Best Practice Guidelines
for Reflective Supervision/Consultation

Alliance for the Advancement of
Infant Mental Health

Michigan Association for
Infant Mental Health
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Purpose of Guidelines

(1) To emphasize the importance of reflective supervision/consultation for best practice
(2) To describe the knowledge, skills, and practices that are critical to reflective supervision/consultation
(3) To better ensure that those providing reflective supervision/consultation are appropriately trained and qualified
(4) To define the type of reflective supervision/consultation that is required for Endorsement®

Those who earn Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health® (Endorsement®) have demonstrated completion of specialized education, work, in-service training, and reflective supervision/consultation (RS/C) experiences that lead to competency in the promotion and/or practice of infant and early childhood mental health (IECMH). The intention of Endorsement® is to:

- Transform the ways in which professionals view, wonder about, consider, understand, and respond to the pregnant women, infants, young children, and families whom they serve.
- Support professionals who offer knowledgeable and skilled support to pregnant women, infants, young children, and families.
- Enhance professionals' ability to identify risks to the physical, emotional, and relational health of infants and young children and to respond appropriately.
- Help professionals develop the capacity to shift perspective, address personal biases, set boundaries, and slow down, observe, and listen[1].
- Invite professionals to experience feeling heard, validated, and affirmed, within the context of a RS/C relationship, for the work that they are doing with or on behalf of pregnant women, infants, young children, and families.

These Best Practice Guidelines are the standards for providers of RS/C and are critical to ensuring that the above intentions are achieved.

For the purposes of this document, RS/C refers specifically to work done in the infant and early childhood-family field on behalf of the infant and young child's primary caregiving relationships. Throughout this document, reflective *supervisor* typically will refer to a provider who also may be the individual's program supervisor and/or is employed by the same organization as the individual. Reflective *consultant* will refer to a provider who is hired contractually from outside the organization to work with an individual and/or a group.

[1] Harrison, M. (2016). Release, Reframe, Refocus, and Respond: A practitioner transformation process in a reflective consultation Program. *Infant Mental Health Journal*, 37(6), 670-683.

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Reflective Supervision/Consultation as Best Practice

Within the RS/C process, practitioners are able to examine with a trusting supervisor/consultant the thoughts, feelings, and reactions evoked in the course of working closely with pregnant women, infants, young children, and their families. Over time and with a reliable reflective supervisor/consultant, the experience of RS/C offers practitioners the opportunity to engage in a safe, reliable, and consistent learning relationship. Through this relationship, strengths are supported, and vulnerabilities are partnered (Fenichel, 1992; Shamoon-Shanok, 2009).

A hallmark of RS/C is the shared exploration of the parallel process. In other words, in RS/C, attention is given to all relationships, including that between supervisor and practitioner, between practitioner and parent, and between parent, and infant/young child. It is critical to understand how each of these relationships affects the others. Thus, RS/C incorporates a process of consciously connecting the lived experience of individuals and their relationships with the lived experience and relationships of others.

> "*When it's going well, supervision is a holding environment, a place to feel secure enough to expose insecurities, mistakes, questions and differences*."
> Rebecca Shahmoon-Shanok, 1992

But RS/C is not only about understanding how these relationships affect each other. It is also about intentionally affecting relationships. In other words, if we want parents/caregivers to see, hold, respond to, and nurture their infants, they must have experienced these caregiving behaviors themselves. For parents who have not been provided such caregiving themselves in the context of a secure, steadying relationship, practitioners may provide a holding environment for these parents (to a degree). In order for practitioners to be able to provide parents with such safety and security, the practitioners must have someone to provide a safe place for them as well. Reflective supervisors/consultants are able to play this role for practitioners. Simply put, reflective supervisors/consultants become a place and a person with whom practitioners can feel seen, held, and supported.

The Diversity-Informed Tenets for Work with Infants, Children and Families state, "Self-awareness leads to better services for families: Working with infants, children, and families requires all individuals, organizations, and systems of care to reflect on our own culture, values and beliefs, and on the impact that racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on our lives in order to provide diversity-informed, culturally attuned services.[2]" RS/C attends to the emotional responses to work with pregnant women, infants, young children, and families and how reactions to the content shared by families affect this work within one's discipline. In this way, RS/C offers opportunities for professionals to increase self-awareness by identifying and addressing personal biases in the context of a safe "relationship for learning." This increased self-awareness is critical to the provision of culturally responsive services.

Finally, there is often greater emphasis on the reflective supervisor/consultant's ability to listen and wait, inviting the supervisee to express thoughts and feeling. This emphasis allows the supervisee to discover solutions, concepts, and perceptions on his/her own without interruption from the supervisor/consultant. Supervisees who are newer to the field may need more direction, guidance, and encouragement in this process. For supervisees in every stage of professional development, however, the reflective supervisor/consultant's emphasis on listening and waiting to promote the discovery of solutions is aligned with another Diversity-Informed Tenet. This particular tenet emphasizes "non-dominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within all families and communities.[3]"

[2] Diversity-Informed Tenets for Work with Infants, Children, and Families https://imhdivtenets.org

[3] Diversity-Informed Tenets for Work with Infants, Children, and Families https://imhdivtenets.org

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Best Practice for IECMH Policy Leaders

Policy work that promotes IECMH is complex and dependent on relationships for success. RS/C can provide strong benefit for those working to promote IECMH within and across systems, even though RS/C is not required for Endorsement® as a Policy Mentor. Policy leaders can engage in RS/C from a range of providers, such as new or experienced providers of RS/C or other policy leaders with experience in facilitating reflective practice experiences and/or collaborative consultation. Other kinds of experiences that might enhance the understanding of the value of RS/C might include permission to observe a group of practitioners who are engaged in RS/C, to attend trainings or courses about the provision of RS/C, to seek discussions and training in reflective practices from seasoned reflective consultants, and to view the Michigan Association for Infant Mental Health (MI-AIMH) training DVDs[4] that include unscripted, unrehearsed RS/C sessions, among other experiences.

Best Practice for IECMH Faculty and Researchers

Higher education professionals have close relationships with the students who will comprise the future of the infant- and young child-family workforce. Being able to speak fluently about RS/C as best practice will grant students the opportunity to begin thinking about RS/C at the start of their careers. Certainly, students may require more didactic training and clinical supervision as they start their applied learning experiences. Nonetheless, they will still benefit from exposure to and participation in RS/C as well. Thus, professionals who teach and/or conduct research about IECMH principles and practices in higher education settings may benefit from engaging in a reflective supervisory relationship, although not required for Endorsement® as a Research/Faculty Mentor. Additionally, they may benefit from relationships with other research/faculty leaders with experience in facilitating reflective practice experiences and/or collaborative consultation. Whether thinking about the impact of experimental design on pregnant women, infants, young children, and families, reflecting on the effects of teaching about attachment and trauma on students who may have related personal struggles, or providing clinical instruction in the evidence-based practices that can best serve pregnant women, infants, young children, and families, there is value in having protected time and space to thoughtfully consider the work of those in higher education.

Support in the Literature for Reflective Supervision/Consultation

The following is a strongly articulated need for RS/C for those working with pregnant women, infants, young children, caregivers, and families across systems and disciplines in "Safe Harbor: Clinical Use of the Reflective Supervisory Relationship to Navigate Trauma, Separation, Loss, and Inequity on Behalf of Babies and Their Families" by Fitzgibbons, Smith, and McCormick (2018):

> *"Like most supervisory models, reflective supervision/consultation (RS/C) aims to support best practice for clients, while simultaneously supporting the professional development of the practitioner. Often described as a relationship for learning (e.g. Fenichel, 1992; Shahmoon-Shanok, 2009), RS/C develops through a compassionate, authentic relationship, where thoughts, feelings, knowledge and wonderings are cultivated on behalf of a deeper understanding of the infant, young child, and family, of the practitioner, and of a relationally driven, developmentally appropriate, culturally responsive intervention approach… RS/C has been considered a Trauma Informed Practice (Van Berckelaer, 2011; Evans, 2011); an approach to mitigating vicarious trauma as well as staff turnover, and a means to ensure best practice.*
>
> *Over 30 years of clinical experience and empirical evidence indicates that RS/C increases the quality of infant mental health services by reducing vicarious trauma, staff turnover, and bias while increasing practitioner knowledge and improved practice, job satisfaction, efficacy, and responsiveness (Gilkerson & Kopel, 2005; Virmani & Ontai, 2010; Watson, Gatti, Cox, Harrison, & Hennes, 2014; Harrison, 2016). This has led to a general consensus in the multidisciplinary field of infant mental health that RS/C is inextricably both a best practice and an essential component for those providing relationship-focused prevention, intervention, and treatment (MI-AIMH, 2017)."*

[4] DVDs can be purchased here https://mi-aimh.org/store

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Defining Reflective Supervision/Consultation: RIOS™

The Reflective Interactive Observation Scale (RIOS™) is a measurement and practice tool that was co-developed by leaders from the Alliance for the Advancement of Infant Mental Health including researchers at the University of Minnesota who then completed it as a measurement to define and operationalize the process and content of RS/C. The RIOS™ provides a framework to clarify the experience of a reflective supervision relationship, or "the space between the two" (Watson, et al., 2016). Each RS/C session contains varying degrees of the Essential Elements and Collaborative Process Tasks that occur within the Reflective Alliance, the working relationship at the heart of RS/C.

Essential Elements of RS/C as identified in the RIOS™ include:

- ***Understanding the Family Story*:** The pair discuss what is currently known about the baby's environment, focusing on the adults surrounding the baby and their relationships. They pay attention to the relationships between the parents as well as between extended family members, other caregivers, and others in the baby's world. Events, interactions and details are discussed with consideration of family history and culture
- ***Holding the Baby in Mind*:** The pair prioritize the baby, his/her experience and well-being, including the baby's physical environment and any potential developmental issues. Specifically, attention is paid to the baby, and to the baby in relationship with others - parents, siblings, extended family members, other caregivers as the focal point
- ***Professional Use of Self*:** Professional Use of Self involves careful attention to one's subjective experiences (thoughts, beliefs and emotional responses) which become important information and lend greater understanding to the work. Attention is paid to the reactions of the practitioner and her/his relationships with others in the work
- ***Parallel Process*:** Parallel Process signifies the way in which one relationship affects and is affected by other relationships. It "describes the interlocking network of relationships between supervisors, supervisees, families and children" (Heffron & Murch, 2010). The pair consciously connect the lived experience of individuals and their relationships with the lived experience and relationships of others.
- ***Reflective Alliance***: The quality of the relationship developing between supervisee and supervisor is of utmost importance. Both must come to the interaction with the intent to explore openly and reflect on the deeper meanings under the surface of the story in order to learn together

These essential elements of RS/C are observed in the following collaborative tasks:

- ***Describing**:* "What do we know?"
- ***Responding:*** "How do we and others think and feel about this?"
- ***Exploring**:* "What might this mean?"
- ***Linking**:* "Why does this matter?"
- ***Integrating**:* "What have we learned?"

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Best Practice Guidelines for Reflective Supervisor/Consultant

Like all relationship-based processes, the decision about how and when to apply the following best practices will vary with the length of the relationship between the provider of RS/C and the practitioner as well as with the practitioner's stage of professional development (e.g., new, intermediate, experienced). To foster a strong RS/C relationship, those providing RS/C should incorporate the following best practices into their work:

- Agree on a regular time and place to meet and arrive on time
- Protect against interruptions (e.g., turn off the phone, close the door)
- Set the agenda together with the supervisee(s) before you begin
- Remain open, curious, and emotionally available
- Based on the supervisee's training, experience, and emotional readiness:
    - Respect the supervisee's/group's pace/readiness to learn
    - Encourage exploration of thoughts and feelings that the supervisee has about the work with infants, young children, and families while considering one's own response(s) to the work (i.e., support the integration of emotion and reason)
    - Apply specialized knowledge to expand the understanding of the case material and teach/guide supervisee as necessary
- Ally with the supervisee's strengths while offering reassurance and praise, as appropriate
- Observe and listen carefully
- Strengthen the supervisee's observation and listening skills
- Suspend harsh or critical judgment
- Invite the sharing of details about a particular situation, including the characteristics of the infant, young child, parent, and/or caregiver involved, as well as their competencies, behaviors, interactions, strengths, and concerns
- Listen for the emotional experiences that the supervisee is describing when discussing the case or response to the work (e.g. anger, impatience, sorrow, confusion)
- Invite the supervisee to have and talk about feelings awakened in the presence of an infant or young child and parent(s)/caregiver(s); foster the reflective process so that it can be internalized by the supervisee
- Wonder about, name, and respond to those feelings with appropriate empathy
- Help the supervisee/group to explore the parallel process, using feelings to inform the understanding of the infant/young child, parent, the early developing relationship, and self
- Encourage exploration of thoughts and feelings that the supervisee has about the experience of supervision as well as how that experience might influence his/her work with infants/young children and their families or his/her choices in developing relationships
- Attend to both the content (i.e., what is happening with a particular infant, young child, family, program or center) and the process underlying these events, including the feelings evoked by both the content and process
- Maintain a shared balance of attention on the infant/young child, parent/caregiver, and supervisee
- Reflect on the RS/C session in preparation for the next meeting
- Remain available if there is a crisis or concern that needs immediate attention
- Engage in RS/C with your own identified mentor/consultant

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Best Practice Guidelines for the Reflective Supervisee/Consultee

The supervisee who is receiving RS/C will be working toward best practices as the relationship with their supervisor strengthens and as his/her own professional development evolves. To foster a strong RS/C relationship, those receiving RS/C should incorporate the following best practices into their work:

- Agree with the supervisor or consultant on a regular time and place to meet and arrive on time
- Remain open and curious
- Come prepared to share the details of a particular situation, home visit, assessment, experience, or dilemma
- Ask questions that allow them to think more deeply about their work with infants, young children, and families and also themselves
- Be aware of the feelings that they have in response to their work and in the presence of an infant or young child and parent(s)/caregiver(s)
- When they are able, they should share those feelings with their supervisor/consultant
- Explore the relationship of their feelings to the work that they are doing
- Allow their supervisor/consultant to support them
- Suspend critical or harsh judgment of themselves and of others
- Reflect on the supervision/consultation session to enhance professional practice and personal growth

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General Guidelines for Reflective Supervision/Consultation

Program Supervisor as Reflective Supervisor

If the reflective supervisor operates within an agency or program, then he/she will most likely address reflective, clinical/case, and administrative content. When the supervisor who is responsible for clinical and administrative supervision also is responsible for providing reflective supervision, it is preferable that they schedule a separate meeting that can be devoted just to reflective supervision time. Some supervisors may choose to address disciplinary concerns during the individual practitioner's regular reflective supervision meeting. However, when doing so, the supervisor should put into a reflective context any concerns that they may have and share how these concerns may be related to the practitioner's direct service and/or the intersection of personal and professional development. Disciplinary action should never occur within a group RS/C session.

Contractual Reflective Consultants

Sometimes, an outside contractual consultant is hired to provide RS/C to an individual or group on behalf of the promotion of IECMH. In addition to possessing the knowledge and skills defined in Reflective Supervision/Consultation that Meets the Criteria for Endorsement®[5], it is recommended that the consultant be:

- Knowledgeable about the community in which the individual/group provides service
- Fully informed about and respectful of agency policies, regulations, protocols, and rules that govern the individual's or group's services as well as program standards and specific components of those services
- Knowledgeable and respectful of leadership roles within the agency
- Able to establish positive working relationships with agency personnel

The consultant will engage in reflective case discussions but will discuss administrative content only when it is clearly indicated in the contract. When discussions related to disciplinary action need to occur, it is the direct supervisor (rather than the consultant) who should address such action.

Reflective Supervision as Distinct from Administrative Supervision

Supervision that is primarily administrative may be concerned with oversight of federal, state, and agency regulations, program policies, rules, and procedures. Such administrative supervision will likely include the following:

- Hiring
- Training/education
- Oversight of paperwork
- Guiding the writing of reports
- Explanations of rules and policies
- Coordination of workload
- Monitoring of productivity
- Evaluation

> *"Although RS/C may incorporate administrative and clinical tasks, and also include attention to collaboration within learning relationships, its primary focus is the shared exploration of the emotional content of infant and family work as expressed in relationships between infants, parents and practitioners and supervisors and practitioners."*
> Weathesrston & Barron, 2009

Reflective Supervision as Distinct from Clinical Supervision

Supervision or consultation that is primarily clinical will likely include the following:

- Review of casework
- Discussion of the diagnostic impressions and diagnosis
- Discussion of intervention strategies related to the intervention
- Review of the intervention or treatment plan

[5] See "Meets the Criteria for Endorsement®" on page 11 of this document.

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- Review and evaluation of the clinical progress
- Guidance/Advice
- Teaching

Clinical supervision/consultation is case-focused and may include content that is didactic in nature. It 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/toddler and family.

Peer Supervision

The phrase "peer supervision" may be defined as colleagues meeting together without an identified supervisor/consultant to guide the reflective process. It supports reflective practice, but is not an alternative for RS/C. It does not meet most[6] of the RS/C criteria for Endorsement® as specified in this guide.

Collaborative Consultation

The phrase "collaborative consultation" may be defined as a mutually satisfying, relationship experience between two experienced professionals who engage in regular exchanges or conversations with one another, each open and supportive of the other's thoughts and feelings, each listening closely, responding as appropriate, and thinking creatively (Adapted from J. Sparrow, 2010). It supports reflective practice, but is not an alternative for RS/C. It does not meet most[7] of the RS/C criteria for Endorsement® as specified in this guide.

Group Reflective Supervision/Consultation

RS/C provided in a group setting can prove to be quite valuable in many ways. It allows for the opportunity to practice reflection with others, provides a larger holding environment for a team or group of professionals who are all serving pregnant women, infants, young children, and families, enables participants to learn from one another's work, and may be more reasonable as it reduces the cost per supervisee (Heller & Gilkerson, 2009). The ideal number of group members seems to be between 6 and 8, while some providers of RS/C have experienced success with groups of up to 10 participants.

While all of the components of RS/C are still necessary in a group setting (i.e., consistency, predictability, and scheduled over time), there are additional factors to consider when providing and receiving group RS/C. Group culture, boundaries, safety, planning, and organization require a different level of focus and attention when working with groups. For example, it is important to establish group ground rules initially and at regular intervals throughout the group process. It is recommended that the reflective supervisor/consultant and supervisees agree on an ongoing schedule that includes a planned presenter for each meeting and an outline for group members to follow as they prepare to share with the group (Heffron & Murch, 2010; O'Rourke, 2011). Overall, it is suggested that all group members work to feel comfortable with the collective reflective process, remain respectful of one another's thoughts and feelings, and contribute to the betterment of each other's work with pregnant women, infants, young children, and families. Further, it is recommended that providers of group RS/C receive and/or renew training in facilitating groups and managing group dynamics.

RS/C Via Distance Technology

Many professionals are now engaged in RS/C via various forms of distance technology, including phone or video conferencing (e.g., Zoom, Skype, Blue Jeans). Technology has revolutionized the art of RS/C, making it possible for many more people to work together in a reflective relationship, spanning vast distances between rural and urban communities as well as across countries and states. With the emphasis on relationship as the instrument for growth and change for families and for service providers, a significant factor to consider when using distance technology is how to build a relationship that will fuel development as well as reflective capacity (Weatherston, 2016). The reflective supervisor/consultant is encouraged to incorporate the strategies identified

[6] See "Meets the Criteria for Endorsement®" on page 11 of this document.

[7] See "Meets the Criteria for Endorsement®" on page 11 of this document.

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in the best practice guidelines identified on page 6 of this document. Of those identified, the following are especially critical in establishing a state of "being with" when using distance technology.

- Establish a regular date/time to talk while considering that the meeting may span different time zones (e.g., monthly on the first Tuesday of the month from 2 to 3 p.m. EST)
- Confirm how the individual or group RS/C will be set up (e.g., phone or video conferencing) and assure that it will work for all involved. Practice with the conferencing system ahead of the first session so that any necessary trouble shooting can occur ahead of the actual session
- For groups using distance technology, consider a smaller number of participants (6-8)
- If working with a group via video conferencing, consider how many faces you will be able to see on the screen at one time when setting group size
- Pay close attention to and engage the supervisee(s)/consultee(s) in explicit discussion about the unique ways to preserve confidentiality, privacy, safety, and respect via distance technology. Usual group dynamics relevant to these issues may require discussion, but discussion regarding unique aspects of confidentiality when using distance technology are also worthwhile
- Consider utilizing virtual connection options for communication between meetings (e.g., discussion threads, emails); explicit discussion around confidentiality, purpose, boundaries, etc. will need to occur if these types of connections are used
- Include discussions about how each individual will protect the meeting time from change or interruption (e.g., consider how to avoid multitasking, consider the possibility that there may be other people in the physical room of a supervisee/consultant)
- Discuss the use of silence, and then ponder together how silence will be navigated. An understanding of how silence may be used is especially crucial when you are on the phone and nonverbal cues are not accessible. The reflective supervisor/consultant may wish to use longer pauses before starting to speak in order to account for the possibility that a supervisee/consultee is thinking before finishing a thought
- Consider having a metaconversation after the first two or three sessions to discuss how the communication is flowing. Include attention to eye contact, i.e., does the technology enable enough eye contact between participants to foster relationship development. Appropriate adjustments can be made based on the feedback generated from this metaconversation
- Establish a framework or format for each session
- Begin each session with a quiet period or a transitional relaxation or mindfulness activity that lasts approximately 1 to 5 minutes. This quiet period may encourage participants to relax into the time together and may combat the desire to multitask

When technology is the primary method of RS/C for an individual or group, it is suggested by many that these meetings be supplemented with opportunities for face-to-face meetings when possible (Mulcahy, 2018). Others suggest that the first session be face-to-face with regular opportunities for face-to-face meetings scheduled throughout the duration of the reflective supervision/consultation experience (Heller & Gilkerson, 2009, Chapter 3).

Keeping the relationship front and center is an ongoing task for effective reflective practice. We are continuously learning what works best to promote and sustain relationships when using distance technology for RS/C.

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Reflective Supervision/Consultation that Meets the Criteria for Endorsement®

A core component of the Endorsement® application is RS/C, provided by a qualified professional who has expertise in the IECMH competencies including but not limited to:

- Infant/young child development
- Attachment, separation, trauma, grief, and loss
- Cultural competence (including impact of oppression and racial trauma)
- Mental and behavioral health (infant/young child and adult)
- Expertise in reflective practice

Categories of IMH-E®:
Infant Family Associate (IFA)
Infant Family Specialist (IFS)
Infant Mental Health Specialist (IMHS)
Infant Mental Health Mentor (IMHM):
Clinical (C), Policy (P), Research/Faculty (R/F)

Categories of ECMH-E®:
Early Childhood Family Associate (ECFA)
Early Childhood Family Specialist (ECFS)
Early Childhood Mental Health Specialist (ECMHS)
Early Childhood Mental Health Mentor (ECMHM):
Clinical (C), Policy (P), Research/Faculty (R/F)

It is the content knowledge and the reflective capacity of the RS/C provider, together, that enable a "relationship for learning."

Requirements for Reflective Supervision/Consultation

The tables below define the Endorsement® standards for earning and renewing Infant Mental Health Endorsement® (IMH-E®) and Early Childhood Mental Health Endorsement® (ECMH-E®) annually. In general, the provider of RS/C should be from IMH Mentor-Clinical/ECMH Mentor-Clinical or IMH Specialist/ECMH Specialist categories. As in relationship-focused practice with families, RS/C is most effective when it occurs in the context of a relationship that has an opportunity to develop by meeting regularly with the same supervisor/consultant over a period of time. Therefore, Endorsement® applicants will have received the majority of the required hours from just one source, with the balance coming from no more than one other source[8].

Infant Mental Health Endorsement®

Applicant	Provider of RS/C	Required or Recommended	Renewal Requirement
IFA	IMHM-C, IMHS, IFS	Recommended	Recommended
Bachelor's prepared IFS	IMHM-C, IMHS, or Master's prepared IFS	24 clock hours over 1-2 years; required	12-hours annually
Master's prepared IFS	IMHM-C or IMHS	24 clock hours over 1-2 years; required	12-hours annually
IMHS	IMHM-C or IMHS	50 clock hours over 1-2 years; required	12-hours annually
IMHM-C	IMHM-C	50 clock hours over 1-2 years; required	12-hours annually until IMHM-C has been maintained for a minimum of 3-years. Then, 10-hours annually; peer supervision or collaborative consultation may be utilized at this point
IMHM-P IMHM-R/F	IMHM-C	Recommended	Recommended

[8] When there are special circumstances (changing jobs, death of the provider of RS/C, etc), the Endorsement® applicant should contact her/his Endorsement Coordinator to create a plan to ensure that the applicant meets the requirements.

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Early Childhood Mental Health Endorsement®

Applicant	Provider of RS/C	Required or Recommended	Renewal Requirement
ECFA	ECMHM-C, ECMHS, ECFS IMHM-C, IMHS, IFS	Recommended	Recommended
Bachelor's prepared ECFS	ECMHM-C, ECMHS, or Master's prepared ECFS IMHM-C, IMHS, or Master's prepared IFS	24 clock hours over 1-2 years; required	12-hours annually
Master's prepared ECFS	ECMHM-C or ECMHS IMHM-C or IMHS	24 clock hours over 1-2 years; required	12-hours annually
ECMHS	ECMHM-C or ECMHS IMHM-C or IMHS	50 clock hours over 1-2 years; required	12-hours annually
ECMHM-C	ECMHM-C IMHM-C	50 clock hours over 1-2 years; required	12-hours annually until ECMHM-C has been maintained for a minimum of 3-years. Then, 10-hours annually; peer supervision or collaborative consultation may be utilized at this point
ECMHM-P ECMHM-R/F	ECMHM-C	Recommended	Recommended

One Exception

A bachelor's prepared IFS/ECFS applicant may receive RS/C from a master's prepared IFS/ECFS provider if the applicant indicates that there are no IMHM-C, ECMH-C, IMHS, or ECMHS providers available or if the bachelor's prepared IFS/ECFS applicant has an existing reflective relationship with the master's prepared IFS/ECFS provider.

Responses to Requests for Additional Exceptions

Exceptions have been requested regarding master's prepared IFS/ECFS applicants being allowed to count toward Endorsement® RS/C hours that come from another master's prepared IFS/ECFS professional, given that the scope of practice for IFS/ECFS does not typically include behavioral health treatment. Additionally, some have wondered if a reflective stance is the most important qualification in a provider of RS/C and if content knowledge is less important.

In response to both questions: Professionals who provide services in promotion and prevention programs (typically IFS/ECFS applicants) inevitably serve some families with high levels of risk. Therefore, the provider of RS/C must have training and experience in how trauma, poverty, oppression, mental illness, interpersonal violence, and addiction affect the infant/young child's caregiving relationships in order to identify and appropriately respond given the practitioner's scope of practice. For example, home visitors in prevention programs across states report that they feel unprepared to manage the needs of families who have experienced trauma and/or mental health problems and/or substance misuse. It also may be the case that practitioners are managing their own experiences (e.g., adverse childhood experiences from their own backgrounds) as well as being subject to vicarious trauma after working with families with a high level of risk. In order to best support these practitioners and the families they serve, it is critical that they receive RS/C from professionals who have

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earned IMHS/ECMHS or IMHM-C/ECMH-C, thus having passed an application review and a written exam to document their competence in these critical areas.

Therefore, providers of RS/C must be knowledgeable about all of the competencies defined for IMH Mentor-Clinical/ECMH Mentor-Clinical, having particular expertise in:

- Pregnancy & early parenthood
- Infant/young child development & behavior
- Relationship-focused therapeutic practice
- Family relationships & dynamics
- Attachment, separation, trauma, grief, and loss
- Psychotherapeutic & behavioral theories of change*
- Disorders of infancy and early childhood
- Mental & behavioral disorders in adults*
- Cultural competence
- Screening & assessment
- Intervention/treatment planning*
- Developmental guidance*
- Supportive counseling*
- Parent-infant/young child relationship-based therapies & practices*
- Reflective supervision*
- Parallel process*
- Capacity to use the above knowledge to assess for risk, specifically prematurity, birth of an infant with special needs, the death of an infant, adolescent parenthood, alcohol and drug abuse, child abuse and neglect, separation, intimate partner violence, homelessness, poverty, oppression, grief and loss

> *"Many professionals in the field believe that RS serves a dual purpose. The first is to assist professionals in understanding the many facets of their work with families… as a result of having a deeper understanding of their work, professionals can more effectively engage families in implementing HV models, developmental interventions or child care curricula. The second purpose is to support those professionals when they struggle with the many challenges in their work, which can include families living in poverty and/or unsafe communities, parents with mental health issues or other challenging circumstances (Lipsky, 2009)… RS addresses the impact on these professionals of these contextual factors so that she can better focus on her particular role with the family."*
> Watson, et al., 2016

The starred (*) knowledge/skill areas are required for IMHS/ECMHS and IMHM-C/ECMHM-C but are not required for IFS/ECFS. Because these areas are not required for IFS/ECFS practitioners, there is no assurance that IFS/ECFS practitioners have attained adequate education and/or training in the competency areas listed above. Of additional importance, an IFS/ECFS applicant has a 24-hour RS/C minimum that he/she must have received, whereas an IMHS/ECMHS or IMHM-C/ECMHM-C applicant must have received a minimum of 50 hours.

Another exception is sometimes requested regarding a bachelor's prepared IFS/ECFS applicant using RS/C hours from an experienced bachelor's prepared IFS endorsed professional. Examples are cited of individuals who have been in the field for many years. Although such individuals may not have earned a master's degree, they have valuable experience to share. Indeed, experienced bachelor's prepared IFS/ECFS professionals do have much to offer more novice professionals, and they should be encouraged to share this experience through every opportunity. A master's prepared IFS/ECFS professional has (in addition to a bachelor's prepared IFS/ECFS) the experience of having successfully achieved an advanced degree that builds upon foundational bachelor's degree learning and involves more complex study, however. Within the area studied, master's graduates are expected to learn at a more rigorous and independent level of ability and to apply their advanced knowledge of theoretical and applied topics to higher order skills in analysis, critical evaluation, or professional application to the ability to solve complex problems. These skills are directly applicable and enhance the reflective process. In many agencies, the program supervisor is bachelor's prepared and supervising bachelor's prepared staff, passing along important knowledge about the scope of practice for the particular program/model within which they work. In order to provide the kind of guidance and support regarding the complex needs of infants, young children, and families that meets the Endorsement® standards, it is critical that a bachelor's

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prepared applicant has access to a provider who has earned a master's degree. This access can be via a contractual arrangement (e.g., monthly or twice monthly reflective consultation in a group).

Responsibilities of the Provider of RS/C to Complete Reference Ratings for Endorsement® Applicants with Whom They Work

Reference ratings for Endorsement® are critically important. They are the primary source for documenting an applicant's skills in the domains of Reflection, Working with Others, and Thinking. Reviewing the questions from the reference rating form is recommended both for applicants and raters. The questions can be used in a supervision session to mutually assess the applicant's professional progress. The questions are available at https://mi-aimh.org/endorsement/tips-regarding-reference-ratings/

When asked to complete a rating form for a practitioner, the provider of RS/C should consider the following:

- Have you known the applicant for at least a year?
- If the applicant is part of a RS/C group that you facilitate, have you heard enough from this applicant to feel that you know his/her skills well enough to rate them? (Rating forms with 6 or more "I do not have enough information to rate/comment" scores may be disqualified)
- Is the applicant providing direct service to families of infants/toddlers (0-36 months) if IMH-E®? Is the applicant providing direct service to families of young children (3 to under 6-years) if ECMH-E®?
- If it is an IMHM-Clinical/ECMHM-Clinical applicant, are you familiar with his/her skills as a provider of RS/C (and not only as a practitioner)?
- Consider reviewing the reference rating questions (see above) with the applicant periodically to help track your assessment of his or her progress over time
- Are you aware of whether or not the applicant has waived his/her right to access the reference form? If the applicant did not waive his/her right, the applicant has the right to know the content of your rating.
- If you have reservations, have you shared them directly with the applicant?
- If you have reservations, consider either declining the request to provide a reference or indicating that you would not recommend him/her at this time

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Summary

As considerations around building capacity for RS/C are made, the *Best Practice Guidelines for Reflective Supervision/Consultation*, along with the resources and references attached, can provide a framework for preparing professionals to become providers of RS/C. Continued investment in reflective practices, whether it be supervision, consultation, or just general reflective practices being implemented across our work environments by all categories of IECMH providers, will foster a sense of well-being for reflective supervisors/consultants, practitioners and professionals, and the families that they serve.

As IECMH-informed work, including promotion, prevention, intervention, and leadership, is carried out, it is important to remember that **relationship** is the foundation for RS/C. Growth and discovery about the work and oneself takes place within the context of this trusting relationship. To the extent that the supervisor or consultant and supervisee(s) or consultee(s) are able to establish a secure relationship, the capacity to be reflective will flourish. Further, as supervisees and consultees feel supported by their supervisors/consultants in their work, they will be able to foster more positive outcomes for even the most high-risk infants, young children, and families. Through this parallel process, supervisors/consultants can foster the reflective capacity of their supervisees/consultants, who in turn will foster the reflective capacity of the parents with whom they work. These parents then can foster the most positive outcomes for their infants and young children. RS/C thereby allows gains to be experienced by the families, caregivers, infants, and young children served as part of a larger network of invested and reflective practitioners and supervisors/consultants, ensuring the best outcomes for our youngest citizens.

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Suggested Resources

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