice and legal prescripts which states that social workers can only be supervised by qualified social workers. Within the Department of Health, social workers are employed at health facilities where they have no access to social work supervisors. They are managed by other medical professionals or allied health staff, but not a social worker.

This study therefore endeavoured to explore if social workers believe that social work supervision is still needed in the Department of Health by exploring the significance of social work supervision. This was done within the framework of understanding the practice of social workers, the organisational context of health services and the developments that have taken place within social work supervision over the last few decades.

The researcher applied a qualitative research approach and as such, semi structured interviews was the data collection instrument which was used to gain a detailed picture of the participants' beliefs on this topic. The research aimed to elicit the experiences of the significance of supervision by social workers and as such, one-on-one interviewing allowed for a more meaningful interaction between the researcher and participants.

For the study, 17 production social workers in the Department of Health, Western Cape were interviewed. The study comprises of two literature chapters outlining the Department of Health as an employer of social workers, the functioning of interdisciplinary teams within this structure, as well as the profession of social work. The last literature chapter covers the role of social work within health and provides an overview of the writings of academics, on the significance of social work supervision within the practice of the profession, but not

necessarily specific to a health service. The 4th chapter is the empirical study and chapter 5 is the findings and conclusions of the research.

The conclusions drawn from the findings identified social work supervision as being significant to equip, develop and provide support to the social work practice within health services. No distinction was drawn between the need for junior versus more senior social workers regarding supervision. Social work supervision is a strong indicator for quality service. The primary recommendation is for the provision of access to social work supervision for social workers employed in the Department of Health.

OPSOMMING

Die maatskaplikewerk-professie het ontstaan in die 19de eeu om sosiale euwels wat veroorsaak is deur armoede aan te spreek. Supervisie is benut om nie-professionele persone te leer hoe om maatskaplikewerk-take te verrig. Dit is daarom dat die deskundiges nou nog die noodsaaklikheid van supervisie vir professionele maatskaplike werkers bevraagteken.

Die praktyk word gereguleer deur 'n etiese kode en wetlike voorskrifte wat bepaal dat supervisie van maatskaplike werkers slegs deur gekwalifiseerde maatskaplike werkers gedoen mag word. Maatskaplike werkers wat in die Departement van Gesondheid werk het egter geen toegang tot 'n maatskaplikewerk-supervisor nie. Hulle word bestuur deur mediese personeel of ander gesondheidswerkers, maar nie 'n maatskaplike werker nie.

Die studie het daarom gepoog om ondersoek in te stel of maatskaplike werkers wat in die Departement van Gesondheid werk beleef dat maatskaplikewerk-supervisie steeds nodig is. Die navorsing is gedoen binne die konteks van die maatskaplikewerk-praktyk en die konteks van gesondheidsorganisasies.

'n Kwalitatiewe navorsingsbenadering is gebruik. Semi-gestruktureerde onderhoude is gebruik om die nodige inligting in te samel. Persoonlike onderhoude is gebruik om die ervaringe van maatskaplike werkers rondom die noodsaaklikheid van supervisie te ondersoek.

Onderhoude is gevoer met 17 produksie maatskaplike werkers wat in die Departement van Gesondheid werk. Die navorsing bestaan uit twee literatuur hoofstukke wat die Departement van Gesondheid as werkgewer, die funksionering van interdisiplinêre spanwerk binne die werksopset sowel as die professie van maatskaplike werk beskryf. Die rol van maatskaplike werk in die gesondheidsdiens word in die laaste literatuur hoofstuk beskryf met 'n oorsig van akademiese skrywes oor die belangrikheid van maatskaplikewerk-supervisie binne die praktyk, maar nie spesifiek in 'n gesondheidsomgewing nie. Hoofstuk vier bied 'n verslag oor die empiriese studie en hoofstuk vyf is 'n verslag oor die gevolgtrekkings en aanbevelings.

Die studie het bevind dat supervisie belangrik is om maatskaplike werkers te ontwikkel en te ondersteun in die gesondheidsdiens. Daar is geen onderskeid getref tussen die noodsaaklikheid van supervisie vir 'n junior teenoor 'n meer ervare maatskaplike werker nie. Supervisie is nodig vir kwaliteit diens. Die primêre aanbeveling fokus op die voorsiening van toegang tot maatskaplikewerk-supervisie vir maatskaplike werkers in die Departement van Gesondheid.

DEDICATED TO MY PARENTS, HENRY AND MARY DAVIDS

“She understood that the hardest times in life to go through were when you were transitioning from one version of yourself to another.”

Sarah Addison Allen

ACKNOWLEDGEMENTS

In my process of “*transitioning*” the past two years, I would like to thank the following people and institutions:

My Heavenly Father for strength, and wisdom, Romans 5:3-4.

The Department of Social Work (Stellenbosch University) for granting me the opportunity to be accepted in the prestige master’s programme.

My supervisor, Professor L.K. Engelbrecht, for all the encouragement, guidance and support.

My family, without whom I would not have been able to do this. Ashwell, thank you for stepping into the gap and holding the reigns, with everything else that I was doing the past two years. You are my rock.

Tristan and Ivana you are just the best kids ever. Thank you for your patience and allowing me the time to do this. Tristan thanks for continuing to excel despite me not always being able to give you my full attention. Ivana thanks for all the massages, my little dancing princess.

My colleagues thank you for supporting me.

My participants for offering their time to take part in my study and allowing me into their world. You make me proud to be a social worker.

And lastly I dedicate this to my parents, my late father whom I love forever and my gorgeous mother for being my inspiration. Thank you for my spiritual foundation and believing in me always. Thank you for teaching me the value of hard work. This is your degree.

TABLE OF CONTENTS

SUMMARY	I
OPSOMMING	IV
ACKNOWLEDGEMENTS	VII
CHAPTER 1_ INTRODUCTION TO THE STUDY	1
1.1 MOTIVATION FOR THE STUDY.....	1
1.2 PROBLEM STATEMENT	8
2. AIMS AND OBJECTIVES.....	9
3. RESEARCH METHODOLOGY	10
3.1 RESEARCH APPROACH	10
3.2 RESEARCH DESIGN.....	10
3.3 RESEARCH METHOD.....	11
3.3.1 <i>Literature study</i>	11
3.3.2 <i>Population and sampling</i>	11
4 METHOD OF DATA COLLECTION.....	12
5 DATA PROCESSING PROCEDURE	13
5.1 METHOD OF DATA ANALYSIS	14
5.2 METHOD OF DATA VERIFICATION.....	14
6 REFLEXIVITY	15
7 ETHICAL CONSIDERATIONS.....	16
8 LIMITATIONS OF THE STUDY	17
9 PRESENTATION	17
CHAPTER 2_ THE PRACTICE OF SOCIAL WORK IN THE DEPARTMENT OF HEALTH.....	19
2.1 INTRODUCTION.....	19
2.2 THE DEPARTMENT OF HEALTH.....	19
2.2.1 <i>Historical context of health services in South Africa</i>	19
2.3 NATIONAL DEPARTMENT OF HEALTH	21
2.4 WESTERN CAPE DEPARTMENT OF HEALTH.....	22
2.4.1 <i>Vision and Mission</i>	22

2.4.2	<i>Health care service</i>	23
2.4.3	<i>Interdisciplinary teams</i>	24
2.4.3.1	Functioning of interdisciplinary teams	24
2.4.3.2	Functional Business Units.....	25
2.4.4	<i>Interdisciplinary supervision</i>	26
2.5	THE PROFESSION OF SOCIAL WORK WITHIN THE DEPARTMENT OF HEALTH	29
2.5.1	<i>Defining the profession of social work</i>	29
2.5.2	<i>Generic training of social work versus specialized service of health</i>	30
2.6	THE ROLE OF SOCIAL WORK IN HEALTH.....	31
2.6.1	<i>The international perspective</i>	32
2.6.2	<i>The South African perspective</i>	34
2.7	NEED FOR SOCIAL WORK SUPERVISION.....	37
2.8	SUMMARY.....	37
	CHAPTER 3 _THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION.....	38
3.1	INTRODUCTION.....	38
3.2	CONCEPTUALISATION OF SOCIAL WORK SUPERVISION	39
3.2.1	<i>Context in which supervision occurs</i>	39
3.2.2	<i>Definition of supervision</i>	40
3.2.2.1	Interface between supervisor and supervisee.....	41
3.2.2.2	Importance of monitoring in supervision	42
3.3	HISTORICAL OVERVIEW TO MODERN TRENDS IN SOCIAL WORK SUPERVISION	42
3.3.1	<i>Historical overview</i>	43
3.3.1.1	Globally	43
3.3.1.2	Nationally	43
3.3.2	<i>Modern trends in supervision</i>	44
3.3.2.1	Reflective supervision	44
3.3.2.2	Emotional Intelligence.....	45
3.4	APPROVED, ESSENTIAL VALUES FOR EFFECTIVE SUPERVISION.....	456
3.4.1	<i>Practice policy</i>	46
3.4.2	<i>Legal prescripts</i>	46
3.4.3	<i>Practice of social work supervision</i>	467

3.5	CHARACTERISTICS OF AN EFFECTIVE SUPERVISOR	47
3.5.1	<i>Role of a supervisor</i>	48
3.5.1.1	In relation to the employer	48
3.5.1.2	In relation to the employee.....	49
3.5.1.3	In relation to the service user	48
3.6	THE OPERATIONALISATION OF SUPERVISION	49
3.6.1	<i>Methods of supervision</i>	490
3.6.1.1	Individual.....	490
3.6.1.2	Group.....	50
3.6.1.3	Peer	50
3.6.1.4	Live	501
3.7	FUNCTIONS OF SUPERVISION	50
3.7.1	<i>Administrative/Managerial</i>	51
3.7.2	<i>Supportive</i>	51
3.7.3	<i>Professional Development</i>	523
3.8	THE PROCESS OF SUPERVISION.....	53
3.8.1	<i>Phases and associated tasks</i>	53
3.9	SIGNIFICANCE OF SUPERVISION.....	545
3.10	EMPIRICAL STUDIES' FINDINGS.....	556
3.11	STRATEGIC OBJECTIVE OF SUPERVISION.....	567
3.12	SIGNIFICANCE OF SUPERVISION RELATIONSHIP ON QUALITY OF SERVICE.....	578
3.13	THE IMPACT OF SUPERVISION ON THE FUNCTIONING OF THE ORGANISATION.....	578
3.14	ACCOUNTABILITY TO SOCIETY	59
3.15	INTRINSIC VALUES	590
3.16	SUMMARY.....	59
	CHAPTER 4_ EMPIRICAL STUDY OF THE EXPERIENCES OF SOCIAL WORKERS ON THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH	612
4.1	INTRODUCTION.....	612
	SECTION A	612
4.2	RESEARCH METHOD.....	612

4.3	PREPARATION FOR THE EMPIRICAL STUDY	623
4.3.1	<i>Research sample</i>	645
4.3.2	<i>Research design, approach and instrument</i>	656
4.3.3	<i>Data gathering and analysis</i>	656
SECTION B: PROFILING OF PARTICIPANTS.....		657
4.4.	PARTICIPANTS.....	657
4.4.1	<i>Gender</i>	69
4.4.2	<i>Number of years practicing social work</i>	69
4.4.3	<i>Number of years practicing social work in the Department of Health</i>	701
4.4.4	<i>Level of health care facility</i>	712
4.5	SOCIAL WORK SERVICE	723
4.5.1	<i>Role of social work</i>	723
4.5.2	<i>Interdisciplinary team</i>	767
4.5.2.1	Functioning of social work in the inter disciplinary team	768
4.5.2.2	In/out patient service within the context of the interdisciplinary team.....	79
4.5.3	<i>Supervision</i>	790
4.5.3.1	Access to supervision	790
4.5.3.1 (a)	Reporting structure.....	790
4.5.3.1 (b)	Social work supervision	812
4.5.3.1 (c)	Type of supervision	834
4.5.3.1 (d)	Frequency of supervision	845
SECTION C: THEMES, AND SUBTHEMES		857
THEME 1: UNDERGRADUATE TRAINING.....		867
4.6	GENERALIST TRAINING VS. SPECIALIST SERVICE.....	867
4.6.1	<i>Newly qualified social worker</i>	867
4.6.2	<i>Impact of no social work supervision on the social worker practice</i>	89
4.6.3	<i>Mandatory supervision</i>	945
THEME 2: FUNCTIONS OF SUPERVISION.....		956
4.7	FUNCTIONS OF SUPERVISION	956
4.7.1	<i>Educational supervision</i>	956
4.7.2	<i>Supportive supervision</i>	978
4.7.3	<i>Administrative supervision</i>	978
THEME 3: SIGNIFICANCE OF SUPERVISION.....		990
4.8	SIGNIFICANCE OF SUPERVISION.....	990

4.8. (a) THE DEPARTMENT OF HEALTH	1001
4.8. (b) THE SOCIAL WORKER	1035
4.8 (c) THE SERVICE USERS.....	1067
THEME 4: VALUE OF SUPERVISION.....	1089
4.9 THE VALUE OF SOCIAL WORK SUPERVISION.....	1089
4.10 CHALLENGES.....	1112
4.11 SUMMARY.....	1123
CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS.....	1135
5.1 INTRODUCTION.....	1135
5.2 CONCLUSIONS AND RECOMMENDATIONS	1146
5.2.1 The research process	1146
5.2.2 Profiling of participants.....	1157
5.2.3 Social work services.....	1168
5.2.4 Social work supervision.....	11719
5.2.5 Generalist vs. specialist training.....	1202
5.2.6 Functions of social work supervision.....	1213
5.2.7 Significance of social work supervision	1235
5.2.8 Value of social work supervision	1257
5.3 RECOMMENDATIONS FOR FURTHER RESEARCH	1268
5.4 KEY FINDINGS	12729
REFERENCES	1281
APPENDICES.....	164

LIST OF FIGURES

FIGURE 3.1: REFLECTIVE LEARNING MODEL	445
FIGURE 3.2: THE CYCLICAL PROCESS OF SUPERVISION.....	545
FIGURE 4.1: THE VALUE OF ADMINISTRATIVE SUPERVISION AS REPORTED BY THE PARTICIPANTS.....	99

LIST OF TABLES

TABLE 4.1: IDENTIFYING DATA OF PARTICIPANTS	667
TABLE 4.2: THEMES AND SUBTHEMES	857
TABLE 4.3: EFFECTS OF NO ACCESS TO SOCIAL WORK SUPERVISION AS REPORTED BY THE PARTICIPANTS	89

LIST OF APPENDICES

<u>ANNEXURE A: ETHICAL CLEARANCE FROM THE UNIVERSITY OFSTELLENBOSCH</u>	<u>150</u>
<u>ANNEXURE B: APPROVAL FROM THE WESTERN CAPE DEPARTMENT OF HEALTH TO CONDUCT THE RESEARCH</u>	<u>153</u>
<u>ANNEXURE C: REQUEST TO HEALTH FACILITY TO CONTACT THEIR SOCIAL WORKERS.....</u>	<u>156</u>
<u>ANNEXURE D: PARTICIPANT INFORMED CONSENT FORM.....</u>	<u>157</u>
<u>ANNEXURE E: INTERVIEW SCHEDULE.....</u>	<u>160</u>

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 MOTIVATION FOR THE STUDY

South Africa is situated at the southernmost tip of Africa. The country is divided into nine provinces with the Western Cape being the fourth largest province (Western Cape Government, 2011). The government's public service departments include amongst others social development, education, home affairs and health. Health services are provided at public health facilities across the country at no cost or on an income based scale to citizens of South Africa. The public health sector provides health care to 80 per cent of the population (National Department of Health, 2015: 4). The primary service providers within the Department of Health are medically trained staff such as doctors and nurses. Allied health staff which includes physiotherapists, psychologists and social workers amongst others are classified as secondary services.

The term allied can be interpreted as services which are not essential to providing direct health care to service users. Social work and nursing are the only professionals in the Department of Health which are not registered with the regulatory Health Professions Council of South Africa. Nurses are however recognised as essential to the service but this exclusion of social work is indicative of the fact that social workers are the only allied health discipline which receive no specialized training to function as health care practitioners.

Social workers are however part of the multi-disciplinary teams in the Department of Health. The teams are referred to as functional business units, which are led by medical specialists. This model promotes the medical specialists as being the leaders to whom all other staff needs to account, except nursing (Department of Health, 2012). There is no acknowledgement of the need for discipline specific supervision. "The Clinical Head of the Functional Business Unit (FBU) will be accountable for all professional clinical staff and the FBU Nurse Manager be responsible for the nursing staff" (Department of Health, 2012: 11).

The FBU model can therefore be interpreted as multi-disciplinary teams being supervised by medically trained staff. This model further highlights the issue of interprofessional supervision, which is defined as interactive learning between members of different

professional groups (Owens, Goble & Gray, 1999: 278). Research conducted found that interprofessional supervision “deepened the exploration and level of understanding about supervision and encouraged participants to question taken for granted professional assumptions” (Davys & Bedoe, 2008: 58). However, a survey done of 107 Australian public hospitals showed that the majority of the staff preferred discipline specific supervision as opposed to interprofessional supervision (Boyce, 2001).

Godden (2012: 3) further reported that in England social workers who work as part of interprofessional teams report a lack of or insufficiency of supervision, poor quality supervision and in some cases supervision is not done by qualified, experienced social workers. This was confirmed by Cleak and Turczynsk (2014). It would thus seem that countries who had introduced a system of interprofessional supervision within a health setting did not find it beneficial to the professional development of the staff. In South Africa the Department of Social Development’s supervision framework for the social work profession (2012: 1) therefore states: “The direct management of social workers by non-social workers often impacts detrimentally on the practice of the profession”. There is thus evidence, both internationally and locally, that promotes discipline specific supervision.

The global definition for social work also contextualizes the importance of discipline specific supervision as it describes the profession’s broad service parameters: “Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing” (International Association of Schools of Social Work, 2014: 1).

Various authors further define social work practice as the application of an eclectic knowledge base, professional values and a wide range of skills to target individual, familial, group, organizational or community systems for change (Bogo & Taylor, 1990; Kirst Ashman & Hull, 1997; Kirst-Ashman, 2013; Teigiser, 2009). Social work is thus an academic discipline and as such, the previous documented finding on research regarding interdisciplinary supervision (Boyce, 2001; Godden, 2012; Cleak & Turczynsk, 2014) which

promotes discipline specific supervision includes the profession of social work. It can therefore be inferred that since social work is an academic discipline and research done on interdisciplinary supervision promotes discipline specific supervision that social workers in health facilities should have access to supervision done by social workers.

However, social workers are trained generically (South African Council for Social Service Professions, 2007: 6) yet are expected to provide a service within the specialized field of health. Within the Department of Health there is also no standardized document outlining the role of social work. The job purpose is defined as providing services through the promotion of social change, problem solving in human relationships and the empowerment and liberation of people to enhance social well-being (Department of Public Service and Administration, 2008). It must however be stated that this job purpose is designed for the Department of Social Development and seems to be applied across other government departments as in this instance, health, which employ social workers.

In terms of generalist social work, Balinsky (as cited in Morales, Sheafor & Scott, 2012: 43) stated for example: "The complexity of human problems necessitates a broadly oriented practitioner with a versatile repertoire of methods and skills capable of interacting in any one of a number of systems". Social work teaching programs strive to graduate students who are competent and skilled in working with diverse populations and in diverse practice settings. These authors (Balinsky, 2012; Beytell, 2014) also confirm the generic nature of undergraduate social work training. Beytell (2014: 173) writes that "the tasks and roles of a social worker in a health context will differ depending on the level or specific focus of care". It is for this reason that Reisch (2012) stated that hospital social work departments will have to develop clearer job descriptions that reflect an inventory of the new tasks staff will be expected to perform.

Crisp (2000) and Judd and Sheffield (2010), in an attempt to describe these tasks therefore postulates that the person-in-environment focus guided the social work role towards assessment of the patient's social situation and its interrelationships with others, assisting patients with issues related to chronic disease and disability, drugs and alcohol, terminal conditions and mental health issues. Hospital social workers have thus had to change their practice to meet these demands (Caputi & Heiss, 1984). Beytell (2014: 173) for example argues that the FBU model "complicates this, as social work roles and tasks are determined

by the specific management of the institution, which will then result in different roles and tasks irrespective of level of care and specific focus”.

Undergraduate training may thus not fully equip social workers to function as independent practitioners in the medical field. In tertiary medical settings, social workers conduct psycho social assessments and make recommendations to medical experts who make life or death decisions with regards to patients needing heart and liver transplants based on the social workers findings (O'Donoghue, 2012). In specialist facilities, social workers make diagnostic assessments (Caputi & Heiss, 1984) and recommend patient treatment programmes (Patchner & Wattenberg, 1985; Wolock & Schlesinger, 1986; Lourens, 1995; Wolpert, 2005) to the multi-disciplinary team. For this reason social workers in health also need expert knowledge regarding health conditions in order to be fully effective within this sector of service.

This remains the most apt way to describe what distinguishes social work in health from other fields of practice. It also however emphasizes the importance of the supervisory role to support and educate newly appointed social workers about the specialized knowledge required within a health setting.

Within the social work profession, supervision is traditionally a process in which a more experienced social worker supports and provides a space for a supervisee to reflect on their practice (Ford & Jones, 1987; Hawkins & Shohet, 1989; Hoffman, 1990; Corey, Corey, Corey, & Callanan, 2014; Zorga, 2002; Mbau, 2005; Tsui, 2005; Ingram, 2013; Kadushin, 2014). Morrison and Wannacot (2010: 1) further asserts that supervision is “...an integral element of social work practices”.

Despite all of this, medical social work is not recognized by the South African Council for Social Service Professions as a specialized field of practice. A social worker with less than three years' experience can be employed in health facilities without any access to a social work supervisor. Management of health facilities can thus define the social work service based on their recognized needs (Beytell, 2014). This could leave social workers vulnerable to misutilisation and burnout, and as such discipline specific supervision is essential.

It is therefore that in 2002, Botha stated that because of the unpredictable, non-routine, non-standardized, individualized and imperceptible nature of social work, practice supervision is required.

Furthermore, the Department of Social Development (DSD) and the South African Council of Social Services Professions (SACSSP), (2012: 8) define supervision of social workers as an “interactive process in a positive non-discriminatory relationship, based on distinct theories, models and perspectives of supervision” entailing administrative, supportive and educational functions. Supervision is part of the social work profession.

Therefore, it may be confirmed that: “Social work is a supervising profession” and the practice was built on a foundation of supervision (Harkness & Poertner, 1989: 115). The role and history of social work supervision in South Africa is also documented by Engelbrecht (2010: 325-327). Social work supervision has thus been an element in the development of the profession since its inception. However, within the profession there is debate about the need for supervision with some social workers fearing that it deprofessionalises social work (Tsui, 1997; Toren, 1969; Veeder, 1990; Wax, 1979; Munson, 2009). Engelbrecht also reported on how authors refer to the practice of supervision as “out dated, unnecessary and an insult to the profession” (2014: 125). An exploration regarding the significance of social work supervision will clarify the perception that providing supervision to social workers deprofessionalises the social work profession.

Social work practice is a social science. The community as such could be uncertain about the competence of social workers hence the need for oversight and monitoring, which supervision provides. It is observed that despite the abovementioned, there is no standardized role identified for social work within the Department of Health in the Western Cape. In some areas of service, social workers report directly to medically trained staff (Department of Health, 2012; Scott, 1980; Continuous NHS Healthcare, 2011). Kadushin (2002: 36) however states that the extent to which a community is willing to grant full autonomy to a profession is dependent on the level of consensus of the profession’s objectives. Where the objectives are unclear, the effects of interventions are unpredictable and the risk of failure is high, workers may need and want a supervisor with whom they can share responsibility (Kadushin, 2002: 36). This need for shared responsibility is included in

the South African Council for Social Service Professions' code of ethics (South African Council of Social Service Professions, 2007: 35).

Social workers are furthermore bound by principles of confidentiality which implies that their work cannot be publicly observed. Confidentiality is one of the ethical considerations enshrined within the profession's code of ethics (South African Council of Social Service Professions, 2007: 14). Without a supervisor monitoring what a worker is doing, confidentiality leaves the client vulnerable to practice abuse. (Kadushin, 2002: 37).

Kadushin (2002) furthermore makes a correlation between the practice of doctors and social workers, but highlights that poor practice from doctors has effects which are easily detected in that patients die or remain ill. The effect of poor/inadequate social work service, especially in the health sector, is not easily detected thus emphasizing the importance of "periodic review of worker activity" Kadushin (2002: 37). This is confirmed by Gilbert (2009) who states that supervision contributes to competent professional practice that serves the best interests of clients.

In an effort to be in sync with this, the Department of Health has cited increased wellness as its strategic priority explaining that it is not the absence of symptoms of ill health which must be strived for but the improvement of overall wellness (Western Cape Department of Health, 2012). This priority can be interpreted as the Department's realization that its secondary professions' (including social work) services, are central to achieving this objective. Social workers (in terms of the profession's global definition) promote social change through the implementation of social sciences which results in an improvement of wellbeing (International Association of Social Work, 2014).

The latter is crucial to the Department of Health's strategy to improve quality care to its service users. In the Western Cape, with a population of 6 116 324 million (Western Cape Government Health, 2015), there are 130 social work posts and 16 supervisor posts (Department of Health, 2015). Persons requiring social work services often do not have a choice as to where they can access these services, as the Department of Health's service is based along geographical areas and level of disease. Communities accessing public health services have to go to the designated service provider. The government holds the monopoly for this service and as such social workers do not "...face the same kind of

penalties that alert them to the need for examining and correcting their practice” (Kadushin, 2002: 38). The need for supervision is therefore great in these settings.

However, Kadushin (2002: 39) also states that if professional training strives to successfully teach the social work student to develop a professional conscience, then the supervisory function is internalized. The individual social worker thus becomes his/her own supervisor. The author does not define what he means by prolonged training but in the Department of Health, compared to the medically qualified primary service providers, social workers is required to have fewer years of training to qualify as a professional practitioner. It can thus be interpreted as indicative of the need for supervision.

Lord Laming, reporting from an English perspective in 2009, stated that supervision of social workers strengthens the services they provide and is therefore the cornerstone of good social work practice. Kadushin (2014: 25) confirms this when he states that social workers are often exposed to and involved with situations that are so affectively challenging that in dealing with it, the social worker is left emotionally drained. It is for this reason that, within the profession of social work, there is such a great need for support and the restoration of morale which is achieved by supervision. It is thus imperative that social work is practiced in a supportive environment that is geared towards the continuous development of professional judgement and skills. Regular, good, quality, supervision is essential (Morrison et al, 2010: 1).

Therefore, employers who provide an enabling environment for supervision are likely to see increased productivity, improved service delivery, a satisfied clientele and retention of core competencies (Department of Social Development, 2012: iii). Cloete (2012: 18) wrote that authors such as Botha (2002: 1) and Kadushin (1992: 20) postulate that supervision increases accountability and equips new and inexperienced social workers with the necessary skills and knowledge to deliver effective social welfare services to the client system. Lastly, Engelbrecht (2010: 3) confirms the importance of supervision as a means to retain social workers.

These arguments put forward by Kadushin (1992), Botha (2002), and Engelbrecht (2010) as stated in the previous paragraphs, emphasize the importance of supervision within the profession of social work, yet social workers report to medically trained staff in health care

facilities in the Western Cape. Within the Department of Health, there is acknowledgement that healthcare workers are incorrectly placed and unevenly distributed. There are policies that govern the management of human resources, but they are not applied effectively which often translates to poor performance management and weak accountability (Department of Health, 2010: 10). This indicates that policies on human resource management need to be effected to bring about change in service delivery outcomes, which could include social work supervision for social workers. The researcher has thus far outlined the literature on the significance of social work supervision but has not yet shown how policies or legislation can guide employers of social workers regarding the provision of social work supervision.

Legislation that underpins fair labour practice in South Africa, that can be linked to social work supervision and includes the Constitution of the Republic of South Africa (1996, Chapter 10, Section 195(1) (a) (h)), states that a high standard of professional ethics must be promoted, and good human resource management and career development practices must be cultivated to maximize human potential. The standard for professional ethics referred to can further be linked to the South African Council's Code of Ethics section 27(1)(a) and the Social Service Professions Act (110 of 1978, as amended), which stipulates that a social worker may only be supervised on social work matters by another registered social worker. Lastly, the country's Labour Relations Act, 66 of 1998 confirms this as it ensures the right to fair labour practices and reflects workers' and employers' rights as envisioned by the Constitution.

Based on the preceding discussion, it is evident that the Department of Health, an employer of social workers in the Western Cape, is not compliant with the provision of supervision for social workers by social workers. This research will therefore attempt to gain an understanding of the significance of social work supervision for social workers in this government department, as a means to contribute to recommendations to the Department of Health regarding the provision of supervision for social workers.

1.2 PROBLEM STATEMENT

Social workers receive generalist undergraduate training but are employed and expected to function optimally within the field of health without the necessary support and guidance from a social work supervisor. Social workers report to medically trained staff (Continuous NHS

Healthcare, 2011). The Department of Social Development reports in its Draft Recruitment and Retention Strategy document (2006) that the inability to retain social workers is exacerbated by the lack of support and poor working conditions social workers are subjected to. According to the Social Service Professions Act, 110 of 1978 (amended) and the South African Council of Social Service Professions' Code of ethics (2007), a social worker may only be supervised on social work matters by another competent and registered social worker. Therefore, the supervision of social workers by a social work supervisor in a health context is important.

Several renowned authors on social work supervision point to the significance of supervision, such as Kadushin (2002), Munson (1979), Tsui (2004 & 2005) and Engelbrecht (2014), but it is however not within the context of health. Research done on medical social work in South Africa (Jeftha, 2001; Swart, 1992; De Jager, 2003; Mbau, 2005; Vermeulen, 2008; Du Plooy, 2011; Beytell, 2014) has however not focused on the significance of social work supervision. The question that thus remains is: whether social work supervision is needed by social workers working in a medical/health setting? What are the experiences of social workers, who receive supervision, on the significance of social work supervision within a health setting?

2. AIMS AND OBJECTIVES

The goal of the research was to gain an understanding of the experiences of social workers on the significance of social work supervision in the Department of Health, Western Cape.

The following objectives were deemed appropriate, as a means to achieve this goal:

- To contextualize the Department of Health as an employer of social workers, by describing the role of social work and its complexities as a secondary profession;
- To conceptualise the supervision of social workers within a health context and explain the role of supervision within this context, specifically focusing on the significance of social work supervision;
- To empirically investigate the experiences of social workers in the Department of Health, Western Cape with regards to the significance of social work supervision;

- To draw conclusions and make recommendations to social workers and relevant stakeholders in the Department of Health on the significance of social work supervision.

3. RESEARCH METHODOLOGY

3.1 RESEARCH APPROACH

The study employed a qualitative approach, which refers to a “systematic, interactive, subjective approach used to describe life experiences and give them meaning, thus providing a dense description of reality as it is perceived” (Burns & Grove, 2009: 717). Other authors (De Vos, Strydom, Fouchè & Delpont, 2011) state that this research method is used to elicit participant accounts of meaning, experience or perceptions. It involved examining and reflecting on the less tangible aspects of a research subject, example, values, perceptions and in this instance the experience of social workers (University of Bradford, 2007).

Cresswell (2013: 76) reports that the focus of phenomenology is on “what” people experience and “how” they experience it. In qualitative research there is a focus on the social context within which events occur and the meaning it holds within that context (Ryan, Coughlan & Cronin, 2007). The social context was thus the Department of Health, where social work services are rendered and where the emphasis was to look at the significance of supervision of social workers by social workers.

3.2 RESEARCH DESIGN

The research design focuses on the end product, that is, the kind of study that was done. An exploratory and descriptive research design was used. Fouche and De Vos (2011: 95-96) explain that an exploratory design is used to gain insight into a situation, community or individual. They further assert that “the descriptive design presents a picture of the specific details of a situation and focuses on how and why”. They postulate that by using this design, the researcher got a description from the participants, who were social workers, regarding the specific details of how they experience social work supervision in the Department of Health.

This assertion is further confirmed by Bless, Higson-Smith and Kagee (2011: 47) who state that a descriptive design assists in gaining a “broader understanding of a situation”. By using this design, new information was elicited and more factual and truthful descriptions were provided (Botma, Greeff, Malaudzi & Wright, 2010; Polit & Beck, 2010). The researcher was able to gain an understanding of how social workers in the specific community of the Western Cape’s Department of Health experience social work supervision.

3.3 RESEARCH METHOD

3.3.1 Literature study

A literature review was aimed at contributing to a clearer understanding of the nature and meaning of the problem that was identified. By conducting a literature review, the researcher conceptualised the research problem and located it in a body of theory (De Vos et al., 2011: 134-135). The literature review thus positioned the research study in a broader context. It also indicated if the researcher has identified gaps in previous research and showed how the study has filled a demonstrated need (Delpont, Fouche & Schurink, 2011: 302).

In this research the literature review focussed on an understanding of social work supervision within the context of the Department of Health in the Western Cape. Published books, journals both local and international, articles and theses were used.

3.3.2 Population and sampling

Bless et al. (2011: 98) define a sample as the “subset of the population which is investigated by the researcher”. Sampling is therefore used in research to determine feasibility, as it is seldom possible when conducting research to use the entire population (Strydom, 2011: 224). The term population however sets boundaries on the study units as it refers to individuals in the universe who possess specific characteristics. De Vos Strydom, Fouchè & Delpont, (2002: 198) define the universe as all potential subjects who possess the attributes in which the researcher is interested. For the purpose of this research the main focus included social workers, employed by the Department of Health, Western Cape as production workers for more than two years.

The type of sampling used needed to be specified. Strydom (2011: 232) describes purposive sampling as being based on the judgment of the researcher in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population that serve the purpose of the study best. By using this sampling method the researcher ensured that the individuals selected met the inclusion criteria of the study.

The criteria for inclusion in the sample study were:

- a) Social workers employed by the Department of Health, Western Cape.
- b) Social workers employed as production social workers.

Once the Department of Health approved the request to conduct the research, the researcher approached the management of the health facilities listed below requesting permission to interview their social workers:

- 10 Primary Health care facilities across the Cape Town district
- 4 District hospitals
- 1 Regional, Tuberculosis, Psychiatric and Rehabilitation hospital
- 2 National Central Hospitals
- Red Cross Children's Hospital

When permission was granted the researcher requested the contact details of the most senior social worker. The researcher approached him/her in writing explaining the research and requested the names of social workers who would be willing to be interviewed. The researcher then proceeded to contact the social workers to arrange appointments to meet with them. Some social workers may have felt that they do not have a choice if they were approached by management. The researcher therefore checked with individuals regarding their willingness to participate by providing them with all the necessary information to make an informed decision.

4. METHOD OF DATA COLLECTION

Data analysis is a search for patterns in recurrent behaviour, objects or a body of knowledge (Neuman, 1997: 426). The researcher did data analysis as a means to organize and structure data obtained during the empirical study in such a manner that a meaningful

conclusion could be reached (Polit & Beck, 2005: 570). The researcher applied a qualitative research approach and as such, semi-structured interviews were the data collection method. De Vos, (2002: 302) asserts that semi-structured interviews can be used to gain a detailed picture of a participant's beliefs, or perceptions, or accounts of a particular topic whilst giving the researcher and the participant much flexibility. The research aimed to elicit the experiences of the significance of supervision by social workers and as such one on one interviewing allowed for a more meaningful interaction between the researcher and participants.

For this study, 17 production social workers in the Department of Health, Western Cape were interviewed using the semi-structured (Refer to appendix E) method of interviewing, which is defined as "those organized around areas of particular interest while still allowing considerable flexibility in scope and depth" (Greeff, 2011: 348). The researcher stopped the interviews once she reached a point of saturation, which was after interviewing 17 social workers. Monette, Sullivan and De Jong (2005: 242) describes saturation as occurring when the researcher no longer learns anything new, as all participants give similar responses to the questions.

To ensure that the research presents the true experiences of the respondents, each interview was tape recorded with the permission of the participants. Tape recording afforded the researcher the opportunity to engage more actively during the interview process. This does however not mean that the researcher was not required to make written recordings of the interview. Greeff (2011: 359) proposes that field notes be done immediately after the interview as they provide a written account of all information gleaned in the interview.

5. DATA PROCESSING PROCEDURE

De Vos et al. (2011: 397) reports that the purpose of research is to produce findings which "involves the reducing of the volume of raw information, sifting significance from trivia and constructing a framework for communicating the essence of what the data reveal". Data analysis refers to the dissection of data into manageable themes, patterns, trends and relationships to gain an understanding of the various elements of the researcher's data and between concepts, constructs and variables, to see whether there are any patterns that can be identified (Fouché & De Vos, 2005: 108).

5.1 METHOD OF DATA ANALYSIS

Baxter, Killoran, Kely & Goyder (2010: 211-226) describes data analysis as the inspection of results to determine any relationships between concepts, constructs or variables to identify patterns or establish themes in the data. In processing the data, the information collected during the recorded interviews was transcribed to identify themes and correlations across the spectrum of the participants' experiences. The researcher transcribed and coded the data into themes to identify not only commonalities, but also unique themes. The transcribed notes were rechecked and compared with the field notes to ensure that the data had been correctly transcribed.

5.2 METHOD OF DATA VERIFICATION

a) Credibility

The goal of this is to ensure that the enquiry was conducted in such a manner as to ensure that the subject had been accurately identified and described (De Vos et al., 2011: 419,420). Lincoln and Guba (1985) describe credibility as confidence in establishing the truth of the findings. The same author writes that credibility can be established by staying in the field until saturation occurs, which will limit researcher biases and compensate for the effects of unusual or seasonal events.

b) Transferability

De Vos et al. (2011: 420) explain that this process is earmarked by the researcher, determining whether the findings of the research can be transferred from one situation to another. In qualitative studies this cannot be done as the sample of the population used to provide the data cannot be generalized to the entire population. Lincoln and Guba (1985) confirms this by stating that knowledge gained from one context will not have relevance for other contexts, but states that a thick description will ensure that sufficiently detailed descriptions of data will allow for judgments about transferability by the reader.

c) Dependability

The researcher needs to show that the research process was logical, well documented and audited (De Vos et al., 2011: 420). Dependability is shown by reporting in detail on

the study process, thus ensuring that any other researchers will be able to use the research even if they do not get the same results (Shenton, 2004: 71).

d) Conformability

In De Vos et al. (2011: 420), Lincoln and Guba (1999) elaborate on the importance of determining whether the findings of a study could be confirmed by any other study. There was however limitations in ensuring real objectivity as questionnaires that were used in the study were designed by humans. There was therefore a risk for researcher biases. The most important element of conformability is that of objectivity and thus measures were put in place to ensure that the work's findings are the results of the experiences of the participants (Shenton, 2004: 72). A key criterion for conformability is the extent to which the researcher acknowledges his/her own predispositions (Shenton, 2004: 72).

6. REFLEXIVITY

By using qualitative data, the researcher was a primary instrument in the analysis of the findings, and it was therefore imperative that the researcher was aware of their feelings towards the subject area of their study and more importantly remained focussed on not allowing their feelings to influence the findings. This was significant in order to ensure that the researcher was able to recognise, separate and prevent their bias, feelings and opinions from influencing the overall research process (De Vos et al., 2011).

The researcher has been employed as a social worker within the Department of Health for more than 10 years. She has worked as a production social worker as well as a supervisor and therefore has experience of social work supervision within the Department of Health. It was thus important for her to remain aware of her own perceptions of the value of a social work supervisor.

The researcher used supervision by and regular personal reflection with her thesis supervisor to ensure that personal bias and feelings did not influence the research process or findings in any way.

7. ETHICAL CONSIDERATIONS

Strydom (2011: 114) defines ethics as the moral principles, suggested by people that are subsequently accepted by a wider group of persons. These principles offer rules and behavioural expectations about the most correct behaviour towards experimental subjects and respondents, other researchers, assistants and students.

The researcher is registered with the South African Council for Social Service Professions (SACSSP) as a social worker. She ascribes to the SACSSP's code of conduct. To conduct the study the researcher needed permission from the research and ethics committee of the Department of Health (Refer to appendix B) as well as the Departmental Ethical Screening Committee of Stellenbosch University (Refer to appendix A). The greater aim of university ethical review boards is to ensure that moral standards for research involving human subjects are upheld and that these key principles are adhered to: respect for persons, beneficence and justice (Christians, 2005).

Standards of research quality are closely linked with ethical standards. The following ethical issues were considered for the study:

- a) **Voluntary participation:** Participants had to be voluntary and thus no one was forced to participate (Rubin & Babbie, 2005: 71).
- b) **Informed consent:** As indicated above the researcher ensured that participants were informed regarding the goal of the research, the expected duration, procedures to be followed during the investigation and the credibility of the researcher (Strydom, 2011: 117). Participants signed an informed consent form (Refer to appendix F).
- c) **Violation of privacy/anonymity/confidentiality:** The research investigated the experiences of social workers of social work supervision in the Department of Health and as such it was important to assure participants that their identity would not be revealed to readers. Strydom (2011: 119) states the importance of keeping to oneself that which is not intended for others, to analyse and to safeguard the privacy and identity of participants.
- d) **Debriefing of participants:** The reality of qualitative fieldwork required the researcher to be responsive, sensitive and able to cope with other people's thoughts, feelings and issues; knowing how and when to refer problems to professionals and how to build trust and confidence within appropriate boundaries (Lincoln & Guba, 1985). The researcher

did however not probe emotional information as participants were interviewed on their views. It is for this reason that debriefing was not predicted but participants would have been referred to an appointed social worker if it was deemed necessary.

8. LIMITATIONS OF THE STUDY

De Vos et al. (2011) reported that limitations in a research study are important elements which the researcher needs to be aware of, recognise, acknowledge and present clearly. There were specific limitations to conducting this study. The literature available on social work supervision within a health context does not provide expansive reporting on the significance of it. The South African literature focuses on the supervision methods and functions (Mbau, 2005; Lourens, 1995). The number of social workers who were interviewed also meant that the findings cannot be generalized. The participants however represent all the spheres of health services, from primary to tertiary, which allowed for the gathering of rich information.

9. PRESENTATION

The final report comprises of 5 chapters:

1. Chapter one is an introduction to the study explaining how the study will be done.
2. Chapter two is the literature study contextualizing the Department of Health as an employer of social workers, describing the role of social work and its complexities as a secondary profession in the Department and explaining the role of supervision within this context.
3. Chapter three is a literature study conceptualizing supervision of social workers within the context of the Department of Health, with a specific focus on the significance of social work supervision.
4. Chapter four encompasses the empirical investigation of the experiences of social workers in the Department of Health on the significance of social work supervision.
5. The final chapter provides conclusions and recommendations linked to the literature review and the empirical study.

CHAPTER 2

THE PRACTICE OF SOCIAL WORK IN THE DEPARTMENT OF HEALTH

2.1 INTRODUCTION

In Chapter 1 the motivation for the research was explained. Social work is described as a profession with a firm foundation in the practice of supervision. This profession which started out as a voluntary service in charity organisations centuries ago, is now part of the interdisciplinary teams in health service settings. Social workers who are trained generically provide a psycho social service in medical facilities alongside other allied health professions. With social workers in the Western Cape having no specialized undergraduate training in health and medical conditions, this research aims to explore the significance of social work supervision for social workers in health facilities.

As indicated in the previous chapter, the first objective of this study is to present an overview of social work in the Department of Health, which will include a historical overview to contextualize the current state of health services in South Africa. This chapter incorporates a description of the role of social work and its complexities as a secondary profession in health facilities. It will also provide an understanding of the Department of Health as an employer of social workers, the functioning and management of interdisciplinary teams, and the role of medical social workers.

2.2 THE DEPARTMENT OF HEALTH

2.2.1 Historical context of health services in South Africa

South Africa's history is permeated with discrimination based on race and gender which has had a pronounced effect on the health of its people and the current health policies and services. From 1948, the state policy of Apartheid consolidated the political exclusion, economic marginalisation, social separation and racial injustices of the preceding hundreds of years (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). One of the most important

influences on the health of South Africans has been the impoverishment of the black population in the face of general white affluence (Coovadia et al., 2009).

Deficiencies in health personnel, facilities, equipment, funding and the racial fragmentation and politicization of health services perpetuated discrimination in health care access (Kautzky & Tollman, 2008: 21). By the end of the Apartheid era, there were 14 separate health departments in South Africa which were consolidated into one national and nine provincial health departments (Coovadia et al., 2009: 824).

However, the South African Constitution now binds the state to work towards the progressive realization of the right to health. Yet 21 years after democracy, the country is still grappling with massive health inequalities. There are marked differences in rates of disease and mortality between races, which reflect racial differences in the access to basic household living conditions and other determinants of health (Coovadia et al., 2009). A key remaining challenge for the new administration of health is to reduce inequalities and interprovincial and urban–rural differences with regards to access to health and its related services (Coovadia et al., 2009).

The Health Plan, published in 1994, was the post-apartheid model for health system change (Coovadia et al., 2009). It had its antecedents in the concept of primary health care and envisioned a system based on community health centres, in which children younger than 6 years as well as pregnant mothers would receive free health treatment. Primary health care became available without cost to users (Coovadia et al., 2009)

Despite some successes, the ability to take forward the new policy vision has been constrained by several factors, such as inadequate human resource capacity and planning, leadership and management (Coovadia et al., 2009). Despite the free provision of PHC and exemptions from hospital fees for the poor, costs associated with clinic and hospital visits (specifically transport and opportunity costs) remain a serious deterrent to health system utilisation (Kautzky & Tollman, 2008: 27). All of these factors impact on the need for social workers to support the psycho social needs of health care users. South Africa is a country still transitioning from its past history of fragmentation which has left the majority of the population struggling with severe psycho social stressors.

A central challenge of the health system has however been a reluctance to strengthen the management of human resources. In addition to this, there is a serious shortage of training, support, and supervision (Coovadia et al., 2009). This links directly to the research of the significance of social work supervision for social workers in health. Coovadia et al. (2009: 831) reported that, within the Department of Health in South Africa, the management system is ineffective and that the lack of supervision at the level of implementation of decisions is lacking. This could be perceived as a reference to the previous system which prescribed that only medically qualified staff could manage health facilities implying that a doctorate in medicine equips you to be a manager.

2.3 NATIONAL DEPARTMENT OF HEALTH

In under-developed and developing countries, healthcare systems are faced with challenges such as maternal and child morbidity which result in the escalation of healthcare costs and a shortage of human resources in the health-care system (Shezi, 2014: 1). According to Statistics South Africa, the province of the Western Cape however had the lowest poverty headcount (which can be regarded as indicative of an under or developing country) of all provinces in 2001 and 2011 but the intensity of poverty experienced was the second highest (Western Cape Government Health, 2015). These statistics can specifically be related to the need for quality social work services as it can be assumed that people accessing public health services are compounded by multi-dimensional elements of poverty. The prognosis for recovery from ill health is thus dependent on the psycho social interventions provided by social workers.

South Africa has a two tiered health care service: private and public health care. In 2011 the Gross Domestic Product spent on health was split as follows: R120.8 billion in the private sector which covers 16.2% of the population and R122.4 billion in the public sector which is made up of 84 per cent of the population (National Department of Health, 2015). Private health care is thus a service only accessible by a minority of the population. The government contributes 40 per cent of its expenditure on health, but the public sector provides health care services to approximately 80 per cent of the population (National Department of Health, 2015). This could have resulted in the public sector being under resourced with poor management. In previous paragraphs this disparity was ascribed to the history of segregation and the skilled medical staff being employed in the private sector (Coovadia et

al., 2009). There are 4 200 public health facilities in South Africa and approximately 13 718 people (files/cases) are treated per clinic, which is 37 per cent more than the World Health Organisation's guideline, with one person visiting a clinic an average of 2.5 times per year (National Department of Health, 2015).

This is further complicated by the high levels of unemployment and poverty which increases the demand on the public service health sector. To remedy all of this, the government has however responded with a plan to improve the quality of health services (Western Cape Government Health, 2015) which includes:

- a) Provision of strategic leadership and creation of a social compact for better health outcomes.
- b) Improving the quality of health services.
- c) Overhauling the health care system and improve its management.
- d) Improving human resources management planning and development.

These National Health Systems Priorities amongst others focuses on public health and human resource management as a means to upgrade and improve the quality of health services in preparation to implement National Health Insurance (NHI). The NHI is the government's attempt at redressing the inequalities of the previous health system by ensuring that everybody has access to the same quality health service thereby decreasing the private health sector (Western Cape Government Health, 2015). At least three of the points listed above refer to human resource management, which is a component of supervision thus relating to this research.

2.4 WESTERN CAPE DEPARTMENT OF HEALTH

2.4.1 Vision and Mission

The Department's vision is to provide person centred, quality care (Western Cape Government Health, 2015: 6). This relates specifically to holistic healthcare which focuses on the entire human being, that is, socially, emotionally and physically. The mission is to "provide equitable access to quality health services in partnership with the relevant stakeholders within a balanced and well managed health system to the people of the Western Cape" (Western Cape Government Health, 2015: 6).

In the Western Cape, with a population of 6 116 324 million (Western Cape Government Health, 2015), there are 516 public health care facilities providing the following levels of health care:

- 462 primary health care facilities
- 34 district hospitals
- 5 regional hospitals
- 2 national central hospitals
- 1 tertiary hospital
- 11 specialist facilities, that is, 6 for Tuberculosis, 4 for Psychiatry and
- 1 Rehabilitation facility (Western Cape Government Health, 2015)

The health care service is provided along geographical lines, which mean that the public must access the health facility that is located closest to their home. However, in instances where there are large amounts of the population occupying a smaller geographical area, this is problematic as people's access to health care is limited by the excessive waiting periods for service at primary health care facilities. The country also promotes a primary health care focus, that is, service users must access health at the lowest level which is normally a community health facility.

2.4.2 Health care service

The Department of Health has however embarked on a new direction as it became apparent that the level of disease within the country far outweighs the capacity of health services the government is able to provide. In the Western Cape, the Department has therefore cited increased wellness as its strategic priority explaining that it is not the absence of symptoms of disease which must be strived for but the improvement of overall wellness (Western Cape Department of Health, 2012). This is as a means to decrease the occurrence of chronic lifestyle diseases. It can however also be interpreted as the Department's realization that its secondary professions' services are central to achieving wellness which encompasses not only physical wellbeing but also emotional, financial and overall social wellness.

In the previous chapter the country's history was outlined describing high rates of disparity based on race and gender. This has caused high levels of poverty which influences lifestyle

choices which in turn result in diseases of lifestyle, for example diabetes (Coovadia et al., 2009). This in turn has led to many people seeking health services reactively, resulting in large sectors of the population needing chronic medication (Western Cape Government Health, 2015). The burden of disease on government funding has necessitated the need for refocusing, as health education and social wellbeing can alleviate the financial burden on government to provide health care services.

2.4.3 Interdisciplinary teams

It is because of the dire psycho social living circumstances, including unhealthy lifestyle choices, moral and material poverty which is linked to low education and high levels of unemployment and crime, which are outlined above within which the Department of Health allied health professionals are employed. These professions, also known as secondary services, function as part of multidisciplinary teams otherwise known as interdisciplinary teams. The term interdisciplinary implies the following: a group of professionals from different disciplines; who share a common purpose; embraces interrelatedness on a range of professional perspectives to guide their decision making; requires active communication; and role identification based on their expertise and commitment to collaboration (Abramson & Bronstein, 2004). The term interdisciplinary however inadvertently requires a focus on the term discipline.

A discipline exists from the moment a set of 'knowledge comes to be policed by a system of rules, which are applied in the purpose of transforming this knowledge into a body of knowledge" (Couturier, Gagnon, Carrier & Etheridge, 2008: 342). Based on this the profession is thus a discipline.

2.4.3.1 Functioning of interdisciplinary teams

Thompson's (2007: 562) critique of the process of interdisciplinary teams in health departments is that it creates an impression that the team engages in clinical meetings and family sessions where families voice their views or preferences regarding the treatment of the patient. The same author however goes further in postulating that inter professionalism in the health care community is an excellent way of maintaining a patient-centred focus (Thompson, 2007).

This thus confirms that the government's policies to improve health care which includes a patient centred approach may be achievable by the advancement of interdisciplinary teams. Fundamentally, the purpose of an interdisciplinary team is to undertake a holistic assessment, make professional recommendations and plan and provide the care for people who live with complex needs (Continuing NHS Healthcare National Programme, 2011: 7). It is the inclusion of the term complex which relates specifically to the public service users of the Western Cape which has the highest intensity of poverty (Western Cape Government Health, 2015) and as such, complex needs can be inclusive of social work service. Interdisciplinary collaboration is an effective and satisfying way to provide health care services (Drotar, 2002; Hanson, Spross & Carr, 2000; Robinson & Kish, 2001; Leipzig, Hyer, Wallenstein, Vezina, Fairchild & Howe, 2002). These authors thus all confirm the benefits of inter professional team work in health care settings.

In social work practice and health care settings, serving clients effectively is impossible without collaboration with professionals from other disciplines (Bronstein, 2003). Social workers are integral members of interdisciplinary hospital teams. They work with doctors, nurses and other allied health professionals, ensuring that they are aware of the social and emotional aspects of a patient's illness (National Association of Social Work, 2011: 1). The involvement of social work in the team makes a positive difference (Black, 2005).

This is why interdisciplinary teams that include social work have been associated with increased attention to patients' wishes (Black, 2005) and to "greater patient and family involvement in ethical decision-making processes that are inherent to health care situations" (Joseph & Conrad, 1989).

2.4.3.2 Functional Business Units

In South Africa, more specifically the Western Cape, inter-disciplinary teams are referred to as functional business units (FBU). The introduction of the functional business unit model is part of the government's quality improvement initiative for health services. It is a model of decentralised management where clinical teams under the leadership of a medical specialist are responsible to manage a clinical service (Western Cape Department of Health, 2012).

The FBU model promotes the medical discipline as being the leaders to whom all other staff needs to account, except nursing. There is no acknowledgement of the need for discipline specific supervision as the medical specialist is appointed as the head of the FBU. He/she is accountable for all professional clinical staff whilst a distinction is made for the FBU Nurse Manager to be responsible for the nursing staff (Western Cape Department of Health, 2012: 11).

It would seem that South Africa's implementation of the FBU model does subscribe to traditional hierarchical systems in which doctors are perceived to be the dominant profession in health care. Social workers are part of the allied health teams and therefore not essential to health, although health is classified to include overall wellness.

In addition, American academics state that professional education does however not adequately teach students from different professions who enter health services about the contributions made by other professions or about the skills needed for teamwork; instead, professional education usually emphasizes discipline-specific priorities (Forrest & Derrick, 2010; Interprofessional Education Collaborative Expert Panel (IECEP), 2011; Ramsammy, 2010). It can thus be postulated that professionals, including social workers entering the health system, are not equipped to function within the interdisciplinary model. In America, local service agencies have also flattened organisational hierarchies, replacing discipline-specific departments by new structures. Some hospital social work departments have been closed or downsized (Patford, 1999: 3).

However, in South Africa, specifically the Western Cape, many community health facilities face similar challenges as they have no social workers and those who do, have no access to supervision. The tertiary and specialized health facilities still have functional social work departments but not all of them have supervisors. The district hospitals have on average two social workers with no or limited access to social work supervision.

2.4.4 Interdisciplinary supervision

Within the functional business unit model there is no acknowledgement of the need for discipline specific supervision. As previously stated, the medical expert is the leader of the

team and all staff is accountable to him (Beytell, 2014). This can be interpreted as interdisciplinary teams being supervised by medically trained staff. It highlights the issue of interdisciplinary supervision which is defined as interactive learning between members of different professional groups (Owens et al., 1999: 278). Research conducted in New Zealand with interdisciplinary teams in health settings of whom one member was a social worker found that interdisciplinary supervision “deepened the exploration and level of understanding about supervision and encouraged participants to question taken for granted professional assumptions” (Davys & Bedoe, 2008: 58). Cleak (2014), writing from an Australian perspective, also confirmed this. She wrote that a similar system was implemented in Australia and even the United States, where social workers were managed within specified clinical service areas as opposed to their discipline (Cleak, 2014).

The result was that the role and specialized value which the profession of social work brings to health services was not recognized by hospital management (Barth, 2003; Globberman et al., 2002; Mazrahi & Berger, 2001). In South Africa within a climate of cost saving being pivotal to the survival of the public health care system, health services are constantly looking for ways to save costs and often it is then that this role blurring of social workers will disadvantage the on-going existence of the profession in health settings.

Interprofessional supervision however presents opportunities for learning and skills in practice development. It can be regarded as a means of internal up-skilling of professions. However, challenges can arise because of differences in status, values, language and theoretical orientation (Townend, 2005: 588). This supervisory process can therefore be a personal and professional challenge, as it requires the supervisor to constantly learn about and adapt to the professional needs of the supervisee. It is also a challenge for the supervisee who needs to be open and allow another (the supervisor) to learn about their profession and its associated values (Townend, 2005: 588). The same author goes further and states that both supervision and interprofessional working is complex and poorly understood processes, especially when combined.

After conducting a national survey of 107 Australian public hospitals, the results showed that professional departments formed the preferred source of identification for employees, meaning that staff preferred discipline specific supervision as opposed to interdisciplinary supervision (Boyce, 2001). Godden (2012) further reported that in England, social workers

who work in multidisciplinary teams express a lack of or inconsistency in the frequency of supervision. They also report poor quality supervision and in some instances, a lack of supervision given by qualified experienced social workers. Until relatively recently it was built into professional codes of practice in the United Kingdom that supervision must always be provided within a discipline (Emerson, 2004). They have thus moved away from interdisciplinary supervision.

It would seem that countries who had introduced a system of interdisciplinary supervision within health settings did not find it beneficial to the professional development of the staff. In South Africa, the Department of Social Development's Framework on Supervision (2012: 1) states that "The direct management of social workers by non-social workers often impacts detrimentally on the practice of the profession". There is thus evidence internationally and locally that promotes discipline specific supervision.

It is also indicated by other disciplines in the health sector. Jones, Bennett, Lucas and Muller (2007: 494) accentuate the importance of nurses being competent and being given support in order to render quality patient care and make appropriate decisions. A lack of supervision of community service nurses in the clinical area by experienced professional nurses thus seem to have a negative effect on the delivery of quality patient care, thereby promoting the importance of effective support systems.

There is therefore evidence supporting interdisciplinary supervision, but most authors referenced above promote discipline specific supervision.

National and international reports (Emerson, 2004; Department of Social Development, 2012) confirm that discipline specific supervision of social work is important. The Functional Business Unit model however promotes interdisciplinary supervision, which negates the significance of discipline specific supervision and the development of leadership amongst allied health staff. One of the Department of Health's most progressive quality assurance initiatives however promotes patient centred care which speaks to developing discipline specific leadership (Western Cape Department of Health, 2012).

2.5 THE PROFESSION OF SOCIAL WORK WITHIN THE DEPARTMENT OF HEALTH

The chapter has thus far outlined the Department of Health as an employer of allied health staff which includes social workers. It has elaborated on the current management situation within inter professional teams which is the backbone of service delivery to patients. The next section will focus specifically on the profession of social work as an employee in the health department.

2.5.1 Defining the profession of social work

The international association for social work defines the profession as follows: “Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing” (IAASW Website, 2014).

Olickers (2013: 49) confirmed this by reporting that social workers are skilled in using theories of human behaviour and social systems to provide their social interventions. The implications of rendering social work services are that it requires trained people to work with people with personal problems and with problems in their environment. It can thus be deduced that a social worker has to be able to use their personal qualities, the knowledge they gained by training and their social work skills and techniques in the professional activities.

It is therefore that the profession of social work’s global definition, as outlined in a previous paragraph, describes it as a profession that encourages positive social development within a society that embraces human rights and the optimal capacitation of human beings (IAASW Website, 2014). The values of social work evolved from humanitarian and democratic ideals. It is based on respect for the equality, worth and dignity of all people (Wolpert, 2005: 96). Various authors further define social work practice as the “application of an eclectic knowledge base, professional values and a wide range of skills to target individual, familial,

group, organizational or community systems for change” (Bogo & Taylor, 1990; Kirst-Ashman & Hull, 1997; Kirst-Ashman, 2013; Teigiser, 2009).

Social workers are thus change agents who improve the wellbeing of their clients. They must develop evidence based practice and culturally sensitive care as they position themselves to be leaders and active participants in health care administration and as part of interdisciplinary teams (Galambos, 2013: 13). The discipline of social work has much to offer the team in its movement toward providing a patient centred approach to health care. This does link the profession directly with the Department of Health’s strategic priority to improve wellness of its service users (Western Cape Department of Health, 2012). It would thus seem that the profession is strategically placed within this Department.

2.5.2 Generic training of social work versus specialized service of health

Health is a specialized service field. Social workers are trained generically and the training is similar to that of psychology, reports Patford (1999) writing from an Australian perspective. Social workers (including those in South Africa) may however experience more challenges in projecting their identity, demonstrating competencies and skills and most importantly demarcating occupational territory (Patford, 1999: 5). Morales, Sheafor and Scott (2012: 43) however wrote that human problems are complex and social workers need a range of skills and methods to practice effectively. Thus, the objective of baccalaureate-level social work programs is to graduate students who are competent and skilled in working with diverse populations and in diverse practice settings.

Maguire (2002) explained that generalist social work relies on the biopsychosocial function. It acknowledges that individual problems that require the interventions of a social worker are linked to either a biological, psychological or social problem. Williams, Crayton and Agha (2014) goes further in stating that generalist social work professionals master the core knowledge, values and skills to empower service users, navigate a variety of host settings and evaluate service outcomes to improve the quality of client services by using the problem-solving process, critical thinking skills and the strength-based perspective, yet are expected to provide a service within the specialized field of health.

2.6 THE ROLE OF SOCIAL WORK IN HEALTH

Social workers have an important role to play in health settings as they help patients and families deal with the impact of illness and treatment. Within the Department of Health there is however no standardized document outlining the role of social work. In relation to the discussion above regarding the generalist training of undergraduate social work, the job purpose of a social worker is defined as providing services through the promotion of social change, problem solving in human relationships and the empowerment and liberation of people to enhance social well-being (Department of Public Service and Administration, 2008).

It must however be stated that this job purpose is designed by the Department of Social Development specifically for the generic functioning of their social workers, is similar to the global definition of social work and therefore seems to be applied across all areas of service in South Africa. Beytell (2014:173) writes that “the tasks and roles of a social worker in a health context will differ depending on the level or specific focus of care”. Hospital social workers practice in increasingly specialized environments and are frequently assigned to specific medical units that are based on diagnosis, age or gender (Gibelman, 2005).

Examples of social work specialization within a hospital include paediatrics, oncology, nephrology, transplant and emergency/trauma. In addition to clinical roles, social workers are also employed in hospital leadership roles and may serve as managers or administrators for specific hospital programs such as mental health, aging or community outreach (National Association of Social Workers [NASW] Centre for Workforce Studies & Social Work Practice, 2011: 1). In tertiary medical settings, social workers conduct psychosocial assessments and make recommendations to medical experts who determine life or death for patients needing heart and liver transplants (Caputi & Heiss, 1984; NASW Centre for Workforce Studies & Social Work Practice, 2011). In specialist psychiatric facilities social workers make diagnostic assessments and recommend treatment programmes for patients to the multi-disciplinary team (Patchner & Wattenberg, 1985; Wolock & Schlesinger, 1986).

2.6.1 The international perspective

According to the International Association of Schools of Social Work (2014), the social work profession's core mandates include promoting social change, social development, social cohesion and the empowerment and liberation of people. However, as indicated earlier, there is no universally accepted idea of a valid set of knowledge, skills or expertise for social workers but a common agreement that social work is committed to human rights and justice and to help those who are suffering due to social inequalities (Jones & Truell, 2012).

The purpose of social work, therefore, is to enhance the problem-solving and coping capacities of people. It strives to link people with systems that provide them with resources, services, and opportunities that will contribute to the development and improvement of social policy (Triegaardt, 2012). Within a health facility it is therefore the social worker who is best equipped to obtain the social history and composition of the family from the patient and to share this information with all the members of the interprofessional team (Thompson, 2007: 562). This role is further described as social workers helping patients and their families to understand a particular illness by working through the emotions of a diagnosis and by providing counselling about the treatment decisions that need to be made (NASW Centre for Workforce Studies & Social Work Practice, 2011: 1).

Social workers also took on the role of educating patients, assisting in navigating the health care setting and providing the link between the hospital and community sectors (Crisp, 2000; Judd & Sheffield, 2010).

The NASW Centre for Workforce Studies and Social Work Practice (2011) listed the following tasks of a social worker in a health setting:

- Comprehensive psychosocial assessment and evaluation of patient and families;
- Helping patients and families understand the illness and treatment options, and the consequences of the various treatments or treatment refusal;
- Helping patients/families adjust to hospital admission; possible role changes due to the admission and illness; exploring emotional/social responses to illness and treatment;
- Educating patients on the roles of the interdisciplinary team members; assisting patients and families in communicating with one another and to members of health care team;

- Educating patients on the levels of health care (that is acute, sub- acute, home care); and community resources;
- Facilitating decision making on behalf of patients and families;
- Crisis intervention;
- Diagnosing underlying mental illness; providing or making referrals for individual, family, and group psychotherapy;
- Educating health teams on patient psychosocial issues;
- Coordinating patient discharge and continuity of care planning;
- Promoting patient referral pathways;

Research conducted in 27 health facilities in New York subsequently yielded this description of the role of social work by a medical professional: “The social worker is a jack-of-all-trades” (Mizharhi & Rizzo, 2008: 113). The role which social workers hold in health settings in Australia is explained as having broadened and has moved beyond the immediate medical concerns of patients into the broader ecological context and its impacts on health (Crisp, 2000; Judd & Sheffield, 2010).

The Australian perspective is that psychosocial assessment, education and information, discharge planning and referral are the main activities of social workers in hospitals (Cleak, 2002). A more recent study interviewed 90 social workers working with adult cases in a number of health networks in Melbourne, Australia (Nilsson, Joubert, Holland & Posenelli, 2013). The findings demonstrated that the hospital social work role is multidimensional across a number of domains but centres predominantly on assisting clients and their significant others with issues of altered social roles and functioning, particularly in relation to role responsibility, dependency and managing associated role-change losses (Nilsson et al., 2013: 291)

The objectives of social work are thus to help individuals, families, communities and groups of people who are socially disadvantaged and to contribute to them conditions that will enhance their social functioning and prevent breakdown.

2.6.2 The South African perspective

The South African Council for Social Service Professions (2007) reports that social workers in health settings assess the psychosocial functioning of patients and families and intervene by linking patients and families to support community services. They also do supportive counselling and psychotherapy.

Wolpert stated that the realization of the importance of social work services in health was due to the development of an understanding that a patient's disease cannot be treated effectively without taking into account his social circumstances (2005: 90). Within the Department of Health, social workers are viewed as key strategic resources in addressing the needs and challenges of society. Their diverse knowledge and skills make them a resource to the social development sector and other sectors which include health (Department of Social Development, 2006: 7).

In her research on social work services in mental health, Ornellas (2014) stated that although social workers continue to perform their traditional tasks of working with patients and families to ensure improved communication between them and health service providers, they are also now performing tasks such as case management (which includes assessment, planning, co-ordination of services and crisis intervention), psychosocial support, family therapy and facilitation of reintegration into community living for persons with mental health conditions.

Olckers (2013), who had also done research on the need to provide social workers who work in the field of mental health specialist training on the use of the diagnostic statistical manual, described the role of the social worker in mental health as providing counselling and psychotherapy to individuals and families etc., participating in relevant legislative processes, maintaining, restoring and improving psychosocial functioning and facilitating interaction and relationships between service users within resource systems.

It is therefore that doctors and administrators see that it is absolutely important that there are social workers at each health facility integrated into the delivery of services. A mental health team without a social worker can't achieve the required results in terms of looking at the person holistically. Social workers are critical to delivering quality health care (Mizharhi & Rizzo, 2008: 113).

One of the biggest national health facilities in the Western Cape (Groote Schuur Hospital, 2015) lists the following key performance areas for a social worker:

- a) Provide a social work service in an assigned clinical area by assessing the needs of patients, interviewing and counselling patients and families and attending clinical rounds.
- b) Administration and management, which include amongst others report writing, recording of clinical notes and statistics.
- c) Education by providing student training, staff training and self-development.

The mental health care facilities have the following key outputs (Valkenbeg, Alexandra and Lentegour Hospital, 2015):

- a) To provide clinical intervention and facilitate rehabilitation of service users by attending clinical meetings and working within multi-disciplinary teams.
- b) Social workers have to do psychosocial assessments, design treatment plans and act as primary liaison between families and service users and community resources.
- c) In mental health, social workers also have a vital role in ensuring that the regulations of the Mental Health Care Act are adhered to for service users and are often called upon by the Mental Health Review Board to account for this.
- d) Advanced project management by identifying, developing and managing projects that are relevant to service users and in line with the Department of Health's operational requirements. This involves community outreach, awareness programmes and capacitating community based service providers to not discriminate against persons with disabilities.
- e) To utilize resources and network with relevant role players by establishing community partnerships as many service users require support with placement and supported living upon discharge. The social work service is often critical in determining when a patient can be discharged.
- f) To contribute and participate in the training of social workers and others.

Social workers thus function as part of the multi-disciplinary teams assessing the needs of patients and intervening accordingly. Some of the ethical dilemmas include having to make recommendations for life saving surgeries based on people's living conditions, bearing in mind the country's history of inequality. Social workers often have to advocate for the rights of patients even when the rest of the health team disagrees with them. Skills and knowledge required include amongst others: analytical, assessment, knowledge about diagnosis,

medication, functionality, a broad knowledge of the law and all relevant legislation, negotiation skills and clear concise communication skills. In both examples of key performance areas cited above, training of other social workers is indicated.

However, within the current health system this is not reflected. Social workers based in community health facilities have no access to social work supervision. They report to a facility manager who functions as an administrator. In primary health care services there is no post for social work supervisors (Department of Public Service and Administration, 2008). The most senior social worker will provide support and mentoring to the more junior social workers but the social work service reports to a medical professional. Informal consults with these social workers reveal how frustrated and unsupported they feel. In tertiary and regional hospitals there are social work supervisors and social work managers. The supervisors however have a clinical load too. In the four mental health facilities in the Western Cape there are few supervisor posts and only two social work manager posts.

A social worker within health care with generalist undergraduate training and as indicated above have limited, if any, access to social work supervision must make choices reflective of the patient's needs and service demands. Without access to social work supervision, she/he must understand the health care system and processes to access health services (Wolpert, 2005: 93). There can be no doubt that social workers in health thus need expert knowledge regarding health conditions in order to be fully effective within this sector of service. This emphasizes the importance of the supervisory role in teaching newly appointed social workers about the specialized knowledge required within a health setting.

Within a health system where hospitals are experiencing an increased demand for health services with no matching of resources to meet the demand, the profession of social work has to review its role and show capacity to adapt to change in the practice situation. The objectives of social work services within health services also include: humanizing the hospital experience for patients by offering emotional and practical support; acting as advocates for patients; offering education about their disease process and coping strategies; and, together with the interdisciplinary team, planning for discharge which includes assessment and referral to appropriate community agencies (Thornton, 1997).

Their role in speedily affecting the discharge of patients to meet the demand for beds will have to be balanced with their role of managing more complex medical conditions and the resulting intricate psychosocial implications (Cleake et al., 2014: 209). This once again relates to the significance of social work supervision for the generically trained profession of social work within health, who will require the support and education that supervision provides to meet the requirements of their practice within health.

2.7 NEED FOR SOCIAL WORK SUPERVISION

Despite all of this, social work services in health are also not recognized (by the South African Council for Social Service Professions) as a specialized field of practice. This is why the profession of social work is unique within health, as social workers receive no specialized training at undergraduate level to adequately equip them with knowledge regarding health conditions. Management of health facilities can thus define the social work service based on their recognized needs.

It is for these reasons that Harmse (1999: 17) states that the social worker needs a supervisor who is available within the organization with whom he/she can share responsibility for decision making, from whom they can receive direction and to whom they can look for support.

2.8 SUMMARY

This chapter has elaborated on the Department of Health as an employer of social workers within the historical context of South Africa. The contextualization is especially imperative to explain the importance of the social work profession within the department in lieu of its quality improvement initiatives. The profession of social work is described as providing an essential service towards achieving the goal of patient centred care. This chapter has also shown how the allied health staff is managed within the department under the auspices of the FBU model. The legacy of inequality and disparity which the department is trying to overcome makes mention of the human resource incapacity but no reference to the supervision of social work. Lastly the role of social work within the Department of Health was described as a means to introduce the next chapter which will focus on the aspect of supervision of social workers.

CHAPTER 3

THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION

3.1 INTRODUCTION

In South Africa the public health services have needed to implement quality improvement strategies as a means to improve its focus on patient centred care. This has placed a lot of emphasis on aspects of staff capacity to provide the quality of service required. The importance of wellness for staff and service users has become pivotal in achieving the Department of Health's goals (Western Cape Department of Health, 2012).

The profession of social work, which is part of the allied health team as is articulated in the previous chapter, also has to aspire to improved service delivery on par with the department's goals. As an important element in delivering social work services, supervision is central to achieving quality assurance but has a particular role in developing a skilled and professional workforce (Hafford-Letchfield, Chick, Leonard & Begum, 2008). Supervision is an indirect practice within the context of a human service organization, such as the Department of Health (Hoffman, 1990: 206)

In other contexts, such as Australia, a study that was done into why some social workers have chosen to remain in the profession for many years, supervision was reported by all participants as being important for their wellbeing, as well as the reason they were still practicing social workers (Chiller & Crisp, 2012). This research focuses on the profession of social work within the Department of Health and the significance of social work supervision for them. The previous chapter covered the relevant aspects of the Department of Health as the employer and how the profession of social work as part of the allied health team functions within this service.

A former South African Minister of Social Development (Skweyiya, 2006) describes the purpose of social workers as assisting the most vulnerable citizens in any society. In Chapter 2, the researcher elaborated on how people in South Africa suffered social injustice, highlighting the need for and importance of services rendered by social workers (Coovadia et al., 2009). In this chapter, social work supervision will be conceptualized, its

historical development outlined and the essence of supervision to the profession of social work explained. This chapter will explore the significance of social work supervision within the context that social workers have no specialized training in health, is the only allied health discipline not recognized by the health professions council, has to report to medically trained managers who are not qualified social workers and has limited and in most instances no access to social work supervision.

3.2 CONCEPTUALISATION OF SOCIAL WORK SUPERVISION

Botha (2000), an author and academic in the field of social work, already reported on how the need for supervision has been debated. The on-going financial pressures and reduction in resources including human resources has led to the continued existence of supervision and its effectiveness being questioned.

3.2.1 Context in which supervision occurs

Supervision occurs within a context where there is on-going synergy between theory and practice, values, fears and intrinsic conflicts (Riva & Ratsika, 2015: 178). In research done in the health department in Limpopo, Mbau (2005: 20) explains that supervision is geared towards benefiting the social worker, the agency clients and the agency where the social worker is employed. Despite the important role of social workers as stated earlier, there are however several risk factors observed in the social work profession which include amongst others work overload and staff shortages, depression, secondary traumatic stress, compassion fatigue, burnout and poor supervision (Truter, 2014: 6). In the previous chapter it was reported that allied health disciplines under the FBU model are managed by medical experts with often no access to social work supervision, possibly accounting for the poor supervision (Truter, 2014).

Adding to this, within the Department of Health as is the case in many sectors, social workers are often required to work with individuals who do not wish to be helped and who can be aggressive or even violent towards them (Coffey, Dudgill & Tattersall, 2009). This on-going exposure to trauma makes social work an emotionally draining and demanding profession (Dollard, Winefield & Winefield, 2001; Guy, Newman & Mastacci, 2008; Russ, Lonne & Darlington, 2009). Within other provinces in South Africa health care staff is being paid a

danger allowance as government recognizes the risk to staff within health services of being victims of violence within the work space or the surrounding environment.

In the Western Cape there are on-going discussions in the Bargaining Chamber, the labour and employer interface, regarding the roll out of a danger allowance for health care providers as the current proposal excludes social work. Social work is thus not perceived as being in the front line, yet they often have to be the bearer of difficult news to families and the fact that most of their work gets done in private increases the risk for harm from service users, for example mental health care users and primary health care users.

Supervision must therefore be understood as one of the fundamental tools to offer and to ask for in order to carry out one's work well in help relations (Riva & Ratsika, 2015: 184). It is pivotal as part of a path of lifelong education, going through stages of experimentation, evaluation and redesigning, facing constant monitoring of the needs and learning of the individual or of the team (Barker, 2003; Hawkins & Shohet, 1989). Morrison and Wannacot further assert that supervision is "an integral element of social work practices" (2010: 1). This confirms that it is part of the practice of social work, thus not optional but rather imperative.

In social work, supervision is not just line management or assessment of performance. It includes support, education and other activities (Australian Association of Social Work (AASW), 2010: 8). The context of social work supervision includes four elements: a supervisor, supervisee, client system and a work context. The first two elements are the direct elements within the supervision process, with the latter two being incorporated into the process (Hawkins & Shohet, 2006). The content of social work supervision further addresses four main areas: direct practice, professional impact, continued learning and job management (Kadushin & Harkness, 2002; Shulman, 2010). Supervision is thus an inherent part of the social work profession as it fosters quality, efficient service to clients.

3.2.2 Definition of supervision

Supervision is a formal engagement between a more senior, appropriately qualified and experienced social worker and a more junior social worker where the latter can review and reflect on their work (Ford & Jones, 1987; Hawkins & Shohet, 1989; Hoffman, 1990; Corey

et al., 2014; Zorga, 2002; Mbau, 2005; Tsui, 2005; Ingram, 2013; Kadushin, 2014; National Department of Social Development, 2012). Therefore, social workers in health who are managed by a medically qualified professional are not receiving supervision.

Supervision furthermore ensures that supervisees are equipped with advanced knowledge to apply their skills and abilities to client populations in an ethical and competent manner (National Association of Social Workers, 2013: 7). This links directly with the health service because social workers, as previously indicated, are generically trained (Williams et al., 2014) and thus require additional specialised knowledge about health conditions to improve the effectiveness of their service. Supervision therefore interrupts practice as it supports unlearning whilst facilitating new learning. Social work supervision will enhance the quality of health services as new learning can be interpreted as the learning required provide for a service of excellence to health care users. Supervision helps to make new connections and helps supervisees to think systemically (Carroll, 2009: 218).

Supervision plays a leading role in university training for educators, social workers, psychologists, tutors, teachers and nurses because it tries to connect the theory with practice. Supervisors are experts with university training but also with great experience in the field (Riva & Ratsika, 2015: 180). It is thus not only used by social workers but also by other professions.

4.2.2.1 *Interface between supervisor and supervisee*

“Professional supervision is defined as the relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanour and ethical practice take place” (National Association of Social Workers, 2013: 6). It is a process by which one worker is given responsibility by the employer to work with another worker(s) in order to meet organisational, professional and personal objectives, which together promote the best outcomes for their service users (Ford & Jones, 1987; Morrison, 2005).

It is the relationship between a more senior and junior colleague striving to achieve the service goals of the organization by applying and adapting the theoretical teachings of their profession to the needs of the clients within the broader community in which they practice.

Within the Department of Health there are few social work supervisor posts. As indicated in the previous chapters, social workers need to report to medically trained staff who manages them but do not supervise them. This is largely due to the fact that medically trained staff cannot guide them to adapt their theory to practice.

3.2.2.2 *Importance of monitoring in supervision*

The National Department of Social Development (2012: 8) defines supervision of social workers as an “interactive process in a positive non-discriminatory relationship, based on distinct theories, models and perspectives of supervision” entailing administrative, supportive and educational functions. Mbau (2005: 20) describes it as monitoring the performance of social workers in such a manner as to improve the quality of services being rendered and to ensure that it is in line with the organizational goals. Du Plooy (2011: 14) confirmed this by stating that supervision enables social workers to grow professionally and personally. She goes further and reports that the supervisor does this by monitoring the work done by the social worker, evaluating it, developing the social workers knowledge and skills and supports the social worker within a positive working relationship.

Within the Department of Health, social workers report to medically trained managers who do not have adequate knowledge of the profession to monitor the work done by the social workers and comply with what is expected of a social work supervisor (Western Cape Department of Health, 2012; Beytell, 2014). It can therefore be postulated that social workers within health may not always provide good quality social work service to clients as there is no one who can correct their poor service if the manager does not know what the standard of service should be of a social worker.

3.3 HISTORICAL OVERVIEW TO MODERN TRENDS IN SOCIAL WORK SUPERVISION

In order to understand the modern/current trends in supervision, it is essential to present an overview of the historical development of supervision within the profession. This will also shed light on the issue of whether social work is a profession if the staff needs to be supervised.

3.3.1 Historical overview

3.3.1.1 *Globally*

Supervision can be dated back to the end of the 19th century in England, when the first forms of social work developed to meet the great increase in poverty and social deterioration (Riva & Ratsika, 2015: 179). Before the accreditation of social work teaching in academic settings, social workers were trained or mentored in agencies by experienced social work field educators who taught them what social work was. They were also shown how to perform social work tasks, how to build relationships with clients and how to develop self-awareness for effective practice (AASW, 2010: 8). All of this occurred before the accreditation of social work as a profession.

Expert social workers, called supervisors, used a method of dialogue and consultation to offer help and support to the younger social workers which was based on the master-apprentice relationship (Riva & Ratsika, 2015: 180). Supervision was thus used as a means to teach lay persons how to perform social work tasks, hence the reason why some experts in the field question the need for its continuance as social work is a profession implying that once you qualify as a social worker you no longer need a more experienced person to tell you how to practice.

4.3.1.2 *Nationally*

The history of social work supervision in South Africa is documented by Engelbrecht (2010: 325-327). He identified the following three distinct periods:

- a) **Emerging and dominantly administrative years, 1960-1975.** During this period, Du Plessis (1965) found that working conditions led to supervision not receiving its rightful attention which in turn impacted on service delivery. The previous chapter on the Department of Health and the lack of adequate resources seems to lean towards the profession within health moving back to this state.
- b) **Period of integrated supervision functions, 1975-1990.** In 1978 the first course on supervision was offered at a university in South Africa. There was thus an acknowledgement of the need and significance of supervision.
- c) **Times of change, 1990 and beyond.** The focus was on service delivery and although plenty of research was done on supervision it was not based on the South African

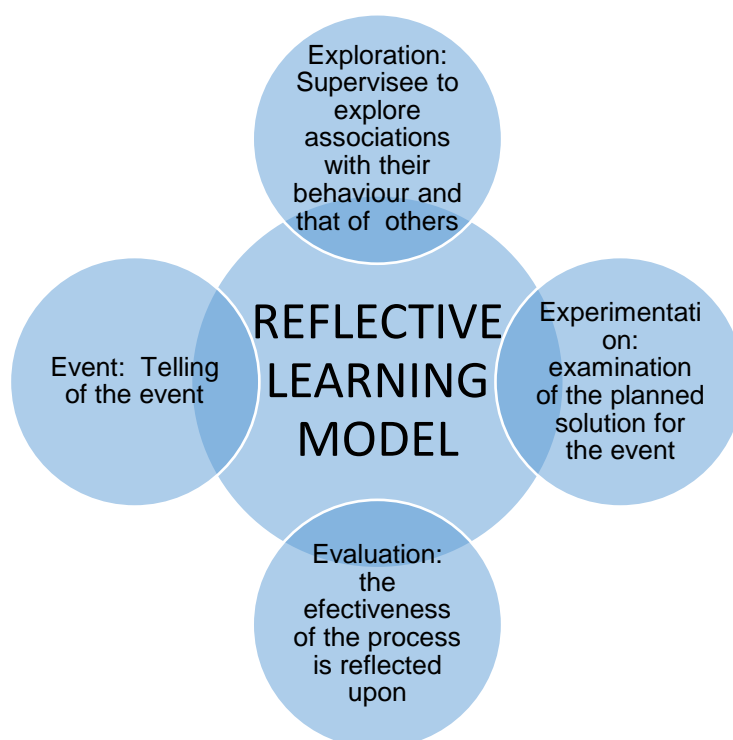
context. This has however been remedied by the research done by Botha (2002); Hoffman (1990); Engelbrecht (2010, 2012, 2013 & 2014).

3.3.2 Modern trends in supervision

3.3.2.1 *Reflective supervision*

Supervision in social work is traditionally known to develop reflexive knowledge and opportunities for learning. The partnership between dialogue and reflection, which are integral to supervision, are essential elements contributing to organizational trust (Kramer, 1999). Social work is about action and supervision helps practitioners to analyse their actions (Synnöve, 2003). The term analyse is significant as historically supervision was used to teach; now it is a means to reflect and develop a deeper understanding of practice. Davys and Beddoe (2010) developed the reflective learning model as shown in Figure 1.

Figure 3.1: Reflective learning model



This model might be difficult to apply in a busy medical setting, but the importance of reflection as a means to reduce burnout can never be minimized.

3.3.2.2 *Emotional Intelligence*

This is the ability to monitor one's own and others' feelings and emotions and to use the information to determine practice (Salovey & Mayer, 1990). It involves four processes: recognizing emotions, using it, understanding it and managing it. Within supervision the supervisor is responsible to support the development of emotional intelligence (EI) and ensure that supervisees are using it effectively (Engelbrecht, 2014). The same author goes further in stating that emotions are information and the ability to understand them is essential to practice.

Ingram (2013) wrote about the importance of incorporating emotional intelligence in social work practice. Prior to that, Hawkins and Shohet (2006) reported on how the supervisor must allow the display of emotion within supervision as a tool for learning. In the Department of Health, where social workers are managed by medically qualified practitioners, it can be postulated that the processes outlined above are not being engaged with. The risk for burnout can thus be greater when there is no processing of the emotional impact of the work.

3.4 APPROVED, ESSENTIAL VALUES FOR EFFECTIVE SUPERVISION

The Framework for Supervision (National Department of Social Development (NDSD), 2012) identified norms and standards for the practice of social work supervision in South Africa. This was done as a means to standardize social work supervision across all service areas and is evidence of the importance the most prominent employer of social workers within the country affords to the practice of social work supervision, which links directly to the current research. The following are the agreed upon minimum standards that an employer of social workers must adhere to.

3.4.1 Practice policy

Any employer of social workers must have a context specific policy based on the Framework (NDS, 2012: 20) outlining how they will provide supervision for social workers. It must include staffing ratios per supervisor, theoretical models underpinning the practice of supervision and a non-discriminatory practice. The researcher, having worked more than 10 years in the Department of Health and at different components of health, is aware that there is no such policy.

3.4.2 Legal prescripts

The supervision of social workers is mandated by the South African Council for Social Service Professions' Code of Ethics (SACSSP, 2007) and Social Work Act (RSA, 1978) which states explicitly that social workers must be supervised by social workers. A person supervising a social worker must be a qualified, registered to practice social worker, with relevant experience in supervision (NDS, 2012: 22). This does not occur in the Department of Health. In Chapter 2, literature reported how the decentralized model of management is leaving social workers in district and community health care centres with no social work supervision (Beytell, 2014). These social workers are managed by medically trained staff. The Department of Health as an employer of social workers is thus in contravention of legislative mandates regarding the provision of social work supervision.

3.4.3 Practice of social work supervision

The profession of social work has a Code of Ethics which should be ascribed to in the practice of supervising social workers (SACSSP, 2007). The Department of Health can thus not comply with this as their managers of social workers are not trained social workers. The Framework provides specific guidelines for the provision of supervision for newly appointed inexperienced social workers versus experienced social workers who are new to an organization (NDS, 2012: 22, 23). Chapter 2 outlined that newly qualified social workers can be appointed in the Department of Health as there is no prescripts prohibiting this. They can however be employed in centres where they are managed by non-social workers and not receiving social work supervision.

In a meeting held for social workers in health at Tygerberg Hospital on 13/11/2015, an experienced social worker based in a primary health care facility reported on the frustration of working without supervision and support. Performance appraisals are done by managers who do not have knowledge of the profession and can therefore not evaluate if the service being delivered is in accordance with practice standards for social workers. The lack of knowledge of the profession further leads to poor planning regarding skills development for social workers and no support of the need for social workers to receive training. Social work was declared a scarce skill in 2006 (Department of Social Development, 2006) due to many qualified social workers leaving the country to work abroad. This declaration of the profession as a scarce skill has reaffirmed the significance of supervision as a means to retain social workers within the profession of social work in South Africa.

3.5 CHARACTERISTICS OF AN EFFECTIVE SUPERVISOR

Supervision contributes towards ensuring that a supervisee functions effectively and efficiently within an organization (Du Plooy, 2011: 14). A social work supervisor is responsible for the ethics applied by social workers within their practice and the ultimate work done by them (National Department of Social Development, 2012: 8).

Munson (1993) identified the following characteristics:

- a) **Reading:** the supervisor must be up to date with relevant literature to be able to guide and advise the supervisee appropriately.
- b) **Writing:** the supervisor role models to the supervisee how to maintain good records, compile comprehensive reports, draft proposals and write presentations.
- c) **Watching:** the supervisor needs to have excellent observation beyond what is reported by the supervisee.
- d) **Verbal communication:** clear and sound communication is the foundation of the supervision relationship.

These characteristics are key within the health department, as social workers not only require knowledge about the profession but also health conditions, confirming the importance of reading. Writing in medical files which can be subpoenaed to court and being able to write crisp process notes is crucial within health. The observing of work done is difficult within health as supervisors will not be based in the same office with the social workers and will often only see each other when they meet for supervision. Talking is what

health staff does a lot of, as social workers need to know how to remain visible within teams and how to communicate effectively. A good supervisor will thus be able to impart and model all of this to a supervisee.

3.5.1 Role of a supervisor

3.5.1.1 *In relation to the employer*

Skilled supervisors are responsible for the protection of clients, for the advancement of social work practice and for the professional development of the individual worker (Shulman, 2013: 11). A social work supervisor is an agency administrative staff member to whom authority is delegated to direct, coordinate, enhance and evaluate on-the-job performance of the supervisees for whose work he (or she) is held accountable (Kadushin, 1992: 20). Within health, where social workers are part of clinical teams, supervisors are not solely administrative staff as they also have a clinical load which often compromises their role.

4.5.1.2 *In relation to the employee*

The supervisor supports the social worker, imparts information, especially to less experienced social workers and those new to a particular organization, and they also help staff to identify and control their biases (Farley, Smith & Boyle, 2003: 125). Supervisors are professional role models for newly qualified social workers and bridge the gap between the agency and the experienced worker who is new to the agency.

“The supervisor is responsible for providing direction to the supervisee, who applies social work theory, standardized knowledge, skills, competency and applicable ethical content in the practice setting” (National Association of Social Workers, 2013: 6). This is not the case in the Department of Health where junior social workers can be employed without the support of a social work supervisor.

4.5.1.3 *In relation to the service user*

The supervisor is responsible to ensure that the supervisee provides competent, appropriate and ethical services to the client (National Association of Social Workers, 2013: 6). The supervisor ultimately guides and influences the service the client receives from the social worker. “In the South African context, supervisors are also challenged to fulfil the role of

researcher, owing to the scant research findings on supervision in the country in order to respond to unique local supervision issues” (Engelbrecht, 2014: 129).

Supervision thus impacts the quality of service clients receive. The lack of supervision and more specifically social work supervision can thus have dire consequences for the organization as it is directly linked to quality of service.

3.6 THE OPERATIONALISATION OF SUPERVISION

Different theories on supervision models and perspectives determine the course of the supervision process. The distinct phases in the process and the cyclical nature of the process are evident and have to be operationalized through specific tasks, which include supervision sessions.

3.6.1 Methods of supervision

For the purpose of this study the researcher will discuss four methods of social work supervision: individual, group, live and peer supervision. The supervisor can choose any of these methods depending on the needs of the organization and the social workers as well as the time available for supervision.

3.6.1.1 *Individual*

This is based on a one to one relationship which is structured planned sessions between a supervisor and social worker only. According to Kadushin (1992: 149) it is individual conferencing which has as its aim the fulfilment of administrative, educational and supportive functions of supervision. During this method the supervisor reviews the social workers’ work records and identifies teaching-learning points for the worker. Individual supervision promotes personal professional growth as it addresses individual needs (Kadushin, 1992). This can be linked to the strengths based model which is focused on the identification of the individual’s strengths as a social worker rather than problem driven. It is however time consuming, especially if the supervisor has more than one person to supervise as well as carry a dual function of supervisor and clinician as is the case in the Department of Health.

3.6.1.2 *Group*

Group supervision emerged as a powerful tool for social workers (Hensley, 2002: 108). In group supervision the supervisor is the team leader and the session is geared towards achieving the aims of supervision. All the group members are able to learn from each other and the supervisor (Skidmore, 1995). There are thus two sources of knowledge and learning, two elements essential to social work within health, which allows for a richer experience of supervision. It is however not useful for supportive and administrative supervision which is often more person specific.

3.6.1.3 *Peer*

In peer supervision there is no designated leader or supervisor. All the members are perceived as equals. The functions are similar to that of group supervision as there is sharing of knowledge and learning can take place. However, the risk of not having a designated leader or more senior person is that less experienced staff may not be able to contribute meaningfully to the discussion (Skidmore, 1995: 258).

3.6.1.4 *Live*

This involves direct observation of the social work practice via a one way mirror and gives opportunity for immediate guidance to the supervisee and is more popular in mental health settings. It also allows for a period of debriefing after the session. This method has advantages as it corrects inefficient practice immediately thus ensuring that the client receives good quality service, but it also holds a disadvantage in that the supervisee's practice may be negatively influenced by the added anxiety of being observed by superiors or colleagues (Skidmore, 1995). This method can also be disconcerting to the client who may be left unsure if he can trust the social worker to be able to function independently.

3.7 **FUNCTIONS OF SUPERVISION**

Professional supervision is regarded as having three distinct functions that involve:

- Administrative/ managerial support to achieve competent accountable performance,
- welfare and personal (to support the professional in work which may be complex and emotionally challenging), and

- professional development to ensure staff has the necessary knowledge, skills, values and ethics, and typically involves a less experienced supervisee and more experienced supervisor, who meet to discuss the work of the former.
- The fourth role relates to mediation (between the individual worker and the organisation, and between other professions) (Davys & Beddoe, 2010; Kadushin, 2002).

3.7.1 *Administrative/Managerial*

“Administrative supervision is oriented toward agency policy or organizational demands and focuses on a supervisee’s level of functioning on the job and work assignment” (National Association of Social Workers, 2013: 8).

Tsui (2005) describes the following administrative functions:

- **Planning** needed for supporting the supervisee to effectively plan their time as well as work load management.
- **Organising** refers to the act of the structuring of the pre-determined tasks of the supervisor. Principles of responsibility, delegation and authority are essential. The supervisor has the authority to delegate tasks but remains accountable for the execution thereof (Botha, 2002).
- **Activation** is the ability of the supervisor to delegate, communicate, encourage, direct, lead and discipline supervisees (Botha, 2002).
- **Control** measures the effectiveness or programmes of organization for quality assurance, protection of limited resources and effective planning.

The administrative function thus focuses on the establishment of sustainable good standards of work, compliance with organizational and professional policies and sound practice (Cloete, 2012). This cannot be done by a person who is not a qualified social worker.

3.7.2 Supportive

The provision of emotional support is what distinguishes social work supervision from other professions (Cloete, 2012). “Supportive supervision is underscored by a climate of safety

and trust, where supervisees can develop their sense of professional identity” (National Association of Social Workers, 2013: 8).

Tsui (2005) reported four forms of support:

- **Emotional support** which is expressed by an attitude of warmth and caring.
- **Appraisal:** where the supervisor affirms the work done by the supervisee.
- **Instrumental:** supervisor guides and assists supervisee towards effective service delivery.
- **Informative:** supervisor imparts relevant information for quality service delivery.

“Supervision contributes to the benefits that clients receive from clinical social work treatment” (Hensley, 2002: 108). There have been several recommendations aimed at encouraging retention of social workers. Foremost among these has been the call in Australia to recognise the importance of regular and supportive supervision (Brewer & Shapard, 2004; Kickul & Posig, 2001; Stalker, Mandell, Frensch, Harvey & Wright, 2007). Various authors, (Ekstein & Wallerstein, 1972; Kadushin, 1992; Munson, 1993) all address the issue of supervision as an antidote for burnout and stress.

3.7.3 Professional Development

Educational supervision “includes activities in which the supervisee is guided to learn about assessment, treatment and intervention, identification and resolution of ethical issues and evaluation and termination of services” (National Association of Social Workers, 2013: 8).

Supervision increases the production of knowledge and develops competences. It is a tool for the evaluation of strengths and criticalities of the work. Supervision must bring about changes in the depth of the understanding of events, and in recovering overlooked variables (Riva & Ratsika, 2015).

“Supervision is the creation of that free space where the supervisee lets herself tell back events of practice so that she hears herself afresh and invents in imagination how she can best be for her client in their next session” (Houston, 1990: 7). Supervision thus provides a reflective space for critical analysis of work done. It contributes to the professional

development of the individual, the development of confidence within the individual to provide a good quality service to their clients.

This confirms the important function of supervision to the professional practice of social work. It is aimed at developing reflective competences, capable of investigating the fundamentals of one's professionalism (Riva & Ratsika, 2015: 184).

3.8 THE PROCESS OF SUPERVISION

The process of supervision includes several functions and responsibilities which are interrelated. Each of them contribute to a larger responsibility or outcome that ensures clients are protected and receive competent and ethical services from professional social workers (National Association of Social Workers, 2013: 6).

The cyclical process of supervision that will be presented is based on a strengths model which postulates a focus on strengths, competencies, capacities, capabilities and resilience instead of problems and pathology. In a management context, this perspective is based on "concepts such as empowerment, capacity, ownership, partnership, facilitation and participation" (Engelbrecht, 2014: 32).

This model is considered to be the more appropriate within a developmental social service arena as is the case in South Africa (Engelbrecht, 2010). With the advent of democracy and the introduction of a human rights culture in South Africa, an atmosphere of uncertainty and blame can result in a defensive versus empowering practice (Cooper, 2005) where professional supervision becomes more focused on the avoidance of making risky decisions in the context of professionals' concerns about being pilloried in the media should 'things go wrong'.

3.8.1 Phases and associated tasks

The following illustrates the phases and tasks associated with each task in the cyclical process taken from Engelbrecht (2014: 144).

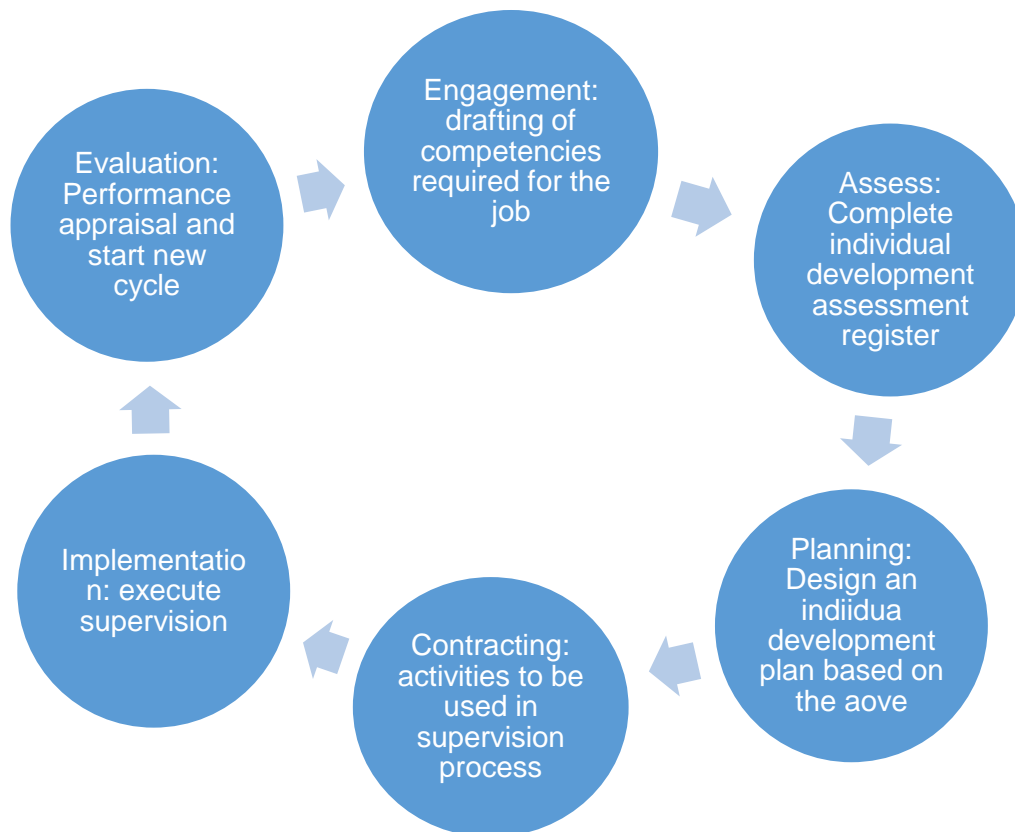


Figure 3.2: The cyclical process of supervision

The nature of a cyclical process allows for flexibility as participants can remain longer in one phase but also return to a specific phase if need be. It also infers the interminable nature of supervision.

3.9 SIGNIFICANCE OF SUPERVISION

Academics who report on supervision regard it as being out dated, and an insult to the profession (Engelbrecht, 2012a). Rabinowitz (1987:88) reports that the “quality of social work service delivery has always been determined by the quality of supervision”.

The supervision relationship is probably the single most important factor for the effectiveness of supervision (Kilminster & Jolly, 2000: 827). The service clients receive and the quality thereof is another determinant. “Therefore, improvements in outcomes for patients/clients are one major test of effective supervision” (Kilminster & Jolly, 2000: 827). In medicine, there is evidence to suggest that increased deaths are associated with less supervision of junior doctors (McKee & Black, 1992). It can also be inferred that no or poor

supervision of junior staff can lead to poor service outcomes. Research done in the UK on social workers' effectiveness and the effects of supervision on client outcomes were investigated in two geographically separate teams (Burke, 1997). Results demonstrated that client outcomes varied according to the social workers' experience/qualifications and supervision; more risk cases were resolved with additional supervision.

Characteristics of effective supervision as reported by Watkins (1997) are: empathy, support, flexibility, clear instruction, development of appropriate knowledge, interest in supervision, good tracking of supervisees, interpretative, respectful, focused and practical.

3.10 EMPIRICAL STUDIES' FINDINGS

Research findings confirm that the supervision of social workers contributes to competent professional practices that serve the best interests of service users (Gilbert, 2009 as reported in Engelbrecht, 2014).

Similarly research done in Australia's State of Victoria found that participants experienced common themes centering around the importance of supervision which included: its ability to act as a medium through which stresses and concerns can be externalized and explored. Social workers working in health and social care have been shown to experience higher levels of stress than the rest of the social service sectors (Walsh, Turner, Lines, Hussey, Chen & Agius, 2005; Health and Safety Executive, 2014) thus confirming the importance of supervision as a means to combat this.

According to research by Bogo and McKnight (2005), professionals valued the learning aspects of supervisory practice, such as the supervisors' practical knowledge of theory and interventions for social work, the importance of practice knowledge and the ability to be in agreement about what realistically can be expected to be achieved. Kadushin goes further and states that supervision "maximizes the worker's capacity to do his job more effectively and to help the worker feel good about doing his job" (1992: 20). Supervision is thus significant as it ensures efficient and effective social work services to clients. This seems to be the recurring theme when describing the significance of supervision: it benefits the client. In the context of the Department of Health it is thus aligned to patient centred practice.

3.11 STRATEGIC OBJECTIVE OF SUPERVISION

Supervision was thought to be useful to facilitate critical reflection and as an important forum for learning (Chiller & Crisp, 2012). “Supervision is a strategic withdrawal to meditate, contemplate and think about our work” (Zachary, 2000). Whilst paying attention to and reflecting on, social workers learn how to work differently and better. That is the goal of supervision: it’s an interruption of work to set up reflective dialogues through which staff learn from the work they do. They reflect on their experience affording the work the opportunity to teach them (Zachary, 2000). Supervision is also an opportunity to seek and receive emotional support for undertaking what can often be a demanding and stressful role (Carpenter, Webb, Bostock & Coomber, 2012: 1).

The profession of social work often places social workers in emotionally charged situations which could interfere with the workers’ objectivity. In these situations professional supervision is one of the most effective tools for facilitating and supporting individuals to contain and work with the anxiety that arises within social work.

The Department of Social Development (2006) reports that the inability to retain social workers is exacerbated by lack of support and poor working conditions social workers are subjected to. “Agencies that value and prioritise regular professional supervision have a greater ability to retain social worker employees” (Chiller et al., 2012: 239). This therefore supports the importance of supervision for social workers.

The Department of Health employs social workers in areas where they have no access to social work supervision. It can be inferred that this may result in high staff turnover and burnout. The employer’s actions can also be interpreted as self-sabotaging as social work practiced in a supportive environment that allows space for reflection can hugely impact on improvement of the patient’s experience of the health service.

In supervision the shift in the supervisee takes place in the supervision room and is then transferred to work (Hawkins & Smith, 2006), resulting in the implementation of the supervision discussion to improve the direct service to the health care service user.

3.12 SIGNIFICANCE OF SUPERVISION RELATIONSHIP ON QUALITY OF SERVICE

The interaction of a supervisor and clinician thus influences the interactions of the clinician and client, and vice versa (Hensley, 2002: 99). The concept stems from the idea that what happens between the client and social worker can be reflected between the social worker and supervisor. Kadushin (1985) refers to it as the parallel reflection process.

When positive interactions are happening between the supervisor and social worker, it can be deduced that there will be positive energy between social worker and client (Hensley, 2002: 99). This is the value that supervision brings to the practice of social work. Interminable supervision should thus be embraced as an asset in the practice of social work within an organization with a people centred focus (such as the Department of Health) as one of its fundamental principles (Engelbrecht, 2014).

Kadushin goes further and makes a correlation between the practice of doctors and social workers, but highlights that poor practice has effects which are easily detected in that patients die or remain ill. The effect of poor/inadequate social work service, especially in the health sector, is not easily detected thus emphasizing the importance of “periodic review of worker activity” (Kadushin, 2002:37). It therefore confirms the notion that supervision determines quality of service received by clients.

3.13 THE IMPACT OF SUPERVISION ON THE FUNCTIONING OF THE ORGANISATION

Social Workers work in bureaucratic organisations where supervision is required and as such, when a social worker commences work, they expect to be supervised. “Social agencies are concerned with problem situations that present a great danger to the community and where the community has a strong vested interest” (Kadushin, 2002:35). This leaves social workers needing to account to external agencies such as political bodies which approve policy and legislation which guides social work service. An example of this is the Department of Health’s patient rights charter and the development of core values, which prescribes the quality of service patients can expect in health care facilities and according to which social work services are monitored.

3.14 ACCOUNTABILITY TO SOCIETY

Kadushin (2002) highlights the importance of the community expecting a level of accountability for services provided by a social worker and as such, supervision is needed. Social work supervision is needed to respond to the clients' needs and the mandate of society to restore people to their full capacity (Farley et al., 2003). Social Workers can therefore never be fully autonomous, as their service is dependent on the community providing the clients and agency required within which to perform their duties.

The extent to which a community is willing to grant full autonomy to a profession is dependent on the level of consensus of the profession's objectives. Social work practice is a social science. The community as such is uncertain about the competence of social workers as the outputs cannot be easily measured to determine success, hence the need for oversight and monitoring in the form of supervision.

Social workers are bound by principles of confidentiality which implies that their work cannot be publicly observed. By doing this "we create an unusual situation of role performance invisibility and interdicted observability which leaves the client without effective protection from practice that might be damaging if there were no system for supervisory review of what the worker is doing" (Kadushin, 2002:37).

Persons requiring social work service often do not have a choice of where they can receive that service. The Department of Health service is based along geographical areas and level of disease. Communities accessing public health services have to go to the designated service provider (in the Western Cape that is the primary health care services). The provider thus holds the monopoly for service and as such, social workers do not "face the same kind of penalties that alert him/her to the need for examining and correcting his practice" (Kadushin, 2002:38). The need for supervision is thus great in such settings (yet as indicated before there are no social work supervisor posts in the primary health care facilities).

Kadushin (2002:36) states that where the objectives are unclear, the effects of interventions are unpredictable and the risk of failure is high, workers may need and want a supervisor with whom they can share responsibility. This need for shared responsibility is

included in the South African Council for Social Service Professions' Professional Code of Conduct (2007: 35) which states the following:

“(e) The supervisor could be held liable in an instance where a complaint of alleged unprofessional conduct is lodged against the supervisee/social worker”.

3.15 INTRINSIC VALUES

“If the process of occupational selection is deliberate, and the program of training is prolonged, the need for elaborate supervisory procedures is lessened” (Kadushin, 2002:39). The author further states that if professional training is to successfully teach the student to develop a professional conscience, then the supervisory function is internalized. The individual social worker thus becomes his/her own supervisor.

Kadushin reports that many people who pursue a career in social work are from previously disadvantaged communities. They do not have a familial history of social work graduates, which means their first exposure to the profession is either as recipients of the service or in their training. He therefore indicates that it is especially for this reason that the provision of supervision is important to instil professional values and the internalized supervisory function.

The above highlights the significance of supervision in the profession of social work with some specific links to the public health care service.

3.16 SUMMARY

If learning, professional identity, support, growth and mentoring have traditionally been gleaned from the supervisory experience, then making sure that supervision is a mainstay of agency and other practice situations is essential (Hensley, 2002: 108).

The significance of social work supervision to improve service outcomes, retain social workers in the profession and ensure compliance with agency/organisational processes have been outlined above. The profession of social work is based on supervision. Social

workers' most important tool in the fulfilling of their duties is themselves and as such, the support of supervision is pivotal to ensuring their professional wellbeing.

CHAPTER 4

EMPIRICAL STUDY OF THE EXPERIENCES OF SOCIAL WORKERS ON THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH

4.1 INTRODUCTION

The research was done to explore how social workers within the Department of Health experience social work supervision, including who they report to if they do get social work supervision, and what their needs are in terms of supervision. In this chapter, the findings of the social workers' experience of the significance of social work supervision within the department of health in the Western Cape will be presented. A qualitative study with semi structured interviews was done with 17 production social workers.

SECTION A

4.2 RESEARCH METHOD

A qualitative approach was used to gather “a dense description of reality as perceived” by the respondents (Burns & Grove, 2009: 717). This method was used as the researcher wanted to explore how social workers in health experience social work supervision. It must however be noted that the participant profile for the study is extensive which results in quantitative elements being presented but these do not override the qualitative research methodology. This study emphasised exploring and describing the profession of social work in health, bearing in mind the complexity of working within the multidisciplinary teams, not being medically trained at under graduate level and having to work without access to social work supervision in some facilities. In exploring, this research examined a topic that “may lead to insight and comprehension” (Babbie & Mouton, 2007:79) but the findings cannot be generalized as it's a qualitative study and the number of participants do not necessarily represent the views of the majority of the population they represent, that is social workers in health in the Western Cape. It however provided an opportunity for the participants to express their views and experiences on the subject matter.

This means that the researcher will thus reveal the broad landscape of the data obtained in this study (Bernard & Ryan, 2010). In describing, this research provided detailed and precise information about social workers' experience of the significance of social work supervision within the health service (Bernard & Ryan, 2010:9). The researcher used an exploratory and descriptive design to show the specific details regarding the social workers' experience (Fouchè et al., 2011: 96).

Chapters 2 and 3 present the literature review that was done. It sketched the context of the profession of social work, the historical significance of supervision placing this within the broader spectrum of the Department of Health. These chapters contributed to the conceptualization of the research problem and linked it to existing theory, both international and national (De Vos et al., 2011: 134-135).

4.3 PREPARATION FOR THE EMPIRICAL STUDY

The aim of the study was to interview production social workers ranging from primary to national health care. The researcher required consent from the university ethics committee as well as the Department of Health. Upon receiving ethical clearance from the university (See Annexure A) the researcher approached the Department of Health (See Annexure B) listing all the health facilities that she needs to engage to complete the study.

The process to access social workers in health care involves having to get approval from the department's ethics division. The application has to be made online and the webpage is closed over the December period for approximately a month which resulted in the first delay. The Western Cape is the only province whose online application is closed over this period.

The approval from the respective health facility then has to be forwarded to the ethics division which forwards it to the researcher who then has to make contact with the facility to negotiate access to the social workers (See annexure B). This is a tedious process, especially when the health facility does not respond to the researcher's emails. In the end the researcher was contacted by social workers even before their facilities had provided the

formal approval. This is due to word of mouth communication amongst the social workers in health, but also an indication that the research topic is so important to social workers in health that they did not want to miss out on an opportunity to have their voices heard. The researcher however complied with the department's regulations to not interview participants until their employer had given written consent via the department. The researcher applied online in January 2016 and only received the first response middle March, two months later.

The researcher was further hampered by miscommunication regarding the process from the outset in that the national health facilities have to be contacted directly and not via the ethics committee. Furthermore, one of the national facilities insisted on getting a copy of the questionnaire beforehand. As indicated in Chapter 1, the researcher was prepared to give the questionnaire to the participants when conducting the interview. Giving it to the social work manager before the time could have resulted in the participants being briefed about their responses, which could have impacted the credibility of the findings. The researcher therefore declined to comply with the request and was not granted access to the social workers.

Upon receipt of approval from the department, the researcher contacted the health facilities' contact person asking permission to contact the social worker (See Annexure C). This in itself required follow up and in some cases telephonic contact if the identified staff member, who in most instances is the CEO/facility manager, did not respond to the email. When they did reply it was merely to grant permission for the social worker to be contacted. The researcher then proceeded to contact the social worker to schedule an appointment. This process had to be followed with each of the 11 facilities and was time consuming. It was also interesting to note that the facilities which did not have a social work supervisor took the longest to respond and often required additional prompting to get a response.

This could be regarded as a first finding regarding the significance of social work supervision within the Department of Health as a means to develop and promote the profession of social work. In the absence of a social work supervisor, there is no one engaging at a management level with respect to the interest of the social workers. This is directly linked to the literature which confirmed that in the absence of a social work supervisor there is less development of the profession (Cleak & Turczynsk, 2014). The flow of communication to social workers can thus be more restricted in these instances.

4.3.1 Research sample

A sample is the category of the population which was investigated by the researcher (Bless et al., 2011: 98). Production social workers, employed by the Department of Health, Western Cape, were earmarked for this study as was indicated in the inclusion criteria. Production social workers have no supervisory responsibilities. Patton explains that choosing individuals as the unit of analysis “means that the primary focus of data collection will be on what is happening to individuals in a setting (in this case social workers in the department of health in the Western Cape) and how individuals are affected by the setting” (Patton, 2002: 228).

Two of the social workers interviewed had less than two years’ experience. These social workers are employed in the primary and district health care sector. The literature study had revealed that social workers in this sector often had no access to a social work supervisor (Department of Health, 2012; Godden, 2012; Cleak et al., 2014; Beytell, 2014). The researcher thus included them in the study to assess the experiences of qualified social workers with less than two years’ experience and who has no access to social work supervision. The findings was then compared to those who had been in the Department of Health for longer and who had experience outside of health before their employment in the health sector. The researcher was able to interview 17 social workers across primary, district, specialised and national health care in the Western Cape metro as well as rural settings.

The interviews were conducted in private in the participants’ office with the exception of one participant. The social workers based in primary health care facilities were difficult to interview due to the constant disturbances from patients knocking on their doors. The majority of them locked their office doors as the “session in progress” notice was not enough of a deterrent for patients. This is indicative of the high demand for the service but also confirmed the pressure under which these social workers have to work.

The participants were put at ease about the nature of the questions and the purpose for which the data would be used (Greeff, 2005: 295). Each participant granted the researcher permission to use a voice recorder and signed a consent form (Annexure D) before being interviewed. The researcher encouraged the participants to ask for clarification if they did

not understand a question. The participants were also allowed to make general comments at the end of the interview in relation to the topic.

4.3.2 Research design, approach and instrument

Seventeen production social workers were interviewed (See annexure E for a copy of the interview schedule).

4.3.3 Data gathering and analysis

Semi structured interviews ranged from 36 minutes to 1 hour in duration. All of the participants were comfortable being interviewed in English and those who preferred to respond in both Afrikaans and English (of which there were two) were accommodated. The questions were adapted to the specific interview. In some instances, a participant provided a lot of rich data with the first questions linking everything to the significance of social work supervision, in which case the last questions were not posed in detail but rather as a means to ensure that the participant had said everything that he/she wanted to on the topic.

The participants had difficulty responding specifically to the educational significance, supportive and administrative significance of supervision, so these questions were asked as one but the information elicited was recorded under the respective sub sections. The data obtained during the interviews were transcribed, interpreted and analysed to reveal the findings of the study. All the interviews were written out in full. Themes were identified from the information and linked to the significance of social work supervision. The findings are presented in the following section.

SECTION B: PROFILING OF PARTICIPANTS

The specific characteristics of the respondents that were extrapolated during the empirical study will be outlined in table 1 below.

4.4. PARTICIPANTS

Each participant was allocated a number as a means to protect their identity. Data focused primarily on their practice history specifically looking at total years of practice as a social worker in the department of health.

Table 4.1: Identifying data of participants

	<i>GENDER</i>	<i>YEARS EXPERIENC E PRACTICING SOCIAL WORK</i>	<i>YEARS PRACTICING SOCIAL WORK IN HEALTH</i>	<i>LEVEL OF HEALTH CARE FACILITY WHERE YOU ARE EMPLOYED</i>	<i>ACCESS TO SW SUPERVISION</i>
1	<i>F</i>	20	9	<i>Specialized (Mental Health)</i>	<i>Y</i>
2	<i>F</i>	13	7	<i>Specialized (Mental Health)</i>	<i>Y</i>
3	<i>M</i>	34	11	<i>National</i>	<i>Y</i>
4	<i>F</i>	23	23	<i>National</i>	<i>Y</i>
5	<i>F</i>	6	6	<i>National</i>	<i>Y</i>
6	<i>F</i>	20	8	<i>District (Metro)</i>	<i>Y</i>
7	<i>F</i>	36	2	<i>Specialized (Mental Health)</i>	<i>Y</i>
8	<i>F</i>	5	1	<i>District (Rural)</i>	<i>N</i>
9	<i>F</i>	14	8	<i>Specialized (TB)</i>	<i>Y</i>
10	<i>F</i>	10	10	<i>Specialized (TB)</i>	<i>N</i>
11	<i>F</i>	23	23	<i>Rehabilitation</i>	<i>Y</i>
12	<i>F</i>	37	22	<i>Rehabilitation</i>	<i>Y</i>
13	<i>F</i>	12	7	<i>Primary health care (Community health centre)</i>	<i>N</i>
14	<i>F</i>	20	9	<i>Primary health care (Community health centre)</i>	<i>N</i>

	<u>GENDER</u>	<u>YEARS EXPERIENCE PRACTICING SOCIAL WORK</u>	<u>YEARS PRACTICING SOCIAL WORK IN HEALTH</u>	<u>LEVEL OF HEALTH CARE FACILITY WHERE YOU ARE EMPLOYED</u>	<u>ACCESS TO SW SUPERVISION</u>
<u>15</u>	<u>F</u>	<u>18 months</u>	<u>18 months</u>	<u>Primary health care (Community health centre)</u>	<u>N</u>
<u>16</u>	<u>F</u>	<u>24</u>	<u>10</u>	<u>Primary health care (Community health centre)</u>	<u>N</u>
<u>17</u>	<u>F</u>	<u>20</u>	<u>4</u>	<u>Primary health care (Community health centre)</u>	<u>N</u>

Seventeen social workers were interviewed. They have a total of 298 years and 6 months in combined experience but not all of it was spent in health services. The social workers interviewed in this study work across primary and national health care services in metro and rural regions of the Western Cape.

The social workers who do not have access to social work supervision are based in primary health care and district health. The latter is often the only social worker at the health facility and therefore has no collegial support from another production social worker. This is the case in most of the primary health care facilities where social workers were interviewed except for one where there are two production social workers.

Production social workers are social workers who do not have supervisory responsibilities. The social workers at the Tuberculosis (TB) hospitals are supervised by a production social worker who is not employed as a social work supervisor but has accepted the responsibility of providing supervision to her peers. She is however managed by an allied health professional, that is, someone who is not a social worker.

Those who reported to have access to social work supervision are working in the bigger health facilities which provide inpatient hospital care and who employ more than two social

workers. It is important to note that it is also at these health facilities where the participants reported to have the longer work history in the Department of Health. It can thus be surmised that the access to social work supervision and the support that it provides makes it easier for social workers to stay in those services as reported by Chiller et al. (2012) and Department of Social Development (2006). The findings below will provide more detail to this, outlining the specific situation of social workers in health as it relates to supervision.

4.4.1 Gender

Seventeen social workers were interviewed. One of them is male and 16 are females. This is the expected gender ratio within the profession of social work which is dominated by females (Mbau, 2005; Department of Social Development, 2006). All the social workers interviewed in primary health care are female. These are the facilities located in the community and are often vulnerable to the social evils which plague the community, for example gangsterism, substance abuse, etcetera, which is associated with increased levels of violence. This further confirms the importance of support through supervision for these social workers as they are exposed to trauma based on the societal evils within the communities which they serve (Morrison & Wannacot, 2010; Kadushin, 2014).

4.4.2 Number of years practicing social work

Six of the social workers interviewed have more than 20 years' experience, ranging from 20 to 24 years. Three of the social workers have more than 30 years' experience practicing social work with the highest number of years being 37. This means that the majority of the social workers interviewed have more than 20 years' experience in the profession and of those all have access to a social work supervisor except for one. These are thus experienced social workers who function as experts in the field of social work.

None of the social workers reported during this research that they do not need social work supervision. A social worker who is based at a community health facility and does not have access to a supervisor reported the following when asked if she needs social work supervision:

*“It’s about having **someone who understands your profession**, who you can talk to who can support you”.¹*

After 24 years in the field and ten years at the same health facility, this is the significance of supervision for her. This will be further reported on in this chapter.

Of the 3 social workers who have less than 10 years’ experience, two have less than 2 years’ experience working as social workers in health care. They are based in primary health care and were included in the study to assess if their responses to the questions on whether undergraduate training adequately equips social workers for practice within a health setting would be vastly different from social workers with more than 2 years’ experience working in the Department of Health. This is based on the assumption that social workers who have been in the field for a while, that is, two years and more cannot truly recall whether they were in fact equipped to commence working within a health setting and more especially if they have had previous work experience. In this study, one social worker who had less than two years work experience was appointed straight after graduating. She therefore has no other experience as a social worker.

She reported on how she experienced the Department of Health without access to a social work supervisor and based in a primary health care facility:

“What I’ve learnt at university and what I see here is not the same, it’s totally different. Alone I wouldn’t have made it” (Participant 15).

This social worker is supported by another production social worker based at the same health facility. Together they have no access to social work supervision. Her response is not very different from a social worker who has access to supervision and who has been practicing for more than 20 years within the Department of Health:

“It’s like sending a new social worker into the lion’s den” (Participant 6).

¹ Throughout the document, participants were quoted verbatim to preserve authenticity, and no changes were made to spelling or grammar with regards to direct quotes.

Both responses emphasize the sense of aloneness and anxiety which can be alleviated by access to support and supervision.

4.4.3 Number of years practicing social work in the Department of Health

Nearly half of the social workers interviewed (eight) have less than 10 years' experience working in the Department of Health. The majority (nine) have worked in the Department of Health for more than 10 years. None of the social workers interviewed have more than 25 years' experience working in the Department of Health. Two of the social workers interviewed have 23 years' experience practicing social work and all of the 23 years was spent working in health, with one social worker having worked at the same facility for all of those years. This social worker has had access to a social work supervisor all of those twenty three years in health. This could be a contributing factor to her remaining in health and at the same health facility for so long as reported by literature in the preceding chapters (Department of Social Development, 2006; Engelbrecht, 2010; Chiller & Crisp, 2012). When asked if she still needs supervision with all her experience working in health, her response was:

“Yes everyday there are challenges at work. There are times when I cry. It’s a rollercoaster. I speak to my supervisor, just to listen” (Participant 4 based at a national health facility).

Of the two social workers who have less than 2 years, one has 5 years practicing experience with the other one having 18 months of which all is in health services. This confirms that the Department of Health has no prescripts in its recruiting process which prohibits the appointment of newly qualified social workers. It however also does not provide the support needed by a newly qualified social worker within the specialized field of health in that these social workers have no access to a social work supervisor. This is in contravention of the Department of Social Development's prescripts and other academics in the field regarding the supervisory requirements for social workers (NDSD, 2012; Harmse, 1999; Wolpert, 2005). The social worker with 5 years practice experience is employed at a district health facility with no other social work colleagues and no access to social work supervision.

4.4.4 Level of health care facility

The majority, ten of the social workers interviewed are from the primary health care and specialized sector. The primary health care sector comprises of clinics and day hospitals. The work experience of the primary health care social workers range from 18 months to 10 years working for the Department of Health. None of the social workers in primary health care have access to social work supervision.

This is however the first point of entry for the community into the health care system. The service is free of charge but with the Department of Health providing health care to 80 per cent of the population and the intensity of poverty experienced in the province being second highest out of the nine provinces (Western Cape Government Health, 2015), it can be assumed that the majority of the population will use this service to meet their health requirements. The government's focus to advance the quality of the health care experience is to develop the primary health care service to ensure that service users receive optimal comprehensive health care.

This therefore includes the discipline of social work as integral to the achievement of a comprehensive health care service as it has to effectively deal with the psychosocial aspects of public health care service users (Caputi & Heiss., 1984; NASW Centre for Workforce Studies & Social Work Practice, 2011; Crisp, 2000; Judd et al., 2010; Rogowski, 2013). Social work supervision is well documented as an important element in delivering a quality social work service, and has a particular role in developing a skilled and professional workforce (Hafford-Letchfield et al., 2008).

This confirms the significance of social work supervision as a determining factor for quality intervention. The lack of social work supervision at this level negates the objective of comprehensive health care. In the Western Cape's public health facilities, social workers have no access to social work supervision. This means that although the Department strives to provide a comprehensive primary health care service, it is however not ensuring appropriate staff components at this level. The fact that there are social work supervisors at secondary, specialist and national health care services could be interpreted as the services which require quality focused social work service meaning that patients get assessed at primary health care as opposed to receiving social work intervention.

4.5 SOCIAL WORK SERVICE

The question that was posed to the respondents is what their role is at the health facility, bearing in mind that the research set out to explore the significance of social work supervision within the context that social workers have no specialized training in health, has to report to medically trained managers who are not qualified social workers and has limited and in most instances no access to social work supervision.

This section envisioned to determine if they perform generic social work duties and if they require specialized skills to work within a health setting. The response was linked to the need for social work supervision in the effective performing of their duties. Their responses included the following: individual/case work, group work, ward rounds, referrals to community organisations or other government departments, outreach to stakeholders, community work, discharge planning, counselling, generic social work are amongst those roles listed by participants.

4.5.1 Role of social work

Social workers work with individuals, families and their social support systems to address social challenges with a view to improving their lives (Ornellas, 2014). Their role as described by participant 2 who is based in a mental health facility is:

“I assess family dynamics and how it impacts on the mental health of the patients. I do home visits and family meetings and group sessions.”

The same social worker went further in stating:

“I’m currently in the challenging area, forensic unit and my basic role in the unit is groups for in patients, ranging from sexuality, victim empowerment and singing as a method to providing stimulation”.

It is however not only social workers who work in specialist health services who conduct home visits. Participant 8 who work in a district health facility and is the only social worker at the facility stated:

“We deal with a lot of malnutrition cases and kids being admitted for gastro where I assess home circumstances, to rule out deliberate neglect. I do home visits to expedite discharges”.

This further highlights the importance of diverse interventions and knowledge base required by health social workers. It confirms the importance of holistic health care services but also shows the psycho social needs within society.

Participant 14, who works in a community health centre even stated that she does *“Group work focusing on substance abuse with school learners who are not patients”* at the health care facility. This can be seen as part of community outreach. The social worker employed at the health facility recognizing the need in the community and as a means to provide a proactive service intervenes at the point of need.

Participant 16, who works in a community health facility, says she does:

“Work with the health promoter to facilitate HIV programmes, adopt a school for a year, and do hero book programme with a group of learners every week.”

Ornellas (2014: 70) stated that the broad scope of services that are provided by the health social workers is indicative of the wide knowledge and expertise exhibited and required within the social work profession. The response from participants in this study confirms this. Unlike doctors who specialise in a particular field of health, for example oncology, a social worker has to know about a range of health conditions to effectively provide the most appropriate psycho social interventions.

The importance of health social workers having strong partnerships with community based organisations was also emphasized as part of the participants’ referral focus. As indicated before social workers in health care conduct assessments with a view to provide short term focused interventions but the post discharge support is pivotal in ensuring holistic recovery from an illness (Thornton, 1997; Olckers, 2013; Mizharhi & Rizzo, 2008).

Participant 3, who works in an oncology unit at a national health facility (in respect of his role to conduct assessments) stated:

“I conduct assessment, in terms of, acceptance and response to the diagnosis, psychologically how are they coping with it, socially how has it affected them, what is the plan once they are for discharge.”

It is however not enough to assess, but also to consider the access to appropriate services once the patient leaves the health facility. Participant 2, based in a mental health facility, stated:

“It’s important for me to link with the social workers in the community.”

This speaks to the issue of placement, which is also part of the social work role in health care. Patients who require rehabilitation services after their treatment or who have no place to reside, are referred to the social worker to look at options for accommodation etcetera. Participant 8, who works in a district health facility, had the following to report on this:

“Placement is a big thing in hospitals, discharge plans and making sure that we don’t have people coming to the hospital recurrently”.

The extent of the need for placement within the role of social work was further highlighted by Participant 5 who has less than 10 years’ experience and is based at a national health facility. Her work area covers four medical wards with 32 beds each and ten clinics:

“On average we have 5-6 strokes per week of which all of them get referred to me for placement. It’s very stressful, a lot of paperwork and a lot of liaising and discussions with families to explain why the patient needs placement and if there’s any cost involved”.

She goes further explaining:

“This year there’s been an increase in social cases: homelessness, substance abuse, poor circumstances at home, no one to care for a sickly patient, a lot of dumping; unknowns.”

This confirms the literature on how the role of social work has evolved to include discharge planning which is dependent on resolving the dilemma of placement first (Cleak, 2002; Cleake et al., 2014; NASW Centre for Workforce Studies & Social Work Practice, 2011).

This is why participant 11 who has 23 years' experience in health services and is based at a rehabilitation facility in explaining the integral role social work has within the multi-disciplinary team states:

“Discharge planning gets done with the social worker.”

Participant 6, based at a district health facility, confirms this as she has the added role of child protection services:

“The baby stays in the hospital until we can refer to a place with family or Non-Government Organisation. The social worker has the final say as to when the baby can be discharged.”

Social workers also do counselling. Participant 1, based at a mental health facility reported:

“Counselling is one of the main issues. I had to provide grief counselling to a patient that was sexually molested by another one.”

This includes bereavement counselling and having to support patients and families to deal with loss albeit of a person or a body part. Participant 6 is based at a district health facility and deals with a range of health conditions explained that she does:

“A lot of death and dying support to families.” The same social worker elaborates on her role doing *“Pre-op counselling for amputations, and people being diagnosed with cancer”*.

Psycho education and transplant counselling is also done by the social worker. Participant 4, based at a national health facility for 23 years reported:

“I see donors to see what they know about the illness (leukaemia). Do they know anything about it and the treatment?”

This requires specialized medical knowledge about leukaemia and being a donor.

The activities of the participants reflect the needs of health service users from the profession of social work. The findings demonstrate that the social work role within health care is multidimensional across a number of domains (Nilsson et al., 2013: 291). As reported by a respondent above, social work within health endeavours to connect service users with systems that provide them with resources, services and opportunities (Triegaardt, 2012). A social worker has to be generically trained but develop therapeutic skill and medical knowledge to function efficiently within a health setting. This links directly with the definition of social work practice as the “application of an eclectic knowledge base, professional values and a wide range of skills to target individual, familial, group, organizational or community system for change” (Bogo & Taylor, 1990; Kirst-Ashman & Hull, 1997; Kirst-Ashman, 2013; Teigiser, 2009).

It is clear that there is no distinction regarding the social work services across the health service spectrum; everybody does what is expected to meet the need of the patient and the community irrespective of whether they have access to a social work supervisor. The latter do not provide a more specialized service but they seem to stay longer in health services. It also confirms that social workers have to provide such a diverse service emphasising the importance of discipline specific supervision to support them to remain focused in terms of their interventions. The specialized knowledge needed to have a comprehensive understanding of the patient’s condition further aligns to the role supervision plays to ensure the appropriate skills match for the required service.

4.5.2 Interdisciplinary team

Within health, social workers are part of inter disciplinary teams (Abramson et al., 2004; Drotar, 2002; Hanson et al., 2000).

4.5.2.1 *Functioning of social work in the inter disciplinary team*

Participant 1, who works in a mental health facility, explains:

“We do have ward rounds, psychosocial rehabilitation meetings and forensic ward rounds”.

These are the meetings with the interdisciplinary team to discuss patient care and treatment planning. Participant 11, working at a rehabilitation health facility reports to attend a “*weekly ward round, 3 hours per week.*” This is an indication of the time spent in clinical meetings with interdisciplinary teams but it’s not prevalent across health services. In primary health care settings social workers function independently as the interdisciplinary teams do not engage in this manner.

The same profession who does not have access to discipline specific supervision within the department of health although it is mandated and the literature study has confirmed its significance in ensuring quality service to its service users provides staff wellness to their colleagues (Botha, 2002; Kadushin, 2014). Participant 6, who is working at a district health facility reports that she has to provide “*support to nursing staff if the child dies*”.

Participant 11, who has 23 years’ experience in health says:

“Experience makes that you support younger therapists (other allied health staff). We supervise the emotional aspects the therapists deal with.”

Both these social workers have access to social work supervision, but Participant 14 who works at a community health facility and has to “*do wellness for the staff, not recipient of wellness*” is very clear in that she has to support her colleagues in the absence of dedicated support for her. Social workers skills are thus utilised by the employer to provide the much needed support and debriefing to their colleagues but they are not seen to be in need of it themselves. There is almost a sense of them being excluded from the work force in the same manner that they are the only allied health profession who is not aligned to the health professions council, the statutory body for all health professionals.

One social worker who is not employed as a social work supervisor explains her role to fellow social workers. Participant 10:

“I co-ordinate the social work services of two health facilities. I am not a supervisor. In meetings I am expected to provide responses and information

as per a supervisor but I'm not a supervisor. I supervise two social workers and a social auxiliary worker. I don't get paid for it."

4.5.2.2 In/out patient service within the context of the interdisciplinary team

The participants were asked to indicate if they work in out- or inpatient clinical areas (Refer to Table 1) as a means to determine the need for support, as out patients require a more immediate intervention whilst in patients allow social workers who do not have access to a supervisor time to consult with a colleague in the field.

The majority of the participants interviewed work with inpatients only. A small number reported to work with both in- and out-patients and six of those interviewed work in outpatient facilities. The latter are mainly based in primary health care where they have no access to a social work supervisor. The literature review indicated that within health services, a model of inter disciplinary service is beneficial to quality client care (Leipzig et al., 2002; Thompson, 2007). The same authors reported that effective social work practice is dependent on access to social work supervision.

In social work practice and health care settings, serving clients effectively is impossible without collaboration with professionals from other disciplines (Bronstein, 2003). A participant based in a community health care centre's (that is an outpatient service) experience of her team speaks to her sense of isolation rather than collaborations with her team.

"Sometimes you need someone at the facility to talk to. Often colleagues don't know what your role is. They don't understand differences in roles from different social workers, example health versus education." (Participant 13)

This confirms the opinion of Patford (1999), who wrote that social workers in interdisciplinary teams may experience more challenges in projecting their identity, demonstrating competencies and skills and delineating occupational territory. In a primary health care setting where there is often only one social worker this can be very challenging. Social workers need to be competent and skilled in working with diverse populations and in diverse practice settings (Morales et al., 2012). Without access to social work supervision a social

worker must on her own try and understand the health care system and processes to access health services (Wolpert, 2005: 93).

A social worker based in health care for 23 years stated that *“You question your own sanity when you listen to people’s stories”*. This is the most apt way to describe what the social worker experiences when having no access to a social work supervisor in the execution of her work. This statement from an experienced social worker who started out in the profession in health having no access to a social work supervisor shows the significance of social work supervision within the health service. It reduces the emphasis placed on the significance of the interdisciplinary team.

4.5.3 Supervision

4.5.3.1 Access to supervision

In this section respondents were asked to indicate which profession they report to, what their experience is of this and if they have access to a social work supervisor.

4.5.3.1 (a) Reporting structure

The majority of the social workers (10) report to a social work supervisor. It must however be noted that the majority of the social workers are also based in national and specialist health facilities where they have access to a social work supervisor. In the preceding literature chapters it was stated that the Department of Health has adopted a decentralized management system where allied health staff report to medically trained colleagues as is reported by the participants (National Department of Health, 2015; Department of Health, 2012; Beytell, 2014). Within this functional business unit model there is no acknowledgement of the need for discipline specific supervision, hence this quote from a participant in this study.

Participant 12 who has a total of 37 years’ experience in social work with 22 years being in health stated:

“We heard about plans to have teams working under a leader who is not going to be a social worker and we said no. There’s no other profession supervising us. How does a senior occupational therapist judge me, in terms of my

counselling skills? It will just be what I bring to the table. How will you know if it's fact/fiction?"

In this instance this social worker has access to a social work supervisor. She has access to peer supervision from a team of experienced social workers. She provides support to allied health colleagues yet she firmly expresses her non acceptance of a system which will result in her having to report to and be supervised by a profession other than social work. She emphasizes the importance of being assessed by someone who knows what your professional capacity should be, what value your profession adds to the service; the importance of being supervised by a person who has the same qualification as hers.

There is certainly great pride for the profession of social work evident from this quote from Participant 13 and this is indicative of the significance of social work supervision. It can be inferred that social work supervision gives social workers confidence to express their needs to management. It gives social workers a voice within the management of their facility, an aspect highlighted by the writings of Beytell (2014) regarding the power of health managers to determine the role of social workers.

In this study a few of the social workers report to a facility manager who is a qualified professional nurse. Some of them report to other allied health professionals, that is a psychologist and pharmacist, and some report to family physicians. It must be noted that reporting to these disciplines does not imply that these social workers are being supervised by them.

Participant 8 based in a district health facility (who reports to a medically trained employee) stated:

"The only time I ask him is when I want to do a home visit. I explain to him what a home visit is but he doesn't understand social work and what it's about."

The social worker is not being supervised which means that she is basically functioning as an independent, private practitioner with one years' experience in health services.

As previously stated, the medical expert is the leader of the team and all staff is accountable to him/her (Beytell, 2014). The FBU model promotes the medical discipline as being the leaders to who all other staff needs to account, except nursing. (Western Cape Department of Health, 2012: 11). This system negates the need for discipline specific supervision but the findings from this research do not confirm this.

4.5.3.1 (b) Social work supervision

This section will cover the access social workers have to social work supervision, the frequency of social work supervision as well as the type.

Morrison and Wannacot (2010) wrote that supervision is essential to social work practice. It includes four elements: a supervisor, supervisee, client system and a work context (Hawkins et al., 2006). Ten participants, that is the majority interviewed, have access to a social work supervisor.

Participant 3 and 4 who work in a national hospital stated:

“My supervisor is a practitioner and has insight into the nature of the work. She’s a medical social worker and can identify with the kind of experience I have in my situation.”

Participant 4 (describing her supervisor): *“She’s a social worker. She’s a senior. Been working here almost 40 years.”*

These narratives speak to a sense of trust, a feeling of being able to rely on the supervision advice to be in line with the profession. The supervisor knows what they’re supposed to do and can support them to do it, it makes them feel understood. This is contrary to the experience of Participant 8 in section 5.5.3.1(a) above.

Seven of the participants interviewed have no access to a social work supervisor. The social workers are mainly based in primary health care and one is in a specialized health facility. They report to medically trained staff.

Participant 10 who have 10 years' experience as a social worker stated:

"It's not nice to work and have to report to someone who knows nothing about your profession."

Godden (2012) reported that in England, social workers who work in multidisciplinary teams express a lack of or inconsistency in frequency of supervision. They also report poor quality supervision as reported by Participant 10. The quote below from a participant in this study confirms this. It presents an image of the social worker feeling isolated within the multidisciplinary team.

Participant 13 who is based in a primary health care facility and has 12 years' experience of which 7 is in health stated:

"I have not had a supervisor for 7 years. It's challenging. There are times you need a supervisor. Sometimes you need someone at the facility to talk to. Often colleagues don't know what your role is. They don't understand differences in roles from different social workers, example health versus education."

This ignorance regarding the role of the social worker could inadvertently create expectations based on what colleagues think the social worker should do resulting in strain in the team with the social worker having to defend her interventions. The following quote from another participant further endorses Godden's views (2012) that social workers who are being managed by other medically trained staff do not get supervision.

Participant 9 has 14 years' experience as a social worker with 8 years in health. She is based at a specialized health facility:

"The psychologist is the manager of the PAMS, (a term used to refer to allied health staff). We don't always get a solution for our concern 'cause she has the background of a psychologist. Basically we don't have supervision."

Participant 14 has 20 years' experience with 9 years in health:

“We just report to her (medical professional) administratively nothing that has to do with our clinical work.”

These responses give a very clear picture of the fact that social workers in health who have no access to a social work supervisor do not get supervision of their work. There is no one who knows what they are supposed to do and no one who checks that they provide appropriate interventions. This system could thus impact negatively on the department’s vision of quality holistic patient centred care.

4.5.3.1 (c) Type of supervision

In this section participants were asked what type of supervision they receive.

Eight, which is less than half, of the social workers reported to receive individual supervision which is reported to be significant to promote personal, professional growth as it addresses individual needs of social workers (Kadushin, 1992; Hafford-Letchfield et al., 2008). This quote from Participant 2 who is employed in a mental health facility and has a total of 20 years’ experience describes her view on the significance of individual supervision:

“I get individual supervision, 2-3 hours once a month. In preparation for supervision I compile a report stipulating interventions that were done with clients that we discuss and my supervisor advises me. She reminds me of another angle and I find that helpful.”

After 20 years in the profession and 7 years in health she values the supervision she receives from her social work supervisor. This is indicative of the timeless nature of supervision. It is not limited to junior social workers just entering the field of practice. Five of the participants engage in peer supervision and none of the social workers reported to engage in group supervision. Two of the social workers who receive peer supervision reported that it occurs as part of their administration meeting and is not time specifically set aside for peer supervision.

Participants 11 and 12 work at a rehabilitation facility and have 23 and 37 years’ experience in health:

“A supervisor is not a production worker so the best supervision is from your colleagues (social workers) who work on the ground with you.”

Participant 12 said: *“We have lots of peer supervision.”* Together these social workers have 60 years’ experience as social workers. There is no disregard for the value of supervision from them. They still find the sharing of clinical discussion with their peers as significant to their practice. Participant 15 who have less than two years’ experience:

“We have a monthly meeting with other primary health care social workers. It’s a training slot. A case gets presented then that’s it. I don’t feel anything.”

This social worker has less experience; she is based in a primary health care facility. She has no access to a social work supervisor. Her need regarding the type of supervision is different as it would seem that she is more in need of individual supervision as experienced by social worker 2 above. It can thus be deduced that the type of supervision may differ based on the years’ experience in the field but the participants are still in agreement that social workers in health need supervision.

4.5.3.1 (d) Frequency of supervision

Of the 10 social workers who receive supervision, the frequency of the supervision sessions varies from fortnightly to as and when they need it. The latter scored the highest, with four social workers reporting to get supervision when they request it. Three social workers reported to get supervision once a month; two receive it quarterly bearing in mind that the latter coincides with the quarterly performance review schedule and one social worker receives supervision twice a month.

The social workers who reported to not get social work supervision indicated that they try and support each other by arranging an in service training session once a month which they also use as a space to reflect and discuss cases. The downfall of this however is reported by the following quotes:

Participant 17 has 24 years’ experience and is based in a primary health care facility:

“Facility managers say social workers must be here all the time.”

The facility manager is a medically trained professional. From this quote there seems to be no support from the manager to develop the social worker by allowing her the time to engage with fellow social workers around topical issues to advance her practice. The practice is essential as she cannot do without the social worker but the employee is possibly not seen as a resource which as is the case for equipment needs to be maintained.

Participant 16 also has 24 years’ experience:

“Challenge to access this monthly session is access to an official vehicle.”

The official vehicle is the government vehicles used to conduct business. It would thus seem that she is expected to use her own resources. This could imply that meeting with fellow social workers for peer supervision is not considered part of official business. It is not needed.

In summary, 17 social workers were interviewed in this study, 10 have access to supervision, most of them receiving individual supervision. Great significance is placed on the importance of supervision irrespective of years’ experience.

SECTION C: THEMES, AND SUBTHEMES

From the interview schedule appropriate themes were identified. These themes were then subdivided into sub-themes and categories relating to the data provided by participants. All of this is presented in the table below:

Table 4.2: Themes and subthemes

THEMES	SUB THEMES
1. Undergraduate training	1.1 Generalist vs. specialist training
	1.2 Impact on practice
2. Functions of supervision	2.1 Educational

	2.2 <i>Supportive</i>
	2.3 <i>Administrative</i>
3. <i>Significance of supervision</i>	2.4 <i>The Department of health</i>
	2.5 <i>The social workers</i>
	2.6 <i>The service users</i>
4. <i>Value of supervision</i>	
5. <i>Challenges</i>	

THEME 1: UNDERGRADUATE TRAINING

4.6 GENERALIST TRAINING VS. SPECIALIST SERVICE

In this section, social workers were asked if under graduate training adequately equips them to function optimally in a health setting and if not how does employing newly qualified social workers in health impact on their practice and lastly if social work supervision should be mandatory.

4.6.1 Newly qualified social worker

Participants were asked if undergraduate training adequately equip a social worker to work in health services without the support of a supervisor.

All of the social workers interviewed reported that undergraduate training does not equip a social worker to practice within the Department of Health without the support of a social work supervisor. A quote from a junior social worker based in primary health care who does not have a post graduate qualification in social work reads as follows.

Participant 15 has less than two years' experience:

“What I’ve learnt at university and what I see here is not the same, it’s totally different. For the first two weeks I was depressed, presented with cases that I could not imagine is happening in our homes. Alone I wouldn’t have made it.”

When the same social worker was asked if she would have coped without having a more senior social worker at the health facility as she does not have a social work supervisor but has a more experienced colleague based at the same facility: *“No not at all. I would have looked for other work.”*

This confirms the importance of having a more senior social worker available to guide and support you. It also speaks to the issue of specialised knowledge being associated with years' experience. Authors describe a supervisor as the worker who is given responsibility by the employer to work with another worker(s) in order to meet professional and personal objectives, which jointly advances the best outcomes for their service users (Ford et al., 1987; Morrison, 2005). In this case, the more senior colleague was not given the responsibility, she is not remunerated for it or acknowledged for it but she does it none the less.

Participant 12 who now has 37 year's practice experience says:

“When I started working we had structured, case discussions; supervision. Without that I would have been lost.”

Williams et al. (2014) stated that generalist social work professionals master the core knowledge, values and skills to empower service users, and evaluate service outcomes to improve the quality of client services yet are expected to provide a service within the specialized field of health. The latter participant reflected on her early years as a social worker in health and affirmed what Participant 15 said. Social work supervision is crucial to the practice of a social worker especially a more junior social worker.

4.6.2 Impact of no social work supervision on the social worker practice

The responses from the participants are outlined in Table 3 below highlighting the impacting factors and the specific quotes from the participants. Thereafter the researcher will expand on each factor in more detail linking it with relevant theory.

Table 4.3: Effects of no access to social work supervision as reported by the participants

<i>Effects as reported by participants</i>	<i>Quotes from participants</i>
<p>1. Challenging for the social worker</p>	<p><i>Participant 16 works in a primary health care facility: “Lack of supervision leaves a huge gap”</i></p> <p><i>Participant 6: “If you are newly qualified, wanting to please, the doctors will step on you.”</i></p> <p><i>Participant 10: “Doctors want you to do things the way they want you to do it. They will tell you what their outcome must be. It will be difficult for a new social worker.”</i></p>
<p>2. Difficulty to cope with the demands of the team</p>	<p><i>Participant 11: “Current staff will have expectations of the new person re what to do and they will not want to do it.”</i></p> <p><i>Participant 12: “You not an entity on your own. You need to be able to work in your field and also understand how you fit in the broader picture.”</i></p> <p><i>Participant 17: “A new social worker will leave the profession. Support from the rest of the multi-disciplinary team is minimal”</i></p>
<p>3. Constant doubting of practice decisions</p>	<p><i>Participant 5: “They will constantly second guess if they’re doing the right thing, is this appropriate service for the patient. Is it most beneficial to the patient? Even being here six years you have the odd occasion and you like: what now, but I can ask my supervisor.”</i></p> <p><i>Participant 10: “You need affirmation.”</i></p> <p><i>Participant 15: “Did I do more harm? You don’t know the right and the wrong”</i></p> <p><i>Participant 12: “Will feel overwhelmed. Will leave the door open for other professionals to pick up that you not confident.”</i></p>
<p>4. Emotional impact</p>	<p><i>Participant 14: “Would supervision include debriefing? That’s the most important part.”</i></p> <p><i>Participant 16: “I never get emotional support”</i></p>
<p>5. Not knowing what to expect</p>	<p><i>Participant 6: “There’s no time for emotional and functional preparation. You will go out not knowing what to expect.”</i></p>

<i>Effects as reported by participants</i>	<i>Quotes from participants</i>
6. <i>Decreased job satisfaction</i>	<p><i>Participant 10:</i> “University does not prepare you for what’s in the field.”</p> <p><i>Participant 6:</i> “You won’t survive.”</p> <p><i>Participant 15:</i> “I have to work. Clients have to be seen. I need to deliver a service. Make or break. You have to”</p> <p><i>Participant 9:</i> “You won’t look forward to come to work.”</p>
7. <i>Burnout</i>	<p><i>Participant 16:</i> “Biggest frustration is that they don’t understand my work”.</p> <p><i>Participant 17:</i> “Burnout is rife. I sometimes feel burnout. Complacency is a symptom of burnout”.</p>
8. <i>Increased stress</i>	<p><i>Participant 16:</i> “You on your own. No matter what storms you go through. You on your own”</p> <p><i>Participant 6:</i> “It’s like sending a newly qualified social worker into the lion’s den.”</p>
9. <i>Lack of supervisor liability</i>	<p><i>Participant 12:</i> “You need somebody behind you, who’s covering your back.”</p> <p><i>Participant 16:</i> “If I do something wrong it comes back to me. I have no one that I can blame.”</p> <p><i>Participant 9:</i> “You will spend hours tackling one case, not knowing what to do.”</p>
10. <i>No guidance increases inefficiency</i>	<p><i>Participant 10:</i> “She will not be efficient and effective. Every discipline comes with their demands to the social worker. She definitely needs support.”</p>
11. <i>Risk of complacency</i>	<p><i>Participant 17:</i> “No one checks if you’re doing what you supposed to be doing. You can get away with poor practice”</p>
12. <i>No support</i>	<p><i>Participant 8:</i> “They would feel overwhelmed because that’s how I felt. You can feel like an island. You feel isolated, like nobody cares, nobody knows you there.”</p>

1. Challenging for the social worker: Throughout this chapter the impact of not having a supervisor has been reported on by social workers in the field of health. There can be little doubt that supervision helps social workers to be more competent in their practices (Gilbert, 2009 as reported in Engelbrecht, 2014). Without this confidence social workers feel very

vulnerable, as the profession is so broad that it is easy to unintentionally err in your service to clients

- 2. Demands of the team:** Thompson (2007) wrote that inter professionalism in health care promotes a focus on patient-centred care. The functioning of the interdisciplinary team is however reported (as indicated above) to be a negatively impacting factor for a newly qualified social worker who has no access to social work supervision. A narrative from the research conducted reads as follows:

Participant 12 who is based at a specialist health facility, when asked how a newly qualified social worker will cope in her setting:

“That won’t happen. Too much to learn in a specialized setting. Other people (meaning the multi-disciplinary team) will take over your role. It’s vital to have social work supervision.”

Various authors wrote that inter disciplinary teams made social workers feel that their role within health is not acknowledged (Barth, 2003; Globberman et al., 2002; Mazrahi et al., 2001; Cleak, 2014). This was confirmed with these findings. The quotes reported on above clearly express how disempowered these social workers feel within inter disciplinary teams.

- 3. Doubting of practice:** The above quotes from participants experienced in the practice of social work confirms that supervision is needed to get the most out of the worker’s ability to work effectively, thereby improving their confidence about their service (Kadushin, 1992). The significance of supervision is that it provides a space for the supervisee to receive advice regarding their practice, which ultimately guides their intervention (Bogo et al., 2005). It is very clear that the training at university level does not necessarily produce professionals who can practice independently from the outset. Kadushin (2002) made the comparison regarding the years of training versus professional conscience which leads to an internalized supervisory function. Social workers receive four years of under graduate training, whilst doctors receive seven years of training with an additional year community service during which time they are closely supervised. This alone confirms why social work supervision is essential more especially for junior social workers.

- 4. Emotional impact:** The other impacting factor in this study is the emotional challenge of working without the support of a supervisor. Many of the participants confirmed that they get emotional support in supervision, as reported by Carpenter et al. (2012). They however emphasized that this support is only experienced as being effective when it comes from a fellow social worker who understands the profession and the interventions of the social worker. The term debriefing as seen in the quote above was used often in this research by participants. It is reflective of the social workers experiencing their work as traumatic, which is indicative of the societal evils that they have to deal with. The use of this particular term could be interpreted as an expression of the participant's dire need for supervisory support.
- 5. The unknown:** This factor again relates to the social workers' level of preparedness to function optimally in the field without a supervisor. Zachary (2000) wrote that supervision affords social workers the space to reflect on their work experience, thereby allowing the work the opportunity to teach them. Riva and Ratsika (2015) and the NASW (2013) went further in stating that supervision makes sure that supervisees are equipped with advanced knowledge to apply their skills and abilities to client populations in a competent manner. In the absence of social work supervision the participants report feeling anxious about their interventions. There is a lack of confidence in their knowledge in relation to the service they have to provide.
- 6. Job satisfaction:** The above quote is very telling of an employee who seems to be taking great strain in the performance of her work. It would seem that the authors who wrote about the importance of supervision as a means to retain staff, especially social workers who are deemed a scarce resource, are thus affirmed by these research findings (DSD, 2006; Chiller et al., 2012). Social workers are one of the most cost effective professions as they do not require expensive equipment to do their work and as such the provision of supervision could be seen as a means to increase job satisfaction thereby ensuring staff retention. In other contexts, such as in Australia, a study that was done on why some social workers have chosen to remain in the profession for many years, supervision was reported by all participants as being important for their wellbeing, as well as the reason they were still practicing social workers (Chiller et al., 2012).
- 7. Burnout:** From the terms used to describe how they feel it can be interpreted that some of the respondents are already experiencing burnout. The antidote for this is social work

supervision (Ekstein et al., 1972; Kadushin, 1992; Munson, 1993). The literature study revealed that supervision is a fundamental tool to offer and to ask for, as it is essential for social work practitioners to carry out their work well in help relations (Morrison & Wannacot, 2010; Riva et al., 2015). From the responses received from participants there was definitely an indication that some of them are experiencing increasing tension, which in turn could impact on their service.

- 8. Stress:** The one quote above is very clear in its message; as a social worker in a multi-disciplinary team within health you are on your own. There is no sense of being supported. Although only one quote was reported in the study, there are other social workers who reported similar experiences and in this chapter, some of those quotes have been used in different contexts. The literature study revealed that health social workers experience higher levels of stress than the rest of the social service sectors (Walsh et al., 2005; Health and Safety Executive, 2014), confirming the importance of supervision as a means to combat this. This could be due to the fact that in primary health care there is often one social worker at a facility. Therefore, you have no other social work colleagues to engage and consult with. In the absence of a supervisor to guide you regarding your work you often have to find your own way around the facility and within the system, which can be daunting if you are a junior social worker. There is also greater reliance on you to manage your work load without a sense of understanding of why it might be impossible for you to comply with the team's expectations, as indicated under point number two above. All of these factors point to the significance of a social work supervisor, not necessarily based at the facility, but accessible.
- 9. Shared liability:** Kadushin (2002) and the SACSSP (2007) reports on the importance of shared liability in that a supervisor can be held liable if a social worker errs in her intervention to clients. This can be interpreted as the statutory body's endorsement of the fact that the profession of social work is based on the premise that a more senior social worker must monitor the work being done by a social worker. The fact that this is a legal mandate from the council attests to the importance it holds. This must be understood within the context of the writings of Kadushin (2002) that speaks to the fact that the service of social work is practiced in private and as such it is not easy to detect its wrongdoing, thereby leaving the public vulnerable to receiving poor service. In this research the social workers express their need to have another senior social worker monitoring their practice, once again emphasizing that a social work supervisor is needed in practice.

10. Increased inefficiency: This links directly to point number 9. The lack of a supervisor within the context of our current human rights focus places the social work practitioner at risk. A junior social worker, as was reported on in this chapter, will not necessarily know that her practice is ineffective as she is working under great pressure in what the researcher perceived to be a demanding health service and as such in her efforts to intervene she may not realize that she could be doing things differently. This innocent ignorance would not necessarily be wrongful practice but is more inclined to not be effective, for example sending clients to the South African Social Support Agency (SASSA) office to apply for a Disability Grant instead of negotiating with SASSA to come to the health facility. In this instance, the role of the supervisor is to always find ways to make the officer's work easier by connecting her with service partners.

11. Complacency: In research done in the Health Department in Limpopo, Mbau explains that supervision is geared towards benefiting the social worker, the agency clients and the agency where the social worker is employed (2005: 20). The lack of a supervisor means that the social worker has no one who knows what she is supposed to do. It is linked to the issue of professional conscience, the importance of doing the right thing even when no one at your facility other than you knows what that is. The fact that some social workers in health have no access to a supervisor could be interpreted as the employer's expression of trust in the profession of social work, and that it has mastered internalizing their professional conscience.

12. Support: This was echoed by most of the participants. There seems to be a need for them to be able to have a safe space to reflect, someone to vent their frustrations to. Participant 5 who has 6 years' experience and works in a national health facility reports on the significance of supervision:

"It provides so much support because we have high caseloads, we deal with different things; it's important to have someone who can help you through."

All of the quotes outlined in Table 3 above relate to the importance of social work supervision. It describes the effect of no supervision thereby reporting why supervision is needed.

4.6.3 Mandatory supervision

In this section, social workers were asked if they believe that social work supervision should be mandatory. Of the 17 social workers who responded to this question, they all responded in the affirmative.

Participants 3 and 4 who are based at a national institution reported as follows:

“It should definitely be mandatory. Social work across health in clinics, in district services definitely needs it. I speak to social workers in primary health care and of the things they are concerned about is that they don’t get supervision from a professionally qualified social worker. There’s a lack of understanding around the issues faced by social workers particularly in the primary health care setting.”

“To me I thought it’s compulsory: supervision.”

There was definitely a sense from the last comment that social work supervision is a given. It is compulsory and as such, social workers should have access to it. Participant 7 works in mental health and has 36 years’ experience. She responded as follows to the same question: *“Definitely. Probably for most of the working career.”* The researcher has in the previous section reported on the writings of Kadushin (2002), DSD (2006) and the SACSSP (2007) who elaborated on the need for supervision to be mandatory with the latter providing the legislative framework for it within this country.

Participant 15 has less than two years’ experience and works in a primary health care facility with no access to a social work supervisor:

“It should be. It has to be mandatory. We need the support.”

In this section, links were drawn to legislation and the training of social workers in that it could confirm the fact that although undergraduate training produces generalist social work practitioners, health services requires of the social worker to acquire specialized medical knowledge for which a social work supervisor plays an essential role. As an important

element in delivering social work services, supervision is thus central to achieving quality service (Hafford-Letchfield et al., 2008).

The responses from the participants confirm the important role social work supervision plays in their practice. Social workers with years' experience expressed how they still need supervision. It was astounding how the participants responded to this question. There was no hesitation when they responded in the affirmative with most of them using the term "definitely" in response to whether social work supervision should be mandatory.

THEME 2: FUNCTIONS OF SUPERVISION

4.7 FUNCTIONS OF SUPERVISION

In this section the researcher set out to explore if Kadushin's (2014) elements of supervision does contribute towards equipping social workers to function optimally within the Department of Health.

4.7.1 Educational supervision

Social workers were asked what their experience of the value of educational supervision is. The following is their responses. Some of them reported that it **increases independent functioning**: Participant 13 has 12 years' experience and no access to supervision:

"I access training. We were forced to become independent and active re our own development."

Other participants explained how they learn about medical terminology and diagnoses in supervision. They receive guidance from the supervisor, as reported by Participant 17 who has 24 years' experience:

"Need debriefing, guidance, education. Someone to monitor us and ensure we do the right thing."

This confirms what the NASW (2013) describes, that educational supervision is an opportunity for supervisees to be guided to conduct assessments, learn about treatment and intervention. It increases the production of knowledge and develops competences (Riva et al., 2015).

Responses from other participants reported that supervision clarifies interventions to be implemented with families and facilitates on-going learning. It is therefore even more significant for junior social workers as it results in improved practice. The latter was reported by Participant 9 who has 16 years practice experience:

“Better service delivery, better allocation of work so that it’s more manageable.”

Supervision helps social workers to adjust to their role within health, to distinguish between personal values and professional ethics and lastly it’s reported to be empowering. The social workers, as is evidenced above, reported that educational supervision does add value to their practice.

Another social worker with 10 years’ experience and no access to a social work supervisor in relation to the value the employer holds for the social work profession reported:

“It feels like you don’t belong. When it comes to patient care you’re important but when it comes to the discipline of social work no one is interested. It lacks development of the social work department. There is no professional development. We are stuck.”

This was one of the most profound statements to this question. It encompassed not only the essence of this research but the importance of employers taking care of their most important asset, human resources. It also spoke to the terms used to refer to social workers and physiotherapists, etc. in health: allied health which could be a means of not acknowledging the specific discipline and its role; it is an add-on, not necessarily required.

4.7.2 Supportive supervision

Participants were asked to respond to the significance of supportive supervision.

The provision of emotional support was the most significant for the participants. It is what distinguishes social work supervision from other professions (Cloete, 2012). “Supportive supervision is underscored by a climate of safety and trust, where supervisees can develop their sense of professional identity” (NASW, 2013: 8). The finding indicates that emotional support is most required by social workers. This links to debriefing and understanding which was mentioned by many participants.

Some quotes from participants:

Participant 5 has access to social work supervision and has 6 years’ experience:

“Supervision provides so much support. It’s important to have someone who can help you through not just the positive things but the difficult things too. Someone who’s in the profession, who understands what’s behind the profession, is the best.”

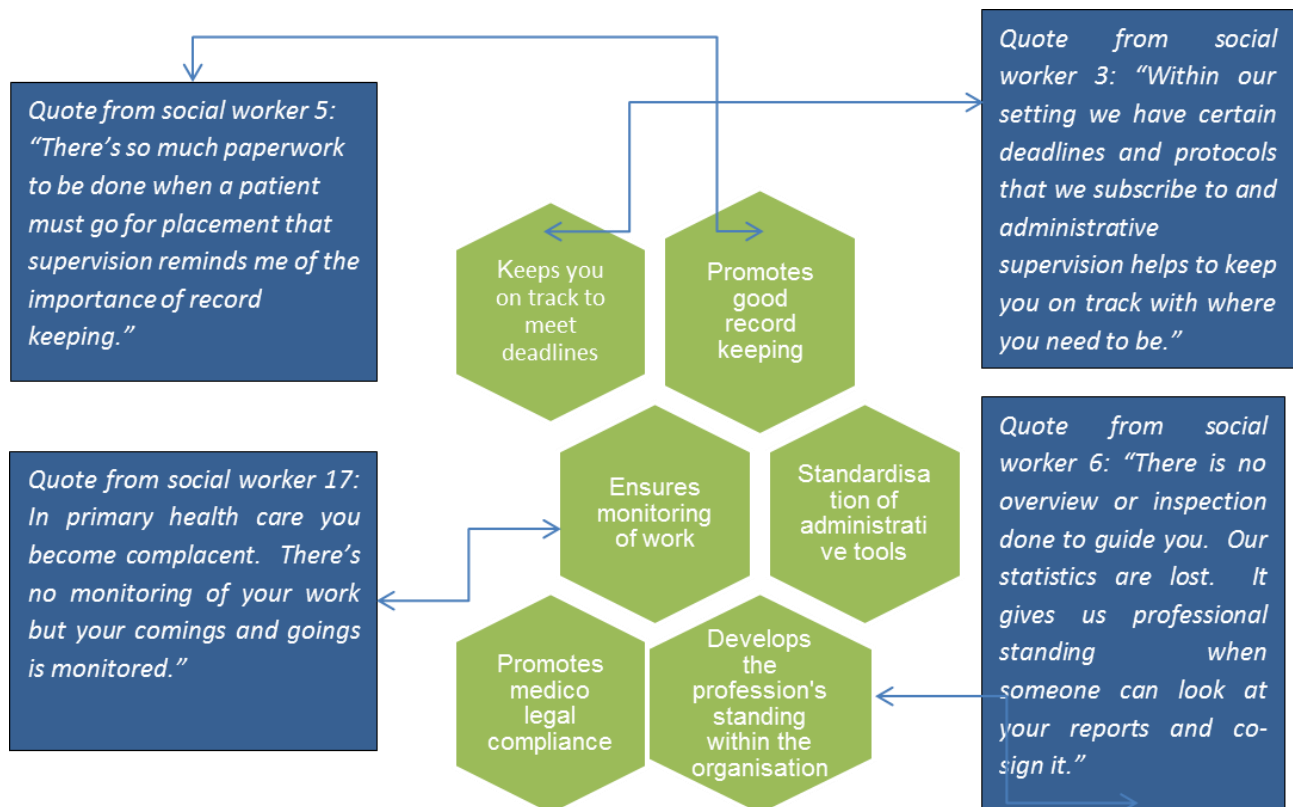
Participant 7 has 36 years’ experience and access to a social work supervisor:

“Support is allowing the person to debrief; to be able to share the emotional impact of what happened is important.”

This confirms the importance of the emotional support social work supervision provides. It’s not psychotherapy; it’s someone who understands the profession and the responsibility of the practice.

4.7.3 Administrative supervision

The following diagram shows the terms and quotes used by participants to describe the value of administrative supervision:

Figure 4.3: The value of administrative supervision as reported by the participants

Social workers interviewed reported that they become so absorbed in their work with patients that they lose track of the administrative duties and protocols associated with their work and that administrative supervision helps them to bring that balance into their work. The National Association of Social Workers (2008) reported that administrative supervision focuses on agency policy, organizational demands and the social workers' operational functioning.

This was confirmed by Participants 16 and 17 who are in primary health care:

"Nobody checks if I do my work. You can do the minimum. The community does what a supervisor should do. They hold you to account." (Participant 16)

"No one checks if we're doing what we supposed to be doing. You can get away with poor practice." (Participant 17)

It confirms Kadushin's (2002) sentiment that a profession that provides its service away from public scrutiny, that is not appropriately monitored and supported, can thus be at risk of

under or poor performance. In Chapter 1 and 2 of this research the context of the service users of public health care was explained. South Africa has a history (Coovadia et al., 2009) which could impact on whether the community is empowered to know that the social work service can be checked and to hold service providers accountable for poor service. In the absence of this and a social work supervisor, poor practice will go unnoticed.

This quote from Participant 1 is the response from a social worker who has access to a social work supervisor.

“There is trust that we can be able to function independently but at the same time there must be supervision to check, in terms of the work that you did, if it was effective/not.”

Supervision is reported to include the monitoring of the performance of social workers in such a manner as to improve the quality of services being rendered and to ensure that it is in line with the organizational goals (Mbau, 2005). The absence of supervision can also be inferred to mean the opposite. The quotes outlined above are a clear indication that where supervision is not being offered, as is the case with social workers in primary health care who are being managed by other disciplines, the risk of poor or inadequate service increases.

THEME 3: SIGNIFICANCE OF SUPERVISION

4.8 SIGNIFICANCE OF SUPERVISION

This is the primary element that this research endeavoured to uncover: what is the significance of social work supervision for social workers in the Department of Health in the Western Cape? In this section respondents were asked what the value of social work supervision is for the employer, that is, the Department of Health, towards benefiting the social worker, the agency clients and the agency where the social worker is employed.

The qualitative data reported on throughout this chapter have highlighted the significance of social work supervision. It confirms what Harmse (1999: 17) stated that the social worker needs a supervisor who is available within the organization with whom he/she can share

responsibility for decision making, from whom they can receive direction and to whom they can look for support.

Participant 9 has 14 years' experience as a social worker with 8 years in health and expresses the frustration experienced by social workers who have no access to a supervisor within health services:

"I was told we'd never have a supervisor post. The CEO called the social workers together explaining they don't have a supervisor post but wants someone to act. We asked her how someone can act in a post that is not on the establishment."

It would thus seem that there is recognition for it but not resources to affect it.

4.8. (a) THE DEPARTMENT OF HEALTH

Skilled supervisors are responsible for the protection of clients, for the advancement of social work practice, and for the professional development of the individual worker (Shulman, 2013: 11). All of the participants indicated that the employer benefits by them having access to social work supervision. Below are some direct quotes from participants:

Participant 7 works in mental health and has 36 years' experience:

"Supervision is one thing that helps you get the best out of your staff. Supervision provides care for the carer in a way that helps the carer do his job. It provides better service for the clients and saves money for the hospital. If social workers as individuals work better we have less pressure on the hospital."

Riva and Ratsika's (2015) writes that supervision is a fundamental tool which an employer of social workers must offer staff so that they can carry out their work well in help relations, as was confirmed by this participant. The researcher had previously indicated that provision of social work supervision could be a cost saving measure by the employer as it will go a

long way towards retaining the skill of expert health social workers and improve the efficiency of their service (DSD, 2006; Chiller et al., 2012). A lot of emphasis was placed on the role of social work supervision to improve the quality of service.

Participant 9 with 14 years' experience as a social worker with 8 years in health, describes the significance of social work supervision as meaning:

“Better service delivery, better allocation of work so that it's more manageable”.

This links with Mbau (2005) and Du Plooy (2011), who reported that supervision monitors the performance of social workers to improve the quality of services being rendered. This quote aptly describes what some of the other participants also reported. A social work supervisor would assist to ensure equitable work load allocation and also ensure that the more complex work is done by a more senior worker. This ensures that the social worker is developed according to her practice years. It will also result in less anxiety around burnout as reported earlier in this research.

Participant 11 has 23 years' experience in health and says supervision “*ups the quality of service*”. The absence of social work supervision can thus be inferred as resulting in poor service quality. This is important as social workers report being managed by non-social work professionals which means that no one is monitoring the quality of their work. It leaves the service users more vulnerable. Participant 13, with 12 years' experience based in primary health and with no access to social work supervision:

“Some people were comfortable to not have to account to anyone to improve their services. When nobody knows what you supposed to do you can get away with not performing”.

Participant 17, also based in primary health care with no access to a supervisor, reports on her need for “*someone to monitor us and ensure we do the right thing*”. It is clear that social workers do not perceive themselves as not needing supervision. For the social worker supervision is an important element of their practice.

Participant 12 who has almost 40 years' experience and access to peer as well as individual supervision's response to the significance of supervision for the employer:

“Streamline the service. Imagine speaking to all the social workers. Get the supervisor to engage with the social workers and give feedback to management.”

This social worker has more than five social work colleagues at her health facility and it therefore makes sense that the profession be represented by one person who acts as the liaison between the social workers and management (Kadushin, 1992; Shulman, 2013). Du Plooy (2011) wrote that the supervisor supports the social worker to grow professionally by monitoring the work done, evaluating it and developing it. The research findings thus confirms that social workers within health may not always provide good quality social work service to clients as there is no one who can correct their poor service if the manager does not know what the standard of service of a social worker should be.

It is because of this that Kadushin (2002:37) reported that the effect of poor/inadequate social work service is not easily detected, emphasizing the importance of “periodic review of worker activity”. In the Department of Health an audit system, National Core Standards, was introduced as a quality assurance tool but it does not measure/audit social work service (Western Cape Government Health, 2015). It is important to note that the social workers who gave the quoted responses are employed in the primary health care sector where there is primarily one social worker allocated to a clinic.

The last few quotes relates to the sense of belonging which social workers in health report to not experience. The term “allied” once again is relevant here. Health Care 2030 (Western Cape Government Health, 2015) promotes patient centred care and wellness but the health service is still based on a medical rather than bio-psycho social model.

Participant 1 based in mental health and with access to a social work supervisor:

“We have to find where we fit in whereas we are here that is serving also the department of health.”

This sense of not being a part of, being a contracted service to health, was echoed by Participant 10 (based in a specialist facility and who reports to an allied health professional) who reported that her colleague always says *“health is not our home”*.

Participant 14 with no access to a social work supervisor expresses what she needs in a supervisor:

“All the other disciplines have a supervisor except social work. It’s about someone who really understands what we do, how it affects us.”

This is echoed by Participant 15 with less than two years’ experience and also no access to a supervisor:

“You’ll have an energized, more productive social worker. You’d be able to see more clients. You’d have a healthy, stable employee”.

Lastly Participant 6 who has 20 years’ experience and access to a supervisor:

“When you alone you like a law unto yourself. Nobody knows what you supposed to do. We lose our respect as we become office based, not client based. ”

The relevance of these quotes is that they are the actual, felt and lived experiences of social workers in the field of health care service. It is interesting to note that it’s not just social workers who have no access to a social work supervisor but even those who have access can relate to the issue of the significance of social work supervision. Social work supervision is thus important to ensure appropriate, quality interventions for service users. It provides support for the social workers and instead as being seen as deprofessionalising the profession, it is regarded as adding value to the professional status.

4.8. (b) THE SOCIAL WORKER

In this section the manner in which social work supervision benefits social workers in health care was explored. The responses below are from social workers who have supervisors and those who do not.

CORE BENEFITS:

Improved relationship with clients: Participant 1 who works in mental health for 9 years:

“Having a supervisor helped me to establish a more intensive relationship with them.”

Accountability: Participant 6, 20 years’ experience:

“With a supervisor you know you must be visible, you must be accessible, and you are accountable.”

The supervisor supports the social worker, imparts information especially to less experienced social workers and those new to a particular organization and they also help staff to identify and control their biases (Farley et al., 2003).

Continuous professional development: Participant 6, 20 years’ experience:

“Previously I could decide what training I want to do with no one questioning the appropriateness of the training regarding my career pathing”.

This social worker now has a supervisor who will explore her choice in training and guide her appropriately. Therefore, the significance of supervision is to have someone who helps you stay on track regarding developments in theory and to support you to link it to your practice. This is lacking when there is no social work supervisor.

Improved service: Participant 4 with less than 10 years’ experience in one health facility:

“The supervisor guides you in cases where you don’t know what to do or which resources to contact and this will make you offer good service for the hospital.”

Similarly Participant 16 with a total of 24 years' experience of which 10 years are at the same health facility and no access to a supervisor reported:

"The better I function the more efficient I am. I work faster."

Ensures appropriateness of courses attended: Participant 9 with 8 years' experience in health:

"A supervisor will understand what the learning needs should be."

Participant 10, 10 years' experience and no access to supervision:

"No one does it for you. My colleague does not go on training. They don't stop you from going on training but there's no one who sits and engages with you around it."

Participant 11 with 23 years in health:

"I reported to a doctor before for 6 years. I had to learn about illnesses. People expected me to know the work. It's hard work to up skill yourself all the time."

Earlier in this chapter findings reported that most of the social workers interviewed have less than 10 years' experience working in the Department of Health. Two of the social workers interviewed have 23 years' experience practicing social work and all of the 23 years was spent working in health. The findings in this research thus correlates to the increased service stability as social workers stay longer in service of the Department of Health. Two of the three social workers who responded 'no' to the appropriateness of training attended have no access to a social work supervisor and reflected on how this allowed them access to any training as there is no one to check the appropriateness of training they want to attend. Kadushin (2002) highlights the importance of the community expecting a level of accountability for services provided by a social worker and as such supervision is needed. Social work supervision is needed to respond to the clients' needs and the mandate of society to restore people to their full capacity (Farley et al., 2003).

4.8 (c) THE SERVICE USERS

All of the participants gave a positive response to this question affirming that social work supervision benefits the client. The supervisor is responsible to ensure that the supervisee provides competent, appropriate and ethical services to the client (National Association of Social Workers, 2013). Below are some of the responses.

Participant 2 works 7 years in health:

“The families feel good knowing the buck doesn’t stop with you. It’s a safety thing for the families”.

This quote is directly linked to the importance of supervision versus internalized professional conscience.

Participant 7 has 36 years’ experience:

“If we demonstrate to clients that we ask for help we are creating an important experience for the client. Our clients appreciate the fact that it doesn’t stop with us.”

This relates to the writings of Kadushin (2002:36) who stated that where the objectives are unclear, the effects of interventions are unpredictable and the risk of failure is high, workers may need and want a supervisor with whom they can share responsibility.

Participant 3 has 34 years’ experience with 11 years in health:

“You’ve got the person in front of you, you’ve got what you learnt in terms of theory, but then you’ve also got what you picked up in supervision, when you’ve previously dealt with a similar case.”

Kadushin wrote that supervision “maximizes the worker’s capacity to do his job more effectively” (1992: 20). The findings of this study confirm that it is needed to ensure efficient and effective services to clients.

The following responses are specifically from social workers who have no access to a social work supervisor. Participant 9 has a total of 16 years' experience with 8 spent in health:

“What impact does it make on the patient if I'm frustrated and have no support?”

Participant 15 has less than two years' experience:

“Some clients will tell you, you look tired.”

Kadushin (2002) stated that if professional training is to successfully teach the student to develop a professional conscience then the supervisory function is internalized. The individual social worker thus becomes his/her own supervisor. This was not confirmed by the research. Participant 10, with 10 years' experience in health:

“Sometimes I feel we can do better, but to motivate each other; we don't have the time. You feel down sometimes.”

Participant 11 has 23 years' experience in health and echoed this by reflecting on her early years as a junior social worker:

“I made mistakes which could have been avoided/limited if I had a supervisor. I gained experience but at that stage my clients suffered through my mistakes.”

The effect of poor/inadequate social work service especially in the health sector is not easily detected thus emphasizing the importance of “periodic review of worker activity” (Kadushin, 2002:37). The Department of Health as an employer of social workers is currently not complying with the approved essential values (NDSD, 2012) underpinning the provision of effective social work service. A profession that provides its service away from public scrutiny that is not appropriately monitored and supported can thus be at risk of under or poor performance (Kadushin, 2002). The non-compliance by the employer to ensure that social workers have social work supervision can be surmised as the lack of commitment to provide this service to its service users and the on-going perception that the service of health only requires medically trained personnel.

Research done within the Department of Health by a sociology student on assessment and access to disability grants found that persons with mental health conditions often could not explain to doctors at primary health care facilities why their condition warrants their grant being recommended for renewal. This resulted in them then being readmitted to mental health facilities (Kelly, 2013) as they saw this as the only means to access the much needed grant. This could be as a result of the multi-disciplinary team not acknowledging the role of the social worker in being able to advocate on behalf of the patient. It also speaks to the functioning of the multi-disciplinary team at primary health level to ensure the best comprehensive health service to the patients.

This negates the vision of person centred care, which embraces the holistic care of service users. Research that was done in the UK on the effects of supervision on client outcomes demonstrated that client outcomes varied according to the social workers' experience/qualifications and supervision; more risk cases were resolved with additional supervision (Burke, 1997).

THEME 4: VALUE OF SUPERVISION

4.9 THE VALUE OF SOCIAL WORK SUPERVISION

Almost all of the participants indicated that they value social work supervision. One social worker questioned whether supervision is required. She preferred to receive consultation seeing supervision as an option for career pathing and not a necessity for social workers. This social worker is based in a district hospital and has no access to a social work supervisor. She has been working in health for a year.

Historically supervision was seen as a means to teach lay persons how to perform social work tasks, hence the reason why this participant questions the need for its continuance, as social work is a profession implying that once you qualify as a social worker you no longer need a more experienced person to tell you how to practice. It also relates to the issue of power which underpins a supervisor supervisee relationship. This was reported by various academics as a process by which one worker is given responsibility by the employer to work with another worker(s) in order to meet organisational, professional and personal objectives,

which together promote the best outcomes for their service users (Ford & Jones, 1987; Morrison, 2005).

However, the content of social work supervision goes beyond this as it also incorporates four main areas: direct practice, professional impact, continued learning, and job management (Kadushin & Harkness, 2002; Shulman, 2010). It is for this reason that the majority of the respondents acknowledge the value it holds for them.

Another social worker reported that although she sometimes misses not having a social work supervisor she has to find a way to cope. She networks and relies on colleagues in the field. The following quotes are from some of the participants:

Participant 7 has 36 years' experience:

"It's powerful. A supervisor can instil passion in me."

It is a strong statement of the value supervision holds for her. It also links to the impact of the work, the element of trauma reported on earlier in the findings and the fact that supervision improves morale by "instilling passion".

Participant 12 has been working at the same health facility for 22 years and a total of 37 years as a social worker:

"I trust the feedback of my supervisor 'cause she thinks like I do. The significance of a social work supervisor is that he/she can relate to you. A supervisor understands the social workers' experience. This is the difference in being supervised by a social worker and being managed by an allied health or medical colleague".

The word "trust" is significant in this response. It implies mistrust of someone other than a social worker because ultimately the qualified social worker is the only person who knows what a social worker should do.

Participant 8 has 5 years' experience of which 1 year is in health:

“Who makes sure that I don’t burn out on this side? Nobody looks out for me.”

A supervisor supports, advocates on behalf of the social worker and gives the social worker a sense of value within the organization (Farley et al., 2003; Cloete, 2012; National Association of Social Workers, 2013). Participant 9 has a total of 16 years’ experience with 8 years spent in health:

“In 2012 our management told us if we need a social work supervisor we must find another post. Other allied health staff have a hierarchy. They have chiefs. We don’t feel valued.”

With occupation specific dispensation, social work ranks changed from junior, senior chief to production and supervisor (Department of Public Service and Administration, 2008). This was done to ensure that social workers who wished to remain in production work receive the same salary as those who move into a management stream of supervision, etcetera. This is the issue of hierarchy referred to above. In the past, chief social workers could function as supervisors in the absence of a specific supervisor post. Now that cannot be done.

Participant 6 has 20 years’ experience of which 8 years is in health with access to supervision:

“The support you get (from supervision) will help you push through difficult periods in your career and motivate you to continue. If you not getting good support it can make you back away from social work.”

Supervision furthermore ensures that supervisees are equipped with advanced knowledge to apply their skills and abilities to client populations in an ethical and competent manner (National Association of Social Workers, 2013). Social work supervision is significant for social workers as it links directly to staff morale, service efficiency and service user satisfaction.

4.10 CHALLENGES

Social workers who have access to a social work supervisor reported challenges in finding time for supervision. Those who have no access to a social work supervisor reported the lack of social work supervision to be their greatest challenge. Quotes from some of the participants regarding this are reported below.

Participant 5 have been working in a national health facility for 6 years:

“My speed dial goes off all the time. Trying to find time, an hour to meet is difficult.”

Participant 15 has no access to a supervisor and less than two years practice experience:

“I know what it’s like to get up and not want to come to work. Taking sick is not the answer. You too scared to take off sick. You come back and everything is waiting for you. You don’t take proper care of yourself. You just think my clients, my clients, my work. You feel guilty when you off sick. I’ve normalized this for me.”

Participant 10, with no access to a supervisor and 10 years’ experience:

“The situation becomes unbearable. I’m looking for other work. Supervision in health is a big problem. I want a supervisor who understands what I do. It must be a social work supervisor”.

A social workers’ most important tool in the fulfilling of their duties is themselves and as such the support of supervision is pivotal to ensuring their professional wellbeing. Some of the social workers expressed frustration being managed by a medical colleague: Participant 14, 29 years’ experience, being managed by a medical colleague:

“You review me but you don’t know what I do”.

It can be deduced that the Department of Health does not regard the service of social work as an important commodity. It is not seeing it as a resource able to contribute to the person's experience of the health care service. Shulman (2013) wrote that a skilled supervisor is responsible for the protection of clients, for the advancement of social work practice, and for the professional development of the individual worker. The Department of Health promotes patient centeredness and wellness. The inability to provide social work supervision however leaves its patient population vulnerable to not realizing this vision of wellness.

4.11 SUMMARY

In conclusion, a quote from Participant 17:

“Hope the research will make an impact on the voice of social work so that there is a structure in primary health.”

This “structure” is reference to a hierarchy for social workers in primary health.

This chapter presented an analysis of the empirical findings that were collected through the semi-structured interviews. The aspects relating to supervision were divided into themes and subdivided according to the specifics of the particular theme which covered areas such as, access to supervision, the method of supervision they are exposed to and lastly the significance of social work supervision.

The findings were presented in narrative form. The next chapter will provide concluding thoughts and recommendations based on the findings

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This was an exploratory study aimed at researching the views of production social workers on the significance of social work supervision within the Department of Health. The research problem is based on the researchers' observations after more than 10 years as a social worker in the Department of Health and hearing concerns raised by social workers based in primary health care who have no access to social work supervision. The study was guided by a range of questions inclusive of whether newly qualified social workers are adequately equipped to function within the department of health without access to social work supervision, the significance of supervision to social workers and their access to supervision.

The objectives of the study were to:

- Contextualize the Department of Health as an employer of social workers, by describing the role of social work and its complexities as a secondary profession;
- Conceptualise supervision of social workers within a health context and explain the role of supervision within this context, specifically focusing on the significance of social work supervision;
- Empirically investigate the experiences of social workers in the Department of Health, Western Cape on the significance of social work supervision;
- Draw conclusions and make recommendations to social workers and relevant stakeholders in the Department of Health on the significance of social work supervision.

Chapter 1: An exhaustive literature study is the theoretical framework around which the research is based. This chapter covered the rationale for the choice of study, goal and objectives of the study, research approach, research procedure, type of research, target population and ethical issues.

Chapter 2: Here the researcher expanded on describing the role of social work and its complexities as a secondary profession in health facilities. It also elaborated on

understanding the Department of Health as an employer of social workers, the functioning and management of interdisciplinary teams, and the role of social workers in health.

Chapter 3: The final literature chapter focused on social work supervision, its historical development and the essence of supervision to the profession of social work. This chapter explored the significance of social work supervision within the context that social workers have no specialized training in health, is the only allied health discipline that is not aligned to the health professions council, has to report to medically trained managers who are not qualified social workers and has limited and in most instances no access to social work supervision.

Chapter 4: The empirical findings of the study were presented. In this chapter relevant conclusions will be presented towards the realization of the research objectives. Recommendations will be made regarding the significance of social work supervision for social workers in the Department of Health.

5.2 CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations will be presented in an integrated manner in accordance with the empirical findings as reported on in Chapter 4. This final chapter will provide conclusions and recommendations linked to the literature reviews and the empirical study. The conclusion will thus be presented with the corresponding recommendation. The importance of this chapter is to determine what the results as presented in Chapter 4 means to the profession of social work in the Department of Health. The researcher will analyse the findings and establish if new information was uncovered by this study. Challenges experienced by the researcher in conducting the study will also be evaluated.

5.2.1 The research process

The aim of the study was to determine if social workers in health care regard social work supervision as significant for their development and service delivery. Seventeen production social workers ranging from primary to tertiary health care were interviewed, at which stage the researcher reached a point of saturation. It can be concluded that production social

workers who work in the Department of Health who heard about the study were keen to have their voices heard as they believe in the importance of the subject matter.

It is therefore recommended that a more extensive study be conducted which could use focus groups to reach the majority of the social work population in the department of health.

5.2.2 Profiling of participants

The majority of the social workers interviewed are females based in primary health care facilities with no access to a social work supervisor. Some of these social workers report to medical or other allied health staff. The findings revealed that they are not receiving supervision. Their work is not being monitored and no one ensures that they are complying with social work standards for service delivery. This means that a large group of social workers interviewed in this study are expected to comply with quality standards for ethical practice with no monitoring of their work.

Those who have access to a social worker to supervise them have been employed in health for more than 10 years, with some working in health more than 20 years. Social workers who thus have access to a social work supervisor are easier to retain within the service, which means their expertise is not lost to the service. It also ensures better continuity and development for the social work service within health. It can thus be concluded that social work supervision contributes to the retention of skilled, expert social workers within the field of health services.

Despite most participants indicating that only experienced social workers must be employed in health services due to the complex nature of the work, the findings of this study indicate that in practice there is no policy/rule stating this and as such a newly qualified social worker can be employed in health services as was found in this study. The study did not explore the quality of service of the junior social worker who has no access to a social work supervisor versus the more experienced social worker who has no access to a social work supervisor. It merely revealed that there are no prescripts prohibiting the employment of junior social workers in facilities where they will have no access to a social work supervisor. The findings from this study is that social workers who report to medically trained staff are not being supervised and their interventions are not being assessed to determine the

appropriateness thereof. The study has not confirmed that they cannot access social work supervision but rather that the employer is not providing this. Furthermore, attempts to access support from colleagues are not well supported by the managers. This thus concludes that social work supervision is not regarded as essential to quality social work service. It is not seen as a tool needed by a social worker to effect quality service.

The Department of Health should thus consider revising its recruitment criteria to preferably ensure that social workers with at least practice experience are employed. It should also look at giving social workers access to social work supervision. This must be clarified as it does not mean access at the facility where they are based, but it could imply that a supervisor be appointed across a few facilities. This would also enhance the supervision experience as it will include better cohesion amongst the team of social workers and could also lead to the development of peer supervision.

5.2.3 Social work services

From this study a range of key activities were listed, ranging from therapeutic interventions, counselling pre- and post-amputation of limbs, bereavement counselling, termination of pregnancy counselling, to generic social work duties. People accessing public health services are compounded by multi-dimensional elements of poverty, for example tasks relating to placement, social assistance being prominent in this research.

This study has thus confirmed that social workers employed in health care require a range of knowledge and expertise to manage the interventions required from them. They have to be able to work across the life span of an individual rather than just focusing on for example, child protection or foster care as is the case in Department of Social Development.

This relates directly to the significance of social work supervision. The profession is broad in terms of its scope of practice as was found in this section. A social worker has to be able to function generically as well as acquire specialised knowledge in order to provide an effective service. Supervision is thus important to teach social workers specialised knowledge regarding health conditions, thereby aligning their skills to meet the demands of the health services.

The findings of this research have reported on the importance of supervision to provide guidance regarding appropriate interventions. For a social worker to counsel a patient on the amputation of a leg and what that will mean to their quality of life, and then to engage with them about the process of applying for a grant after their leg is amputated, is just an example of the complex nature of the work. It is easy for the social worker to be so affected by the patient's grief regarding the loss of their leg that she forgets to engage with the patient around the practical implication of accessing government funding. In this study it was thus found that social workers benefit from having a supervisor, as the latter reminds them of the elements of interventions required to affect a comprehensive patient centred service.

It is thus recommended that social workers in health be exposed to training appropriate to health services. It is further recommended that this training be done by a more senior social worker who has experience in the field of health and has the knowledge that is required by a social worker to function optimally within health services.

5.2.4 Social work supervision

The research found that less than half of the participants report to a social work supervisor. The rest of the participants report to medically trained staff, including pharmacists, psychologists and facility managers who are mainly qualified nurses. These staff have limited to no knowledge of the social work service. The study found that they primarily focussed on the administrative processes of managing an employee but did not engage with the evaluation and development of the profession's service within the sphere of health services. These social workers are not being supervised. It confirms that, despite the code of ethics of social workers (2007) and the Social Service Professions Act, 110 of 1978 (amended) which states that a social worker can only be supervised by another qualified social worker, the Department of Health is not complying with this.

In this study it was thus found that less than half of the participants interviewed receive social work supervision. This means that the Department of Health as an employer is not complying with the professions' code of ethics regarding supervision. It also means that the Department of Health does not regard supervision as an essential tool to social work service.

The majority of the social workers who do not receive social work supervision are based in primary health care, which is the first point of entry into health care services. Government's plan to reduce the referral pathway to secondary services, as it is not always geographically accessible to the community, will be difficult to achieve if workers who perform a key role in addressing the psycho social constraints are not adequately capacitated to function optimally at this level.

In essence the study revealed that social workers in primary health care, which is the entry point for social work services, have no access to social work supervision. The question which therefore remains is whether these social workers are equipped and supported to provide the best quality service to ensure that these service users do not end up in secondary health care services. In essence, these social workers' service are not being monitored and evaluated against acceptable standards for social work service. It leaves the community receiving this service vulnerable to possible poor service. Social work supervision is important in order to remedy this. This study did not assess the quality of social work interventions. Further study in this regard is thus needed to confirm the capacity of social workers to function optimally in primary health without access to a supervisor.

The Department of Health acknowledges the need for a comprehensive health care service. For social work to be adequately equipped to do this, the social work supervisor could be instrumental to equip and develop the profession of social work to function optimally within health. Social work supervision is regarded as significant to provide emotional support to social workers thus enabling them to cope better with the demands of their work. This study found that the social workers based in primary health care, who are often alone at a facility and have to see patients who experience acute post-traumatic stress, for example children who have been raped, will often first report to a primary health facility as it's the most easily accessible health point, are the most in need of support. However, these social workers who work in the forefront have no access to support.

It is recommended that these social workers receive regular debriefing and on-going support. The literature study revealed that supervision provides the space for social workers to reflect on their work, in order to understand the emotional impact of their work on themselves so that they can maintain objectivity within the service and as an antidote to burnout.

The study found that the social workers who have access to a social work supervisor are experienced social workers who are based at health facilities where they have ready access to social work colleagues who also have extensive experience in social work. It would thus seem that the health facilities where there are social work supervisors are more prone to employ social workers with experience. This could be because they understand the complex nature of the patient problems and the service required by the social worker. Facilities where younger, less experienced social workers are employed have no social work supervisors. The latter are essential in the recruitment process at health facilities and could be the determining factor to ensure the recruitment of experience appropriate to the service.

This essentially confirms the importance of social work supervision to ensure the correct skills package to be employed within the health service. It also confirms the lack of knowledge of services which does not employ social work supervisors. This can be directly linked to the code of ethics prescribing that a social worker can only be supervised by another qualified social worker because only the latter will know what the service of a social worker should be.

It is recommended that senior, experienced social workers be part of the recruitment process of new social workers within health, that junior social workers only be employed in health facilities where they will have access to social work supervisors and that experienced social workers be employed in primary health care facilities.

The research found that the majority of the social workers who receive social work supervision report to receive individual supervision. This type of supervision is time consuming and as such it should be noted that the majority of the participants indicated that they receive social work supervision as and when required. It can thus be inferred that individual supervision is the preferred type of supervision, but it does not occur on a set regular time. This further confirms that supervision is part of life-long learning and support required by social workers, as none of the social workers interviewed in this study who have more than 20 years' experience reported to not need supervision. The fact that they are still engaging in supervision is indicative of the importance of supervision for experienced social workers.

Peer supervision occurs more frequently, but this could be because it occurs as part of the social workers' administration meeting which could be a way to conceal the fact that supervision is occurring. This could be further confirmation of the possibility that the Department of Health as an employer is not supportive of the practice of supervision. In the previous section it was found that social workers deliver a diverse, broad service to meet the needs of patients. The importance of a supervisor to support this process was identified.

This study however found that the majority of the participants do not get social work supervision. These social workers are primarily based in facilities where large numbers of patients attend on a daily basis and where there is often a great need for the services of a social worker. It concludes the importance of social work supervision across all levels of service in health and irrespective of years of experience. It also concludes that social workers who report to non-social workers are not receiving supervision but are being managed administratively.

The department of health as an employer of social workers should endeavour to provide appropriate support to the social workers. This would ensure better accountability regarding service delivery. It is thus recommended that the employer in consultation with social workers develop a suitable model for access to social work supervision.

5.2.5 Generalist vs. specialist training

The research determined to ascertain if undergraduate training adequately equips social workers to function within a health setting. The research findings confirmed that undergraduate training does not equip social workers to function optimally within a health service without the support of social work supervision. Therefore, the research concluded that the impact of a newly qualified social worker being employed in health care without access to a social work supervisor places a huge emotional burden upon that social worker. She/he will have difficulty coping with the demands of the service, the multi-disciplinary team and constantly doubt her practice, which could lead to burnout and exiting the profession of social work. It is therefore recommended that social workers employed within health receive on-going training relating to the specific field of service.

The junior social workers who were interviewed in this study reported grave difficulty adjusting to the work environment. Social workers with many years' experience were also able to reflect on their early years in health without a social work supervisor, acknowledging that their interventions were not always sound. They were however unaware of their wrongdoing at the time. This is the risk of employing newly qualified social workers within the health service without access to social work supervision and inadvertently affirms the significance of social work supervision. There was agreement that social workers require specialized knowledge about health to function in health services. They also need to be supported in terms of their interventions to ensure the patients receive appropriate services. None of the findings relate to under graduate training being inadequate, but rather to the need for service specific information once a junior social worker is employed in a specialised field of practice.

The research findings confirmed the legislative prescripts of the profession of social work in South Africa, concluding that social work supervision should be mandatory. The recommendation for the employer is to develop an appropriate training programme, as is being done by the South African Police Service or the Defence Force, in order to equip social workers with relevant knowledge on medical treatment. This training cannot be incorporated into tertiary training as the profession's scope of practice is so vast that training has to be job specific.

5.2.6 Functions of social work supervision

Educational: The research findings concluded that within the Department of Health, social workers need professional development as a means to fully equip them to function optimally. Terms used by participants in this research to describe the value of educational supervision included: guidance, empowering and improved practice. The educational element of social work supervision thus holds great value for social workers in health. Social workers need specialised knowledge on health conditions to help them align their services accordingly. Supervision is essential to providing these teachings. Without supervision social workers have to manage on their own with the risk of perhaps not gaining this much needed knowledge. This will inevitably impact on their quality of service. Educational supervision

is thus needed in health to appropriately equip generically trained social workers to function optimally within the specialised field of health.

Supportive: The research found that most social workers associated support with emotional support and debriefing. Social workers report to experience emotional trauma with no space to be able to engage with a senior colleague in an effort to understand the effect of their work on their emotions. Issues of burnout was also highlighted which is symptomatic of a lack of appropriate support. The aspects of supportive supervision, as listed by the participants, concludes the significance of supportive supervision and also highlights what social workers who are not receiving supervision from a social worker are lacking. Supportive supervision is thus a means for social workers to reflect on their work and to get guidance regarding more appropriate interventions. It reduces the risk for practice abuse as social workers are more emotionally adept to engage with the extreme emotional trauma their patients' experience. It's a means to combat burnout and to retain the social worker in the profession. It is recommended that the employer ensures that social workers receive appropriate on-going emotional support.

Administrative: The participants concluded that administrative supervision is essential to the quality of their practice. It keeps them on track to meet administrative deadlines, ensures good record keeping as they know that their work will be monitored and develops the profession's standing within the organisation. The latter not only relates to the significance of social work supervision but also concludes that social work supervision does not de-professionalise it. In contrast, it develops standards for good working conditions and should also develop appropriate job descriptions for social workers incorporating both their generic and specialist services.

It can be concluded that these three functions of supervision are essential to social workers in health. Support is needed to represent a voice for the profession, education to ensure that social workers are on par with the specialized knowledge needed in health and administrative to comply with the government processes.

It is recommended that the employer ensures that social workers receive adequate support. This does not necessarily mean social work supervision, but it does imply support from a

professional who understands the profession of social work and the service. This support has to be on-going and not just in the form of once off/occasional debriefing.

5.2.7 Significance of social work supervision

Participants concluded that supervision facilitates a better service delivery to the clients. It improves the productivity and efficiency of staff. The Department as the employer benefits, as it has an employee who is equipped to deliver a service of which the quality is being monitored, whilst the employee is being supported to remain resilient within the service. Social work is a social science based on theoretical practices but not an exact science. Supervision thus reduces the risk to patients receiving substandard service. It reassures patients that there is accountability for the service.

Those social workers who have no access to social work supervision reported that it negatively impacted on their professional development. They are able to access training but have no one to guide them and ensure that it's appropriate for their career pathing. There is a huge sense of invisibility within the Department of Health. They have no hierarchy within the department; no one at management level to advocate for them and as such felt they are not acknowledged as a profession. The lack of a social work supervisor leaves them feeling vulnerable to the point of not trusting the employer. Literature also revealed that the social worker and supervisor relationship impacts on the quality of intervention the client receive. The absence of that relationship can thus mean that the quality of interventions is negatively impacted.

The social workers who have access to supervision reported the opposite experience. They have a supervisor who can advocate for them at management level. They are able to develop professionally and thus have a generally more positive experience of working in the Department of Health. This results in a more efficient service to their clients as they have the necessary support to focus on service delivery. It can thus be concluded from the findings that social workers within the Department of Health who have access to social work supervision values the fact that it positively impacts on their professional development and the service they provide to their clients.

The interdisciplinary team however does not necessarily have a positive impact on the social workers. From the responses of the participants in this study it is clear that the interdisciplinary team cannot replace the social work supervisor. Social workers work in interdisciplinary teams within other government sectors too and as such it is recommended that tertiary institutions look at whether they are imparting skills for team work in under graduate training.

All the participants indicated that social work supervision benefits the clients. The service is offered behind closed doors and adheres to strict principles of confidentiality. There is no one observing the intervention and no means to prove wrongdoing in the event of a complaint. It is therefore that supervision is essential to add credibility to the profession. It adds value to the service as the social worker has the added advantage of another more senior social worker's experience that she takes with her in to her sessions with clients. The social worker also feels confident knowing that her work is monitored and as such mistakes can be corrected. The importance of joint liability was also voiced strongly by participants. Having a social work supervisor means that families and clients can feel safer knowing they can complain if they're not happy with the service. It enhances trust in the social work service. Supervision is thus recommended, as it will protect the integrity of the profession.

A further finding from the study is that social workers who report to non-social work professionals are not being supervised. Their work is not being monitored and is at risk of disadvantaging service users. These social workers receive administrative management but not supervision of their work and interventions. They are basically functioning as private practitioners and within the profession of social work, even social workers in private ensure that they have access to a supervisor. Within the context of South Africa, where a large part of the population were denied their human rights as reported on in Chapter 2, the chances are great that the service user will not know what to expect in terms of quality service, thus implying that poor service will continue unchecked. One of the social workers in this study reported that she did not deliver sound practice interventions when she worked as a junior social worker without access to a social work supervisor. At the time she did not know that she was doing wrong as she had no one telling her, and this confirms the risk to clients within health. When there is no monitoring of the social work service it could place the Department of Health at risk of being litigated for poor practice.

It can thus be concluded that social work supervision is significant for the social worker, the Department of Health as well as the service user. There was no reporting of social work supervision deprofessionalising social work as a discipline. Instead the positive outcomes for service users were highlighted.

Based on this, it is very clear. Social workers need support, they need specialised knowledge to practice and they need a supervisor who has an understanding of the context of their work. The Department of Health needs equipped social workers who are emotionally well to function optimally within the work space. Central to all of this is the provision of social work supervision, which will encompass all that is needed for the benefit of the concerned parties. The provision of social work supervision is therefore the only recommendation that is appropriate in this context and based on these findings.

5.2.8 Value of social work supervision

Social workers were asked if they value social work supervision. The majority responded in the affirmative. Irrespective of years of experience within or outside of health services, as well as whether they have access to supervision, they were in agreement that social work supervision is important for the profession of social work.

One of the participants questioned the need for supervision as she regards it as a means to advance the social work supervisor's career. There thus seems to be mistrust in the legitimacy of the supervisor's motivation to advance the quality of the supervisee's intervention. This response was in the minority in comparison to the overwhelming positive response from participants who value supervision irrespective of their years' practice experience.

Findings from the research confirm the significance of social work supervision to develop and affirm the profession of social work. None of the participants reported it to negate the standing of social work as a profession.

It is therefore recommended that social work supervision be made available to social workers irrespective of years' experience as the findings confirmed that it is regarded as essential to lifelong learning and to liaise between management and the workers.

5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

The research focused on production social workers' experience on the significance of social work supervision. Findings confirmed that they value social work supervision. Social work is however one of the allied health groups who report to medically trained staff. It is thus recommended that further research focus on how all allied health professions in health experience their current reporting structure versus their need for supervision.

This study targeted production social workers only. Further research could explore the functioning of social work supervisors within the context of health, how they cope with the work load, whether they feel equipped to provide supervision and whether they regard their service as still relevant.

Many of the participants reported on their sense of invisibility as a profession within the Department of Health. Literature reported on the realization of the importance of social work service in health being due to the development of an understanding that a patient's disease cannot be treated effectively without taking into account his social circumstances. A study which investigates how health managers perceive the role of social work in providing quality health care is recommended.

A further study assessing the knowledge base of the medical staff who manage social workers in health regarding the services and scope of practice of a social worker is recommended. This will be used to assess their capacity to manage social work services which includes whether they have knowledge to determine standards for social work practice.

This study emphasised the importance of supervision to determine the quality of social work interventions, a comparative study on the quality of interventions for social workers who receive social work supervision versus those who don't is recommended. This will substantiate the finding on the significance of supervision for social workers in health.

Some of the participants in this study reported on how the community holds them to account for quality service. A study on the patients' experience of the social work service in health care is therefore needed to ascertain their perceptions regarding the impact of the service versus their expectations thereof.

Lastly this study did not provide findings which can be generalised to the social work population within the Department of Health as it is a qualitative study. A study encompassing both qualitative and quantitative methodologies is recommended to engage a larger group of social workers as it was clear that the social workers have a need for this topic to be explored with definitive recommendations for the Department of Health as an employer of social workers

5.4 KEY FINDINGS

Social workers report social work supervision to be significant to their profession and service within health care. The study has found supportive supervision to be an essential element to be lacking by those who are managed by professionals who are not qualified social workers. There is a definitive sense of inadequacy regarding capacity to navigate the health service and not being understood by these managers. The findings has confirmed legislative prescripts that the supervision of social workers is mandated by the South African Council for Social Service Professions' Code of Ethics (SACSSP, 2007) and Social Work Act (RSA, 1978) which states explicitly that social workers must be supervised by social workers. A person supervising a social worker must be a qualified, registered to practice social worker, with relevant experience in supervision (NDSD, 2012: 22).

Many participants reported on the importance of employing experienced social workers within health services. This could be regarded as discriminatory practice and seen as a means to remedy the lack of access to social work supervision. Although this was not the focus of the study, the experienced social workers in this study all reported the on-going need for access to a social work supervisor.

The key finding of this study is that social work supervision is regarded as essential to equip, develop and provide support to the social work practice within health services.

REFERENCES

- Abramson, J.S. & Bronstein, L.R. 2004. Group process dynamics and skills in interdisciplinary teamwork. In Garvin, C., Galinsky, M. & Gutierrez, L. (eds.), **Handbook of social work with groups**. New York: Guilford.
- Babbie, E. & Mouton, J. 2007. **The practice of social research**. SA edition. Cape Town: Oxford University Press.
- Barker, R.L. 2003. **The social work dictionary**. Washington, DC: NASW Press.
- Barth, M.C. 2003. Social work labor market: A first look. **Social Work**, 48(1), 9-19.
- Baxter, S., Killoran, A., Kely, M.P. & Goyder, E. 2010. Synthesizing diverse evidence: the use of primary qualitative data analysis methods and logic models in public health reviews. **The Royal Society for Public Health**, 124(2): 211-226.
- Bernard, H. & Ryan, G. 2010. **Analyzing qualitative data: systematic approaches**. Thousand Oaks, CA: Sage.
- Beytell, A. 2014. Fieldwork education in health contexts: experiences of fourth-year BSW students. **Social Work/ Maatskaplike Werk Journal**, 50(2): 170-193.
- Black, R., M. Collyer, R. Skeldon, and C. Waddington. 2005. **A survey of the illegally resident population in detention in the UK**. Home Office Online Report 20/05. Available at <http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr2005.pdf> (Accessed 27/04/2016): 552–564
- Bless, C., Higson-Smith, C. & Kagee, A. 2011. **Fundamentals of Social Research Methods: An African Perspective**. 4th ed. Cape Town: Juta & Co. Ltd.
- Bogo, M. & Taylor, I. 1990. A Practicum Curriculum in a health specialization: a framework for hospitals. **Journal of Social Work Education**, 26(1): 76-86.

- Botha, N.J. 2002. **Supervision and Consultation in Social Work**. Bloemfontein: Drufooma.
- Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. **Research in health sciences**. Cape Town: Pearson Education.
- Boyce, R. 2001. Hospital restructuring – The implications for allied health professions. Australia. **Australian Health Review**, 14(2): 147-154.
- Brewer, E. W. & Shapard, L. 2004. Employee burnout: A meta-analysis of the relationship between age and years of experience. **Human Resource Development Review**, 3 (2): 102-123.
- Bronstein, L. R. 2002. Index of interdisciplinary collaboration. **Social Work Research**, 26(2), 113–126.
- Burke P. 1997. Risk and supervision: social work responses to referred user problems. **British Journal of Social Work**, 25: 115-129.
- Burns, M. 1958. **The historical development of the process of casework supervision as seen in the professional literature of social work**. Unpublished doctoral dissertation. Chicago: University of Chicago.
- Burns, N. & Grove, S.K. 2009. **The Practice of nursing research: appraisal, synthesis, and generation of evidence**. 6th ed. St. Louis, Missouri: Saunders.
- Carpenter, J Carpenter, J., Webb, C., Bostock, I. & Coomber, C. 2012b. **Effective supervision in social work and social care**. Social care institute for excellence. [Online] Available: www.scie.org.uk. (Accessed: 27/12/2015).
- Caputi, M.A. & Heiss, W.A. 1984. The DRG Revolution. **Health and Social Work**, 9(1):5-12.
- Carroll, M. 2009. Supervision: Critical Reflection for Transformational Learning, Part 1. **The Clinical Supervisor**, 28: 210–220.

Chiller, P. & Crisp, B. R. 2012. Professional supervision: a workforce retention strategy for social work. **Australian social work**, 65 (2): 232-242.

Christians, C. 2005. **Ethics and Politics in Qualitative Research**. In: Denzin, N & Lincoln, L. (eds.) The Sage handbook of qualitative research. 3rd ed. Thousand Oaks: Sage.

Cleak, H. 2002. A Model of Social Work Classification in Health Care. **Australian Social Work**, 55(1): 38–49.

Cleake, H.M. & Turczynski, M. 2014. Hospital Social Work in Australia: Emerging Trends or More of the Same? **Australia: Social Work in Health Care**, 53(3): 199-213.

Cloete, V. 2012. **The Features and us of mentoring as an activity in supervision of newly qualified social workers**. Unpublished MA thesis. Stellenbosch: University of Stellenbosch.

Coffey, M., Duggill, L., & Tattersall, A. 2009. Working in the public sector. **Journal of Social Work**, 9: 420-442.

Continuing NHS Healthcare National Programme. 2011. **Multidisciplinary Working: A Framework for Practice in Wales**. Wales: National Government.

Cooper, L. 2006. Clinical supervision: Private arrangement or managed process? **Social Work Review**, 18: 21-30.

Coovadia, H. Jewkes, R. Barron, P. Sanders, D. & McIntyre, D. 2009. **The health and health system of South Africa: historical roots of current public health challenges**, 374: 817-834.

Corey, G., Corey, M.S., Corey, C. & Callanan, P. 2014. **Issues and ethics in the Helping Profession**. Australia: Brooks Cole.

Couturier Y, Gagnon D, Carrier S, Etheridge F. 2008. **The interdisciplinary condition of work in relational professions of the health and social care field: a theoretical standpoint**. Bethesda: U.S. National library of Medicine

Cresswell, J.W. (ed.) 2013. **Qualitative Inquiry & Research design: Choosing among five approaches**. Thousand Oaks California: Sage Publications.

Crisp, B. 2000. A history of Australian social work practice research. **Research on Social Work Practice**, 10(2): 179–194.

Davys, A. & Bedoe, L. 2008. Interprofessional learning for supervision: ‘taking the blinkers off’. **Learning in Health and Social Care**, 8(1): 58-69.

Davys, A. & Bedoe, L. 2010. **Best practice in professional supervision**. England: Jessica Kingsley Publishers.

De Jager, H. 2003. **Burnout, engagement and stress of medical practitioners**. Unpublished mini thesis. Potchefstroom: University of Potchefstroom.

Delport, C.S.L., Fouche, C.B. & Schurink, W. 2011. Theory and Literature in qualitative research. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. **Research at grass roots: for the social sciences and human service professions**, (3rd ed) Pretoria: Van Schaik Publishers, 297-306.

Department of Health. **About Us**. [Online] Available from: www.westerncape.gov.za/dept/health/aboutus (Accessed: 9 February 2015).

Department of Health: Health care in South Africa. [Online] Available from: <http://www.southafrica.info/about/health/health.htm> (Accessed: 28/05/2015).

Department of Health. 2010. **National Service Delivery Agreement. 2010**. Pretoria: National Department of Health.

Department of Public Service and Administration. 2008. **Occupation Specific Dispensation: Social Work**. Pretoria: Government Printers.

Department of Social Development. 2006. **Draft Recruitment and retention strategy for social workers**. Pretoria: National Department of Social Development.

Department of Social Development (DSD) & South African Council for Social Service Professions (SACSSP). 2012. **Supervision framework for the social work profession in South Africa**. Pretoria: National Department of Social Development.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delpont, C.S.L. 2002. **Research at grass roots: for the social sciences and human services professions, 2nd edition**. Pretoria: Van Schaik Publishers.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delpont, C.S.L. 2004. **Research at grass roots: for the social sciences and human services professions**. Pretoria: Van Schaik Publishers.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delpont, C.S.L. 2011. **Research at grass roots: for the social sciences and human service professions** (4th ed.) Pretoria: Van Schaik Publishers.

Dollard, M. F., Winefield, H. R. & Winefield, A. H. 2001. **Occupational strain and efficacy in human service workers: When the rescuer becomes the victim**. Dordrecht, The Netherlands: Kluwer Academic.

Drotar, D. 2002. Reflections on interdisciplinary collaboration in the new millennium: Perspectives and challenges. **Journal of Developmental & Behavioral Pediatrics**, 23(3), 175-180.

Du Plessis, G.A. 1965. **Supervisie as hulpmiddel in maatskaplike werk met besondere aandag aan die Departement van Volkswelsyn en Pensioene**. Unpublished MA Thesis. Pretoria: University of Pretoria.

Du Plooy, A.A. 2011. **The functions of social work supervision in the department of health and social development Ekurhuleni region**. Unpublished MA Thesis. Johannesburg: University of Johannesburg.

Ekstein, R. & Wallerstien, R. 1972. **The teaching and learning of psychotherapy**. New York: International Universities Press.

Emerson T. 2004. Preparing placement supervisors for primary care: an interprofessional perspective from the UK. **Journal of Interprofessional Care**, 18(165–182).

Engelbrecht, L.K. 2010. Yesterday, today and tomorrow: Is social work supervision in South Africa keeping up? **Social Work/Maatskaplike Werk**, 46(3): 324-340.

Engelbrecht, L.K. 2012. An interpretative framework for strengths-based social work supervision. Paper presented at the Association of Schools of Social Work in Africa (ASSWA) conference, Witrivier: South Africa. [Online] Available from: <http://scholar.google.co.za/citations?user=YUORtfMAAAAJ> (Accessed: 02/06/2015).

Engelbrecht, L.K. 2013. Social Work Supervision Policies and Frameworks: Playing Notes or Making Music. **Social Work/Maatskaplike Werk**, 49(4): 456-468.

Engelbrecht, L.K. (ed.) 2014. **Management and supervision of social workers: Issues and challenges within a social development paradigm**. Andover: Cengage Learning EMEA Limited.

Farley, O.W., Smith, L.L. & Boyle, S.W. 2003. **Introduction to Social Work**. London: Pearson Education Incorporated.

Ford, K. & Jones, A. 1987. **Student supervision**. London: Macmillan Education.

Forrest, C. & Derrick, C. 2010. Interdisciplinary education in end-of-life care: Creating new opportunities for social work, nursing and clinical pastoral education students. **Journal of Social Work in End of Life & Palliative Care**, (6): 91–116.

Fouche, C.B. & De Vos, A.S. 2011. Formal formulations. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. **Research at grass roots: for the social sciences and human service professions** (3rd ed.) Pretoria: Van Schaik Publishers, 89-100.

Galambos, C. 2013. Health Care: Overview. **Encyclopaedia of Social Work**. (A) (O) 10.1093/acrefore/9780199975839.013.549 (Accessed 10/06/2015): 1-18.

- Gibelman, M. 2005. **What Social Workers Do (2nd ed.)**. Washington, DC: NASW Press.
- Gilbert, C. 2009. Editorial. **The Clinical Supervisor**, 28:1-2.
- Godden, J. 2012. **Research on supervision in social work with particular reference to supervision practice in multi-disciplinary teams**. British Association of Social Work: England.
- Greeff, M. 2005. Information collection: interviewing. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. **Research at grass roots: for the social sciences and human service professions** (3rd ed.) Pretoria: Van Schaik Publishers, 286-313.
- Groote Schuur Hospital, 2015. **Job Description Production Social Worker**. Cape Town: Western Cape Department of Health.
- Guy, M. E., Newman, M. A. & Mastracci, S. H. 2008. **Emotional labor: Putting the service in public service**. New York: ME Sharpe.
- Hafford-Letchfield, T., Chick, N.F., Leonard, K. & Begum, N. 2008. **Leadership and Management in Social Care**. Thousand Islands: London, Sage.
- Hanson, C. M., Spross, J. A. & Carr, D. B. 2000. Collaboration. In Hamric, A.B., Spross, J.A. & Hanson, C.M. (Eds.). **Advanced practice nursing: An integrative approach** (2nd ed.) Philadelphia, PA: W. B. Saunders, 315-347.
- Harkness, D. & Poertner, J. 1989 Research and social work supervision: a conceptual review. **Social Workers**, 34 (2): 115-119.
- Harmse, A.D. 1999. **Support systems for social work supervisors in the Department of Welfare**. Unpublished thesis in fulfilment of PHD. Pretoria: University of Pretoria.
- Hawkins, P. & Shohet, R. 1989. **Supervision in the helping professions: an individual, group, organizational approach**. London: University Press.

Hawkins, P. & Shohet, R. 2007. **Supervision in the helping professions.** (3rd ed.). Berkshire: Open University Press.

Hawkins, P., & Smith, N. 2006. **Coaching, mentoring and organizational consultancy: Supervision and development.** Maidenhead, UK: Open University Press.

Hensley, P. H. 2002. The Value of Supervision. **The Clinical Supervisor**, 21(1): 97-110

Hoffman, W. 1990. **Field practice education. A social work course model.** Pretoria: HAUM Tertiary.

Ingram, R. 2013. Emotions, Social Work Practice and Supervision: An uneasy Alliance? **Journal of Social Work Practice**, 27(1): 5-19.

International Association of Social Work. 2014. **Global definition** [Online] Available from: www.iassw-aiets.org (Accessed: 10/05/2015).

International Federation of Social Work. 2004. **Ethics in Social Work Statement of Principles.** [Online] Available from: <http://www.ifsw.org/en/p38000324.html> (Accessed: 20/07/2015).

Jeftha, E.M. 2001. **The application of the support function in supervision to social workers in a mental health set-up.** Unpublished MA Thesis. Stellenbosch: University of Stellenbosch.

Jones, D.N. & Truell, R. 2012. The global agenda for social work and social development: A place to link together and be effective in a globalized world. **International Social Work**, 55: 454–472.

Jones, M, Bennett, J., Lucas, B., Miller, D. & Gray, R. 2007. Mental health nurse supplementary prescribing: experiences of mental health nurses, psychiatrists and patients. **Journal of advanced nursing**, 59(5): 488-496.

Joseph, M. V., & Conrad, A. P. 1989. Social work influence on interdisciplinary ethical decision making in health care setting. **Health and Social Work**, 14(1): 22–30.

Judd, R.G. & Sheffield, S. 2010. Hospital social work: Contemporary roles and professional activities. **Social Work in Health Care**, 49(9): 856–871.

Kadushin, A. & Harkness, D. 2002. **Supervision in Social Work** (4th ed.) New York: Columbia University Press.

Kadushin, A. & Harkness, D. 2014. **Supervision in Social Work** (5th ed.) New York: Columbia University Press.

Kautzky, K. & Tollman, S.M. 2008. **A Perspective on Primary Health Care in South Africa**. Witwatersrand: University of the Witwatersrand School of Public Health.

Kelly, G. 2013. Regulating access to the disability grant in South Africa, 1990-2013. **CSSR Working Paper No. 330**. Cape Town: University of Cape Town.

Kickul, J. & Posig, M. 2001. Supervisory emotional support and burnout: An explanation of reverse buffering effects. **Journal of Managerial Issues**, 13(3): 328-344.

Kilminster, S.M. & Jolly, B.C. 2000. Effective supervision in clinical practice settings: a literature review. **Medical Education**, 34: 827-840.

Kirst-Ashman, K.K. & Hull, G.H. 1997. **Generalist practice with organizations and communities**. Chicago: Nelson Hall Publishers.

Kirst-Ashman, K.K. 2013. **Introduction to social work and social welfare**. 4th ed. Belmont: Brooks/Cole.

Kramer, R.M. 1999. Trust and distrust in organizations: emerging perspectives, enduring questions. **Annual Review of Psychology**, 50: 1-705.

Laming, W.H. 2009. **The protection of children in England: a progress report**. London: The Stationery Office.

Leipzig, R. M., Hyer, K., Ek, J., Wallenstein, S., Vezina, M. L., Fairchild, S. & Howe,

J. L. 2002. Attitudes toward working on interdisciplinary healthcare teams: A comparison by discipline. **Journal of the American Geriatrics Society**, 50: 1141-1148.

Lincoln, Y.S. & Guba, .E.G. 1985. **Naturalistic inquiry**. Newbury Park, CA: Sage Publications.

Lincoln, Y.S. & Guba, E. 1999. Establishing trustworthiness. In: Bryman, A. & Burgess, R.G. (eds.) **Qualitative Research Vol III**. London: Sage.

Lourens, H. S. 1995. **Die aard van maatskaplike werk in die hospital as werkplek**. Unpublished MA Thesis. Johannesburg: University of Johannesburg.

Maguire,L. 2002. **Clinical social work: Beyond generalist practice with individuals, groups, families**. California: Brooks/Cole-Thompson Learning.

Mbau, M.F. 2005. **The educational function of social work supervision in the department of health and welfare in the Vhembe district of Limpopo province**. Unpublished MA Thesis. Pretoria: University of Pretoria.

McKee, M. & Black, N. 1992. Does the current use of junior doctors in the United Kingdom affect the quality of medical care? **Social Science Med**, 34 (5): 549-58.

Monette, D.R., Sullivan, T.J. & De Jong, C.R. 2005. **Applied Social Research: a tool for the human services**. 6th ed. Australia: Thomson Brooks/Cole.

Morales, A.T., Sheafor, B.W. & Scott, M.E. 2012. **Social work: A profession of many faces**. New York: Allyn & Bacon.

Morrison, T. 2005. **Staff supervision in social care**. Brighton: Pavilion Press.

Morrison, T. & Wonnacott, J. 2010. **Supervision: Now or Never Reclaiming Reflective Supervision in Social Work**. [Online] Available from: <http://www.in-trac.co.uk/reclaiming-reflective-supervision.php> (Accessed: 05/08/2015).

Munson, C.E. 1979. **Social work supervision classic statements and critical issues.** New York: Free Press.

Munson, C.E. 1983. **An Introduction to clinical social work supervision.** New York: Taylor and Francis Press.

Munson, C.E. 2002. **Handbook of clinical social work supervision.** 3rd ed. New York: The Haworth Press.

Neuman, W.L. 1997. **Social research methods: qualitative and quantitative approaches.** London: Allyn & Bacon.

Nilsson, D., Joubert, D., Litt et Phil, L., Holland, L. & Posenelli, S. 2013. The why of practice: Utilizing PIE to analyze social work practice in Australian hospitals. **Social Work in Health Care**, 52(2–3): 280–295.

O'Donoghue, K. 2012. Windows on the supervisee experience: an exploration of supervisees' supervision histories. **Australian Social Work Journal**, 65(2): 214-231.

Olckers, C.J. 2013. **A training programme in the DSM system for social workers.** Department of Social Work and Criminology. Pretoria: University of Pretoria. (Doctoral Thesis)

Owens, C., Goble, R. & Gray, D.P. 1999. Involvement in multiprofessional continuing education: a local survey of 24 health care professions. **Journal of Interprofessional Care**, 13: 277-288 .

Patchner, M.A. & Wattenberg, S.H. 1985. Impact of Diagnosis Related Groups on Hospital Social Service Departments. **Social Work**, 30(3): 259-61.

Patford, J. 1999. What's happening in health: Progress and prospects for social work. **Australian Social Work**, 52(1): 3-7.

Patton, M. 2002. **Qualitative research and evaluation methods**. 3rd ed. Thousand Oaks, CA: Sage.

Polit, D.F. & Beck, C.T. 2004. **Nursing research: principles and methods**. 7th ed. Philadelphia: J.B. Lippincott.

Polit, D.F. & Beck, C.T. 2010. **Essentials of nursing research: appraising evidence for nursing practice**. 7th ed. Philadelphia: Lippincott.

Rabinowitz, J. 1987. Why ongoing supervision in social casework: An historical analysis. **The Clinical Supervisor**, 5(3): 79-90.

Ramsammy, L. 2010. Interprofessional education and collaborative practice. **Journal of Interprofessional Care**, 24(2): 131–138.

Reisch, M. 2012. The challenges of health care reform for hospital social work in the United States. **Social Work in Health Care**. 51: 873–893.

Republic of South Africa. 1978. **Social Service Professions Act, 110 of 1978**. Pretoria: Government Printers.

Riva, M.G. & Ratsika, N. 2015 **Supervision as a kind of qualitative evaluation**, Technological Educational Institute (TEI) of Crete: Greece.

Robinson, D. & Kish, C. P. 2001. **Core concepts in advanced practice nursing**. St. Louis, MO: Mosby.

Rubin, A. & Babbie, E. 2005. **Research methods for social work**. 5th ed. Australia: Thomson Brooks/Cole.

Russ, E., Lonne, B., & Darlington, Y. 2009. Using resilience to reconceptualise child protection workforce capacity. **Australian Social Work**, 62: 324-338.

Ryan, F. Coughlan, M. Cronin, P. 2007. Step-by-step guide to critiquing research Part 2: qualitative research. **British Journal of Nursing**, 16(12): 738-744.

RSA (Republic of South Africa). 1996. **Constitution of South Africa, No 108 of 1996**. Pretoria: Government Printers.

Salovey, P. and Mayer, J. 1990. Emotional intelligence. **Imagination, Cognition, and Personality**, 9(3): 185–211.

Scott, W.R. 1980. Managing professional work: three models of control for health organisations. **Health Services Research**, 17(3): 213-240.

Shenton, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. **Journal of Education for Information**, 22(2): 63-75.

Shezi, B.E. 2014. **The needs of community service nurses with regard to supervision and clinical accompaniment**. Unpublished MA Thesis. Potchefstroom: North West University.

Skidmore, R.A. 1995. **Social work administration: Dynamics, management and human relations**. New York: Allyn and Bacon.

Skweyiya, Z. 2006. **South Africa: General shortage of social workers**. (A) (O) <http://www.ifsw.org/p38000867.html> (Accessed: 20/08/2015).

South African Council for Social Service Professions. 2007. **Policy guidelines for course of conduct, code of ethics and the rules for social workers**. Pretoria: Government Printers.

Stalker, C. A., Mandell, D., Frensch, K. M., Harvey, C. & Wright, M. 2007. Child welfare workers who are exhausted yet satisfied with their jobs: How do they do it? **Child and Family Social Work**, 12 (2): 182-191.

Strydom, H. 2011. Sampling in the quantitative paradigm. In: De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. **Research at grass roots: for the social sciences and human service professions**. 3rd ed. Pretoria: Van Schaik Publishers,

Swart, M.C. 1992. **Social work supervision in the CPA: branch hospital and health services in the Western Cape.** Unpublished MA Thesis. Stellenbosch: University of Stellenbosch.

Synnöve, K. 2003. **Social work Supervision – contributing to innovative knowledge production and open expertise.** In Gould, Nick & Baldwin, Mark (eds.) *Social Work, Critical Reflection and Learning organisation.* Aldershot etc: Ashgate.

Teigiser, K.S. 2009. New approaches to generalist field education. **Journal of Social Work Education**, 45(1): 139-146.

Thompson, E.A. 2007. Interprofessionalism in health care: Communication with the patient's identified family. **Journal of Interprofessional Care**, October 2007; 21(5): 561 – 563.

Thornton, A. 1997. Social work with cardiac patients. **Australian Social Work**, 50 (3): 53 -57.

Toren, N. 1969. Semi-professionalism and social work: A theoretical perspective. In A. Etzioni (Ed.). **The semi-professions and their organization: Teachers, nurses, social workers** (pp. 141-195). New York: The Free Press.

Townend, M. 2005. Interprofessional supervision from the perspectives of both mental health nurses and other professionals in the field of cognitive behavioural psychotherapy. **Journal of Psychiatric and Mental Health Nursing**, 12: 582–588.

Triegaardt, J. 2012. **Social work commemoration speech.** Johannesburg: University of Johannesburg.

Truter, E. 2014. **South African social workers at risk: exploring pathways to their resilience.** Vaal Triangle: North-West University. (Thesis submitted in fulfillment of the degree philosophies doctor in social work).

Tsui, M. 1997. The roots of social work supervision: An historical review. **The Clinical Supervisor**, 15(2): 191-198.

Tsui, M. 2004. Supervision Models in Social Work: from Nature to Culture. **Asian Journal of Counselling**, 11(1&2): 7-55.

Tsui, M. 2005. **Social work supervision contexts and concepts**. California: Sage Publications.

University of Bradford, School of Management. 2007. **Introduction to research**. Bradford: University of Bradford.

Valkenbeg, Alexandra and Lentegeur Hospital, 2015. **Job Description Production Social Worker**. Cape Town: Western Cape Department of Health.

Veeder, N.W. 1990. Autonomy, accountability, and professionalism: The case against close supervision in social work. **The Clinical Supervisor**. 8(2): 33-47.

Vermeulen, A. 2008. **Understanding the work experiences, coping strategies and organisational retention of social workers in a Gauteng in-patient substance abuse treatment clinic**. Unpublished MA Thesis. Johannesburg: University of the Witwatersrand.

Walsh, L., Turner, S., Lines, S., Hussey, L., Chen, Y. & Agius, R. 2005. The incidence of work-related illness in the UK health and social work sector: The Health and Occupation Reporting network 2002-2003. **Occupational Medicine (Oxford)**, 55 (4): 262-267.

Watkins, C.E. 1997. **Handbook of psychotherapy supervision**. Canada: John Wiley.

Wax, J. 1979. Time limited supervision. In: Munson, C.E. (ed.) **Social work supervision** (pp. 111-121). New York: The Free Press.

Western Cape Department of Health. 2012. **Health care 2030 in the Western Cape**. Cape Town: Western Cape Department of Health.

Western Cape Department of Health. July 2012. **Functional Business Unit (FBU): Framework for executive managers and FBU managers**. Cape Town: Western Cape Department of Health.

Western Cape Department of Health. **The provincial strategic plan in the Western Cape.** Cape Town: Western Cape Department of Health: 2012-2016 [Online] Available from: <http://www.westerncape.gov.za/health> (Accessed: 20/03/2015).

Western Cape Government Health. 2015. **Strategic Plan 2015 – 2019** [Online] Available from: <http://www.westerncape.gov.za/health> (Accessed: 15/05/2015).

Western Cape Government Health. 2015. **Annual performance plan 2015 – 2016** [Online] Available from: <http://www.westerncape.gov.za/health> (Accessed: 10/04/2015).

Williams, L.D., Crayton, B. & Agha, A.E. 2014. Generic practice of social work. **Social Work Encyclopaedia.** (A) (O) 10.1093/acrefore/9780199975839.013.27 (Accessed: 15/05/2015).

Wolock, I. & Schlesinger, E. 1986. Hospital Social Work and Decision Making. **Social Work in Health Care.** 11(1): 59-70.

Wolpert, A. 2005. **A systemic paradigm for the (mental) health Profession.** Unpublished MA Thesis. Pretoria: University of South Africa.

Zachary, L. 2000. **The mentor's guide: Facilitating effective learning relationships.** San Francisco: Jossey-Bass.

Zorga, S. 2002. Supervision: the process of life-long learning in social educational professions. **Journal of Interprofessional Care,** 16 (3): 265-276.



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

Approved with Stipulations

New Application

09-Dec-2015

Silence, Estelle E

Proposal #: SU-HSD-001821

Title:

THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH, WESTERN CAPE: SOCIAL WORKERS' EXPERIENCE

Dear Mrs Estelle Silence,

Your **New Application** received on **19-Nov-2015**, was reviewed

Please note the following information about your approved research proposal:

Proposal Approval Period: **08-Dec-2015 -07-Dec-2016**

The following stipulations are relevant to the approval of your project and must be adhered to:

The researcher may proceed with the envisaged research provided that the following stipulations, relevant to the approval of your project are adhered to or addressed. Some of these stipulations may require your response. Where a response is required, you must respond to the REC within six (6) months of the date of this letter. Your approval would expire automatically should your response not be received by the REC within 6 months of the date of this letter.

If a response is required, please respond to the points raised in a separate cover letter titled "Response to REC stipulations" AND if requested, HIGHLIGHT or use the TRACK CHANGES function to indicate corrections / amendments of ATTACHED DOCUMENTATION, to allow rapid scrutiny and appraisal.

This is a generally well written application to research the significance of social work supervision in the Department of Health, Western Cape by investigating the experiences of social workers who have been working as such for at least two years.

1. INFORMED CONSENT PROCESSES AND FORMS

Due to the fact that the participants will be from the Western Cape consideration should be given to have the consent forms translated into Afrikaans and/or Xhosa. If only English participants will be used this should be addressed in the research proposal.

2. CONFIDENTIALITY

It is suggested that the researcher address the issue on who would have access to the collected data and how and when the data will be destroyed upon completion of the research. This information should be included in the informed consent form. [RESPONSE REQUIRED]

3. INSTITUTIONAL PERMISSION

The researcher has indicated an awareness that institutional permission will be required from the Dept. of Health, Western Cape and the various health care institutions mentioned in the research proposal. No such request for permission was attached to the documents and it does not seem as if permission have been obtained as yet. The researcher is requested to confirm whether a request has been submitted to the relevant authorities and is herewith reminded that data collection may not commence without formal permission from the institution.

The researcher should also send copies of written permission letters from these departments/authorities to the REC once it has been obtained. [RESPONSE REQUIRED]

Please provide a letter of response to all the points raised IN ADDITION to HIGHLIGHTING or using the TRACK CHANGES function to indicate ALL the corrections/amendments of ALL DOCUMENTS clearly in order to allow rapid scrutiny and appraisal.

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number (SU-HSD-001821)** on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

Included Documents:

DESC Report - Williams, Rochelle

REC: Humanities New Application

Sincerely,

Clarissa Graham

REC Coordinator

Research Ethics Committee: Human Research (Humanities)



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvenoot • your knowledge partner

Approval No ce

Submited documents/requirements

15-Jun-2016

Silence, Estelle E

Proposal #: SU-HSD-001821

Title: THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH, WESTERN CAPE: SOCIAL WORKERS' EXPERIENCE

Dear Mrs Estelle Silence,

Your submited documents/requirements received on 12-May-2016, was reviewed and **accepted**.

Please note the following information about your approved research proposal:

Proposal Approval Period: 08-Dec-2015 - 07-Dec-2016

General comments:

Please take note of the general Investigator Responsibilities attached to this letter.

If the research deviates significantly from the undertaking that was made in the original application for research ethics clearance to the REC and/or alters the risk/benefit profile of the study, the researcher must undertake to notify the REC of **these changes**.

Please remember to use your **proposal number (SU-HSD-001821)** on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2015 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

Sincerely,

Clarissa Graham

REC Coordinator

Research Ethics Committee: Human Research (Humanities)

**STRATEGY & HEALTH SUPPORT**

Health.Research@westerncape.gov.za
 tel: +27 21 483 6857: fax: +27 21 483 9895
 5th Floor, Norton Rose House,, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2015RP13_380
 ENQUIRIES: Ms Charlene Roderick

Highlands Dr Lentegur

Cape Town

7786

For attention: **Mrs Estelle Silence**

Re: THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH, WESTERN CAPE: SOCIAL WORKERS' EXPERIENCES.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Alexandra Hospital	L Meyer	Contact No: 021 503 5009
Brooklyn Chest Hospital	P Spiller	Contact No: 021 508 7403
Delft CHC	J van Heerden	Contact No: 021 954 2237
Eerste River Hospital	A Anthony	Contact No: 021 902 8000
Elsies River CHC	R Kasker	Contact No: 021 9316023
Karl Bremer Hospital	L Naude	Contact No: 021 918 1223
Mitchells Plain CHC	Z Xapile	Contact No: 021 391 7991
Stikland Hospital	L Koen	Contact No: 0219404455/4570
Bishop Lavis Clinic	R Carelse	Contact No: 021 934 6129

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely


DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 9/3/2016.

CC: P OLCKERS
A PANTENTIA
K GRAMMER
M PHILLIPS

AO HAWKRIDGE.

DIRECTOR: KLIPFONTEIN MITCHELLS PLAIN

DIRECTOR: NORTHERN/ TYGERBERG

DIRECTOR: SOUTHERN/ WESTERN

DIRECTOR: KHAYELITSHA/ EASTERN



**Western Cape
Government**

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2015RP13_380
ENQUIRIES: Ms Charlene Roderick

**Highlands Dr Lentegour
Cape Town
7786**

For attention: **Mrs Estelle Silence**

Re: THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH, WESTERN CAPE: SOCIAL WORKERS' EXPERIENCES.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the following sites:

Western Cape Rehab Centre

Jenny Hendry

Contact No: 021 370 2316

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 12/4/2016.
CC:

AJ HAWKRIDGE

Estelle Silence

From: Jenny Hendry
Sent: 11 July 2016 11:56 AM
To: Estelle Silence
Subject: RE: WC_2015RP13_380

Dear Estelle

Please could you give me some progress / feedback regarding your study?

Thankx

Jenny

From: Estelle Silence
Sent: 13 April 2016 10:53 AM
To: Jenny Hendry
Subject: FW: WC_2015RP13_380

Dear Ms Hendry

Thank you for granting me permission to conduct my research at your institution. Attached is the written proof from the department of health confirming that my proposal to conduct research has been approved thereby granting me permission to make contact with you.

I need to conduct individual interviews with a few of your production social workers. The interviews should not be longer than an hour. I am prepared to come to your facility during office hours to conduct the interviews. Attached are the necessary information pertaining to the criteria as well as a letter of consent for the social workers which I shall bring with for them to sign.

I await your reply.

Once again thank you.

Estelle Silence



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH, WESTERN CAPE: SOCIAL WORKERS' EXPERIENCES

You are asked to please participate in a research study conducted by Estelle Silence (BSW, UWC) from the Department of Social Work at Stellenbosch University. The result of the research will contribute to the fulfillment of a Masters Research Thesis.

You were selected as a possible participant in this study because you possess the following criteria for inclusion;

- A social worker registered with the South African Council for Social Service Professions.
- Practicing social work in the department of health, Western Cape as production social worker.

1. PURPOSE OF THE STUDY

The purpose of this study is to gain an understanding of the experiences of social workers on the significance of social work supervision in the Department of Health, Western Cape.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following:

To participate in an individual interview with the investigator at the health facility, where you as the participant is employed as a social worker. The interview guide containing the interview questions will be made available to participants. The duration of the interview will be approximately 1 hour.

With the consent of the participant, this interview will be recorded with a voice recorder.

3. POTENTIAL RISKS AND DISCOMFORTS

By volunteering to participate in this study, there is no physical threat to the participants. The participants will be responding to the interview questions in a professional capacity. There is limited risk for emotional discomfort. Information shared during the interview will be gathered with respect for the participants worth and dignity. Any uncertainties on any of the aspects of the schedule participants may experience during the interviews can be discussed and clarified at any time. You will not be placed in a situation that is confrontational or threatening.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The information and insight gathered after interviews with social workers can contribute to the department of health's decision making regarding the provision of social work supervision to staff which will in turn ensure better outcomes for service users.

5. PAYMENT FOR PARTICIPATION

The involvement in this study comes without remuneration as the participant will not receive any payment.

6. CONFIDENTIALITY

Confidentiality is of utmost importance and you need not indicate your name or any particulars on the interview schedule. The schedule will be completed during an interview conducted by the researcher.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of removal of identifying details for disclosure purposes. The data collected during the interview will be safeguarded in a research file that will remain secure and will only be used by the investigator and the research supervisor.

The interview recording and identifying details will not appear anywhere in the research record. The participant has the right to request to view the recordings. Permission to provide access to anyone besides the investigator and research supervisor will be obtained from the participants.

7. PARTICIPATION AND WITHDRAWAL

To participate in the study is completely voluntary. The participant may withdraw at any time without any consequences. The participant may refuse to answer questions and still remain in the study. The investigator may withdraw the participant from this research should circumstances arise which warrant doing so.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact;

Principle Investigator: Estelle Silence (084 426 0258)

esilence123@gmail.com

Research Supervisor: Professor Lambert Engelbrecht (084 951 2448)

lke@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was described to me by Estelle Silence in English and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Name of Organisation

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [name of the subject/participant] He/she was encouraged and given ample time to ask me any questions. This conversation was conducted in English and no translator was used.

Signature of Investigator

Date

THE SIGNIFICANCE OF SOCIAL WORK SUPERVISION IN THE DEPARTMENT OF HEALTH, WESTERN CAPE: SOCIAL WORKERS' EXPERIENCES

Interview Schedule

1. INTRODUCTION TO THE RESEARCH PROJECT

- Rationale for the topic and goal of the study
- Structure of the interview
- How information will be processed, confidentiality, disposal of data, publication of findings, etc.
- Obtain consent

2. PRACTICE HISTORY

2.1 Years practicing social work:

2.2 Number of years practicing social work in DOH:

2.3 Please provide a brief description about your current work context, i.e. clinical / medical area where you are placed, specific tasks associated with it, etc.

3. QUESTIONS:

3.1 ACCESS TO SUPERVISION

3.1.1 Which **profession do you report to** and what is your experience of the current reporting structure?

3.1.2 Do you get **social work supervision** and from whom? *Elaborate on your answer.*

3.2 GENERALIST VS SPECIALIST TRAINING

3.2.1 In your opinion would a **newly qualified** social worker be **equipped** to deliver effective social work services in the DOH without a social work supervisor? *Please elaborate on your opinion.*

3.2.2 How do you think it would **impact on a social worker's practice** in the DOH if he/she did not receive social work supervision?

3.2.3 Should social work **supervision be mandatory in DOH**? *Please explain your response.*

3.3 SIGNIFICANCE OF SUPERVISION

3.3.1 In your experience, does the:

educational functions of supervision have the potential to equip social workers to function optimally within the DOH?

supportive functions of supervision have the potential to equip social workers to function optimally within the DOH?

administrative functions of supervision have the potential to equip social workers to function optimally within the DOH? *Elaborate on each of the functions.*

3.3.2 What is the **significance of supervision** for social workers in the DOH in terms of the (*elaborate the particular reasons for each*):

(a) **Department of Health** as an organisation?

(b) **social worker's development** as a professional ?

(c) **service user**?

3.3.3 Do you **value social work supervision** within the Department of Health? *Substantiate your answer.*

3.3.4 What are the **challenges** within your current supervision situation?

4. Any **general comments** regarding the significance of social work supervision in the department of health that you wish to share.