

# Training in Reflective Supervision/Consultation: Nationwide Survey Results

JANUARY 22, 2020

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FUNDING FOR THIS PROJECT WAS GENEROUSLY PROVIDED BY

THE LYNNE AND ANDREW REDLEAF FOUNDATION

# Introduction

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This report describes the results of a nationwide survey which examined the training, delivery and impact of reflective supervision/consultation (RS/C) on practitioners working in the early childhood field. This information is presented to facilitate conversations in the field to build and strengthen the infrastructure for effective training on RS/C.

## Background

Reflective supervision/consultation (RS/C) is a model of professional development that supports the relationships between practitioners, children, and their families. These relationships are the foundation of high-quality child and family services (Fifolt et al., 2016; Shonkoff & Phillips, 2000). Therefore, there is growing recognition that those who provide early care and education and specialized supports to children and families need their own ongoing support to maintain both quality services and staff morale in the face of the challenges presented by their work. RS/C focuses on the staff and their networks of surrounding relationships. It provides a consistent time and place to discuss the emotions, perspectives, and relational dynamics of the professionals and of the children and families they are serving. This relationship-based workforce support strategy, which arose from the field of infant mental health, reduces burnout, strengthens relationships between the professional and their clients, and enables higher-quality work (Harrison, 2016; Virmani & Ontai, 2010; Watson & Gatti, 2012). Hence, RS/C is considered a best practice for supporting front-line practitioners and has been rapidly expanding to diverse professionals working with children and families, including home visitors, early education teachers, early interventionists, child welfare workers, public health nurses, child care providers, juvenile justice workers, and allied health professionals.

Reflective supervisors and consultants are expected to provide an experience that is reflective, collaborative, and consistent (Shahmoon-Shanok, 1991). Providing RS/C requires a sophisticated set of skills, content knowledge and experience. There is a general consensus in the literature about the qualities and skills RS/C providers should have, including theoretical knowledge about child development and family systems, an open, curious, and emotionally available approach to supervision, high levels of reflective capacity, and interpersonal skills such as suspending judgement and inviting vulnerability (AAIMH, 2018). While content and procedural knowledge can be learned through didactic training, the necessary emotional intelligence and relationship-building skills are likely to be learned only experientially. Thus, ideally a reflective consultant or supervisor has received their own RS/C in addition to professional development or formal academic training in infant mental health, relationship-based practice, and how to provide RS/C (AAIMH, 2018). The expansion of RS/C has been largely organic, occurring ahead of a solid evidence base for how to effectively train and sustain RS/C providers to enable the provision of high-quality RS/C.

There are multiple paths to becoming a trained RS/C provider. An increasing number of higher education institutions provide training and/or experience in RS/C for those seeking degrees such as social work or clinical psychology. Other practitioners may have spent years in the field before becoming acquainted with RS/C, and complete all of their training post-degree. Some national home visiting models incorporate RS/C and provide training for supervisors working in that model. Many RS/C providers use an endorsement system through their state infant mental health association (state association) to ensure they have solid theoretical foundations, as well as direct service and reflective practice experiences in infant/early childhood/family work. The infant mental health associations of thirty states and two countries are members of the Alliance for the Advancement of Infant Mental Health, which provides a shared endorsement system, some training in RS/C, and a shared definition of RS/C best practices. In order to renew the shared endorsement credential annually, some categories require that the individual receive on-going RS/C, and in one case, that the individual receive training about the provision of RS/C. A few states have their own endorsement systems.

To help further high-quality training on RS/C, we recognized a need to create centralized shared knowledge about current professional development and educational practices and experiences around the country. We wanted to learn more about how people are engaging in education and training opportunities around RS/C and more closely examine the paths infant and early childhood professionals take to become RS/C providers. To do so, we conducted a nationwide landscape survey which examined the training, delivery, and impact of RS/C on practitioners working in the infant and early childhood field. We queried state associations and RS/C providers about the opportunities they either offered or availed themselves of that provided the knowledge, skills and experience necessary for infant and early childhood professionals who want to become RS/C providers. In the survey, we used the word training as an umbrella term to refer to any learning opportunities and experiences, including academic education, continuing education, and professional development. In this report, we describe the current landscape of training for RS/C providers. This information is presented to facilitate conversations in the field to build and strengthen the infrastructure for effective training on RS/C.

This report addresses two major research questions:

1. How do state associations train and support RS/C providers?
2. What are RS/C providers' perceptions of the training they have received?

## Method

The data in this report were obtained through two phases of our landscape survey. Phase I of the survey targeted state associations to learn about the services offered, barriers and solutions to offering RS/C training and supports, and individual state contexts. Thirty-eight states were identified as having a state association, and contact information was found online or provided by the Alliance for the Advancement of Infant Mental Health. One person from each of 31 associations responded to our survey (82% response rate;

see Figure 1). Surveys were completed in the winter of 2017-2018. Of the 31 responding states, 27 are members of the Alliance for the Advancement for Infant Mental Health.

Phase 2 of the survey targeted RS/C providers to gather information about the characteristics of RS/C providers, the training and experiences they obtained to become RS/C providers, and the ways in which they currently provide RS/C. Contact information for Phase 2 was gathered via snowball sampling: first, state associations were asked to identify people in their state who provide RS/C, and those initial RS/C providers were also asked to identify people they knew who provided RS/C. In total, 210 RS/C providers were contacted and 97 across 27 states responded to the survey (46% response rate; see Figure 1). There was a range of 1 to 14 respondents per state (Average = 3.6). Surveys were completed in the spring of 2018.

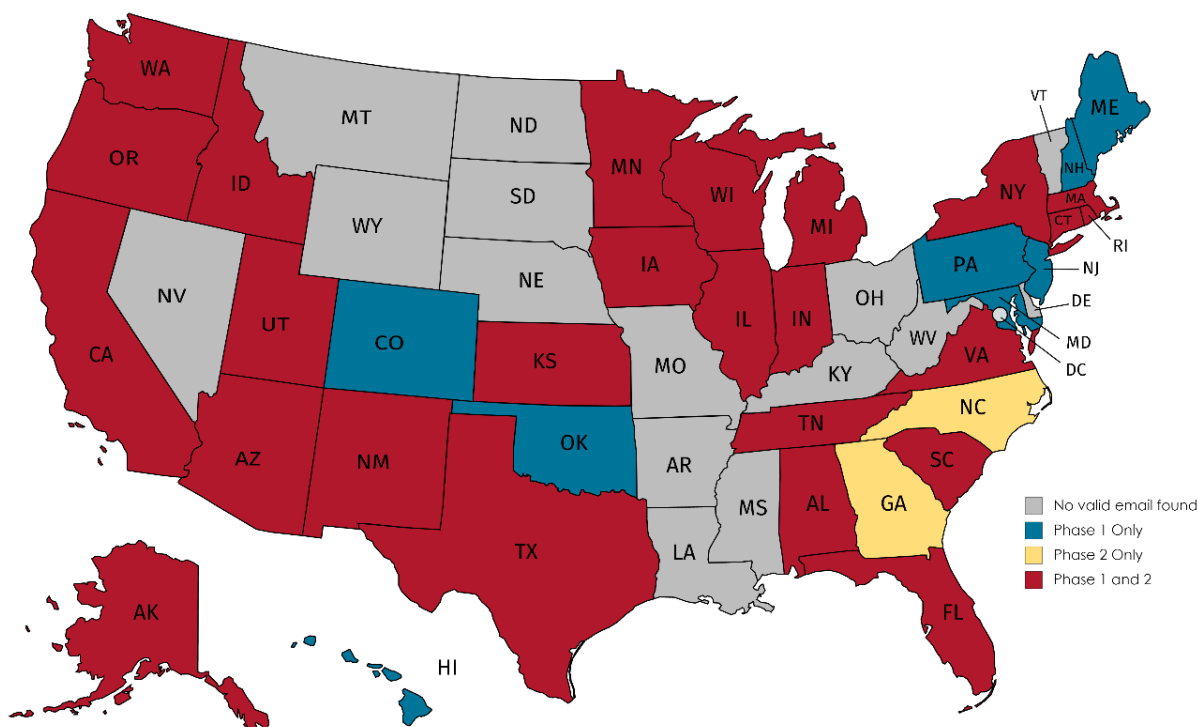


Figure 1: National representation in the two phases of the survey

## Findings

### What RS/C Training Is Currently Offered around the Country?

Of the 31 state associations that participated in Phase 1 of the survey, 21 (68%) reported that they offer training around how to provide RS/C. Eighteen respondents provided further information on those services. Of those, 94% offer face-to-face training, but a substantial amount of training using distance technology was also reported, with 50% offering training via online, phone, or hybrid modes. Most state associations provide trainings that offer participants continuing education credit (72%), with only two respondents offering academic credit. Many state associations (61%) reported providing ongoing RS/C as part of their offerings. There was a range of qualifications/requirements to participate in the RS/C training, with six

respondents offering training regardless of background or qualifications, six offering training based on endorsement or credential, five offering training for specific professions, and two offering training for those accepted into an academic or training program. A couple of the state associations reported that they are in the process of developing new training.

Both the state associations and the RS/C providers described a variety of modes of training on RS/C. The training modes they described range from awareness-raising conferences and workshops, to online training modules, to in-person day-long and week-long trainings, extended learning collaboratives, and ongoing professional development that usually included receiving RS/C. Conferences and workshops were the most frequently mentioned mode of training. Length and intensity of training varied from hours to days to a year, depending upon the mode of training and agency capacity. As a result, there appears to be a lack of standardization in training across states; for example, a 5-day training and a 1.5-day training are both considered introductory-level trainings for different states.

RS/C providers reported participating in trainings individually, with colleagues as part of employment-related responsibilities (including a supervisor-supervisee pairing), via a cohort that receives multiple trainings, or as part of a consistent learning collaborative. Some sought out training on their own, particularly if they provide RS/C as independent consultants. While most respondents appreciated the opportunity to participate in RS/C or other relevant trainings online, there was a smaller group (8%) that preferred engaging in this type of relationship-based work in person.

Participation in RS/C is also considered an aspect of preparing individuals to provide RS/C, as the experiential learning is key to effective delivery of RS/C. Some RS/C consultants have their own reflective supervisor, while others participate in group supervision, and still others do a combination of both individual and group RS/C. Respondents discussed that participating in RS/C as an RS/C provider is essential to keeping them grounded and authentic. It also positively reinforces their RS/C skills.

"Whew! The short answer is that my participation in RSC keeps me grounded, humble, more self-aware and more confident that even without a mental health license, I have (and continue to develop) the necessary skills to contribute to children/parents/caregivers, and providers across a broad spectrum of service settings including mental health (child/family counseling, infant mental health treatment)."

"Participation in RS/C has been life-changing for me. It has made me a more patient, mindful, and observant practitioner. It has helped me learn how to use myself and awareness of what I am thinking and/or feeling to be more accepting of my clients and colleagues and frankly, myself. It has decreased my stress, made me feel less 'alone' in the work with young children and their families. It is the hour I look forward to the most each month."

"Receiving individual and group RS was critical in my development as a relationship-based practitioner. RS cultivated my capacity for self-reflection as a critical clinical ability. RS promoted my practice of perspective-taking."

Almost half of respondents also cite peer and collegial support as a helpful supplement to training and participation in RS/C. For some it is more formal, and for others, it is informal.

"Our leadership cohorts get together in a reflective group—you could call it a reflective support group."

"We have created an occasional meeting of reflective supervisors, which has been wonderful to have to problem-solve and hold each other."

"I connect with others in my university to share resources and access peer support, but not regularly."

"I don't receive any organized support, however, I have a peer group and we often talk informally about provision of supervision."

## What Paths Do Professionals Take to Becoming an RS/C Provider?

The 97 RS/C providers who responded to the Phase 2 survey were well educated, with 91% possessing a master's or doctoral degree. Almost 60% were currently working as mental health clinicians or therapists, while others worked as home visitors (15%), early interventionists/allied health professionals (10%), in child care (4%) or child welfare (3%), or other (7%). Seventy-seven percent had completed an endorsement or credential in infant/early childhood mental health, mainly through an association that had licensed the Michigan Association for Infant Mental Health Endorsement through the Alliance for the Advancement of Infant Mental Health (72%), the California Center for Infant-Family and Early Childhood Mental Health Endorsement (18%), or another, unnamed system (10%).

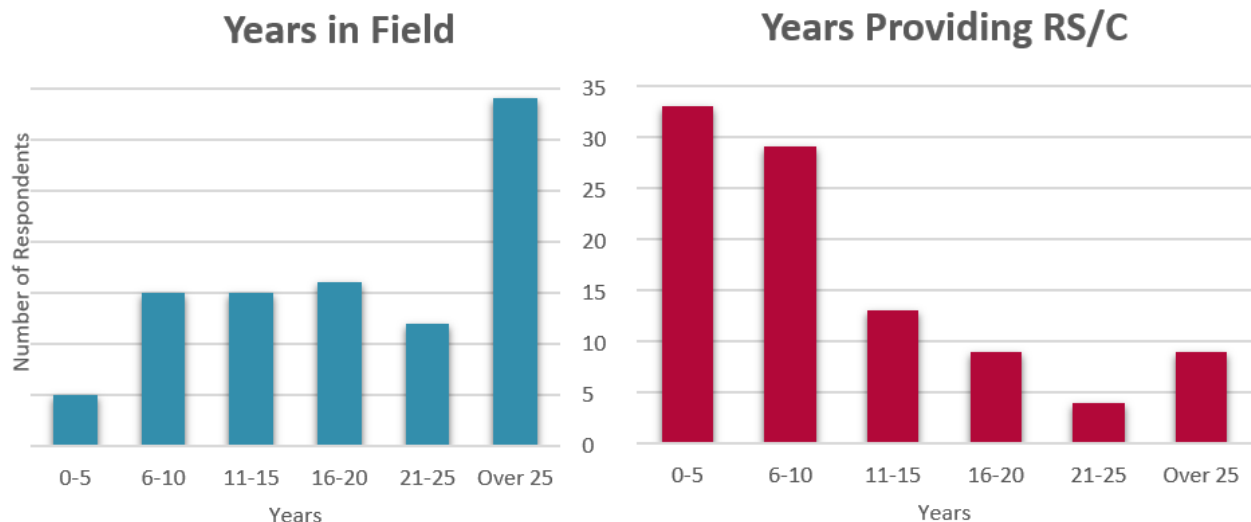
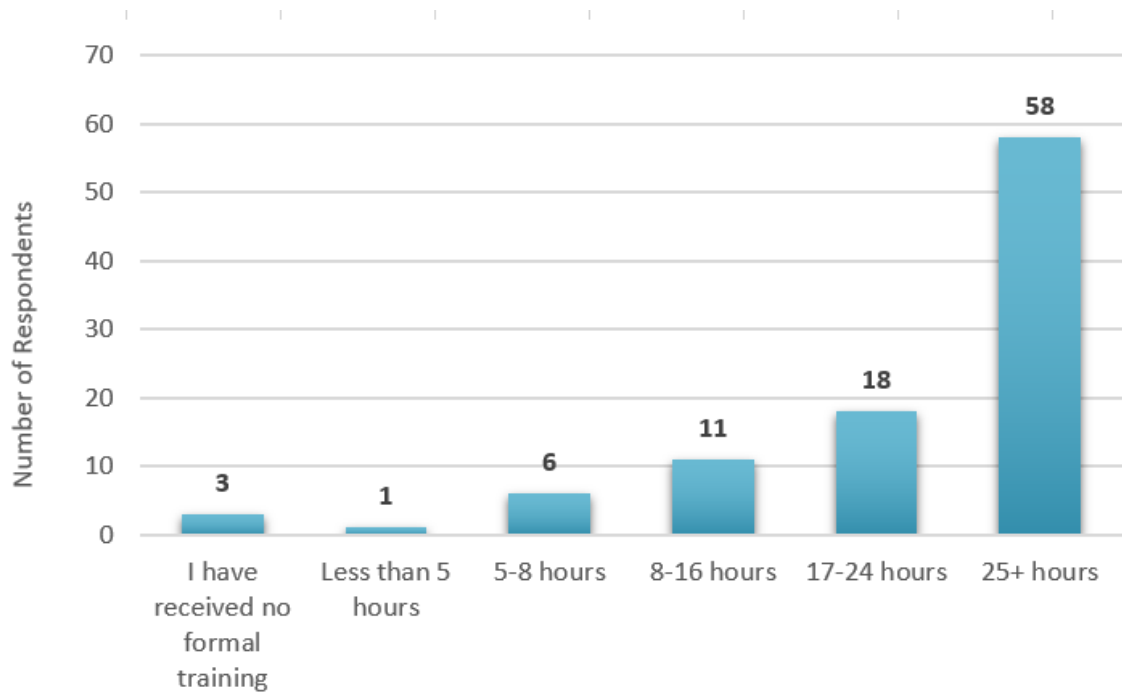


Figure 2: Respondents' years of experience in early childhood field and years of providing RS/C

It seems that a common path for becoming an RS/C provider includes an advanced degree, generally including clinical training. However, receiving specialized training and experience in RS/C post-degree is also often necessary. Although the majority of RS/C providers had significant experience in their field, providing reflective supervision was a newer addition to professional practice for many (see Figure 2).

In our sample, just over 75% had at least 17 hours of training on how to provide RS/C, exclusive of the hours they received RS/C (see Figure 3), and 77% received their most recent training within the last two years of completing the survey.



**Figure 3: Reported hours of training on providing reflective supervision**

The majority of trainings they attended to learn how to provide RS/C were offered by a state association (34%) or professional organization (19%), by other organizations (16%), by academic institutions (15%), through a program such as Early Head Start or Healthy Families America (12%), or by a community health organization (4%). Of the 78 who reported on the type of credit they received for their training, 76% reported receiving continuing education credit, 11% received academic credit, 10% reported receiving another kind of credit, and 3% reported receiving no credit.

The RS/C providers who responded to our survey report obtaining specialized training in a variety of ways. Some described seeking out additional training on RS/C after receiving it themselves or learning about it in other ways.

"Once becoming endorsed in infant mental health, and becoming more involved in our CT-AIMH (Connecticut Association for Infant Mental Health), I had the opportunity to become better informed about 'reflective supervision' as a practice, and have had the opportunity to receive training on how to provide RS to others."



"Supervision has always been a part of my professional training and life, and it seemed natural to embrace a reflective approach once I decided to specialize in infant/early childhood mental health. I have taken, and continue to utilize, professional development opportunities to hone knowledge, skills, and capacities."

Others reported receiving training during their education, or as part of their employment when providing RS/C was a work responsibility.

"Learning the fundamentals through my Supervisor training with Nurse Family Partnership."

"I was a participant in a two-year reflective facilitation in training program that my department offered. The core value of the program which is to support people of color in the field of early childhood to take on more leadership within their organizations. The group met monthly to strengthen our understanding of the theoretical foundations of reflective supervision and to build on our skill level. This was achieved through monthly readings and reflective responses as well as sharing of a video/audio taped supervision session that was presented by each participant to our cohort. We had an opportunity to present two taped supervision sessions per year and receive feedback on our reflective supervision skills."

## What Are RS/C Providers' Perceptions of Their Training?

As the field looks to increase capacity and meet the growing demand for RS/C across the nation, of particular interest are the education and experiences of RS/C providers who learn to provide RS/C. Descriptions of the trainings in which RS/C providers participate indicate that the trainings vary on a number of dimensions including the mode, length, consistency, intensity, and content. Some providers reflected that as a result, it is difficult to self-assess whether they have received enough of the essential content, skills and experience to offer high-quality RS/C.

"My training has been sporadic and not cumulative. I am looking to assess my abilities in providing RS/C and want more formal training so I can train others."

"Since training is not standardized, I am not sure what is missing."

When asked what had been most helpful in learning and maintaining RS/C provision skills, one-third of respondents listed training, conferences, or education. They appeared quite eager to obtain training and ongoing learning and expressed interest in taking whatever is available to them.

"I see myself as a new, growing and learning RS provider, so [I] would look forward to all continuing RS training opportunities."

"Ongoing mentorship, is a part of my practice I have continued to seek out, yet not required. I think this is a valuable aspect of the training, continued growth and learning. I think it is important for providers and training to understand that reflective practices is an ongoing work." [sic]



"Either as a provider of RS or as a participant, it is a never-ending, life-long process."

When asked about top barriers/difficulties in learning and maintaining RS/C skills, a quarter of respondents noted a lack of access to training as a problem (20/80 respondents). They noted issues such as availability in their region, agency capacity, a limited number of colleagues, and/or a preference for in-person opportunities.

"Actual 'training' around RSC is virtually non-existent in my state. "

"...more training needed in community on a more frequent basis."

"Difficulty in ongoing training around it. It's such a visceral learning experience and hard to pass on except by being part of it."

Sixty-nine RS/C providers answered a question about whether anything was missing from their training around providing RS/C. Seventeen (25%) reported they saw no gaps. Others provided the following thoughts on what was missing, with the two most common desired topics being specifics about providing RS/C and group supervision. Table 1 shows the themes generated by these responses, the number of responses around each theme, and exemplar quotes for each.

Theme	N*	Example Quotes
Specifics about providing RS/C	N = 13	"I am currently most interested in trainings on how best to provide RS/C"  "I'd like more training around picking up on themes that come up during supervision. I think I miss those sometimes."  "How do you balance teaching with holding and wondering when both are needed?"
Group supervision	N = 13	"I'd love to have more focused training on the unique pieces in providing group RS/C."  "I think that providing reflective supervision in a group setting really needs specialized training, both focused on holding the experience of all group members, as well as practical training around group dynamics and facilitation."
Types or formats of training	N = 9	"I would like to see more opportunities to practice while receiving feedback from the trainer."  "Most of the 'examples' I've seen at trainings are too 'sterile' and neat. It is not common to work with providers who have it 'together' when they come in. This is a brand new concept to our state and our providers are all still so new to this process."
Self-regulation as a provider	N = 6	"How do you manage your own emotions as they are

		awakened in the presence of a supervisee?"
Theoretical knowledge	N = 6	"Would like to consider more in depth exploration of developmental processes"
How to work with practitioners in specific disciplines	N = 6	"foster care and the details that go with foster care and the legal aspects"
Diversity-informed RS/C	N = 6	"Navigating intensity of emotions related to the complexities of difference (race, culture, context)"
Managing challenges as a provider	N = 4	"Engaging when there are situational or inherent challenges to reflection"
How to train other providers	N = 4	"In providing training to others who are providing rsc."
Lack of advanced training	N = 4	"There seems to be easier access to more introductory level RSC professional development than to opportunities to take my practice to a deeper level of expertise."
Working with organizations/institutions	N = 2	"The most difficult aspects of providing RSC have been around obtaining institutional buy-in."

**Table 1: RS/C providers' reports of what is missing from their training.**

\* Some providers gave answers classified into more than one category.

## Conclusion

This report describes the results of a nationwide survey of state associations and RS/C providers to create a centralized knowledge base of current training practices in RS/C. Eighty-two percent of state associations responded, indicating that the results in this report are representative of state associations across the nation. Our sampling procedure for RS/C providers, which relied on state associations, allowed us to gather data from RS/C providers who are connected with their state association, and who are likely well established and invested in RS/C. The majority of the RS/C providers who participated in this study have clinical backgrounds. We gathered fewer data from non-clinicians who are providing RS/C, who may have different experiences and needs.

In the survey we used both quantitative and qualitative data, which complemented each other to provide multiple perspectives on current training practices and experiences. We used broad, open-ended questions, which allowed us to assess what was most pressing for respondents. However, participants offered a significant variation in the level of detail in their responses to some questions. Also, in Phase 2, the number of respondents varied across states. Therefore, it is possible that not all RS/C training activities occurring in each state have been captured by this survey.

RS/C is being adopted as a valued form of ongoing professional development and support for infant and early childhood practitioners in diverse disciplines. As it is growing in use, it becomes increasingly important

to define how those who have the responsibility for providing it can be best prepared to fulfill that role. This report provides information about the current state of training in RS/C and is a beginning step in building the criteria and mechanisms for consistent, relevant training for RS/C providers.

## Key Findings

1. RS/C providers in this sample most commonly held an advanced degree with some clinical training, combined with specialized training in RS/C.
2. RS/C is a newer practice for most of the professionals surveyed. They obtained specialized training through continuing education/training, formal academic coursework, and their employment. The majority of RS/C providers had 17 or more hours of training on how to provide RS/C.
3. State associations offer the most RS/C training, but professional organizations and employers offer it as well.
4. There are multiple modes of RS/C training, and they vary in type, content, length, intensity and consistency. Didactic and experiential training are both seen as necessary to build the skills of reflective practitioners. However, the variation in training makes it difficult for RS/C providers to assess whether they have sufficient training to provide high-quality RS/C.
5. RS/C providers expressed an eagerness to deepen their knowledge and skills in the provision of RS/C and identified gaps in training content and modes of training.
6. Accessibility to RS/C training is a concern. Face-to-face RS/C training is most common, but a substantial amount of RS/C training is also conducted using technology. The majority of RS/C providers were open to use of technology for RS/C training.
7. The requirements or qualifications for taking RS/C training vary by training organization. Further exploration of this issue is recommended to understand more about the rationale for requiring prerequisites, and their impact on capacity building and quality of RS/C services.

## Implications

### Training and Educational Organizations

State associations and others (training organizations, institutions of higher education, etc.) are critical in building capacity, launching careers, and maintaining a cadre of well-trained, well-supported RS/C providers. They can improve preparatory mechanisms through the following actions:

1. Attend to issues of accessibility by increasing the availability of current trainings, including increasing the use of technology to offer training. There may be opportunities to partner with other local, state or national organizations or institutions to address accessibility issues and make training opportunities more comparable across states.
2. Develop new training to address gaps in content and skills.
3. Decide if trainees require specific qualifications prior to learning RS/C.

4. Help trainees align training and experiences so they can assess whether they are choosing appropriate training options and whether they possess sufficient training and skills to provide high-quality RS/C. This could entail identifying a consistent set of trainings that at a minimum should be sufficient for RS/C providers to offer RS/C.<sup>1</sup>
5. Determine how best to incorporate specialized RS/C training in clinically-oriented and academic programs and provide guidance as to what training and experience non-clinicians should receive in preparation for providing RS/C.<sup>2</sup>

## Practitioners

Since RS/C has not been consistently adopted by agencies and organizations, and thus preparation for providing it is not universally offered, it is frequently incumbent upon practitioners to take responsibility for seeking training and ongoing RS/C for themselves.

1. Follow a path to becoming a reflective practitioner that includes both didactic and experiential learning. Understanding the principles and practices of infant and early childhood mental health and receiving RS/C over an extended period of time are essential to becoming a reflective practitioner and a reflective supervisor.
2. Build relationships with others in your state and community who are or are interested in becoming reflective practitioners.
3. If your state has an infant mental health association, get involved! Learn about their work and what they offer.
4. Rely on best practice guidelines to serve as guides to acquire the recommended competencies for becoming a skilled reflective practitioner and/or reflective consultant. The "Best Practice Guidelines for Reflective Supervision/Consultation" (Alliance for the Advancement of Infant Mental Health, 2018) and the report entitled "Reflective Supervision: A Guide from Region X to Enhance Reflective Practice Among Home Visiting Programs" are two excellent resources.

## Researchers

1. Researchers can play an important role in defining optimal RS/C training options. Currently, knowing how to best support the development of competent RS/C providers is a gap in the field.

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<sup>1</sup> The "Best Practice Guidelines for Reflective Supervision/Consultation" (Alliance for the Advancement of Infant Mental Health, 2018) describe the knowledge, skills, and practices that are critical to reflective supervision/consultation, which could be used to define recommended minimum core training in RS/C. The report entitled "Reflective Supervision: A Guide from Region X to Enhance Reflective Practice Among Home Visiting Programs" is an additional resource for this purpose, and also includes a self-assessment tool.

<sup>2</sup> Providers of RS/C who are endorsed by Alliance member states must have experience that meets the criteria for IMH Specialist (III). The work experience for that category almost always requires a mental health license.

2. Conduct studies focused on identifying the most effective modes of training. Attend to whether there are characteristics of RS/C trainees that are more or less likely to benefit from various training modes.
3. Confirm whether there is a minimum amount of training and experience required to prepare individuals to effectively provide RS/C.
4. Address capacity-building in RS/C by exploring whether there are differences in the characteristics and/or quality of RS/C provided by clinically-trained providers versus those who come from non-clinical disciplines such as early intervention and education.<sup>3</sup> Studies could also explore whether there are different methods of training required to prepare non-clinical providers versus clinically-trained providers.
5. Validate RS/C competencies and link them to specific RS/C training practices.

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<sup>3</sup> Providers of RS/C who are endorsed by Alliance member states must have experience that meets the criteria for IMH Specialist (III). The work experience for that category almost always requires a mental health license.

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