Using Reflective Supervision to Support Trauma-Informed Systems for Children

A white paper developed for the Multiplying Connections Initiative

By: Anje Van Berckelaer, MD

Introduction

Many child service agencies serve populations with a high prevalence of trauma.[1] Consequently, both mental health and child service agencies have increasingly taken steps to become Trauma-Informed Systems (TIS) in an effort to improve services to these traumatized populations by implementing policies that reduce re-traumatization and reinforce personal integrity, autonomy, and control. This paper offers a rationale to administrators, program directors, and supervisors in child service agencies for the adoption of reflective supervision as a supervisory approach consistent with TIS.

Context: burnout, vicarious trauma, and staff turnover

Both clinical and non-clinical direct care staff in child services working with traumatized families may undergo vicarious traumatization, burnout, and heavy staff turnover.[2, 3] While staff turnover is associated with many factors, inadequate supervisory support and burnout have specifically been cited by workers in these settings as a cause.[3] Hodas (2005) proposes three "domains of functioning" to empower direct care staff in child services to provide quality care. These include values and beliefs, job-specific expectations and competencies, and professional self-awareness and self-control.[4] Each of these domains, he writes, should be reinforced by the organization's structure, mission, and human resources practices. Indeed, each of them is amenable to an appropriate supervisory strategy.

There are many ways to build trauma-informed systems, but these models do not typically specify the management or supervisory model they employ. Briefly, TIS aim to provide services and providers that are consistent and **trustworthy** in an environment that is physically and emotionally **safe.** Furthermore, they prioritize consumer **empowerment,** choice, and **control,** maximizing **collaboration** with the consumer.[5] A supervisory model consistent with this approach should itself promote trust, empowerment, and control, and ideally model the relationship or interaction desired between the helping professional and the client.

What is reflective supervision?

Reflective supervision is the regular collaborative reflection between a service provider (clinical or other) and supervisor that builds on the supervisee's use of her thoughts, feelings, and values within a service encounter. Reflective supervision complements the goals and practices of TIS.

Reflective supervision in practice

Supervisor and supervisee meet regularly (for example, for an hour weekly or monthly) to discuss difficult cases. The case and direction of discussion are chosen by the supervisee, who is guided by the supervisor to examine her feelings or thoughts about the case and use this awareness to better serve the client. The relationship between supervisor and supervisee in reflective supervision models the desired relationships between provider and client in a therapeutic/helping relationship. In particular, like TIS, the relationship is based on collaboration, choice, trust, and control.

> *"Reflective supervision is essential to maintaining staff morale and retention."*
>
> Jane Pray, RN, Supervisor, Nurse Family Partnership

Evidence

The evidence supporting reflective supervision comes from qualitative studies in early childhood services, where its presence is associated with greater resilience among providers, or where the lack of continuing education and appropriate, supportive supervision contributes to provider burnout.[6] In addition, observational studies show that child welfare agencies with more relationship-based supervision and greater time devoted to continuing education, both elements of reflective supervision, have lower rates of turnover and greater success in obtaining permanent placement for children.[7] Critics may argue that reflective

supervision is resource-intensive, taking the supervisor's time from other tasks and the worker's time away from direct services. Indeed, it does require dedicated resources, including up-front training at the time of implementation, ongoing support for supervisors, and time for supervisor and supervisee to devote to reflective practice. While these resources must be taken into consideration, the studies cited above suggest that this investment may yield returns in staff retention and potentially in client outcomes.

Existing supervisory models are less consistent with Trauma-Informed Systems

The principal alternatives to reflective supervision include administrative supervision and peer consultation. The former consists of an administrative approach to the assessment of worker performance, for example quantitative assessments of client-hours, or caseload. Because ongoing case-based reflection is not formally incorporated in this approach, individual cases are reviewed typically in times of crisis, and the nature and quality of supervision is entirely dependent on the individual supervisor. Crisis review or critical incident debriefings approach the supervisee's work when there has already been an adverse event. In contrast, TIS is a strengths-based approach to services (focusing on the strengths and abilities of the client) that takes place regularly in a safe setting.

The Structured Peer Consultation Model was developed and implemented with counseling professionals, in part to respond to the need for insufficient supervisory support; using the structured format, counselors create their own supervision-like experiences and receive support and critical feedback from peers.[8] This model's efficacy has not been evaluated in settings that serve traumatized populations. Although it has some of the relational and supportive attributes and non-hierarchical approach that would be consistent with TIS, advocates of TIS argue that the emotional content of the supervision may not be appropriate at the peer level.

Core elements and potential pitfalls

In existing programs that have previously been using other supervisory styles, the transition to reflective supervision may be challenging. Several essential aspects must be aligned before RS can be successful.

- Leadership commitment
  Every level of the organization must be engaged in order for time to be regularly dedicated to RS. This commitment to RS is essential: not only must the supervisor/supervisee prioritize it, but its scheduled time must take precedence even over client visits if it is to be maintained and flourish as a method of staff reflection and development. A focus on caseload alone, or pressure on supervisors to increase productivity to the exclusion of supervision time, leads to shortchanging reflective practice.
- Support for supervisors
  A tiered mentoring/supervisory structure is also important: Supervisors offering RS need to be supervised and receive support modeling reflective practice from their own supervisors.
- Trust, privacy and time
  In order for RS to work, supervisees must be able to trust that the information they share is private, and that the work they do in supervision is part of a professional growth process. This is facilitated by setting aside time and private space for supervision. In settings where the supervisory approach has been less relational and more administrative, it may take time to build the kind of trust necessary for effective reflective supervision.

Why now?

Reflective supervision is an attractive staff supervision model for TIS, because it provides a good theoretical match between the supervisor/supervisee relationship and the supervisee/consumer relationship that is critical for trauma informed practice. Indeed, the validation, support, and reflection received in reflective supervision are precisely what the helping professional seeks to offer to the consumer. Although other supervision models exist, none have been systematically applied in this context. The most common alternative, administrative supervision, leaves formal supportive reflection vulnerable to competing time pressures in the best case; in the worst case, it is absent altogether or occurs only in response to crisis. Although the evidence is currently rudimentary, the potential benefits to the child service agencies and the populations they serve are promising, in terms of staff retention, and improved staff training, awareness, and morale. We recommend that child service agencies implement this model with an eye toward documenting staff retention, costs, and consumer outcomes including satisfaction.

> *"Reflective supervision is a parallel process. My goal is to model the desired relationships between provider and client in the therapeutic/helping relationship through the use of reflective supervision with my supervisees."*
>
> Maria Frontera, LSW
> Director, Children and Family Services

Case study and interview

To further explore the practical experience of using reflective supervision, we interviewed Jane Pray, a supervisor in one of Philadelphia's three Nurse-Family Partnership (NFP) sites. NFP is a home visit intervention for high-risk first-time mothers. One of its core model elements is reflective supervision (RS). An important feature of the NFP is that its well-studied and proven outcomes rely on staff retention: the loss, mid-cycle, of a home visiting nurse, can lead to 50-75% attrition of clients. **Consequently, staff supervision models must be very focused on effective retention measures.**

Implementation

NFP programs use reflective supervision as a core element. When the NFP began in Philadelphia in 2001, the teams of supervisors and home visiting nurses trained together in the model. Ms. Pray notes that a fresh start made it easy for the team to embrace the process. As new staff were hired over the years, they joined a team in which reflective practice was the norm.

As a supervisor, Ms. Pray notes some common experiences in RS:

- For new staff, it can be helpful for the supervisor to integrate training and orientation needs into the reflective practice in the beginning, as the relationship is built.
- The modeling aspect of the relationship is very important – for example, in the NFP, the supervisor/supervisee relationship models the worker/client relationship in not having all the answers to issues that arise, and by helping the supervisee or client to work through difficult situations herself.
- A common question asked by supervisors new to RS, is, "How do I provide reflective supervision and maintain my administrative, hierarchical reporting needs (such as case loads and reporting requirements)?" In practice, RS does not exclude routine administrative supervision – rather, it provides a constructive, supportive process through which to address administrative/organizational issues. While discipline is still part of the supervisory role, it's integrated into the supervisory relationship. "You have to trust that by using the process, performance will improve."

How staff and supervisors feel about RS

Ms. Pray remarks that among the nurse home visitors, there is recognition that time is needed to reflect and process the demanding work involved in providing services to high-risk mothers and their babies. Said one staff member: "I'll never give up my supervision time."

Further Reading

Best practice guidelines for reflective supervision/ consultation. Michigan Association for Infant Mental Health; 2009.

Available at: http://www.mi-aimh.org/downloads.php

References

1. Pecora P, Williams J, Kessler R, et al. Assessing the effects of foster care: early results from the Casey National Alumni Study. Seattle: Casey Family Programs; 2003.

2. Woltmann EM, Whitley R, McHugo GJ, et al. The Role of Staff Turnover in the Implementation of Evidence-Based Practices in Mental Health Care. Psychiatr Serv 2008;59:732-7.

3. Barak MEM, Nissly JA, Levin A. Antecedents to Retention and Turnover among Child Welfare, Social Work, and Other Human Service Employees: What Can We Learn from Past Research? A Review and Metanalysis. The Social Service Review 2001;75:625-61.

4. Hodas G. Empowering direct care workers who work with children and youth in institutional care. Harrisburg: Pennsylvania Office of Mental Health and Substance Abuse Services; 2005.

5. Harris M, Fallot R. Trauma-Informed Systems of Care: An Update 2007.

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. National Council on Crime and Delinquency. Relationship between staff turnover, child welfare system functioning and recurrent child abuse. Oakland: National Council on Crime and Delinquency; 2006.

8. Benshoff JM. Peer consultation for professional counselors. . In: ERIC/CASS. Ann Arbor, MI; 1992.

About the Author

Anje Van Berckelaer is a family physician who trained at Harvard Medical School and Harbor-UCLA Medical Center. She is currently a Robert Wood Johnson Foundation Clinical Scholar at the University of Pennsylvania where her research and advocacy interests include quality of care in safety net institutions, in particular community health centers.

Multiplying Connections is a cross system collaborative under the auspices of the Health Federation of Philadelphia. Our mission is to translate the research on early childhood brain development into better practice through professional training and organizational policy change. Multiplying Connections is developing materials and strategies to promote trauma-informed systems. This capacity building initiative is generously funded by the William Penn Foundation.

www.multiplyingconnections.org