MHC19/31712

Mental Health Network

Perinatal and Infant Mental Health Sub Network

Position Statement

Clinical Reflective Supervision for Professionals Working with Families with Infants and Young Children

May 2019

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Executive Summary

The aim of this Position Statement is to provide a standardised, generic and flexible approach to clinical and reflective supervision for Health Professionals working with families with infants and young children. Provision of clinical and reflective supervision is an important strategy in supporting health professionals to provide good clinical care. This document is particularly relevant to mental health clinicians, general practitioners, midwives, child health nurses and allied health practitioners, however is also useful for other front line workers such as those working in child care.

Working with any family can be emotionally taxing for professionals and may compromise good clinical care. Supervision provides the opportunity for clinicians to explore their own emotional responses that may be triggered by this relationship-based work.

Reflective supervision is now commonly required for staff of many programs that provide services to infants, young children and their families.[1] [2] [3] [4]

The Position Statement is aligned with the Perinatal and Infant Mental Health Model of Care 2016 which identified the importance of clinical and reflective supervision. Across the Position Statement there is a focus on integration to improve outcomes for children through the adoption of five principles provided later in this document.

This document acknowledges that there are some differences across professional groups regarding understandings and definitions for clinical and reflective supervision. The overriding consideration of this Position Statement is to ensure that regardless of the language used, supervision should be responsive to all professionals' knowledge, capacity for self-reflection, and experience within the various clinical settings in which they work with families during the perinatal period and early years of childhood.

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[1] Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Reaching toward an evidence base for reflective supervision. *Zero to Three, 31*(2), 39-50.

[2] Heffron, M. C. & Murch, T. (2010). *Reflective supervision and leadership in early childhood programs.* Washington, DC: Zero to Three Press.

[3] Weigand, R. (2007) Reflective supervision in child care: The discoveries of an accidental tourist. ZERO TO THREE, Vol. 28, No. 2. (November, 2007).

[4] Elita Amini Virmani, Katherine E. Masyn, Ross A. Thompson, Nicola A. Conners-Burrow and Leanne Whiteside Mansell 2013. Early Childhood Mental Health Consultation: Promoting Change in the Quality of Teacher–Child Interactions (pages 156–172) March/April 2013 Volume 34, Issue 2 Pages 95–188.

Background

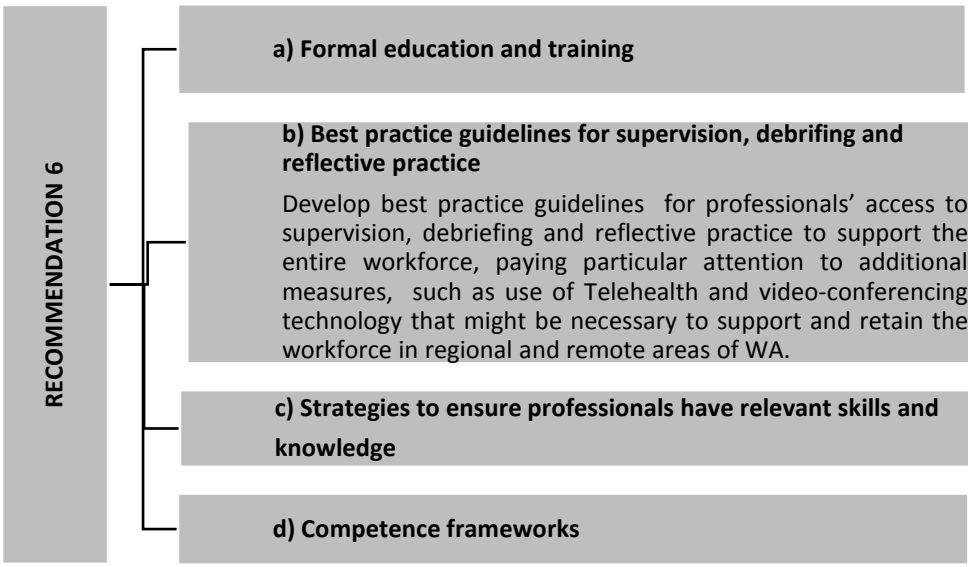
The Mental Health Network aims to improve health outcomes for people with mental health conditions by enabling consumers and carers, health professionals, hospitals, health services and the Mental Health Commission, as system manager to engage and collaborate effectively to facilitate health policy and increased co-ordination of care across the State. The Mental Health Network is WA's 18th health network comprised of ten sub networks, including Perinatal and Infant Mental Health (PIMH).

The PIMH sub network is committed to supporting the development of adequate skills and resources for health professionals to provide quality and safe services. Clinical and reflective supervision is a relationship-based activity and a continual ongoing process that ensures safe high quality practice. Limited access to clinical and reflective supervision has been highlighted by a range of stakeholders as an ongoing concern with the potential to impact on service provision and best practice (See Perinatal and Infant Mental Health Model of Care).

Context

Within the WA context, the PIMH Model of Care 2016 identified seven key recommendations; including four strategies supporting the professional and personal development of practitioners (see Figure 1). The position statement focuses on recommendation six 'Supporting the workforce: Consolidate perinatal and infant/child mental health service provision through the development of a dedicated and competent workforce'.

Figure 1 – Summary of Recommendation Six Strategies in PIMH Model of Care 2016.



Recommendation six highlights:

"Good clinical care can be compromised when workers are not able to acknowledge their own needs, or find support in circumstances where they find themselves overwhelmed. Ensuring staff have effective and timely support mechanisms such as clinical and reflective supervision, helps to reduce the burden on health professionals and ultimately improves service functioning and the patient journey. For many front line service providers such as child health nurses, midwives, peer support workers or GPs working with women and their families, participation in reflective clinical supervision has not traditionally formed part of their expected role and responsibilities, and this constitutes an unrecognised gap." (WA Department of Health 2016:64)

Supervision

Clinical and reflective supervision is provided to professionals working with families with infants and/or young children with a particular focus on those dealing with complex social vulnerabilities or where mental health is compromised. All workers need access to appropriate and timely supervision that is an embedded part of ongoing/regular clinical practice. Supervision may be delivered individually or in a group setting, with consideration for early career professionals who may need more frequent one on one sessions. Consideration must also be given for those workers in other settings, such as childcare and community services, who are also supporting families with infants and young children, often in settings of high emotional intensity.

Supervision needs to be responsive to different professionals' knowledge, capacity for self-reflection, and experience within various clinical settings. Across all professions the central goal is to ensure safe quality patient care, provided by a competent and well-supported workforce. Reflective and clinical supervision forms part of a practitioner's competency development in perinatal and infant mental health across the continuum of care. Effective supervision can impact on and improve how the whole system supports vulnerable families during this period of development.

It is important to clarify that clinical and reflective supervision differs from other forms of supervision such as line management, clinical teaching, preceptorship, mentoring/coaching and performance development: all core to overall personal and professional development of clinicians. It is essential that poor performance must be appropriately addressed by the manager and employee in accordance with organisational human resource policy.

Benefits of clinical and reflective supervision

Research suggests that access to reflective supervision results in higher quality of service and the potential for better outcomes for families.[5] The evidence supporting reflective supervision comes from qualitative studies in early childhood services, where its presence is associated with greater resilience among providers, and reduces burnout.[6] In addition, observational studies show that child welfare agencies with more relationship-based supervision and greater time devoted to continuing education have lower rates of turnover. A study by Watson, Neilsen, Gatti et al provides qualitative accounts of practitioners' experiences, demonstrating positive effects on work practice and reduction of job stress[7]. Further, there is good evidence that reflective supervision is connected to positive child/family outcomes, [8] skill building, fosters new ideas,[9] [10] increases job satisfaction[11] and results in higher quality service. [12] [13]

This suggests that organisational investment in reflective supervision may yield returns in staff retention and potentially improve client outcomes. It is important to note that reflective supervision requires organisational commitment and dedicated resources. This includes training, ongoing support for supervisors and time for supervisor and supervisee to devote to reflective practice.

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[5] Heffron, M.C. (2005). Reflective Supervision in Infant, Toddler, and Preschool Work. In K. Finello (Ed.), The Handbook of Training and Practice in Infant and Preschool Mental Health. San Francisco: Jossey-Bass, pp. 114-136.

[6] Turner SD. Exploring Resilience in the Lives of Women Leaders in Early Childhood Health, Human Services, and Education. Corvallis: Oregon State University; 2009.

[7] Christopher Watson , Shelley Neilsen Gatti , Megan Cox , Mary Harrison , Jill Hennes , (2014), Reflective Supervision and its Impact on Early Childhood Intervention, in Eva Nwokah , John A. Sutterby (ed.) Early Childhood and Special Education (Advances in Early Education And Day Care, Volume 18) Emerald Group Publishing Limited, pp.1 – 26.

[8] Christopher Watson , Shelley Neilsen Gatti , Megan Cox , Mary Harrison , Jill Hennes , (2014), Reflective Supervision and its Impact on Early Childhood Intervention, in Eva Nwokah , John A. Sutterby (ed.) *Early Childhood and Special Education (Advances in Early Education And Day Care, Volume 18)* Emerald Group Publishing Limited, pp.1 - 26

[9] Ibid.

[10] Leslie Forstad 2012 'Home visiting and reflective practice: when systems change means practice change' Reflective Practice International and Multidisciplinary Perspectives. Volume 13, 2012 - Issue 1

[11] Leslie Forstad 2012 'Home visiting and reflective practice: when systems change means practice change' Reflective Practice International and Multidisciplinary Perspectives. Volume 13, 2012 - Issue 1

[12] Heffron, M.C. (2005). Reflective Supervision in Infant, Toddler, and Preschool Work. In K. Finello (Ed.), The Handbook of Training and Practice in Infant and Preschool Mental Health. San Francisco: Jossey-Bass, pp. 114-136.

[13] Christopher Watson , Shelley Neilsen Gatti , Megan Cox , Mary Harrison , Jill Hennes , (2014), Reflective Supervision and its Impact on Early Childhood Intervention, in Eva Nwokah , John A. Sutterby (ed.) *Early Childhood and Special Education (Advances in Early Education And Day Care, Volume 18)* Emerald Group Publishing Limited, pp.1 - 26

Modes of Supervision

Clinical supervision

Clinical supervision is a formal process of professional support and learning between two or more practitioners within a safe and supportive environment that enables critical reflection on care to ensure quality patient services; the development of professional skills and clinical autonomy of supervisees.[14] Supervision is provided through regular, time protected, facilitated sessions during which practitioners can reflect on complex issues that impact and influence their practice.[15]

Supervision that is primarily clinical is often a necessary requirement in a given discipline, and is likely to include many or all of any given administrative objectives. [16] Clinical supervision does not necessarily consider what the practitioner brings to the intervention nor does it necessarily encourage the exploration of emotion as it relates to work with an infant/young child and family. Also, clinical supervision may not attend to all of the relationships, including the relationships between practitioner and supervisor, between practitioner and parent, and between parent and infant/young child.

Reflective supervision

Reflective supervision places emphasis on recognising and understanding the interrelationships between the supervisor, supervisee, parent and infant/young child. Reflective supervision relates to personal and professional development within one's discipline by recognising the emotional content of the work and giving consideration as to how our own thoughts and feelings can impact on work with families and relationships[17]. Reflective supervision is an ongoing professional development process that provides a way for practitioners to enhance their effectiveness, by allowing them to reach greater understanding of the people that they work with, facilitating quality care and outcomes for infants, young children and their families.

One of the key organising principles of reflective supervision is the "parallel process",[18] where the primary focus is: "…the shared exploration of the emotional content of infant and family work as expressed in relationships

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[14] Bishop, V. (ed) (1998) *Clinical supervision in practice.* London: Macmillan/NT research

[15] Bond, M., & Holland, S. (2010). *Skills of Clinical Supervision for Nurses. A Practical Guide for Supervisees, Clinical Supervisors and Managers* (2nd ed.). Berkshire: Open University Press.

[16] Michigan Association for Infant Mental Health. (2002, 2011). MI-AIMH Endorsement for Culturally Sensitive, Relationship-focused Practice Promoting Infant Mental Health® and MI-AIMH Competency Guidelines.

[17] Weatherston, D., Weigand, R. F., & Weigand, B. (2010) Reflective supervision: Supporting reflection as a cornerstone for competency. Zero to Three November 22-30.

[18] Ibid.

between parents and infants, parents and practitioners and supervisors and practitioners"[19]. Exploration of this parallel process is a distinguishing feature of reflective supervision, paying close attention to all the relationships involved. Here it is understood that the practitioners own feelings and behaviours are important sources of information and that the quality of the professional's interactions with the client can influence the intervention outcomes.[20]

Key elements of reflective supervision include a secure and trusting relationship between supervisor and supervisee with a sustained emotional presence over time. Consistency and regularity of supervisory sessions are essential. There must be time allowed for personal reflection after exploration of parallel processes and careful attention to reactions and emotions that may be evoked. The supervisor must be able to listen attentively, allow space for reflection and discovery as well as provide support and guidance as needed.[21]

Reflective supervision is an important tool to enable health professionals to develop new knowledge, translate that knowledge into actual skills and strategies, and build a meaningful professional presence that provides support to families with infants and young children. Reflective supervision is particularly crucial for those working in the perinatal and infant mental health field given the vulnerability of the infant, importance of nonverbal communication and the need to understand the meaning of interactional patterns. For the worker, infant vulnerability can evoke strong feelings that need to be recognised and understood.

[19] Weatherston, D. & Barron, C. (2009). What does a reflective supervisory relationship look like? In S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision*. Washington, D.C.: Zero to Three Press.

[20] Heffron, M. C. & Murch, T. (2010). *Reflective supervision and leadership in early childhood programs.* Washington, DC: Zero to Three Press.

[21] Michigan Association for Infant Mental Health (n.d). *Best Practice for Reflective Supervision/Consultation Guidelines*

Underlying Principles

The position statement identifies key principles for clinical and reflective supervision central to promoting the personal and professional development of health professionals and improving consumer and family outcomes. The key principles include:

1. *Clinical and reflective supervision available for all workers*

Health agency planning should incorporate clinical and reflective supervision for all employees working with parents, infants and young children. Both modes of supervision have essential functions and features, and it is critical that reflective supervision is formally incorporated into clinical supervision processes.

2. *Appropriately qualified supervisor available for all workers*

High quality reflective supervision with an appropriately qualified supervisor, should be available and accessible to all professionals working with infants, children, parents, and families (including workers in isolated, rural and remote areas).

3. *Reflective supervision supports professional and personal decision making, and personal resilience and mental health*

A person's mental health and resilience is determined in part by genetic predispositions, and founded on the persons secure attachment relationships during infancy and throughout life and on the person's life experiences and opportunities. Further, mental health and resilience are improved and sustained by the process of reflecting on one's thoughts and feelings, and those of others, so that a broader understanding of context is available for forward planning and decision-making across different circumstances.

4. *Relational / interpersonal dynamics*

Work within the perinatal and infant mental health field occurs within a relational context. The nature of this work can be personally challenging. Staff bring their own attachment and personal histories when working with parents, infants and young children, and they require regular opportunities to reflect on their training, education, experiences, emotions and ethical issues arising in the course of their work.

Enablers and Implementation Considerations

For clinical and reflective supervision to be accepted and embedded in clinical practice, employing bodies/agencies and health professionals have a shared responsibility to commit to implementing the process in the interests of patient safety. The following enablers and considerations are listed to assist implementation of supervision.

- Adequate resources are allocated for reflective supervision (time and money).
- Clinical and reflective supervision takes place in a safe, supportive and confidential space.
- Value is focused on improving quality patient outcomes by emphasising client/staff relationships and client safety.
- Supervisors are suitably qualified and experienced.
- Roles, responsibilities and expectations of clinical and reflective supervision are clearly defined.
- Clinical and reflective supervision is multidisciplinary and actively explores issues of culture and diversity.
- Clinical and reflective supervision is monitored and evaluated for continuous improvement.
- Best practice supervision is supported and promoted according to an agency's policy and guidelines.
- The model and delivery of supervision chosen by an agency is one that best suits the needs of their clients and staff i.e. face to face, by teleconference, videoconference. Journaling for clinicians in rural or remote areas may also be considered as a part of the supervision process.

Further Reading

- Australian Association Infant Mental Health – Best practice reflective supervision 2015
- Australian Association of Social Workers 2014 Supervision Standards
- Australian College of Mental Health Nurses – clinical supervision
- Barnett, B., and Drum, M. 2013. Supervision: What is it and can it be measured? CQ: The CAPA Quarterly.
- Best start Resource Centre 2012. When compassion hurts: Burnout, vicarious trauma and secondary trauma in prenatal and early childhood service providers. Toronto, Ontario, Canada.
- Bruen, S. 2013. An experience of reflective practice – finding a reflective space, Perspectives in Infant Mental Health Vol. 21(2), 1-2.
- Goldberg, S. 2015. Reflective supervision/consultation – What is it and why does it matter? Perspectives in Infant Mental Health.
- Health Education and Training Institute 2015. NSW Health clinical supervision framework
- Mares, S., Newman, L., and Warren, B. 2011. Clinical skills in infant mental health: The first three years. (2nd ed), ACER Press: Melbourne Victoria.
- Priddis, L.E., Matacz, R., and Weatherston, D. 2015. Building a workforce competency-based training program in infant/early childhood mental health, Infant Mental Health Journal, Vol 36(6), 623-631.
- Roth, A.D., and Pilling, S. 2015. A competence framework for the supervision of psychological therapies, Research Department of Clinical, Education and Health Psychology, University College London.
- Sendiak, C. 2013. A reflective practice model of clinical supervision, Conference paper presentation: Advances in Clinical Supervision Conference, Sydney Australia 4-6 June 2013, NSW Institute of Psychiatry.
- Tomlin, A., Weatherston, D., and Pavkov, T. 2014. Critical components of reflective supervision: Reponses from expert supervisors in the field, Infant Mental Health Journal, Vol. 35(1), 70-80.
- Watson, C.L., Bailey, A.E., and Storm, K.J. 2016. Building capacity in reflective practice: A tiered model of statewide supports for local home-visiting programs, Infant Mental Health Journal, Vol. 37(6), 640-652.
- Wiegand, R.F. 2012 Reflective supervision: Discoveries of an accidental tourist, Perspectives in Infant Mental Health,
- Wonnacott, J. 2012. Mastering social work supervision. Jessica Kingsley Publishers: London UK.

Related Documents

- Mental Health Policy Framework: Accountability and improvement – Accountable service based on contemporary best practice and committed to continuous improvement.
- Clinical Governance, Safety and Quality policy framework: Principles – Led for high performance – Executive and clinical staff have the right qualifications and skills to provide safe, high quality health care, and to foster a culture of openness, collaboration and continuous improvement; Organised for safety – Minimisation of clinical risks and incidents and a systems approach to harm minimisation
- Occupational Safety and Health Act 1984 – DOH develops safe systems and work practices that reflect its commitment to safety and health
- Australian Health Professional Regulation Agency (AHPRA)

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