

Recommendations for Clinical Supervision in the AOD Field

1. All AOD organisations/agencies should provide clinical supervision to their practitioners as routine practice, given the evidence from the mental health field that clinical supervision reduces staff burn-out, increases job satisfaction and promotes quality practice.
2. Clinical supervisors should receive training in the process (e.g. contracting frequency/timing, timeframe and review, handling grievances/disputes) and content (e.g. core topics, issues and competencies to be covered) of supervision, as evidence indicates that it increases the quality of supervision. It is widely acknowledged that clinical supervisors must be:
 - open and trusting
 - non-judgemental
 - affable
 - highly accessible
 - up-to-date in their knowledge of evidence-based interventions
 - have the ability to impart skills.
3. AOD organisations/agencies should incorporate policies and procedures for clinical supervision in their clinical guidelines, to ensure a shared understanding amongst all personnel as to the function, process and structure of supervision for staff.
4. A clear distinction should be made between clinical supervision and line management/supervision. Clinical supervision is focussed on developing the worker's clinical roles and performance. Line management/supervision, in contrast, is concerned with the evaluation and appraisal of all aspects of a worker's performance. Ideally, a clinical supervisor will not be the worker's line manager/supervisor, and for counselling staff there are advantages in having a clinical supervisor who is external to their agency and therefore independent of organisational processes and issues.
5. The exchange of information in supervision sessions follows the usual requirements for, and limits to, confidentiality that are observed in clinical practice. The supervisee must be informed as to the limits of confidentiality and the requirements of mandatory reporting at the outset of supervision.
6. Adequate time must be allocated to each supervision session to ensure all currently pressing issues for the clinician are addressed (less than one hour is unlikely to be sufficient). It is not possible to specify optimum frequency of supervision sessions as experienced clinicians are likely to require fewer sessions than the inexperienced, and workloads vary greatly. As a general guide, a full-time clinician is likely to require supervision at least monthly (given the challenging nature of alcohol and other drug work), and an inexperienced clinician will benefit from sessions at least fortnightly. Inexperienced clinicians will have a greater need for one-on-one individual supervision.
7. Clinical supervision should proceed according to a shared understanding (expressed in an informal contract) of the purpose, structure and mutual obligations of the organisation, the supervisee and the supervisor. Specific goals and tasks should be negotiated and outcomes monitored. Clinical supervision should be guided by principles of adult-learning, in which the supervisee determines the areas, tasks, and the pace at which their learning occurs (i.e. 'self-directed learning'). Learning should be active and coached within salient clinical contexts. Learning of specific clinical techniques via observation of clinical demonstrations (modelling) is effective, but care must be exercised that the supervisee does not attempt to mimic the supervisor's, or any other demonstrator's, style in its entirety at the expense of their natural style.
8. Many AOD workers may be apprehensive about clinical supervision when it is first introduced to their agency, fearing that their clinical competency may be challenged. Therefore, managers and supervisors must devote time and energy to providing a strong rationale for, and building belief in, clinical supervision.
9. Quality clinical supervision should:
 - a. Increase the supervisee's ability to reflect and critically analyse their clinical practice (occasional observation by the supervisor of the supervisee's practice will be helpful)
 - b. Develop the supervisee's knowledge of evidence-based 'best practice' in the AOD field and their understanding of theoretical perspectives
 - c. Develop skills in delivering interventions via modelling and skill rehearsal
 - d. Map further areas of professional development and career enhancement.
10. Professional boundaries in clinical supervision must be observed. Clinical supervision should never become therapy for the supervisee's personal issues. Whilst issues that impact on clinical performance can be identified and discussed, therapeutic remedies for those issues should occur elsewhere. Nor should the supervisee and supervisor develop or pursue a friendship or relationship beyond that which is appropriate within the supervision sessions.
11. When a poor 'match' between the supervisee and supervisor is hampering the supervisory process, both parties are at liberty, and should be advised, to terminate the arrangement. If clinician's have strong preferences for certain characteristics in supervisors (e.g. gender), then every attempt must be made to satisfy those preferences.
12. When one-on-one supervision cannot occur in person, other modes of delivery should be considered (e.g. electronically at a distance, group supervision).
13. Like many relationships, eventually a sense of diminishing returns may occur after a lengthy period of supervision. This should be openly acknowledged, and a new clinical supervisor sought that can further progress the supervisee's professional development.
14. Evaluation of the effectiveness of clinical supervision should occur within every agency, even if limited in scope. The process of evaluation should be determined when planning the supervision program.