# The integrated model of restorative supervision for use within safeguarding

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**ABSTRACT**
This paper offers a review of a new model of supervision; the integrated restorative model, to underpin effective safeguarding supervision in health settings. This seeks to capitalize on the benefits of using both restorative supervision (Wallbank, 2010) and an integrated model commonly referred to as the 4x4x4 model (Morrison 2005, Wonnacott, 2012). It challenges the notion that restorative supervision is a stand- alone supervisory process sitting outside of safeguarding supervision and demonstrates how effective safeguarding supervision needs to combine critical reflective practice and critical thinking with a restorative experience in order for the professional to feel supported and maintain their capacity to think. The paper urges health settings to ensure that individuals undertaking safeguarding supervision are appropriately trained to identify how those sessions can support professionals to retain their reflective capacity and decision-making skills.

**KEYWORDS**
Safeguarding, supervision, burnout, stress, governance

## BACKGROUND

Clinical supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient/client protection and safety of care in complex clinical situations (CQC, 2013).

Literature reviews relating to 'clinical supervision' show that its use as a ubiquitous term may well be problematic as it is often an umbrella statement with little clarity around function and purpose (Berggren et al., 2013). The evidence of the effectiveness within health settings of clinical supervision has been scant and often limited to specialist groups such as mental health nursing. There is little literature dedicated to the use of appropriate and specific strategies to be used within the clinical supervision session (Howard, 2008) leaving managers with a need to improvise as to best practice. Given that managers often have the shared responsibility of the supervisory role, it has not surprising that the purpose and effect of clinical supervision has not been clear.

This lack of clarity is reflected in the child protection context with child protection or safeguarding supervision (CQC, 2013) either being seen as one form of clinical supervision or something entirely separate. This is a false dichotomy with evidence suggesting that general clinical supervision is an important aspect of protecting children along with an opportunity to focus on specific cases. (Lister & Crisp, 2005).

There is the potential for further lack of clarity and confusion between the terms safeguarding and child protection supervision. Safeguarding is a term used to describe a wide range of activities related to protecting children from maltreatment, preventing impairment of health and development and promoting their welfare. Child protection is part of safeguarding and promoting welfare and although the supervision activity may be referred to as "safeguarding supervision", the reality is that it is often focused on a narrow group of children who have been identified as in need of a child protection plan. Given that many of the children who die as a result of abuse or neglect are not on a child protection plan this is not a helpful approach (Davies & Ward, 2012). This paper therefore uses the term "safeguarding supervision" to refer to supervision activity focused on the needs of children receiving services beyond universal provision.

There continues to be confusion regarding models of clinical supervision particularly in health settings. There is little guidance from policy nationally or locally where 'supervision' is often discussed as being imperative but not described in a way that supports a practitioner to understand what the content or purpose of supervision needs to be in order to be effective. With the absence of guidance, safeguarding supervision is vulnerable to becoming a space that is solely driven by an organisational demand to be assured that practice is safe. The need for management assurance through checking, challenging, and auditing can overtake the restorative, reflective and learning

nature of the session without a strong and skilled supervisor. Given the increase in newly qualified workforces such as Health Visiting the need for this space to remain supportive as well as hold organisational assurance is critical.

The process of conducting safeguarding supervision should not be a punitive one however in the absence of direction as to how the sessions should be conducted; at times this is how it can be experienced by health professionals.

*'It is argued that current strategies to manage risk in child protection are, paradoxically, making it harder for professionals to learn how to protect children better.'*

(Munro, 2012).

## RESTORATIVE SUPERVISION OVERVIEW

The model of restorative supervision (Wallbank, 2010) was developed as a solution to the emotional demands being placed upon a range of health professionals. It was initially piloted with hospital midwives, gynecology nurses and Doctors in 2009 in response to earlier studies (Wallbank & Robertson 2008), which demonstrated the impact of loss on this group. It has since been used with over 3500 health professionals within the UK and Australia and the evidence that the model supports the professional to think and make decisions continues to grow (Table 1).

The model was designed to focus on the capacity of the individual to deliver complex care in a variety of settings. The dominance of the restorative nature of the model and its' emphasis on the wellbeing of the individual, arose from the initial research findings which demonstrated the lack of focus on the professionals own health and wellbeing and it's link to thinking clearly within their role (Wallbank, 2010).

Working within health services regardless of job role, is often hard and challenging work (Point of Care Foundation, 2013) and often creates a degree of anxiety or negative emotions that need to be worked through (Wallbank, 2010) We can see from the Francis report into findings at Mid Staffordshire (Francis, 2013) when staff feel overwhelmed by their work, the detrimental impact that has on patient care.

**Table 1: Impact of restorative supervision sessions on health professionals**

| Scale Measure | All participants Baseline N-3094 | All participants post Supervision N=3084 |
|---|---|---|
| Compassion Satisfaction | **44.20** (4.18) | **44.72** (4.17) |
| Burnout | **42.81** (4.23) | **24.71** (5.13) |
| Stress | **43.35** (4.12) | **16.86** (4.02) |

Key: 22 or less Low, 23-31 Average, 31+ High

Within children and family services, difficult emotions are often evoked because of the nature and content of the work. The capacity of the professional to remain resilient within their role depends on the support systems e.g. supervision to manage those negative emotions well and to use emotional responses positively as a tool to understand any issues in the family that may be impacting on the care of the child. For example where a member of staff is experiencing anxiety or fear, what might this be saying about the experience of the child within that family environment?

Key facets of the restorative model are:

- Providing a supportive and challenging supervisory environment
- Improving the capacity of the individual to remain resilient in the face of challenging case work through their ability to recognise personal triggers
- Enhancing the ability of professionals to relationship build with fellow professionals to avoid isolation and reduce difficult collegiate behaviours
- Encouraging the professional to focus on the events and/or situations they can change so they experience less helplessness
- Improve the ability of the professional to communicate issues so they can escalated effectively

Results from the programme have shown how individual sessions of restorative supervision followed by group experiences has a significant impact on reducing burnout and stress whilst maintain compassion satisfaction (the pleasure one derives from their work.

As the use of restorative supervision has grown within health settings an artificial delineation between this as a model of supervision alongside others has become a point of discussion and contention. The immediate need to adopt a restorative model came from the levels of stress and burnout being experienced by professionals. This does not limit that restorative skills e.g. the ability to create and develop a supportive space for the professional exist in a range of supervisory models, not least of which is the safeguarding supervision space. Developing a model which therefore took the best of both models appeared important to support health professionals undertaking safeguarding work.

## SAFEGUARDING SUPERVISION OVERVIEW

Individual practitioners working in the health community e.g. health visitors have been a particular focus for the restorative model. They are also a group of practitioners who have a very active role in safeguarding and given this active role there is a dual need for the individual to undertake clinical supervision to enhance their practice as well as supervision which fulfills the requirements set out in statutory child protection guidance.

*"..Organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children …appropriate supervision and*

*support for staff, including undertaking safeguarding training"* Working Together (2013: 47)

Health visitors and other health professionals involved in safeguarding activity should have access to supervision which reviews the progress and outcome of children who are subject of a child protection plan as well as those 'vulnerable children' who may not yet be subject of a plan but are causing concern for the professional. The key issue is how the restorative model is integrated into this activity.

The essence of a good safeguarding session is the capacity of the practitioner to think, reflect and develop their own solutions around what needs to happen next with families. The restorative nature of the session is therefore paramount to support the professional in their capacity to do this thinking. Alongside this is the need for the organization to be assured that child protection practitioners are competent, any factors that might be inhibiting good practice (both individual and organisational) are identified and acted upon and there is a clear focus on improving outcomes for children.

The emotional impact of safeguarding work has been recognized for many years (Morrison 1990; Ferguson 2005) and one implication of this is that emotions need to be worked with within supervision in order to assist the worker in recognizing and working with complexity. Any situation where there are concerns about the capacity of parents to care for their child is unlikely to be simple and will involve making sense of often contradictory information and managing a degree of uncertainty. Where the worker's emotional responses are raising anxiety this may lead to the very opposite approach whereby the worker manages anxiety by striving for simple explanations and solutions.

The supervisor during a safeguarding session needs to work at a number of levels in order to draw out and explore the complexity of the work and support the practitioner in their ability to make sound professional judgments. This focus on the work of the individual practitioner is overlaid by the need to consider their practice within the context of a complex multi-agency environment where the capacity to manage relationships is key. Developing emotionally intelligent safeguarding practice is therefore of fundamental importance and a point where restorative skills are crucial to effective safeguarding supervision.

**Table 2: The 4x4x4 Model**

| Four Functions | Four Stakeholders | Four Elements of the Supervision Cycle |
|---|---|---|
| Management | People who use services | Experience |
| Support | Staff | Reflection |
| Development | The organization | Analysis |
| Mediation | Partner Organisations | Action planning |

The supervision space should be honest and open in order to allow for a focus on restorative processes in order to enhance thinking as well as enabling an approach which challenges the worker to critically reflect on the assumptions that are underpinning their approach to work with a particular child and family. This space needs to be located within a framework which respects the supervisory relationship as a vehicle for promoting good practice but is equally clear that the supervisor is responsible not only to the supervisee, but also the organisation and ultimately the child.

As the integration of accountability within a restorative framework may not have been commonly understood, the role of the supervisory space may be confused and the balance of the session lost. The new integrated restorative model of ensures that the appropriate degree of restorative efforts take place within the session to support the supervisee whilst the space is sufficiently developed to explore assumptions, complexity and impact of the work.

As a mandated activity within health settings, the organizational importance of the session is critical. Whilst the traditional restorative session emphasized the need to have an open space, the combined use of the integrated restorative model provides a balanced approach which maintains a focus on the outcomes for the child whilst supporting and challenging the practitioner. This ensures that both supervisor and supervisee are able to continue to assure the organization of the safety of the work being undertaken as well as its effectiveness.

Given the degree of media scrutiny around safeguarding work it is not surprising that a blame culture arises and organisations are reduced to being unable to recognize the role of safeguarding supervision as being more than a task focused process. The supervisor's role becomes solely one of checking on practice and providing advice and direction. The result is that either practitioners may disempowered both within supervisory relationship and the whole safeguarding system. It is interesting that serious case reviews frequently identify lack of challenge between professionals as an issue; the capacity to challenge involves practitioners feeling empowered and confident to do so (Add a reference here). Supervision should play an important role in promoting this aspect of their practice.

The learning from restorative supervision has been the need for professionals to remain in a resilient place themselves to deliver the care and this needs to underpin the safeguarding session not be separate to it. The more we artificially separate the models the further gravitational pull towards managerial supervision, safeguarding sessions become. This creates the dichotomy of the restorative session being 'good' and the safeguarding session being 'bad'; neither of which are true or helpful to enhancing the ability of the practitioner to think.

## RELATIONSHIPS TO EACH OTHER

Given the ongoing success of the restorative model the concern for the authors was that restorative skills should

be seen as intrinsic to the safeguarding supervision space rather than separate to it.

One model of supervision that has been used extensively within a child protection context is the integrated (4x4x4) model first developed by Tony Morrison. (Morrison 2005; Wonnacott 2014). This model recognises the interdependence of the functions of supervision, their impact on key stakeholders and the four elements of the supervision cycle.

This model is useful within safeguarding as it integrates both a focus on accountability through a management process alongside, supporting and developing the supervisee. Linked to this, are the key skills that need to be used for effective child protection of reflection, analysis and action planning.

The model has developed over time drawing on practice knowledge developed from training thousands of supervisors as well as a wide range of professional literature. This literature includes the development of expertise, (Fook et al., 1997), adult learning (Kolb, 1984), reflective practice (Schon, 1983, Ruch, 2000), emotional intelligence, (Goleman, 1996, Morrison, 2007). In relation to child care practice the model has continued to develop taking account of lessons from serious case reviews, the developing literature on influences on decision making (Munro, 2008, Kahneman, 2011) and national guidance (HM Government, 2013).

The model was used as the basis for the national training programme for the supervisors of newly qualified social workers and the final evaluation of the project (Carpenter et al., 2012) found that where supervisees had received their full entitlement to supervision, outcomes in respect of self-efficacy, role clarity, role conflict, job satisfaction and stress were higher than in situations where supervision was only partially implemented. The clearest difference was in relation to stress.

At the core of the model is the supervision cycle and if this is used effectively it enables an integration of case management with the staff support, critical reflection and critical thinking needed to promote good practice. The new integrated restorative model ensures that at all stages of the supervision cycle a restorative approach continually supports practitioners to engage in all these critical aspects of the supervision process.

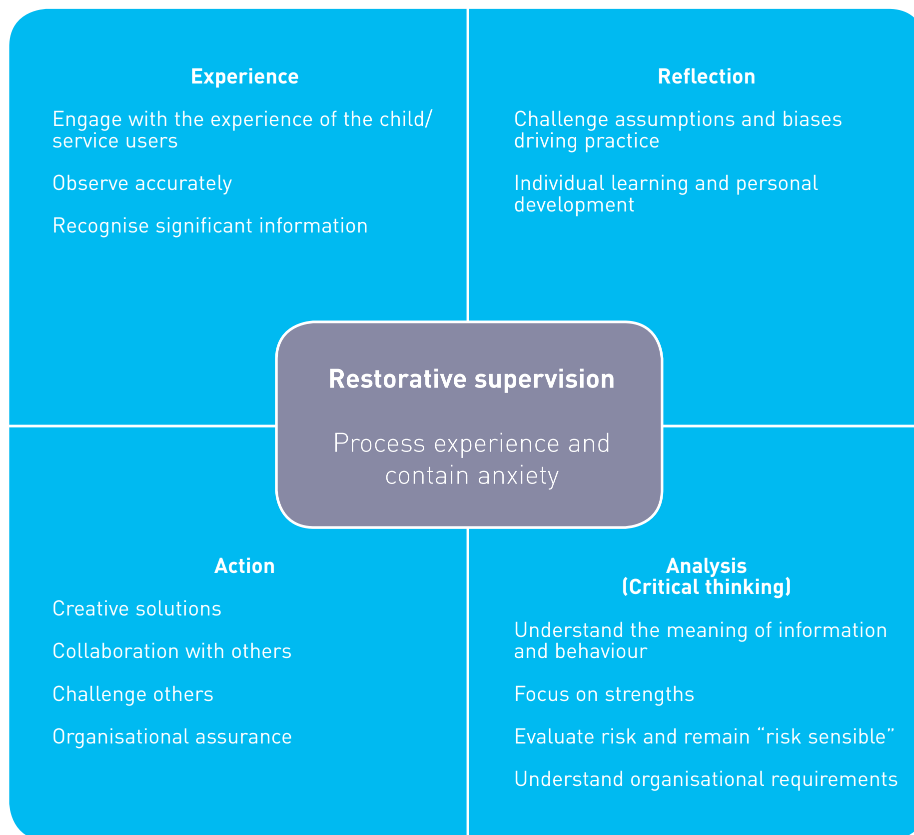


**Figure 1: The integrated restorative model of supervision in safeguarding**

## THE SUPERVISION CYCLE AND RESTORATIVE SUPERVISION

Telling the story- In order to understand the experience of the professional within safeguarding supervision, the supervisor needs to engage the supervisee to elicit accurate observations – this method of telling the story, reflecting on events, thinking about the voice of the child in the story is interfered with if the professional is in a difficult or overwhelmed space. Often the story becomes about the professional's experience of the family rather than the family itself. Containment of the individual and their capacity to slow down their thinking to reflect appropriately on the family is key. This is a significant skill in restorative supervision, creating a space that feels supportive and enhances learning.

Reflection – Sharing feelings about the story and previous stories – In order to be thinking about making connections and recognizing patterns the professional needs to be thinking clearly. The space they are sharing with the supervisor needs to be an open and honest one where thoughts of, what is this evoking for me and what is this linked to are able to be shared without judgement. The capacity of the supervisor to listen in a non-judgemental way and know when to challenge and support connection making is again a key skill in restorative sessions. The supervisor does not remain a sponge but offers a mirror experience, reflecting and identifying patterns in a way that can be heard by the supervisee.

This requires a deeper level of thinking and pattern making by both the supervisor and supervisee. To be reflective in this way, the relationship between the supervisor and supervisee needs to be reciprocal and trusting as the supervisee may need to reveal some vulnerabilities. If the professional is feeling insecure or

vulnerable because of workload stress etc. then this process will be slowed down. The professional is likely to be more defensive and unable to see their own contribution in these difficulties.

**Analysis** – what does the story mean – supporting the professional to translate reflective experience into professional evidence – This requires the supervisor to be expert and facilitator at the same time, the supervisor needs to feel that the supervisee is in a place to use the knowledge gained from the reflective process to understand what life is like for the child. Understanding what life is like for the child, exploring different perspectives and weighing up alternative ideas are key to the supervisory process. Being in a position to analyse rather than adopt a defensive position in favour of one's own practice occurs best when both supervisor and supervisee are able to think clearly. Pattern identification, considering research evidence and own practice experience all take place within a supportive supervisory space. If the supervisee is still overwhelmed by their own experiences because they have not been contained or reciprocal in the session they are unlikely to be able to hear the conversations on the appropriate level. In fact they are more likely to be still focusing on their own experiences.

**Plans/Action** – The final element of an effective safeguarding session would be to agree what plans and actions need to be taken. Whilst a professional who is not in a good enough mode can agree and sign up to these they are not likely to contribute to a shared understanding of what needs to be done and are more likely to feel that the session has been done unto them rather than being an active participant in the process.

## USE OF AN INTEGRATED APPROACH

The use of the integrated restorative model (Figure 1) has begun with a series of pilots conducted by the authors who will be evaluating the training and use of the model and its impact on:

- Capacity of supervisor and supervisee to contain emotive nature of the work
- Capacity of the supervisor to explore complexity
- Multi-agency working  discussions within the sessions
- Supervisor and Supervisee ability to explore assumptions
- Outcomes for children

## CALL FOR EXPLICIT USE OF SUPERVISORY MODELS

Given the difficult nature of the work within safeguarding and the wider organizational and cultural context professionals find themselves operating in, it would be helpful for organisations to understand the benefits of being explicit about the purpose and content of supervision. The directive to engage in 'supervision' is ? insufficientwithout specifying the method of delivery of delivery being understood and aligned with expected outcomes. In seeking appropriate organisational assurance that the professionals are able to think and act appropriately learning from their previous experiences rather than being overwhelmed by them a restorative and reflective such as the integrated restorative model needs to be considered.

More explicit national guidance relating to the type of model used within safeguarding (especially given the dearth of evidence currently available) would be welcomed and embraced by professionals and safeguarding boards alike. This would also ensure that the space remains an effective one for both supervisor and supervisee.

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### Key points

- Safeguarding supervision needs to support professionals capacity to think and feel restored
- Effective safeguarding supervision combines critical reflective practice and thinking with a restorative approach
- Restorative approaches to supervision need to retain governance and accountability
- The new integrated restorative model of supervision ensures that the appropriate degree of restorative efforts are combined with a mature space to explore assumptions, complexity and impact of the work.
- Organisations need specific guidance around the type of supervision being adopted rather than an assumption that any form of supervision is beneficial.

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