Enhancing multidisciplinary responses through cross-reflective practice

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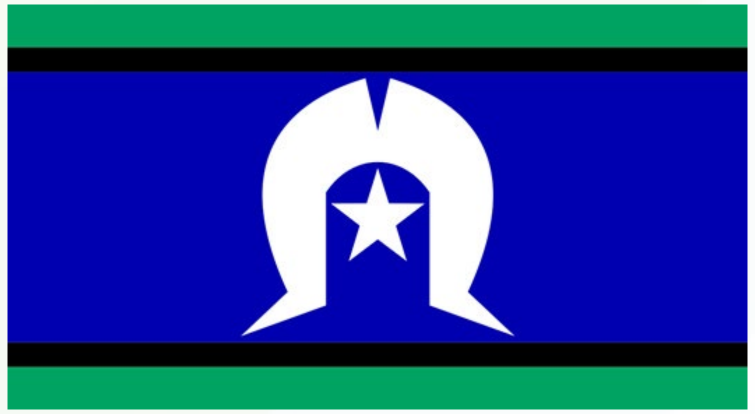
I’d like to begin by acknowledging the traditional owners of the land on which we meet today. I would also like to pay my respects to their elders past and present.



I’d also like to recognise people in our communities with a lived and living experience of substance use and other co-occurring conditions.

I recognise that each person’s journey is unique and valued.

I recognise their adverse experience of stigma, but also their strength and resilience.

Overview

- Supervision
- Pilot
- Recommendations

Why is supervision critical?

Professional and clinical supervision is an essential component of our continuing professional development.

The primary focus of good supervision is to provide a customised learning experience and environment for a clinician.

Lifelong learning is critical to our work. If we're doing the same things we were doing five years ago we are going backwards.

What is supervision?

Supervision is a collaborative process that focuses on the practitioner's learning from their experience and also aims to increase their competency.

Supervision has 3 components:

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The importance of supervision

Research shows supervision provides wide-ranging benefits for employees and workplaces, including:

- Improving quality of clinical care and reduced clinical errors.
- Enhanced skill development and engagement in reflective learning.
- Encouraging safe, reflective practice where we are more aware and sensitive to the clients needs.
- Increased professional confidence and job satisfaction.
- Employee retention.
- Development of one’s professional identity.
- Prevention of burnout, minimisation of compassion fatigue and vicarious traumatisation.

The reality of supervision when times are tight

Whilst we are aware that clinical supervision focuses on the quality of an individual's clinical practice whilst operational/line management supervision focuses on performance against role appraisal and PDP processes, the reality is that due to organisational demands, tight funding and competing needs, the line manager becomes by default the clinical supervisor of a team.

The risks of a blended approach

Blurred roles

Low openness to share due to performance concerns

Can carry a high organisational agenda and highly driven by supervisor

Can feel very tick box, more like a caseload review

Low self-reflection, little focus on skills, more aligned with organisational protocols

Background to the pilot

BHN participated in an integrated systems of care pilot with other community health organisations that addressed ways AOD and other co-occurring issues can be embedded in clinical governance and practice.

Staff and managers completed some questionnaires to evaluate the current status of the program and because of this, an action plan was completed.

As part of the plan, it was identified that the AOD and Generalist counselling teams have similar clients and capacity building needs. As such, a pilot was initiated between both teams.

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The pilot

Each team met once a month for Reflective Practice. This was led by a staff member rostered who had support of a rostered Coordinator.

Coordinators were rostered every second month with their team, the alternate month they were rostered with the other team.

Each coordinator reached out prior reflective practice to prepare with that staff member. This allowed the opportunity to discuss a theme, client presentation, etc.

A review was conducted at the end of the year to review aspects of the space.

Evaluating the pilot

At the end of the 12 month pilot, each team was provided an anonymous form to evaluate the pilot:

- 14 participants (7 members per team)
- Areas evaluated:
    - Group safety.
    - Relevance and applicability to daily practice.
    - Perceived input/benefit of having a different manager in reflective practice.
    - Further areas for development.

Results

- It's been beneficial to have different insights and perspective. Both coordinators have a wealth of different experiences which compliment each other.
- There have been new perspectives and approaches, exploring questions.
- I have appreciated a different perspective in our client cohort.
- Different perspective, freedom to engage with someone from another team, more open.
- I have been able to share and become more vulnerable in the space

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Where to from here?

- Teams have kept their reflective practice and have opted for an interdisciplinary bimonthly reflective practice for 2025.
- As part of integration with other teams, smaller teams have been added.
- Teams have agreed to do more theme-based discussions as they considered it brought more benefit to their practice.
- Some focus on skills/capacity building component (e.g. incorporating a family violence lens between AOD and MH)
- This approach has sparked interest in other teams and there have been new arrangements between some programs (e.g. Child, youth and family and NDIS paediatrics)

How do we address expectation vs reality?

Whilst we are aware that separating clinical supervision vs line management supervision is best clinical practice, this is not always possible.

Some small but practical considerations:

- Creating peer led supervision spaces
- Separating clinical supervision and operational reviews
- Interdisciplinary review meetings of shared clients
- Co-occurring capacity building
- Sourcing out internal/external facilitation options
- Co-case management of clients where appropriate