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The Effects of Empowerment on Case Consultation in the Self-managed Team Environment

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MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

This study examined the effects of empowerment on the efficacy of case consultation and clinical supervision in the self-managed team environment. The literature reviewed for this study showed a lack of research regarding self-managed work teams in the mental health field as well as a lack of research regarding empowerment as related to case consultation and clinical supervision. This study surveyed individuals who were part of a self-managed team in a mental health organization. The survey used demographic questions, scaling items, and open ended questions to gather information regarding respondents and their perceptions of empowerment, psychological safety, and the efficacy of case consultation in both self-managed team and hierarchical environments. Findings of this study indicate a correlation between perceptions of empowerment and the efficacy of case consultation and clinical supervision. There was not a significant relationship between empowerment and psychological safety. A correlation was found to exist between psychological safety and case consultation. Implications for practice in the social work and mental health fields would include training, programs, and policies to sustain the empowering capacity of self-managed teams and case consultation efficacy. Implications also point to a need for further research to determine if the findings of this study would be replicated.

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Introduction

Many articles have been written about the empowering capacity and effectiveness of self-managed work teams in the manufacturing industry and more recently in the healthcare field. Considerable research has been conducted about case consultation and clinical supervision in the mental health field. However, surprisingly little research can be found about the use of self-managed work teams and empowerment in the mental health field.

Self-managed work teams originated in the manufacturing industry as a way to empower workers, create a greater sense of ownership, and consequently result in a higher quality of the finished product. An increasing number of healthcare organizations have adapted the self-managed work team model to likewise empower employees and so increase employee ownership of management processes, build on creativity and participation, and likewise provide a higher quality of services (Moss, 1996).

Case consultation and clinical supervision occurring in staff groups is a common model used in the mental health and social service fields. Staff groups in human services, as described by Shulman (1992) have four functions. These include staff meetings with the focus on job management tasks, in-service trainings where education and ideas are presented in a general manner, case consultation with discussion focused on the case and service delivery, and group supervision, where professional development of the worker is considered. A single group under this model, with one supervisor who performs both managerial and clinical tasks, might engage in all four functions. Obstacles experienced over management tasks may affect the consultation and subsequently affect services with the client.

Traditional clinical supervision has been described as a dyadic relationship with a supervisor providing clinical education to a supervisee. There has been a rapid decline of this model of clinical supervision in recent years. Lack of financial resources and reduced hours available to devote to supervision within social service agencies have been identified as two significant reasons for this trend (Schamess, 2006).

If we consider that case consultation/clinical supervision, directed by a clinical supervisor who has a dual role as an administrative supervisor, may be negatively affected by obstacles over managerial tasks, we may be led to also consider the success that healthcare agencies have found with self-managed work teams that result in a high degree of empowerment, staff participation, and quality of service. Further exploration in the direction of self-managed work teams in tandem with group consultation or supervision would be worth considering for empowering clinicians to provide a high quality of care with mental health clients in the social service field. This study will look at the empowerment of individuals in a self-managed team setting and the subsequent effectiveness of case consultation and clinical supervision.

Literature Review

Self-managed Team Environments

Self-managed work teams have become increasingly prevalent in the last two decades. It has been estimated that 30 to 50 percent of organizations in the United States now use self-managed work teams (Elloy, 2008). Such teams were found to foster self-leadership behaviors, empower employees, and allow employees more control in the workplace. This has led to a more meaningful work experience (Elloy, 2008). Beyond self-managed teams, it has been estimated that up to 80% of organizations with 100 plus employees utilize some form of teams in aspects of day to day management (Solansky, 2008).

Changing customer demands, the need to deliver products with speed, and changing technology require higher levels of flexibility. In order to address these needs, organizations have turned to more lateral and less hierarchical work structures. Decision making has trended toward a lateral process rather than a vertical process. This has increased organizational learning as well as flexibility, efficiency, and speed of outcomes (Cherin, 1999; Solansky, 2008).

High performance, self-managed work teams stemmed from the Total Quality Management (TQM) model, a work system introduced in the early 1950's by Tavistock group in England that became popular in the 1980's. TQM focused on worker empowerment through tasks, such as continuous improvement, and relationship by way of management support (Cherin, 1999; Gibson & Tosone, 2001).

Cherin cited W. Edwards Deming as a major contributor to TQM in identifying the increased understanding of the worker to worker connection and the connection between workers and their task. The TQM model declined in popularity in the late 1980's due in part to high over-head costs and lack of worker support. This last was attributed to hierarchical decision making that occurred separately from workers and so was less meaningful to workers. Though the TQM model lost popularity and for the most part faded out of use, it provided the basis that led to the self-managed work team model (SMT). The emphasis on the importance of relationships and task was an integral part of both models and became more refined in use of high performance, self-managed teams (Cherin, 1999; Gibson & Tosone, 2001).

Self-managed work teams moved away from hierarchical management, flattening the organizational structure and putting responsibility for outcomes in the hands of work groups. Self-managed teams generally consist of 8 to 12 members that function autonomously with involvement in hiring decisions and profit sharing. Self-managed teams have required a shift in function of members from specific to more general activities. The benefits of SMT's have included increased intrinsic rewards and less employee turn-over. Job security, compensation such as profit sharing previously mentioned, team-building and policies that empower employees have been identified as necessary for successful implementation of SMTs (Gibson & Tosone, 2001).

The empowering capacity of self-managed work teams has been described as enabling employees to make decisions and act for organizations, leading to increased individual motivation and increased productivity. When employees were empowered and

involved in creative processes related to their jobs, they were said to have felt more motivated and involved in the success of the organization. (Elmuti, 1996)

Self-managed teams have frequently been mentioned as used in manufacturing and technology firms such as General Electric, Saturn, and Texas Instruments. Likewise, self-managed teams have been implemented in service organizations such as the IRS and Federal Express (Elmuti, 1996).

In the healthcare field, benefits of self-managed work teams have been described as creating a greater sense of ownership and responsibility for quality of the finished product. Such self-managed teams have also been credited with results that include higher motivation, creativity, and participation among staff. The primary focus of these self-managed teams has been identified as that of task oriented goal attainment (Moss, 2008).

In hierarchical organizations employees have often been controlled by managers. This has contributed to inhibited leadership behaviors in employees and a sense of powerlessness (Elloy, 2008). Management in top-down organizations described as compliance driven or punitive have been identified as “suboptimal” and have lead to defensive behaviors in the workplace as well as employee turnover (Claiborne & Lawson, 2011). In contrast, managerial duties in a self-managed team environment have taken on a facilitative aspect rather than a directive approach (Elloy, 2008). In the social service field, planning and decision making in work teams has been described as leading to improved outcomes for clients and overall system performance (Claiborne & Lawson, 2011).

Team Learning and Psychological Safety

Psychological safety has been identified as one element of self-managed teams that affects team training and team learning. Shared belief about consequences of interpersonal risk taking, the presence of trust, respect for each other's competence, and care for individual teammates were described by Edmondson (1999) as contributing to psychological safety and team learning. A lack of psychological safety was found to discourage asking for help. Both in turn were found to affect team performance. Team structure in the form of a clear goal, adequate resources, information, and rewards, as well as leadership in the form of coaching and direction setting was also identified as significant factors in creating psychological safety. Team structure was identified as central to team functioning and includes defining roles and relationships (Edmondson, 1999).

According to Bunderson & Boumgarden (2010), team structure processes have some effect on team learning. In teams dealing with stable tasks, structure was seen to promote learning within teams that function in a safe, predictable environment. In such teams, with roles and relationships clearly defined through use of hierarchical structure, information was shared more readily and conflicts reduced. In contrast to Edmondson's (1999) findings, Bunderson & Boumgarden found that though there is a significant relationship between psychological safety and team learning, information sharing and conflict frequently affected that relationship. Their implications suggested that rather than avoiding structure when seeking process improvement and continuous learning, teams should consider the benefits of structure (Bunderson & Boumgarden, (2010).

Shared Leadership

In contrast to the use of hierarchical structure, a more loosely structured view of self-managed teams identified one of the underpinnings of the self-managed team model as that of shared leadership. Through shared leadership team members were said to have ownership in the team's objectives. The concept of shared leadership is not a new management style; however singular leadership has most often been the assumption. Shared leadership has been identified as more likely to occur in self-managed teams due to their functioning as an independent entity (Solansky, 2008)

This perspective found that, within the context of shared leadership, members of self-managed teams have been found to have a greater confidence in their ability to perform their job. This increased sense of efficacy was identified in a study on leadership and team processes conducted by Solansky (2008). The same study also found transactive memory to be stronger in teams where leadership is shared. Transactive memory was described as the awareness of specialized abilities within a team; as such team members know who to go to for specific answers. With such awareness or transactive memory, team members were said to have a shared understanding of what is possible based on their knowledge (Solansky, 2008).

Self-managed Teams in the Human Services

Cherin (1999) suggested that, with the rapidly changing work environment and the complexity of decision-making that has occurred between work groups, the functionality of the self-managed team environment would fit well within the conceptual framework of social work. The ecological model (Bronfenbrenner, 1979) in the social work field has been effective in addressing engagement needs, between not only micro,

meso, and macro systems, but also those that occur at the point where self-managed work teams collaborate with one another to bring about finished product. However, the focus of those in the social work field has most often been on providing services for the client, leaving a need for further consideration of self-managed teams within the ecological model (Cherin, 1999).

Providing such critical services at times of crisis or life-threatening situations, where regulations often dictate procedures, has been described as very complex. Work in such situations can be highly stressful and with rigid supervision. However, some autonomy and participation in decision making does occur through implementation of work teams. These work teams have been described as providing a variety of interventions. The author of this study went on to describe the role of the team in problem solving regarding client needs. Through use of a team approach, the opportunity to find workers with knowledge of a client and issue was increased, as was the possibility of desired outcomes. Team members were found to be more engaged and problems became more solvable than was the case with one supervisor framing the solutions (Claiborne & Lawson, 2011).

This study also found teams to be an important factor in reducing negative outcomes, not only for clients, but also from managerial tasks. With teams in social services there was less need for micro-management techniques and corrective actions. Rather, teams were instrumental in reducing workforce resistance, and providing the training on a day-to-day basis (Claiborne & Lawson, 2011).

Limitations of self-managed teams have been described as a need for adequate training for teams to be implemented or to function well, abuse of authority, poor

judgment by employees, difficulty in defining boundaries of authority, lack of motivation, and difficulty in getting along in groups (Elmuti, 1996).

Case Consultation and Clinical Supervision

Some have found that difficulties experienced in work teams have likewise been experienced in therapy teams and supervision groups and consider that in groups across the board individuals experience a desire to be part of the group as well as a desire to be separate. This tension is said to create ambivalence and group disruption (Clarke & Rowan, 2009).

The benefits of supervisor led case consultation groups as outlined by Shulman (1992) included several mutual aid processes. These were the sharing of information, group member challenges, a sense of empathy between group members, and the possibility for discussion of sensitive subjects such as sex, loss, or challenges to authority, that may not be brought up in dyadic interaction with a supervisor, but might be risked by a group member (Shulman, 1992).

Many positive outcomes of group supervision have been identified as well. Among these were self-responsibility and increased interpersonal skills. Supervisees had the opportunity to learn from the experiences of others with diverse skills and experiences, using different approaches and interventions. Less experienced practitioners could observe those with more experience and explore the ideas presented in a non-threatening environment (Claiborne & Lawson, 2011; Clarke & Rowan, 2009; Landis & Young, 1994).

Another aspect to consider is the ability of students to learn the skills and language needed for intervention through observation (Haley, 1988; Hillerbrand, 1989; as

cited in Landis & Young, 1994). Student therapists were also described as more likely to emulate the peers they have observed rather than supervisors or experts (Landis & Young, 1994).

Some negative aspects of group supervision and therapy identified by Clarke and Rowan (2009) include anxiety and competition, challenges in relationships with authority as related to the supervisor, competition and rivalries, and challenges to competence by group members or supervisor. In describing these difficulties, the authors suggested that supervisees may re-experience childhood crises and stages of trust and autonomy, and must confront such issues within group setting (Clarke & Rowan, 2009).

Other functions of group supervision or case consultation and therapy teams may be problematic as well. Clarke & Rowan (2009) cited Selvini and Selvini Palazzoli (1991) in describing these. One problematic process found was competition between group members in presenting ideas. This has the potential to cause confusion of ideas and negatively impact the client or family. A second negative process was described as a group member marginalized through scape-goating or alliances within the group. A third of these negative functions identified effect of rigid or overly hierarchical structure within the group leading to passivity of group members, rebellious, or immature reactions. The last process identified as negative focused on the role of a supervisor or therapist becoming an object of displaced aggression or left with all responsibility due to passivity of group (Clarke & Rowan, 2009).

Clarke and Rowan also noted Freud's work that suggested that group mentality influences the mental states of the individual, causing distortion or complete loss of individuality to the group mentality. The psychological processes involved, according to

Freud, are projection, introjection, idealization, and identification. Group members might idealize the group leader or leadership function. This may be a shared belief or distortion about the leadership function, whether an actual leader is involved or not. Identification was described as individual's sense of belonging with the group identifying with the norms of the group. These functions were identified as decreasing an individual's ability to self-reflect and see the group from an objective perspective (Clark & Rowan, 2009; Pocock, 2006).

Staff groups in the human service field have been described as serving four functions. Staff meetings address administrative or managerial tasks such as performance evaluation, division of labor among the group, discussing policy, or discussing programs and needs. In-service trainings present ideas in general for education. In group case consultation, the focus is on the case and client rather than the practitioner. A fourth function, group supervision, addresses the professional and job management skills and is generally used along with individual supervision (Richmond, 2009; Shulman, 2006).

Richmond (2009) proposed a multi-layered approach to supervision that would utilize teams for task management, group consultation, and peer support. This multi-layered approach also included individual supervision. However, in traditional organizations with staff teams as described above, all four groups may be led by one supervisor and consist of the same or different group members for each meeting. The meeting one week could address the implementation of a new policy, case consultations another, and clinical supervision another. Group clinical supervision and case consultations are functions of teams that are distinct from managerial tasks of organizations (Richmond, 2009; Schulman, 2006).

Consideration of what Schamess (2006), citing Eckstein and Wallerstein (1958), noted as of the use of "parallel process" in supervision, and of what Kaiser (1997) identified as "experiential education," brings to light that interaction between the supervisor and supervisee may be reflected in the relationship between the supervisee and client. It was presented that clients benefit more when administrative tasks and evaluation tasks are handled outside the clinical supervision relationship. The relationship would then involve fewer dynamics that may cause friction or negatively affect the relationship and in turn negatively affect the relationship with the client (Kaiser, 1997).

Recursive patterns of communication, such as those described above that occur among family system, therapy system, and supervision team systems have been played out in group supervision and therapy teams. Isomorphism is a concept that involves the parallel process previously described. This reoccurring pattern of interaction reflects family system processes within the team, influences interaction in the team, and likewise interaction in the team may affect the family system. The need for openness to explore and talk about group process is necessary and advantageous in addressing and utilizing such process issues (Clarke & Rowan, 2009; Kaiser, 1997).

Discussion about similarities and differences was described as an important aspect of group supervision and case consultation as well. While group unity may enhance team functioning and lead to smoother problem solving, it may not be helpful in consultation. Shared theoretical perspectives and shared objectives, as well as understood ways of managing conflict have been identified as beneficial to groups. However, it has also been suggested that such unity denies the purpose of the group, that of the availability of

diverse perspectives. The contrasting perspectives may be the source of conflict, but the variety of viewpoints would provide knowledge that could not be obtained through one person (Clarke & Rowan, 2009; Solansky, 2008).

Group management functions have been found to generate internal consistency and compliance with group thinking. Tasks that were used to keep groups functioning encouraged consistency of ideas and process. However, as stated above, such unity of thought does not always generate the richest solutions or interventions in consultation. Unique perspectives or conflict of ideas may not be risked. Clarke & Rowan (2009) noted steps that might be taken to prevent such restrictive group norms. These included mixing up the consultation groups, recording team discussions for later viewing, and bringing in outside consultants. Maintaining a balance between unity and acceptance of different perspectives was also put forth as necessary to a well-functioning supervision group, consultation or therapy team (Clarke & Rowan, 2009).

Clarke and Rowan (2009) suggest that the dynamics of group supervision and consultation processes should be looked at in context in order to address issues and maintain balance. In discussing this, Clarke & Rowan cited Foulke (1973) who introduced the concept of a matrix or backdrop consisting of a group's history and interactions from the beginning of the group to the present. Foulke's matrix would serve as the common ground that holds the shared meaning of all of the group's events. Everything then happens in context and has meaning in relation to the matrix or life of the group. Communication occurs on conscious, preconscious, and unconscious levels and between. Aspects of group functioning can be talked about or dealt with by looking

at how group members support, interact, and fit together as a team (Clarke & Rowan, 2009).

Another aspect of group process was outlined by Bion (1961) as cited by Clarke & Rowan, this entailed three basic assumptions regarding the conflict between group mentality and individual needs of group members. Dependency basic assumption position was described as a group that focuses primarily on meeting the dependency needs of its members. A leader may be idealized and expected to protect and make group members feel good. Groups acting on this assumption also were said to hold an unconscious resistance to dealing with the group's real tasks or difficulties. The fight/flight assumption identified a group acting as if in defense of an external threat. This assumption also looked to a leadership function to solve the problem or organize the group to ward off the perceived threat. Functioning under this assumption would prevent a group from focusing on the real difficulty, but would also serve to bring the group together against a common threat. The third function Bion gave us was that of the pairing basic assumption position. This is the belief that problems in the group can be solved by two people getting together or pairing such as if the leader pairs with and external person or agency (Clarke & Rowan, 2009).

Functioning under this assumption would lead a group to focus on the future rather than the painful present in order to solve its problems. Groups were said to operate under different assumptions throughout the life of the group when facing unresolved conflicts or predicaments and would tend to operate under a particular mode when facing difficulties (Clarke & Rowan, 2009). At a later date, another basic assumption was suggested by Lawrence et al (1996). This assumption was called the me-ness basic

assumption. This described the way a group might relate as a group of individuals rather than a collective group. Under this assumption, group members would isolate from the group, avoiding relating and functioning as part of a group (Clarke & Rowan, 2009).

As mentioned earlier, the recent trend in clinical supervision has been moving toward group supervision. Traditional clinical supervision, in the form of a dyadic relationship, where learning is advanced through the supportive, case focused, mentoring relationship was described by Schamess (2006) as an endangered activity because agencies have often determined it not cost effective.

Summary

The self-managed work team model was built on the fading trend of Total Quality Management of the 1980's. Still widely used today, self-managed work teams have been found to be highly effective in a changing and challenging task environment. Flexibility and a lateral structure that relies on knowledge and information sharing of multiple persons have been shown to provide more answers to problems being reviewed. Many other forms of teams have been utilized in the workplace as well, from participatory to highly structured hierarchical.

The recent trend in supervision has been toward group supervision and case consultation. This has been necessitated by increasing costs for supervisors and limited time available for non-billable tasks. Group consultation and supervision has many benefits such as engagement in processes, opportunities to learn from and emulate peers, and a wider pool of knowledge sources than with individual supervision.

Challenges of group consultation and supervision have been identified as assumptions teams operate under that distract from present needs, maintaining a balance of unity and differences within teams, and relationship management tasks within the team; that is, identifying what is happening and why, the effects on members, and the team as a whole, and how that affects the finished product. In spite of the prevalence of group supervision, consultation, and therapy, there has been little focus on processes within such teams and their impact on group or team supervision and therapy, as well as the resulting effect on clients and families.

Though much research could be found regarding self-managed work teams and much research has been done regarding group supervision, very little research could be found that explores the use self-managed teams in relation to case consultation and clinical supervision. Given the lack of research and literature in this specific area, the research problem this paper considers is: "What is the effect of staff empowerment on case consultation and clinical supervision in a self-managed team environment?"

Conceptual Framework

The concept of empowerment as a theory is said to have derived from Friere in 1973 when he proposed liberating the oppressed through education. According to Hur (2006), empowerment is, by definition, shared power between relationships. The process of sharing power in a relationship empowers all involved and so creates more power (Hur, 2006).

The conceptual framework of empowerment as proposed by Thomas and Velthouse (1990) has its roots in the cognitive perspective. In this model, a cycle of environmental events, task assessments, and behaviors stimulate the perception of consequences of task behavior, conditions, and events in anticipation of future behavior of an individual (Thomas & Velthouse, 1990; Spreitzer, 1996). According to Thomas and Velthouse (1990), this cycle affects the individual's perceptions of four aspects of the empowerment framework. These are impact, competence, meaningfulness, and choice. The individual's intrinsic valuation of such consequences provides impetuous for future behavior which in turn impacts one's environment and in that manner the cycle continues (Thomas & Velthouse, 1990).

Impact refers to how effective an action is seen in accomplishing its purpose. Also identified as locus of control or learned helplessness, a low sense of control or belief in ability to have an impact contributes to learned helplessness, and reduced motivation. Meaningfulness refers to how relevant the task is seen as in relation to one's personal values. A low degree of meaningfulness has been connected with apathy, while high levels of meaningfulness have been connected with high levels of engagement (Thomas & Velthouse, 1990). Competence or self-efficacy (Bandura, 1977) refers to how well the

individual can perform tasks. Low self-efficacy may prevent individuals from challenging themselves and so increasing their competence. High self-efficacy results in initiative and persistence (Thomas & Velthouse, 1990). The last assessment in this model is choice. Also described as locus of causality, this assessment describes one's perception of self-determination. A sense of self-determination is a necessary condition of intrinsic motivation. Likewise, a necessary aspect of self-determination is choice (Thomas & Velthouse, 1990).

The four elements of the individual conceptual framework have been applied by Kirkman and Rosen (1999) to the concept of team empowerment and so develop the framework further. They defined four assessments, or dimensions of team empowerment as potency, meaningfulness, autonomy, and impact.

Potency is similar to the individual empowerment assessment of competency or self-efficacy (Bandura, 1977; Thomas &Velthouse, 1990). However, potency refers to the team's collective belief in its overall effectiveness and its team performance. Meaningfulness in the framework of team empowerment refers to the team's belief that its tasks and mission are of value. Team members share this belief and so team member perspectives can affect other team members. Autonomy is similar to the individual empowerment assessment of choice (Thomas &Velthouse, 1990). Within the team empowerment framework, autonomy describes the team's shared decision-making ability. As such, higher levels of team autonomy in decision-making would actually decrease individual autonomy. Impact is the fourth team empowerment element. Similar to individual impact (Thomas &Velthouse, 1990), a team would experience a sense of having a high degree of impact by producing work that is perceived by an

organization as significant or important (Kirkman & Rosen, 1999). This study will further explore the effect of empowerment on case consultation and clinical supervision in a self-managed team setting.

Methods

Sample

The population of this study was comprised of 75 mental health clinicians who provide therapeutic services for children, families, and/or adults and administrative staff of the same mental health organization. The study population included individuals who are part of a self-managed team as part of the function of their job, who also participate in or support the function of group case consultation and/or clinical supervision with those on their self-managed team or with others.

The sample was a non-probability sample using availability sampling procedures. Individuals were recruited for this study by emailed request which included a brief description of the study and its purpose, followed by a request in person, and in a written consent form. The sample was drawn from a single agency of approximately 150 employees across greater Minnesota. This agency is a private, nonprofit, mental health agency that provides services for children, families, and adult individuals of various cultures often living near or below the poverty line.

Agency approval was obtained and documented with a consent form approved by the University of St. Thomas Institutional Review Board. Limitations of this sample included that of a study sample that was drawn from a single agency, a small sample size, and though respondents represented over 35 counties across greater Minnesota, only a small portion represented urban areas.

Because this is a non-probability sample, the results have not been identified as representative of the larger population. However, this sample provided enough data,

based on experiences gained in both a self-managed team environment and in hierarchical agencies, to give evidence to the empowerment of workers and the subsequent effectiveness of case consultation and clinical supervision in the self-managed team environment.

Research Design

This study used mixed method design that included both qualitative and quantitative questions. Quantitative data were used to describe and measure the independent variables of empowerment and demographic information in relation to the dependent variables of psychological safety and efficacy. Qualitative questions were used to explore more in depth content and beliefs of respondents.

Data were collected by asking volunteer subjects to complete a survey that includes questions measuring the variables mentioned above. The survey was provided to participants during breaks at agency gatherings. Individuals were given the option to participate or excuse themselves for the brief time when respondents completed the survey. Respondents were asked to place the surveys in an envelope provided to ensure anonymity.

The confidentiality and anonymity of subjects was assured and consent obtained from the University of St. Thomas Institutional Review Board prior to the study. Individuals participating in the study were informed of the voluntary nature of the study and that they could withdraw from the study at any point and any records returned would be used as part of the study. Records with identifying information created in the course of this study were kept confidential. Research records were kept in a locked file at my

home. All electronic documents and recordings with identifying information were password protected. All identifying information was destroyed.

Measurement

Quantitative measures.

The survey instrument (Appendix C) included items that gathered demographic information. These variables were nominal measures that identified gender, professional role and degree. To operationalize these variables, the survey asked respondents to, "Please circle the correct response or fill in the blank." The survey then asked the question, "What is your current primary role with this agency?" and asked respondents to select, "Licensed Therapist," "Counselor," "Administrative Staff," "Clinical Supervisor," or "Other." This variable was used to answer the research question, "What is the professional role of respondents?" The statistical procedure used for this nominal variable was a frequency distribution.

The survey used the question, "What is your gender?" and provided responses, "Female," or "Male. This variable was used to determine the gender of respondents. The statistical procedure used to describe this variable was frequency distribution.

The question, "What is the highest degree that you have earned?" was used to determine the education of respondents. Respondents were given the opportunity to select, "Diploma," "Associate degree," "Baccalaureate degree," "Masters degree," or "Doctorate." This variable was used to answer the research question, "What is the education level of respondents?" This statistic was also described with a frequency distribution.

Demographic information also included ratio level measures regarding respondents' length of experience in the mental health field, within the agency, and in their current position. To operationalize this variable, the survey provided blank lines for respondents to fill in the number of years and months and asked "How long have you been employed:" "With this agency?, "In your current position with this agency?," "In the Mental Health Field (total)?." This variable was used to answer the research question, "What is the length of experience of respondents within the agency, current position, and within the mental health field?" The statistical procedure used for this variable was measures of central tendency and dispersion with histograms.

One ordinal, scaling question included in the demographic information identifies introverted and extroverted attitudes toward the world. To operationalize this variable, a scaling question asked respondents: "On the scale below, please circle the number that best indicates your preferred approach toward the world." A likert scale was provided for response and was numbered 1 – 5, with "1" indicating "Very Extroverted" and "5" indicating "Very Introverted." This variable answered the research question, "What do respondents perceive as their preferred approach to the world?" The statistical procedure used to describe this variable was a frequency distribution with bar chart.

One item sought to measure perception of team-efficacy in a self-managed team environment. This statistic looked at the ordinal variable that described team effectiveness. To operationalize this variable, the survey used the question, "My team is effective at managing its tasks." Respondents were asked to "Please indicate the extent to which you agree or disagree with the statements based on your experience or observations." A likert scale was provided for responses and was numbered 1 – 5, with

"1" indicating "Strongly Disagree," "2" indicating "Disagree," "3" "Neutral," "4" indicating "Agree," and "5" indicating "Strongly Agree." This variable answered the question, "What is the perception of respondents regarding team effectiveness at completing tasks?" The statistical procedures used to describe this variable were measures of frequency distribution and histogram.

Four scaling questions from the Survey of Psychological Empowerment (Spreitzer, 1995) were used to measure elements attributed to individual empowerment. The operational definition of the empowerment variable was a compilation of questions 6.1 through 6.4. In these questions, the respondents were asked to "Please indicate the extent to which you agree or disagree with the statements based on your experience or observations." Again, a likert scale was provided for responses "Strongly Disagree," "Disagree," "Neutral," "Agree," and "Strongly Agree." In eliciting responses to the four assessments of empowerment, the respondents were asked to rate on the likert scale, "The work I do is meaningful to me," "I have mastered the skills necessary for my job," "I have significant autonomy in determining how I do my job," "My impact on what happens in my department is large." A higher score would indicate greater empowerment. This variable was used to answer the research question, "What is the perception of empowerment among respondents?" Validity and reliability of this statistic may have been reduced across intervals as respondents beliefs vary and questions are subject to interpretation. The statistical procedure used to describe this variable was measures of central tendency and dispersion with a histogram.

Another measure included four scaling questions to determine beliefs specific to psychological safety in a self-managed team environment. The operational definition of

the psychological safety variable was a compilation of questions 6.6, 6.7, 6.10 and 6.13. In these questions, the respondents were asked to "Please indicate the extent to which you agree or disagree with the statements based on your experience or observations." The likert scale provided the responses "Strongly Disagree," "Disagree," "Neutral," "Agree," and "Strongly Agree."

To determine psychological safety, the respondents were given the opportunity to respond to the following, "Counselors and therapists consult about problems that occur with clients," "It is safe to talk openly in staffings about work with clients," "Staff members feel they can discuss any client situation in case consultation," "Staff members feel they can discuss any client situation with their clinical supervisor." A higher score would indicate greater degree of psychological safety in case consultation in the self-managed team environment. This variable was used to answer the research question, "What is the perception of psychological safety in case consultation in the self-managed team environment?" Validity and reliability of this statistic may also have been reduced across intervals as respondents beliefs vary and questions are subject to interpretation. The statistical procedure used to describe this variable was measures of central tendency and dispersion with a histogram.

Four questions assessed beliefs about respondents' perceptions of the effectiveness of case consultation. This variable was a compilation of questions 6.8, 6.9, 6.11, and 6.12. To operationalize this variable, respondents were asked to "Please indicate the extent to which you agree or disagree with the statements based on your experience or observations." The likert scale provided the responses "Strongly Disagree," "Disagree," "Neutral," "Agree," "Strongly Agree."

To measure perceptions of effectiveness of case consultation, respondents were given the opportunity to respond to the following, "Staff members receive specific feedback about things they do well," "Staff members receive specific comments about things they could improve," "In case consultation, issues such as counter transference are challenged in respectful ways," "There is a high degree of integrity in case consultation." A higher score would indicate higher perceptions of the effectiveness of case consultation in the self-managed team environment. This variable was used to answer the research question, "What is the perception of the effectiveness of case consultation?" Validity and reliability of this statistic may also have been reduced across intervals as respondents beliefs vary and questions are subject to interpretation. The statistical procedure used to describe this variable was measures of central tendency and dispersion with a histogram.

Qualitative measures.

Qualitative data were obtained to look at respondents perceptions of the empowering capacity of self-managed teams, impressions of case consultation in a self-managed team environment as compared to experiences in hierarchical work environments, and the advantages and disadvantages of group case consultation as compared to individual consultation. The variables used open-ended questions to explore respondent perceptions.

Respondents were asked, "In what ways does the self-managed team environment at this agency empower co-workers to succeed in their role?" Another question inquired about impressions of case consultation in a self-managed team environment as compared to experiences in hierarchical work environments, "Please briefly describe your impressions of clinical supervision and case consultation in the contrasting environments

(self-managed team/hierarchical)." The third qualitative question focused on respondents opinions on the advantages and disadvantages of group case consultation as compared to individual consultation. "What do you see as the advantages and disadvantages of group or individual (supervisee – supervisor) case consultation?"

Research questions and hypotheses.

Three research questions were answered with use of inferential statistics obtained from the interval scaling variables. One inferential statistic was obtained by looking at the relationship between the interval variable scales of empowerment and effectiveness of case consultation and clinical supervision. A comparison of these variables sought to answer the research question, "Is there a relationship between perception of empowerment and perceived effectiveness of case consultation?" The hypothesis was that there is a relationship between empowerment and perceived effectiveness of case consultation. The null hypothesis was that there is no relationship between empowerment and perception of effectiveness of case consultation. The statistical procedure used was a correlation, and scatter plot was used to illustrate the relationship.

A second statistic was obtained with use of the interval variable scales of empowerment and psychological safety. A comparison of these variables would answer the research question, "What is the relationship between perception of empowerment and perception of psychological safety?" The hypothesis was that there is a relationship between empowerment and psychological safety. The null hypothesis was that there is no relationship between empowerment and psychological safety. The statistical procedure used was a correlation, and scatter plot was used to illustrate the relationship.

A third inferential statistic was derived from the interval variable scales of psychological safety and effectiveness of case consultation. These variables were compared to answer the research question, "What is the relationship between psychological safety and perception of effectiveness of case consultation?" The hypothesis was that there is a relationship between psychological safety and perceived effectiveness of case consultation. The null hypothesis was that there is no relationship between psychological safety and perceived effectiveness of case consultation. The statistical procedure used was a correlation, and scatter plot was used to illustrate the relationship.

Findings

Data Analysis

Data for quantitative statistics were analyzed using SPSS data analysis software. Descriptive statistics were used to describe respondents' demographic characteristics and other nominal or ordinal statistics. Survey questions, including the nominal measures of gender, professional role, professional degree, and the ordinal variables of introversion/extroversion and perception of team efficacy, provided descriptive statistics in the form of frequency distributions and bar charts.

The statistical procedure used for the ratio level variable for length of experience in the mental health field, within the agency, and in your current position, was measures of central tendency and dispersion with histograms. The interval scaling variables of empowerment scale, case consultation efficacy scale, and psychological safety scales also provided statistics using measures of central tendency and dispersion with histogram. Inferential statistics in the form of correlation analyses and scatter plots were obtained by looking at the relationship between the interval variable scales of empowerment, case consultation efficacy, and psychological safety.

Qualitative data from respondent perceptions of the empowering capacity of self-managed teams, experiences in self-managed team and hierarchical environments, and opinions on advantages and disadvantages of individual and group consultation were analyzed using grounded theory. This method of analysis allowed theory to emerge from the data through the interaction between data collection, data analysis, and developing theory (Monette et al, 2011). Codes were identified through a process that consisted of

reading through the data two times, then identifying initial codes, reading through the data a third time and finding themes from initial codes that have reoccurred at least three times (Berg, 2009). The coded data and themes were then crosschecked and considered for accuracy and reliability.

The nominal variable, "Gender" answers the research question, "What is the gender of respondents?" The findings for this variable, as shown in Table 1, indicate that 64 respondents (85.3%) responded with female and 11 respondents (14.7%) responded male. The findings indicate that the majority of respondents are female.

Table 1. *Gender Distribution*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female (1)	64	85.3	85.3	85.3
	Male (2)	11	14.7	14.7	100.0
	Total	75	100.0	100.0	

A second descriptive statistic, shown in Table 2, looks at the nominal variable that describes professional role of respondents. This variable answers the research question, "What is the professional role of respondents?" The findings show that of 75 respondents, seven (9.3%) indicated "Licensed Therapist," 55 (73.3%) selected "Counselor," seven (9.3%) indicated "Administrative Staff," one (1.3%) chose "Clinical Supervisor," and five (6.7%) selected "Other."

Table 2. *Professional Role*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Licensed Therapist (1)	7	9.3	9.3	9.3
	Counselor (2)	55	73.3	73.3	82.7
	Administrative Staff (3)	7	9.3	9.3	92.0
	Clinical Supervisor (4)	1	1.3	1.3	93.3
	Other (5)	5	6.7	6.7	100.0
	Total	75	100.0	100.0	

The nominal variable, "Professional Degree" answers the research question, "What is the professional degree of respondents?" Table 3 describes findings for this variable and shows that one respondent (1.3%) indicated diploma, two respondents (2.7%) indicated Associate Degree, 28 respondents (37.3%) replied Baccalaureate Degree, 44 respondents (58.7%) indicated Masters Degree, and no one indicated Doctorate Degree.

Table 3. *Professional Degree*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Diploma (1)	1	1.3	1.3	1.3
	Associate Degree (2)	2	2.7	2.7	4.0
	Baccalaureate Degree (3)	28	37.3	37.3	41.3
	Masters Degree (4)	44	58.7	58.7	100.0
	Total	75	100.0	100.0	

Table 4 displays the three variables that answer the research question, “What is the length of experience of respondents within the agency,” “current position,” and “within the mental health field?” The possible response options range from zero to 100%. Of 75 respondents, the mean length of experience in the mental health field is 122.84 months with a standard deviation of 109. The minimum response is less than one year and the maximum response is 464 months experience. The histogram in Figure 1, page 35, shows that the responses are positively skewed because the data are more common on the left end of the histogram and sparser on the right end of the histogram.

Table 4. *Experience in the Mental Health Field*

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Length of Experience in Field, Total Months	75	0	464	122.84	108.508	1.291	.277
Valid N (listwise)	75						

Table 5 shows that, of 75 respondents, the mean length of employment with the agency is 53.44 months with a standard deviation of 67. The minimum response is less than one month with the agency and the maximum response is 264 months with the agency. The histogram in Figure 2 shows that the responses form a positively skewed curve with the greatest density on the left end of the histogram and a small number of data on the right.

Table 5. *Length of Employment with Agency*

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Agency Employment, Total Months	75	0	264	53.44	66.745	1.760	.277
Valid N (listwise)	75						

Table 6 shows that, of 75 respondents, the mean length of time in current agency position is 34.04 months with a standard deviation of 55. The minimum response is less than one month in the current agency position and the maximum response is 264 months in the current agency position. The histogram in Figure 3 shows that the responses form a positively skewed curve with the greatest density on the left and a small number of data on the right end of the histogram.

Table 6. *Total Months in Current Agency Position*

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Agency Position, Total Months	75	0	264	39.04	55.040	2.394	.277
Valid N (listwise)	75						

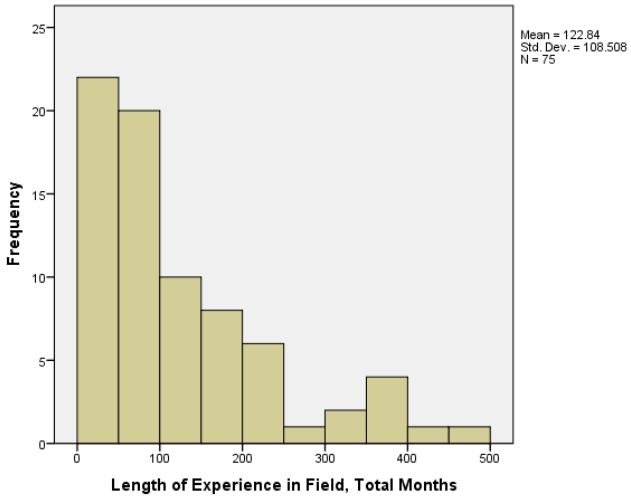

Figure 1. Length of Experience in Mental Health Field
Minimum = 0, Maximum = 464, Mean = 122.84

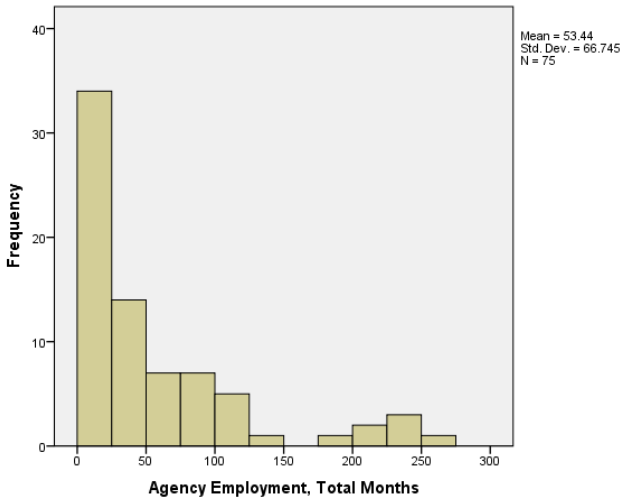

Figure 2. Agency Employment Total Months
Minimum = 0, Maximum = 264, Mean = 53.44

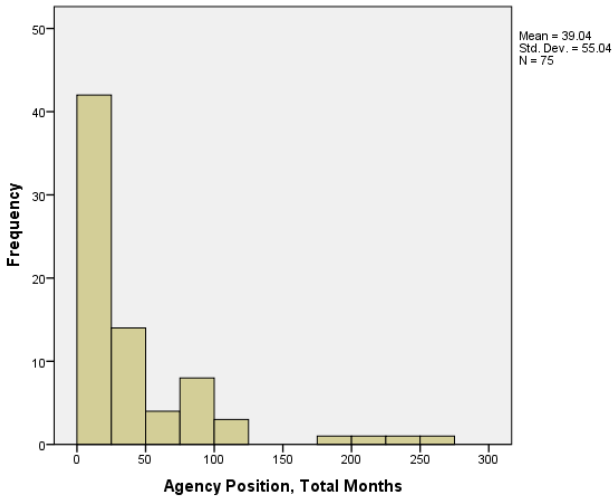

Figure 3. Time in Current Agency Position, Total Months
Minimum = 0, Maximum = 264, Mean = 39.04

The descriptive statistics shown in Table 7 and Figure 4 look at the variable that describes preferred approach to the world. This variable answers the research question, "What is the preferred approach to the world of respondents?" The findings of this study show that of 75 respondents, four respondents (5.3%) indicated "Very Extroverted" as their preferred approach to the world, 21 respondents (28%) chose "Extroverted," 35 respondents (46.7%) selected "In-between," 15 respondents (20%) indicated "Introverted," and no one indicated "Very Introverted" as their preferred approach to the world.

Table. 7 *Preferred Approach toward the World*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 (Very Extroverted)	4	5.3	5.3	5.3
	2 (Extroverted)	21	28.0	28.0	33.3
	3 (In-between)	35	46.7	46.7	80.0
	4 (Introverted)	15	20.0	20.0	100.0
	Total	75	100.0	100.0	

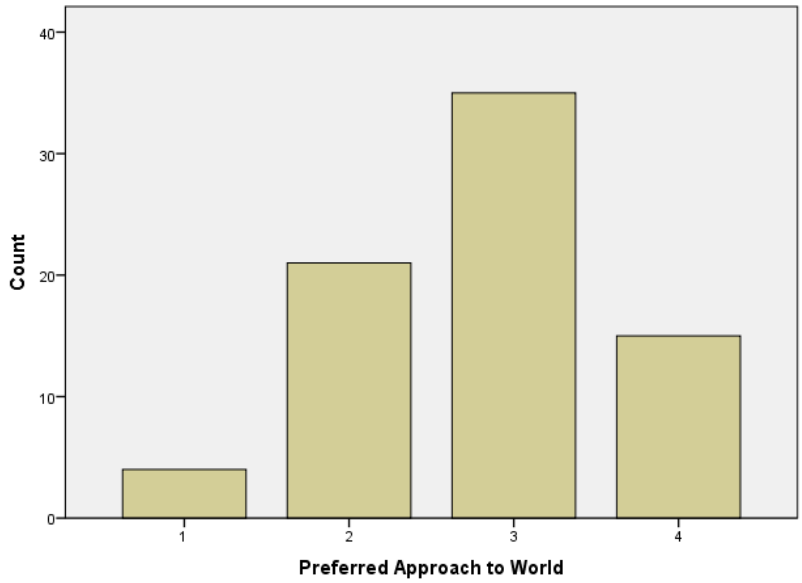

Figure 4. Preferred Approach Toward the World

1 = Very Extroverted, 2 = Extroverted, 3 = In-between, 4 = Introverted, 5 = Very Introverted

The ordinal variable, perception of team efficacy answers the research question, "What is the perception of respondents regarding team effectiveness at completing tasks?" Table 8 and Figure 5 show that there are 73 of 75 responses to the question, "My team is effective at managing its tasks." Of these, no one indicated "Strongly Disagree," three respondents (4%) indicated "Disagree," 13 respondents (17.3%) chose "Neutral," 46 respondents (61.3%) indicated "Agree," and 11 respondents (14.7%) indicated "Strongly Agree."

Table 8. *Perception of Team Efficacy*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2 Disagree	3	4.0	4.1	4.1
	3 Neutral	13	17.3	17.8	21.9
	4 Agree	46	61.3	63.0	84.9
	5 Strongly Agree	11	14.7	15.1	100.0
	Total	73	97.3	100.0	
Missing	System	2	2.7		
Total		75	100.0		

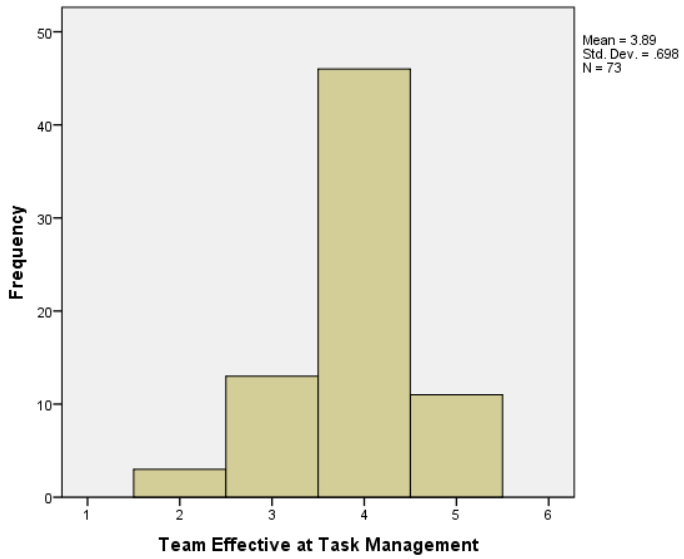

Figure 5. Perception of Team Efficacy
2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

The empowerment scale variable is a compilation of questions 6.1 through 6.4 and answers the research question, "What is the perception of empowerment among respondents?" The possible response options range from zero to 20. Table 9 shows that of 74 responses, the mean is 15.95 with a standard deviation of 1.76. The minimum response is 11 and the maximum response is 20. Figure 6 shows the values form close to a normal curve with the values distributed relatively evenly around the mean and skewness = -.18.

Table 9. *Perception of Empowerment*

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Empowerment Scale	74	11.00	20.00	15.9459	1.75867	-.180	.279
Valid N (listwise)	74						

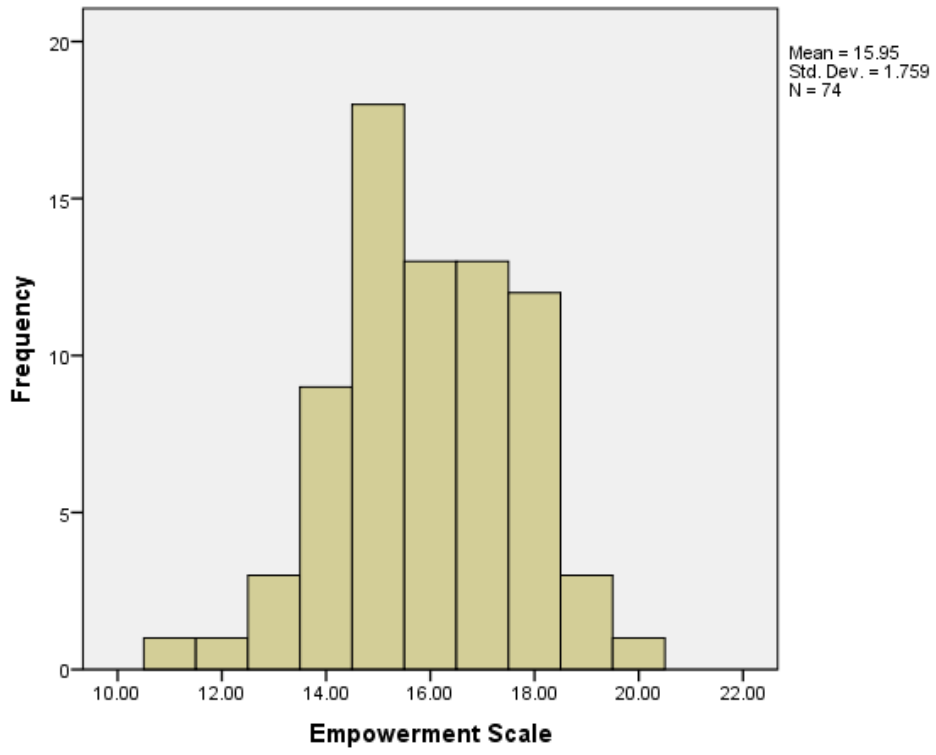

Figure 6. Perception of Empowerment Scale
Minimum = 11, Maximum = 20, Mean = 15.95

The case consultation efficacy scale variable is a compilation of questions 6.8, 6.9, 6.11, and 6.12 and answers the research question, "What is the perception of the effectiveness of case consultation?" The possible response options range from zero to 20. Table 10 shows that of 73 respondents, the mean is 14.64 with a standard deviation of 2.34. The minimum response is nine and the maximum response is 19.50. The histogram in Figure 7 shows the values form a normal distribution with the values distributed relatively evenly around the mean with skewness = .14.

Table 10. *Case Consultation Efficacy*

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Consultation Efficacy	73	9.00	20.00	14.6438	2.35331	-.137	.281
Valid N (listwise)	73						

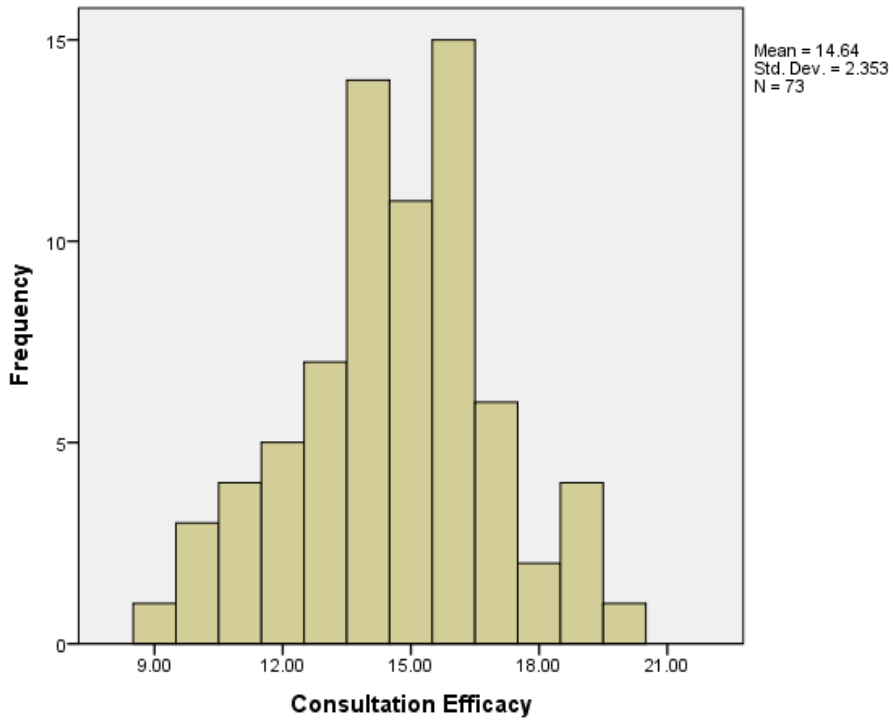

Figure 7. Case Consultation Efficacy
Minimum = 9, Maximum = 20, Mean = 14.64

The psychological safety scale variable is a compilation of questions 6.6, 6.7, 6.10, and 6.13 and answers the research question, "What is the perception of psychological safety in case consultations in the self-managed team environment?" The possible response options range from zero to 20. Table 11 shows that of 73 respondents, the mean is 17.12 with a standard deviation of 2.03. The minimum response is 12 and the maximum is 20. Figure 8 shows a mild negative skew with a greater density of data to the right of the mean and a fewer data to the left of the mean.

Table 11. *Perception of Psychological Safety*

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Psychological Safety Scale	73	12.00	20.00	17.1233	2.02721	-.316	.281
Valid N (listwise)	73						

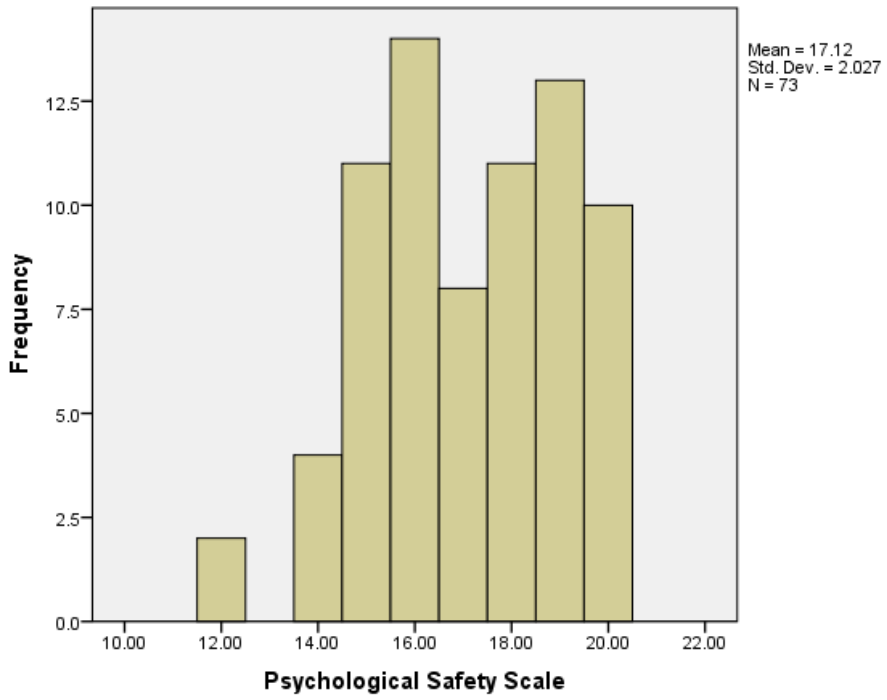

Figure 8. Psychological Safety

Minimum = 12, Maximum = 20, Mean = 17.12

The correlation matrix below answers the research questions: "Is there a relationship between perception of empowerment and perception of efficacy of case consultation?" "Is there a relationship between perception of empowerment and perception of psychological safety?" and "Is there a relationship between perception of psychological safety and perception of effectiveness of case consultation?" Table 12 and Table 13, along with Figures 9, 10, and 11show the statistics between the three variables.

Table 12. *Descriptive Statistics for the Relationship between Perceptions of Empowerment, Case Consultation Effectiveness, and Psychological Safety*

	Mean	Std. Deviation	N
Empowerment Scale	15.9459	1.75867	74
Consultation Efficacy	14.6438	2.35331	73
Psychological Safety Scale	17.1233	2.02721	73

Table 13. *Relationship between Perceptions of Empowerment, Case Consultation Effectiveness, and Psychological Safety*

		Empowerment Scale	Consultation Efficacy	Psychological Safety Scale
Empowerment Scale	Pearson Correlation	1	.357**	.084
	Sig. (2-tailed)		.002	.484
	N	74	72	72
Consultation Efficacy	Pearson Correlation	.357**	1	.414**
	Sig. (2-tailed)	.002		.000
	N	72	73	73
Psychological Safety Scale	Pearson Correlation	.084	.414**	1
	Sig. (2-tailed)	.484	.000	
	N	72	73	73

**. Correlation is significant at the 0.01 level (2-tailed).

As shown in Table 13, results indicate that respondents' perceptions of empowerment are positively associated with their perceptions of efficacy of case consultation ($r = .357$, $p < .01$). As perceptions of empowerment increase, perceptions of efficacy of case consultation also increase. This is demonstrated in Figure 9 as the data are scattered low on the left and higher on the right of the scatter plot in a positive slope. Since the p-value ($p<.01$) is less than .05, the null hypothesis is rejected. There is a significant relationship between perceptions of empowerment and efficacy of case consultation. Therefore, the results support the hypothesis that there is a relationship between perceptions of empowerment and efficacy of case consultation.

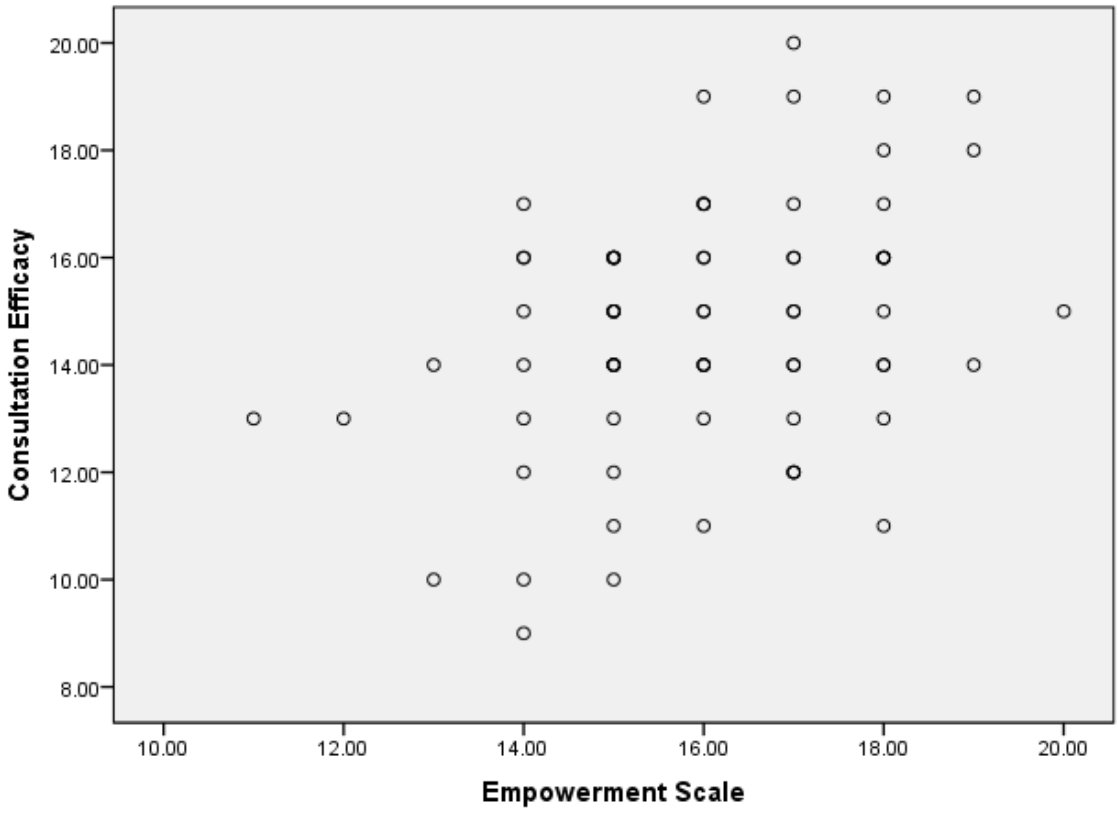

Figure 9. Empowerment Scale and Case Consultation Efficacy Scale
r = .357, p <.01

The results in Table 13 do not show a statistically significant relationship between respondents' perceptions of empowerment and perceptions of psychological safety (r = .084, p =.484). Since the p-value (p=.484) is greater than .05, the null hypothesis stands. There is not a significant relationship between empowerment and psychological safety. The data in Figure 10 do not describe a linear relationship.

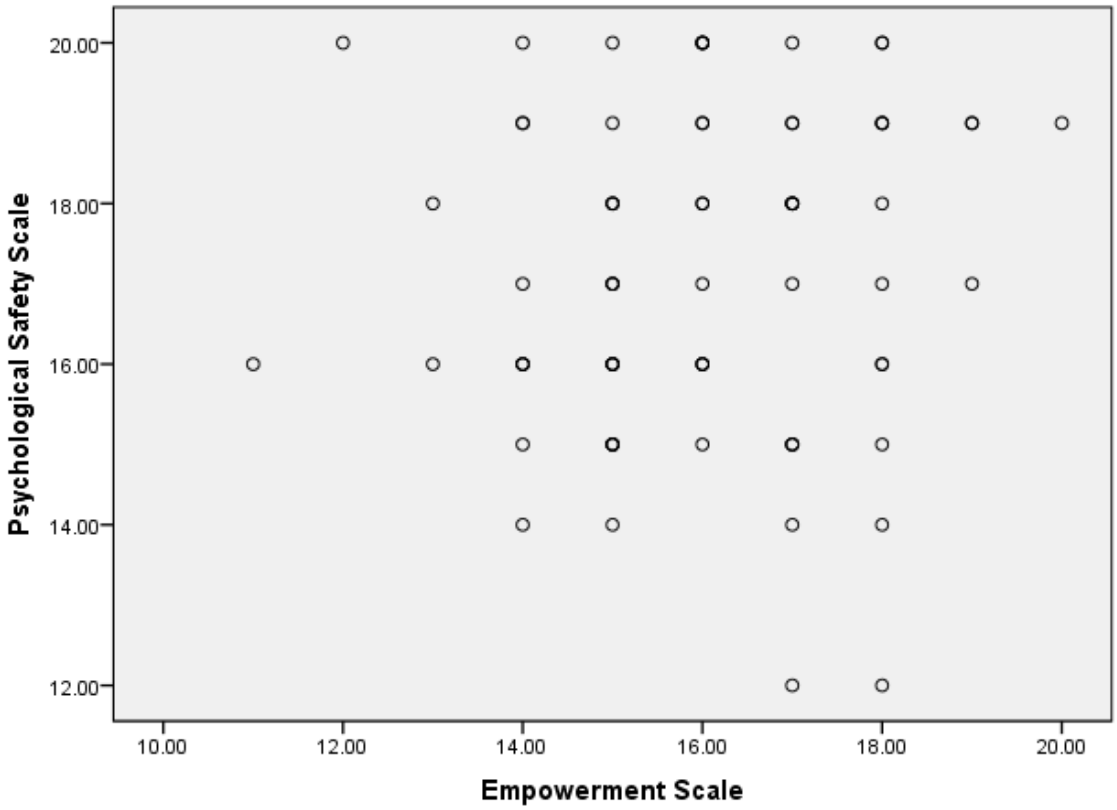

Figure 10. Empowerment Scale and Psychological Safety
r = .084, p = .484

The results as shown in Table 13 indicate that respondents' perceptions of psychological safety are positively associated with their perceptions of efficacy of case consultation ($r = .414$, $p < .001$) As the variable for perceptions of psychological safety increases, the variable of perceptions of effectiveness of case consultation also increases. This is described in Figure 11 with a scatter plot that has a positive slope with data low on the left and higher on the right.

Since the p-value ($p<.001$) is less than .05, the null hypothesis is rejected. Therefore, the results support the hypothesis that there is a relationship between perception of psychological safety and effectiveness of case consultation.

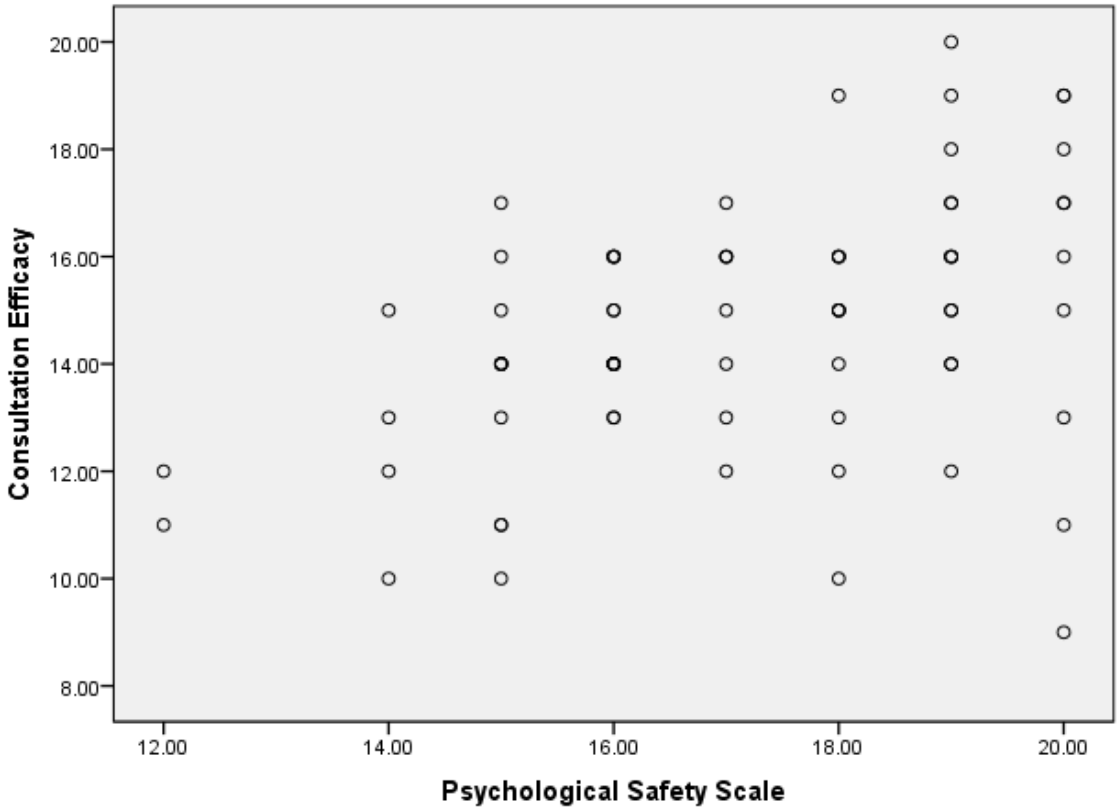

Figure 11. Psychological Safety and Case Consultation Efficacy
r = .414, p < .001

Qualitative data are described in Tables 14, 15, and 16. Table 14 displays respondents' perceptions on the empowering capacity of self-managed teams as aligned with eight themes that emerged from the data. A minimum of three comments are displayed with each theme. Seventy-one respondents replied to this research question with comments that demonstrate agreement or disagreement with the themes.

Ten comments align with the theme, "Team Problem Solving and Decision Making." Twenty-three comments align with "Freedom to use Strengths, Creativity, Mastery." There are 29 agreement comments and two disagreement comments with the theme "Supportive, Openness, and Respect." There are 17 statements about how the self-managed team environment "Encourages more Autonomy and Independence." There are 14 agreement comments and one disagreement comment with the theme, "Sense of Ownership and Responsibility." Respondent replies show 14 agreement comments and three disagreement comments within the theme "More Immediate Feedback or Accountability by the Team." Respondent replies indicate 10 comments about "Commitment to Team, Closer to Team and Co-workers." There are 11 responses identifying "Different Strengths and Knowledge of Team Member to Draw From" as empowering factors of self-managed teams.

Table 14. *Perceptions of Empowerment in Self-managed Team Environment*

Empowerment Themes	Comments
Team Problem Solving and Decision Making Agreement Comments (N=10)	"…more helpful answering questions/problem solving since they are all doing the same/similar work." "It provides a level playing field for input - regardless of position &/or degree/lic." "Making decisions on our own."
Freedom to use Strengths, Creativity, Mastery Agreement Comments (N=23)	"The freedom this setting allows for helps me be a counselor in a way that best uses my strengths." "Encourages employees to contribute more personally & professionally than standard [hierarchical]structures." "…Create or follow their own ideas, use their creativity in their Job."
Supportive, Openness, Respect, Agreement Comments (N=29) Disagreement Comments (N=2)	"Self managed teams offer a strong support system for new employees." "Offers supportive as needed feedback while still allowing individuals to self manage." "Difficult to see peers as both empowering and corrective."
Encourages more Autonomy and Independence Agreement Comments (N=17)	"Good for people who prefer autonomy & are okay with lack of structure." "You have a high degree of autonomy as an employee/counselor & are trusted to do your job & meet required expectations." "…Feel like a counselor for everyone."
Sense of Ownership and Responsibility, Agreement Comments (N=14), Disagreement Comments (N=1)	"I feel more of a responsibility than in previous jobs where I was told what to do & how to do." "More Investment & Ownership of Mission & Dream within the Agency." "Balance between personal responsibility and peer responsibility. Challenges are when this does not happen effectively."
More Immediate Feedback or Accountability by Team, Agreement Comments (N=14), Disagreement Comments (N=3)	"Immediate and consistent feedback from peers, Positive Feedback, constructive comments." "Allows team members to hold each other accountable instead of a supervisor telling them what to do. "Too often corrective rather than empowering."
Commitment to Team Closer to Team and Co-workers Agreement Comments (N=10)	"SMT … allow people to get to know one another. I feel this allows us to empower our co-workers." "To build a union of trust, therefore helping to achieve better outcomes." "It makes everyone feel like we are in this together instead of out to get each other."
Different Strengths and Knowledge of Team Members to Draw From Agreement Comments (N=11)	"Able to really use the different strengths of team members." "We need each others specific knowledge and expertise." "*Mentor each other."

Table 15 displays respondents' impressions of case consultation in a self-managed team environment as compared to experiences in hierarchical work environments. Seven primary themes emerged from the data. A minimum of three comments across two categories are displayed with each theme. Sixty-two respondents answered this research question with comments regarding their experiences of case consultation in a self-managed team (SMT) environment and hierarchical environments.

There are 16 SMT responses and three comments about hierarchical aspects that align with the theme "Diverse Feedback from Several." Respondent replies show 19 SMT statements and two statements about hierarchical environments that align with the theme "Positive, Informative, Respectful." The theme "Taken Seriously, Productive" has 12 comments about the SMT environment and three comments about hierarchical environments. There are 10 SMT responses and one hierarchical response within the theme "Meeting Requirements, Limited Time." Six respondent comments indicate "No clear Guidelines, Disorganized" regarding the SMT environment, with no hierarchical comments regarding this theme. There are 14 SMT statements and four statements about hierarchical settings that agreed with or disagreed with the theme "More Relaxed, Comfortable, Not Rigid." There are twelve respondent statements regarding the SMT setting and five statements regarding hierarchical settings in relation to "Clinical Supervision in Case Consultation."

Table 15. *Perceptions of Case Consultation/Clinical Supervision in Self-Managed Team and Hierarchical Environments*

Case Consultation Comparison Themes	Comments SMT Environment	Comments Hierarchical Environment
Variety of Feedback from Several, SMT (N=16), Hierarchical (N=3)	"SMT are more of a team approach to figuring out the problems or issues with families." "Feedback from several professionals, especially when they differ." "Brainstorm and come up with different ideas based on different perspectives."	"Opinion of 1 person." "Hierarchical…feel less open to sharing my thoughts…for worry of censorship or going against political agendas of agency." "Hierarchical feels like supervisor make overall decisions, not team."
Positive, Informative, Respectful, SMT(N=19), Hierarchical (N=2)	"Helpful to hear feedback from co-workers working with the same populations." "More likely to give feedback as they do care about progress & results w/ client." "Wish TEAMS could be more constructive in difficult situations."	"It was helpful that all people were involved in case would staff together (such as psychiatry, therapy, skills." "The hierarchical approach may not encourage growth for all workers."
Taken Seriously, Productive, SMT (N=12), Hierarchical (N=3)	"Taken more seriously at GMFS" "INVESTED/PASSIONATE about clients" "Occasionally challenged to step beyond current scope of service."	"…effective, with integrity" "More honest." "More productive and individualized in hierarchical…"
Meeting Requirements, Limited Time, SMT(N=10), Hierarchical (N=1)	"Done to fulfill a requirement." "Frustrating to staff cases when all we have time for is a few details and a quick signature…" "More supervision this way than having all the responsibility fall on just a few people."	"Only a few cases were reviewed."
No Clear Guidelines, Disorganized, SMT (N=6), Hierarchical (N=0)	"Wish that more direction was given…" "...allows more freedom & creativity in helping clients achieve their goals." "At times team needs more guidance."	
More Relaxed, Comfortable, Not Rigid, SMT (N=14), Hierarchical (N=4)	"Allows for a more horizontal approach to consulting." "Less pressure to perform and self-promote in SMT setting." "Works well and a comfortable environment."	"Hierarchical is TOP down Teacher-Student style." "A hierarchical approach would…be more rigid and less practitioner driven." "Less comfort sharing sensitive issues in hierarchical…"
Clinical Supervision in Case Consultation, SMT (N=12) (Hierarchical. (N=5)	"…more on equal footing and done to encourage imp[ro]vement." "No real depth in the supervision unless it is 1 on 1 w/ my Q." "SMT - Clinical supervision more about client interaction/suggestions."	"I got better supervisions 1 on 1 in a hierarchical agency." "Hierarchical - clinical supervision more about specific details - paperwork, attitude, etc."

Sixty-one Respondents answered the research question regarding the advantages and disadvantages of group case consultation as compared to individual consultation. These are displayed in Table 16. Responses align with six themes that emerged from the data. A minimum of three comments across two categories is displayed with each theme.

There are seven statements about group consultation and seven statements about individual consultation around the theme that emerged as "Validity of Input." The theme "Range of Feedback and Perspectives" has 37 comments regarding group consultation and nine comments regarding individual consultation. There are 11 group consultation comments and three individual consultation comments about the theme, "Attention, Time." Respondent replies show 16 statements about group consultation and no statements about individual consultation within the theme, "Educational, Hearing Experiences of Others." There are two group consultation comments and nine individual consultation comments about the theme, "In-depth, More Personal, Counter Transference Challenged." Respondent statements indicate 13 comments about group consultation and five comments about individual consultation that align with the theme, "Safe, Approachability, Comfort."

Table 16. *Perceptions of Group and Individual Case Consultation*

Case Consultation Comparison Themes	Group	Individual
Validity of input, Group (N=7), Individual (N=7)	"Ideas that are tried and true." "Similar situations on job & much knowledge w/ experience." "Timidness to confront TEAM members."	"Consistent insight from same person." "Helpful to get feedback / a different perspective from someone working in the field for many years." "Lack of meaningful individual supervision."
Range of Feedback/ Perspectives, Group (N=37), Individual (N=9)	"Advantages group: A broader spectrum of opinions, insight and suggestions. " "Multiple levels of feedback." "Disadvantage of individual [case consultation] is the power…differential."	"Limited opinions." "One perspective but better depth." "Personal feedback."
Attention , Time, Group (N=11), Individual (N=3)	"Sometimes feel rushed or not listened to because others in group are busy or doing other things." "Multitasking and distracted." "Often staffing is rushed so everyone can have a turn."	"[Not] getting off topic." "More focused."
Educational, Hearing of Experiences Others, Group (N=16), Individual (N=0)	"Chance to hear different views or different styles of coworkers." "You gain much more experience from situations of others." "Interdisciplinary by Nature. Yea!"	
In-depth, More personal, Counter Transference Challenged, Group (N=2), Individual (N=9)	"Groups are often more kind and less willing to challenge or confront." "Co-[workers] will challenge you (respectfully) on ideas, transference, etc"	"More personalized suggestions in individual." "Individual staffing gives more time to fully flush out the dynamics of a case." "More honest &more able to meet individual needs."
Safe, Approachability, Comfort Group (N=13), Individual (N=5)	"Build connections." "Discuss individual styles, concerns without concern of judgment." "Less directive (in difficult cases)"	"Disadvantage of individual cc is the power of differential & ... personality conflict." "Scheduling supervision time is a challenge."

Discussion

The results of the study suggest that empowerment, as fostered in a self-managed team environment, strengthens the perceptions of the efficacy of case consultations and clinical supervision. In an organization with many new staff, the study indicates significant perceptions of empowerment, case consultation effectiveness, and psychological safety. Although this study did not find a significant correlation between empowerment and psychological safety, correlations were found between empowerment and case consultation efficacy, as well as between psychological safety and case consultation.

The results indicating there is not a significant correlation between empowerment and psychological safety may point toward a high number of new staff members, who as such, have not realized a high degree of autonomy, impact, or mastery within their current work role. The data from this sample simply did not indicate a significant correlation. Qualitative data seem to support the results for the individual variables as themes that emerged corresponded between quantitative and qualitative data and overall supported variables of empowerment, psychological safety, and case consultation.

The correlation between empowerment and case consultation efficacy suggests that the dimensions which comprise empowerment: Competence, meaningfulness, impact, and choice (Thomas & Velthouse, 1990) align with the elements indicated in the literature as important to case consultation: Improvement comments, counter-transference challenges, positive feedback, and perception of integrity of consultation (Claiborne &

Lawson, 2011; Clarke & Rowan, 2009; Kirkman & Rosen, 1999; Landis & Young, 1994; Shulman, 1992; Thomas & Velthouse, 1990).

Perhaps the above association also conveys the effect of perception of team empowerment as supporting this correlation. Building on the concept of individual empowerment, team empowerment, as defined by Kirkman and Rosen (1999), includes the assessments of potency (efficacy), meaningfulness, autonomy (choice), and impact.

Such elements similarly related to teams and group case consultations were identified as important in the qualitative comments made by respondents. This may indicate that both perceptions of individual and team empowerment have a significant impact on the efficacy of case consultation.

The correlation between psychological safety and case consultation efficacy corresponds with the literature that identified psychological safety as supporting interpersonal risk-taking and respect for the competence of others. The presence of psychological safety was said to encourage seeking input, asking for help and admitting mistakes (Edmondson, 1900; Elloy, 2008; Cherin, 1999). The implication that follows suggests that psychological safety has a positive effect on case consultation. As psychological safety increases, the efficacy of case consultation increases because respondents are more likely to present dilemmas and ask for feedback.

Qualitative responses support the correlation between psychological safety and case consultation efficacy as well. Though several comments indicate negative effects that could be attributed to too much psychological safety, most comments identify positive effects such as openness, approachability, and diverse feedback in case

consultation. As such, the qualitative data appears to correspond with both the literature and quantitative findings of this study.

The conclusions suggested by the research indicate that perceptions of individual empowerment and perceptions of team empowerment, as well as psychological safety, have a positive effect on the efficacy of case consultation and clinical supervision.

Implications for future social work research suggest further study of the relationship between psychological safety and individual and team empowerment with respondents having gained more experience within the self-managed team setting. Such a study may provide a more accurate picture of the correlation between the variables. Future social work research may also be indicated in the direction of self-managed work teams in tandem with empowerment theory as related to group consultation and supervision to determine if the results of this study would be replicated.

Implications for practice in the social work and mental health fields would include training, programs, and policies to sustain the functioning of self-managed teams. The ensuing empowerment of social workers and clinicians would enhance the effectiveness of case consultation and engender a higher quality of care with mental health clients in the human service field.

References

Bandura, A. (1989). Social cognitive theory. In R. Vasta (Ed.), *Annals of child development. Vol.6. Six theories of child development* (pp. 1-60). Greenwich, CT: JAI Press.

Berg, B. (2009). *Qualitative research methods for the social sciences*. Boston, MA: Allyn & Bacon.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Bunderson, J. S., & Boumgarden, P. (2010). Structure and learning in self-managed teams: Why "bureaucratic" teams can be better learners. *Organization Science*, 21(3), 609-624.

Cherin, D. A. (1999). Organizational engagement and managing moments of maximum leverage. *Administration in Social Work*, 23(3-4), 29-46. DOI: 10.1300/J147v23n03_03.

Claiborne, N., & Lawson, H. A. (2011). A two-site case study of consultation to develop supervisory teams in child welfare. *Administration in Social Work*, 35(4), 389-411.

Clark, G., & Rowan, A. (2009). Looking again at the team dimension in systemic psychotherapy: is attending to group process a critical context for practice? *Journal of Family Therapy*, 31, 85-107.

Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative Science Quarterly*, 44(1999), 350-383.

Elloy, D.F. (2008). The relationship between self-leadership behaviors and organization variables in a self-managed work team environment. *Management Research News*, 31(11), 801-810.

Elmuti, Dean. (1996). Sustaining high performance through self-managed work team. *Industrial Management*, 38(2), 6-9.

Gibson, J. W., & Tosone, D. V. (2001). Management fads: emergence, evolution, and implications for managers. *The Academy of Management Executive*, 15(4), 122-133.

Hur, M. (2006). Empowerment in terms of theoretical perspectives exploring a typology of the process and components across disciplines. *Journal of Community Psychology*, 34(5), 523-540.

Kaiser, T. (1997). *Supervisory relationships: Exploring the human element*. (1st ed., p. 181). Pacific Grove, CA: Brooks/Cole Publishing.

Kirkman, B.L., & Rosen, B. (1999). Beyond self-management: Antecedents and consequences of team empowerment. *Academy of Management Journal*, 42(1), 58-74.

Landis, L. L., & Young, M. E. (1994). The reflecting team in counselor education. *Counselor Education and Supervision*, 33(3), 210-219.

Monette, D.R., Sullivan, T.J., & DeJong, C.R. (2011). *Applied Social Research*. Belmont, CA: Brooks/Cole.

Moss, M.T. (1996). Perioperative nursing in the managed care era: self-managed work teams: the rainbow model. *Nursing Economics*, 14(3), 185-186.

Pocock, D. (2006). Six things worth understanding about psychoanalytic psychotherapy. *Journal of Family Therapy*, 28, 352-369.

Richmond, D. (2009). Using multi-layered supervision methods to develop creative practice . *Reflective Practice*, 10(4), 543-557.

Schamess, G. (2006). Transference enactments in clinical supervision. *Clinical Social Work Journal*, 34(4), 407-425.

Shulman, L. (1992). *Interactional Supervision*. Washington, D.C.: NASW Press.

Solansky, S. T. (2008). Leadership style and team processes in self-managed teams. *Journal of Leadership and Organizational Studies*, 14(4), 332-341.

Spreitzer, G. (1995). Psychological empowerment in the workplace: Dimensions, measurement, and validation. *Academy of Management Journal* 38 (5). 1442-1464.

Appendix A

Institutional Review Board
University of St. Thomas

Agency Consent Form

Researcher: Please provide your agency with the information about your project and have your agency contact complete this form.

Agency: Please read this form and ask any questions you may have before agreeing to allow this study to take place at your agency. Please keep a copy of this form for your records.

Project Name	The Effects of Empowerment on Case Consultation and Clinical Supervision in the Self-managed Team Environment	**IRB Tracking Number**	284754-1

General Information Statement about the study:

This study will survey agency staff members regarding their experience and observations of staff empowerment, psychological safety, and efficacy in relation to group supervision and consultation in the self-managed team environment.

Your agency is invited to participate in this research.
The agency was selected as a host for this study because:

This mental health agency was selected because of its use of self-managed teams, focus on staff empowerment, and experience of supervision and case consultation in a self-managed team environment.

Study is being conducted by:	Mary McDonnell
Research Advisor (if applicable):	Jeong-Kyun Choi
Department Affiliation:	Graduate Social Work

Background Information
The purpose of the study is:

To explore the effectiveness of self-managed work teams in tandem with group consultation or supervision in providing a high quality of care with mental health clients in the social service field.

Procedures
Study participants will be asked to do the following:
State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.

Participants will be asked to complete a survey of twenty questions seeking information about demographics and beliefs about empowerment and their experience of case consultation.

Risks and Benefits of being in the study

The risks involved for subjects participating in the study are:
There are no risks involved for subjects participating in this study.
The direct benefits the agency will receive for allowing the study are:
There are no direct benefits associated with this study.

Compensation Details of compensation (if and when disbursement will occur and conditions of compensation) include:
Respondents will receive no compensation for participating in this study.

Confidentiality The records of this study will be kept confidential. The types of records, who will have access to records and when they will be destroyed as a result of this study include:
Records with identifying information created in the course of this study will be kept confidential. Research records will be kept in a locked file at the home of the researcher. All electronic documents and recordings with identifying information will be password protected. All identifying information will be destroyed after the research project is complete.

Voluntary Nature Allowing the study to be conducted at your agency is entirely voluntary. By agreeing to allow the study, you confirm that you understand the nature of the study and who the participants will be and their roles. You understand the study methods and that the researcher will not proceed with the study until receiving approval from the UST Institutional Review Board. If this study is intended to be published, you agree to that. You understand the risks and benefits to your organization.

Should you decide to withdraw, data collected about you	will be used in the study

Contacts and Questions You may contact any of the resources listed below with questions or concerns about the study.	
Researcher name	Mary McDonnell
Researcher email	
Researcher phone	
Research Advisor name	Jeong-Kyun Choi
Research Advisor email	
Research Advisor phone	
UST IRB Office	

Statement of Consent			
I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.			
Signature of Agency Representative ☒ *Electronic signature*		Date	
Print Name of Agency			11/12/2011

Representative			
Signature of Researcher ☒ *Electronic signature**		Date	
Print Name of Researcher	Mary McDonnell 11/9/2011		

*Electronic signatures certify that::
The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.

Appendix B

RESEARCH INFORMATION AND CONSENT FORM

THE EFFECTS OF EMPOWERMENT ON CASE CONSULTATION AND CLINICAL SUPERVISION IN THE SELF-MANAGED TEAM ENVIRONMENT

Introduction:
You are invited to participate in a research study investigating the experiences and observations of staff empowerment, psychological safety, and efficacy in relation to group supervision and consultation in the self-managed team environment. This study is being conducted by Mary McDonnell, a graduate student at the School of Social Work, College of St. Catherine/University of St. Thomas.

You were selected as a possible participant in this research because of your involvement in a mental health agency that has a self-managed team environment. This study includes individuals who are part of a self-managed team and also participate in or support the function of group case consultation and/or clinical supervision. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:
This study will explore the effectiveness of self-managed work teams in tandem with group consultation or supervision in providing a high quality of care with mental health clients in the social service field. Approximately 80 people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to complete a survey of twenty-one questions seeking information about demographics and beliefs about empowerment and your experience or observations of case consultation/clinical supervision. The survey should take about ten to fifteen minutes to complete.

Risks and Benefits:
The study has no known risks for participating. There are no direct benefits to you for participating in this research.

Confidentiality:
Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable. I will keep the research results in a password protected computer and/or a locked file cabinet in my home and only I and the research project chair, Jeong-Kyun Choi, PhD, University of St. Thomas, will have access to the records while I work on this project. I will finish analyzing the data by May 31, 2012. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:
Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with [this agency] or the University of St. Thomas in any way. You can refuse to answer any question if you choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

Contacts and questions:
If you have any questions, please feel free to contact me, Mary McDonnell, at [omitted]. You may ask questions now or at a later date. If you have any additional questions the research advisor will be happy to answer them. You may contact my research advisor, Evan Choi, at [omitted]. If you have other questions or concerns regarding the study and would like to talk to someone other than the researchers, you may also contact University of St. Thomas Institutional Review Board. You may keep a copy of this form for your records.

Statement of Consent:
You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

_____

I consent to participate in the study.

_____

Signature of Participant Date

_____

Signature of Researcher Date

Appendix C
Survey

Demographic Information

This section asks general questions about your background. Please circle the correct response or fill in the blank.

1. What is your current primary role with this agency?
    a. Licensed Therapist (1)
    b. Counselor (2)
    c. Administrative Staff (3)
    d. Clinical Supervisor (4)
    e. Other _____ (5)

2. How long have you been employed:

    a. With this agency? _____ Years _____ months (1)

    b. In your current position with this agency? _____ Years _____ months (2)

    c. In the Mental Health Field (total)? _____ Years _____ months (3)

3. What is your gender?
    a. Female (1)
    b. Male (2)

4. What is the highest degree that you have earned?
    a. Diploma (1)
    b. Associate degree (2)
    c. Baccalaureate degree (3)
    d. Masters degree (4)
    e. Doctorate (5)

5. On the scale below, please circle the number that best indicates your preferred approach toward the world.

Very Extroverted	Extroverted	In-between	Introverted	Very Introverted
1	2	3	4	5

Work Role and Case Consultation

6. Using the following scale, please indicate the extent to which you agree or disagree with the statements based on your experience or observations.

	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly agree 5
1. The work I do is meaningful to me.	□	□	□	□	□
2. I have mastered the skills necessary for my job.	□	□	□	□	□
3. I have significant autonomy in determining how I do my job.	□	□	□	□	□
4. My impact on what happens in my department is large.	□	□	□	□	□
5. My team is effective at managing its tasks.	□	□	□	□	□
6. Counselors and therapists consult about problems that occur with clients.	□	□	□	□	□
7. It is safe to talk openly in staffings about work with clients.	□	□	□	□	□
8. Staff members receive specific feedback about things they do well.	□	□	□	□	□
9. Staff members receive specific comments about things they could improve.	□	□	□	□	□
10. Staff members feel they can discuss any client situation in case consultation.	□	□	□	□	□
11. In case consultation, issues such as counter transference are challenged in respectful ways.	□	□	□	□	□
12. There is a high degree of integrity in case consultation.	□	□	□	□	□
13. Staff members feel they can discuss any client situation with their clinical supervisor.	□	□	□	□	□

Based on your experience in the mental health field working in a self-managed team environment and (if applicable) a more hierarchical work environment, please complete the following:

7. In what ways does the self-managed team environment at this agency empower co-workers to succeed in their role?

8. Please briefly describe your impressions of clinical supervision and case consultation in the contrasting environments (self-managed team/hierarchical).

9. What do you see as the advantages and disadvantages of group or individual (supervisee – supervisor) case consultation?

Thank you for participating in this survey. ☺